Public Board of Directors

Schedule	Thursday 7 March 2024, 10:00 — 13:00 GMT
Venue	Rooms 3 & 4, Acre Mills Outpatients
Organiser	Amber Fox

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Date: Thursday 2 May 2024
Time: 10:00 am
Venue: Rooms 3 & 4, Acre Mills Outpatients
To Note - Presented by Helen Hirst

1. Welcome and Introductions:

Invited Public Governors:

Kate Wileman

Christine Mills

To Note

Presented by Helen Hirst

2. Apologies for absence:

To Note

Presented by Helen Hirst

3. Declaration of Interests

To Receive

4. Minutes of the previous meeting held on 11 January 2024

To Approve

Presented by Helen Hirst

Draft Minutes of the Public Board Meeting held on Thursday 11 January 2024 at 10.15 am, Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

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

IN ATTENDANCE

Rob Birkett	Chief Digital and Information Officer
Anna Basford	Deputy Chief Executive/Director of Transformation and Partnerships
Victoria Pickles	Director of Corporate Affairs
Jonathan Hammond	Chief Operating Officer
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd.
Andrea McCourt	Company Secretary
Louise Croxall	Chief Nurse Information Officer **(item 08/24)**
Wendy Kilner	Lead Nurse, Neonatal Unit **(item 08/24)**
Andrea Gillespie	Freedom to Speak Up Guardian **(item 20/24)**
Rachel Westbourne	Public Health Lead **(item 10/24)**
Sarah Rothery	General Manager, Resilience, Acute Flow and Transformation
Amber Fox	Corporate Governance Manager (minutes)

OBSERVERS

Brian Moore	Public Elected Governor
Gina Choy	Public Elected Governor
Krish Pilicudale	Insight Development Programme
Arley Byrne	Senior Clinical Educator for Allied Healthcare Professionals (Shadow Board)
Laura Douglas	Deputy Director of Midwifery (Shadow Board)
James Houston	Consultant Paediatrician (Shadow Board)
Alexandra Keaskin	Matron, Patient Expérience

01/24 Welcome and Introductions

The Chair welcomed everyone to the Board meeting held in public, in particular the presenters Louise Croxall, Wendy Kilner, Andrea Gillespie, Rachel Westbourne and invited governors, Brian Moore and Gina Choy as observers to the meeting.

The Chair explained the Shadow Board was now part of the governance arrangements and Arley Byrne, Laura Douglas and James Houston were in attendance from the Shadow Board to observe.

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

02/24 Apologies for absence

No apologies were received.

03/24 Declarations of Interest

The Board were reminded by the Chair to declare interests at any point in the agenda.

04/24 Minutes of the previous meeting held on 2 November 2023

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

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 2 November 2023 as a correct record.

05/24 Matters Arising and Action Log

The action log was reviewed and updated accordingly.

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

06/24 Chair's Report

The Chair's report was received which details the actions and activity of the Chair since November 2023.

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

07/24 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.

This was a positive report which formally acknowledged how much CHFT staff had achieved consistently throughout 2023 despite the increasing complexity and demand throughout the hospitals and community services, with the added challenges due to the industrial action that had been ongoing for almost a year.

KH echoed the Chief Executive's congratulations to staff given the challenges and queried the next steps from the BMA with regards to the Consultant and junior doctor ballots. The Director of Workforce and OD provided an update on the position for the different staffing groups: the result of the referendum on the pay offer the BMA put to Consultants is expected on 23 January 2024, there will be a pay offer put forward from the BMA Specialty and Specialist (SAS) Doctors Committee to a referendum and the position is unknown for junior doctors. The Director of Workforce and OD added that divisional colleagues have managed relationships amazingly. She noted the potential for further action by other professional groups and for more localised pay negotiations, for example re: healthcare assistants (HCAs) following the Trust's response to a pay issue raised by Unisons for HCAs in the Emergency Department (ED).

The Medical Director explained junior doctors have a mandate to call a strike until the end of February 2024 with two weeks notice and are committed to go out for a further six month ballot if they do not receive a positive response from the Government.

The Chief Executive and Chair congratulated and thanked all staff on behalf of the Board for how they responded during this challenging time.

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

08/24 Digital Story - Neonatal Intensive Care Unit and Badgernet EPR

The Chief Digital and Information Officer introduced Louise Croxall and Wendy Kilner who were in attendance to share a digital story explaining how they optimised digital systems and electronic patient record (EPR) to reduce risk and make improvements to outcomes and patient safety in neo-natal care.

Wendy Kilner, Lead Nurse for the Neonatal Unit, shared how they implemented Badgernet as a full paperlight patient record solution to align with the Trust's Digital Strategy on the Neonatal Unit. The key highlights were:

- Several suppliers were considered, and Go See visits completed, Badgernet met the needs of the department, Trust, neonatal patients, and carers
- Staff training commenced May 2023 for the full clinical team
- Go Live date of 14th July 2023 which was not impacted by the doctors' industrial action that took place
- Benefits of Badgernet include:
    - Full paperless care record solution and patient history available for all neonatal units involved in the care and treatment of babies
    - Documentation and patient history legible and in date order
    - Family friendly (parents access to baby diary / photos and clinical updates)
    - Data local and nationally easily accessible, record is transferrable between all 99% of neonatal units in the country
- Phase 2 – Includes interfacing with pathology to view results in Badgernet, reducing the change of transcribing errors and it was hoped to go live with phase 2 by the end of October 2024.

Louise Croxall added when this project first started, the neonatal team approached the digital team as they wanted to move away from paper records. She stated it was the engagement and energy from the medical and nursing team in the department that made the implementation a success as they were the ones who had driven it. Louise explained a solution had to fit with their high standards of care. Staff in the neonatal team were keen to be part of the project. She explained this was one of a few digital projects that ran to time and delivered on time, which was a credit to staff on the neonatal unit.

The Director of Corporate Affairs asked what communication and engagement took place with parents. Wendy responded that the team were already asking parents if they would like to sign up to baby diary and explaining the benefits and parents were on board. Wendy explained the team always keep a diary to capture these moments, including for babies adopted or fostered. Wendy acknowledged they could use Badgernet to involve patients more and the team will be reviewing the feedback from patients and the friends and family test (FFT) survey.

The Chief Nurse explained that as part of some assurance reviews across West Yorkshire she had been in an organisation which has phase 2 of Badgernet which will bring greater governance in this area.

The Chief Executive stated Wendy has led this incredibly well and asked how this works for non-English speaking families. Wendy responded the team translate any messages on baby diary and parents are able to view photos that are shared. The Chief Executive highlighted the impact of the Countess of Chester events on neonatal units leading to national scrutiny of neonatal services. Wendy responded Badgernet currently can provide some useful data that could help identify any care issues and the system is continually developing.

DS highlighted the enthusiasm and energy from the team and asked what the next steps were. Wendy responded phase two is the next step which will pull more data across from equipment in ICU, such as ventilators and improve patient care as it allows nurses to spend more time with babies and families.

Krish Pilicudale highlighted the efficiencies generated by integrating with other systems and asked if these efficiencies are captured to share as a story. Wendy responded there are efficiencies in the handover for the nursing and medical team and Louise added there has been an improvement of quality looking at different metrics, for example, releasing time for staff to care.

The Chief Operating Officer asked if the neonatal team receive fewer 'phone calls from anxious patients and asked if there is an opportunity to expand something like this further in the Trust to

share messages and updates on patients in hospital with family members. Wendy responded it has improved the culture and it felt like there were fewer 'phone calls each morning.

James Houston thanked the Board for supporting this incredibly powerful tool for sharing information and highlighted the clinical benefits that will come from this.

The Chair stated this provided a level of confidence around safety and there were two areas for the team to consider further from the feedback:

1. Engagement with patients in the development of the system
2. Development work for patients where English is not their first language.

The Chair thanked Wendy Kilner and Louise Croxall for attending the Board to share their story.

OUTCOME: The Board **NOTED** the Badgernet Digital Story from the Neonatal Intensive Care Unit.

09/24 **Digital Health Strategy and Update**

The Chief Digital and Information Officer presented the third annual review of the 5 year Digital Strategy approved by the Board of Directors in July 2020. The key updates were:

- First nationally to have an Electronic Controlled Drug Register (eCDR)
- Same Day Emergency Care – first nationally to have developed this module in EPR
- Robotic process automation (RPA) – now into its second year, working on several large, automated processes on a routine basis which are listed below:
    - Referrals eRS (e-referral service) into EPR
    - Radiology scan acceptance
    - Radiology plain film booking
    - Outpatient procedure coding
    - Waiting list validation - future outpatient appointments
- Cerner EPR contract was extended last year and now runs to 2030 to support longer term developments.
- Third cohort of digital nurses this autumn

The Chief Digital and Information Officer gave an assurance that governance of digital health services was effective and gave examples of partnership working.

PW highlighted the brilliant progress and asked if the upcoming patient portal will improve communication and engagement with patients in terms of letters, results and appointments. The Chief Digital and Information Officer responded that there is an opportunity to improve this and engagement with patient groups is a key part of the plan. He explained the upcoming patient portal links to the national NHS application. The patient portal will link to several systems with the letter element of the portal focused on first, it is anticipated the project will take place over a few years.

Krish Pilicudale highlighted the impressive work and fantastic achievement where the complexities cannot be underestimated and asked how recruitment and retention is being managed. The Chief Digital and Information Officer responded it has been challenging to recruit and has been difficult to compete with private sector organisations; however, the Health Informatics Service has been good at attracting and growing our own staff. He explained lots of staff are re-trained to move into a new area, such as Information Governance staff moving into Cyber Security. The Director of Workforce and OD shared positive feedback that the Trust digital maturity attracted candidates to roles.

TB asked if there was an opportunity for technology to help with any key issues or risks such as length of stay, early discharge and A&E attendances. The Chief Digital and Information Officer

confirmed there was and explained this went well in 2023 and will be carried forward into 2024. The Chief Operating Officer added the IT teams are fantastic and responsive which helps with all improvement projects, and they have started to explore how artificial intelligence can help with demand models, particularly in ED to predict estimated discharge dates.

AN reminded the Board not to underestimate the kit involved in infrastructure and the funding required to continue investing and maintaining this. AN also highlighted the importance in having change leads in post for any reconfiguration projects.

The Deputy Chief Executive/Director of Transformation and Partnerships fedback that she had recently attended a Yorkshire and Humber Innovation Network which considered the role of digital which made it clear CHFT was significantly ahead of other organisations.

The Chair congratulated the Chief Digital and Information Officer and the team for all the positive work they have done digitally.

OUTCOME: The Board **NOTED** the good progress that has been made against the commitments laid out in the Trust 5-year Digital Strategy for 2023.

10/24 **Health Inequalities 12 month review**

The Deputy Chief Executive and Rachel Westbourne, Public Health Specialist Lead provided a 12 month review on health inequalities. The key updates were:

- new national requirements for reporting on health inequalities will be included in the Trust 2023/24 annual report
- CHFT was commended by the national team for presentation of health inequalities information to the Board and has made positive progress against the actions set out in the Trust's Health and Inequalities Strategy
- Feedback from the Health Inequality Group was that meetings were positive and productive, with opportunities to share learning, present projects, and establish new actions to address inequalities
- During Q3 of 2023-24, the action plan was updated to reflect work completed and achievements over the previous 12 months and new actions were added to reflect new work and priorities in the following year
- Continue delivery of the BLOSM service (including the Trauma Navigator pilot) in ED and compile and present service evaluation data. The BLOSM team are continuing to work with partners to secure recurrent funding for the service beyond 24/25.
- We have joined the Kirklees Tackling Poverty Partnership and the Calderdale Poverty Steering Group and are setting out our role as a place partner in addressing poverty as a health issue. Planning a Master Class later in 2024 on managing poverty.
- Targeted work to reduce DNAs, particularly amongst patients from the most deprived communities.

The updated plan on a page for health inequalities was shared. The plan highlighted additional areas of work, including the impact of poverty on the health of our local population and exploring our role as a PLACE partner. Targeted work to reduce DNAs for patients from the most deprived areas was noted, informed by a health inequalities matrix which triangulates data and predicts which patients are at most risk of coming to harm and facing inequalities.

Arley Byrne stated he was proud of this work and all the positive steps taken and asked what active approach was being taken to address DNA rates. He suggested student projects could help map the issues. He asked how this translates to clinical areas, e.g. digital literacy, so colleagues could become more aware of how to support those colleagues from deprived

backgrounds with their workforce digital skills development. The Chief Operating Officer welcomed the comments from the Shadow Board.

DS referred to the diverse and inclusive workforce action plan and root out racism programme and asked what evidence there was that the approach for root out racism is effective and successful in increasing awareness of racism. The Director of Workforce and OD responded that data is available and the Trust has taken on 350 people as part of the wider participation programme on health inequalities i.e. apprenticeships, with 89% of people from more deprived areas and 47% from BAME backgrounds.

Brian Moore stated DNA rates was a large problem in deprived areas and asked if we did any research to find out why patients do not attend. Rachel Westbourne responded an audit was undertaken with a sample of some patients with some learning from this, which has led to a focus on patient communication and letters. The Deputy Chief Executive added that data will be provided every three months to understand what we can do to support the most vulnerable patients i.e., offer transport, free parking.

Gina Choy, governor champion for equality, diversity and inclusion, shared her experience in the community and of developing relationships with Todmorden Council who were arranging winter wellness events looking at poverty. She also visited food banks to see the work that goes on which she found very humbling. Gina commented on the quality of the work resulting from the Health Inequalities Group and requested an invitation to attend a meeting.
Action: Rachel Westbourne to invite Gina Choy to a Health Inequalities Group meeting.

KH queried how the Trust was embedding health inequalities on a day to day basis, such as within policies. Rachel Westbourne explained an equality impact assessment (EQIA) is in place for any service change, and the EQIA form was being updated to include poverty and low income and broader inclusion groups, with more guidance provided on the impact for these groups.

The Board reflected on this report and the Chair commended the Public Health input to this work and response to the Director of Public Health report on poverty.

OUTCOME: The Board **NOTED** the 12 month update on Health Inequalities.

11/24 Workforce Committee Highlight Report

KH presented the Chair's highlight report from the Workforce Committee meeting of 18 December 2023. The key points to note were:

- Strategic theme was Health and Wellbeing and one culture of care
- Introduced financial planning and support now available to colleagues
- Revised IPR format - easier to see progress and identify where improvements needed
- Turnover has reduced in workforce and organisational development
- Quarterly deep dive into vacancies – challenges in nursing and medical still remain which is a national issue
- Nursing and Midwifery Safer Staffing Report was received providing assurance we are not out of line with the national picture and in some areas we are stronger
- Review using birth rate plus toolkit is to be commissioned
- Improvement of quality mark for national preceptorship framework
- A positive update from the nursing and midwifery AHP Steering Programme with comprehensive dashboard developed – it was noted how strong AHP recruitment had been with turnover decreasing to 4% from 13% - a real success story which is worthy of putting forward as a national case study

- Received annual report of the Trust's age profile which has not changed significantly with focus on areas with a more aging workforce to look at strategies to address this
- Presentation on the Retention Strategy to gain insight from other Trusts

Laura Douglas asked how the health and well-being offers translate to harder to reach staff groups i.e. night shift, weekend workers. She also asked how the Trust triangulate the benefits and learning from health and well-being to other areas, such as reducing turnover. KH responded the Commitee discussed triangulation and the benefit of hot house meetings which were helpful in hearing from colleagues. The Director of Workforce and OD confirmed triangulation will take place reviewing a number of metrics, including the staff survey and absence figures. The Director of Workforce and OD welcomed suggestions for how to reach weekend and night time workers and offered to share a response with Shadow Board members for their feedback.

Action: Director of Workforce and OD to share a response with Shadow Board members on how health and well-being support can translate to harder to reach staffing groups such as night shift and weekend workers for their feedback.

TB queried the reason for the pause in international nursing recruitment and the Chief Nurse responded that this was due to a reduced band 5 nurse vacancy position.

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

12/24 **Quality Committee Chair Highlight Report**

DS presented the Chair's highlight report from the Quality Committee meetings of 23 October and 20 November 2023 and KH presented the updates from the meeting held 19 December 2023. The key points to note were:

- Continue to provide scrutiny around patient safety issues i.e. response to the two NG tube never events - Internal audit provided a limited assurance recommendation and a re-audit will take place in Q4 to ensure that actions taken have made an improvement. Training is in place and has been enhanced. Daily reviews provided by matrons and clinical site matrons for all patients receiving NG feeds.
- Update on the Board Assurance Framework (BAF) risks overseen by Quality Committee were presented.
- 7 day services risk has been removed from the BAF – the standards are still in place and audits of progress against the standards will continue to be reported.
- Update from CQC Group – progress made on CQC roadmap and responded to new regulation framework from CQC.
- NHS adult inpatient survey 2022 benchmarking report was presented, an encouraging report with the Trust in the top 5 for four indicators in the region – key areas identified from the survey will be developed into action plan which the Patient Experience and Caring group will have oversight of – the link to this can be shared
- Good progress with NHS Health and Safety Workplace Standards. There is a focus on the personal safety of colleagues in terms of violence and aggression and security. A new policy with an escalation process is in place.
- Review of three neonatal deaths in November 2022 – conclusion was these were three different cases, areas were identified where practice could have been better and these have been addressed. It has been suggested an external audit now takes place.
- Legal services provided an update in terms of Martha's Rule which would give all patients the legal right to request a second opinion from a senior clinician in the same hospital if a patient is deteriorating rapidly.
- Review of Trusts Patient Safety Quality Boards with revised structure and the Committee asked for an updated diagram to understand these changes.

- Received the Safeguarding bi-annual report and noted the good progress.

  NB informed the Board an update on the limited assurance internal audit report on Naso Gastric tubes will take place at the Audit and Risk Committee at the end of January as an extra level of assurance.

  NB highlighted the issue around in neonatal cot capacity. The Chief Nurse explained there will be a partial external audit by another organisation and the new Director of Midwifery will take this forward. The Chief Executive added cot capacity was a national issue which was why babies are moved across the country to meet capacity needs.

  Arley Byrne suggested different types of clinicians are involved in Martha's rule, which guarantees a second opinion for patients who are deteriorating, so they have the skills to take this forward. The Chief Nurse confirmed to date this had been progressed with the critical care outreach and out of hours response teams which deal with acutely unwell patients, with these teams being developed into an acute response team which will respond to Martha's rule, with go live planned for April 2024, including engagement.

  Sarah Rothery offered assurance that the Violence and Aggression management policy was launched on 1 December 2023 and was being promoted in the Trust. Sarah and Alex Keaskin visited every ward and provided them with resources from within the policy to display. Sarah and Andrea Dauris visited all the wards at Calderdale Royal Hospital during December to explain the principles within the policy and how to use it. The policy has landed well and is really positive. Stage one was to promote the policy and include it in the weekly bulletin and on CHFT live. The next step is for an interactive booklet to be provided.

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

13/24 Finance and Performance Committee Chair Highlight Report

AN presented the Finance and Performance Committee highlight report to the Board from the meetings held on 28 November 2023 and 2 January 2024. The key updates from the Committee were:

- Leading Trust for cancer performance with all targets being met and a positive news item on Sky News.
- No patients waiting over 65 weeks and just 27 patients waiting 52 weeks
- 40 week wait stretch target to reduce to 0 – behind trajectory for 40 week waiters due to issues in ENT and the impact of industrial action.
- Outpatient follow ups deep dive took place as the backlog has increased.
- Update from Peter Howson on The Health Informatics Service (THIS) Commercial Strategy – highlighting 50% of new business as a result of promotion work.
- Number of Appointment Slot Issues (ASIs) continues to be a concern with numbers continuing to rise. ENT is the main area for concern as it is for elective recovery. A task and finish group has agreed some actions, and the committee conducted a deep dive review of ENT and the proposed actions.
- Financial position improved at month 8.

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

14/24 Month 8 Financial Summary

The Director of Finance presented the financial position as reported at Month 8, the key points to note were:

- £2.4m away from the planned £20.80m deficit plan, the Integrated Care Board (ICB) are committed to work together to try bridge this gap collectively

- Cost of latest industrial action and activity – £2.09m (December industrial action affected 546 outpatient appointments, 52 elective appointments and the January industrial action affected 617 outpatient appointments and 50 elective appointments)
- £9m out of £14m capital programme spent with lots to spend in the last quarter.

OUTCOME: The Board **NOTED** the Month 8 Financial position for the Trust as at 30 November 2023.

15/24 Integrated Performance Report

The Chief Operating Officer presented the Integrated Performance Report for November 2023. The key points to note were:

- Feedback from NHS England's recent review of the IPR was received which was broadly positive and they rated the new report 5/5 with only 12 Trusts out of 210 rated 5/5. Feedback was incorporated in December on the narrative as the SPC language was technical at times and the colour coding metrics were updated. A further review will take place in six months time.
- ENT is a challenge with lots of focus on this and an action plan in place.
- 52 weeks - longer-term risk to the 52-week position is specifically from ENT ASIs and the non-ENT patients have treatment plans in place for the end of December 2023.
- Triaging out 18% of referrals – using consultant triage
- Impacts of the industrial action - RTT total waiting list under 4,000 off trajectory, day case and elective lost 68, these patients would have come off RTT and lost just under 5,000 new and follow ups.
- Pressure on urgent and emergency care during December.
- Daily discharge rate / transfer of care – 15 a day (currently above this)
- Cancer – lots of hard work behind this, recognition to teams involved and alterations made during industrial action, still met cancer performance targets despite this.

The Medical Director highlighted work that was taking place keeping patients safe during the period of industrial action.

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

16/24 High Level Risk Register

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

- All divisions are working to strengthen their risk management arrangements and described this as part of their governance presentations at the Quality Summit in October 2023
- Performance Review Meetings and Risk Group – triangulation
- Divisional processes have been strengthened relating to the management of high-level risks and the risk register is used in a much more active way.
- Transitioning from Datix to the new risk, incident and performance reporting system (Inphase) this year which will support a risk register that can be triangulated across several key indicators which includes safeguarding, Freedom To Speak Up concerns, incidents, and complaints. A project plan is currently being developed to support transition.

The Director of Corporate Affairs shared that an internal audit report on risk management was underway which will guide further strengthening of risk management processes.

AN highlighted it was positive to see improvements and mitigations were better aligned with the most recent updates provided. AN asked how the Trust make sure there is no duplication with other risk registers and the broader Board Assurance Framework (BAF) risks. The Director of Corporate Affairs confirmed this will be picked up with the new Programme Director for Reconfiguration to ensure there is no duplication between risk registers and the BAF. The Deputy

Chief Executive/Director of Transformation and Partnerships explained a sub-set of strategic risks will become live for the Trust risk register as they move into becoming operational risks during 2024 as reconfiguration progresses.

KH asked what the timescale was for the new Inphase reporting system. The Director of Corporate Affairs confirmed this will be a 12 month process. The Chief Nurse confirmed this process has started, with the first start up project meeting having taken place. The teams are keeping safe by using both Datix and Inphase systems during switch over.

NB highlighted the financial sustainability risk of not achieving the financial plan for the current year was reduced to 12 as agreed at the last Finance and Performance Committee which will be reflected in the next update.

DS thanked the Director of Corporate Affairs and the team for working on this more dynamic approach to risk management and noted the improved level of confidence in consistency of risk scoring across services.

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

17/24 **Safeguarding Adults and Children Bi-Annual Report**

The Chief Nurse presented the Safeguarding Adults and Children Bi-Annual Report. The key updates were:

- CHFT remain a good partner and the Trust is represented on both Kirklees and Calderdale Safeguarding Adults Boards/ Children's Partnership.
- Improvements to referrals with the local authority.
- Continue to monitor training compliance.
- Stories and case studies are included in the report to demonstrate safeguarding underpins one culture of care.

DS queried whether a reduction in training compliance was linked to a return to face to face training delivery. The Chief Nurse confirmed this was a factor as well as updated intercollegiate documents regarding role specific training at advanced levels. The Chief Nurse gave an assurance that the Safeguarding Committee has oversight of safeguarding training compliance and will continue to monitor this, including oversight of colleagues who need more advanced training. The Director of Corporate Affairs confirmed safeguarding training compliance had been reviewed, with a risk that compliance would drop for a period of time and training improvement trajectories were in place in key service areas.

The Chair commented the Badgernet implementation for babies and the BLOSM service in ED were clear evidence of supporting vulnerable people.

OUTCOME: The Board **NOTED** the key activity of the Safeguarding Team for the reporting period April 2023 - September 2023.

18/24 **Nursing and Midwifery Safer Staffing Hard Truths Bi-Annual Report**

The Chief Nurse presented the Bi-Annual Safer Staffing report which had been reviewed at both the Quality Committee and Workforce Committee.

The report now included Allied Health Professional (AHP) staffing capacity and compliance and the developing workforce models. The Chief Nurse highlighted that colleagues support in these services has contributed to a reduction in vacancies and turnover and AHPs continue to develop and grow.

Further work is taking place to improve the vacancy position and it was noted that colleagues under 25 years was the highest group of turnover amongst registered nurses. More focus and understanding on this will be provided in the next report.

AN highlighted the improved position and asked what the drivers were for the increase vacancy position forecast in 12 months. The Chief Nurse explained there were peaks and troughs and there was a deterioration in March 2023 with a high number of leavers and a big outtake in September which meant domestic recruitment was in an improved position and continues to look favourable.

OUTCOME: The Board **RECEIVED** and **NOTED** the ongoing plans to provide safe staffing levels within nursing, midwifery and AHP disciplines across the Trust, **NOTED** the ongoing recruitment plans to support each service, **NOTED** the maternity staffing position and the local position which is common with the national profile and **NOTED** the compliance against the triangulated approach that underpins the Trust's establishment processes and the ongoing quality of data it provides.

19/24 Fire Safety Annual Report

The Chief Operating Officer presented the Fire Safety Annual Report which was presented at Audit and Risk Committee in October 2023. The key points to note were:

- Workplan from last year will continue for the year ahead to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.
- Trainee Fire Officer is taking a course to become a qualified Fire Officer.
- Close links with the Fire Officer and the Trust's reconfiguration plans in place to improve compartmentation and further compartmentation surveys which will allow us to start a rolling annual programme of fire compartmentation and fire door replacement schemes working alongside operational colleagues to decant ward space.

KH highlighted the Workforce Committee were concerned about the level of essential fire safety training which has been monitored over a period of time and they are now assured the level of fire safety training has much improved.

AN asked how big the risk was of not being able to undertake fire compartmentation work because of operational pressures. The Chief Operating Officer responded the risk is at HRI rather than CRH, due to the age of the building and the speed of fire spread. This is being mitigated through fire training, including evacuation training.

The Chair asked for an update on the lifts at HRI. The Chief Operating Officer responded there is now one functioning fire lift at HRI and the team are reviewing the other lifts to ensure there is one lift in each area that is fire compliant.

OUTCOME: The Board **RECEIVED** and **NOTED** the Fire Safety Annual Report.

20/24 Emergency Planning Resilience (EPRR) Core Standards Compliance

The Chief Operating Officer introduced this item relating to Trust responsibilities as a category 1 responder under the Civil Contingencies Act (see presentation). He presented the revised process for the annual assessment of compliance against the NHS Core Standards for EPRR.

- In 2023 there have been significant changes to the core standards for EPRR assurance process in the North East and Yorkshire (NEY) region, with new timelines
- 62 indicators apply to acute trust with evidence required against each indicator
- Significant amount of evidence uploaded and initial self-assessment submitted by end of September 2023 which received a level of 'partial compliance' with an overall score of 85% – received comments back with 5 days to review
- 43 out of 62 indicators were challenged
- Within five working days, we submitted supplementary evidence for 24 of the 43 challenged standards, including the two standards challenged to non-compliant (red).
- Upon secondary review, NHS England (NHSE) Regional EPRR team accepted 8 of the 24 supplementary evidence submissions. The two red standards were also accepted and upgraded – one to amber and one to green
- Final confirm and challenge score was 31% (non-compliance)
- Trusts could either accept or not accept the position on their level of compliance, one organisation in the region decided not to accept their position
- CHFT accepted this position at 31% overall compliance
- Only one acute Trust was the highest at 32% compliance
- Command and Control framework has been drafted.
- An action plan has been developed and progress will be reported to the Board of Directors
- A 2 hour training session will be taking place at Executive Board in March 2024
- A multi-agency exercise will also take place with the fire service, Yorkshire Ambulance Service, police, Yorkshire Water and the Trust with command and control in place, other agencies have been through the same process.

Action: Sarah Rothery to be invited to the Board meetings in May and July to provide progress updates on the Action Plan.

OUTCOME: The Board **RECEIVED** and **NOTED** the outcome of the annual NHS Core Standards for EPRR assessment for Calderdale and Huddersfield NHS Foundation Trust and were assured that a comprehensive action plan is being implemented.

21/24 Freedom to Speak Up 6 Month Report and Qualitative Presentation

Andrea Gillespie, Freedom to Speak Up Guardian provided a response to the questions that were raised at the last Board meeting related to the Freedom to Speak Up (F2SU) process. The key points to note were:

- Colleague follow up and feedback - when a concern is closed on the portal an email is sent to the colleague who raised it, where there is an anonymous concern, it is not possible to provide feedback. An improved process and documentation is being developed for launch in April 2024, which includes clear objectives, such as checking on the colleague's wellbeing, to determine whether the colleague has experienced any form of detriment and whether actions taken have been effective/sustained.
- Expanding the F2SU ambassador network- currently there are 23 FTSU Ambassadors with 36% from ethnic minority groups. Two medical colleagues are ambassadors and two more clinical colleagues have expressed interest in being an ambassador.
- New guidance from the National Guardian's Office published in November 2023 sets out principles for the development and support of Freedom to Speak Up champion/ ambassador networks, with clear purpose and principles of the role, training, support, monitoring and ensure diversity amongst ambassadors as well as the introduction of reporting on what ambassadors are doing to promote the role.

DS asked if there are enough ambassadors from every network inclusion group. The Freedom to Speak Up Guardian confirmed they are approaching networks to see if there are any volunteers, and they now have a volunteer from the Race Equality Network group.

James Houston asked what good looks like and how do we show we are an organisation that speaks up. The Freedom to Speak Up Guardian responded that a high number of concerns can be seen as a negative; however, shows positively staff are comfortable raising concerns. There are different perspectives of what good looks like.

James asked if there is cross checking with other areas such as the staff survey to identify any themes. The Freedom to Speak Up Guardian confirmed they cross check with the staff survey; however, more could be done and additional resource with the guardian role can allow this to happen.

James asked if there is generalised learning available to share. The Freedom to Speak Up Guardian explained the difficulty in sharing learning as some concerns raised are personal and can be very specific e.g. a process that has not worked for someone. Information is shared with the department that is affected and a report is shared with the Workforce Committee looking at the process with an opportunity to look at any themes.

OUTCOME: The Board **NOTED** the contents of the report, the number of concerns raised in Q1 and Q2 2023 and the work of the FTSU Guardian and Ambassadors.

22/24 Update on reinforced autoclaved aerated concrete (RAAC) in leased premises

Stuart Sugarman had left the meeting at this time; therefore, TB provided an update.

TB confirmed a survey had taken place on all properties and there has been no evidence of RAAC with the exception of one property where the age of the building falls into this period and a follow up with the landlord is taking place to carry out an intrusive survey at Westgate.

OUTCOME: The Board **NOTED** the steps CHS have taken to ascertain the presence of RAAC in occupied properties and that to the best of our knowledge no properties leased by CHFT contain RAAC.

23/24 Governance Report

The Company Secretary presented the Governance report which contained:

a. **Updated Governance Structure**
   There have been changes to some of the subgroups and the structure has been updated to reflect these changes. A recent change was highlighted which is a national change to rename the Organ Donation Committee to Organ and Tissue Donation Committee.

b. **Senior Independent Non-Executive Director and Deputy Chair Arrangements**
   PW and DH left the meeting for this discussion.
   It is proposed that Peter Wilkinson is appointed as Deputy Chair and Denise Sterling is appointed as the Senior Independent Non-Executive Director, subject to ratification by the Council of Governors at its meeting on 25 January 2024, with effect from 28 February 2024.

c. **Board Development Plan 2024**
   The Board agreed the focus will be on system partnership working and transformation and innovation.

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

OUTCOME: The Board **NOTED** the updated governance structure, **APPROVED** the appointments to the Deputy Chair and Senior Independent Non-Executive Director with effect from 28 February 2024, **NOTED** the Board Development plan for 2024 and **APPROVED** the Board Workplan for 2024/25.

24/24 Items to receive and note
The following were provided for assurance:

- Finance and Performance Committee Minutes - 25.10.23, 28.11.23
- Quality Committee Minutes - 23.10.23, 20.11.23
- Workforce Committee Minutes - 17.10.23
- Partnership papers: Kirklees Health and Care Partnership and Calderdale Cares Partnership

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

25/24 Any Other Business
The Chair reminded colleagues it was Karen Heaton's last formal Board meeting and formally thanked Karen on behalf of the Board for being a tremendous Non-Executive Director.

26/24 Date and time of next meeting
The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 13.58 pm.

Date: Thursday 7 March 2024
Time: 10.00 am
Venue: Boardroom, Learning Centre, Huddersfield Royal Infirmary

5. Matters Arising and Action Log

To Note

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2024

Position as at: 28.02.24

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
11.01.24 12/24	**Quality Committee Chair Highlight Report** Director of Workforce and OD to share a response with Shadow Board members on how health and well-being support can translate to harder to reach staffing groups such as night shift and weekend workers for their feedback.	Director of Workforce and OD	Director of Workforce and OD to feedback and discuss support for harder to reach staffing groups at meeting 9 April 2024 with Shadow Board. Shadow Board members to be invited to Hot House on Health and Well Being later in the year.	7 March 2024		04.02.24
11.01.24 20/24	**Emergency Planning Resilience (EPRR) Core Standards Compliance** Sarah Rothery to be invited to the Board meetings in March and May to provide progress updates on the Action Plan. **To note:** EPRR Annual Report will be presented to the Board in May 2024 after Audit and Risk Committee in April 2024.	Sarah Rothery	Invites sent to Sarah Rothery to attend the Board meetings in March and May 2024. Action closed.	2 May 2024		28.02.24
11.01.24 10/24	**Health Inequalities 12 month review** Rachel Westbourne to invite Gina Choy to a Health Inequalities Group meeting.	Rachel Westbourne	Rachel has reached out to Gina Choy. Action closed.	7 March 2024		31.01.24
6.07.23 93/23	**Integrated Performance Report** Develop narrative summary report using non-SPC language and review within 3 months – Full review of IPR to be completed by end of November.	Chief Operating Officer	The Chief Operating Officer explained the narrative reflects the SPC charts and further adjustments will be made with some feedback provided to Peter Keogh. **Action complete. A further review will take place in 6 months' time.**	11 January 2024		11.01.24

6. Staff Story: Allied Health Professional Workforce Transformation

Presented by:
Jenny Clarke, Associate Director of Therapies
Arley Byrne, Senior AHP Clinical Educator
Jessica Loxam, Occupational Therapy Clinical Educator
Dave Nuttall, Community Therapy Team Leader

To Note

7. Chair’s Report including Charitable Funds Committee Chair's Highlight Report

To Note

Presented by Helen Hirst

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 March 2024
Meeting:	Board of Directors
Title:	Chair's Update
Author:	Helen Hirst, Chair
Sponsoring Director:	N/A
Previous Forums:	None
Purpose of the Report	To update the Board on the actions and activity of the Chair.
Key Points to Note	The enclosed report details information on key issues and activities the Trust Chair has been involved in over the past two months within the Trust, with local system partners and regional and national work.
EQIA – Equality Impact Assessment	The attached paper is for information only and does not disadvantage individuals or groups negatively.
Recommendation	The Board is asked to **NOTE** the report of the Chair.

Chair's Report to the Board

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

1. **Trust activities**

Council of Governors

Along with its usual business, the Council of Governors in January received two interesting presentations one on quality and length of stay from Renee Comerford which gave governors great insight into why reducing length of stay is important for quality of care and patient experience. The second accompanied the discussion on quality priorities where Catherine Briggs updated on care of the acutely ill patient.

The Council of Governors and Non-Executive Directors held an informal workshop in February. The main purpose was to engage governors in the refresh of the strategic plan for 2024/25. There was also a discussion about future development time and how to improve attendance at Council of Governors meetings. The conclusion of the discussion was to hold two joint Board and Council of Governors development sessions each year and one for Governors only and to seek maximum attendance at fewer sessions. For the Council of Governors, a hybrid option would be used this year to enable online attendance. This will be kept under review.

I enjoyed meeting the two new associate youth governors and it will be interesting to see what we can learn from this new development in terms of engagement of younger people and hearing their perspectives on the care we deliver.

Board business

Recruitment of Board members has been a feature of the start of this year with two new non-executives recruited to replace Karen Heaton who finished her term with us on 28 February and Andy Nelson who is with us until April. We should be able to announce their names once all fit and proper persons processes have been completed. We have also started the recruitment for a new medical director to replace David Birkenhead when he retires later in the year. It is always a pleasure to talk to interested applicants and hear their motivation for wanting to join the Trust which nearly always includes something about One Culture of Care.

The Board held the first of its 2024 development sessions with a focus on our partnerships. Colleagues from Kirklees, Calderdale and West Yorkshire joined us to

consider the potential opportunities and challenges. Our next Board development session in April will be a reflection on what we heard and how we need to respond strategically as a Trust to the partnership operating environment.

I try and drop into all our Board Committees at some point during the year and this month I have been to workforce and finance and performance. Both report to this board but I did want to give a shout out to the teams who presented at the workforce committee about a wide range of improvement activity. It was really uplifting to hear about the progress, what's gone well and the challenges including our QI approach - working together to get results, critical event support, headlines from the staff survey, recruitment, apprentices and medical staffing.

Other

This last month I chaired the Organ and Tissue Donation Group and the Charitable Funds Committee. A report on the latter is appended to this report. In the Organ and Tissue Donation Group we discussed our activity and performance along with the campaigns planned over the coming months. In the first six months of the year the Trust had 5 consenting donors, facilitated 3 donations impacting on 7 people receiving a transplant. In addition, four corneas were received from the Trust via the eye bank. We benchmark in line with national averages for referral of potential donors and exceptional for specialist nurse presence.

2. Health and Care System

West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common met at the end of January where the strategic focus for the meeting was Workforce. We approved the final draft of the WYAAT strategy which will now go to each member board for sign off. We discussed the challenging financial situation and how WYAAT works together to share good practice.

The West Yorkshire Community Provider collaborative also met in January and along with a presentation from Yorkshire Ambulance Service about their 5-year strategy discussed how to better support left shift. The area of shared best practice presented came from Bradford Pro-active Care Team.

Yorkshire and Humber Chairs meeting this quarter included speakers from NHS Providers, NHSE Board and the North East and Yorkshire Regional Director. It was an excellent session sharing useful intelligence from national bodies about workforce, financial situation and board governance.

West Yorkshire Chairs and Leaders exchange this time discussed the vision for mental health, learning disabilities and autism for children and young people along with the usual exchange of what places were doing across the partnership.

West Yorkshire Partnership hosted a visit from the NHS England Chair Richard Meddings. He spent time in Leeds and Kirklees including a visit to our new A&E. I

attended dinner with him where we discussed amongst other things the demands on the NHS along with the financial challenges.

National/other

I attended a national meeting of ICB and Trust Chairs in London last week. This was hosted by the Board of NHS England, most of whom were present and a number of them spoke about issues ranging from transformation, patient safety, financial climate, performance priorities and workforce.

My role of interim Chair at Bradford Teaching Hospital NHSFT is coming to an end. The new Chair, Sarah Jones, former chair of Sheffield Children's Hospital NHSFT, will take up her appointment on 4 March 2024.

Helen Hirst
Chair
28 February 2024

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Charitable Funds Committee
Committee Chair:	Helen Hirst
Date of meeting:	6 February 2024
Date of Board meeting this report is to be presented:	7 March 2024
ACKNOWLEDGE	The Committee received a thorough report from the Charity Manager about the progress of the strategy and the different fundraising initiatives including £35k for orthopaedic outpatients, £15k to enhance in patient experience for patients within child and adolescent mental health services and £2k for dementia support in A&E at Calderdale. The Committee heard about the Childrens' Diabetic Nursing Fund, fundraising methods and areas of spend.
ASSURE	The Committee considered funding request processes and the expectations of the Committee to ensure evidence of impact was included in the decision making. The Committee discussed and invited further consideration of the bidding process ensuring this went beyond 'first come first served'. The Committee continues to review former approvals that have not been fully utilised. The Committee agreed to ensure that where posts are funded that an exit plan is in place.
AWARE	The Charity is going to develop a different finance and activity report going forward working to an agreed budget. The Committee is expecting to receive the outputs from the review of the charity from the company called Gifted Philanthropy. The League of Friends at CRH are working with the Charity to transfer their charitable funds subject to appropriate governance and approvals with regard to draw down. The Trust is considering future arrangements for the annual audit of the charity's annual report and accounts.

8. Chief Executive’s Report

To Note

Presented by Brendan Brown

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 March 2024
Meeting:	Public Meeting of the Trust Board
Title of report:	Chief Executive's Report
Author:	Victoria Pickles, Director of Corporate Affairs
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None
Purpose of the Report	This report provides a focused update on the Trust's response to specific elements of its service delivery and the evolving health and care landscape.
Key Points to Note	• We continue to perform well against an international backdrop of conflict and national political uncertainty. • Achievement of the emergency care standard is a key area of NHS focus during March, and we are holding a 'perfect week' to deliver safe, effective patient flow and patient experience. • The National Staff Survey 2023 results will be published the day we meet as a Board. Early indications of the Trust's results show a consistent and positive improvement in our scores. • This is in the context of continuing national strike and industrial action by NHS staff. • The financial planning guidance for 2024/25 has not yet been received. We know that it will be a challenging year with a significant cost improvement ask and a need to make difficult decisions about how we make best use of our funding.
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
1 March 2023

1. Introduction

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

1.2. We have arrived in March, the start of the meteorological spring. We haven't quite reached the end of the NHS Winter however, as attendances continue to be high at both of our emergency departments, and the Trust continues to see a high number of patient admissions with respiratory illness, particularly flu.

1.3. There continues to be conflict abroad which, as we have seen in the local by-elections, resonates locally and impacts on both our colleagues and our patients. We are about to see the start of the pre-election period ahead of the local elections in May, and it is likely to be a period of significant political uncertainty leading to the General Election later in the year. NHS Providers, on behalf of provider organisations across the country, has set out the commitments it would like to work with in the next government to ensure:

- A responsive and effective NHS, meeting the current and future health needs of patients and communities.
- An NHS that continuously improves and whose people are proud and excited to work there.
- An NHS that is a key player in driving a healthy and productive society

A copy of the full briefing is attached at Appendix 1.

1.4. The NHS Confederation has equally published the results of their work with NHS organisations and the proposed manifesto for a new government:

- Put the NHS on a more sustainable footing, with no top-down structural reform in England for the next parliament.
- Increase NHS capital spending across the UK and reform how the capital regime operates.
- Commit to fund and deliver the NHS Long Term Workforce Plan for England, alongside an equivalent plan for social care.
- Provide more care closer to home by enabling local health systems to proportionately increase investment upstream into primary care and community-based services, mental health, and social care.
- Deliver a strategy for national health.

1.5. Both have similarities and colleagues will recognise these asks from the discussions we have had as a Board about our expectations for the future.

1.6. The current national uncertainty is also reflected in the fact that, at the time of writing this report we have not yet received the planning guidance for 24/25 and we would usually be approving our response to this guidance and our plan for the year at this Board meeting. We do know that the year ahead will be a significant challenge both financially and in

meeting the expected emergency care performance standard and elective recovery targets.

1.7. Throughout the context we are currently operating in, it is important that we remain committed to our ethos of One Culture of Care. Looking after our colleagues and each other, in the same way we look after our patients and their families is key to us continuing to perform well and provide high quality compassionate care. We recently had a refresh of our One Culture of Care branding, using this as an opportunity to remind colleagues what it means and why it is important. The early view of our staff survey results would indicate that this approach works and, while there is always more we can do, is having an impact on our colleagues experience of working for Calderdale and Huddersfield NHS Foundation Trust.

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

2.1. Colleagues will see from the attached Integrated Performance Report that we continue to perform well across most areas of the Trust. There is a significant focus from NHS England on achievement of the emergency care standard (ECS) by the end of March of 76% of patients being seen within four hours. This has been a challenge for us, and when we meet as a Board we will be on day four of our 'Perfect Emergency Department Week'. The aim of the 'perfect week' is to create the conditions whereby patient flow through the emergency department operates smoothly, efficiently, and effectively, with optimal patient care, staff satisfaction, and operational performance against the 4-hour ECS. All areas of the Trust have been involved in planning for the week. There will be a sit-rep at each site management meeting and system partners are being invited to these. An update on how the week has progressed will be given at the meeting.

2.2. Our Gynaecology Cancer Team at CHFT are the now the top performing trust in North East and Yorkshire for the 62-day combined performance and cancer waiting time target. This means that 100% of our patients are diagnosed and start treatment within 62 days of a referral. This is despite the challenges of 37% more cancer referrals since 2019. Across West Yorkshire and Harrogate, CHFT is the only trust to meet all gynaecological cancer waiting times targets:

2.3. Our Trust continues to receive external scrutiny from a variety of sectors. Over the last month we have had a review of paediatric surgery by NHS England Yorkshire and the Humber who gave extremely positive feedback about our services; and a Joint Advisory Group Accreditation visit for endoscopy. We have also received an initial visit to our pathology services by the United Kingdom Accreditation Service ahead of their full medical laboratory inspection in March. In March we will also have a review of our paediatric oncology and paediatric audiology services by NHS England.

2.4. Last month we also welcomed Richard Meddings, Chair of NHS England to look at our new accident and emergency department at Huddersfield. Richard talked to Mark Davies, Clinical Lead for reconfiguration and Tom Ladlow, Head of Nursing for Medicine about the plans for how we will improve patient flow using more Same Day Emergency Care for core conditions, direct access arrangements and a centralised triage arrangement in the new department.

2.5. Colleagues may have seen in the news that 'Martha's Rule' will be rolled out to at least 100 sites across the NHS from April. Once fully implemented, patients, families, carers, and staff will have round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition. Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury. Martha's family's concerns about her deteriorating condition were not responded to promptly, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier. We are expecting the criteria to understand what would be required to be one of the 100 pilot sites to be released by NHS England imminently. It is likely that this will include:

- All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, which they can contact should they have concerns about a patient.
- All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital and more widely if they are worried about the patient's condition.
- The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

2.6. In April we will be introducing our new Acute Response Team, bringing together the Hospital Out of Hours Team and the Critical Care Outreach Team into a standardised, consolidated service, 24/7 across both hospital sites. This will be part of our response to implementing Martha's Rule within CHFT.

2.7. You will be aware that an Independent Inquiry was established in November 2021 at the request of the Secretary of State for Health and Social Care to investigate how David Fuller was able to carry out inappropriate and unlawful actions in the mortuaries at Maidstone and Tunbridge Wells NHS Trust and why they went apparently unnoticed. The first phase of the Inquiry, on matters relating to Maidstone and Tunbridge Wells NHS Trust, concluded in November 2023 with the publication of the Phase 1 Report. Phase 2 of the Inquiry will look at the broader national picture and consider if procedures and practices in other hospital and non-hospital settings, where deceased people are kept, safeguarding the security and dignity of the deceased. As the next step in its investigations, the Fuller Inquiry will be conducting a short survey of Trusts via a questionnaire.

2.8. A similar approach is being taken in the Thirwall Inquiry, set up to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital. Following initial submissions by the Trust based on a series of questions and requests for documents, a questionnaire is being issued to maternity and neonatal staff to complete. We will of course keep Board members appraised of these two inquiries as they progress.

2.9. Other recent national policy announcements include new ministerial powers to intervene in service reconfiguration and changes to the powers of scrutiny committees in service change. This will not have a bearing on our reconfiguration plans. A link to the summary is here.

2.10. We have also recently received the Annual Report Manual for the 2023/24 Annual Report and Accounts process. This year the Report must include more detail on both climate change activities and health inequalities.

2.11. Both additional areas of focus are priorities in our Strategic Plan. An update on our progress against the 2023/24 priorities and the proposed plan for 2024/25 are included on the agenda for this meeting. Board colleagues will note the good progress we have made against all key areas for this year.

3. Transforming services and population outcomes

3.1. As we await the confirmation of the finalised funding for the second stage of reconfiguration on the Calderdale site, we are progressing work in preparation. We will start to take delivery of the modular sections of the new learning and development centre in April so that construction can start in earnest, and we expect this build to be completed in early Autumn 2024. Some of the existing services in Calderdale Royal Hospital (CRH) will be moved to enable changes to be made to the front entrance. Some of these services are moving within the site and there may need to be moves to some services across other sites in community or to HRI. Public information and engagement plans are being developed for any proposed changes.

3.2. Next week we will start conversations with colleagues across the Trust about the start date for the build of our new 800 space multi-storey car park on the CRH site and the likely impact on parking for colleagues and the public for the duration of the build. The team are currently finalising options for the mitigations including park and ride facilities. This helpfully coincides with the introduction by West Yorkshire Combined Authority of the bus service between CRH and HRI. This new service runs every 15-minutes during the day and there are additional early and late journeys.

3.3. In April our Chief Digital and Information Officer (CDIO), Rob Birkett, will expand his role, taking up a joint role as CDIO for both CHFT and Mid Yorkshire Teaching NHS Trust, for an initial of twelve months. This is a new approach for both trusts, but it will no doubt provide huge opportunities to share joint learning as Mid Yorkshire progress their new EPR journey.

3.4. Work is currently underway to refresh our clinical strategy. The Strategy describes our clinical priorities for the next five years, and will support other CHFT strategies and priorities, such as reconfiguration, workforce, digital, and estates. This refresh will look at what colleagues feel is important to them, our patients, and the wider organisation, to take us forward for the next five years. We will seek to understand the aspirations of our clinical specialties. We are engaging widely on the content and considering the themes of

- Patient Centred Care
- Reducing Health Inequalities
- Digitally Enabled
- Eliminating Unwarranted Variation – Getting it Right First Time
- Research and Development
- Care Closer to Home
- Service Reconfiguration
- Regional Network
- One Culture of Care – workforce, training, recruitment retention

4. Inclusive workforce and local employment

4.1. As we meet on the 7 March, the National Staff Survey Results will be published. We have seen an early embargoed set of results for the Trust. These show a positive response across all themes. Our engagement score has increased by 0.2 points from 6.8 to 7 and Morale score increased by 0.3 points from 5.7 to 6. Most National People Promise categories also received an increase, with 'we work flexibly' receiving the biggest increase of 3 points:

	2023	2022	2021
We are compassionate and inclusive	7.4 (+0.1)	7.3 (=)	7.2
We are recognised and rewarded	6.0 (+0.2)	5.8 (+0.1)	5.7
We each have a voice that counts	6.8 (=)	6.8 (=)	6.7
We are safe and healthy	6.1 (+0.2)	5.9 (+0.1)	5.8
We are always learning	5.6 (+0.2)	5.4 (+0.3)	5.1
We work flexibly	6.2 (+0.3)	5.9 (+0.1)	5.8
We are a team	6.7 (+0.1)	6.6 (+0.1)	6.5

4.2. The full published results will show CHFT's scores benchmarked against other similar organisations. A high impact actions plan is being developed, alongside specific actions to support individual areas and these will be discussed at the workforce committee in April.

4.3. These staff survey results are particularly notable during a year when we have seen the longest period of industrial action within the NHS. The most recent junior doctors strike took place from Saturday 24 – Wednesday 28 February and I would like to take the opportunity to thank all colleagues who prepared for and covered shifts during this and the previous strikes. We have seen an impact on our elective and outpatient activity, and we closely monitor the quality and safety impacts of any industrial action, while continuing to fully respect the right of colleagues to exert their right to strike.

4.4. It is likely, particularly given the current political climate, that we will continue to see industrial action whether that be in the form of strikes or other trade union activity. Most recently, the BMA has rejected a pay offer for specialist, associate specialist, and specialty (SAS) doctors in England following a majority no vote in a membership referendum.

4.5. Board members will be aware that there has been coverage surrounding the role of physicians associates (PAs) in the national media. PAs are not a new role and have been in the NHS for around 20 years. PAs form a valued part of the workforce and, with appropriate supervision, free up junior doctors and consultants time to focus on complex clinical duties and decisions around patient care. Last week, the House of Lords approved the Anaesthesia Associates & Physician Associates Order 2024, and it can progress to become law. The passing of this legislation confirms that the General Medical Council (GMC) will regulate PAs. The GMC will progress towards the opening of a register for PAs by the end of the year and 'Physician Associate' will become a regulated title. Regulation is important for both patients, and the PA profession. As well as implementing a register, the GMC will set standards of practice for PAs. Regulation of the profession means that PAs may progress their skills more broadly in the future.

4.6. Our work supporting newly recruited internationally educated nurses, midwives, and Allied Health Professionals here at CHFT is paying dividends. We are one of only three trusts to have been allocated £3,000 in funding which will be used to help colleagues further advance their career with us. Our Stay, Thrive, Advance Yourself (STAY), supports internationally

educated colleagues (IEC) to feel valued as part of our workforce, reach their professional potential, and embrace our One Culture of Care philosophy. To help build a sense of belonging, our Clinical Education Team offers a wealth of support to IECs including:

- Pastoral Support. A recruitment specialist member of the team provides a seamless link between pre-employment communications and arrival in the UK.
- Buddy Scheme. Each IEC is introduced to a buddy who is an established CHFT colleague, previously recruited through the international programme. They provide additional Objective Structured Clinical Examination (OSCE) support and exam preparation where appropriate, and informal pastoral support.
- The team have also developed a booklet as a resource for both the Buddy and the IEN/IEC to provide information on the roles and responsibilities of each role. The induction programme includes information about the CHFT Race Equality Network, local town tours, and cultural food stores.

4.7. NHS England has published a new NHS leadership competency framework for board members in February. It is intended to support NHS organisations to recruit, appraise and develop board members. The framework applies to all board members of NHS provider organisations, integrated care boards (ICBs) and NHSE's board and applies equally to non-executive directors (NEDs) and executive directors as members of unitary boards. It is based on six domains:

- Driving high quality and sustainable outcomes
- Setting strategy and delivering long-term transformation
- Promoting equality and inclusion, and reducing health and workforce inequalities
- Providing robust governance and assurance
- Creating a compassionate, just, and positive culture
- Building a trusted relationship with partners and communities

4.8. As colleagues will be aware, David Birkenhead, our Medical Director, has announced his intention to retire later in the year. To ensure that there is a suitable handover period in place, interviews for his replacement take place during week commencing 11 March 2024. These new appraisal competencies will be built into the recruitment process for this post, and into the appraisal and development process for all directors later in the year.

4.9. We have continued to support colleagues across all our networks over recent months. We held a Ramadan Awareness event to increase understanding of Ramadan and the significance this religious festival has for Muslim patients, visitors, and colleagues. Only through increasing our understanding of others can we achieve a culture of compassion and respect for each other. The network meetings for Pride were launched with online coach, KT Quinn, as a guest speaker who talked about her journey, why she got into coaching, what she delivers and how it is tailored for the LGTBQ+ community. February also saw the annual LGBT History Month celebrating LGBT+ peoples' contribution to the field of Medicine and Healthcare both historically and today. February also saw the launch of our new men's mental health and wellbeing programme.

4.10. I would like to take an opportunity to recognise several colleagues across the Trust who recently been shortlisted in a variety of awards.

- ISS Porter, Dave Fairbairn, was shortlisted in the Porter of the Year Award.
- Our Communications Team are shortlisted for two awards in the NHS Communicate Awards run in partnership between NHS Providers, NHS Confederation, and the Centre for Health Communications Research. The award categories are Internal

Communications and Staff Engagement, and Best Use of Digital Engagement. Winners will be announced on 7 March.

- Following a year-long break, the Unsung Hero Awards have returned, and we've four finalists preparing for the ceremony next month in Manchester. Due to the sheer quality and number of nominations put forward, CHFT has also been shortlisted for a new Special Recognition Award. The UHAs are the only National Awards for non-clinical, NHS staff and volunteers. Our finalists are:
    - Corporate: Colleague Engagement Advisor, Carys Bentley
    - IT and Digital: Performance and Intelligence Lead, Charlotte Anderson
    - IT and Digital: Performance and Intelligence Lead, Oliver Hutchinson
    - IT and Digital: Scan 4 Safety Inventory Management Team

4.11. The UHA Special Recognition Award is awarded to the Trust that has delivered the greatest number of nominations, to the highest levels in the whole judging process. The award is a recognition of the Trust-wide quality of staff and the high standards achieved by their non-medical, non-clinical individuals and teams. The winners will be announced on 15 March.

4.12. With a combined career of more than 650 years working in the NHS – and all with 40 years or more - it was great to be able to present long service awards in January and thank colleagues for their continued commitment to CHFT, our patients and their colleagues.

5. Financial, economic, and environmental sustainability

5.1. The finance report at this meeting shows a £21.05m deficit, a £3.62m adverse variance from plan. The in-month position is a deficit of £3.51m, a £1.82m adverse variance. The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £1.70m.

5.2. Key drivers of the adverse variance include higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £3.80m pressure due to impact on associated efficiency plans and surge capacity; strike costs of £2.93m; and non-pay inflationary pressures. It is assumed that strike costs will be fully funded through additional ICS allocations. Other pressures are offset to some extent by additional Elective Recovery Funding, identification of some CIP mitigation and higher than planned commercial income in our pharmaceutical manufacturing institute.

5.3. As reference at the start of this report, we have not yet received the national planning guidance. In the meantime, we are planning based on the priorities set out in the 23/24 planning guidance focusing on increasing urgent and emergency care capacity, increasing diagnostic and elective activity, maintaining focus on cancer care, and reducing waiting times for patients.

5.4. What we also know is that this will be one of our most financially challenging years to date. There is unlikely to be any additional funding, and the non-recurrent nature of our cost improvement programme this year will mean that, we will need to deliver at least £25m of

savings during 24/25 and there will be very little available for pressures or developments. This will mean difficult decisions in relation to the replacing of posts, and delivery of services. It is important that colleagues across the organisation understand our financial position and this week we have gone out with clear messages about the nature and scale of the challenge.

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.

NHS Providers

February 2024

A PICTURE OF HEALTH
DELIVERING THE NEXT GENERATION NHS

The NHS is the keystone in the health of our nation, inextricably linked to our economic and social prosperity.

A comprehensive health service, providing for every individual based on clinical need and not ability to pay, aspiring to the highest standards of care. A service which is accountable, committed to delivering value for money, and to working closely with key partners to offer person-centred care.

These key principles of the NHS – as set out in its constitution – must be championed and protected at the same time as reflecting on the challenges it faces.

We must rally around our next generation NHS – an NHS which serves the population as it is now and as it will be, rather than as it was in 1948. An NHS which is agile in deploying its people, its resources, its partnerships, its technology. An NHS which is responsive to health needs, but which is not solely responsible for them. This is the NHS which wins the trust of the people it serves, which helps drive national productivity and excellence, and which government and parliament can robustly both hold to account and endorse. This is the next generation NHS.

A picture of health

- A responsive and effective NHS, meeting the current and future health needs of patients and communities.
- An NHS that continuously improves and whose people are proud and excited to work there.
- An NHS that is a key player in driving a healthy and productive society.

The government and the NHS must work together to deliver the next generation NHS and create a picture of health. Five shared commitments will realise this vision.

Five shared commitments

1. **Reaffirm commitment to the core values of the NHS to improve health and care for all and reduce inequalities.**
2. **Build a new infrastructure programme for the NHS.**
3. **Nurture a thriving health and care workforce.**
4. **Champion a culture of openness, improvement and innovation.**
5. **Provide care in the right place at the right time.**

Reaffirm commitment to the core values of the NHS to improve health and care for all and reduce inequalities

We see multiple inequalities across the population, driven by a range of factors including levels of poverty and deprivation, safe and healthy housing, education, employment and access to healthy food and green space. The NHS has significant potential to contribute towards a comprehensive approach to supporting people's health, and this needs to be supported by a prioritisation of health and wellbeing across government policy and action.

We need to support and reform the NHS and social care, and to elevate health as a public good, vital to a thriving economy and to our wellbeing as a society. The government needs to take responsibility not just for treatment when we are sick, but for health, with cross-departmental accountability for the health of the population.

Housing. Food. Employment. Welfare. Education. Justice. The environment. Transport. Culture. The wider determinants of health and the levels of deprivation experienced have the most profound impact on a person's wellbeing and lifelong health. We need to build this into a model of care across the government, making the NHS sustainable, and our national health and wealth prosper.

Through this, we will see a return on the investment and support NHS sustainability. NHS spending has a profoundly positive impact on economic outcomes and regional growth. Every £1 spent on healthcare returns £4 in increased productivity and employment. The impact of a holistic approach to health and wellbeing across the government would be all the greater, with a healthy society driving growth across the economy, innovation and culture.

The actions we must take together

- Set out, consult on and implement a health and care strategy which looks across the needs of the whole population, now and over the decades to come.
- Reform and fund social care to put it on a sustainable footing and develop the workforce to enable the right care in the right place at the right time.
- Integrate health impact assessments into the work of every government department ensuring the contributions to health of key services such as transport, environmental services, criminal justice, housing and education are better understood, as well as the contribution of a vibrant voluntary sector.
- Assess funding levels and funding flows across the public sector to ensure they best support health, public health, social care and the wider determinants of health.
- Expand the remit of the Office for Budget Responsibility, alongside its existing role, to include consideration of health and care impacts and costs.
- Engage employers, the private sector and the voluntary, community and social enterprise sector, on the importance of their role in societal health and wellbeing through staff and wider community action.
- Support the breadth of sectors and interventions which heavily influence the health of our communities.

By focusing on prevention and early intervention, and integrating health and care within the work of every part of government…

we will ensure the sustainability of the NHS and secure a significant social and economic return on investment.

Build a new infrastructure programme for the NHS

NHS leaders understand their responsibilities for offering value for money and for improving productivity. A drop in productivity in the public sector follows years of underinvestment and the impacts of the pandemic and high inflation. Trusts are embracing the challenge of improving the productivity of the NHS and delivering value for the taxpayer, for example, by developing alternative models of care to enable faster discharge. However, to set the NHS up to meet the challenges of the future, then the government must commit to equipping it with the resources it needs to unlock productivity gains. Sustainable

productivity growth depends on key enablers, notably capital investment in infrastructure and digital technologies.

Current capital allocations are not sufficient to cover the cost of delivering safety critical repairs to NHS estates and equipment. Tight operational capital budgets leave trusts with little headroom to invest in their estate and update antiquated equipment, compounding the impact on the rising maintenance backlog which now stands at around £12bn. Capital investment in acute, specialist, mental health, community and ambulance sectors is essential to address the record-high maintenance backlog and halt the deterioration of the NHS estate, and to enable a more productive NHS.

Alongside this, to meet developing patient needs, the NHS needs an increase in capital funding to strategically invest in estate transformation and an expansion of its capacity in community and inpatient settings. This means widening access to strategic capital investment and enabling trusts to use the money they already have by increasing national capital departmental expenditure limits (CDEL).

A sustainable funding settlement for the NHS, with a strategic investment approach across revenue and capital will make short-term funding needs clearer and offer greater long-term returns. It will also show where productivity of the NHS is interdependent with factors such as staff wellbeing and investment in digital capacity, equipment and modernising the estate, as well as social care and the wider determinants of health.

The actions we must take together

- Enable digitisation of the service on an industrial scale.
- Clear the maintenance backlog of nearly £12bn, and urgently address instances of unsafe reinforced autoclaved aerated concrete (RAAC).
- Increase CDEL to provide greater flexibility to invest in NHS estates without breaching national spending limits.
- Expand the NHS bed base and transform the estate – across the hospital, mental health, community, ambulance and primary care sectors – through capital investment and new routes to capital.
- Invest in management as vital to enabling operational efficiencies, improving patient satisfaction, reducing the frontline administration burden on clinicians, and facilitating innovation.

By investing in eliminating the maintenance backlog and the systematic renewal of our facilities, technology and estates...

we will improve the quality and safety of patient care and deliver even greater value for money.

Nurture a thriving health and care workforce

People are the backbone of the NHS, and trust leaders know that caring for their workforce enables them to care for others. NHS working conditions must enable safe care for patients and service users, and give them timely access to care, a positive experience of their care, and the best possible outcomes.

However, since 2010, the demands of working in the NHS have been compounded by rising staff vacancies, squeezed funding, increases in patient demand, an underfunded social care system, and a health system designed around treatment rather than prevention. The Covid-19 pandemic, the cost of living crisis and the longest period of industrial action in NHS history have exacerbated these pressures and drive up the rate of staff leaving the service. NHS staff survey data shows that almost half of all staff often or always feel worn out at the end of their shift, over a third feel burnt out because of their work, and almost a third often think about leaving their organisation.

As NHS staff continue to tackle the extraordinary pressures they are facing and look to keep the service fit for the future, it is clear a focus on wellbeing and experience at work will be key. There is a wealth of evidence to show that support for staff wellbeing is a sound investment, helping sustain a happy and healthy workforce and leading to better patient outcomes.

Addressing these issues means implementation of the NHS long term workforce plan, which must be fully funded beyond 2028, and sustainable resolution on pay. There also needs to be a focus on staff wellbeing, morale, retention and making the NHS a great place to work, ensuring compassionate, courageous and inclusive leadership at all levels. This includes action on race equality and tackling discrimination, pursuing a culture of speaking up, investing in excellent management and leadership capacity, and modernising ways of working.

The actions we must take together

- Sustain work with the unions, medical royal colleges and other sector partners to demonstrate commitment to valuing, retaining and upskilling the workforce.
- Fund and deliver the NHS long-term workforce plan.
- Continue implementation of the Messenger report, leadership for a collaborative and inclusive future.
- Commit to supporting the work underway to improve the equality, diversity and inclusivity of the NHS and tackling discrimination.
- Commit to enabling the NHS in developing a culture of openness, where staff and leaders alike feel confident in speaking up and being met with a supportive response.

By delivering the NHS long term workforce plan, and redoubling efforts to improve the equality, diversity and inclusion experienced by our people...

we will create the capacity and capability to deliver the best possible patient care, now and in the future.

Champion a culture of openness, improvement and innovation

Supporting the right cultures and enabling the right behaviours to support safety, quality and improvement is one of the biggest and most important challenges in healthcare. Healthcare is delivered each day through the constant interaction of numerous relationships, processes and events.

It is essential that every individual feels able to speak up about anything that isn't working as it should and is confident they will be listened to, with meaningful actions and learning to follow. Developing a positive, values-led culture takes sustained effort, but it is the first and critical step in enabling and driving improvement. We know quality of care – including safety and patient outcomes – is greatly enhanced by building a closer connection between senior leaders and frontline staff, empowering staff, and involving patients in decisions about their care.

We need to continue to create the culture and conditions for continuous improvement within the NHS, allowing trusts to focus on the priorities that matter to their patients and staff, and deliver improvements in experience and outcomes. The implementation of improvement methods and co-production with staff and patients significantly improves the quality of care, patient safety and patient experience. It also positively impacts financial and operational performance and staff experience.

Trusts are clear of the value of a continuous improvement approach, and would welcome long-term support to build improvement capacity and capability. The development of a single, shared NHS improvement approach through NHS IMPACT is an important first step in reinforcing the principles that underpin a systematic approach to continuous improvement and high performance.

A structured approach to improvement works to support the NHS as a world-leading research organisation. The service has been at the forefront of medical breakthroughs making the UK a global hub for the medicines and health technologies industries, stimulating economic growth and opportunity.

The UK is primed to pioneer and capitalise on innovation, particularly in artificial intelligence and digital technology, through its world class universities, and the unique patient datasets the NHS generates as a universal service. We need to prioritise research as an integral part of service delivery, realising its positive impact on quality of care and enabling evidence-based decision making, by investing in workforce capacity and capability across the NHS.

The actions we must take together

- Prioritise an open, learning culture across the system as the linchpin for success in improvements across NHS safety, quality of care and improvement.
- Support investment over multiple years in embedding a culture of improvement and building capacity and capability.
- Maintain consistency and clarity at national level about the role of improvement, with alignment of priorities across the system.
- Promote the benefits of and skills for evidence-based decision making within the NHS.
- Provide support for a wider range of NHS organisations to secure research funding and develop their research capabilities.
- Continue to focus on improving the status of the UK and NHS as a world-leading research base through streamlined and supportive regulatory approaches and maintaining partnerships with international networks.

By enabling a learning culture and investing in the skills for continuous improvement and evidence-based decision making...

we will improve the safety and quality of care, productivity and staff experience.

Provide care in the right place at the right time

A narrow, historical and political focus on hospital and ambulance performance at the expense of a focus on early intervention, community services and mental health can distort our view of the health care model people need. Instead, we need to enable care in the right place at the right time across the system. Integrated care systems are well placed to play a strategic convening role, supporting development and delivery of the services that are right for their local communities in local places, as well as services that are better, and more safely, delivered at scale.

Building on work already underway, a revitalised primary care service working closely with local social care, community services and the voluntary sector, would enable care to be given as close to home as possible, and would better support mental health care as well as those with multiple long-term conditions, and help prevent deterioration through early intervention.

We need to be realistic about the level of unmet mental health need, particularly amongst children and young people, and the socioeconomic factors contributing to increasing demand. And in response we need to build up the mental health offer to fully meet those needs so that we can stem the rising tide of demand and acuity and support a healthy population who can lead fulfilling lives.

Hospital and specialist services need to work together to establish where provision is best placed to meet community needs in a timely way. We can better capitalise on the skills of our ambulance services, drawing on their insights into population data and health inequalities, supporting them to refer callers to the right care pathways for their needs, as well as ensuring their capacity to respond when people most need help.

This work needs to take place alongside investment in public health, social care and wider public services and support. By working with primary care, the voluntary, community and social enterprise (VCSE) sector, social care, and across organisational boundaries, NHS trusts and foundation trusts are better serving its patients and achieving more for taxpayers. This is essential so that each can play to its strengths, delivering care in the most effective and efficient way.

The actions we must take together

- Set out a clear strategy for substantially increasing the proportion of patient demand that is met within primary and community care, with the necessary investment and prioritisation attached.
- Agree a definition of parity of esteem for mental health, and pursue equity of mental health care, with a focus on health inequalities and the socioeconomic drivers of mental ill health.
- See beyond the urgent and emergency care pathway as a proxy indicator of NHS performance, and meaningfully support flow through the system with investment better following patient and community needs.
- Continue to invest in data sharing, interoperability, and data governance skills to support the NHS in focusing its resources where they are most needed.
- Invest in the skills and capacity of the social care sector, accepting that the robustness of social care plays a key role in the performance and sustainability of the NHS.

By meeting more patient needs in the community and creating a robust social care sector...

we will support the performance and sustainability of the whole health and care system.

Delivering the next generation

The NHS provider sector – acute hospitals, mental health, community and ambulance trusts – has a vital role in creating a healthy, equitable and productive society.

We need to rally around our next generation NHS. This is an NHS that serves the population as it is now and as it will be, and that plays a key role within a strong network of public services.

The NHS can achieve the greatest social and economic value by working with the government, and with patients and communities at the centre of every conversation.

Strategy: Transforming and Improving Patient Care

9. Annual Strategic Plan Progress Report - 2023/2024

To Note

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 March 2024
Meeting:	Public Board of Directors
Title:	**2023-24 Annual Strategic Plan – Progress Report**
Author:	**Anna Basford, Deputy Chief Executive / Director of Transformation and Partnerships (with input from all Executive Directors)**
Sponsoring Director:	**Brendan Brown, Chief Executive**
Previous Forums:	Informed by discussions at previous Trust Board and Council Governor Workshops.
Purpose of the Report	Provide an update on progress against the 2023-24 annual strategic plan.
Key Points to Note	In March 2023 the Trust Board approved a refreshed five year strategic plan and the one year strategic objectives for 2023-24. The strategic plans describe the Trust's ambitions across the four goals: • To transform patient care and population health outcomes • To provide the best quality and safety of care • To be the best place to work, supporting a workforce for the future • To be sustainable in our use of financial and environmental resources This report provides an update on progress to implement the 2023-24 annual strategic objectives.
EQIA – Equality Impact Assessment	For each objective described in the annual strategic plan the Lead Director is responsible for ensuring that Quality and Equality Impact Assessment is undertaken and where possible that this follows best practice to involve patients, public and colleagues in the process of assessment and the agreement of any required actions to mitigate risks or negative impacts
Recommendation	The Board is requested to **NOTE** the assessment of progress against the 2023-24 strategic plan.

Calderdale and Huddersfield NHS Foundation Trust
2023-24 Strategic Plan – Progress Report March 2024

Purpose of Report

The purpose of this report is to provide an update on progress made against the Trust's 2023-24 strategic annual plan (appendix 1 and image shown below).

Structure of Report

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

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

For each objective the following information is provided:

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

Summary

This report highlights that of the 15 objectives:

0	are rated red
2	are rated amber
12	are rated green
1	has been completed

Recommendation

Note the assessment of progress against the 2023-24 objectives.

2023-24 strategic plan on a page

The content below summarises the CHFT One Year Strategic Objectives that will support delivery of the Five Year Strategic Plan

Our vision:

Together with partners we will deliver outstanding compassionate care to the communities we serve.

Our values and 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 and results:

Transforming services and population outcomes

We will have opened the new A&E at HRI and commenced construction of the new Learning and Development Centre and Multi-storey Car Park at CRH.

We will deliver our 12-month digital programme to improve integration within the Trust and across the system, this will provide digital developments and products (e.g. Patient Portal, SDEC module), and ensure the infrastructure and end user devices are secure, current and designed for the role.

We will make progress against the Year 1 milestones in the Trust's Health Inequalities Strategy within the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion and provide updates on these to the Board.

We will continue with the established successful clinical research portfolio, engaging with Partners; participate in the ICB Place Based Research Collaborative; work to address Health Inequalities; broaden the research portfolio to a wider group of patients, and further encourage participation in R&D.

Keeping the base safe – best quality and safety of care

We will deliver the quality, safety and experience strategies; implement PSIRF; meet the KPIs of the Trust Quality priorities; undertake a programme of work to maintain HSMR/SHMI within expected range; support and respond to a CQC Inspection of Maternity Services.

Working within the resources available we will meet national standards in relation to elective recovery. We will meet priority KPIs for cancer services. We will maintain our position within the top quartile of diagnostic performance. We will maintain our position within the top quartile nationally of ED performance, with a focus on ambulance waits over 30 minutes and over 12 hour ED waits.

We will complete the governance review; deliver the key elements of the System Oversight Framework (SOF); ensure compliance with the new CQC framework.

We will implement the RESPECT programme; deliver the Carers strategy including Johns Campaign; work with partners to review Birth Centre provision across CKW footprint; continue to reduce Health Inequalities working with partners to support meeting people's individual needs e.g. Learning Disabilities.

Inclusive workforce and local employment

We will increase emphasis on appreciation and continue to focus on providing a healthy workplace, providing access to physical, mental and financial wellbeing advice.

We will ensure personal and professional development is accessible and open to all through health academies, apprenticeships, equality, diversity and inclusion education and awareness.

We will deploy workforce planning tools to design roles and approaches to deliver our reconfigured hospital and community services and implement an inclusive recruitment approach aligned to our values and behaviours.

We will increase routes into employment, working with Calderdale and Kirklees Councils and further education partners to develop a Health Academy for Calderdale and Kirklees.

Financial, economic and environmental sustainability

Deliver the ICB and NHSE approved financial plan. Demonstrate improved performance against Use of Resources key metrics and NHSE productivity metrics.

We will develop a calendar of sustainability engagement events for 2023/24; achieve a minimum recycling target of 40% for non-clinical waste streams; work to reduce single occupancy vehicle journeys by 5% by 2026; make progress towards our targets of a 100% reduction in emissions by 2040 and to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028.

We will demonstrate the additional social value generated by investment in the new A&E at HRI to create local jobs, training opportunities and to support local businesses.

Goal: Transforming and improving patient care

Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
We will have opened the new A&E at HRI and commenced construction of the new Learning and Development Centre and Multi-storey Car Park at CRH.	**AMBER** Off track with plan	Construction of the new A&E at HRI has been completed. Opening of the unit has been delayed and the Trust is working with the Construction Partner to commission the building prior to confirming the opening date for service delivery. The Trust is progressing positive dialogue with DHSC and Treasury regarding approval of the Reconfiguration OBC. Plans have been developed to commence enabling works for the MSCP at CRH in Summer 2024. Construction of the new Learning and Development Centre at CRH has commenced and is on track for completion by August 2024.	**We will have built new 'state of the art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.** **Lead: AB** Transformation Programme Board , Trust Board ICS, NHSE, DHSC	20 BAF Risk 1/19 Reconfiguration	• Opening date of new A&E • Confirmed dates for construction of new L&D Centre and MSCP at CRH
We will deliver our 12-month digital programme to improve integration within the Trust and across the system, this will provide digital developments and products (e.g. Patient Portal, SDEC module , and ensure the infrastructure and	**GREEN** on track	Good progress has been made in line with the digital strategy and prioritised against operational demand and clinical requirements (COO, CN, MD). Over the last 12mth key developments within the programme include: • Relaunch of Nursing Documentation • Electronic Controlled Drug Register • NICU EPR roll out • Pharmacy Catalogue upgrade (Multum) • Development of SDEC EPR Module.	**Patients and colleagues will be digitally enabled to provide and receive care wherever this is needed.** **Lead: RB** Divisional digital boards	12 BAF Risk 02/20 Digital Strategy	• HIMSS level (Achieve level 6 in 24/25) • Progress against CHFT Digital Strategy (e.g. continual delivery of our digital roadmap/plan) · • NHSE Digital Maturity

end user devices are secure, current and designed for the role.		• Increased use of RPA to drive efficiency • 3rd Cohort of Digital Nursing Placements. • Our approach to Data Science has been defined through further work on waiting list validation and frailty, alongside initiating a place-based response to a High Risk Adult cohort of patients. • Our infrastructure continues to be fit for purpose through the edge device replacement programme and security is assured through a compliant DSPT submission alongside Cyber Essentials accreditation, External testing and ISO 27001. Update was presented to Trust Board - January 2024	Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.		Assessment (DMA) • Maintain 3 ISO Standards (27000/9001/20000) • DSPT compliance
We will make progress against the Year 1 milestones in the Trust's Health Inequalities Strategy within the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion and provide updates on these to the Board.	**GREEN** on track	Delivery of the 1-year milestones in the Health Inequalities strategy continues. This includes: • Health inequalities indicators now included within the Trust Integrated Performance Report. • Continue to develop a "Health inequalities vulnerability index" to identify patients at increased risk of experiencing inequalities. • Continue to maintain equity of access for people with a learning disability. • The BLOSM service continues and has been recognised nationally for work done to support vulnerable service users. • Presented and shared progress at a number of national forums/learning events.	**Working with partners we will use population health data to prevent ill health and reduce health inequalities.** **Lead: RA** Health Inequalities Group Executive Board Board of Directors Health Inequalities	12 BAF Risk 07/20 Health Inequalities	• Delivery of actions within the Trust's approved Health Inequalities strategy 2022-2025 • Inclusion of Health inequalities indicators within the Trust Integrated Performance Report. • Maintain equality of elective care access for different protected groups.

		• The NHS England Director of Health Inequalities made a successful visit to the Trust in September 2023. This has led to CHFT being featured in a number of forums/case studies. • The CQC commended the maternity team for the work they have done in relation to health inequalities on their most recent 'Good' inspection visit.	Oversight Group (England)		
We will: continue with the established successful clinical research portfolio, engaging with Partners; participate in the ICB Place Based Research Collaborative; work to address Health Inequalities; broaden the research portfolio to a wider group of patients, and further encourage participation in R&D.	**GREEN** on track	Our NIHR core funding allocation was slightly higher this year & and we have secured in-year additional funding to support improvements in research delivery, including £25K financial award for our excellent performance within commercial research. Our total NIHR income this year is just over £899K. We continue to exceed NIHR recruitment targets and performance metrics. We remain consistent in often achieving the highest recruiting site or the first site to recruit to studies in Y&H ensuring we offer patients meaningful choices and opportunities. We launched our new research strategy in Sept, which provides us with clear direction for the next few years. One of our strategic objectives focuses on continuing excellent collaboration with our partners to improve access to research opportunities. We are planning an internal survey exploring factors that influence clinical research delivery, to help direct our progress. We are also continuing to link with community partners in our area, to establish a Calderdale & Kirklees Research Group to improve research outcomes. This will enable us to contribute to wider policies and agendas, such as the West Yorks ICB research strategy and assist other external partners i.e. Locala and YAS to do research.	**We will participate in research and innovation to improve patient care, prevent ill-health, and achieve better outcomes and faster recovery for patients.** **Lead: DB** Research Group Executive Board Quality Committee	12 BAF Risk 01/20 Clinical Strategy	• Number of colleagues participating in research • Number of patients recruited to participate in research • Breadth of research active specialities • Number of Studies requiring collaboration with external partners

		CHFT are now sponsors for two new studies. The first one, with Lung Cancer/Mesothelioma Nurse Specialist – Simon Bolton as Chief Investigator is looking at trial provision for mesothelioma patients in Y&H and the second, with Physiotherapist – Tash Maher as Chief Investigator looking at the use of shared decision-making in patients with a displaced collarbone injury, this is on the back of a Pre-doctoral Clinical & Practitioner Academic Fellowship (PCAF) award. Both studies have commenced recruitment. We are also lead NHS site for CONNECT – patient decision aid within Cardiology – Prof Felicity Astin. As well as a recruiting site for the study, as Lead NHS site, we also hold the NIHR funding grant for this study and take on the role of Steering committee.			

Goal: Keeping the base safe

Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
We will deliver the quality, safety and experience strategies; implement PSIRF; meet the KPIs of the Trust Quality priorities; undertake a programme of work to maintain HSMR/SHMI within expected range; support and respond	**GREEN** on track	We have developed a new patient experience, involvement and inclusion strategy. The Quality and Safety strategy is under review to ensure it is reflective of the Patient Safety Incident Response Framework (PSIRF) and NHSE recommendations from the NHS delivery and continuous improvement review. The trust is progressing with the implementation of the PSIRF framework. The trust quality priorities are reported in the integrated performance report.	**We will be delivering and enabling outstanding quality, safety and experience of care for people needing hospital and community services.** **Lead: LR**	12 BAF Risk 04/20 CQC rating	• Strategies developed and approved. – progress reports against 1year objectives 23/24 • Progress update against PSIRF national implementation plan • HSMR/SHMI within expected range IPR report metric

to a CQC inspection of Maternity Services		Trust wide MUST scores and the KPIs for Urgent Care Response and Virtual ward within community services are under performing and actions are in place to improve performance. HSMR/SHMI are within expected ranges. The CQC inspection of Maternity services has continued to rate the service as GOOD, and an action plan is in place to respond to the 2 Must Do actions and 5 Should do actions. A quality review summit is planned for October 2023 to review progress against quality and safety indicators and quality improvement priorities with senior leadership team. This was undertaken and a review of the processes across divisions has been commenced and further work in relation to SEPSIS is being undertaken. The trust MUST score compliance has improved significantly. Focussed improvement work is being undertaken to improve the performance of Dementia screening. The trust submitted its action plan to the CQC following the Maternity inspection. This is proactively being implemented and monitored internally and reported back to CQC The quality summit has been held and outputs will form part of the revision of the Quality and Safety strategy. This is being undertaken aligned to the revision of the Trusts Clinical Strategy. The Trusts PSIRF has been submitted to the ICB as planned. The trust continues to implement and progress PSIRF across CHFT and are actively engaged in the	Quality Committee Executive Board		• Quality Priority targets achievement metrics within IPR • Compliance with the Maternity CQC MUST Do action plan

		deployment of Inphase as a digital enabler to support this. The quality team are in the process of recruiting Patient Safety Partners and Experts by Experience to support patient involvement. Performance against the quality priorities is reported within the IPR			
Working within the resources available we will meet national standards in relation to elective recovery. We will meet priority KPIs for cancer services. We will maintain our position within the top quartile of diagnostic performance. We will maintain our position within the top quartile nationally of ED performance, with a focus on ambulance waits over 30 minutes and over 12 hour ED waits.	**GREEN** on track	The Trust has minimal over 52 week waits and had made positive progress on reducing to a max of 40 week waits (except in ENT which has specific workforce challenges). The Trust's elective waiting times compare favourable regionally and nationally and remain on track to meet the target of no over 52 weeks by end of financial year 2023/24. The Trust continues to achieve cancer access standards ensuring that people who have an urgent referral from their GP for suspected cancer receive the timely treatment they need. CHFT is placed in the top 10 Acute Trusts nationally for type 1 ED performance. The trust continues to perform well in relation to timely ambulance handover.	**We will be consistently achieving key performance targets that matter most to patients.** **Lead: JH** Integrated Board Report Executive Board Audit and Risk Committee Finance and Performance Committee Access Delivery Group	16 BAF Risk 05/20 Recovery	• The monthly Integrated Performance Report details performance against key targets.
We will complete the governance review; deliver the key elements of the System Oversight Framework (SOF); ensure compliance with the new CQC framework.	**GREEN** on track	Governance Review complete and changes made to the structure. Will need to do further work on this in 24/25 as part of the governance checklist work. New IPR in place. CQC new Assessment Framework be published. Undertaking self-assessment with divisions using a risk based approach starting in March.	**We will be 'well-led' and governed and compliant with our statutory duties.** **Lead: VP** Executive Board Trust Board	16 BAF Risk 3/23 Partnerships 6 BAF Risk 16/19 Health & Safety 12 BAF Risk 4/20 CQC rating	CQC Good SOF segment 2

We will: implement the RESPECT programme; deliver the Carers strategy including Johns Campaign; work with partners to review Birth Centre provision across CKW footprint; continue to reduce Health Inequalities working with partners to support meeting people's individual needs e.g., Learning Disabilities.	**GREEN** on track	The RESPECT programme continues to progress within the project framework The keep carers caring campaign has been hugely successful and continues to be embedded across the organisation. The trust continues to review the birth centre provision with Mid Yorkshire Teaching Hospital Trust and have updated Kirklees health overview and scrutiny panel on current position at CHFT. We have reviewed actions within the Population Health and Inequalities Strategy, 2022 - 24 Health Inequalities strategy. NHSE have asked the trust to undertake brief health inequality audits for maternity and colposcopy services, following inequalities being identified at a national level. This is to review population, uptake, where there are gaps, understanding who's engaging and who isn't and identifying work the Trust can undertake. Maternity services has an established workstream. The RESPECT project continues to be rolled out across the organisation. Ongoing work within the health inequalities group to deliver the plans working with partners. The birth centre remains suspended at HRI due to the Maternity staffing position. A strategy Director of Midwifery is in place across the CKW place to oversee	**Patients will be able to shape decisions about service developments and their personal care based on 'what matters' to them and their individual strengths and needs.** **Lead: LR** Quality Committee Executive Board	12 BAF Risk 04/19 Patient and Public Involvement	• Number of RESPECT forms being filled • Annual Patient Experience surveys • IPR metrics for HI and LD • PSED annual report

		partnership working across both midwifery services. We are actively introducing the Making Every Contact Count within the organisation and have developed an App to support accessing this and various communication tools to encourage uptake. WE have participated and received results of patient surveys for ED , In-patients and Maternity services and are using the results to focus on areas of improvement. The BLOSM service has been hugely successful since its introduction and the trust is further developing support for people who present to CHFT with Mental Health or Learning disabilities as our continued commitment to reduce health inequalities. A review of the EQIA/QIA process has been undertaken to include impact of poverty and ensure the process supports the trusts duty to involve.			

Goal: A workforce fit for the future

Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
We will increase emphasis on appreciation and continue to focus on providing a healthy workplace, providing access to physical,	**GREEN** on track	• In-person welcome and induction events for new employees reintroduced with a focus on One Culture of Care and showcasing the Trust wellbeing offer. • 12-month engagement and wellbeing calendar developed that focuses on celebrating success, appreciation,	**We will be widely known as one of the best places to work through an embedded one culture of care - supporting the**	12 BAF Risk 11/19 Recruitment and Retention	Reduction in sickness absence rates.

mental and financial wellbeing advice.		recognition, support, reward and increased staff survey uptake paying particular attention to divisional hotspot areas is underway. • Annual CHuFT award event held on 2 November 2023 • Staff survey hotspots identified, and high impact action plans created. • Deep dives into sickness absence hotspots with divisional teams to develop plan on a page for each area. • Partnership with Credit Union launched in January 2024. • Enhanced top up shop offer through partnership with Neighbourly • Workforce Psychologist training volunteers on peer support critical incident debriefing	**health and wellbeing of all colleagues.** **Lead: SD** Workforce Committee		
We will ensure personal and professional development is accessible and open to all through health academies, apprenticeships, equality, diversity and inclusion education and awareness.	**GREEN** on track	• Increased focus on greater apprenticeship take-up and deployment of levy funds with workshops delivered from August 2023 and monthly workstream reports in place. • 'Go see' approach adopted to assess how other organisation measure/ record internal mobility. • All Trust colleagues able to access free of charge Maths and English qualifications. • 'Development for all' offer is in place. • Management Fundamentals now available. • 'New to Manager' programme launched. • 'Empower' personal development programme is continuing.	**We will foster an open learning culture that demonstrates lessons learnt, and actively seeks and celebrates best practice.** **Lead: SD** Workforce Committee	12 BAF Risk 11/19 Recruitment and Retention	Increase in internal apprenticeships

		• A programme of 'Connect and Learn' sessions available to all colleagues. • Shadow Board launched in September 2023			
We will deploy workforce planning tools to design roles and approaches to deliver our reconfigured hospital and community services and implement an inclusive recruitment approach aligned to our values and behaviours.	**GREEN** on track	• Continued work at Trust and Place to embed annual workforce planning activity and refine Trust reconfiguration workforce requirements. • Reconfiguration Workforce Lead working collaboratively with service leads to design future workforce models. • Action plan developed in response to NHS Long Term Workforce Plan. • Tools to support Nursing and AHP future planning have been created and updated on a regular basis. • Workforce Design Hot House on 6 February 2024.	**We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.** **Lead: SD** Workforce Committee	12 BAF Risk 11/19 Recruitment and Retention	-
We will increase routes into employment, working with Calderdale and Kirklees Councils and further education partners to develop a Health Academy for Calderdale and Kirklees.	**GREEN** on track	• Delivery of regular Trust wide careers events working with a range of internal and external stakeholders – 4 events held in 2023/2024. • Active engagement with local community groups targeting under representation in our workforce. • Improved utilisation of apprenticeship levy. • Comprehensive employability support including applications and interview techniques is available. • Continued focus on partnership development including LA's, Princes Trust, DWP, Education providers, Third sector so to enable us to reach out	**We will work with partners to create local employment, career and development opportunities for people.** **Lead: SD** Workforce Committee	12 BAF Risk 11/19 Recruitment and Retention	Increase in apprenticeships, T-levels, Project Search interns

		further and support additional underrepresented groups. • Ongoing explorative work with clinical leads with the focus to target T Level cadets. • First 'New to Care' cohort commences in June 2024. • Continued work with Place partners exploring new routes into employment and coordinated pathways.			

Goal: Sustainability

Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
Deliver the ICB and NHSE approved financial plan. Demonstrate improved performance against Use of Resources key metrics and NHSE productivity metrics.	**AMBER** Off track – with plan	**Delivery of plan** The Trust is forecasting to deliver the planned £20.80m deficit. **Productivity metrics** The latest issue of NHSE Acute Provider Productivity metrics shows an improving productivity trajectory for the Trust. Productivity opportunity remains based on the baseline year of 2019/20 (pre-pandemic), this is in line with peer organisations.). Month 6 data shows the opportunity for CHFT to be lower than national average and lowest amongst WYAAT peers which suggests we have improved our productivity more so than others.	**We will be consistently delivering our annual financial plans and demonstrating value for money.** **Lead: GB / KA** Reported to Finance & Performance Committee Monthly regulator discussions	16 BAF Risk 07/19 Compliance	• Year to date financial performance presented monthly at both Board and Finance and performance committee • Quarterly receipt of NHS productivity / opportunity tool

We will: develop a calendar of sustainability engagement events for 2023/24; achieve a minimum recycling target of 40% for non-clinical waste streams; work to reduce single occupancy vehicle journeys by 5% by 2026; make progress towards our targets of a 100% reduction in emissions by 2040 and to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028	**GREEN** on track	The Green Plan was first approved by Transformation Programme Board in March 2021. Delivery is managed by the CHS and progress against the Sustainable Action Plan (SAP) is monitored through the bi-monthly Green Planning sub-group Chaired by the MD of CHS. The Green Plan is a Board approved document which is submitted at ICS level. Some of the key progress this year include: • The Trusts Green Plan and Sustainability Action Plan outlines individual actions across 11 key themes. In total there are 207 interventions proposed. 163 of these actions are designated as complete. We continue to develop a calendar of sustainability events. • a Travel Plan has been adopted by the Trust to support more active travel. The Travel Plan outlines 47 individual actions across 4 key themes and 39 out of the 47 actions are designated as complete. • The new A&E at HRI met BREEAM Excellent requirements for sustainable design in new construction. • 5 22kw EV chargers installed as part of the ED development at HRI. The 4 charging points at Acre Mill have been upgraded to integrate with the MER user app and back of house software • New secure bike lockers installed as part of ED project at HRI. • Application to the NorthEast and Yorkshire Net Zero Hub Energy Projects Enabling Fund successful.	**We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.** **Lead: SS** Transformation Programme Board Trust Board	8 BAF Risk 06/20 Climate Action	• a 100% reduction in direct (scope 1) carbon dioxide equivalent emissions by 2040. An 80% reduction will be achieved by 2032 • convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028 • a minimum recycling target of 40% for non-clinical waste streams • a 5% reduction in single occupancy journeys by 2026

		CHS awarded £46,000 to implement Coolnomix energy saving project at HRI. • Successful recruitment to the Environment coordinator in the CHS Estates Team. • 200+ light fittings upgraded to LED in Acre Mill Building 1 • MRI Esight energy management software purchased. • Car free day event held at CRH and HRI • Re-purposed planters installed in the Learning Centre Courtyard at HRI to improve quality of outdoor space. Further planting to enhance the space will take place in the spring • We ran events for the Yorkshire Sustainability Week • New bin roll out complete. The new bins have a magnetic labelling system to allow for easier waste segregation in clinical environments. • On site offensive waste compactor approved at HRI. The installation completed at the end of 2023.			
We will demonstrate the additional social value generated by investment in the new A&E at HRI to create local jobs, training opportunities and to support local businesses.	**BLUE** Completed	• The Trust has worked with the Social Value Portal to undertake local needs analysis to assess that between £23m - £39m of measured Social Value could be generated as a result of the Reconfiguration estate investments at HRI and CRH through the creation of jobs, training, and apprenticeships to support the most deprived groups and communities. • In relation to the £15m investment in the new A&E at HRI the Social Value	**Our investments and use of resources will be generating Social Value to support economic recovery in Calderdale and Kirklees Places.** **Lead: AB**	9 BAF Risk 2/23 Social Value	• % Local Labour • % Local Supply Chain

		portal estimated £1.4m to £2.4m of social value could be generated. The construction partner for the new A&E (IHP) has worked with the Trust and local communities, colleges and stakeholders to generate social value. Progress has been regularly monitored through the A&E project board. Following completion of construction of the new A&E a final report has been provided and presented at the Transformation Programme Board in Dec 2023. The report describes actions taken such as training and education, apprenticeships, use of local supply chain, employment - including targeted jobs for long term unemployed, community and charity work, volunteering etc. Overall the stretch target for social value generated related to the £15m investment in the new A&E has been exceeded with local communities, businesses and the West Yorkshire economy benefiting from over £6.65m in added social value. • The learning from the generation of social value in relation to the new A&E will inform the Trust's future work to ensure social value is delivered in relation to the planned investments at CRH.	Transformation Programme Board Trust Board		

10. 2024-25 One Year Strategic Plan

To Approve

Presented by Anna Basford

Date of Meeting:	Thursday 7 March 2024
Meeting:	Public Board of Directors
Title:	**2024-25 One Year Strategic Plan**
Author:	Anna Basford, Deputy Chief Executive & Director of Transformation and Partnerships
Sponsoring Director:	Brendan Brown, Chief Executive
Previous Forums:	Development of the Trust's strategic plans has been informed by discussion at Trust Board and Council of Governor workshops.
Purpose of the Report	The purpose of this report is to approve the one year 2024-25 strategic objectives that will support delivery of the Trust's Five Year Strategic Plan.
Key Points to Note	In March 2023 the Board approved CHFT's Five Year Strategic Plan that describes ambitions across the four goals: 1. To transform patient care and population health outcomes 2. To provide the best quality and safety of care 3. To be the best place to work, supporting a workforce for the future 4. To be sustainable in our use of financial and environmental resources Annual objectives to progress the plan in 2023-24 were agreed and updates on progress have been provided at Trust Board meetings. A refresh of the annual objectives for 2024-25 is now required. Quarterly updates of progress against these objectives will be provided at future Trust Board meetings.
EQIA – Equality Impact Assessment	The Trust's Strategic Plans aim to address the needs of the whole population, including those who currently experience disadvantage. The plans are intended to help improve access, experience, and outcomes for all. Our Five Year and One Year Strategic Plans describe the actions we will take to address health inequalities.
Recommendation	The Board is asked to **APPROVE** the proposed 2024-25 strategic objectives

2024-25 One Year Strategic Plan / Objectives

1. Background

In 2023 the Trust Board approved CHFT's Five Year Strategic Plan that describes ambitions across the four goals:

1. To transform patient care and population health outcomes
2. To provide the best quality and safety of care
3. To be the best place to work, supporting a workforce for the future
4. To be sustainable in our use of financial and environmental resources

A one year annual plan for 2023-24 to support and monitor progress towards achievement of the Five Year plan was developed and a quarterly update on progress has been reported to the Trust Board throughout 2023-24.

A refresh of the annual objectives for 2024-25 is now required. Quarterly update of progress against the 2024-25 objectives will be provided at future Trust Board meetings.

2. Purpose

The purpose of this report is to request Trust Board approval of the 2024-25 strategic objectives.

3. 2024-25 Strategic Objectives

The table that follows describes the proposed annual strategic objectives for 2024-25 and the indicative measures of delivery that will be used in quarterly reports for the Trust Board to report on progress.

4. Recommendation

Trust Board members are requested to approve the proposed 2024-25 strategic objectives.

2024 25 Strategic Objectives and Measures of Delivery

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
We will have built new 'state of the art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.	We will have opened the new A&E at HRI and commenced construction of the new Learning and Development Centre and Multi-storey Car Park at CRH.	Deputy CEO / Director of Transformation & Partnerships (Anna Basford)	We will have opened the new A&E at HRI and reported on benefits realised, completed build and opened the new Learning and Development Centre (LDC) at CRH, commenced construction of the Multi-storey Car Park at CRH.	• Open the new A&E and confirm benefits in post project evaluation report. • Open the new LDC and confirm benefits in post project evaluation report. • Construction underway on MSCP and on track for planned completion by Nov 2025.
Patients and colleagues will be digitally enabled to provide and receive care wherever this is needed.	We will deliver our 12 month digital programme to improve integration within the Trust and across the system, this will provide digital developments and products (e.g. Patient Portal, SDEC module), and ensure the infrastructure and end user devices are secure, current and designed for the role.	Managing Director Digital Health (Rob Birkett)	We will deliver our 12-month digital programme in line with our Trust Digital Strategy. Maintaining a robust and secure infrastructure, developing our digital systems (inc our EPR) in line with our clinical and operational needs (e.g. Patient Portal, Paediatric SDEC); alongside ensuring access to accurate and timely data in order to improve outcomes, operational effectiveness and help shape service redesign.	• HIMSS level (Achieve level 6 in 24/25) · • Progress against CHFT Digital Strategy (e.g. continual delivery of our digital roadmap/plan) · • NHSE Digital Maturity Assessment (DMA) · • Maintain 3 ISO Standards (27000/9001/20000)
Working with partners we will use population health data to prevent ill health and reduce health inequalities.	We will make progress in achieving the Year 1 milestones set out in the Trust's 5 year Health inequalities strategy. This will involve making progress	Deputy CEO (Rob Aitchison)	We will deliver Year 2 of the Trust's Health Inequalities Strategy using the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion as our delivery framework. We will	• Continued delivery of actions within the Trust's approved Health Inequalities strategy 2022-2025

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
	against the milestones within the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion. The Board will receive regular updates from the HI group.		provide updates to the Board on a regular basis.	• Act on the health inequalities indicators within the Trust Integrated Performance Report. • Maintain equality of elective care access for different protected groups including an initiative supporting those groups most likely to not attend (DNA) for contacts with the organisation.
Working with academic, health and social care partners we will participate in research and innovation to improve patient care, prevent ill-health, and achieve better outcomes and faster recovery for patients.	We will: continue with the established successful clinical research portfolio, engaging with: Y&H AHSN, NIHR, Y&H CRN, University and Commercial Partners; participate in the ICB Place Based Research Collaborative; work with the Ethnic Minority Research Inclusion to address Health Inequalities; broaden the research portfolio to include a wider group of patients, and: develop our internal engagement to encourage participation in R&D.	Medical Director (David Birkenhead)	• We will collaborate with external partners, for example YAS, ICB, Locala & South West Yorkshire Mental Health trust to offer research to our patients & deliver this safely. • We will establish a Calderdale & Kirklees (Place based) research Group. • Survey the CHFT workforce (clinicians, nurses, midwives, AHPs) in regard to clinical research to provide us with evidence to enable improvements. • Continue to promote the work of Ethnic Minority Research Inclusion (EMRI) group and	• C&K Research Group Shared goals and terms of reference • Monitor studies we enable as part of this collaboration • Review and act on survey results to make improvements to enable research • Complete the pilot for NIHR reverse mentoring scheme within CHFT research team. • Increase of CHFT chief investigators

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
			reverse mentoring to improve uptake of research in ethnic groups • Support and guide our CHFT workforce to design and lead research as Chief Investigators • To enable this growth, we will review the R&D structure to ensure we are fit for purpose, resilient and safe.	• R&D structure review complete
We will be delivering and enabling outstanding quality, safety and experience of care for people needing hospital and community services.	We will deliver the quality, safety and experience strategies; implement PSIRF; meet the KPIs of the Trust Quality priorities; undertake a programme of work to maintain HSMR/SHMI within expected range; support and respond to a regulatory inspection by CQC across Maternity Services.	Chief Nurse (Lindsay Rudge)	• We will continue the next phase of implementing the National Patient Safety Incident Reporting Framework (PSIRF) and develop the roles of Patient Safety Partners and Experts by Experience. • We will implement the Inphase digital system to support compliance with our PSIR plan • We will set the Trust Quality priorities to support the delivery of the Trust Quality Strategy to ensure the greatest opportunity of improvements in quality, safety and patient experience. • Prepare and support for CQC within the new single assessment framework We will align our internal inspection framework (J2O) with the new	• Continued delivery of actions within the Trust's Patient Experience Strategy 2024/25 and the Trust Quality Strategy 2024/25. • Monitor key performance indicators within the Trust Integrated Performance Report. • Continued monitoring of regulatory standards via the Trust J2O and internal and external inspections/reviews

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
			CQC quality impact statements. • Publish a revised Clinical Strategy and Quality & Safety strategy • Revision of the Nursing & Midwifery Strategy to reflect the newly published national strategy	
We will be consistently achieving key performance targets that matter most to patients.	Working within the resources available we will meet national standards in relation to elective recovery to reduce the length of time people are waiting and to address health inequalities. We will meet priority KPI's for cancer services. We will maintain our position within the top quartile of diagnostic performance. We will respond to demand for acute services by maintaining our position within the top quartile nationally of ED performance, with a focus on ambulance waits over 30 minutes and over 12 hour ED waits.	Chief Operating Officer (Jonny Hammond)	Working within the resources available we will continue to meet national standards in relation to elective recovery. We will continue to meet priority KPIs for cancer services. Diagnostic performance will continue to be a focus and will improve to meet the 95% target by the year end. ED four hour performance targets will demonstrate improvement through the year to meet national expectations, including an aim to reduce over 12 hour waits and to meet national ambulance waiting time targets.	• Elective backlog • 28,31 and 62 day cancer targets. • Diagnostic DMO1 performance target. • ED four hour target. • Volume of patients with 12 hour length of stay in ED. • Average ambulance wait times.

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
We will be 'well-led' and governed and compliant with our statutory duties	We will have completed the governance review; delivered the key elements of the System Oversight Framework (SOF); ensured compliance with the new CQC framework.	Director of Corporate Affairs (Vicky Pickles)	We will review the governance arrangements against the GGI / HFMA framework in line with good financial controls and complete a well led review. We will also undertake the full self-assessment of compliance with the new CQC Inspection Framework at both Board and Divisional levels.	• Review undertaken and recommended actions implemented. • Self-assessment complete across all domains including Board well led assessment
Patients will be able to shape decisions about service developments and their personal care based on 'what matters' to them and their individual strengths and needs.	We will: implement the RESPECT programme; deliver the Carers strategy including Johns Campaign; work with partners to review Birth Centre provision across CKW footprint; continue to reduce Health Inequalities working with partners to support meeting people's individual needs e.g. Learning Disabilities.	Chief Nurse (Lindsay Rudge)	• Review the Patient experience and involvement strategy in April 2024 to ensure services are planned and developed whilst considering the diverse needs of the local population. • Initiation of two new work strands for the Patient Experience Involvement Group**:** Person Centred Care and strengthening working in partnership with people and communities. • Continuation of key strands of work within patient experience and Involvement strategy: insight to inform improvement priorities and Keep Carers Caring. • Introduce Experts by Experience and Patient Safety Partners. We will be working with our experts by experience	• Continued delivery of actions within the Trust's Patient Experience Strategy 2024/25 and the Trust Quality Strategy 2024/25. • Patient Survey Reports • Friends and Family test results • CHFT compliance with statutory guidance "Working in Partnership with People and Communities" • Healthwatch reports • We will continue to monitor assurance via the Trust CQC Compliance Group. In addition, we will ensure regular engagement meetings continue with

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
			to strengthen the patient experience insight to guide improvements making sure that the patient voice is truly heard in any service development or planning of new services. PSPs will support activities to improve patient safety. They will represent the voice of the patient and ensure patients are at the heart of everything we do, by challenging us when things go wrong and helping us to make improvements. • Carers Strategy - We will work with partner organisations and the latest insight findings to develop improvement actions across the local system which will support identification of unpaid carers, improve the involvement of unpaid carers and initiatives to support unpaid carers to improve their health and wellbeing.	our CQC Relationship Owner. • Maternity Incentive Scheme and Ockenden Assurance compliance
We will be widely known as one of the best places to work through an embedded one culture of care - supporting the health	We will increase emphasis on appreciation and continue to focus on providing a healthy workplace, providing access to physical, mental	Executive Director of Workforce and Organisational Development	We will increase emphasis on appreciation and recognition culminating in a successful CHuFT awards event.	• Increase CHuFT nominations • appreciation weeks in engagement calendar

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
and wellbeing of all colleagues.	and financial wellbeing advice.	(Suzanne Dunkley)		
We will foster an open learning culture that demonstrates lessons learnt, and actively seeks ('Go-See') and celebrates best practice.	We will ensure personal and professional development is accessible and open to all through health academies, apprenticeships, equality, diversity and inclusion education and awareness.	Executive Director of Workforce and Organisational Development (Suzanne Dunkley)	We will continue to improve and promote our internal development offer, with a strong focus on leadership.	• Succession plans in place for all Divisions to tier 3 • 2 leadership conferences per annum • 10% of managers having completed WTGR training • 10% increase in cohort of empower graduates • management fundamentals rolled out across the Trust
We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.	We will deploy workforce planning tools to design roles and approaches to deliver our reconfigured hospital and community services and implement an inclusive recruitment approach aligned to our values and behaviours.	Executive Director of Workforce and Organisational Development (Suzanne Dunkley)	We will implement an inclusive recruitment approach aligned to our values and behaviours and increase internal mobility for under represented groups.	• Increased internal mobility for BAME colleagues to band 6 and above roles.
We will work with partners to create local employment, career and development opportunities for people.	We will increase routes into employment, working with Calderdale and Kirklees Councils and further education partners to develop a Health Academy for Calderdale and Kirklees.	Executive Director of Workforce and Organisational Development (Suzanne Dunkley)	We will develop bespoke learning pathways and curriculums to develop a pipeline of local talent into health and social care vacancies	• Increase of number of colleagues recruited from IMD 1-4 • Increase our apprenticeship levy spend by 5%

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
				• We will co-launch a health and social care Academy for Calderdale
We will be consistently delivering our annual financial plans and demonstrating value for money.	Deliver the ICB and NHSE approved financial plan. Demonstrate improved performance against Use of Resources key metrics and NHSE productivity metrics.	Director of Finance (Gary Boothby)	Deliver the ICB and NHSE approved financial plan. Benchmark favourably across both West Yorkshire and Nationally against the National Productivity Metrix	• Deliver approved plan. • Productivity Benchmarks
We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.	We will: develop a calendar of sustainability engagement events for 2023/24; achieve a minimum recycling target of 40% for non-clinical waste streams; work to reduce single occupancy vehicle journeys by 5% by 2026; work towards our target of a 100% reduction in direct (scope 1) carbon dioxide equivalent emissions by 2040; work towards our target to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028	Stuart Sugarman	Deliver a calendar of sustainability engagement events for 2024/25; achieve a minimum recycling target of 40% for non-clinical waste streams; work to reduce single occupancy vehicle journeys by 5% by 2026; make progress towards our targets of a 100% reduction in emissions by 2040 and to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028	• a 100% reduction in direct (scope 1) carbon dioxide equivalent emissions by 2040. An 80% reduction will be achieved by 2032 • convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028 • a minimum recycling target of 40% for non-clinical waste streams • a 5% reduction in single occupancy journeys by 2026
Our investments and use of resources will be generating Social Value to support economic	We will demonstrate the additional social value generated by investment in the new A&E at HRI to create	Anna Basford	During 2024-25 we will work with our Construction Partner for the new Clinical Build at CRH and with local partners and communities to	• Agreed Social Value Action Plan with quantified measures.

5 Year Strategic Ambition	2023-24 Annual Objective	Lead Director	Proposed 2024-25 Annual Objective	Indicative Measure of Delivery in 2024-25
recovery in Calderdale and Kirklees Places.	local jobs, training opportunities and to support local businesses.		agree a Social Value action plan that will enable and measure delivery of economic and social benefits for people in Calderdale and Kirklees (for example through the use of local suppliers, local employment opportunities, the provision of training, work placements, apprenticeships and action to address climate change).	

Integrated Performance

11. Workforce Committee Chair's Highlight Report

To Note

Presented by Denise Sterling

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and OD Committee
Committee Chair:	Karen Heaton
Date(s) of meeting:	19 February 2024
Date of Board meeting this report is to be presented:	7 March 2024
ACKNOWLEDGE	The following points are to be noted by the Board following the meeting of the Committee on 19 February 2024 where the strategic theme was Improvement. • The Committee received presentations on the process of Work Together Get Results. The presentation was informative highlighting an example of where the process had not worked, the learning from this event and how this was then applied to the next situation to ensure success. The aim is to continue to roll out the programme with increasing numbers of staff being trained to apply the process across their own areas of activity and the Trust. • A presentation was given on the soon to be piloted Critical Event Support Debriefing Service. The Committee supported the pilot and agreed that defining a "critical event" could be challenging. However, The Committee would welcome feedback on the pilot and any learning at a future meeting. • The annual Staff Survey results are currently embargoed, and a verbal presentation was provided on the headline results. Overall, these are positive with some areas gaining positive percentage points in feedback from colleagues. A more detailed presentation will be provided as soon as the results are available. • The Committee received a presentation summarising the progress made with CHFT's recruitment strategy. Whilst there are challenging areas nationally in the recruitment of clinicians, nurses and midwives, CHFT continues to make good progress in filling vacancies with applicants stating that One Culture of Care is a unique attraction. • The Committee reviewed the progress being made against the Apprenticeship Strategy which it was agreed isa success story demonstrating how CHFT grows its own talent. Utilisation of the apprenticeship levy is high at 82% and further use

	of the levy is planned for this year. The approach to apprenticeships is multi-faceted and goes from strength to strength. The Government plans further changes to the scheme in April. • The BAF deep dive and the Medical Staffing Report both highlighted that recruitment has improved overall but this remains a challenging area both nationally and locally. The Committee supported the approaches taken and the commitment to ensure the base remains safe and agreed that the overall score of 16 should remain unchanged. • A further deep dive on Recruitment/Retention and Inclusive Leadership was presented and again The Committee agreed that the score of 12 should remain unchanged. • The Quality and Performance Report was presented, and The Committee agreed this is now much improved. There was concern expressed at the number of appraisals completed and supported the need for completion levels to be improved over the year but not at the expense of quality. It was confirmed that areas are being targeted for more intervention by the HR partners.
ASSURE	• The Committee were assured that all was being done to manage the medical workforce staffing levels to ensure the base remains safe. • The ESR annual assessment was presented highlighting two areas where the Trust was not complaint and two areas of partial compliance. These are not significant in that the Trust collects the data through other means. However, the Trust will work toward compliance which is being encouraged ahead of the introduction of a new ESR system in 2030.
AWARE	• The Committee also received the annual Gender Pay Gap report with results showing no real change on the previous year. The Trust will be preparing a report covering the Ethnicity Pay Gap and the Disability Pay Gap. The Committee approved publication of the Gender Pay Gap Report.
ONE CULTURE OF CARE	• One Culture of Care is considered as part of the workforce reports and in discussions.

12. Quality Committee Chair’s Highlight Report

- Update on Maternity Reporting - Verbal Update from Lindsay Rudge
- Director of Infection Prevention Control (DIPC) Q3 Report
- Learning from Deaths Q2 Report

To Note

Presented by Denise Sterling and Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Dates of meeting:	15 January 2024,12 February 2024
Date of Board meeting this report is to be presented:	7 March 2024
ACKNOWLEDGE	• The Patient Safety Incident Response Plan (PSIRP) and Patient Safety Incident Response Framework (PSIRF) Policies were reviewed and approved by Committee. Transition work is underway and go live is planned for 1sApril 2024.
ASSURE	• *Naso-gastric tube action plan* - good progress has been made, 11 actions closed, plans in place for all outstanding actions. • *Dementia screening* - Clinical Outcomes Group updated the Committee on improvements in dementia screening • Overview of *medication and safety issues* was provided by the Medicine Safety and Compliance Group, including the Trust's response to the national patient safety alerts. • *Research* activity and strong performance continues • *Maternity and Neonatal* Oversight report in January: - progress in recruitment, new cohort of newly qualified midwives starting April 2024, however flexible working requests for reduction of hours - funding identified for two Consultant Obstetrics and Gynaecology posts supports a must-do CQC action to increase antenatal clinic capacity. • Positive report (December 2023) from the Local Maternity and Neonatal System (LMNS) assurance visit. An update on the progress of the maternity and neonatal 3 year delivery plan and challenges to delivery was given at the February meeting. • Learning from Death Q2 Report highlighted an improved position of initial screening reviews between quarter 1 and quarter 2 and 44 out of 45 cases identified for a structured judgement review completed during quarter 2. There will be a change in focus to look at the outcomes from reviews and ensure robust action plans. • Annual Controlled Drugs first formal report summarised the governance arrangements and management of Controlled Drugs (CDs) for the period 1 Jan 23 - 31 Dec 23. This comprehensive report provided an overview of CD safety issues and actions taken, compliance checks with CD standards, quality improvement projects, next steps and workplan 2024/25. • Quality report - 2 open never events investigations underway, themes have been identified and work is ongoing, Committee to be kept updated on actions taken. - 94% complaints closed within agreed timeframe (Dec-January)

	- next steps in response to the CQC new approach to regulation outlined - Quality Priorities a) Alternative to Hospital admission, virtual ward doing well, proportion of people seen within 2 hours in the urgent community response is below target, focussed work underway regarding recording and accuracy. b) MUST performance at 80% not achieving target but an improvement from previous position. c) NEWS score is proving challenging. - Significant progress has been made with reviewing and updating policies and the clinical repository • Integrated Performance Report – Committee noted the current pressure points such as 52 week waits, achieving the emergency care standards with high attendance through ED, high levels of delayed transfers of care and effective controls for infection prevention and control with high bed occupancy were noted. Positive performance noted for cancer services, complaints, infection prevention and control with no MRSA (meticillin-resistant Staphylococcus aureus) cases. Further work to analyse and understand patient acuity and length of stay required.
AWARE	• Sepsis in ED - Clinical Outcomes Group update to the Committee confirmed ongoing work to improve the position for sepsis for antibiotics given within an hour, against a target of 80%. • Medical Examiner (ME) service is entering the statutory phase expected to become effective in April 2024, with Consultants and GPs responsible for informing the ME service of patients who have died and provide the cause of death. The ME service will have limited capacity and good engagement and proactivity from consultants is key to minimise delays for bereaved families. The community roll out remains a priority to get all 56 practices on board by the end of March. • Quality Account timeline noted to ensure that the Quality account is submitted within the expected time frames. • Noted proposed quality account priorities for 2024/2025 discussed with the Council of Governors at a recent workshop. • Changes to be made to the IPR in the new financial year to increase the focus on quality by pulling through more of the quality of care metrics in the preceding summary. • A Valproate Action Plan has been developed in response to the National Patient Safety Alert. Changes in legislation is now in place and the must do's identified, the task and finish group will continue to meet monthly and report into the Medicines Safety Group who will provide the monitoring. Escalation points will come to Committee.
ONE CULTURE OF CARE	• One Culture of Care is considered as part of the Quality Committee reports and in discussions.

Date of Meeting:	Thursday 7 March 2024
Meeting:	Board of Directors
Title:	Q3 2023/24 Director of Infection Prevention and Control (DIPC) Report
Author:	Belinda Russell, Lead Nurse IPC (infection Prevention and Control)
Sponsoring Director:	Dr David Birkenhead, DIPC
Previous Forums:	None
Purpose of the Report	The report provides an update on Infection, Prevention and Control (IPC) Performance and activity for the third quarter of 2023/24.
Key Points to Note	Current organism figures are now above or on end of year target expectations and have breached: National targets no longer set for MRSA bacteraemia or MSSA. ANTT competency is now being assessed at the commencement of employment/training for all medical staff which has seen a rise of increased compliance which is hoped to be maintained going forwards.
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 receive and note the content of the report.

Director of Infection Prevention and Control (DIPC) Report
Quarter 3

Introduction

This report covers the period from 1st October – 31st December 2023. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators.

1. Performance targets

Indicator	Objective 2023/24	CHFT Year to date performance Last yr to date figures for comparison in brackets	Actions/Comments
MRSA bacteraemia	0	0 (2)	Not mentioned on this year's targets continue to be monitored by IPC team. 0 - HOHA 1 - COHA
C.difficile (HOHA & COHA)	37	44 (47)	29 -HOHA 15 -COHA (17 -COCA) (Q1 HOHA 4 April, 3 May, 2June =9) (Q2 HOHA 1 July, 6 Aug, 2 Sept = 9) (Q3 HOHA 2 Oct, 6 Nov, 3 Dec = 11)
E. coli bacteraemia	67	51 (62)	23 - HOHA 28- COHA (182 - COCA)
Pseudomonas aeruginosa	2	4 (4)	2 -HOHA 2 -COHA (9-COCA)
Klebsiella spp.	28	31 (28)	13 -HOHA 18 -COHA (51-COCA)
MSSA	0	27 (83)	Not mentioned on this year's targets continue to be monitored by IPC team. 16- HOHA 11 - COHA (56 – COCA)
ANTT Competency assessments (medical staff)	90%	80.17%	Increased 23.02%
ANTT Competency assessments (nursing and AHP)	90%	93.83	Increased 4.43%
Hand hygiene	95%	100%	
Level 2 IPC training (Medical staff)	90%	82.36%	Increased 1.94%
Level 2 IPC training (nursing and AHP)	90%	93.83%	Increased 0.89%

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%	91.62%	
Isolation breaches	Non-set	Not recorded this quarter	COVID-19 patients remain priority for side room isolation

3. MRSA bacteraemia:

No objective for MRSA cases in year. Zero HOHA and 1 COHA case deemed unpreventable to report during the current year to date.

4. MSSA bacteraemia:

There is no objective set for MSSA. The IPC team continue to review these cases. 16 HOHA cases year to date, these have been reviewed with no correlations between the cases.

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 has been a total of 29 HOHA cases and 15 COHA cases year to date. Each case up to the end of September has been investigated following the PIR guidance within the IPC team. All Cases going forwards will have a Patient Safety Incidence Response Framework (PSIRF) review using a Multi-Disciplinary Team (MDT) approach and steps away from blame being apportioned, instead the emphasis is on what learning can be found across the system using contributory factors which are then appraised into themes; these will help to formulate the IPC team annual plan.

6. E. coli bacteraemia:

There have been 23 HOHA plus 28 COHA *E. coli* bacteraemia cases. This is 76% of the years target figure and will continue to be monitored.

7. Outbreaks & Incidents:

Increased incidence Covid-19: There has been a gradual increase in Covid19 cases recorded during Q3 where increased cases mitigations have been in place.

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

Areas closed due to Outbreaks in Q3.
Ward 20B HRI _ Covid 19 _ Closed 06/10/23.
Ward 15A HRI _Norovirus _Closed 09/11/23.
Ward 17 HRI _Covid 19 _ Closed 23/11/23.
Ward 20A HRI _Covid 19 _Closed 05/12/23.

Ward 6A CRH _Covid 19 _Closed 08/12/23.
Ward 20B HRI _Norovirus _Closed 09/12/23.
Ward 20B HRI_ Covid 19 & Norovirus _Closed 13/12/23.
Ward 6A HRI _Norovirus _Closed 18/12/23.
Ward 15B HRI _Covid 19 _Closed 19/12/23.

All areas were monitored for staff compliance, patient symptoms, positive results and reopened at the earliest safe opportunity. Many of these outbreaks were in the older style open ward areas with limited capacity to source isolate any patients who developed symptoms. ALL areas remained open to visitors with advisory signage in place at entrances.

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.

9. Recommendations

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

Learning from Deaths Report

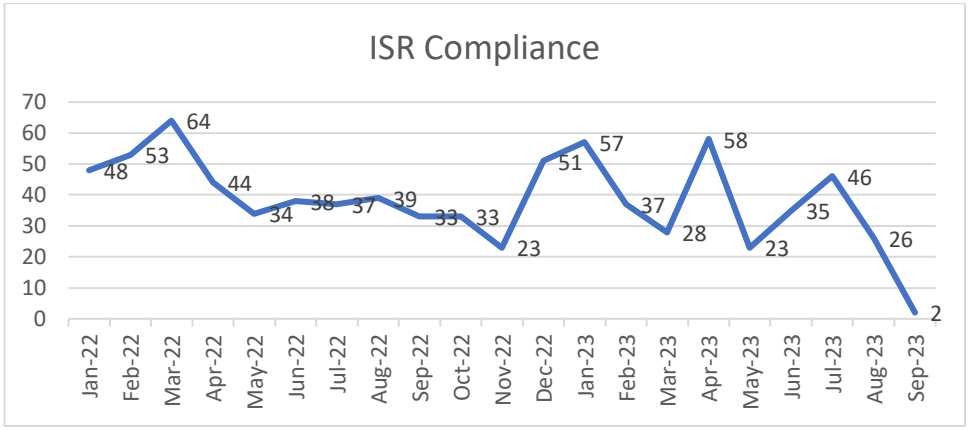
In Quarter 2 (July – September 2023), there were **381** adult inpatient deaths at CHFT recorded on Knowledge Portal.

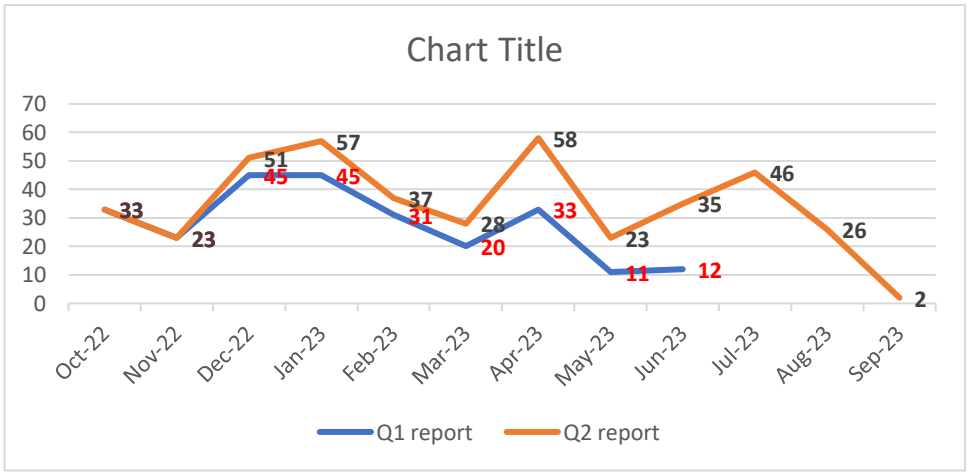
Initial Screening Reviews (ISR)

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

Of the **381** adult inpatient deaths recorded in Quarter 2 of 2023/2024, **88** (**21%**) have been reviewed using the initial screening tool. The committee is reminded of the slight lag between issuing cases for review and completion of this report (MSG have allocated mortalities up to June 2023). However, we are still falling short of the 50% target. Extra capacity for completion of ISRs has been offered by our Trust CT trainees. Trainees will be provided with confirmation of completion for their portfolios once they have undertaken 10 completed ISRs. And Mortality Leads have been contacted to remind all staff that the timeframe from allocation to review is 4 weeks.

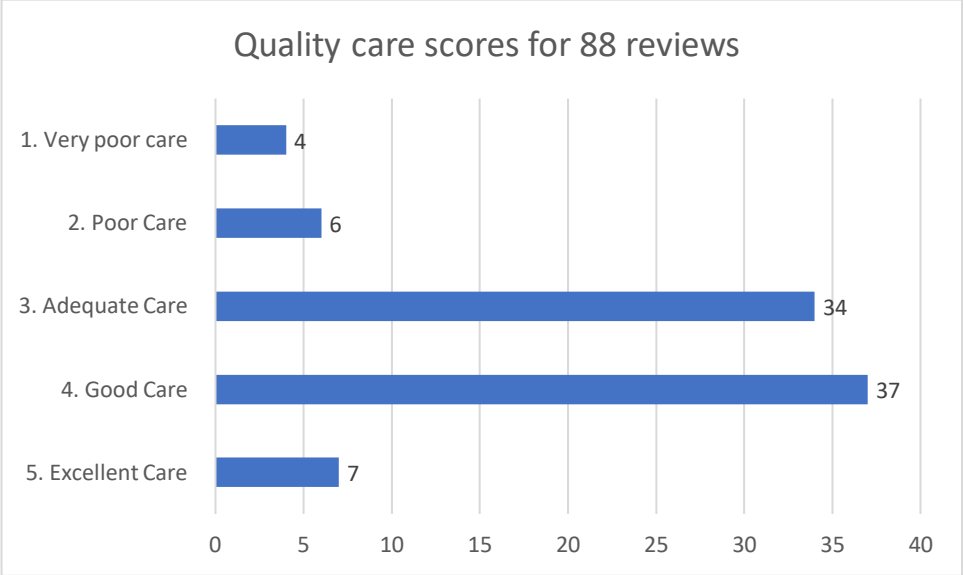
*Data in the **Q1** report demonstrated that of the **419** adult inpatient deaths recorded in Quarter 1 of 2023/2024, **100** (**24%**) have been reviewed using the. Compliance has increased since and is now at **39%** (162 deaths reviewed)*
The table below shows the number of adult inpatient deaths reviewed by ISR by month over the last 12 months.





Quality of care reviewed

% Quality Care Scores for ISRs completed in Q2 (July to September 2023/24) n=88

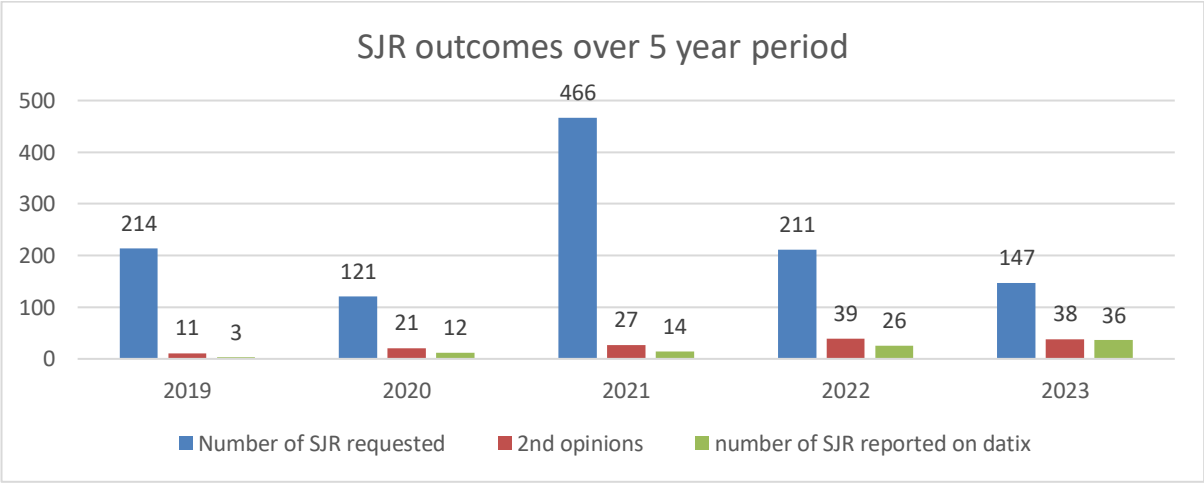


All ISRs that are escalated to SJR must have a valid rationale recorded for escalation purposes.

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

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

SJR Comparison year on year

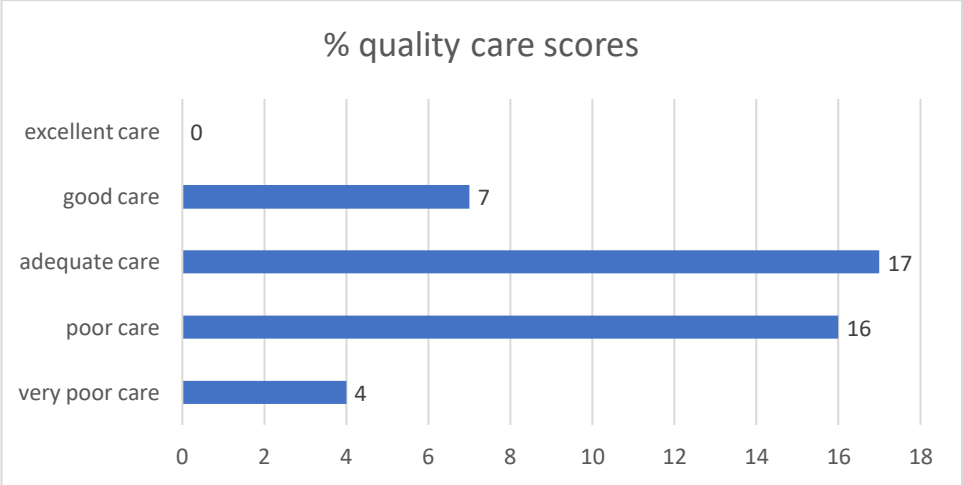


A total of 45 SJRs were requested in Quarter 2 (July to Sept) of 2023/24 of which **44** had been completed at the time this report was done.

	Escalated by ISR	Escalated by ME	2nd opinion	SI Panel	Elective	Learning Disability	HED alerts	Total
total	**6**	**17**	**12**	**4**	**0**	**1**	**4**	**44**

There is currently a backlog of incidents reported via the SJR process that are awaiting discussion & validation at Medicine orange panel. The Learning from Deaths Lead is working with the Division of Medicine to clear this backlog. Extra panel, dedicated to incidents identified by SJR, have been ongoing in the last 3 months

Quality of Care score distribution for 44 completed SJRs



11 SJRs were reported on Datix and escalated to the divisions for validation in Q2.
The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

Of the SJRs completed in Quarter 2 2023/2024 the following learning themes and concerns were identified:

The following good practice was identified:

- The clerking is very detailed.
- There is early input from both dietician and physio with handover from PGH sought.
- Very good, coordinated work with LD matron and ward team.
- Patient deterioration was always actioned appropriately.
- Appropriate review by professionals.
- Prompt assessment and treatment in ED
- Early recognition of a patient approaching end of life
- Senior review every day
- Very good documentation

The following poor practice was identified:

- Diagnosis was delayed by more than 3 weeks.
- Poor A&E care- No treatment or diagnosis made.
- Poor PTWR- no diagnosis and planning, NO DNACPR review or decision-
- NO PPI treatment given.
- Continuation of Aspirin when it should have been stopped

- Despite fainting episode/drop in postural bleed- OGI was not done immediately
- Lack of recognition and appropriate management of AKI
- Failure to establish appropriate ceilings of care leading to futile CPR.
- Lack of consideration for unsafe swallow
- Very delayed clinical review (7 hours) , lack of reviews on deteriorating patient
- Failure to recognise and treat developing metabolic acidosis and worsening renal failure.
- Goals of care and DNACPR considered 1 hour before death.
- Lack of meaningful discussion with the patient and NOK on admission regarding patient's wishes and management plan

Recommendation to Quality Committee

The Board is asked to note the Learning from Deaths Quarter 2 report.

13. Finance and Performance Committee Chair's Highlight Report

To Note

Presented by Andy Nelson

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	30th January and 27th February 2024
Date of Board meeting this report is to be presented:	Thursday 7 March 2024
ACKNOWLEDGE	• Continued strong performance in Cancer with all key targets being met • Recovery performance also remains strong and continues to be the best in the West Yorkshire ICS (see table below). We have seen an increase in 52-week waiters to 89 but 77 of these are in ENT. There is increased focus in ENT to get this number as close to zero as possible by year end. In terms of our target for 40-week waiters we expect all specialties to meet this bar ENT • Quality indicators showing quality of care holding up well despite significant operational pressures in December and January • We are still forecasting to deliver the financial plan for this year. Our cash position is favourable, aged debt stable and better payment practice is above target

ASSURE	• At our January meeting we:
	  ○ We reviewed the National Cost Submission Report and were assured it had been submitted in line with expectations
	  ○ Had a deep dive into Elective Recovery which examined the key reasons behind the success we have had. These included theatre staffing, theatre utilisation and an ongoing focus on theatre productivity; use of a cost per case system for surgical lists at weekends; improved tracking of patients and culture and teamwork
	• At our February meeting we:
	  ○ Approved the updated Terms of Reference for the committee
	  ○ Approved the 2024/25 Capital Plan
	  ○ Reviewed the cash position and the need for a £20m PDC funding request for Q1 of the 2024/25 financial year
	  ○ Undertook a follow-up deep dive into ED performance and plans. This showed performance has unfortunately declined since our last deep dive into ED in May 2023 although we still rank 15th out of 122 Type 1 ED departments. This has primarily been driven by greater demand and high levels of bed occupancy. However, great progress has been made in staffing resulting in £2.4m savings and ED consultant staffing now meeting

	the levels set in the Royal College of Emergency Medicine guidance. The team explained the actions planned to meet the 76% target for treatment within 4 hours in which greater use of SDEC is key
AWARE	• Although some improvement in performance has been seen ENT is the main area for concern for elective recovery and high numbers of Appointment Slot Issues. The committee will be taking another look at progress against the agreed action plan for ENT • Operational pressures are significant, and these continue to play through into our financial position particularly, length of stay, high levels of bed occupancy, high attendance rates at ED, non-pay inflationary pressures and the costs of strike action (although we expect these to be fully funded) • At month 10 we are reporting a £21.05m deficit which is a £3.62m adverse variance to plan. • Current expectation is that a gap of circa £4m will remain in the 2023/24 CIP programme and attention is now being given to developing the £25m 2024/25 programme • The adverse variance to plan across the ICS was £23m YTD at month • The initial draft of the 2024/25 financial plan shows a very challenging position of a worsening deficit position compared to this year even assuming a £25m CIP programme. These plans have been developed absent formal national planning guidance and are subject to continuing scrutiny and review both internally and with the ICB
ONE CULTURE OF CARE	One Culture of Care considered as part of the performance and finance reports. Senior member of WOD now attends F&P on a regular basis plus WOD representation in deep dives. This allowed the Committee to check in on workforce performance (such as sickness levels) and well-being and whether any further actions can be taken given the significant operational pressures staff are facing.

Elective Recovery Position as of 16/2/24

Provider	40 Week Waits	52 Week Waits	65 Week Waits	78 Week Waits	104 Week Waits
Airedale	1,632	652	201	13	0
Bradford	1,961	510	68	2	0
Calderdale and Huddersfield	1,073	89	0	0	0
Leeds	10,859	3,936	1,173	242	4
Harrogate	1,786	541	113	0	0
Mid Yorks	5,606	1,977	591	69	0

14. Month 10 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 March 2024
Meeting:	Public Board of Directors
Title:	Month 10 Finance Report
Author:	Philippa Russell - Assistant Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance & Performance Committee
Purpose of the Report	The purpose of this report is to provide a summary of the financial position as reported at the end of Month 10 (January 2024)
Key Points to Note	**Year To Date Summary** The Trust is reporting a £21.05m deficit, (excluding the impact of Donated Assets and the PFI remeasurement due to IFRS16), a £3.62m adverse variance from plan. The in-month position is a deficit of £3.51m, a £1.82m adverse variance. Key drivers of the adverse variance included: higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £3.80m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.93m; and non-pay inflationary pressures. It is assumed that Strike costs will be fully funded through additional ICS allocations, (£2.1m received YTD). Other pressures are offset to some extent by additional Elective recovery Funding, identification of some CIP mitigation and higher than planned commercial income (HPS). • Position includes additional Elective Recovery Funding of £0.35m to reflect year to date above plan activity performance. Total allocation year to date is £12.87m. • West Yorkshire mechanism for allocating Elective Recovery Funding (ERF) focuses on targeting achievement of waiting list performance rather than activity volumes. The original plan was that Financial penalties would be imposed for any patients not treated within the 52 week target. This target has already been amended to reflect the impact of Strike action and a further amendment is expected following recent national announcements. Year to date the Trust has not incurred any penalties and is forecasting to exceed the current target.

	• Overall Weighted Elective Recovery Position as a percentage of plan was 109.1%. • The Trust has delivered efficiency savings of £21.48m, £2.96m lower than planned. • Agency expenditure year to date was £8.61m, £1.95m lower than the Agency Ceiling, (3.7% of total pay expenditure) but £1.28m higher than planned. **Key Variances** • Income is £8.39m above the plan. Clinical contract income is £4.33m above plan and includes £2.1m additional ICS allocation to support YTD Industrial Action, Covid-19 testing funding (offset to some extent by costs), additional ERF funding (£0.35m) and higher than planned NHSE funded high-cost drugs and devices. Year to date commercial income is above plan (Health Informatics and HPS); there is a favourable variance on Provider to Provider contracts; and the Trust is also receiving additional income to support Community Diagnostic Centres. This additional income supports higher than planned costs in the year to date position. • Pay costs were £6.01m higher than the planned level. Pay pressures are linked: to higher than planned bed capacity (£3.80m) - £0.77m surge capacity, plus £3.03m slippage on efficiency schemes linked to bed closures due to higher than planned numbers of patients requiring Transfer of Care (TOC) and higher than planned Length of Stay (LOS); the impact of strike action (£2.93m impact YTD); supernumerary overseas nurses (£0.90m). These pressures have been offset to some extent by an underspend associated with Elective Recovery, offset in turn by additional costs incurred on Independent Sector spend (Insourcing and Outsourcing) to support the Recovery plan. • Non-pay operating expenditure is £9.85m higher than planned year to date due to: higher than planned rates, utilities and maintenance costs; the impact of actions required to eradicate Legionella; Health Informatics commercial contracts (£1.20m offset by additional income); higher than planned expenditure on clinical supplies including devices, ward consumables, equipment hire, patient appliances and theatre costs; and higher than planned insourcing / outsourcing costs associated with Elective Recovery and key Medical Staffing gaps. **Forecast** The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £1.70m. Key drivers of this forecast deficit are £3.95m slippage on efficiencies, non-pay inflationary pressures, additional bed capacity and Strike costs (assumes no further industrial action). Some internal mitigations have been identified alongside additional ICS allocations to support YTD Strike costs and a further £1.60m of ERF funding expected due to changes to Recovery performance targets. Discussions with the ICS are ongoing regarding potential further funding allocations to close the remaining £1.70m gap to deliver on plan. Current likely case assumes receipt of £16.66m of ERF, £1.63m more than planned. Adjustments to ERF targets have been agreed nationally as

	a result of the Industrial Action and should remove any risk of penalties for the Trust. National / ICB discussions continue to confirm the level of slippage in the agreed waiting list targets that will be allowable as a result of the impact of Industrial action and there is now a strong expectation that there will be the opportunity for the Trust to secure additional funding as a result of the current strong performance on Recovery. Attached: Month 10 Finance Report
EQIA – Equality Impact Assessment	The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.
Recommendation	The Board is asked to **RECEIVE** the Finance Report and **NOTE** the financial position for the Trust as at 31st January 2024.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jan 2024 - Month 10

KEY METRICS

	M10				YTD (JAN 2024)				Forecast 23/24			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£1.70)	(£3.51)	(£1.82)		(£17.43)	(£21.05)	(£3.62)		(£20.80)	(£20.80)	£0.00	
Agency Expenditure (vs Ceiling)	(£1.06)	(£0.73)	£0.33		(£10.56)	(£8.61)	£1.95		(£12.67)	(£10.28)	£2.39	
Capital	£2.85	£4.39	(£1.54)		£24.73	£20.64	£4.09		£34.00	£49.12	(£15.12)	
Cash	£20.06	£28.50	£8.44		£20.06	£28.50	£8.44		£2.19	£1.90	(£0.29)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	96.1%	1%		95.0%	93.9%	-1%					
Cost Improvement Plans (CIP)	£3.42	£2.31	(£1.11)		£24.44	£21.48	(£2.96)		£31.50	£27.55	(£3.95)	
Use of Resource Metric	3	3			3	3			3	3		

Year To Date Summary

The Trust is reporting a £21.05m deficit, (excluding the impact of Donated Assets and the PFI remeasurement due to IFRS16), a £3.62m adverse variance from plan. The in month position is a deficit of £3.51m, a £1.82m adverse variance.

Key drivers of the adverse variance included: higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £3.80m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.93m; and non-pay inflationary pressures. It is assumed that Strike costs will be fully funded through additional ICS allocations, (£2.1m received YTD). Other pressures are offset to some extent by additional Elective recovery Funding, identification of some CIP mitigation and higher than planned commercial income (HPS).

- Position includes additional Elective Recovery Funding of £0.35m to reflect year to date above plan activity performance. Total allocation year to date is £12.87m.
- West Yorkshire mechanism for allocating Elective Recovery Funding (ERF) focuses on targeting achievement of waiting list performance rather than activity volumes. The original plan was that Financial penalties would be imposed for any patients not treated within the 52 week target. This target has already been amended to reflect the impact of Strike action and a further amendment is expected following recent national announcements. Year to date the Trust has not incurred any penalties and is forecasting to exceed the current target.
- Overall Weighted Elective Recovery Position as a percentage of plan was 109.1%.
- The Trust has delivered efficiency savings of £21.48m, £2.96m lower than planned.
- Agency expenditure year to date was £8.61m, £1.95m lower than the Agency Ceiling, (3.7% of total pay expenditure) but £1.28m higher than planned.

Key Variances

- Income is £8.39m above the plan. Clinical contract income is £4.33m above plan and includes £2.1m additional ICS allocation to support YTD Industrial Action, Covid-19 testing funding (offset to some extent by costs), additional ERF funding (£0.35m) and higher than planned NHSE funded high cost drugs and devices. Year to date commercial income is above plan (Health Informatics and HPS); there is a favourable variance on Provider to Provider contracts; and the Trust is also receiving additional income to support Community Diagnostic Centres. This additional income supports higher than planned costs in the year to date position.
- Pay costs were £6.01m higher than the planned level. Pay pressures are linked: to higher than planned bed capacity (£3.80m) - £0.77m surge capacity, plus £3.03m slippage on efficiency schemes linked to bed closures due to higher than planned numbers of patients requiring Transfer of Care (TOC) and higher than planned Length of Stay (LOS); the impact of strike action (£2.93m impact YTD); supernumerary overseas nurses (£0.90m). These pressures have been offset to some extent by an underspend associated with Elective Recovery, offset in turn by additional costs incurred on Independent Sector spend (Insourcing and Outsourcing) to support the Recovery plan.
- Non-pay operating expenditure is £9.85m higher than planned year to date due to: higher than planned rates, utilities and maintenance costs; the impact of actions required to eradicate Legionella; Health Informatics commercial contracts (£1.20m offset by additional income); higher than planned expenditure on clinical supplies including devices, ward consumables, equipment hire, patient appliances and theatre costs; and higher than planned insourcing / outsourcing costs associated with Elective Recovery and key Medical Staffing gaps.

Forecast

The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £1.70m. Key drivers of this forecast deficit are £3.95m slippage on efficiencies, non-pay inflationary pressures, additional bed capacity and Strike costs (assumes no further industrial action). Some internal mitigations have been identified alongside additional ICS allocations to support YTD Strike costs and a further £1.60m of ERF funding expected due to changes to Recovery performance targets. Discussions with the ICS are ongoing regarding potential further funding allocations to close the remaining £1.70m gap to deliver on plan.

Current likely case assumes receipt of £16.66m of ERF, £1.63m more than planned. Adjustments to ERF targets have been agreed nationally as a result of the Industrial Action and should remove any risk of penalties for the Trust. National / ICB discussions continue to confirm the level of slippage in the agreed waiting list targets that will be allowable as a result of the impact of Industrial action and there is now a strong expectation that there will be the opportunity for the Trust to secure additional funding as a result of the current strong performance on Recovery.

Total Group Financial Overview as at 31st Jan 2024 - Month 10

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M10

CLINICAL ACTIVITY

	M10 Plan	M10 Actual	Var
Elective	3,846	3,848	2
Non-Elective	45,083	44,280	(803)
Daycase	41,545	44,000	2,456
Outpatient	361,082	379,321	18,239
A&E	146,120	147,931	1,811
Other NHS Non-Tariff	1,643,364	1,825,951	182,587
Total	**2,241,039**	**2,445,331**	**204,292**

TOTAL GROUP: INCOME AND EXPENDITURE

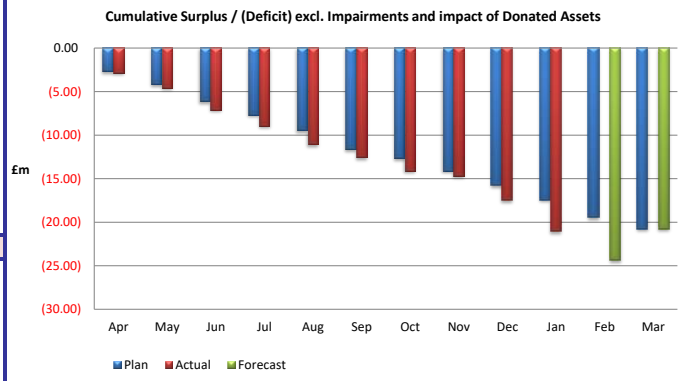
	M10 Plan	M10 Actual	Var
	£m	£m	£m
Elective	£14.69	£15.66	£0.98
Non Elective	£105.53	£109.24	£3.71
Daycase	£29.95	£32.61	£2.66
Outpatients	£36.61	£40.20	£3.58
A & E	£26.34	£27.59	£1.25
Other-NHS Clinical	£182.48	£172.14	(£10.34)
CQUIN	£0.00	£0.00	£0.00
Other Income	£45.98	£52.53	£6.55
Total Income	**£441.58**	**£449.97**	**£8.39**
Pay	(£291.77)	(£297.78)	(£6.01)
Drug Costs	(£39.99)	(£38.06)	£1.93
Clinical Support	(£28.11)	(£29.12)	(£1.01)
Other Costs	(£53.42)	(£63.88)	(£10.46)
PFI Costs	(£13.49)	(£13.81)	(£0.31)
Total Expenditure	**(£426.78)**	**(£442.64)**	**(£15.86)**
EBITDA	**£14.80**	**£7.33**	**(£7.48)**
Non Operating Expenditure	(£32.23)	(£28.37)	£3.86
Surplus / (Deficit) Adjusted*	**(£17.43)**	**(£21.05)**	**(£3.62)**

* 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

	M10 Plan	M10 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£86.91)	(£86.92)	(£0.02)
Medical	(£116.32)	(£119.17)	(£2.84)
Families & Specialist Services	(£78.67)	(£78.63)	£0.04
Community	(£27.49)	(£26.81)	£0.68
Estates & Facilities	£0.00	£0.01	£0.01
Corporate	(£47.79)	(£46.77)	£1.02
THIS	£1.13	£1.09	(£0.04)
PMU	£1.01	£1.90	£0.88
CHS LTD	£0.59	£0.52	(£0.08)
Central Inc/Technical Accounts	£333.85	£334.65	£0.80
Reserves	£3.17	(£0.90)	(£4.07)
Surplus / (Deficit)	**(£17.43)**	**(£21.05)**	**(£3.62)**

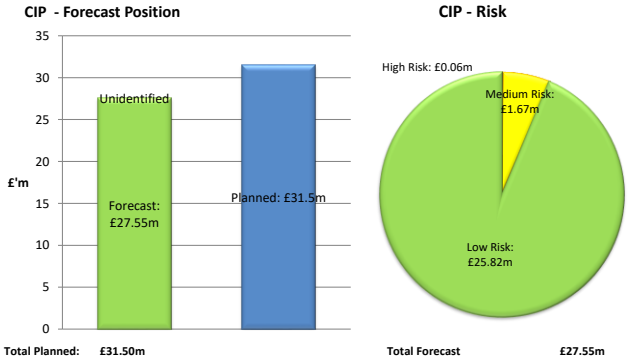
TOTAL GROUP SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date			Year End: Forecast		
	M10 Plan	M10 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£17.43)	(£21.05)	(£3.62)	(£20.80)	(£20.80)	£0.00
Capital	£24.73	£20.64	£4.09	£34.00	£49.12	(£15.12)
Cash	£20.06	£28.50	£8.44	£2.19	£1.90	(£0.29)
Invoices Paid within 30 days (BPPC)	95%	94%	-1%			
CIP	£24.44	£21.48	(£2.96)	£31.50	£27.55	(£3.95)
	Plan	**Actual**		**Plan**	**Forecast**	
Use of Resource Metric	3	3		3	3	

COST IMPROVEMENT PROGRAMME (CIP)



YEAR END 23/24

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	4,636	4,673	37
Non-Elective	53,866	52,898	(969)
Daycase	49,935	53,027	3,092
Outpatient	434,259	457,098	22,839
A&E	174,293	176,454	2,161
Other NHS Non- Tariff	1,975,197	2,194,734	219,537
Total	**2,692,185**	**2,938,883**	**246,697**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£17.69	£19.05	£1.35
Non Elective	£125.90	£130.31	£4.40
Daycase	£36.01	£39.37	£3.36
Outpatients	£44.01	£48.49	£4.48
A & E	£31.42	£32.91	£1.49
Other-NHS Clinical	£219.67	£211.90	(£7.76)
CQUIN	£0.00	£0.00	£0.00
Other Income	£55.28	£62.36	£7.08
Total Income	**£529.98**	**£544.38**	**£14.39**
Pay	(£350.38)	(£356.75)	(£6.37)
Drug Costs	(£47.98)	(£45.86)	£2.11
Clinical Support	(£33.68)	(£34.71)	(£1.03)
Other Costs	(£63.83)	(£76.18)	(£12.34)
PFI Costs	(£16.19)	(£16.57)	(£0.38)
Total Expenditure	**(£512.06)**	**(£530.06)**	**(£18.01)**
EBITDA	**£17.92**	**£14.31**	**(£3.61)**
Non Operating Expenditure	(£38.72)	(£35.11)	£3.61
Surplus / (Deficit) Adjusted*	**(£20.80)**	**(£20.80)**	**£0.00**

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

DIVISIONS: INCOME AND EXPENDITURE

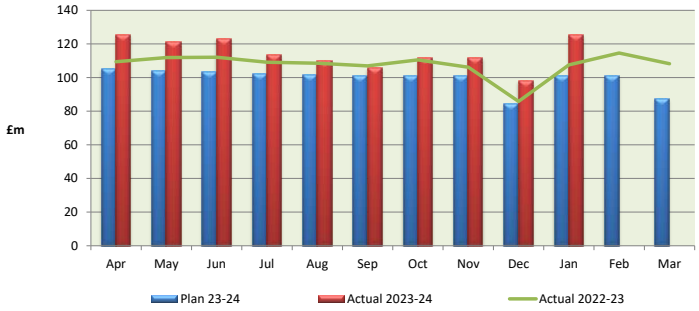
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£104.06)	(£104.73)	(£0.67)
Medical	(£141.03)	(£143.16)	(£2.13)
Families & Specialist Services	(£94.21)	(£94.46)	(£0.24)
Community	(£33.18)	(£32.51)	£0.67
Estates & Facilities	£0.00	£0.01	£0.01
Corporate	(£57.22)	(£56.41)	£0.81
THIS	£1.36	£1.36	£0.00
PMU	£1.20	£2.10	£0.90
CHS LTD	£0.71	£0.63	(£0.08)
Central Inc/Technical Accounts	£401.64	£403.91	£2.27
Reserves	£3.99	£2.46	(£1.53)
Surplus / (Deficit)	**(£20.80)**	**(£20.80)**	**£0.00**

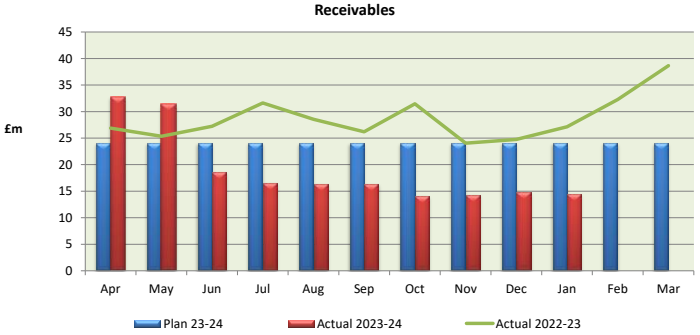
Total Group Financial Overview as at 31st Jan 2024 - Month 10

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

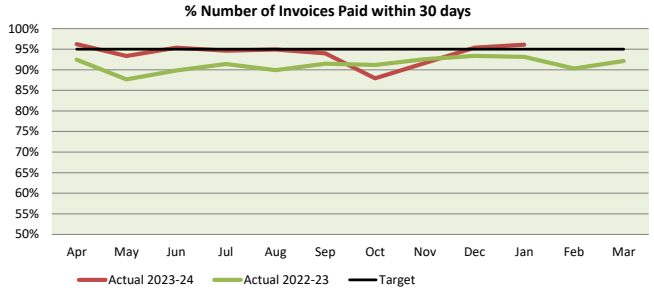
WORKING CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Payables (excl. Current Loans)	(£100.77)	(£125.14)	£24.37	
Receivables	£24.04	£19.46	£4.58	



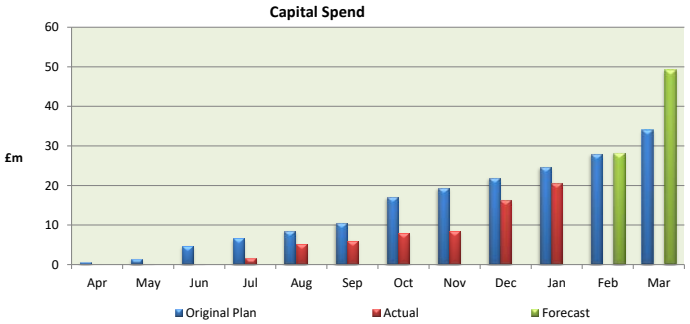


BETTER PAYMENT PRACTICE CODE



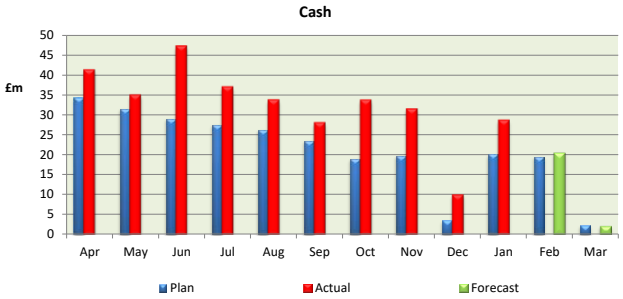
CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Capital	£24.73	£20.64	£4.09	

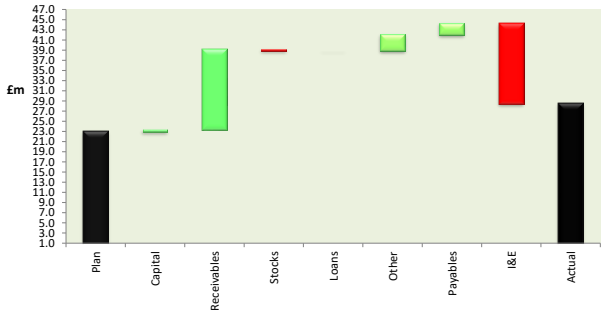


CASH

	M10 Plan £m	M10 Actual £m	Var £m	M10
Cash	£20.06	£28.50	£8.44	
Loans (Cumulative)	£13.25	£13.25	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust is reporting a £21.05m deficit, (excluding the impact of Donated Assets and PFI remeasurement IFRS16), a £3.62m adverse variance from plan.
- Year to date the Trust has incurred higher than planned costs due to: higher than planned additional bed capacity of £3.80m (including slippage on associated CIP); Strike costs of £2.93m; and non-pay inflationary pressures. Strike costs are assumed to be fully funded through additional ICS allocations and other pressures were offset to some extent by the identification of some CIP mitigation and higher than planned commercial income (HPS).
- Position also includes additional Elective Recovery Funding (ERF) of £0.35m to reflect year to date above plan activity performance. Total allocation year to date is £12.87m.
- Overall Weighted Elective Recovery Position as a percentage of plan was 109.1%.
- The Trust has delivered efficiency savings of £21.48m, £2.96m below the planned level.
- The Trust has a cash balance of £28.50m, £8.44m more than planned.
- Capital expenditure is lower than planned at £20.64m against a planned £24.73m.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3, as planned, with one metric (I&E Margin Variance from Plan) away from plan.

NOTES

- The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £1.70m. Key drivers of this forecast deficit are: £3.95m slippage on efficiencies, non-pay inflationary pressures, additional bed capacity and Strike costs (assumes no further industrial action). Some internal mitigations have been identified alongside additional ICS allocations to support YTD Strike costs and a further £1.60m of ERF funding expected due to changes to Elective Recovery performance targets.
- Forecast assumes full receipt of £16.66m of Elective Recovery Funding (ERF), £1.63m more than planned.
- The Capital forecast is to spend £49.12m, £15.12m more than planned. Additional PDC funding has been awarded to support the Community Diagnostic Centre and HPS expansion. Internally funded capital is forecast at £22.47m, £5.45m more than planned, including £8.10m for Reconfiguration where the Capital allocation has been agreed in advance of the Public Dividend Capital Funding.
- The total loan balance is £13.25m as planned. The increased capital expenditure agreed for Reconfiguration will increase the Trust's reliance on Revenue Support Public Dividend Capital (PDC) above the planned level in this financial year. The plan was to draw down £9.5m to support the 23/24 deficit plan, using residual carried forward cash balances to minimise this requirement. Current forecast is £8.3m due to an improved working capital position. The increase in the capital expenditure plan had led to an expectation the Trust would require an increased drawdown, but associated cash requirements are now expected for the new financial year.
- The Trust is forecasting to end the year with a cash balance of £1.90m. The Trust is required to manage cash to this level in order to access Revenue Support PDC.
- The Trust is forecasting a UOR of 3 as planned.

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

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

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

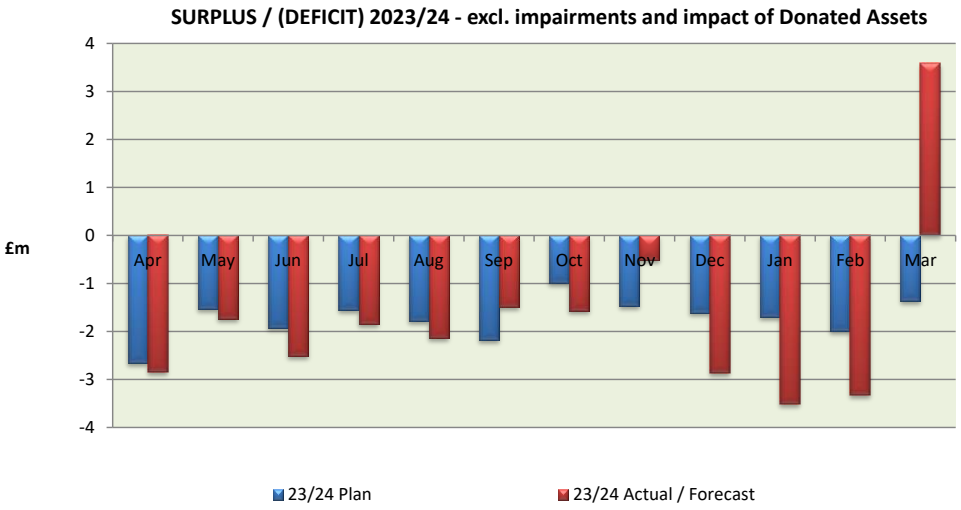
FORECAST 2023/24

23/24 Forecast Position (31 Mar 24)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m	
Income	£530.07	£544.85	£14.78	
Pay expenditure	(£350.38)	(£356.75)	(£6.37)	
Non Pay Expenditure	(£161.68)	(£173.31)	(£11.63)	
Non Operating Costs	(£39.15)	(£47.45)	(£8.30)	
Total Trust Surplus / (Deficit)	**(£21.15)**	**(£32.67)**	**(£11.52)**	
Deduct impact of:				
Impairments & Revaluations (AME)[1]	£0.00	£0.00	£0.00	
Remeasurement of PFI (IFRS16)	£0.00	£11.68	£11.68	
Donated Asset depreciation	£0.43	£0.66	£0.23	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.47)	(£0.38)	
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	**(£20.80)**	**(£20.80)**	**£0.00**	

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

MONTHLY SURPLUS / (DEFICIT)



Forecast Position:

Whilst the Trust is reporting the forecast in line with plan, the 'likely case' forecast indicates that the Trust is currently on track to end the year with a deficit position of £22.50m, £1.70m worse than planned. Key drivers of this forecast gap are £3.95m slippage on efficiencies, non-pay inflationary pressures, additional bed capacity and Strike costs (assumes no further industrial action). Some internal mitigations have been identified alongside additional ICS allocations: the ICS has allocated £2.1m of funding to support YTD Strike costs and is indicating that further funding will be made available to cover the cost of December and January Strikes. A further £1.6m of ERF funding is also forecast due to changes to Elective Recovery performance targets. Discussions with the ICS are ongoing regarding potential further funding allocations to close the remaining £1.70m gap to deliver on plan.

The worst case scenario is a £6.84m adverse variance from plan and in addition to the above includes: further slippage on efficiency schemes; the risk that additional ERF is not secured despite strong operational performance, additional 'Surge' bed capacity during the winter months; and commercial income risk.

Adjustments to ERF targets have been agreed nationally as a result of the Industrial Action and should remove any risk of penalties for the Trust. National / ICB discussions continue to confirm the level of slippage in the agreed waiting list targets that will be allowable as a result of the impact of Industrial action and there is now a strong expectation that there will be the opportunity for the Trust to secure additional funding as a result of the current strong performance on Recovery.

Other Assumptions and Potential Risks / Opportunities

- £32m of additional funding was provided to the ICS to support Industrial Action and other YTD pressures, of which only £15m has currently been allocated to Providers. Discussions are ongoing regarding the allocation of the remaining funds and there is an expectation that some further funding should be allocated to the Trust.
- The forecast excludes any further Junior Doctor Strikes including those just announced. These and any further future strikes will have a direct cost and may also impact on Elective Recovery progress. The forecast assumes that any required activity catch up as a result of Industrial action will incur minimal additional expenditure.
- Forecast assumes that funding for the Community Diagnostic hubs flows to the Trust in full this year as per the approved business cases.

15. Annual Plan 2024/25 - Presentation - Cash support requirements Q1

To Approve

Presented by Gary Boothby

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 March 2024
Meeting:	Public Board of Directors
Title:	Approval of Cash Support
Author:	Kirsty Archer – Deputy Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance
Previous Forums:	Finance & Performance Committee (verbal update)
Purpose of the Report	The purpose of this report is to provide details of the Quarter 1 2024/25 cash position and Public Dividend Capital (PDC) Revenue Support requirements.
Key Points to Note	Based on the latest cash forecast, the Trust will be required to request cash support in the form of Revenue Public Dividend Capital at a value of £20m, due to the planned deficit and prior year creditors. The cash position will continue to be managed closely to defer and minimise the external support requirement as far as possible.
EQIA – Equality Impact Assessment	Not applicable.
Recommendation	The Board is asked to **APPROVE** the Trust's PDC Revenue Support request.

Calderdale and Huddersfield NHS Foundation Trust

REVENUE SUPPORT REQUIREMENTS – 2024/25

Background

The Trust has required cash support in 2023/24. Against a revenue deficit plan of £20.8m, revenue support of £15.3m has been approved to drawdown. Based on management of the cash position and the forecast year end level of creditors the actual cash requirement in 2023/24 has been held beneath this level at £8.3m. It should be noted that these creditors will require payment and consequently cash support in 2024/25. This requirement will be extended by the deficit plan for 2024/25 which stands at £39.1m.

The Trust will be required to request cash support in the form of Revenue Public Dividend Capital. This does incur charges in the form of a PDC Dividend charge at 3.5%. Current forecast shows that Revenue Support of £20m will now be required to support the deficit position across Quarter 1 2024/25.

Cash Management

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

A minimum cash balance of £1.9m is required (£20m prior to payroll leaving the bank) to manage working capital effectively.

Public Dividend Capital (PDC) Revenue Support

Cash support for revenue requirements and cashflow is available to Providers for necessary and essential expenditure to protect the continuity of patient services.

- The Trust needs to demonstrate revenue cash requirements to NHSE.
- Revenue support takes the form of Public Dividend capital (PDC), with no set repayment date, but attracts a dividend payable at the current rate (3.5%).
- The Trust is eligible to apply for Deficit Support on the basis that the organisation is reporting an actual deficit and is forecasting an annual deficit as planned.

Board Approval

Board approval for PDC revenue support is one of NHS England's requirements prior to authorising the transaction.

Recommendation

The Board are asked to approve a request of £20m Revenue Support to be drawn down in Quarter 1 of 2024/25 in order to maintain minimum required cash balances.

16. Capital Plan 2024/25

To Approve

Presented by Gary Boothby

Date of Meeting:	Thursday 7 March 2024
Meeting:	Public Board of Directors
Title:	Capital Plan 2024/25
Author:	Stuart Baron (CHFT Deputy Director of Finance)
Sponsoring Director:	Gary Boothby (Executive Director of Finance)
Previous Forums:	Finance and Performance Committee on 27 February 2024.
Purpose of the Report	To approve of the Trust 24/25 capital plan.
Key Points to Note	***CHFT's Capital Plan Overview*** CHFT have continued to balance operational capital priorities alongside the investment in the new MSCP that supports the Trust's overall Reconfiguration Programme. 2023/24 has seen the Trust utilise Trust and system resource to pull forward operational priorities from 2024/25 so resource is available to support key strategic investments aligned to the Reconfiguration programme. This resource management is compounded by the £15m PDC (£5m in 23/24, £10m in 24/25) for the Medicines Manufacturing national investment which will incur spend across 2024-2026/27. The Trust's capital plan for 24/25 has been prioritised to support significant, critical investments, leaving little to manage failure as it arises. There is no planned investment into the £90m backlog maintenance issue at HRI due to overall affordability constraints (planned investment of £1.3m for 2024/25 in this area was brought forward and will be spent by 31st March 2024) and IT, buildings, medical kit will be supported on a failure only basis. The internal capital resource is made up of: • £12.8m allocation and £2.2m re-prioritisation from LTH (brokered from 23/24) • It excludes any financial or qualitative performance related allocation – this has the potential to increase the allocation by c£1.2m (£0.6m for financial performance, £0.6m for qualitative performance) The key investment areas for the Trust in 2024/25 are: • Continuation of the replacement Catheterisation Laboratory scheme from 23/24 (original laboratory is 23 years old and beyond its useful economic life; • A new plant room at CRH as the existing plant room is full – this is also a critical enabler for air handling units for the cath lab, a CT scanner, a new and upgraded theatre (reconfiguration) • The start of the MSCP to support Reconfiguration at CRH (as supported by the WYICS)

	• The HPS Medicines Manufacturing PDC scheme will commence in 24/25 with the balance of funding being managed by the Trust to align to the spend – this creates a £1.8m contingency reserve to manage Trust risk of estate, IT, medical equipment failure only. This value may increase following finalising the capital allocation for the Trust. In addition to the internal capital resource, we will continue to draw down resource for reconfiguration as and when support is received. This is anticipated to be £12.8m in 2024/25.
EQIA – Equality Impact Assessment	The information outlined within the paper provides facilities and equipment that address the needs of the whole population, including those who currently experience disadvantage and the Trust's capital plans are intended to help improve access, experience and outcomes for all.
Recommendation	It is recommended that the Board **APPROVE** the capital plan for 2024/25.

APPENDIX	£000	£000
Capital Plan 2024/25		
Plant Room Extension -	£5,000	
CRH Main entrance - £3500	£300	
Car Park - CRH	£5,258	
Catheterization Laboratory - BUILD	£4,442	
Contingency - Allocation based on financial performance	£728	
Internal Funding Sub-total		***£15,728***
Reconfiguration Business Case (CRH)	£12,800	
Community Diagnostic Centre (CDC) _ Hudd	£18,276	
Digital Diagnostics Programme - CDC Booking System	£440	
Digital Diagnostics Programme - Infrastructure	£368	
Digital Shared Reporting	£88	
HPS	£7,825	
Contingency	£2,175	
External Funding Sub-total		***£41,972***
Leases		*£5,000*
Donated Assets		*£80*
GRAND TOTAL		**£62,780**

17. Integrated Performance Report

To Note

Presented by Jonathan Hammond

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7th March 2024
Meeting:	Public Board of Directors
Title:	Quality & Performance Report
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Jonathan Hammond, Chief Operating Officer
Previous Forums:	Finance & Performance Committee, Executive Board
Purpose of the Report	To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of January 2024.
Key Points to Note	**Performance Summary** For January 2024 we have followed national guidance and pushed **Quality** to the forefront of our reporting. All quality indicators fall into common cause variation with mainly hit or miss but also pass for some indicators. E. Coli infection rates are now consistently hitting target. Care of the acutely ill patient (% of patients with a NEWS2 of 5+ will not have a higher score during their episode of care) - currently performance is subject to common cause variation, however another data point below the mean will trigger the data to be in special cause variation for concern. A QIP is underway to establish the impact of the mandatory use of NerveCentre devices within the medical team to improve the response time for patients with NEWS 7 or above, and in turn the impact this has on improvement in NEWS score. % of complaints closed on time (target 95%) was 90% in January following periods of sickness and delays in signing off. We continue to perform well in terms of **elective recovery** with the exception of ENT which is working towards achieving zero 52-week waits at the end of March. All other specialties should be in a position to achieve the 40-week target of zero waiters. The plan is to maintain RTT at 40 weeks (ENT 52 weeks) and ASIs at 18 weeks (ENT 40 weeks) for 2024/25. For **diagnostics** we still have challenges in Echo and Neurophysiology although we have seen improvements in both areas over recent weeks.

	The plans to reduce the **follow-up** backlog is still a priority following the deep dives into each specialty where we have already seen improvements in the booking process which has led to reductions in individual specialty numbers. **Cancer** performance continues to be strong with all targets met including faster diagnosis target being achieved for the fifth month running. **ED** performance for January was back to October/November levels at 66.53% with continuing pressures around numbers of attendances and acuity. TOC numbers and bed occupancy have increased although there was a small drop in the number of patients waiting over 12 hours in ED. Proportion of **ambulance arrivals** delayed over 30 minutes saw a small reduction in January. The key change from October is the use of arrival destination as the trigger for when the clock starts which removes any notify times previously used. We have committed to an average of 23.5 minutes for 2024/25. ***Performance Matrix Metrics Changes*** *To note changes in the matrix are now highlighted in a different colour (green improvement, purple deterioration).* • ***Bed Occupancy*** *– high rates still persist.* • ***Hospital Discharge Pathway Activity*** *– improved performance in LoS after 5 months.* • ***E. Coli Infection Rate*** *– improved performance and well within annual ceiling.* • ***Diagnostic activity undertaken against activity plan*** *– improved performance overall.* **New KPIs now included:** **Day Case Rates** - 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. **Capped Theatre Utilisation** - a metric used to measure how well the allocated planned theatre session time has been utilised in an individual theatre list. High capped utilisation signifies that the allocated planned session time has been well utilised.
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 January 2024.

Calderdale and Huddersfield NHS Foundation Trust

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

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

Safe, High Quality Care

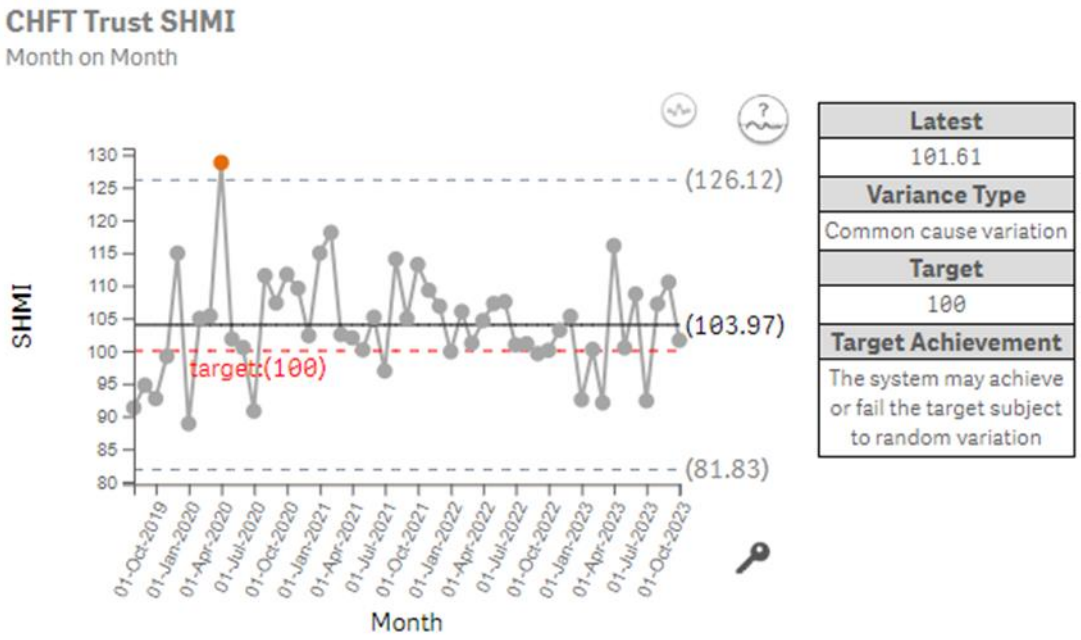
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator	October 2023	102.32	100			103.97	81.83	126.12
Care Hours Per Patient Day (CHPPD)	January 2024	8.7/7.9	-	-	-	-	-	-
Falls per 1000 Bed Days	January 2024	8.4	7.02			7.76	5.57	9.95
CHFT Acquired Pressure Ulcers per 1000 Bed Days	December 2023	1.49	1.58			1.67	0.80	2.53
MRSA Bacteraemia Infection	January 2024	0	0			-	-	-
C.Difficile Infection	January 2024	1	3.1			2.79	0	8.44
E.Coli Infection	January 2024	1	5.6			2.36	0.52	4.20
Number of Never Events	January 2024	0	0	-	-	-	-	-
Number of Serious Incidents	January 2024	2	0			3.09	0	8.66
% of incidents where the level of harm is severe or catastrophic	January 2024	1.14%	2%			0.79%	0%	1.97%
% of complaints within agreed timescale	January 2024	90%	95%			90.46%	73.38%	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



Latest
101.61
Variance Type
Common cause variation
Target
100
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- CHFT SHMI performance has seen an increase for the latest 12-month rolling release and shows performance of 102.32 and has risen back over the 100 mark.
- Month on month performance has improved in October with performance standing at 101.61.
- Performance remains within the expected range in the latest release.
- The latest national SHMI position stands at 98.18 and CHFT now sits very slightly above this national position however remains comfortably within the expected range nationally.

Underlying issues:
- This declining position in CHFT's performance seen in August and September 2023 is largely been driven by performance within the 122 – Pneumonia CCS group. A review is being undertaken to understand this performance.

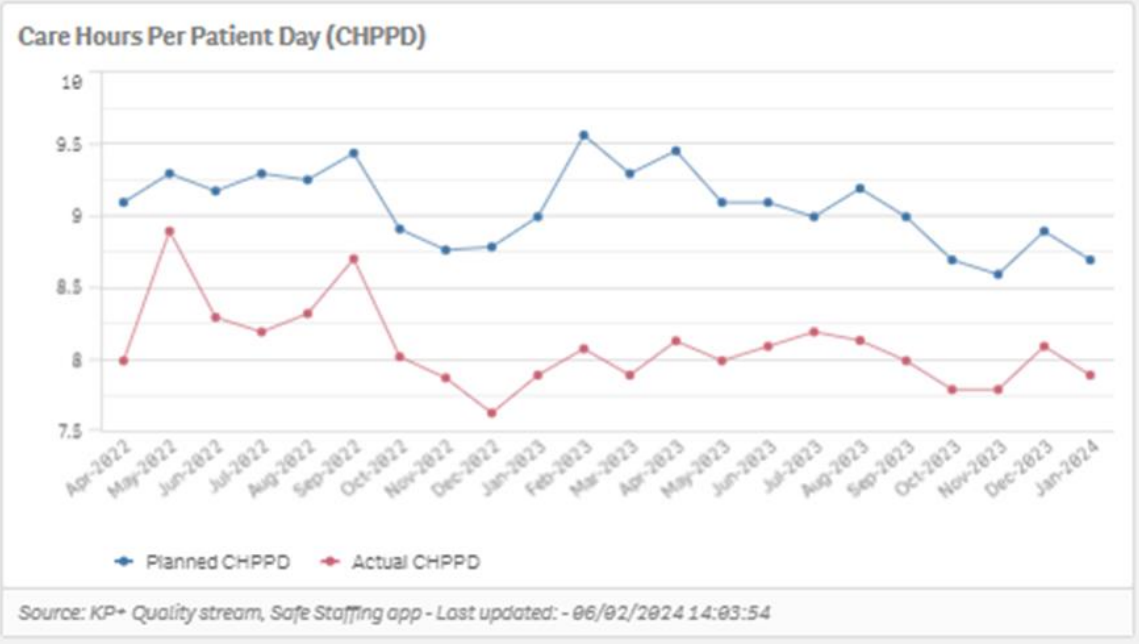
Actions:
- Clinical Lead has contacted all mortality leads in all specialties to communicate the need to increase the level of mortality reviews being carried out on a monthly basis and the timeliness of these reviews being improved.
- The Trust target is for 50% of deaths to be reviewed using the initial screening review methodology, currently performance is not meeting these levels.
- Clinical review of patients within the Pneumonia CCS group being undertaken to establish any potential quality of care issues from the August and September 2023 datasets.

Care Hours Per Patient Day

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

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

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



What does the chart show/context:
- The actual CHPPD is less than the planned by a deficit of 0.8 care hour per patient day.
- The latest data in Model Hospital is from January 2024 when CHFT reported providing 7.8 CHPPD against a peer median 8.7 and national median 8.4.

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

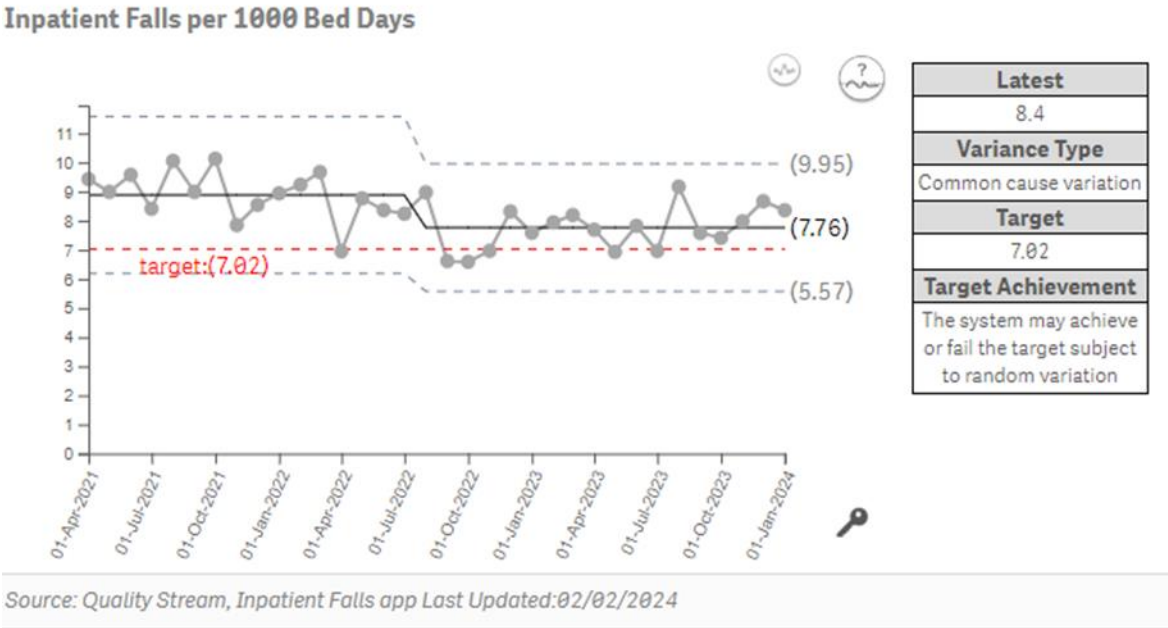
Actions:
- Undertake bi-annual Safer Staffing review. This process provides assurance of the correct workforce models based on an evidence-based methodology. The next bi-annual review is scheduled for March 2024.
- Ongoing monthly reviews of recruitment strategies, including employment of new graduates,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

Falls per 1,000 Bed Days

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

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

Target:
10% reduction from 2022/23



What does the chart show/context:
- The rate of inpatient falls for January was 8.4.
- Currently performance can be expected to vary from 5.57 to 9.95.
- The chart shows that the rate of falls has continued to perform within common cause variation.

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

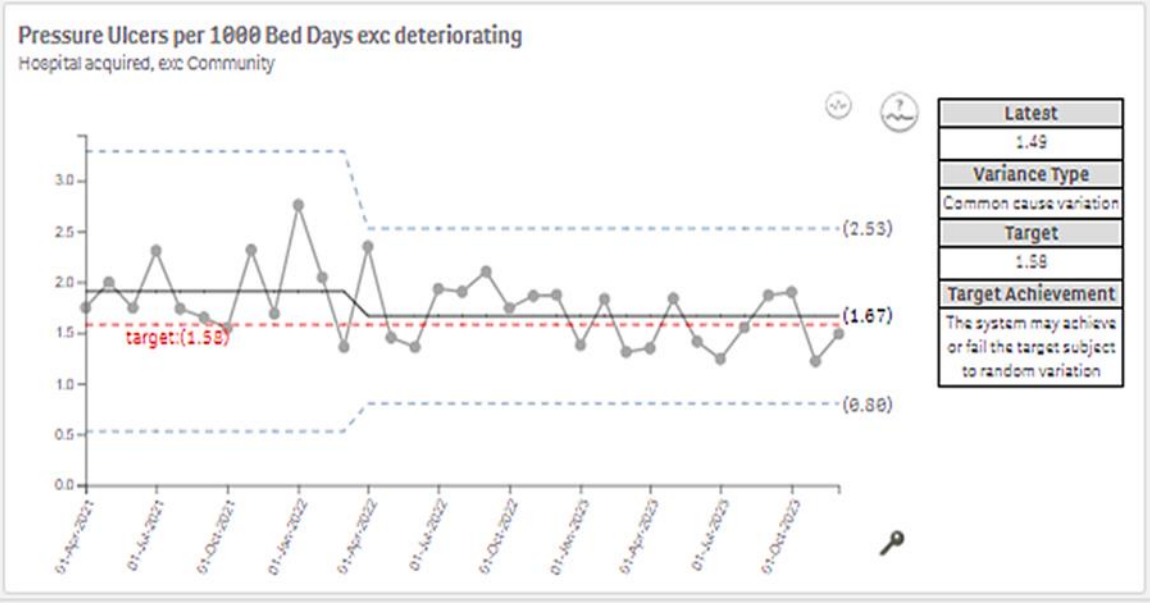
Actions:
- Review of Terms of Reference and falls link nurses allocation now complete.
- Continuing with reconfiguration plan around the Enhanced Care Team, update expected February 2024 and a WTGR session has been arranged .
- Bay tagging/cohorting, education to be rolled out via link nurses that NIC must consider falls risk at the point of admission onto any ward area so that patients at highest risk are placed into a visible/the most visible area on the ward. In addition to this NIC when allocating staff must ensure that someone is allocated to provide supervision that day within the allocated staff resource even if the Enhanced Care team are unable to provide staffing cover.
- Education as part of the revamped Enhanced Care team processes and assessments.
- Bed rails assessment is being reviewed due to concerns it is not reflective of what we need for safe practice – completion date April 2024.
- The Falls policy is in the process of being reviewed – completion date March 2024.
- Commencement of Lying and Standing Blood Pressure improvement project on Acute Floor - February 2024.

Hospital Acquired Pressure Ulcers per 1,000 Bed Days

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

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

Target:
10% reduction from 2022/23.



What does the chart show/context:
- The data has been changed to exclude deteriorating pressure ulcers.
- The incidence of Hospital Acquired PU excluding deteriorating PU for December was 1.49 which exceeded the Trust target.
- Currently performance can be expected to vary from 0.80 to 2.53.

Underlying issues:
- Overall Trust compliance with PU prevention assessment and care planning needs improvement (50% in December as per Ward assurance).
- PU risk assessment within 6 hours on ward transfer requires improvement (44% in December 2023 as per Ward Assurance data).

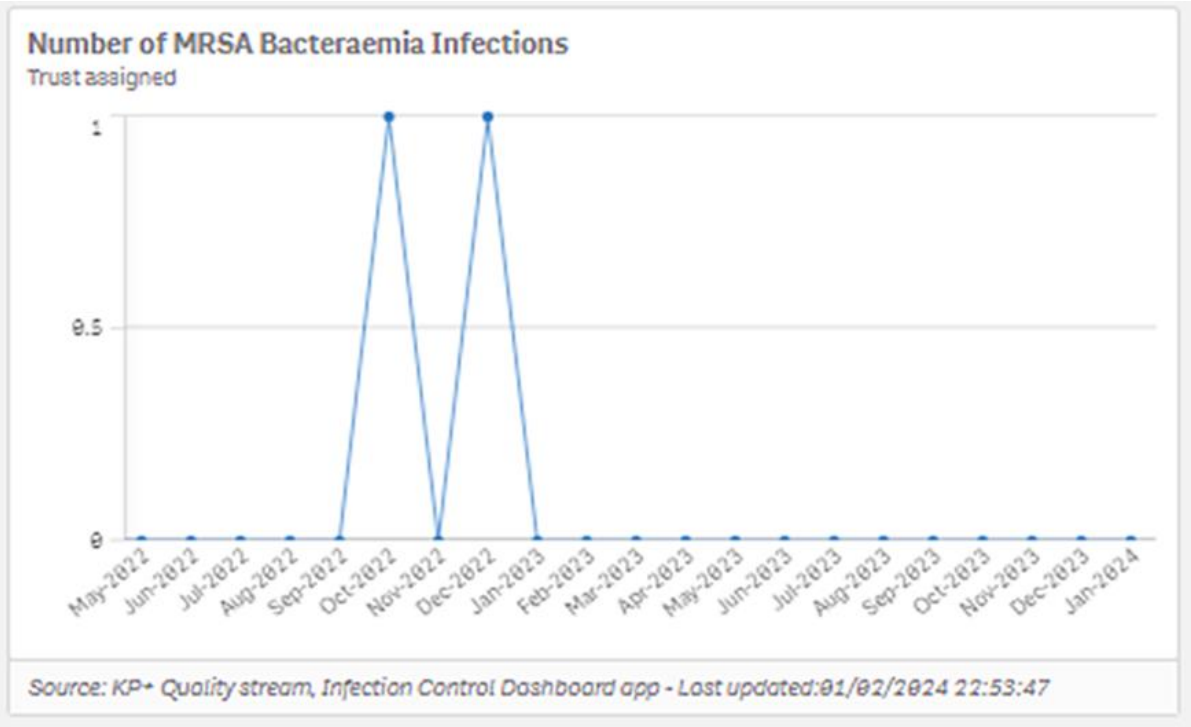
Actions:
- PU risk assessment within 6 hours of admission/ward transfer is now captured on Live Assessment data within KP+.
- Targeted improvement continues for the low performing wards via the PU Collaborative.
- Audit of Purpose T PU risk assessments commenced in January 2024.
- SSKIN bundle changes submitted to the EPR clinical analyst in collaboration with BTHFT and Airedale.
- After Action Review (AAR) template for PU has been rolled out across the Medical Division as part of the PSIRF investigation process.
- New Task & Finish Group to be established to manage national changes with PU surveillance.
- Business case completed and order submitted for replacement of 29 Atlas air mattress following a patient safety concern.

MRSA Bacteraemia Infections

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

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

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



What does the chart show/context:
- There were no MRSA Bacteraemia case infections in January.
- YTD 2023/24 – 0.

Underlying issues:
- Admission/pre-admission MRSA screening data inaccuracies.
- Colonisation suppression prescribing is via a POWERPLAN in EPR.
- ANTT and IPC level2 training is mandated for clinical staff and both require improvement.

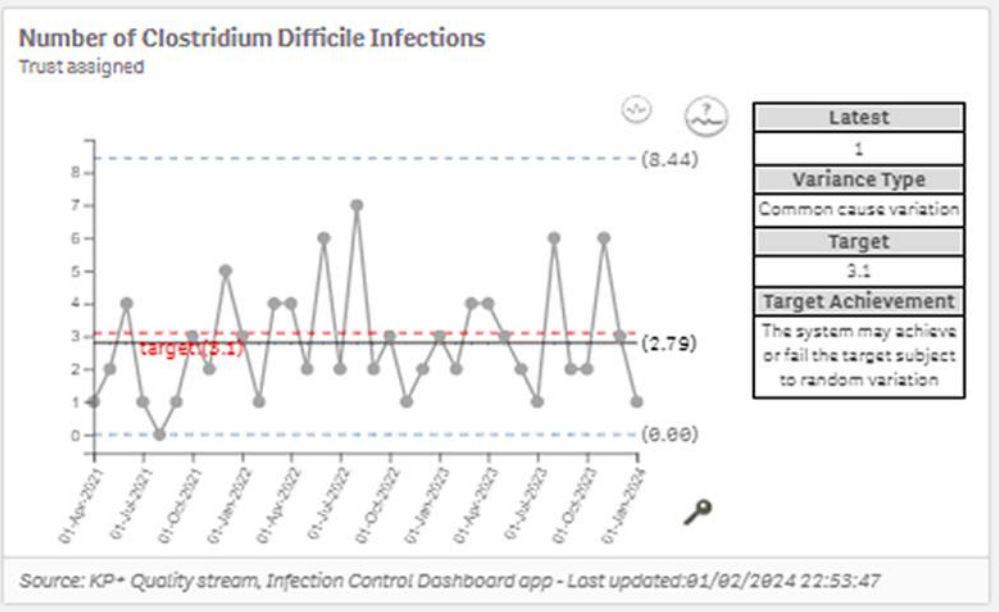
Actions:
- MRSA screening data cleanse has been completed and improvements seen.
- Colonisation suppression visual user guides have been provided to patients to ensure correct application.
- Mandatory training to be monitored through IPC Performance Board on a monthly basis.
- Any infections are investigated and discussed at panel. All learning is shared.

C.Difficile Infections

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

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

Target:
To not exceed 37 cases of C.Diff infections in 2023/24. The risk of healthcare acquired infections to patients should be reduced. Hospital onset healthcare associated (HOHA) & community onset hospital associated (COHA)



What does the chart show/context:
- There was 1 C.Difficile infection in January.
- Currently performance can be expected to vary from 0 to 8.44.
- YTD 2023/24 – 30 against a ceiling of 37.

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

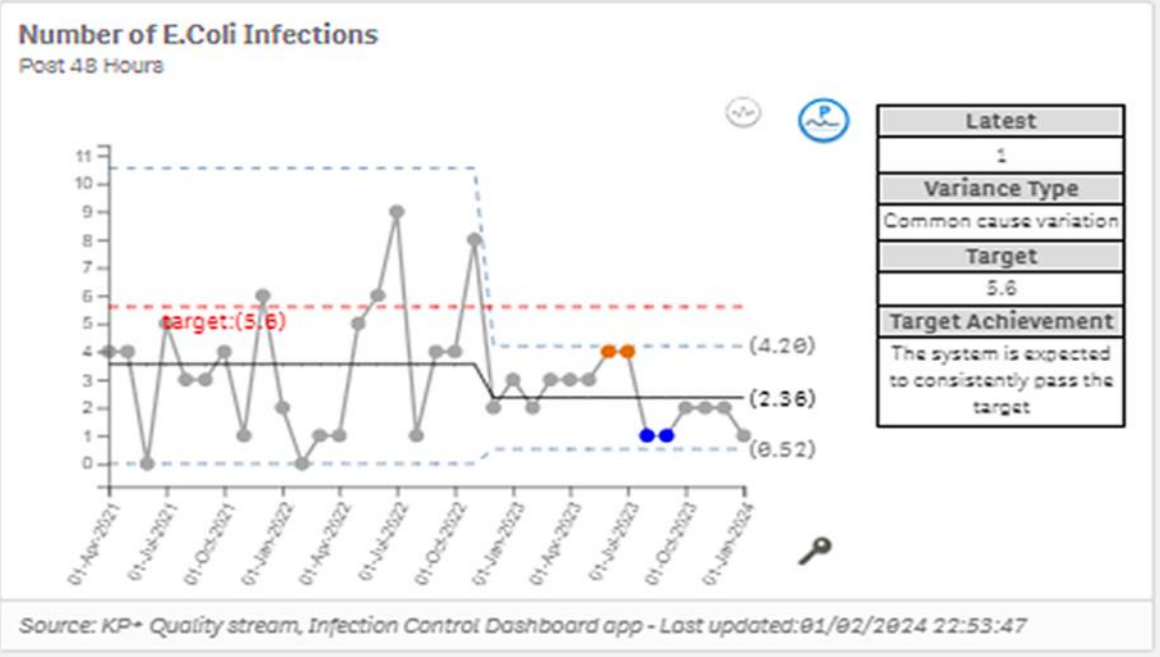
Actions:
- The Trust has implemented an improvement plan including a programme of HPV deep cleaning (to be agreed).
- C.Diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases.
- NHSEI carried out a support visit in March, with positive feedback. Their recommendations will further inform the improvement plan. The improvement plan is monitored at IPC Performance Board.
- The PSIRF for investigating C.Difficile cases has now gone live and this moves it back to divisions to take ownership of cases within their areas. Themes will be pulled on a 6-monthly basis and will form part of the planning for future IPC workstreams.

E.Coli Bacteraemia Infections

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

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

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



What does the chart show/context:
- There was 1 E.Coli infection in January.
- YTD there have been 21 infections against a ceiling of 67.
- Currently performance can be expected to vary from 0.52 to 4.20 and is expected to consistently pass the target.

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

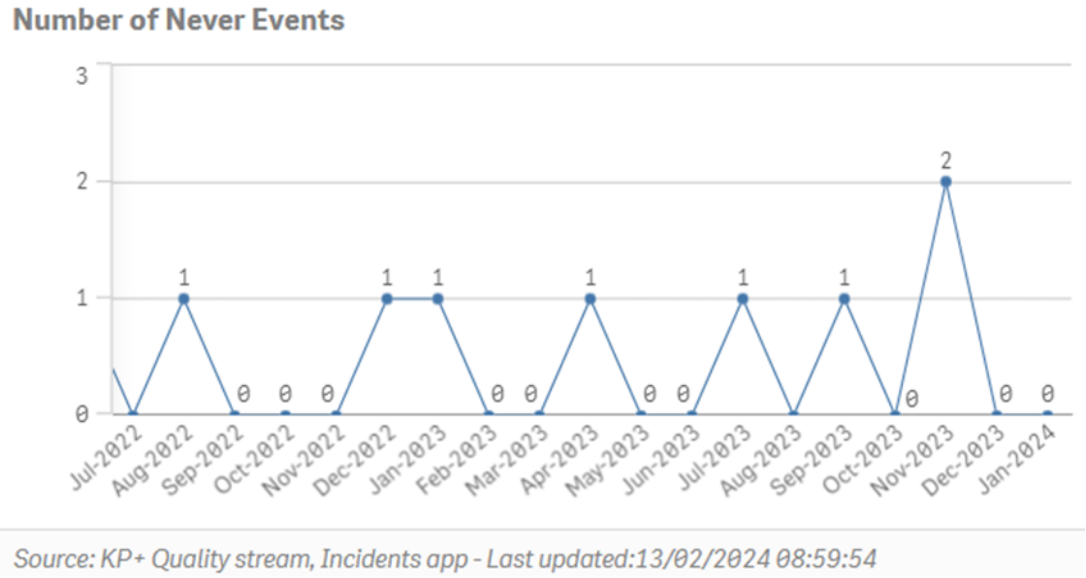
Actions:
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working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

Number of Never Events

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

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

Target:
To have no never events



What does the chart show/context:
- There were no never events reported in January 2024.
- The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month.

Underlying issues:
- No never events reported during this period.

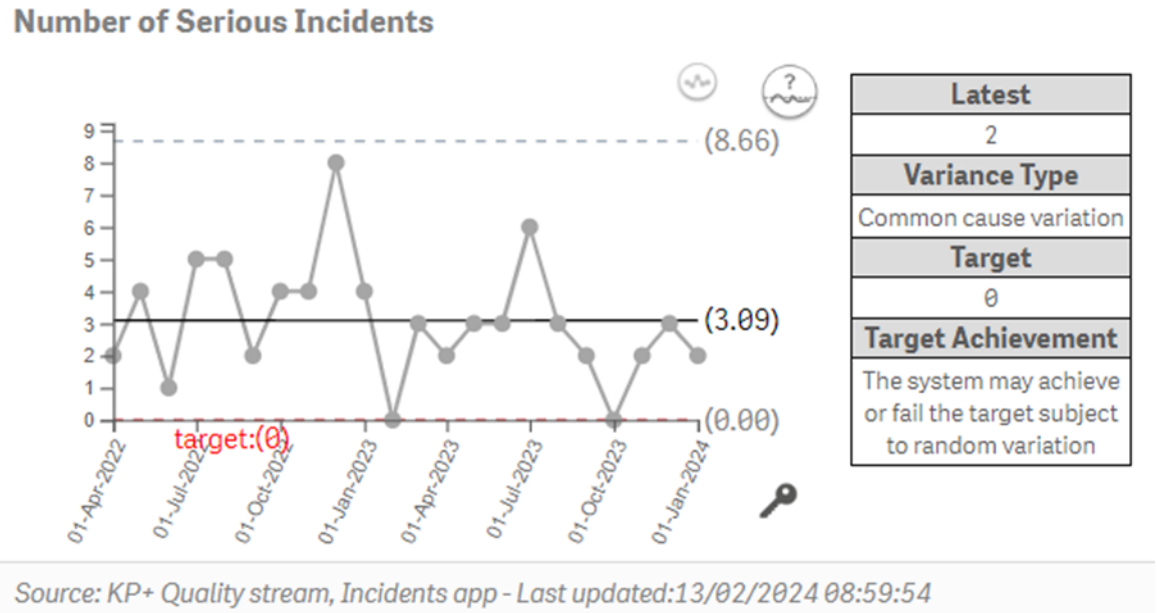
Actions:
- The Trust will continue to hold SWARM huddles as required to ensure learning is identified to keep our patients and staff safe.
- Two investigations are currently ongoing.

Number of Serious Incidents

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

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

Target:
To have no serious incidents



What does the chart show/context:
- There were 2 serious incidents reported in January 2024.
- Currently performance is subject to common cause variation and can be expected to vary from 0 to 8.66.

Underlying issues:
- Both incidents are under the medicines management category and as an action themes will be picked up in FSS as well as the Medicines Management group.

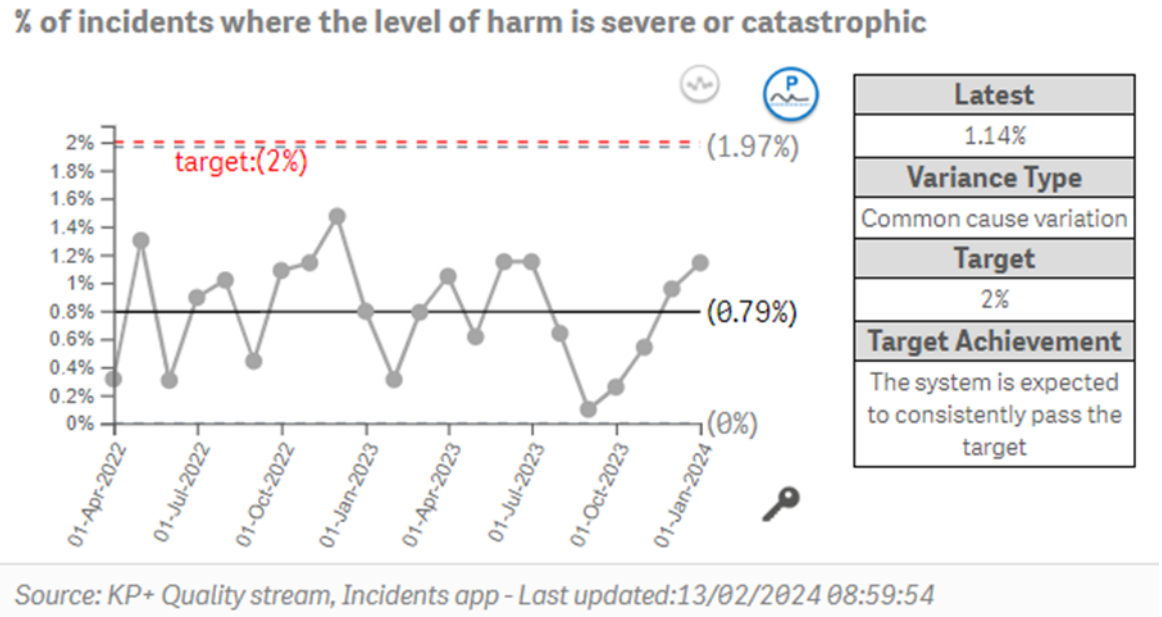
Actions:
- The Risk management Team and the Quality Governance Leads continue to support the Divisions to triangulate and review data for learning.
- Themes and trends will be monitored and reviewed in relation to the categories reported and quality improvement projects commissioned where required.

% 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 1.14% in January 2024.
- Currently performance is subject to common cause variation and can be expected to vary from 0% to 1.97%.
- CHFT is expected to consistently pass the target.

Underlying issues:
- The 2 incidents reported in this period are currently under investigation and have been reported to STEIS.

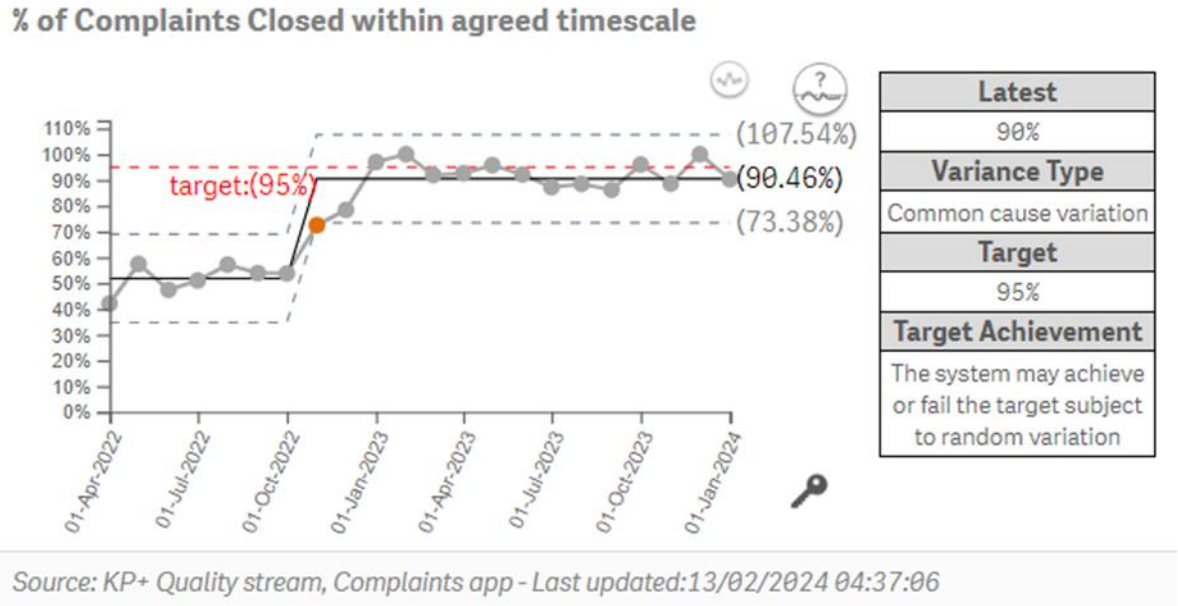
Actions:
- The Risk Management Team and the Quality governance Leads continue to work with clinical teams/departments to identify and triangulate themes and trends for implementation of quality improvement initiatives and shared learning Trust wide.
- To monitor the trend within the upper controls limits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

% of complaints within agreed timescale

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

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

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



What does the chart show/context:
- In January 90% of complaints were closed within the agreed timescale
- Currently performance can be expected to vary from 73.38% to 100% and we may fail or achieve the target subject to random variation.

Underlying Issues:
- Operational demands and pressures appear to have taken priority. Along with unexpected absence in the central complaints team and slight delays in signing off process

Actions:
- Escalated to Divisional Leads for complaints to ensure everything is being done to respond to complainants within agreed timeframes and if not extensions agreed before the due date.
- Continue to monitor Trust performance daily and meet with Divisions on a weekly basis to maintain oversight of performance.

Quality Priorities:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Alternatives to Hospital Admission – Number of referrals into the Frailty service	January 2024	361	TBC		-	324.6	221.83	427.37
% of episodes scoring NEWS of 5 or more not going on to score higher	January 2024	60.1%	70%			63.11%	58.25%	67.96%
% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward.	January 2024	83.63%	95%			78.97%	62.79%	95.14%

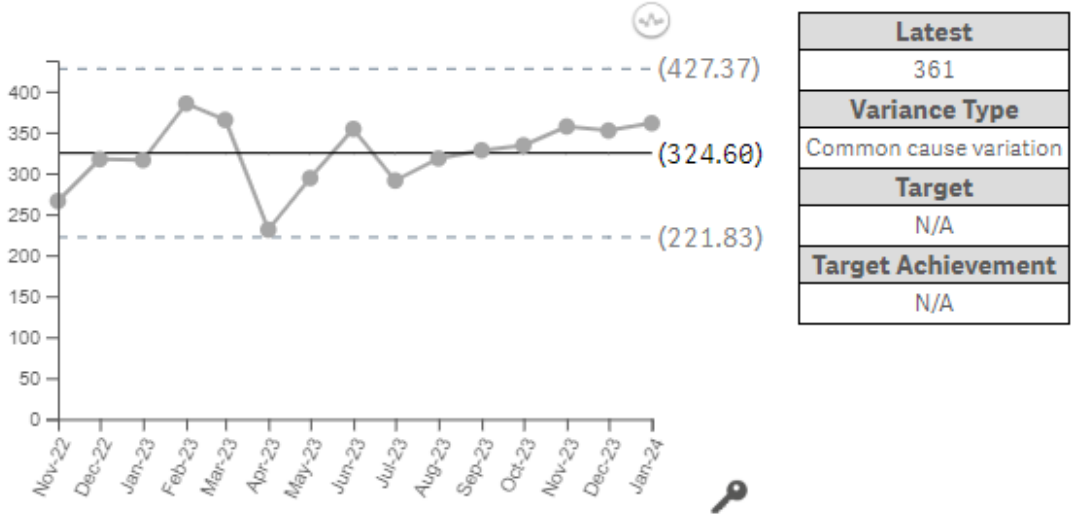
Alternatives to Hospital Admission – Frailty Service

Executive Owner: Lindsay Rudge Clinical Lead: Charlotte Bowdell/ Hannah Wood Business Intelligence Lead: Gary Senior

Rationale:
To enable patients to receive the care and treatment they need in their own home, safely and conveniently rather than being in hospital.

Target:
Target to be confirmed on the number of referrals per month by the end of March 2024.

UCR/Frailty Virtual Ward New Referrals into Service



Latest
361
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Source: SR Data. Last updated 22/02/2024 08:00:48

What does the chart show/context:
- New referrals into service for the whole Urgent Community Response / Frailty Virtual Ward service.
- Average of 325 per month for all. 361 for January 2024.

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

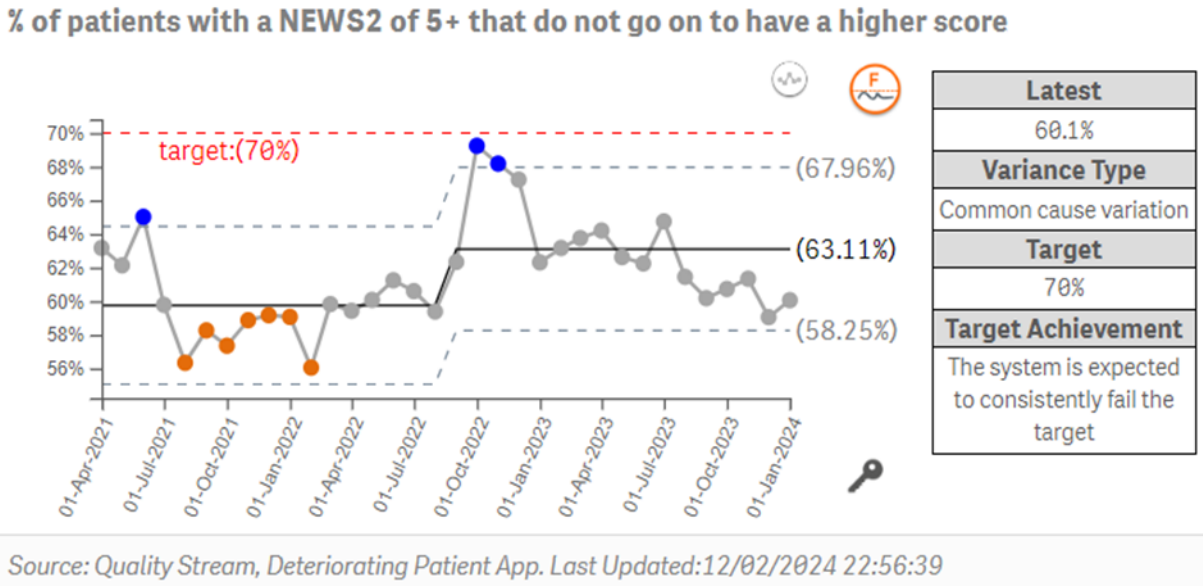
Actions:
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care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

Care of the Acutely Ill Patient

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

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

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



What does the chart show/context:
- Performance was 60.1% in January 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, however another data point below the mean will trigger the data to be in special cause variation for concern.
- Performance can be expected to vary from 58.25% to 67.96%.

Underlying issues:
- Doctors do not carry NerveCenter devices "in hours" and Registrars do not carry devices out of hours.
- Observations not carried out on time, or failure to escalate appropriately in line with policy or escalations.
- Some patients who score higher during the episode of care may be appropriately palliated and die during admission.

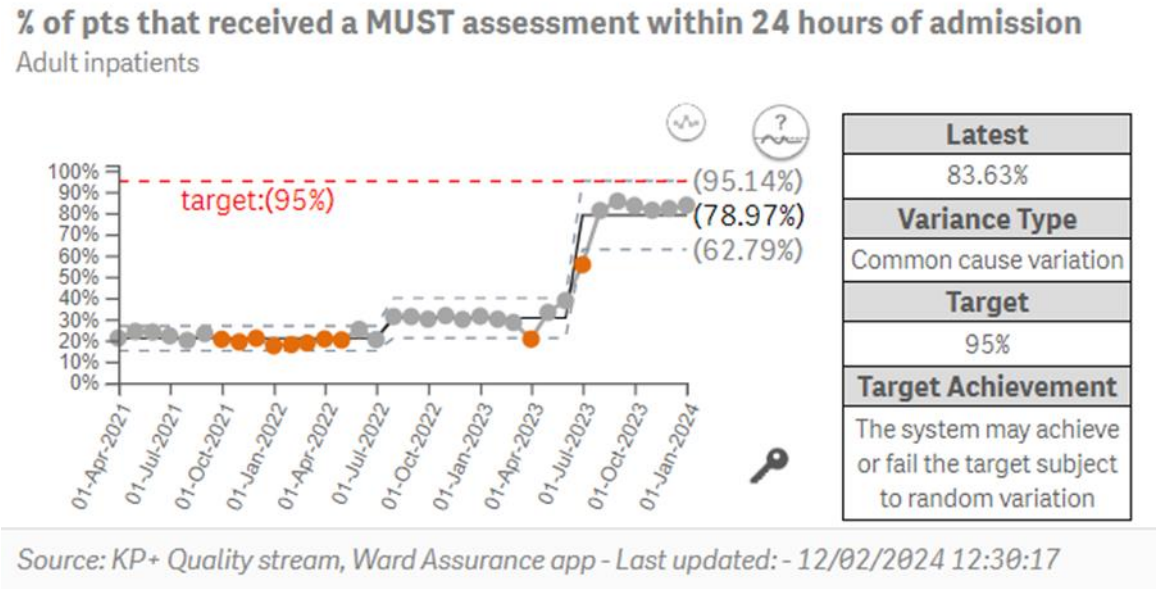
Actions:
- A new KP+ dashboard has been developed and is now live to further understand which wards have the most alerts and whether these are occurring in or out of hours.
- An audit of 14 patients has been conducted for December 2023. This showed that 92.9% were reviewed by a doctor within an hour, with 92.9% having evidence of a clear plan and 85.7% having an escalation plan documented. Only 64.3% of NEWS 7 or more were reviewed by a middle grade doctor or above.
- A QIP is underway to establish the impact of the mandatory use of Nervecenter devices within the medical team to improve the response time for patients with NEWS 7 or above, and in turn the impact this has on improvement in NEWS score.

Nutrition and Hydration

Executive Owner: Lindsay Rudge Operational Lead: Vanessa Dickinson Business Intelligence Lead: Charlotte Anderson

Rationale:
Compliance with completion of MUST to be above 95% across the organisation – this will ensure we have the majority of our patients at risk identified early and referred to the dietitian team.

Target: 95% of adult patients to receive a MUST assessment within 24 hours of admission/transfer to the ward.



What does the chart show/context:
- In January 2024 performance was 83.63%.
- Performance is in common cause variation and improvements are being sustained.
- Currently performance can be expected to be between 62.79% and 95.14% and therefore may achieve or fail the target subject to random variation.

Underlying Issues
- MUST assessment training compliance has improved and has now moved from 73.7% to 80.6%.
- MUST assessment completion within the first 24 hours of a patient's admission remains stable at 82.4%, this needs to be at 95% by the end of January.

Actions:
- MUST assessment, completion and training continues to be monitored through the Nutrition & Hydration Group.
- The Nurse in Charge within each ward continues to monitor and ensure their staff complete the MUST training.

Elective Care:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >40 weeks to start treatment	January 2024	1065	0			-	-	-
Total Patients waiting >52 weeks to start treatment	January 2024	55	0			-	-	-
Total Patients waiting >65 weeks to start treatment	January 2024	0	0			-	-	-
Total RTT Waiting List	January 2024	35,079	31,586			32,485	30,097	34,872
Total elective activity undertaken compared with 2023/24 activity plan	January 2024	108.5%	100%	-	-	-	-	-
Percentage of patients waiting less than 6 weeks for a diagnostic test	January 2024	83.6%	95%			86.2%	79.3%	93.0%
Diagnostic Activity undertaken against activity plan	January 2024	15,767	14,547			13, 354	11,241	15,467
Total Follow-Up activity undertaken compared with 2023/24 activity plan	January 2024	102.0%	100%	-	-	-	-	-
Day Case Rates	November 2023	77.1%	85%			76.84%	74.75%	78.92%
Capped Theatre Utilisation	January 2024	76.2%	85%			81.56%	72.39%	90.72%

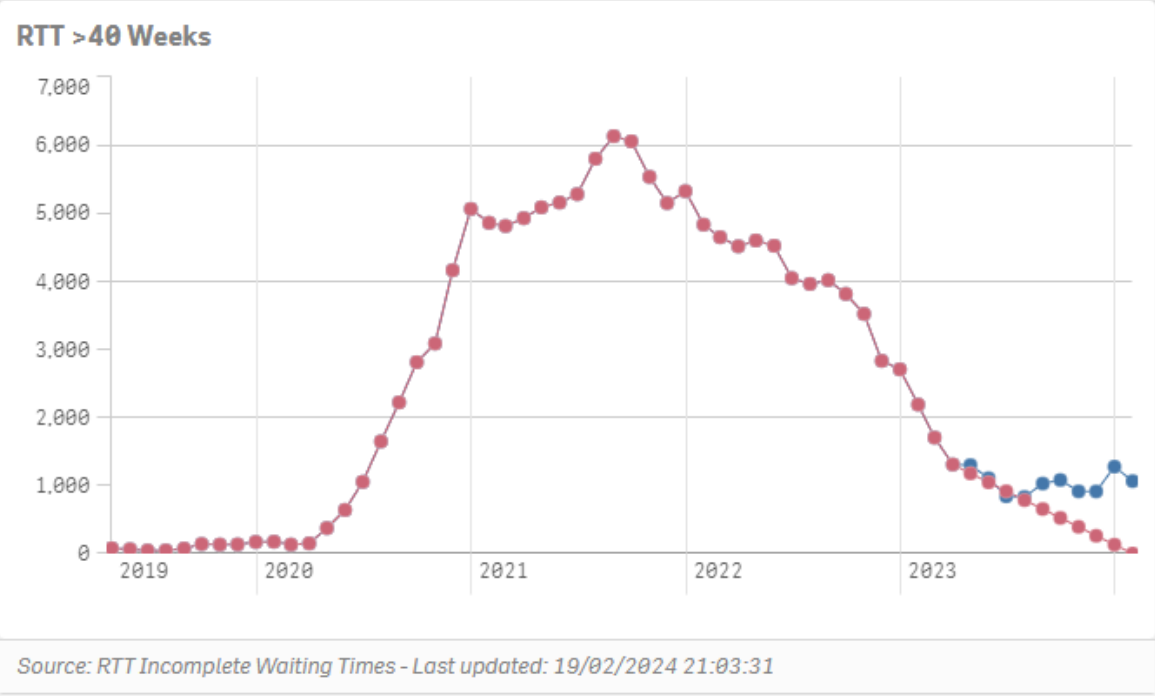
Total Patients waiting more than 40 weeks to start consultant-led treatment

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 1,065 at the end of January against the target trajectory of 0.
- Most of our remaining patients who are waiting over 40 weeks are in ENT (614), Max Fax (35), Urology (46), General Surgery (75), Plastic Surgery (46) Cardiology (63), Neurology (39), Gastroenterology (34) and Gynaecology (38). Of those specialties listed, a number have improved in January, including ENT.

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

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

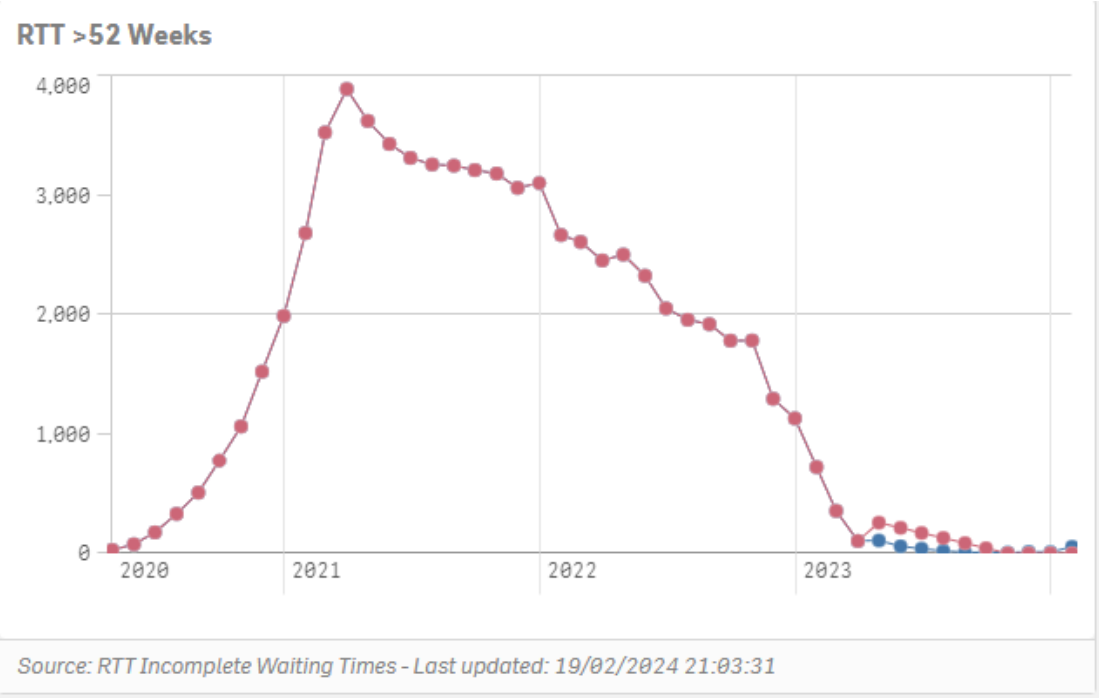
Total Patients waiting more than 52 weeks to start consultant-led treatment

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 55.
- There are 306 patients waiting between 46 and 52 weeks, including General Surgery (12), Urology (11), ENT (205 – up from 188), Plastic Surgery (16) and Cardiology (19).
- All other specialties have fewer than 10 patients waiting between 46 and 52 weeks.

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

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

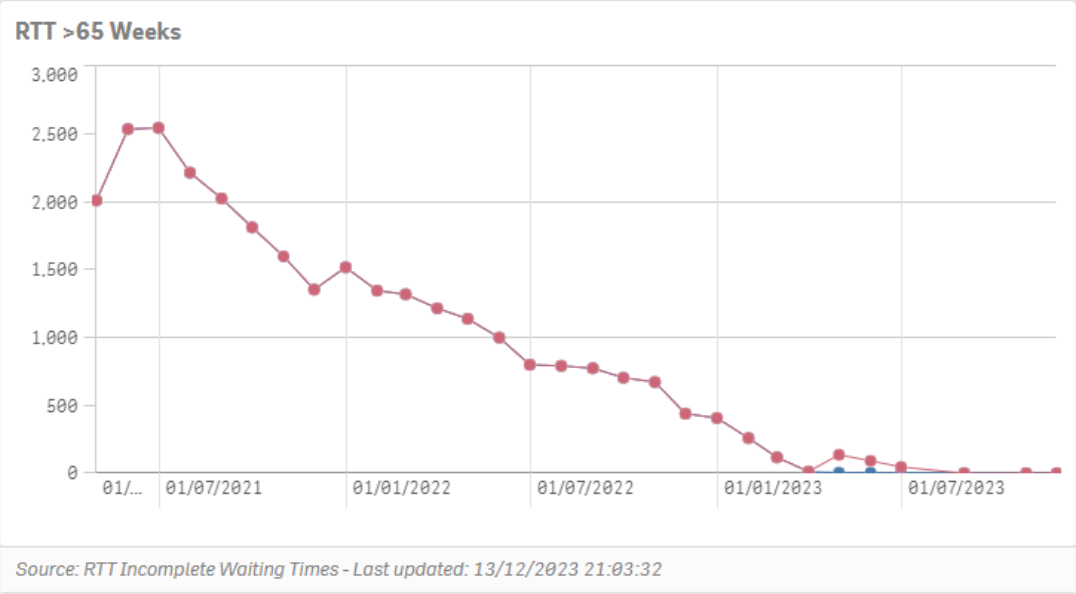
Total Patients waiting more than 65 weeks to start consultant-led treatment

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. Waiting times matter to patients.

Target:
Aim to have 0 patients waiting more than 65 weeks by March 2024 (internal target June 2023).



What does the chart show/context:
- At the end of January there were 0 patient waiting over 65 weeks.

Underlying issues:
- We have an increasing number of over 52/40 Week ENT patients, 2 ENT patients had been waiting between 60-64 weeks at the end of January. However, in mitigation ENT are working to deliver 52-week compliant position by the end of March 2024.

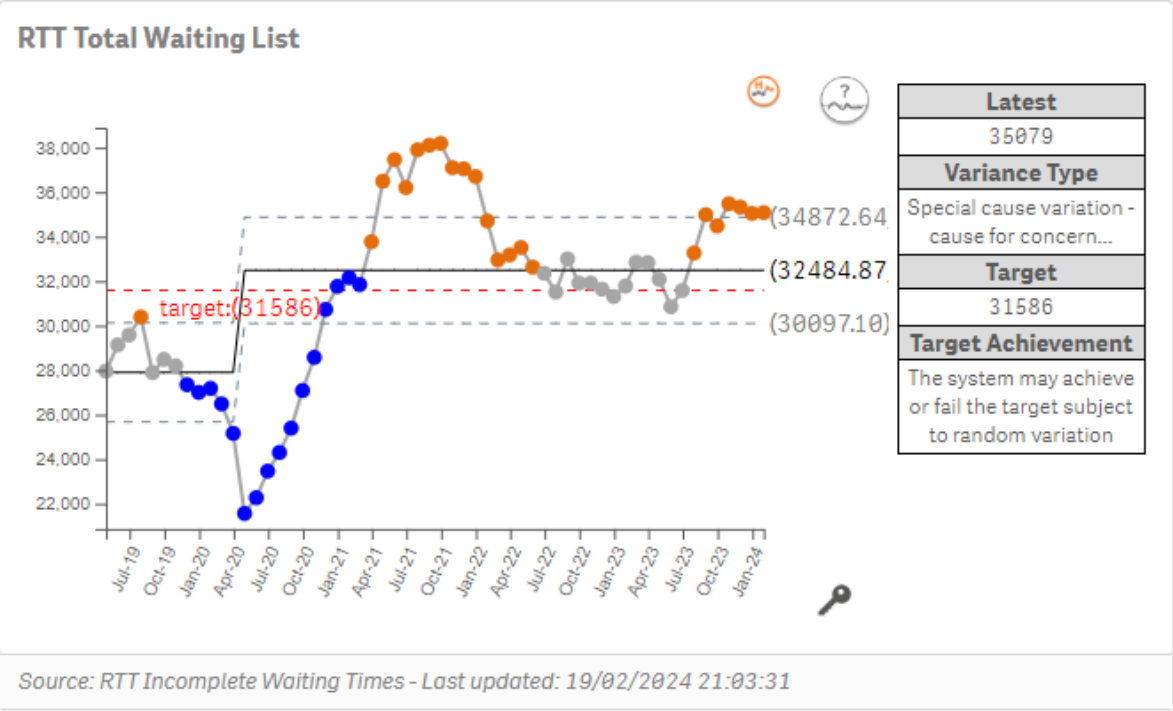
Actions:
- ENT Task and Finish Group concluded with actions in place.

Total RTT Waiting List

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

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

Target:
31,586 (activity plan 2023/24)



What does the chart show/context:
- The list remains high and stands at 35,079 at the end of January.

Underlying issues:
- We currently have a relatively stable RTT Waiting list position, although it has reached the abnormally high threshold 5 times in the last 6 months.
- For ENT and Gynaecology we have seen an increase in ASIs (ENT is a capacity issue whilst Gynaecology has seen an increase in demand).
- Cardiology has seen an increase in wait time for diagnostics (Echo).
- Ophthalmology has increased due to an improvement in data quality which means the inclusion of pathways for those on the portal (EyeV) awaiting triage.
- There has also been a slowdown in elective activity due to industrial action.
- The national position continues to grow monthly. The ICS position suggests we are the only Trust in the region currently not seeing a 20% increase in pathways over the last 12 months.

Actions:
- Validation team to monitor LUNA (National DQ RTT Benchmarking tool – currently in top 30 Trusts in the country for RTT DQ Assurance).
- Meet the trajectory for no ASIs over 18 weeks by the end of March 2024.
- Meet the trajectory for 40/52/65 weeks.
- Operational teams to be tracking patients to at least 40 weeks.
- Validation team to use KP+ RTT model that identifies where RTT Pathways have been created inappropriately or user has selected status code of 99 Not Known that suggests a training issue.

Total elective activity undertaken compared with 2023/24 activity plan

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

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

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

What does the chart show/context:
- CHFT has exceeded the elective activity target in 8 of the 10 months compared with the 2023/24 activity plan.
- Performance in January 2024 was above plan at 108.5% in month.
- Day case activity was above the planned position for January 2024 with electives being slightly down on plan.
- The YTD performance for the elective activity overall remains above the planned position and currently stands at 106.8%, which is a total of 2,541 spells more than the plan at this stage.
- Both day case and elective activity are tracking above 100% against the planned position YTD.

Underlying issues:
- Impact of industrial action.

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

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

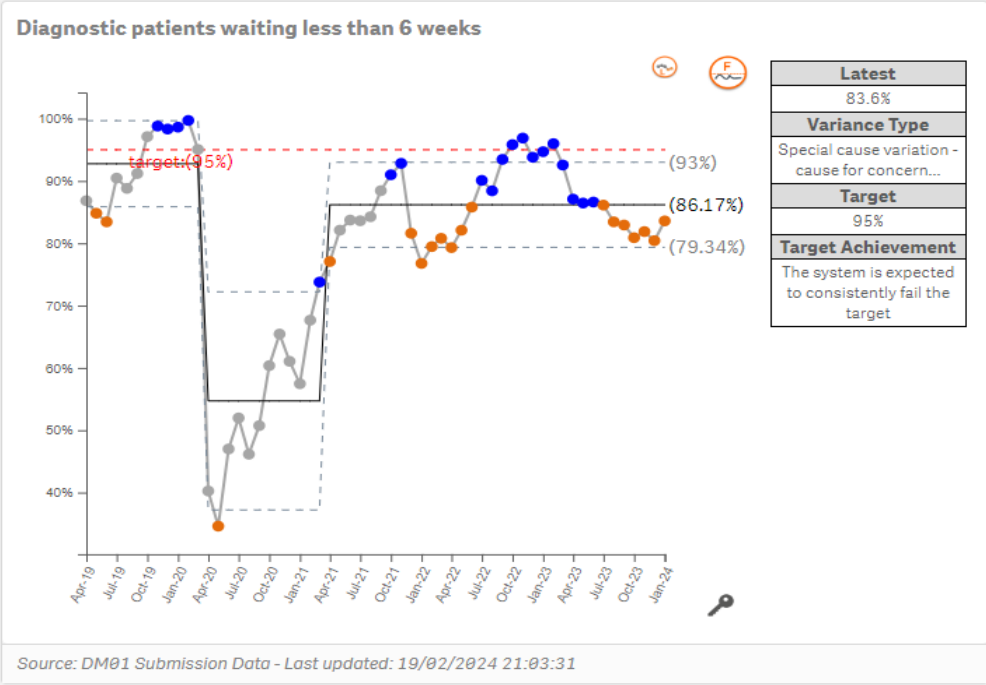
Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond
Business Intelligence Lead: Fiona Phelan

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

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

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



What does the chart show/context:
- The Trust is expected to consistently fail the target of 95%.
- Performance can be expected to vary between 80% and 94%

Underlying issues:
- 2 modalities (Echocardiography/Neurophysiology) still have significant numbers of pathways >6 weeks.
- Whilst the Trust performance is meeting the 95% target in most modalities, we are consistently below this for Echocardiography (47.8%) and Neurophysiology (48.8%).

Actions:

Echocardiography
- Reduction in 6-week breaches to 801 for w/c 19th February.
- Reporting backlog now recovered to a manageable and safe level.
- Weekend clinics running to further reduce scanning backlog in line with trajectory.
- Expectation for trajectory to slow down slightly over the coming two weeks due to period of annual leave in the team.
- A group has been set up looking at a collaborative bank for Echo Physiologists across West Yorkshire to progress in the next quarter.
- Meeting with Mid Yorks echo team to progress accredited staff supporting CHFT with recovery.

Neurophysiology
- Seen a reduction in 6-week breaches and remain on plan to have no breaches by mid-June 2024.
- Agency/Bank Staff – utilising the budget from vacancies prior to recruitment to fund additional EMG and CTS clinics whilst regularly monitoring spend.
- Increase of EMG slots for consultants and doctors, 1/day each.
- Neurophysiology Support Assistant contacting EMG/CTS patients to confirm attendance - mitigating DNAs/last minute cancellations.
- Short-notice cancellation list utilised.
- Band 5 Physiologist – recruited for 1st March 2024
- Band 6 Physiologist – started
- Band 7 Physiologist – recruited for 1st April 2024

Total Diagnostic Activity undertaken against the activity plan

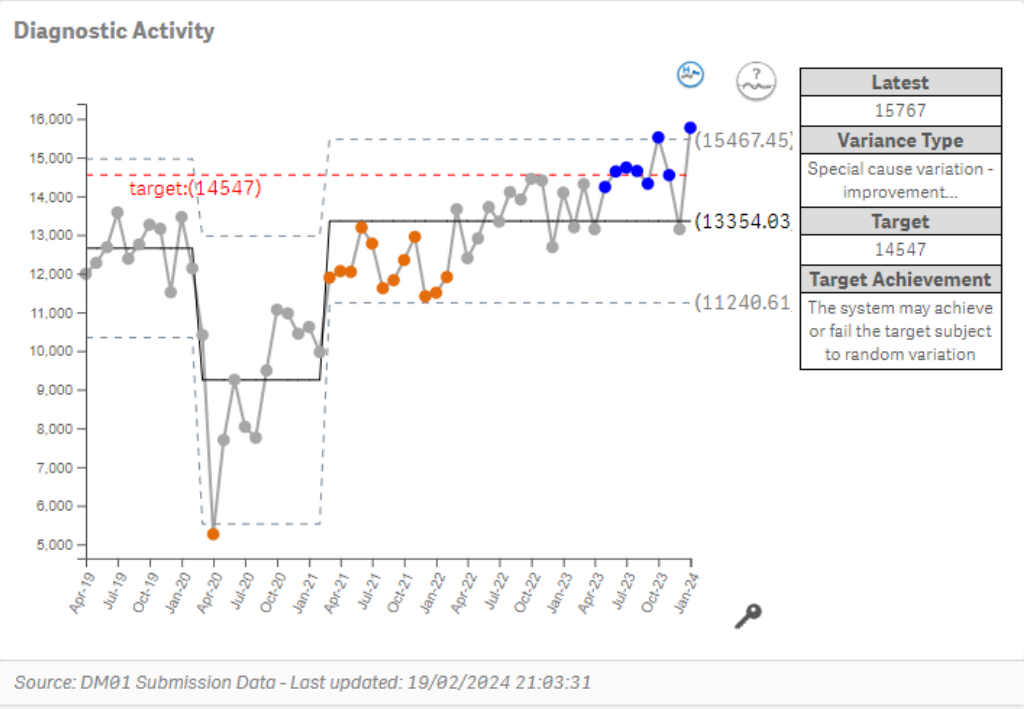
Calderdale and Huddersfield NHS Foundation Trust

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, but it may achieve or fail the target subject to random variation. The activity is back up to 15767 after a drop in December.
- Performance can be expected to vary between 11,241 and 15,467. Activity is similar to pre-Covid levels.

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

Actions:

Echocardiography
- Reduction in 6-week breaches to 801 for w/c 19th February.
- Reporting backlog now recovered to a manageable and safe level.
- Weekend clinics running to further reduce scanning backlog in line with trajectory.
- Expectation for trajectory to slow down slightly over the coming two weeks due to period of annual leave in the team.
- A group has been set up looking at a collaborative bank for Echo Physiologists across West Yorkshire to progress in the next quarter.
- Meeting with Mid Yorks echo team to progress accredited staff supporting CHFT with recovery.

Neurophysiology
- Seen a reduction in 6-week breaches and remain on plan to have no breaches by mid-June 2024.
- Agency/Bank Staff – utilising the budget from vacancies prior to recruitment to fund additional EMG and CTS clinics whilst regularly monitoring spend.
- Increase of EMG slots for consultants and doctors, 1/day each.
- Neurophysiology Support Assistant contacting EMG/CTS patients to confirm attendance - mitigating DNAs/last minute cancellations.
- Short-notice cancellation list utilised.
- Band 5 Physiologist – recruited for 1st March 2024
- Band 6 Physiologist – started
- Band 7 Physiologist – recruited for 1st April 2024

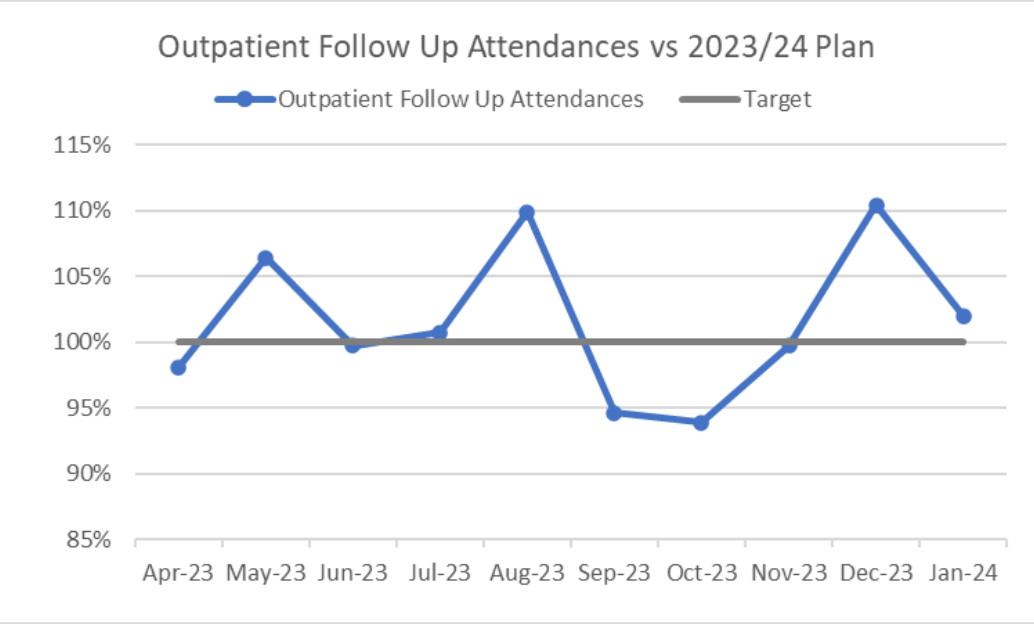
Total Follow-Up attendances undertaken compared with 2023/24 activity plan

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:
% of 2023/24 activity plan (source: activity plan 2023/24)



What does the chart show/context:
- CHFT made the decision at the start of 2022/23 to not adopt the 25% reduction in Outpatient follow-up activity, this has continued for 2023/24.
- Performance has reduced for month 10 and CHFT achieved 102.0% of the planned position in-month for follow-up attendances.
- The YTD position remains above the planned levels standing at 101.4%.

Underlying issues:
- Although the national target for follow-up activity is 75% of 2019/20 activity, due to a significant follow-up backlog (26,411), CHFT have not taken this up.
- 50% of the backlog has been waiting less than 12 weeks.

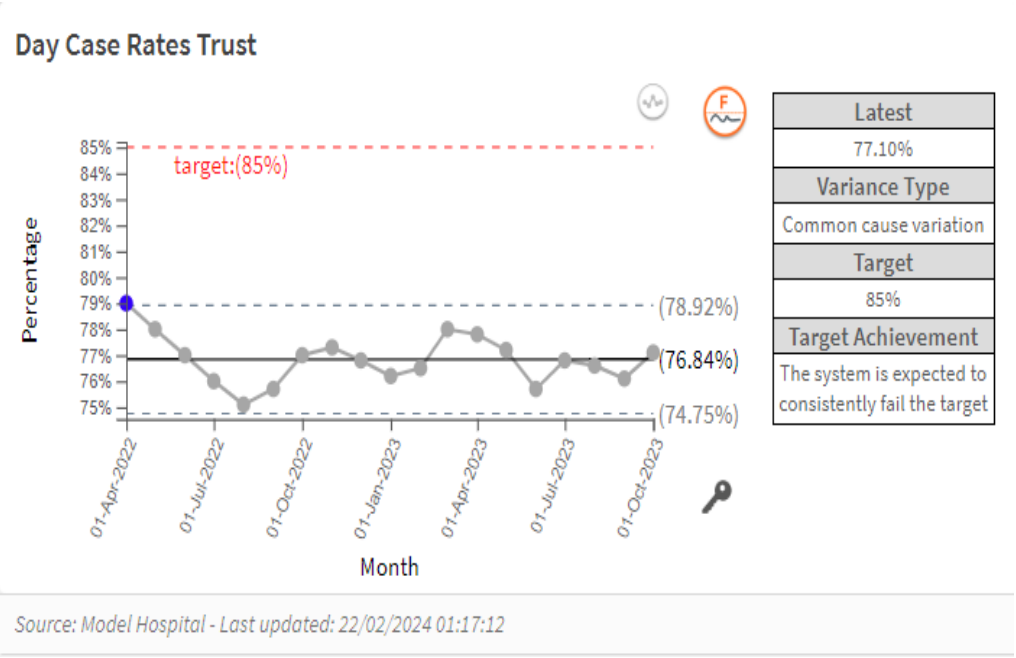
Actions:
- There are currently 10,149 (of the 26,411 backlog) records that are awaiting a clinical prioritisation within CHFT's MPage system, this is a reduction of 400 from last month. Specialties need to have a plan to address this backlog to ensure patients are booked by clinical priority. There are plans to employ the low hanging fruit validation process to the Incomplete Orders on the Mpage to remove any records that do not need to remain open. Specialties will then have a clean Mpage validation list for clinical prioritisation.
- Following the introduction of Targeted Admin Validation of the Holding List (3,500), we now have 26,411 follow-up patients past see by date and this is gradually increasing weekly.
- Deep dives have been undertaken at specialty level, to create a bespoke plan for each specialty to reduce the follow-up backlog and long waiters.
- The follow-up training programme has now been completed in all specialty areas. The impact will be reviewed to identify any further training needs.

Day Case Rates

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

Rationale:
Monitoring day case rates is a valuable practice for healthcare organisations aiming to optimise bed utilisation and improve patient experience.

Target: Over 85%



What does the chart show/context:

- Utilising the new Model Hospital measure (which includes those procedures completed in Outpatients) reported day case rate for the 3 months to the end of November 2023. CHFT performance reported as 77.1% against an 85% target.

Underlying issues:

- Several General Surgery cases that are CEPOD patients are being admitted via SDEC as 'Elective planned'.
- Data quality challenges around "intended management". Cases are being listed on Bluespier and completed as day case however currently these are getting captured as elective admission incorrectly on Cerner.
- Reverse conversion are not counted – If a patient is listed for an inpatient stay but is completed as day case this is not reflected in our day case rate.

Actions:

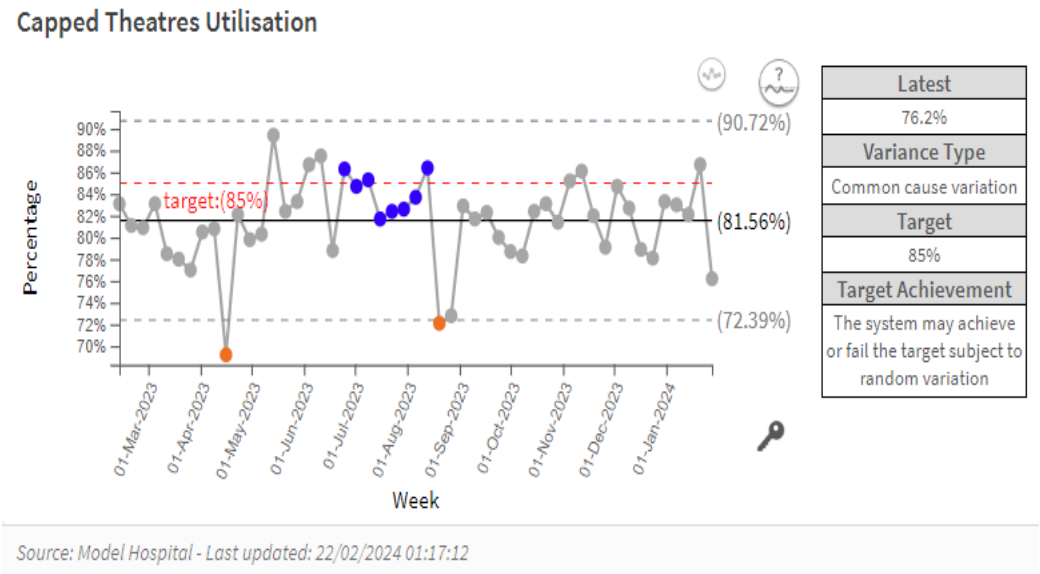
- Day case rates are monitored at a specialty level through the monthly STUG meetings.
- Procedure specific data reviewed each month to identify improvement opportunities or data quality challenges.
- Specific actions in development for procedures where CHFT are identified as true outliers e.g. TURBTs.

Capped Theatre utilisation

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

Rationale:
Monitoring capped theatre utilisation is a crucial part of optimising surgical efficiency and reducing waiting times

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 January 2024 – performance at 76.2%.

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.
- MH unable to explain how they account for 60-minute lunchtime despite this being reported as an 'allowed' gap.

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

Cancer:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >62 days to begin cancer treatment compared with February 2020 baseline	8th Feb 2024	23	35			34.84	20.67	49.01
Proportion of patients meeting the faster diagnosis standard	January 2024	77.66%	75%			76.87%	67.2%	86.54%
Non-Site-Specific Cancer Referrals	January 2024	25	25			22	7	37
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	January 2024	48.0%	75%			48.7%	33.2%	64.1%

Total Patients waiting over 62 days to begin cancer treatment compared with February 2020 baseline

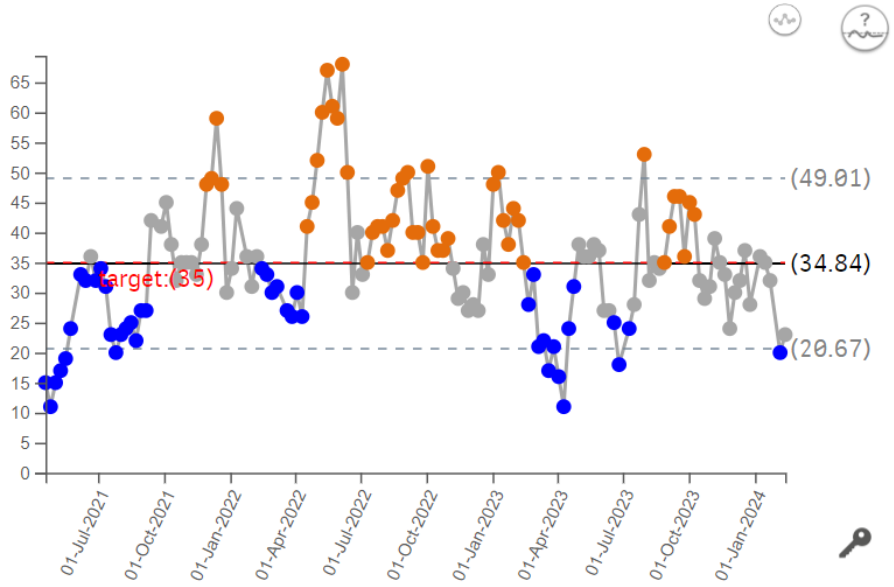
Calderdale and Huddersfield NHS Foundation Trust

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.

Target:
Return the number of people waiting for longer than 62 days to the level in February 2020. Target 35 as per activity plan 2023/24.

People Waiting Longer Than 62 Days



Latest
23
Variance Type
Common cause variation
Target
35
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- As of Monday 12th February there were 23 patients on the long waiters' report.
- CHFT has one of the lowest over 62-day PTLs nationally and this is tied into our 62-day performance which stands as one of the best in the country.

Underlying issues:
- Continue to be in 2 tumour sites H&N and Lower GI.

Actions:
- WTGR with LGI continues.
- Over 62-day waiters continuing to be escalated to divisional teams where appropriate.

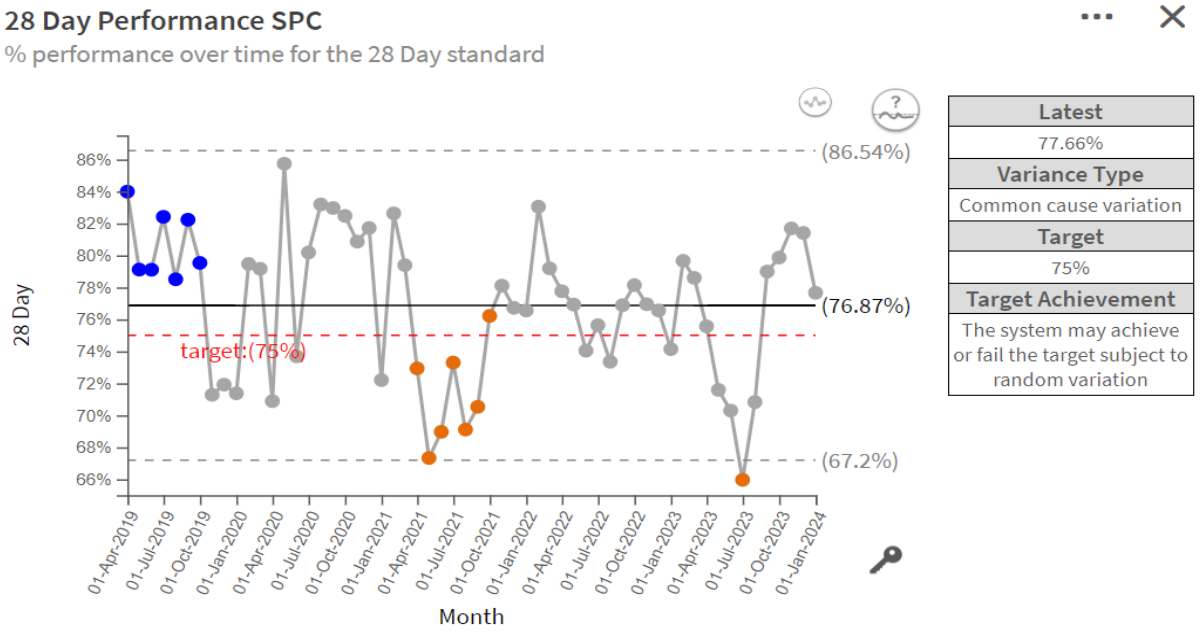
Proportion of patients meeting the faster diagnosis standard

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 75%.



Latest
77.66%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- Latest monthly performance stands at 77.66%.
- National performance tends to be under the 75% target.
- The Trust is unable to consistently meet the target of 75% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 67% and 87%

Underlying issues:
- Nationally, pathways where performance against the 28-day FDS is challenged are; Lower GI, Upper GI and Urology and this is reflected locally. Head and Neck and Haematology are also not meeting the 28-day target.

Actions:
- Skin have reverted back to their face to face clinics, Skin and the overall 28-day target have improved as a result. However implementation of Telederm is a National expectation.
- Pathway navigator in place for Lower GI and Upper GI to support patients to engage with the pathway, this is only financed part year.
- NSS actions include, proforma to be used by Physicians Associate and CNS to order investigations on the day, CNS and PA to join weekly risk meeting, escalation process to be put in place for patients from day 21. No permanent funding for this team.
- Head and Neck, request for mutual aid from other Trusts and frequently chasing results letters/appointments for results, other Trusts struggling with ENT so mutual aid is unlikely.

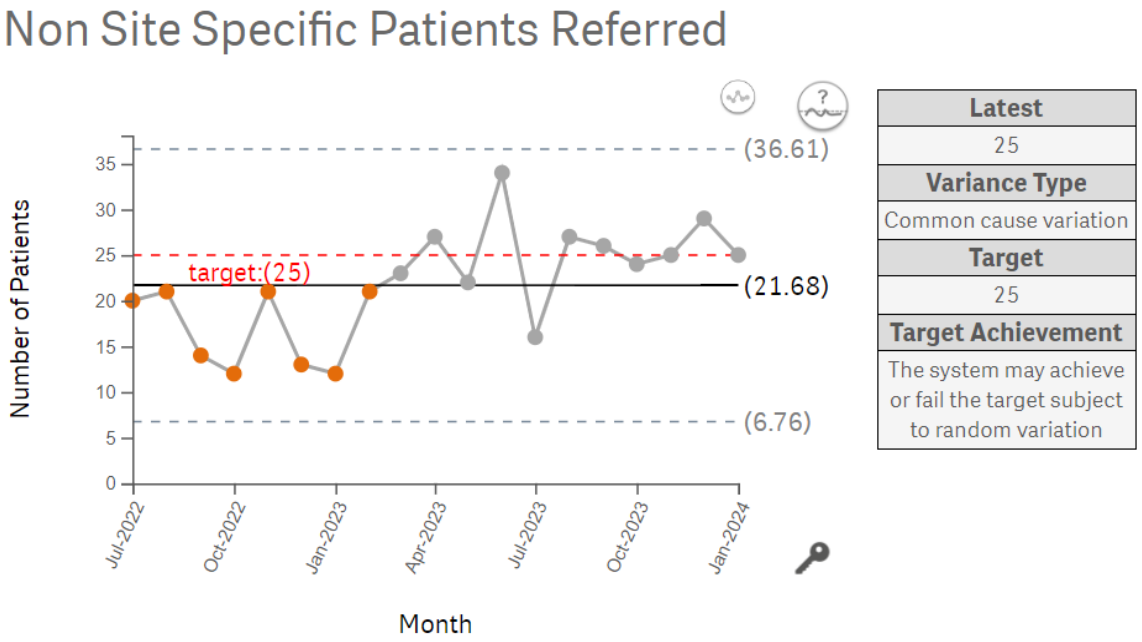
Non-Site-specific Cancer Referrals

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: 25 as per activity plan – March 2024



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

What does the chart show/context:
- The Trust is unable to consistently meet the target of 25 and may achieve or fail the target subject to random variation. Performance can be expected to vary between 7 and 37.

Underlying issues:
- Referrals continue to be variable, around 25 per month.

Actions:
- Share 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.
- Looking to open up to a second PCN in Kirklees (Viaduct PCN).
- Presented to A&E ACPs in December and seen an increase in A&E referrals.

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

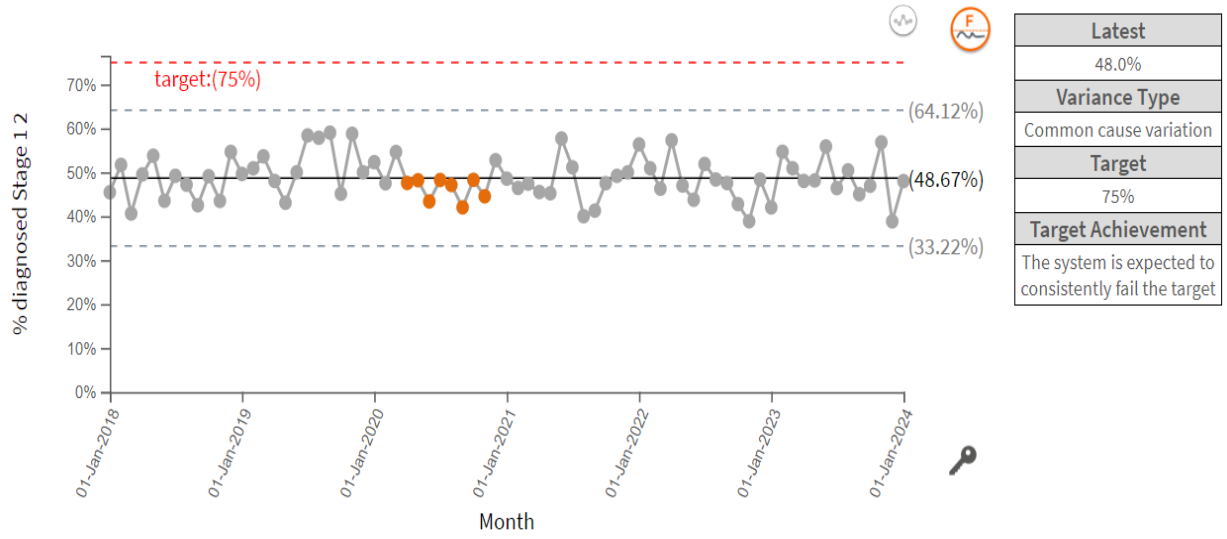
Calderdale and Huddersfield NHS Foundation Trust

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
48.0%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system is expected to consistently fail the target

What does the chart show/context:
- The Trust is expected to consistently fail the target of 75%.
- Performance can be expected to vary between 33% and 64%.
- Nationally this metric stands at 49%.

Underlying issues:
- This metric is an area where CHFT need to work with partners to raise awareness and ensure that ICB colleagues are addressing the issues.

Actions:
- This metric will be rolled out alongside a series of NHSE pilots, including FIT testing, and Dermatoscopes, with the aim that these pilots will improve access and earlier diagnosis.
- The Faster Diagnostic Framework will also support this unit of work.
- Roll-out of self-referral chest x-ray in 2024 and Targeted Lung Health checks will contribute to finding lung cancers at an earlier stage.

Urgent and Emergency Care and Flow:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Proportion of patients seen within 4 hours	January 2024	66.53%	76%			68%	61%	75%
Proportion of ambulance arrivals delayed over 30 minutes	January 2024	6.6%	0%			4%	1%	7%
Proportion of patients spending more than 12 hours in an emergency department	January 2024	5.74%	2%			3%	0.8%	5.3%
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	January 2024	99.8%	96%			98%	96%	100%
% of beds occupied by patients who no longer meet the criteria to reside	January 2024	19%	14.2%			22%	18%	25%
Hospital Discharge Pathway Activity – AvLOS pathway 0	January 2024	4.3	4.1			4.04	3.65	4.44
Transfers of Care	January 2024	128	50			93	51	134

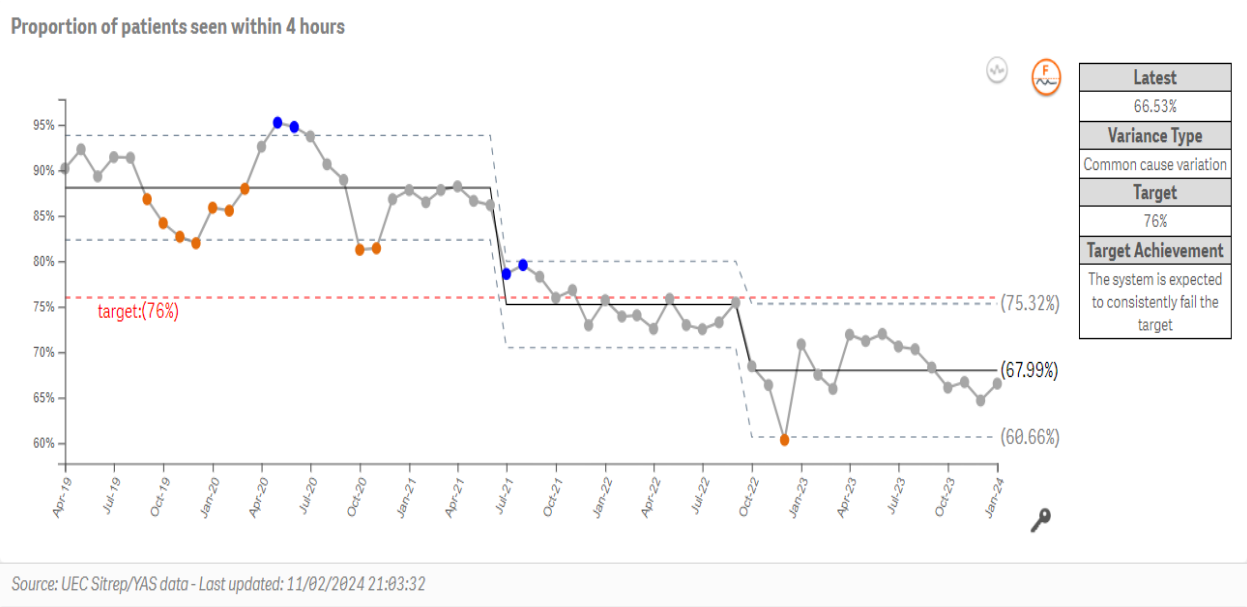
Proportion of patients seen within 4 hours

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 76% (80% local target) of patients are seen within 4 hours by March 2024 with further improvement in 2024/25.



What does the chart show/context:

- The Trust is unable to consistently meet the target of 76% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 61% and 75%.
- The performance for January was 66.53%, this is a slight increase from December but still below the 76% target. However, most Trusts nationally are not meeting the target.
- Performance has been impacted by a high bed occupancy, high acuity and continuingly high level of attendances.

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Underlying issues:

- Increase in occupied beds - long wait for beds.
- Increase in acuity.
- TOC numbers still high.

Actions:

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

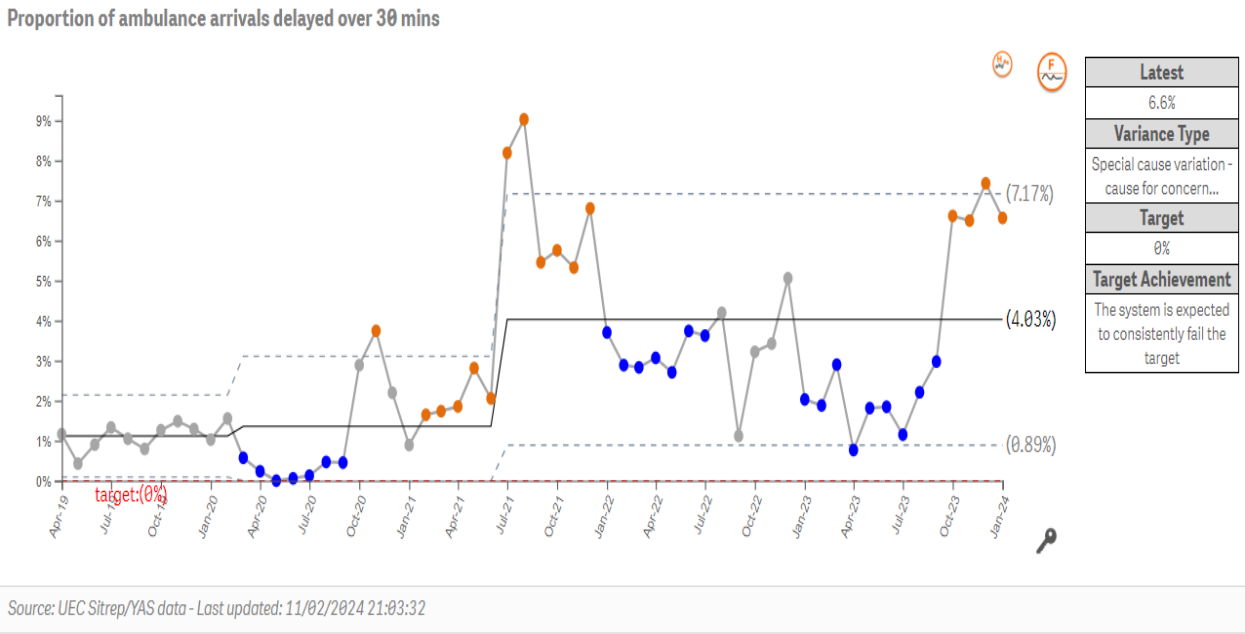
Proportion of ambulance arrivals delayed over 30 minutes

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).



Source: UEC Sitrep/YAS data - Last updated: 11/02/2024 21:03:32

What does the chart show/context:
- The performance for January was 6.6%
- The Trust is expected to consistently fail the target of 0%. Performance can be expected to vary between 1% and 7%.

Underlying issues:
- We have seen a deterioration in performance from October and this will continue as the reporting for YAS handovers has changed. The key change is the use of arrival destination as the trigger for when the clock starts. This removes any notify times previously used and as a result we have seen an increase in handover times.
- We continue to validate all patients over 30 minutes every day. We have found due to this there is a material difference in what is being reported as part of the Daily Ambulance Collection which is taken straight from the figures reported by YAS.
- Increase in attendances.
- Increase in bed occupancy – long waits for beds.
- Increased LOS in ED means the departments can become bed blocked.
- Increased acuity (less fit to sit patients).

Actions:
- Improvement for all metrics for ambulance handovers - SOP in action that ensures consistent approach to validation.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.

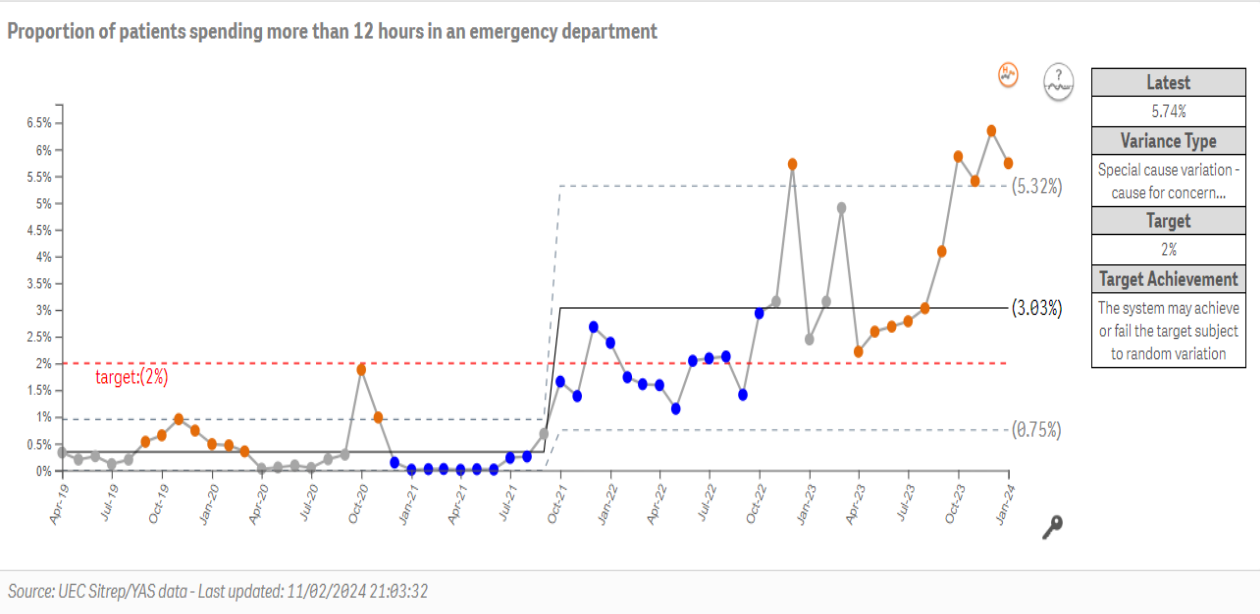
Proportion of patients spending more than 12 hours in an emergency department

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:
- In January the performance was 5.74% with 864 patients waiting over 12 hours in ED.
- The Trust is unable to consistently meet the target of 2% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 0.75% and 5.32%.

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.
- Hot meals service now rolled out on both sites for patients with extended LOS in the EDs.

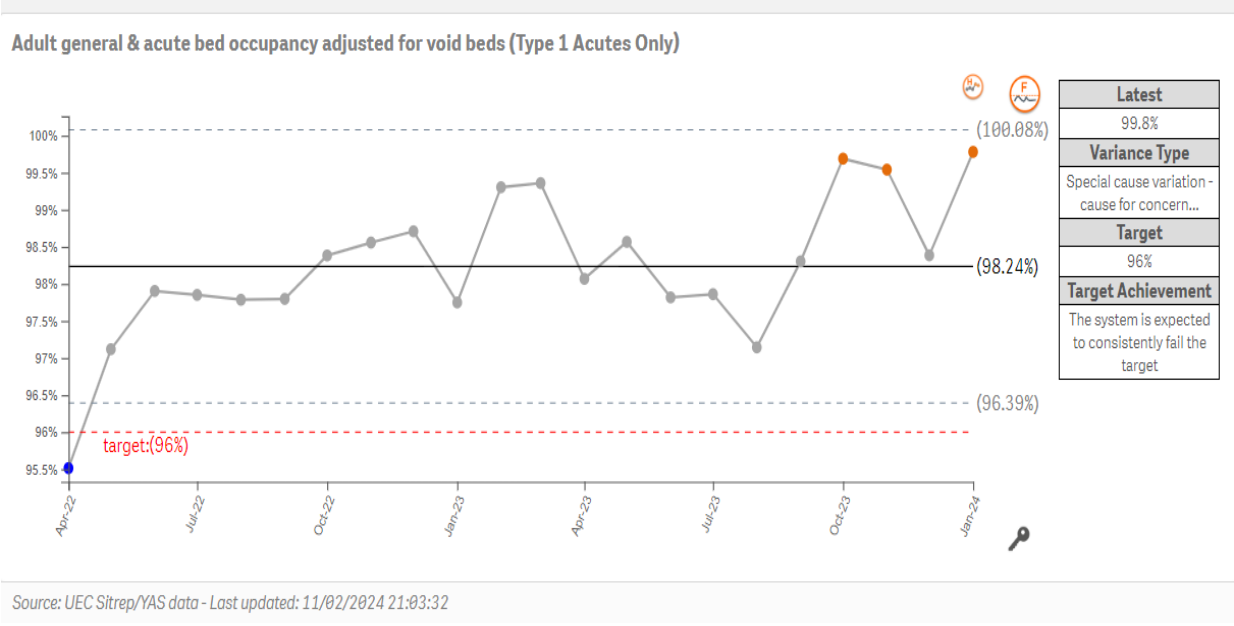
Adult general & acute bed occupancy adjusted for void beds (Type 1 Acutes Only)

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: 11/02/2024 21:03:32

What does the chart show/context:
- Adult bed occupancy in January was extremely high at 99.8%. The Trust is expected to consistently fail the target of 96%.
- It is important to factor in the bed base when analysing this graph.

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

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

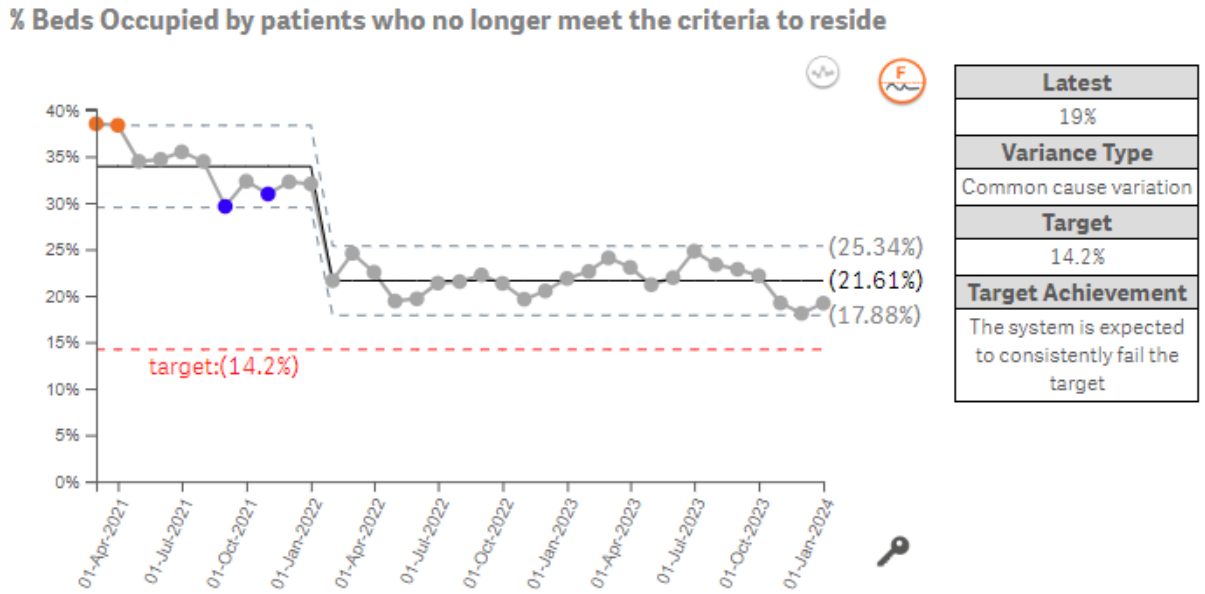
Percentage of beds occupied by patients who no longer meet the criteria to reside

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 2024).



Source: KP+ Information Team stream R2R IPR app - Last updated: 04/02/2024 21:03:32

What does the chart show/context:
- In January 19% of patients had no reason to reside.
- Slightly more beds were occupied in January, but this was still in line with the number of patients with no reason to reside, hence the percentage remaining similar to previous months.
- January's data is below the mean line, but within normal variation.
- The Trust will consistently fail the target of 14.2% and performance can be expected to vary between 18% and 26%.

Underlying issues:
- Increases in acuity across our ward areas.
- Patients not transferred onto the TOC list in a timely manner despite wards waiting for a pathway 1-3 outcome.
- The criteria to reside not being managed at ward and department level in the board and ward rounds.

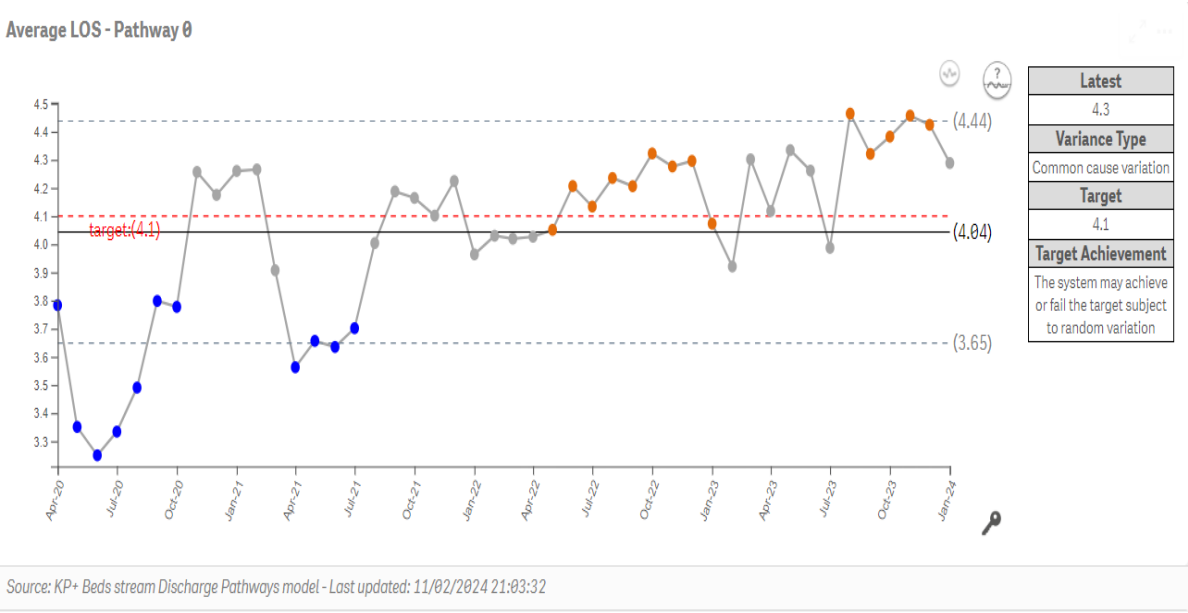
Actions:
- Reason to reside will form part of the board round SOP and discussion, however how it integrates into the digital whiteboard is yet to be established.
- Joint CHFT, Community and Local Authority dashboard under development which will give greater visibility and focus on the delays to discharge for patients on TOC.

Hospital Discharge Pathway Activity

Executive Owner: Jonathan Hammond Operational Lead: Gemma Berriman Business Intelligence Lead: Alastair Finn

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

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



What does the chart show/context:
- In January average length of stay was 4.3 days.
- Performance can be expected to vary between 3.65 and 4.44 days.

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

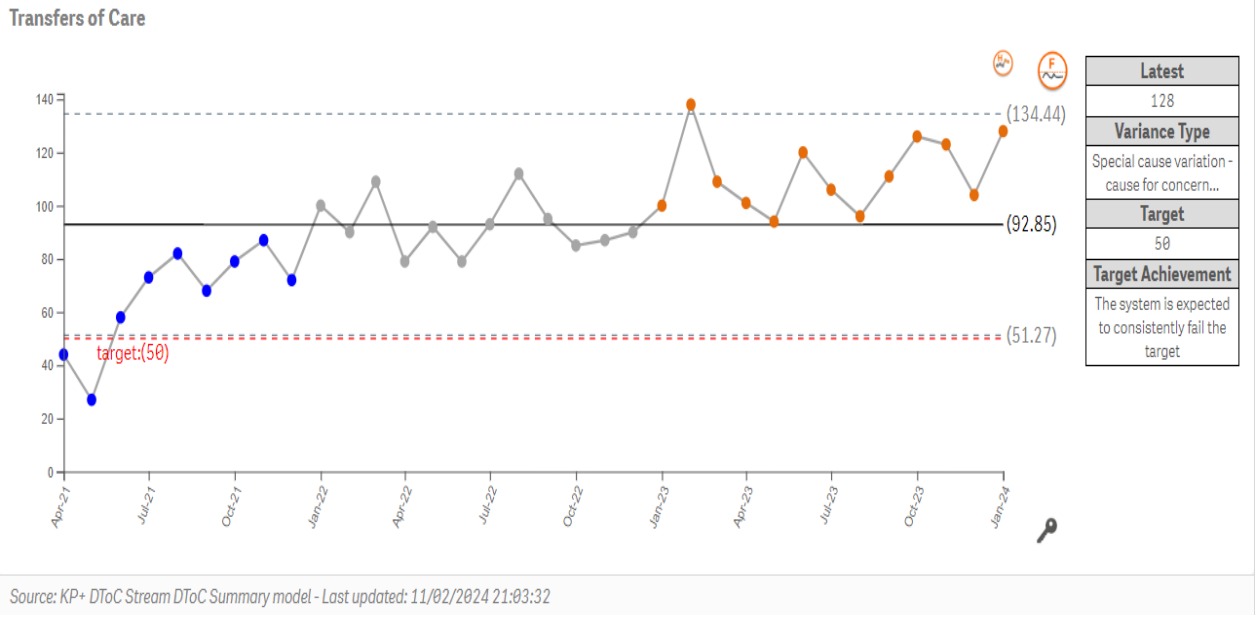
Actions:
- Improvement groups continue with PMO support to develop and improve groups.
- Launch of the Well Organised Ward Programme.
- Approval of funding to reablement and trusted assessors.
- New LOS pack launched in October 2023.
- Governance structures defined within the divisions and through PRMs.

Transfers of Care

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

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

Target: 50 patients or less



What does the chart show/context:
- The snapshot for the end of January was 128 patients on the TOC list which is higher than the target set at the start of the financial year.
- TOC numbers have been climbing since 2021 peaking in February 2023.
- Referrals to TOC have also followed the same trajectory.

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

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

Maternity and Children's Health:

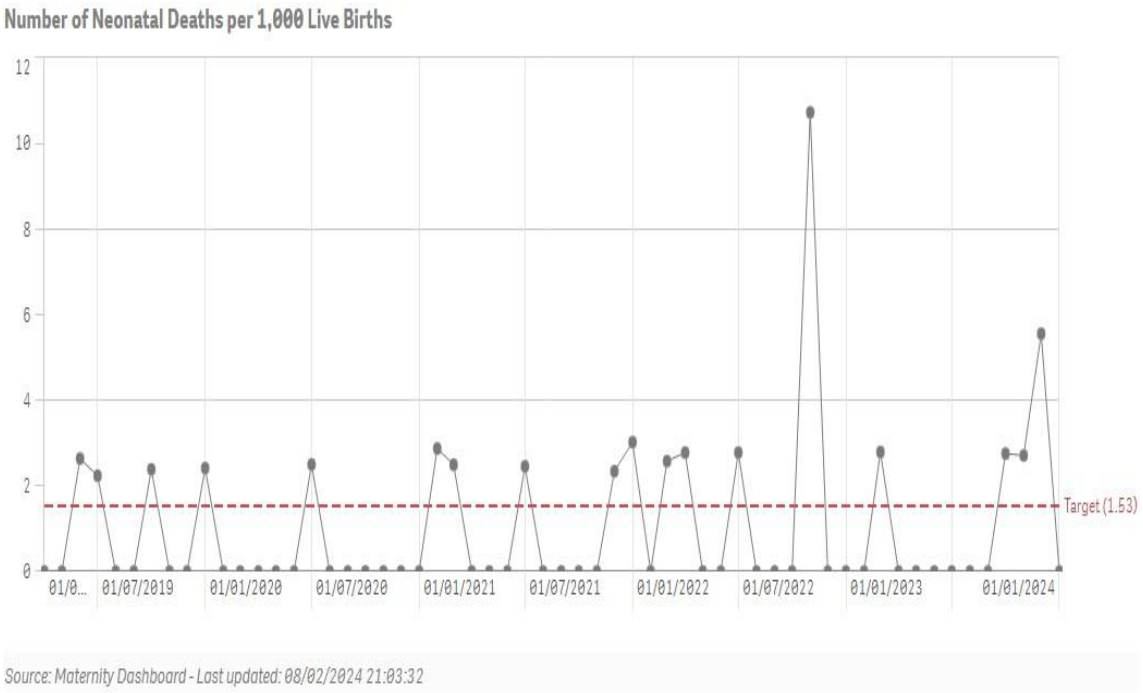
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	January 2024	0.00	1.53	-	-	-	-	-
Stillbirths per 1,000 total births	January 2024	2.86	3.33			3.65	0	13.23
Maternity Workforce	January 2024	tbc	tbc					

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 January

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

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

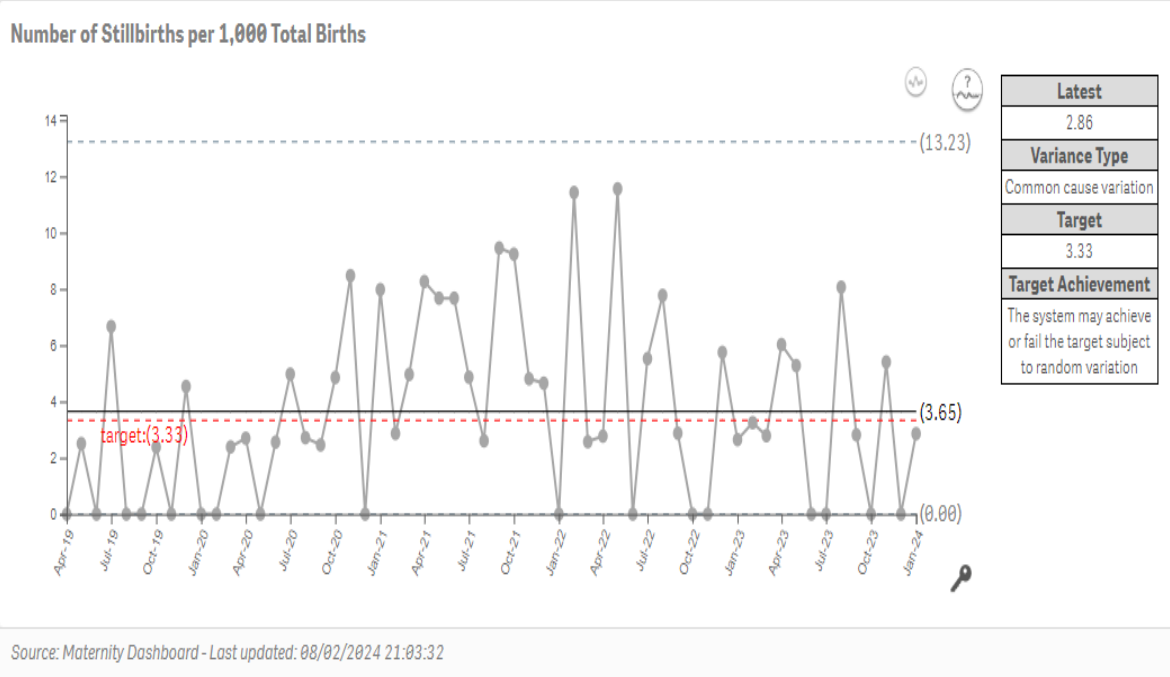
Stillbirths per 1,000 total births

Calderdale and Huddersfield NHS Foundation Trust

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

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

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



What does the chart show/context:
There was one stillbirth per 1,000 total births in January.

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

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

Maternity Workforce

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

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

Target:

What does the chart show/context:
.

Underlying issues:

Actions:

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	January 2024	59.32%	70%			68.38%	50.83%	85.92%
Community Waiting List	January 2024	6,210	4,387 (end 2023/24)		-	5979	5661	6298
Virtual Ward	January 2024	108%	80%			100.1%	55.7%	144.5%
Patients dying within their preferred place of death	January 2024	98.3%	80%			92.94%	81.96%	103.93%

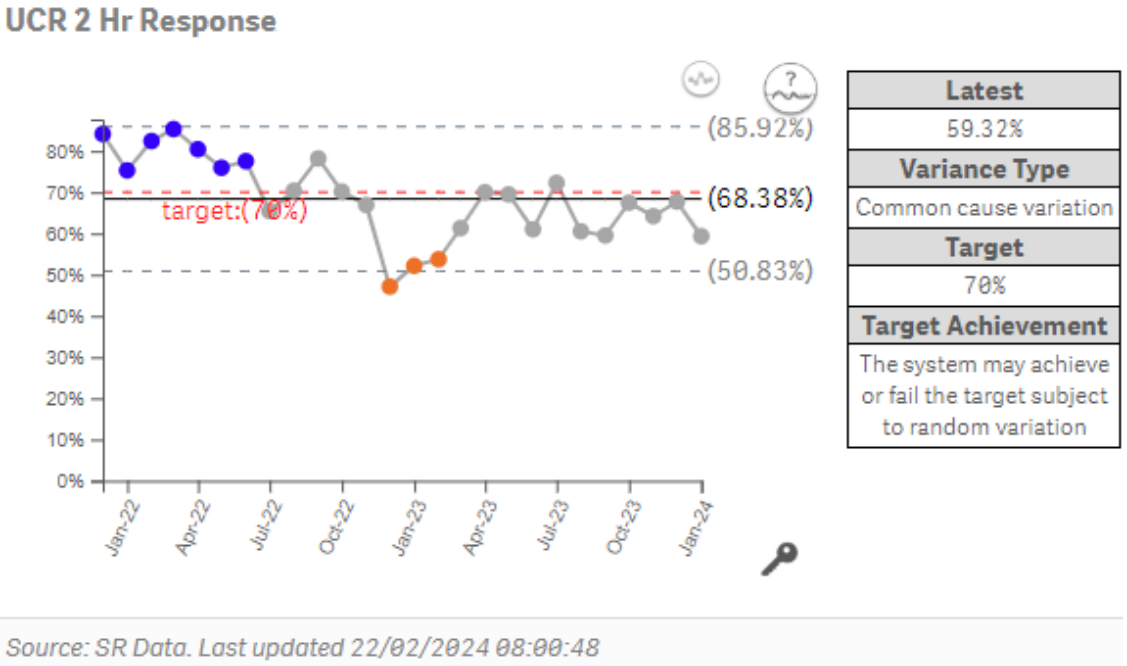
Proportion of Urgent Community Response referrals reached within two hours

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 22/02/2024 08:00:48

What does the chart show/context:
- Current position for January 2024 is at 59.3%.
- The Trust is unable to consistently meet the target of 70% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 51% and 86%.

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

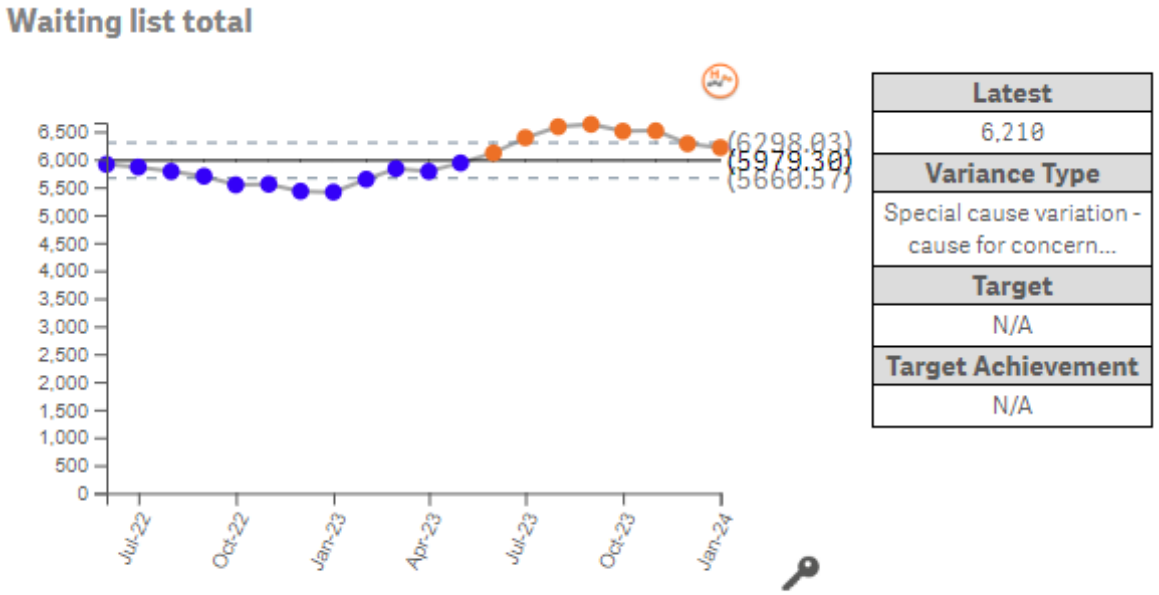
Actions:
- Communications to service leads around accurate data recording.
- Ongoing cases where 2 hours' time is taken by LCD to triage due to their processes therefore is out of the 2-hour window prior to reaching UCR.
- Manual audit being completed to examine the different elements of the 2-hour response.

Community Waiting List

Executive Owner: Rob Aitchison Operational Lead: Michael Folan/Nicola Glasby Business Intelligence Lead: Gary Senior

Rationale:
Understand resilience amongst providers of community health services and provide valuable data on waiting times and waiting list information.

Target:
The total number of patients on community waiting lists at a given time.
Target 4,387 by the end of 2023/24.



Source: SR Data. Last updated 22/02/2024 08:00:48

What does the chart show/context:
- 6,210 total in January 2024.
- Nationally MSK & Podiatry have the highest numbers waiting.

Underlying issues:
- At CHFT Podiatry and Children's SALT are our main concerns.
- The main reasons for current waiting list position in Children's SALT are workforce availability issues, 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. 1x WTE b5 to advert currently and 1x WTE B7 has recently given notice. Team Lead is also reducing hours at financial year end.
- Podiatry is appropriately prioritising high-risk patients, therefore the routine waiting list has been reducing fairly slowly. Additional clinics are now happening following some recruitment and the service specification is also under review which will have an impact.

Actions:
- SALT recruitment pressures supported by locum in post and new staff due to start.
- Professional Lead SALT is now is post.
- Transition to new SALT service structure has begun with percentage increase in wait list reducing since this point.
- The Podiatry service is undergoing a review, including workforce modelling and a review of the service specification. The plan is to implement to new service spec in the new financial year.

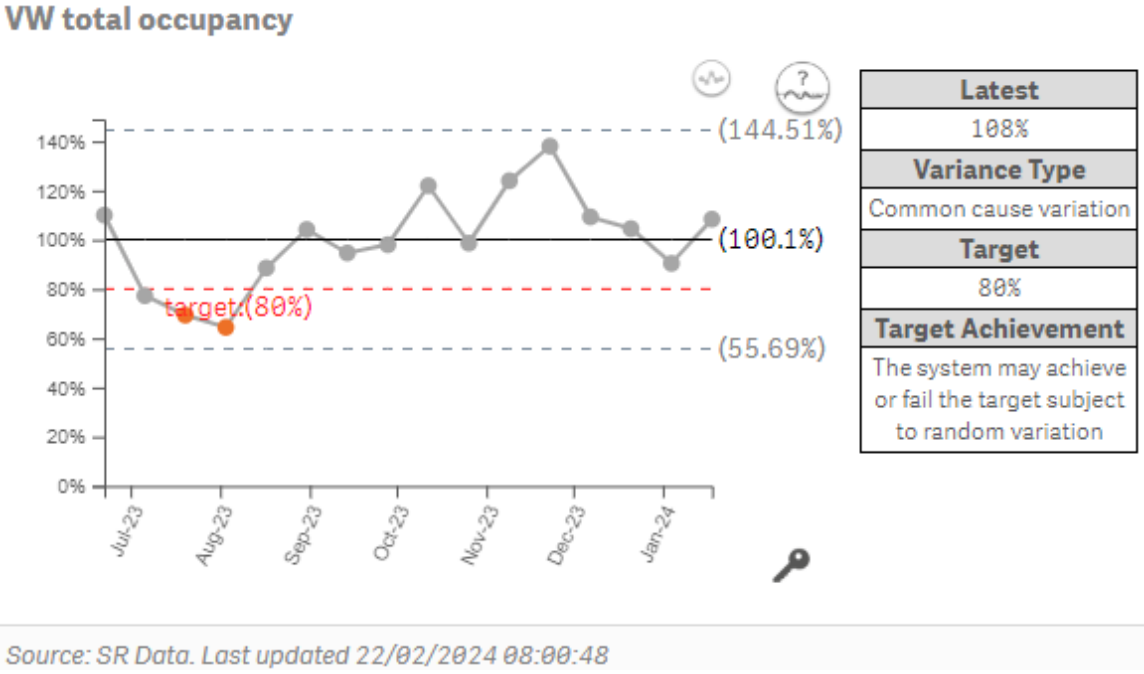
Virtual Ward

Calderdale 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 35 and will rise progressively to 42 total by the end of March24

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



Source: SR Data. Last updated 22/02/2024 08:00:48

What does the chart show/context:
- Current combined position for January 2024 is 108%.

Underlying issues:
- Currently there is only a 5-day consultant offer for frailty virtual ward as 7-day cover is not funded. This limits referrals towards the end of the week due to concern they may need consultant input over a weekend.

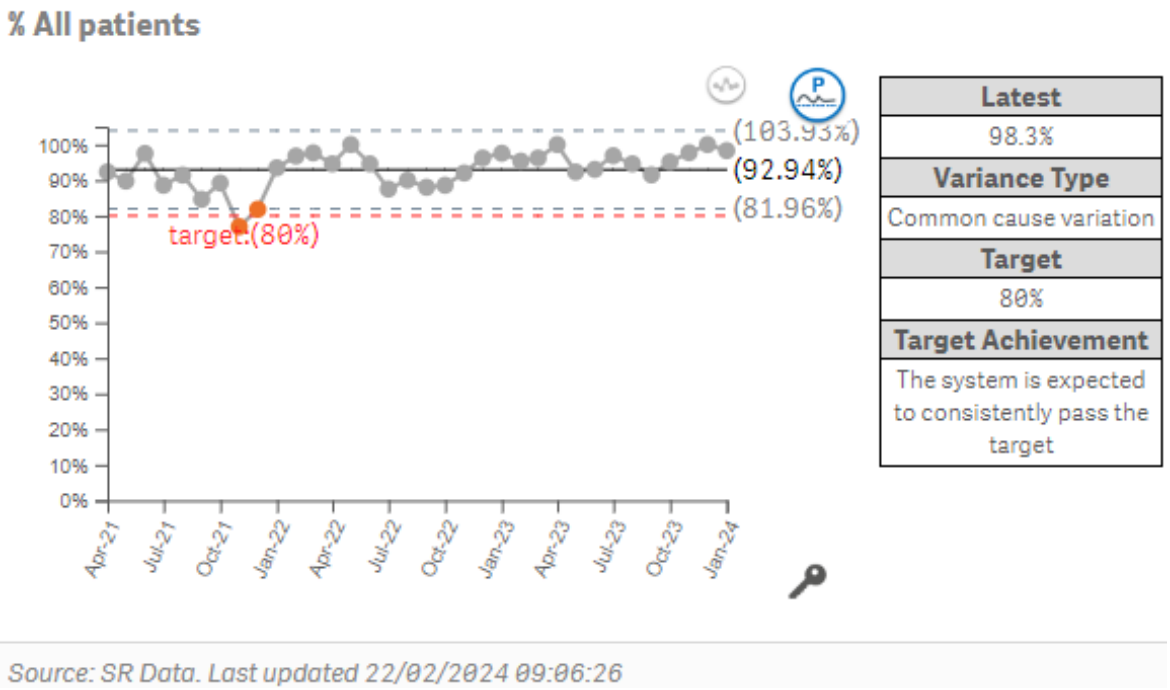
Actions:
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care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

Patients dying within their preferred place of death

Executive Owner: Lindsay Rudge Operational Lead: Michael Folan/Abbie Thompson Business Intelligence Lead: Gary Senior

Rationale:
% of patients dying within their preferred place of death – Community Palliative Care.

Target: Over 80%



Source: SR Data. Last updated 22/02/2024 09:06:26

What does the chart show/context:
- Consistently above 80% target (exception November 2021).
- Current month combined 98.3% (EOL 100% and Palliative 97%).
- Palliative patients – 97% patients died at home – January 2024.

Underlying issues:
- Workload pressures – Palliative day team continue to work additional hours to keep patients safe – limiting GP call-outs by utilising Independent Prescribing / assessment skills and coordinating care with Acute hospital teams to streamline patient interventions and reduce length of hospital stay (avoiding ED wherever possible).
- Acuity and complexity of need – evidenced by number of low performance scores – patients are increasingly in urgent need of specialist intervention due to late presentation / diagnosis or multiple comorbidity.
- OOH EoLC team – currently working extended hours for 12 months (April 2023 – March 2024) as result of successful Innovation bid. Now need to secure funding to facilitate the new WFM to include this (in conjunction with existing joint service agreement with Marie Curie).

Actions:
- To ensure continued and increasing funding for both teams to maintain this strong position of achieving preferred place of death, facilitating the vast majority of dying at home, admission to hospice and reducing deaths in the acute hospital setting.

Health Inequalities: Learning Disabilities

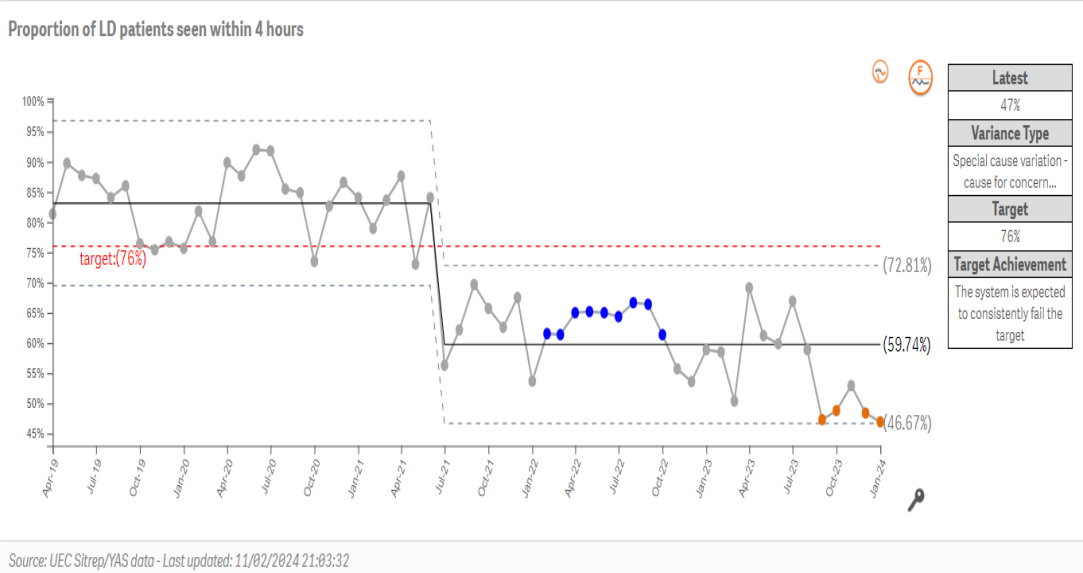
Metric	Latest Month	Learning Disability Measure	Overall Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Emergency Care Standard	January 2024	47%	66.5%	76%			60%	47%	73%
Outpatients DNAs	January 2024	11.0%	6.66%	3%			9.08%	3.2%	14.97%
Cancer Faster Diagnosis Standard	January 2024	75%	77.66%	75%			63%	0%	100%
% of patients waiting less than 6 weeks for a diagnostic test	January 2024	84.7%	80.4%	95%			86.99%	74.45%	99.53%
Patients waiting more than 40 weeks to start treatment	January 2024	3	1,065	0			-	-	-

Emergency Care Standard: Learning Disability

Executive Owner: Rob Aitchison Operational Lead: Jason Bushby/Amanda McKie Business Intelligence Lead: Alastair Finn

Rationale:
To monitor waiting times in A&E for patients with a Learning Disability

Target:
NHS Objective to improve A&E waiting times so that no less than 76% (80% local target) of patients are seen within 4 hours by March 2024 with further improvement in 2024/25.



What does the chart show/context:
- The Trust is consistently failing the 4-hour target of 76% for patients with a Learning Disability attending ED. Performance can be expected to vary between 47% and 74%.
- The performance in January was 47% which is considerably lower than the overall Trust 4-hour standard which was 66.5%.

Underlying issues:
- Bed occupancy levels within the organisation, resulting in bed waits within the ED which in turn causes congestion, lack of clinical space for patients to be reviewed and diverts ED medical and nursing resource to care for patients who would be better cared for in an inpatient bed space.
- Audit showed learning disability patients more likely to need admission often due to late presentation and a longer wait as requirement for a side room on admission (reasonable adjustment).
- Workforce related issues, short term sickness, vacancy levels, which cause on the day workforce model gaps within the ED medical and nursing workforce resulting in potential delays to ED investigation, treatments and time to see clinician.

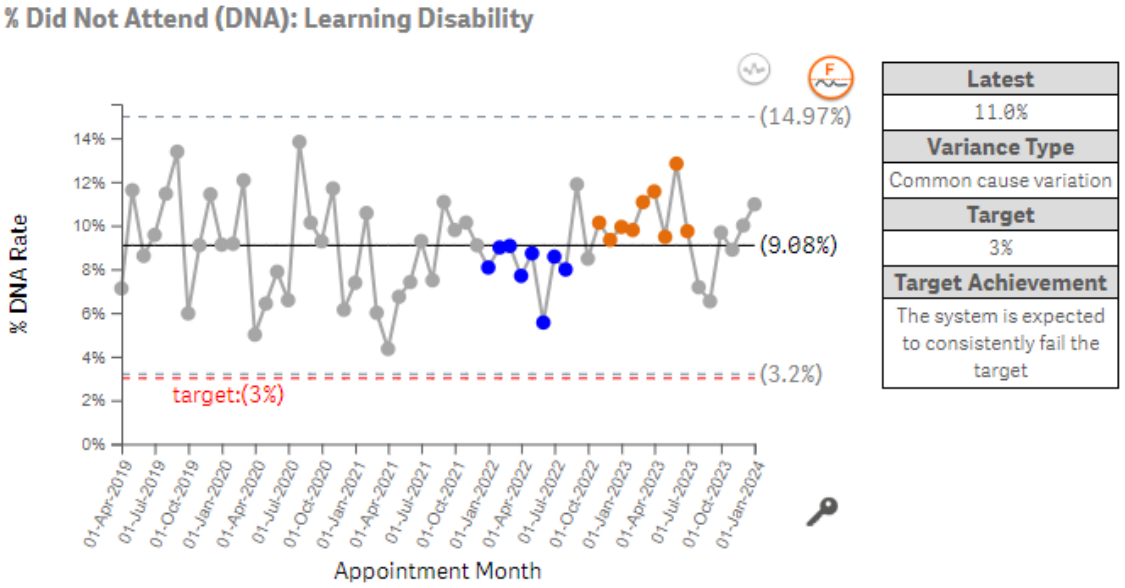
Actions:
- Health Inequalities Meeting to support learning and actions from Learning Disability audit.

% Did Not Attend (DNA): Learning Disability

Executive Owner: Rob Aitchison Operational Lead: Kim Scholes/Amanda McKie Business Intelligence Lead: Oliver Hutchinson

Rationale:
To monitor DNA rates at first and follow-up appointments for patients with a Learning Disability

Target:
3% - Elective Transformation Workstream target to reduce to 3% by the end of 2023/24.



What does the chart show/context:
- The current DNA rate for appointments for patients with a Learning Disability declined in January 2024 and stands at 11.0%.
- This performance has remained within the expected range from April 2019 to date and shows consistent common cause variation throughout that time.
- This sits above the DNA % for the wider population at CHFT for outpatient appointments which currently stands at 6.66% for January 2024.

Underlying issues:
- Need to audit DNAs to understand reasons for high DNA rate for patients with a Learning Disability.

Actions:
- Within the newly launched Elective Care Transformation Board, a DNA workstream has been set up specifically to look at reducing the level of DNAs for all outpatient appointment within CHFT for the year 2023/24.
- This workstream has met and fed back their 'plan on a page' at the latest ECT Board meeting.
- Their headline target for the year is to reduce the DNA rate for all outpatient appointments to 3% by the end of the financial year.
- Audit of patients to understand reasons for DNA to be done January/February 2024.
- Project to improve patient communication and letters – including new templates and considerations of accessible information standards and health literacy.

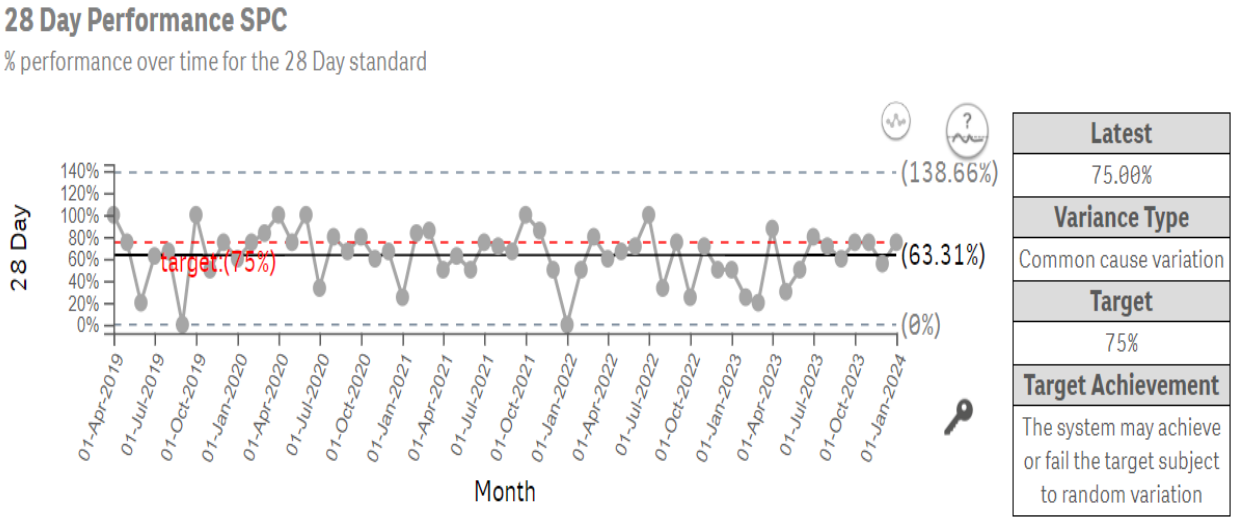
Proportion of patients meeting the faster diagnosis standard: Learning Disability

Calderdale and Huddersfield NHS Foundation Trust

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

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

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



Latest
75.00%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- Latest monthly performance stands at 75% which is in line with the NHSE target and slightly below performance for non-Learning Disability patients.
- The Trust is unable to consistently meet the target of 75% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 0% and 100%.

Underlying issues:
- Capacity of Complex Needs Matron.
- 2-week referral to first seen date is consistently achieved for patients with a Learning Disability so focus needs to be on diagnostic and communication of diagnosis part of the pathway.

Actions:
- Results from audit to be taken to Health Inequalities Meeting for discussion and agreement on any required actions.
- Identified issue of patient needing F2F appointments at clinician review but not actioned to be addressed.

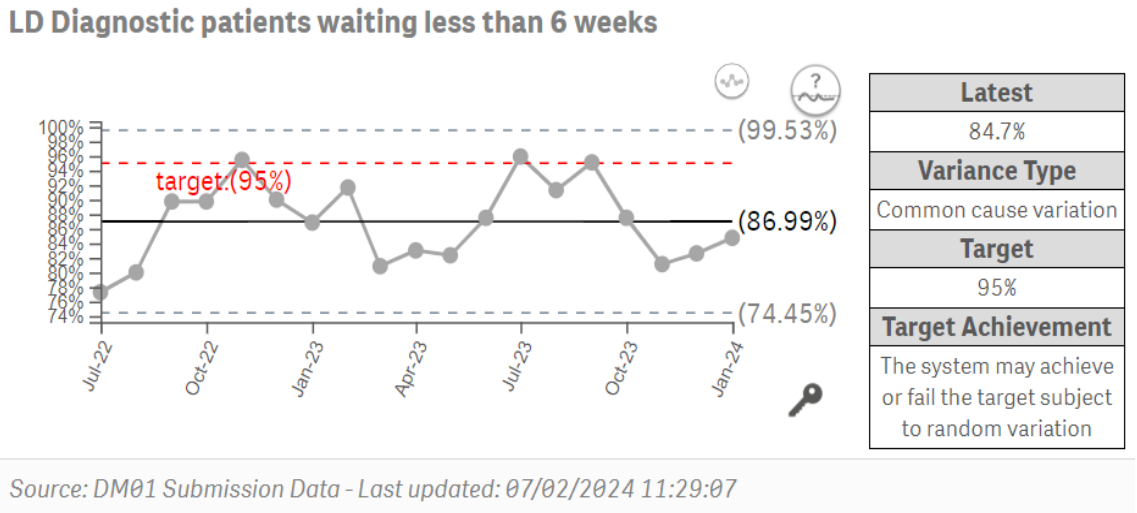
Percentage of patients waiting less than 6 weeks for a diagnostic test: Learning Disability

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Leads: Thomas Strickland/Stephen Shepley/Helen Rees/Amanda McKie
Business Intelligence Lead: Rebecca Spencer

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

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



What does the chart show/context:
- Latest monthly performance stands at 84.7% which does not meet the NHSE target of 95%. In-month performance is slightly above CHFT overall performance which is 83.6%.
- The Trust is unable to consistently meet the target of 95% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 75% and 100%.

Underlying issues:
- Learning Disability patient performance reflects CHFT performance and is being impacted by capacity issues in Echocardiography and Neurophysiology.

Actions:
- Audit Learning Disability breaches to check no other reasons for breaches other than capacity – to be done January/February 2024.
- Matron for Complex Needs given access to KP+ model to monitor Learning Disability patients on a diagnostic waiting list.

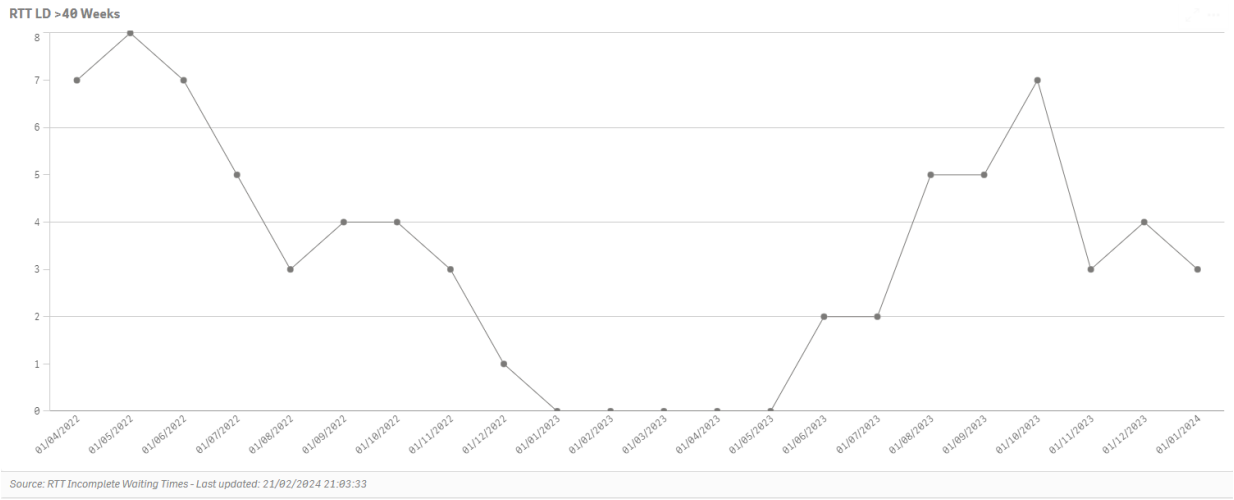
Total Patients waiting more than 40 weeks to start consultant-led treatment: Learning Disability

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Thomas Strickland/Amanda McKie
Business Intelligence Lead: Rebecca Spencer

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

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



What does the chart show/context:

- This chart shows the number of patients on the RTT Incomplete Pathways list who have been waiting more than 40 weeks to start treatment.
- The aim is to show progress towards 0 patients waiting more than 40 weeks by January 2024 (internal target).
- There are currently 3 patients with a Learning Disability who have waited more than 40 weeks

Underlying issues:

- Learning Disability patient performance reflects CHFT performance

Actions:

- Focus to be given at start of Access meetings for any learning disability patients over 40 weeks.
- Results from audit to be taken to Health Inequalities Meeting for discussion and agreement on any required actions.
- Matron for Complex Needs given access to KP+ model to monitor Learning Disability patients on an RTT waiting list and will be included as part or monthly meetings with Surgical team when reviewing waiting lists for Learning Disability patients.
- Identified issue of patient needing F2F appointments at clinician review but not actioned to be addressed.

Health Inequalities: Deprivation (IMD 1 and 2)

Metric	Latest Month	IMD 1& 2 Measure	Overall Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Emergency Care Standard	January 2024	67.6%	66.5%	76%			71%	65%	77%
Outpatients DNAs	January 2024	9.5%	6.66%	3%			9.61%	8.12%	11.11%
Cancer Faster Diagnosis Standard	January 2024	71.53%	77.66%	75%			75.9%	63.1%	88.8%
% of patients waiting less than 6 weeks for a diagnostic test	January 2024	88.4%	80.4%	95%			86.5%	73.5%	99.5%
Patients waiting more than 40 weeks to start treatment	January 2024	340	1,065	0			-	-	-

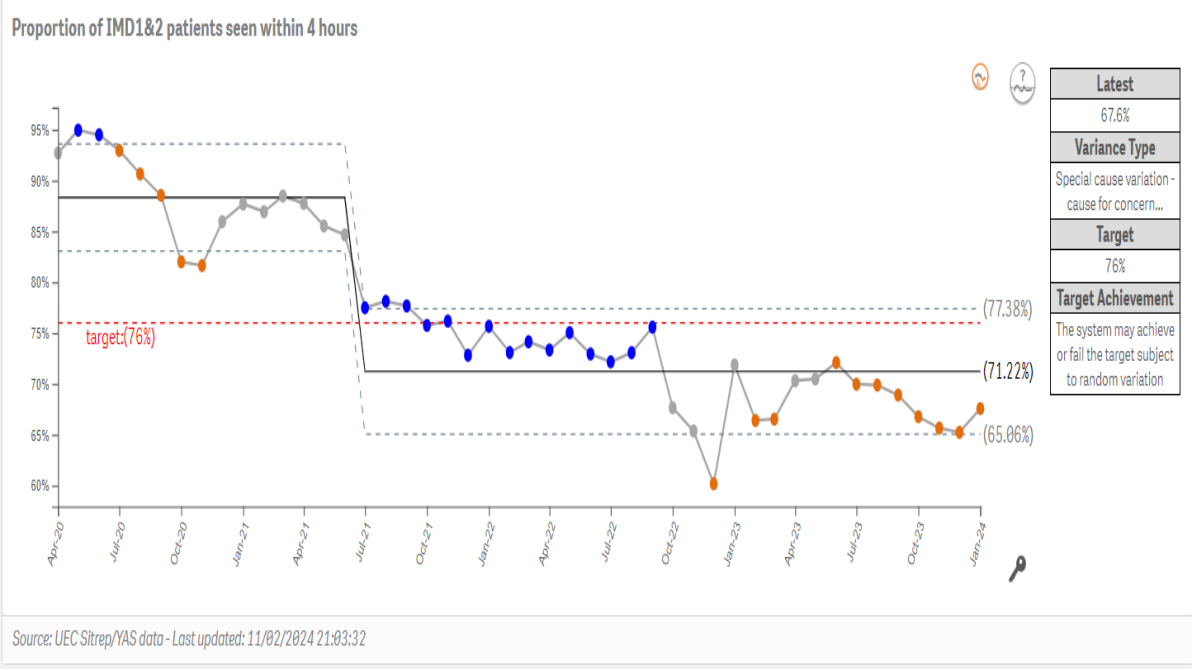
Emergency Care Standard: Deprivation (IMD 1 and 2)

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Jason Bushby Business Intelligence Lead: Alastair Finn

Rationale:
To monitor waiting times in A&E for patients with deprivation levels IMD 1 and 2

Target:
NHS Objective to improve A&E waiting times so that no less than 76% (80% local target) of patients are seen within 4 hours by March 2024 with further improvement in 2024/25.



What does the chart show/context:
- The Trust is consistently failing the 4-hour target of 76% for patients with deprivation levels IMD 1 and 2 attending ED.
- Performance can be expected to vary between 65% and 78%.
- The performance for January was 67.6% which is in line with the overall Trust performance for all ED attendances.

Underlying issues:
- Bed occupancy levels within the organisation, resulting in bed waits within the ED which in turn causes congestion, lack of clinical space for patients to be reviewed and diverts ED medical and nursing resource to care for patients who would be better cared for in an inpatient bed space.
- Workforce related issues, short term sickness, vacancy levels, which cause on the day workforce model gaps within the ED medical and nursing workforce resulting in potential delays to ED investigation, treatments and time to see clinician.

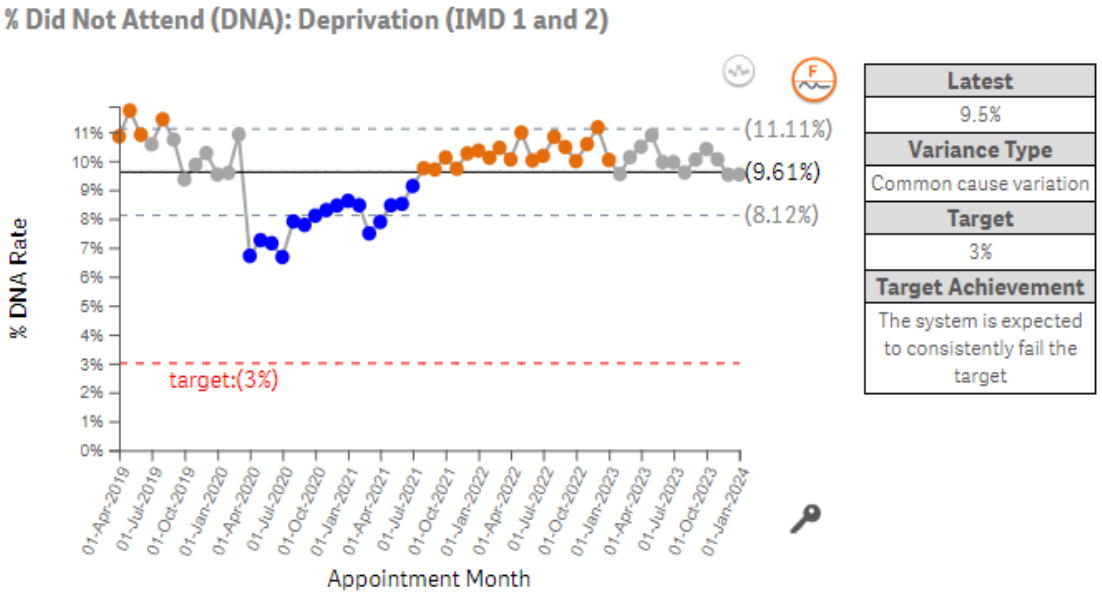
Actions:
- Recruitment into Medical WFM at interview stage, 3 locum consultants appointed.
- Evenings into nights is problematic and breach review identifies poor skill/seniority mix in employed medical workforce. Now addressed with 2 ST4+ on nights and evening consultant staying on until department is clear.
- We are monitoring our admitted and non-admitted performance daily to try improve the overall 4-hour standard performance.
- Testing of full capacity protocol is underway, aimed at supporting reducing long waits in ED.

% Did Not Attend (DNA): Deprivation (IMD 1 and 2)

Executive Owner: Rob Aitchison Operational Lead: Kim Scholes Business Intelligence Lead: Oliver Hutchinson

Rationale:
To monitor DNA rates at first and follow-up appointments for patients who are in the most deprived areas

Target:
3% - Elective Transformation Workstream target to reduce to 3% by the end of 2023/24.



What does the chart show/context:
- The current DNA rate for appointments for patients from the IMD 1 and 2 groups stands at 9.5% for January 2024.
- This performance has remained within the expected range from April 2021 to date and shows consistent common cause variation throughout that time.
- This performance does however represent performance that is consistently failing the target of 3%.
- This sits above the DNA % for the wider population at CHFT for outpatient appointments which currently stands at 6.66% for January 2024.

Underlying issues:
- Need to audit DNAs to understand reasons for high DNA rate for IMD 1 and 2 patients.

Actions:
- Project to improve patient communication and letters – including new templates and considerations of accessible information standards and health literacy.
- Trial to commence calling patients who have DNA'd from IMD 1&2 to offer 'something different' e.g. a mutually agreed appointment, free parking, travel financial aid etc to improve attendance.

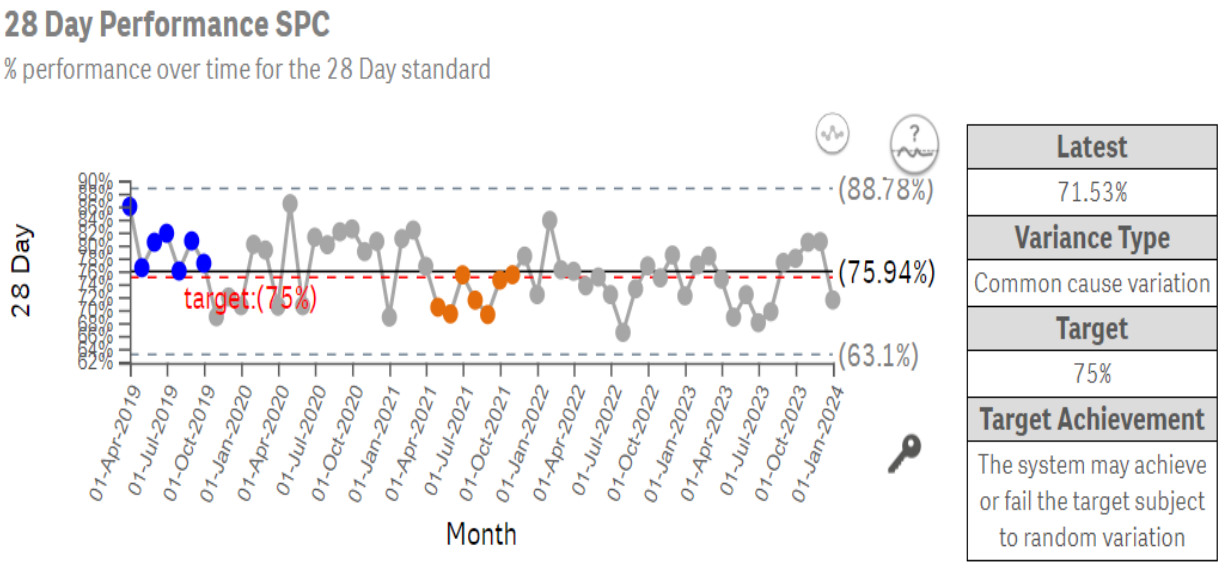
Proportion of patients meeting the faster diagnosis standard: Deprivation (IMD 1 and 2)

Calderdale and Huddersfield NHS Foundation Trust

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

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

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



Latest
71.53%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- Latest monthly performance stands at 71.55% which is below the NHSE target. Performance for this group of patients and the overall Trust performance.
- The Trust is unable to consistently meet the target of 75% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 63% and 89%.

Underlying issues:
- Nationally, pathways where performance against the 28-day FDS is challenged are; Lower GI, Upper GI and Urology and this is reflected locally. Head and Neck and Haematology are also not meeting the 28-day target.

Actions:
- Dermatology is still struggling with minor ops and biopsies
- Head and Neck, continue to have problems with OPA and diagnostics request for mutual aid from other Trusts.

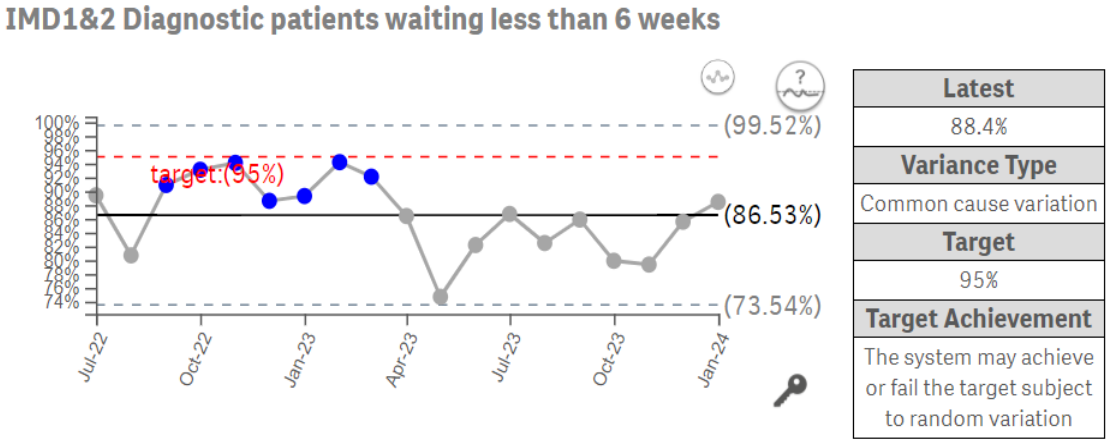
Percentage of patients waiting less than 6 weeks for a diagnostic test: Deprivation (IMD 1 and 2)

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Leads: Thomas Strickland/Stephen Shepley/Helen Rees
Business Intelligence Lead: Rebecca Spencer

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

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



Source: DM01 Submission Data - Last updated: 07/02/2024 11:29:07

What does the chart show/context:
- Latest monthly performance stands at 88.4% which is below the NHSE target. In-month performance is above CHFT overall performance which is 83.6%.
- The Trust is unable to consistently meet the target of 95% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 73.54% and 100%.

Underlying issues:
- 2 modalities (Echocardiography/Neurophysiology) still have significant numbers of pathways >6 weeks.
- Without those modalities, the remaining tests are achieving over 95%.

Actions:
- **Echocardiography and Neurophysiology**
  As per overall Trust action plans.

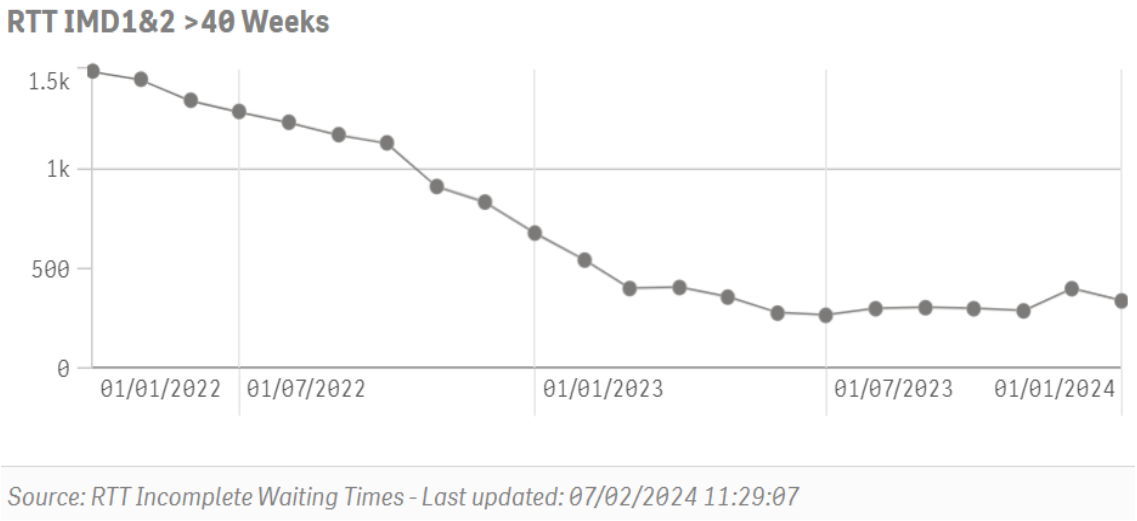
Total Patients waiting more than 40 weeks to start consultant-led treatment: Deprivation (IMD 1 and 2)

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Thomas Strickland Business Intelligence Lead: Rebecca Spencer

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

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



Source: RTT Incomplete Waiting Times - Last updated: 07/02/2024 11:29:07

What does the chart show/context:
- This chart shows the number of patients on the RTT Incomplete Pathways list who have been waiting more than 40 weeks to start treatment.
- The aim is to show progress towards 0 patients waiting more than 40 weeks by January 2024 (internal target).
- Our 40-week position has been reducing rapidly between April 2022 and April 2023 and has since started to level out.
- We have seen a decrease from last month to 340 patients over 40 weeks.

Underlying issues:
- A growing ASI list (especially in ENT) represents a risk to the continuing reduction in list size.
- Cancelled lists/appointments due to strike action may have resulted in a delay in reducing the 40-week position.

Actions:
- Operational teams to be tracking patients to at least 40 weeks.
- KP+ writeback model being used by all operational teams to ensure that tracking actions are transparent and cannot be overwritten by Validation teams.
- ENT Task and Finish Group concluded with actions in place and are working to 52 week compliance by the end of March.
- Actions have been identified in 3 cohort areas:
  - Demand management
  - Increasing internal capacity
  - Increasing external capacity
- Number of >40 week waits impacted by Industrial action is being tracked.

Workforce:

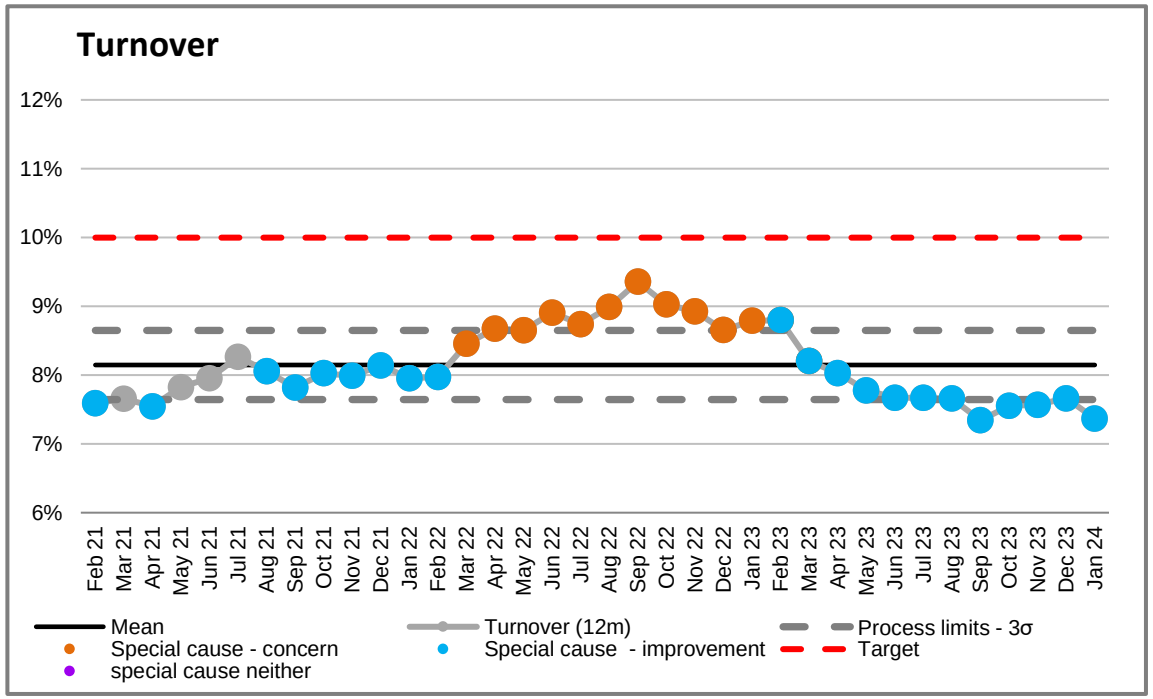
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	January 2024	7.37%	10.0%			8.15%	7.64%	8.65%
Sickness Absence (Non-Covid)	January 2024	5.20%	4.75%			4.84%	4.21%	5.48%
Appraisal Compliance (YTD)	January 2024	83.16%	95.0%	-	-	-	-	-
Core EST Compliance	January 2024	94.23%	90.0%			93.11%	92.03%	94.18%
Bank Spend	January 2024	£3.51M	-			£3.18M	£1.60M	£4.76M
Agency Spend	January 2024	£0.72M	£0.53M			£0.86M	£0.60M	£1.12M

Staff Movement (Turnover)

Executive Owner: Suzanne Dunkley Lead: Adam Matthews Business Intelligence Lead: Mark Bushby

Rationale:
It is healthy for an organisation to have a reasonable level of staff turnover, there is a balance between losing valuable, knowledgeable staff and bringing in new colleagues with fresh ideas and ways of working.

Ceiling: 10.00% **Current: 7.37%**



What does the chart show/context:
- Total FTE lost due to colleagues leaving all employment with the Trust against the average headcount of the reporting period.
- Turnover is consistently below the Trust ceiling of 10.00%.
- Current turnover rate is slightly below the mean average at 7.37%.
- The Trust benchmarks well against other WYAAT organisations.

Underlying issues:
- Directorates with turnover above the 10% ceiling include FSS Management (18.2%), Quality (14.3%), Pharmacy (14.2%) and Workforce and OD (13.4%).
- Note: Pharmacy turnover includes rotational trainee pharmacists. Excluding these, turnover is 9.15% which is under the 10% ceiling.

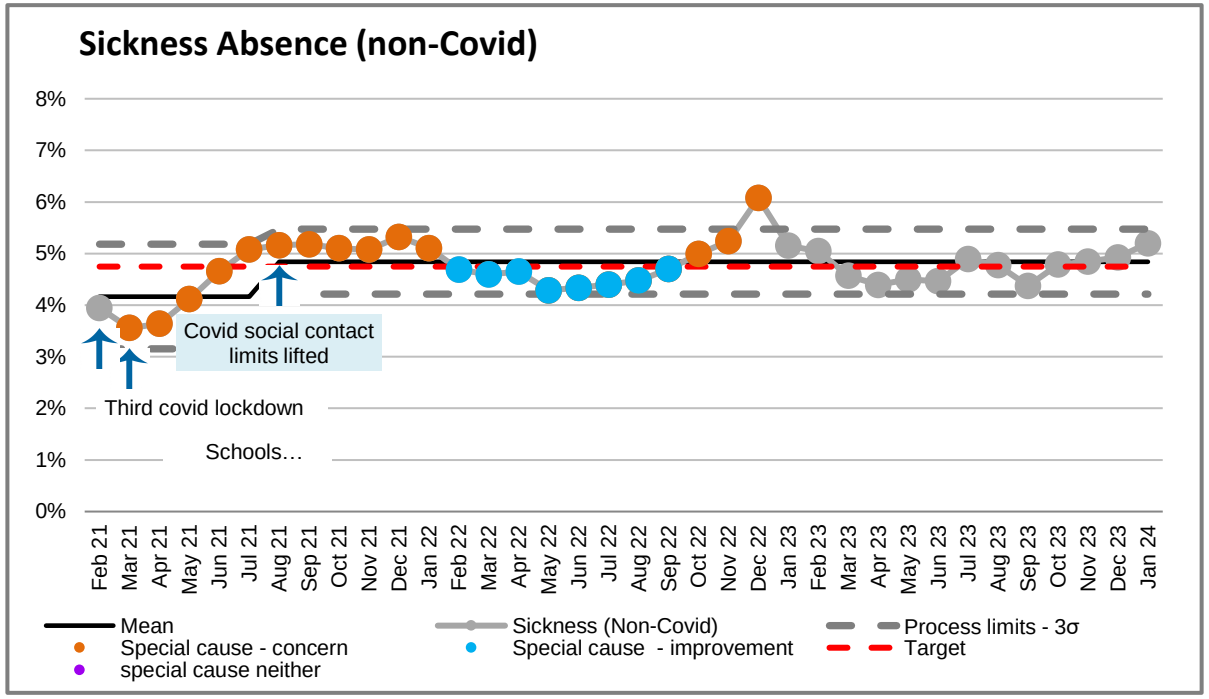
Actions:
- The Colleague Retention Programme paper was presented at Workforce Committee in December 2023.
- Trust level and local level activities underway to continue to improve the Trust retention, turnover and stability rates. These actions include:-
  - Task and finish group to review approach to exit interviews and questionnaires.
  - Review and improve 'stay conversation.
  - Review of workforce metrics to identify gaps in retention activity for certain groups
  - Review of recruitment process to embed inclusive recruitment.
  - Communication of revised national approach to retirement options.

Sickness Absence (Non-Covid)

Executive Owner: Suzanne Dunkley Lead: Azizen Khan Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor sickness absence levels to ensure any trends are investigated to inform future planning around availability.

Target: 4.75%	**Current:**	**Total**	**5.20% (in month)**	**4.73% (12m)**
		Long	**2.88% (in month)**	**3.04% (12m)**
		Short	**2.32% (in month)**	**1.70% (12m)**



What does the chart show/context:
- The target for absence is close to the mean and falls between the upper and lower process limits, as such compliance will be unpredictable on a month-by-month basis due to common cause variation.

Underlying issues:
- Top 3 reasons for sickness in January 2024 – Anxiety/Stress/Depression, Cold, Cough, Flu – Influenza and Chest and respiratory problems

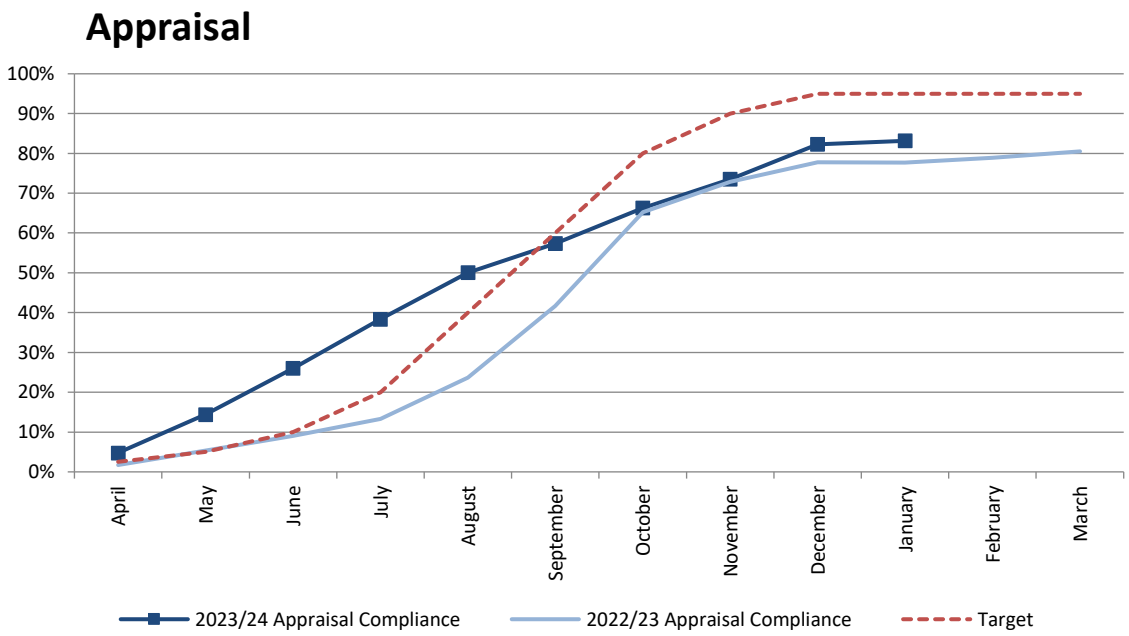
Actions:
- Monthly absence monitoring meetings are in place with Corporate WOD to facilitate identification of trends and themes.
- KLOE identified and wellbeing surveys undertaken to identify themes and actions will be generated from this data.
- Review of all open cases is undertaken on monthly basis including action planning for all long-term sickness cases at 6-month point.
- Early escalation and case conference discussion with Trust Psychologist to support with ASD.
- Focus on MSK absence, which is the second highest reason for absence, with process embedded for escalating self-referral process to OH physiotherapist.
- Divisions continue to undertake deep dives as required within any hotspot areas.
- Guidance around colleagues contracting covid will be re-shared within teams to ensure awareness of the action cards and control measures for colleagues whilst at work.
- Work is ongoing to refine toolkits around key areas for support to managers such as reasonable adjustments. Video and guidance is also available via Management Fundamentals offer on the intranet.
- Work to support the creation of ‘Passports’ which document health conditions and adjustments/working practices that support colleagues to remain well in the workplace.

Appraisal

Executive Owner: Suzanne Dunkley Lead: Liam Whitehead Business Intelligence Lead: Mark Bushby

Rationale:
A performance appraisal is a regular assessment of how an individual is performing in their job role. It can have many benefits in practice, being used to identify individual learning needs, identify continuing development needs of employees and demonstrate competency in practice.

Target: 95.0% (Annual), 95.0% (in month) **Current: 83.16% (in month)**



What does the chart show/context:
- Appraisal compliance has continued to be below the in-month planned position with 83.16% and has not achieved the 95% target set for the end of January 2024.
- Appraisal compliance is performing above the rate of the previous year at the same point in time.

Underlying issues:
- Time and availability of colleagues to undertake appraisal.
- Accurate and timely recording of appraisal conversations on ESR.
- Challenge to colleagues around appraisal being a “tick box” exercise.
- Seasonal variance especially during the summer and winter holidays.
- Regular strike action impacting priorities.

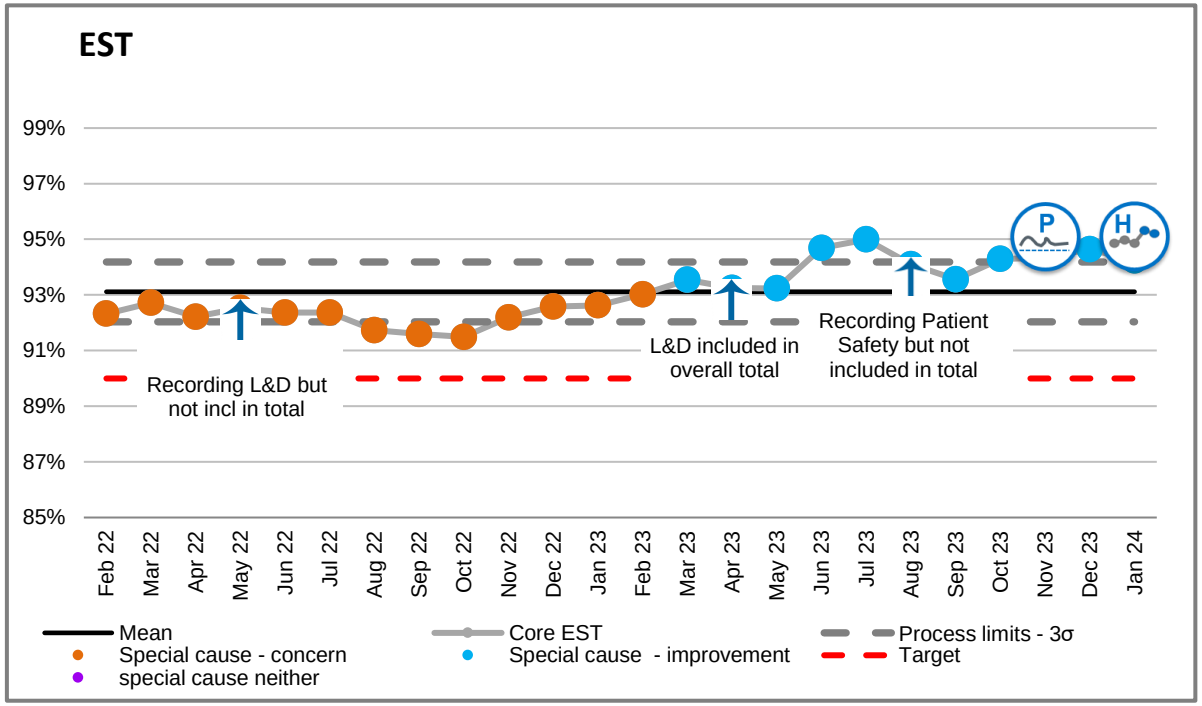
Actions:
- ‘How to’ guide to appraisals video now available as part of our management fundamentals offer, to make it a more people centred conversation.
- New to manager programme launch features appraisals in content.
- ESR recording guidance produced to support managers to ensure all activity is captured.
- Targeted approach to support hotspot areas including Connect & Learn sessions (managers’ and appraisees’ guides) to improve the quality of conversations.
- Connect & Learn sessions ongoing with session attended by 25 managers on 31st August, 58 attendees in October and 41 attendees in November 2023. Additional sessions planned in February 2024.
- Recent audit from NHS England completed showcasing best practice, impact data and general process.
- Hotspot areas targeted via OCOC charter support workshops that includes appraisal management.

Core EST Compliance

Executive Owner: Suzanne Dunkley Lead: Nicola Hosty Business Intelligence Lead: Mark Bushby

Rationale:
Training staff is important in health and social care to ensure the safety of people receiving and giving care and to maintain high standards of care quality. It ensures that colleagues in the Trust are following up-to-date procedures and reduces the risk of errors and prevents accidents. This means they and our patients can be safe in the workplace

Target: 90.0% **Current: 94.64%**



What does the chart show/context:
- The Trust is consistently achieving the 90% target; EST compliance is slightly below the 95% stretch target at 94.23%
- Compliance in January 2024 remains above the mean and above the process limits indicating further ongoing improvement since March 2023.
- From April 2023 Learning Disability Awareness is now included in the overall EST compliance rate

Underlying issues:
- Safeguarding Adults and Childrens compliance has dropped below 90%, this is likely due to a review of RST as safeguarding is tiered learning.

Actions:
- Compliance rates are shared with Directorates on a weekly basis.
- Enhanced Divisional accountability.
- Local campaigns to focus on mandatory learning in Divisions.
- Task and Finish group is being formed to review RST and progress will be fed back to the Education Committee.

Bank Spend

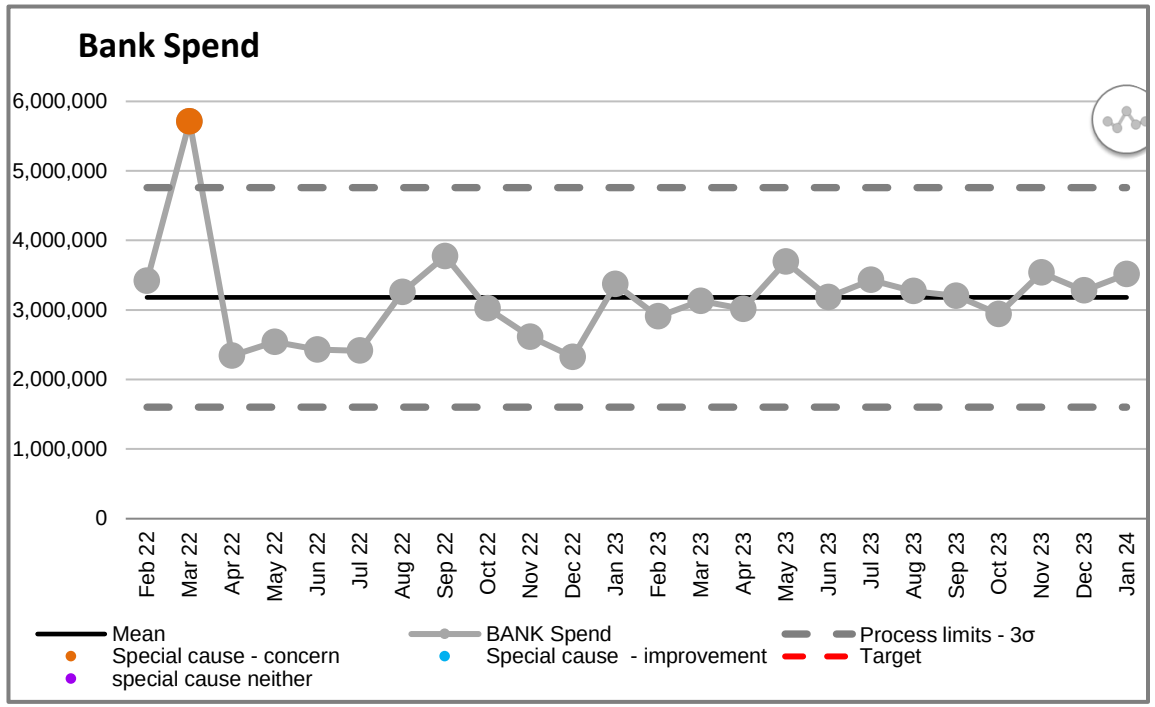
Executive Owner: Suzanne Dunkley

Lead: Samuel Hall

Business Intelligence Lead: Mark Bushby

Rationale:
It is important for the Trust to monitor Bank staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance.

Current: £3.51M



What does the chart show/context:

- The spike in March 2022 was due to an accrual of circa £2m for study leave.
- An increase in May 2023 is due to the 5% pay award for April 2023 and May 2023.
- Bank spend is currently £3.51m in January 2024, an increase from £3.28 in December.

Underlying issues:

- There is a dependency on bank to support the running of extra capacity areas that flex open and closed.
- CHFT have been in extra capacity areas throughout the month of January, resulting in an upward trend.

Actions:

- Plans in place to operationalise removing the 20% premium for Nursing and ODP colleagues, Associate Directors of Nursing managing this within divisions.
- 20% enhancement has largely been withdrawn in the month of January, full withdrawal expected in February 2024.
- Medical Bank and Agency spend reviewed and regular Bank users sent to Senior Management Teams to confirm plan to remove/recruit to positions.

Agency Spend

Executive Owner: Suzanne Dunkley Bushby

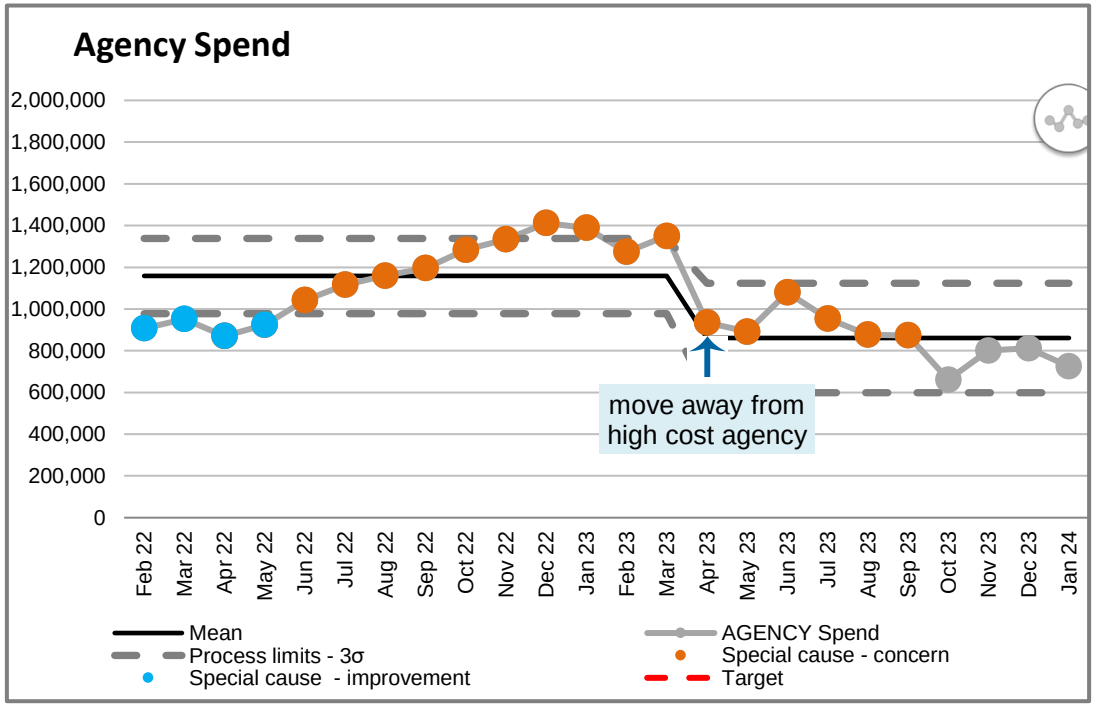
Lead: Samuel Hall

Business Intelligence Lead: Mark

Rationale:
It is important for the Trust to monitor Agency staff spend as it can help to minimise temporary staffing costs ensuring value for money and compliance and can encourage the recruitment and retention of staff.

Target: £0.53M

Current: £0.72M



What does the chart show/context:
- Spend has decreased from April 2023 due to the Trust moving away from high-cost agency.
- Agency spend is now following normal cause variation from October 2023.
- Spend in January 2024 at £0.72m.

Underlying issues:
- There is a reliance on agency usage in some areas as a result of vacancies and difficulties in recruiting.
- Agency cost has consistently lowered from March 2023 to present due to a structured agency retraction plan.
- Agency spend still remains high and a proportion of that spend can be attributed to Agency Consultants working in hard to fill areas, as well as remaining rota gaps in ED.

Actions:
- Long-term Medical Agency usage to be reviewed in January 2024 with MDO colleagues.
- Nursing Agency lead time reduced to 21 days in October 2023 to allow Bank colleagues more time to fill.
- Promote that CHFT colleagues are a priority for additional shifts and Flexible Workforce can cancel booked agency workers to give shifts to CHFT colleagues (screensaver, email to colleagues).

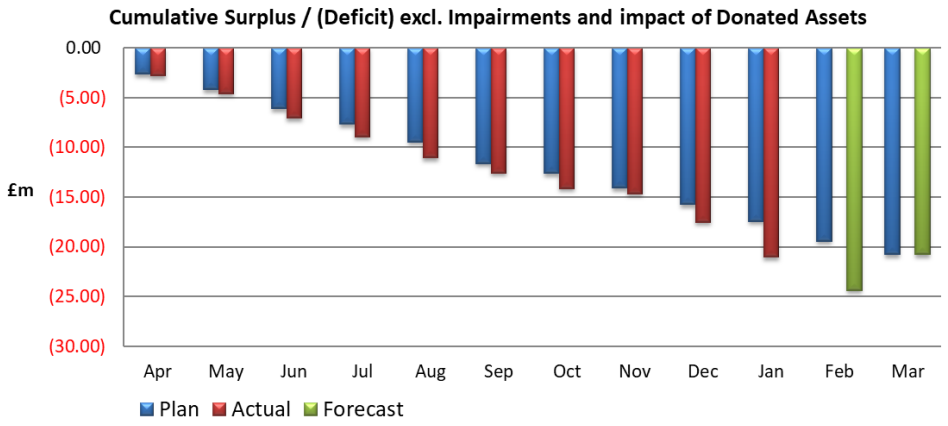
Finance:

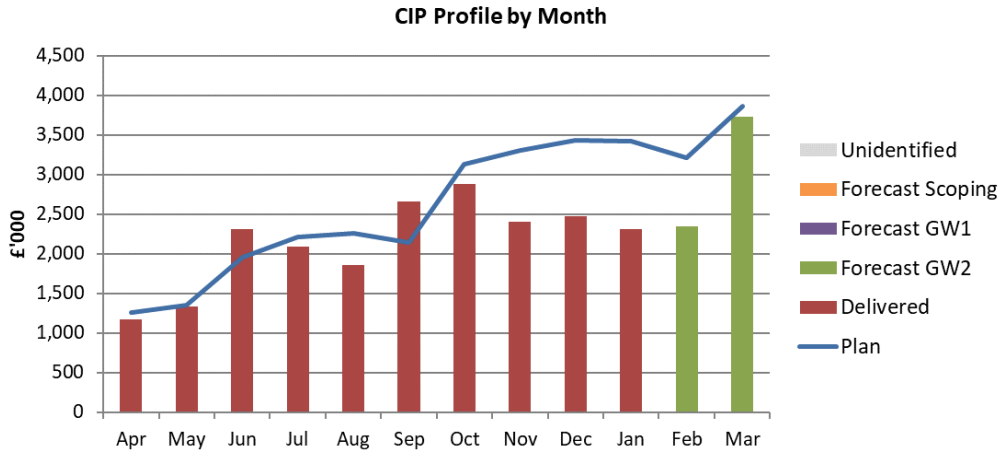
- Cumulative Surplus
- CIP Profile
- Capital Spend
- Cash Balance

Financial Performance

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Gary Boothby Finance Lead: Philippa Russell





Rationale:

- To monitor year to date and forecast performance against the 2023/24 financial plan and efficiency target

Target:

- The financial plan for 2023/24 is a £20.80m deficit and delivery of £31.50m of efficiency savings through the Cost Improvement Programme (CIP).

What do the charts show/context:

- The Trust is reporting a Year to Date (YTD) deficit of £21.05m, a £3.62m adverse variance from plan.
- The forecast is to deliver the £20.80m deficit as planned.
- The Trust delivered efficiency savings of £21.48m year to date, £2.96m lower than planned, and is forecasting a £3.95m shortfall in delivery of CIP.

Underlying issues:

- Key drivers of the adverse variance included: higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £3.80m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.93m; and non-pay inflationary pressures. It is assumed Strike costs will be fully funded through additional Integrated Care System (ICS) allocations, (£21.m received YTD). Other pressures were offset to some extent by additional Elective Recovery Funding (ERF), some CIP mitigation and higher than planned commercial income.
- The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £1.70m. Forecast pressures include £3.95m slippage on efficiencies, non-pay inflationary pressures, Strike costs and additional bed capacity. Some internal mitigations have been identified alongside the additional allocations to support Strike costs and a further £1.6m of ERF funding expected due to Recovery performance.

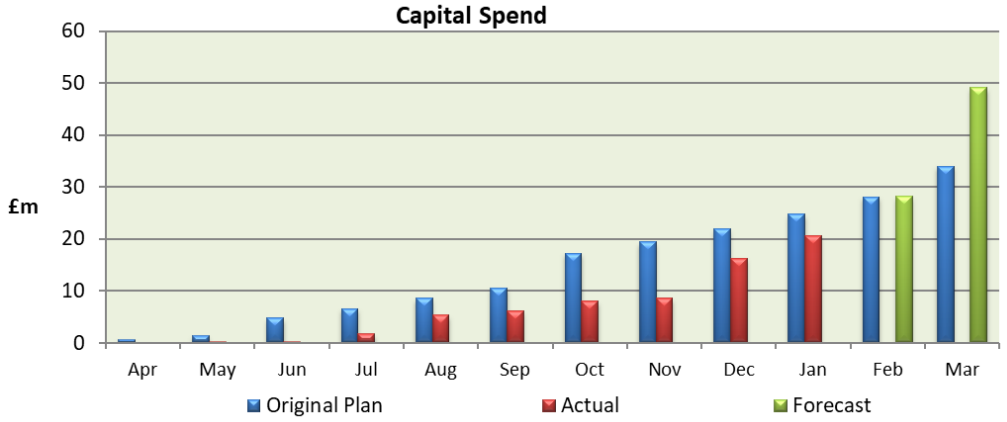
Actions:

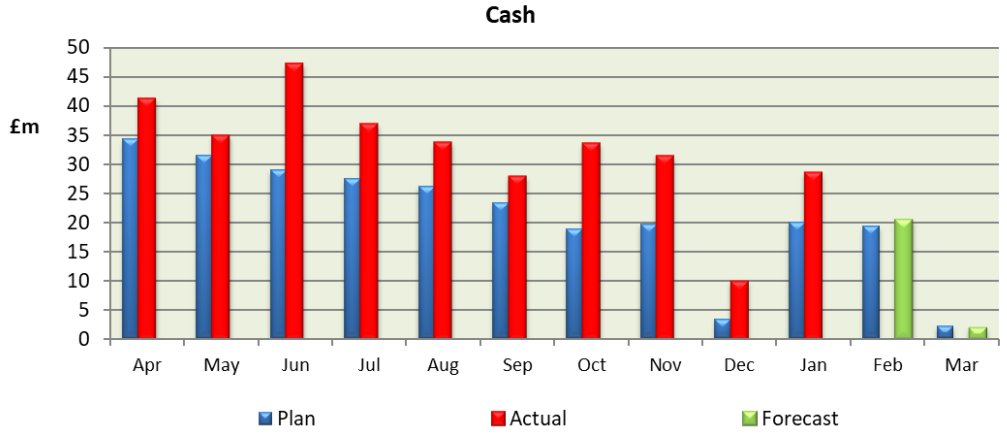
- Discussions with the ICS are ongoing regarding potential further funding allocations to close the remaining £1.70m gap to deliver on plan.

Financial Performance: Capital, Cash and Use of Resources

Executive Owner: Gary Boothby

Finance Lead: Philippa Russell





Use of Resources Metric:	Plan (YTD): 3	Actual (YTD): 3
	23/24 Plan: 3	Forecast: 3

Rationale:

- To monitor year to date and forecast Capital expenditure, Cash balance and Use of Resources metric against the 2023/24 financial plan.

Target:

- The Capital Plan for 2023/24 is to spend £34.01m including £11.89m of externally funded Capital. Cash balance is planned to reduce over the year due to the planned financial deficit and capital expenditure.
- The Trust will be required to borrow cash in the form of Revenue Public Dividend Capital (PDC).
- The Use of Resources metric is the financial element of the Single Oversight Framework, with one overall score derived from the average score across 5 separate metrics: Liquidity, Capital Servicing Capacity, Income & Expenditure (I&E) Margin, Variance from I&E plan and Agency expenditure. A score of 1 is the most favourable and 4 the least favourable. Planned UOR for 23/24 is level 3.

What do the charts show/context:

- The Trust has spent £20.64m on Capital programmes year to date, £4.09m lower than planned. Capital Forecast is to spend £49.12m, £15.12m more than planned: including additional Public Dividend Capital (PDC) funding awarded to support the Community Diagnostic Centre and Huddersfield Pharmacy Specials expansion; and an increased capital allocation for Reconfiguration.
- At the end of January, the Trust had a cash balance of £28.50m, £8.44m higher than planned. Use of Resources (UOR) stands at 3, as planned, with one metric away from plan (I&E Variance from Plan).

Underlying issues:

- The Capital underspend is due to delays in the Pharmacy Robot project, Reconfiguration, and CT Scanner. Leases are also underspent.
- The Trust has revised down its request for Revenue Support PDC to £8.3m, £1.2m less than planned due to an improved working capital position and delays in the capital programme.

Appendix A – Variation and Assurance Icons

Calderdale and Huddersfield NHS Foundation Trust

Variation Icons:

Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of a CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	**Investigate** to find out what is happening/ happened. Is it a one-off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

Assurance Icons:

Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix B (i) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Total Patients waiting >40, 52, 65 weeks to start treatment and Total RTT Waiting List	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list.
Total elective activity undertaken compared with 2023/24 activity plan	A key planning requirement for 2023/24 is to recover elective activity levels to above those seen in the pre-Covid period, to order to address the growing elective care waiting list.
Percentage of patients waiting less than 6 weeks for a diagnostic test	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%.
Diagnostic Activity undertaken compared with 2019/20 baseline	Maximise diagnostic activity focused on patients of highest clinical priority. Recovery of diagnostic testing is a key NHS objective and critical to wider elective recovery, including RTT performance.
Total Follow-Up activity undertaken compared with 2023/24 activity plan	To measure the relative reduction in follow-up outpatient attendances (consultant and non-consultant led) in 2023/24 compared to 2023/24 activity plan
Total Patients waiting >62 days to begin cancer treatment compared with February 2020 baseline	The NHS Constitution outlines what patients can expect and their rights when they are referred on a cancer diagnosis and treatment pathway. The number of patients seen following an urgent suspected cancer referral has remained at a record high since March 2021. Expectation to return the number of people waiting for longer than 62 days to the level in February 2020.
Proportion of patients meeting the faster diagnosis standard	Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. Expectation is that 75% or more of patients will a maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded.
Non-Site-Specific Cancer Referrals	The non-specific symptoms (NSS) pathway provides a route for patients presenting with vague symptoms who may have a serious illness. Measure is number of non-site specific referrals received in a month against target from operational plan for 2024/25
Day Case Rates	Day case surgery, where the patient is admitted, undergoes intervention and is discharged on the same day, is an important aspect of service provision in the NHS. Day case surgery brings recognised benefits for both patients and system-wide efficiencies related to patient quality and experience, reduced waiting times and release of valuable bed stock.

Appendix B (ii) – Metrics Rationale and Background

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 seen within 4 hours	Monitor waiting times in A&E. Longer waits associated with poorer patient outcomes. NHS Objective to improve A&E waiting times so that no less than 76% (80% local target) of patients are seen within 4 hours by March 2024 with further improvement in 2024/25.
Proportion of ambulance arrivals delayed over 30 minutes	Proportion of ambulances which experience a delay (by more than 30 minutes) in transferring the patient over to the care of ED staff. Patients arriving via an ambulance should be transferred over to the care of hospital staff within 15 minutes of arrival at an Emergency Department (ED). Handover delays can be detrimental to the health of the patient and can have a knock-on impact on the ambulance service (crews are unable to attend to other potentially life-threatening calls). Such delays at the front door of ED can also be a sign of potential overcrowding within the ED.
Proportion of patients spending more than 12 hours in an emergency department	To monitor long waits in A&E which could indicate overcrowding in ED and can cause poor patient experience. The number of patients that spend more than 12 hours between arrival and admissions, transfer or discharge, as a proportion of total attendances.
Neonatal deaths per 1,000 total live births	The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. The number of neonatal deaths is influenced by a number of factors, including the quality of care delivered to the mother and baby and appropriate surveillance for all women. The rate of deaths within 28 days of birth per 1,000 live births. A neonatal death is defined as a live born baby born at 24 weeks gestational age or later, or with a birthweight of 400g or more, who died before 28 completed days after birth.
Stillbirths per 1,000 total births	The focus of this indicator is to measure progress in reducing the rate of stillbirths against the trajectory towards the 2025 ambition. Measures the rate of stillbirths per 1,000 live births and stillbirths. A stillbirth is defined as a baby delivered at or after 24 weeks gestational age showing no signs of life, irrespective of when the death occurred.
% 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	Understand resilience amongst providers of community health services and identify specific issues (e.g. changes to activity, the extent of any backlogs). Provide valuable data on waiting times and waiting list information. Data used by national teams and systems to inform recovery plans and reduce waiting lists across community health services.
Virtual Ward	A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology. Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. This includes either preventing avoidable admissions into hospital, or supporting early discharge out of hospital.
Hospital Discharge Pathway Activity	Monitors discharges from hospital to ensure that patients are discharged safely to the most appropriate place and that they continue to receive the care and support they need after they leave hospital.
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	Understand the proportion of adult general and acute beds that are occupied. The proportion of adult general and acute beds occupied (adjusted for Covid void beds). Covid void beds are beds that are closed due to Covid, but which are unoccupied. These beds cannot accept new admissions unless the patient is Covid-positive.
% of beds occupied by patients who no longer meet the criteria to reside	Understand the numbers of beds which are not available for patients who do meet the criteria to reside and therefore points to resources which are unavailable due to discharge issues. There is significant interest in discharges and beds due to ongoing pressures which NHS providers face and even more so over the Winter period. This indicator shows the numbers of beds which are not available for patients who do meet the criteria to reside and therefore points to resources which are unavailable due to discharge issues.
Transfers of Care	Counting DTOCs helps whole systems to understand unmet need and identify bottlenecks and ensures that pathways through the system are patient-oriented rather than organisation or service-centred. Helps systems to improve services for patients by reducing situations where people are in hospital longer than they need to be, which can have a detrimental effect on their recovery, rehabilitation and long-term health and well-being.

Appendix B (iv) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Care Hours Per Patient Day (CHPPD)	CHPPD is the national benchmark measure for safer staffing and provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by totalling the number of hours worked by registered nurses, nursing associates, and in some cases allied health professionals, as well as healthcare support workers on each ward for the 24-hour period, then dividing by the number of patients on the ward each day at midnight. There is no 'correct' number of CHPPD to be achieved. However, variation between the actual and planned CHPPD, should warrant further investigation.
Inpatient Falls per 1000 Bed Days	Inpatient falls are the most frequently reported safety incident in hospital. Not all falls are preventable but 20–30% of falls can be prevented by assessing risks and intervening to reduce these risks.
CHFT Acquired Pressure Ulcer per 1000 Bed Days	Pressure ulcers (PUs) remain a concerning and often avoidable harm for the patients who develop them, and the healthcare professionals involved in their prevention and management. PU are in the 'top ten harms' in the NHS in England. Investigations into the causes of pressure ulcers frequently show that unwarranted variation from evidence-based practice contributes to the development of pressure ulcers.
Summary Hospital-level Mortality Indicator	This is to monitor the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here. It covers all deaths reported of patients who were admitted to Non-Specialist Acute Trusts in England and died either while in hospital or within 30 days of discharge.
MRSA Bacteraemia Infections	HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.
C.Difficile Infections	HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.
E.Coli Infections	HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality risk for those infected.
% of incidents where the level of harm is severe or catastrophic	To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.

Appendix B (v) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Serious Incidents	To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.
Never Events	To identify areas where CHFT can reduce risks and prevent harm, the reporting of all near misses and serious incidents is imperative to ensure we improve safety and learn from these events to prevent recurrence. Promoting a positive reporting culture is essential to CHFT's learning success for all our patients, families and staff.
Complaints	CHFT views any complaint as an extension of our service users' care and the Trust is committed to moving towards a user-centric service. Effective processes and procedures for handling concerns, feedback, stories, compliments, and complaints are pivotal to organisational learning success
Alternatives to Hospital Admissions - Frailty	To enable patients to receive the care and treatment they need in their own home, safely and conveniently rather than being in hospital.
Care of the Acutely Ill Patient	The identification and recording of deterioration, enabling swifter response, which will reduce the rate of preventable deaths. Reducing the need for higher levels of care will free up capacity particularly in ICU by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.
Nutrition and Hydration	95% of adult patients to receive a MUST assessment within 24 hours of admission/transfer to the ward. Compliance with completion of MUST will ensure we have the majority of our patients at risk identified early and referred to the dietitian team.
Emergency Care Standard - Learning Disability	To monitor waiting times in A&E for patients with a learning disability to ensure equity across all patient groups
Outpatients DNA's - Learning Disability	To monitor DNA rates at first and follow-up appointments for patients with a learning disability to ensure equity across all patient groups
Cancer Faster Diagnosis Standard - Learning Disability	Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. Expectation is that 75% or more of patients will a maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded.
Percentage of patients waiting less than 6 weeks for a diagnostic test - Learning Disability	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%. Maximise diagnostic activity focused on patients of highest clinical priority.

Appendix B (vi) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Patients waiting more than 40 weeks to start treatment - Learning Disability	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list for learning disability patients.
Emergency Care Standard - Deprivation	To monitor waiting times in A&E for patients from the most deprived areas (IMD 1 and 2) to ensure equity across all patient groups
Outpatients DNA's - Deprivation	To monitor DNA rates at first and follow-up appointments for patients from most the most deprived areas (IMD 1 and 2) to ensure equity across all patient groups
Cancer Faster Diagnosis Standard - Deprivation	Faster Diagnosis will facilitate an improvement in the Cancer early detection rate and thereby increase the chances of patients surviving. Expectation is that 75% or more of patients will a maximum four weeks (28 days) from receipt of urgent GP (GMP, GDP or Optometrist) referral for suspected cancer, breast symptomatic referral or urgent screening referral, to point at which patient is told they have cancer, or cancer is definitely excluded.
Percentage of patients waiting less than 6 weeks for a diagnostic test - Deprivation	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%. Maximise diagnostic activity focused on patients of highest clinical priority.
Patients waiting more than 40 weeks to start treatment - Deprivation	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. To measure and encourage compliance with recovery milestones for the RTT waiting list for patients from the most deprived areas (IMD 1 and 2)

18. High Level Risk Report

To Note

Presented by Victoria Pickles

Date of Meeting:	Thursday 7th March 2024
Meeting:	Board of Directors
Title:	High Level Risk Report
Author:	Saj Rahman, Risk Manager
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group; Audit and Risk Committee
Purpose of the Report	The purpose of this report is to provide an overview of the risks scoring fifteen or more.
Key Points to Note	**Introduction** High level risks have the potential to impact on the entire organisation. Risks are identified and added to the risk register by colleagues across the organisation. Each division has a governance group in place that looks at all risks scoring 12 or above plus any new risks. Those scoring more than 15 are reviewed at the Trust-wide Risk Group and if accepted are included on the High-Level Risk Register (HLRR). Where a risk presents a risk to the delivery of the Trust Strategy, either individually or as a collective, this is included on the Board Assurance Framework. **Current risk process** The Trust continues to manage and document risks using a bespoke risk register. When a risk is identified, the risk and impact on patient care is documented and then reviewed by the relevant department and division. All the appropriate information, including all mitigating actions to ensure the safety of patients and staff is maintained, is included. The Trust uses the information to not only track potential risks, but it also helps to inform local planning, management decisions and priorities and most importantly, share learning Trust wide. The current risk register system continues to be problematic in terms of being able to triangulate data, identify themes, and track risks and ensure risk owners are aware when updates are required. The Trust will be transitioning to a new risk, incident, and performance system this year. The new system, provided by InPhase, will replace the current Datix system/Be Spoke Risk Register, and will provide a more comprehensive reporting structure to Board and its committees in line with the new Patient Safety Incident Reporting Framework. A project plan is currently underway to support the transition. The risk team continue to work with divisions to comprehensively review their risks and ensure that there is a clear programme of review, management, and mitigation in place.

Current risk profile

Currently there are 30 high scoring risks on the Trust risk register (see details at the end of the report):

- 6 are scored as very high.
- 24 are scored as high.
- All risks have been recently reviewed and the mitigations (progress) updated.
- Of the 30 risks, two have had their risk scores increased.
- Since the last report in January 2024, and there has been a total of 5 risks that have had their risk score reduced. All 5 reduced risk are now scored at 12 and are no longer included in the high-level risk report because of this.
- Since the last report there has been a total of 2 risks that have either been closed or merged with other risks.

Each risk is aligned to one of the Trust's strategic objectives. The current risks scoring very high (20-25) demonstrate the following themes:

- Keeping the base safe:
  - Several risks relating to staffing and vacancies in medical, nursing, and therapy posts across a range of services including the emergency department, maternity, ophthalmology, paediatrics, cancer services, and radiology. Whilst we have seen a positive movement in the vacancy position relating to the general nursing and AHP posts we continue to manage risks in relation to more specialist roles as well as maternity services. We continue to monitor the impact of these through the incident reporting system.
  - There is Risk in relation to meeting targets and waiting times including the emergency care standard, angiogram waiting times, and national radiology targets.
  - 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:

- 14 risks related to staffing, either in relation to fragile services or recruitment challenges in certain staff groups.
- 8 risks are in relation to demand and capacity, particularly in outpatient specialties and some diagnostic services.
- 5 risks reference potential failure of equipment due to it coming towards the end of its period under guarantee – some of these will be addressed by the recent decisions relating to capital expenditure and therefore should be reduced by the time of the next report.

Future actions

The scope has been agreed for an internal audit of risk management, looking at the process from ward to board of risk identification,

	management, mitigation, scoring and reporting. The results of this audit will be presented to Audit and Risk Committee in April 2024. The transition to the new incident reporting system this year will support a risk register that can be triangulated across several key indicators which includes safeguarding, FTSU concerns, incidents and complaints. This will facilitate early identification of emerging themes and trends as well as a better understanding of the impact of any existing risks. A project plan is being developed supported by the risk management and system implementation team. The Datix system will run concurrently alongside this for 12 months to support a safe transition. Divisional processes have been strengthened relating to the management of high-level risks and we are seeing the risk register used in a much more active way. Divisional risk and challenge meetings continue to develop and are moving towards management of all risks on the risk register.
EQIA – Equality Impact Assessment	Risks are assessed considering any impact on equality.
Attachments:	**Appendix 1**- All risks scoring 15 or more. **Appendix 2** - High Level Risk that have reduced in score since last report. **Appendix 3** - Risks that scored 15+ during last report but have now closed/merged. **Appendix 4** - Risks that have increased in scores (High Level).
Recommendation	The Board is asked to **CONSIDER** and discuss risks scoring 15 or more report and **NOTE** the ongoing work to strengthen the management of risks.

Appendix 1 – All Risk scoring 15 or more.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Current Risk Score
Very High	8528	Medical	Emergency Care	Accident and emergency HRI/CRH	Transformation and improving patient care	There is a risk of a reduction in patient experience and quality outcomes due to the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on ED flow. Resulting in poor patient experience, reduction in quality measures and increased length of stays in the ED departments.	20 4 x 5
Very High	8669	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Keeping the base safe	There is a risk of delayed diagnosis, treatment for cancer patients' due consultant who specialise in cancer on long term sickness absence and the fixed term contract of 1 another consultant having expired.	20 4 x 5
Very High	7078	Corporate	Medical Director's Office	Operational	Keeping the base safe	There is a risk of reduced level of service in the Radiology team due to staff vacancies.	20 4 x 5
Very High	8324	Corporate	Planned Access and Data Quality	RTT Validation	Keeping the base safe	There is a risk of high volume of outstanding clinical outpatient validation and prioritisation on Mpage system.	20 4 x 5
Very High	8508	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of not being able to provide a Consultant Glaucoma Service due to no Consultant in post at CHFT.	20 4 x 5
Very High	8509	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of insufficient glaucoma appointments available to cope with demand due to vacancy levels.	20 4 x 5
High	8562	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of Enforced removal of Siemens Track within the Biochemistry Department.	16 4 x 4
High	8161	Family & Specialist Services	Radiology	CT	Keeping the base safe	There is a risk of being unable to provide a CT scanning service in the event of a fatal breakdown of the CT scanner at Calderdale Royal Hospital due to the age of the equipment.	16 4 x 4

High	8098	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of clinic cancelation, delays and reduced capacity in all areas of ophthalmology due to macular injection staff shortages.	16 4 x 4
High	8609	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Keeping the base safe	There is a risk of prolonged waiting times for patients within ENT due to multifactorial elements including an increase in referrals over the last 6 months, and inability to return to pre-covid levels of activity.	16 4 x 4
High	8219	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of loss of Cross-Site Biochemistry Service (24/7) due to the reduction in qualified BMS, inability to recruit and reduced ability to retain qualified staff. (Single qualified BMS staff covers both CRH and HRI out of core hours)	16 4 x 4
High	8009	Medical	Integrated Medical Specialties	All Departments	Keeping the base safe	There is a risk of outpatient capacity not being sufficient to ensure timely appointments for both new and follow up patients across integrated medical specialities.	16 4 x 4
High	7955	Family & Specialist Services	Radiology	Main X-Ray	Keeping the base safe	There is a risk of being unable to deliver plain film services from three plain film rooms at Calderdale Royal Hospital (CRH) due to the rooms becoming obsolete.	16 4 x 4
High	6079	Family & Specialist Services	Appointment and Records	Appointments Service	Transforming and improving patient care	There is a risk of being unable to provide sufficient appointments for patients requiring Outpatients follow-up due to capacity and demand	16 4 x 4
High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Keeping the base safe	There is a risk of care being compromised in the children services due to insufficient Nurses, Midwives, and Healthcare support workers available to deliver safe and compassionate care.	16 4 x 4
High	8121	Family & Specialist Services	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	8650	Family & Specialist Services	Outpatients	Outpatients	Keeping the base safe	There is a risk of no surgical OPD clinic capacity within the OPD estate due to loss of clinic rooms to meet demand due to the closure of area one (surgical OPD) at Calderdale Royal Outpatients for building Cath Lab as part of cardiology transformation plans.	16 4 x 4
High	8606	Medical	All Departments Medical	All Departments	Financial sustainability	There is a risk of not being able to reduce the acute inpatient bed base due to rising patient acuity, non-elective demand and challenges in community bed and social care provision resulting in additional cost	16 4 x 4
High	7413	Corporate	Finance and Procurement	Corporate Finance	Keeping the base safe	There is a risk of fire spread at Huddersfield Royal Infirmary due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients, and visitors.	15 5 x 3
High	8147	Family & Specialist Services	Keeping the Base safe	Radiology Interventional	Radiology	There is a risk of being unable to use the pressure injectors within both intervention labs (@ CRH/HRI) due to the age of the equipment.	15 3 x 5
High	7994	Corporate	Corporate Nursing	Enhanced Care Team	Transforming and improving patient care	There is a risk of not being able to deliver individualised patient centred care for our most vulnerable patients due to the current number of vacancies within the team and inability to fill staff bank requests to provide this service.	15 3 x 5

High	8361	Surgery & Anaesthetics	Critical Care	Pain Clinic	Keeping the base safe	There is a risk of disruption to services in the pain clinic due to impending retirement of Band 6 CNS in January 2024, and potential retirement of Band 7 (CNS) in the new future resulting in only one experienced Band 6 Clinical Nurse to review patients on the wards and nurse clinics would have to stop.	15 3 x 5
High	8398	Surgery & Anaesthetics	General and Specialist Surgical Services	Colorectal	Keeping the base safe	There is currently a risk of high volumes of patients awaiting a follow up appointment within Colorectal surgery due to increased referrals post covid and historical patients waiting for their appointments.	15 3 x 5
High	8315	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of increasing waiting lists and delays to new and follow up appointments in the ophthalmology paediatric service due to not having enough substantive Paediatric Consultants.	15 5 x 3
High	8627	Family & Specialist Services	Appointment and Records	Health Records	Keeping the base safe	There is a risk not being able to deliver effective patient care/experience and having to shut Outpatient Reception desks. Due to high volumes of vacancies, in Outpatient Reception areas.	15 5 x 3
High	8637	Surgery & Anaesthetics	Head and Neck	Audiology	Keeping the base safe	There is a risk of non-compliance with national standards for Audiological testing due to the use of unilateral Visual Reinforcement Audiology System (VRS) instead of the recommended bilateral system resulting in potentially compromising the quality of testing for paediatric (children aged 2.5 and below) patients and breach of any external audits.	15 5 x 3
High	8700	Family & Specialist Services	Childrens services	PAOU	Keeping the base safe	There is a risk of significant staffing shortfalls on the Paediatric Assessment Unit (PAU) due to no agreed workforce model for PAU and the current workforce model encompassing both ward 3 and ward 4 where staff are required to work across both areas.	15 3 x 5
High	8641	Surgery & Anaesthetics	Critical Care	Critical Care Outreach	Keeping the base safe	There is a risk of non-compliance with national standards (GPICS) due to inadequate pharmacy staffing in CHFT's critical care units resulting in staff burnout, increase in medication errors, risk to patient safety and exposure to legal consequences or regulatory penalties.	15 3 x 5

Appendix 2 – High Level Risks that have reduced in score since last report

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Current Risk Score	Reason for reduction
Moderate	7874	FSS	Women's Services	Gynae OPD HRI/CRH	Keeping the base safe	Due to several factors waits for colposcopy low grade appointments is currently running at 27 weeks this could result in a delay in ongoing treatment, poor patient experience and a delayed Diagnosis for local women.	Risk scoring 12. (Previously scoring at 15)	Risk merged with risk 7762
Moderate	8504	FSS	Women's Services	Yorkshire fertility clinic	Financial sustainability	There is a risk of delayed fertility treatment due to a current 18 week wait for Fertility patients to have a semen analysis. This has impacted in the business aspect off the service which in turn has a direct impact on patient fertility journey, poor patient experience.	Risk scoring 12. (Previously scoring at 15)	Pathology, offered to take back booking of YF patients to free up Phone lines - awaiting response. Option given for patients to go privately for andrology appointments.
Moderate	8344	FSS	Woman's Services	Maternity	Keeping the base safe	There is a risk of human error in transcribing information, due to the lack of maternity reporting software resulting in misinterpretation of doppler waveforms. This may lead to an error in identifying women at risk of severe growth restriction or incorrect management of growth restricted fetuses - both of which may result in stillbirths	Risk scoring 12. (Previously scoring at 15)	Funding-approved at dragons' den - in process of placing an order to reduce score to 12
Moderate	7970	Trustwide	Outpatients Therapy	Childrens therapy	Keeping the base safe	There is a risk that delays in availability of videofluroscopies for Children could result in harm from aspiration.	Risk scoring 12. Previously scoring at 16)	New Lead started in post and Leeds have 2 slots available. Decrease risk score from 16 to 12
Moderate	8057	Corporate	Financial and Procurement	Trust wide Finance	Financial sustainability	Risk of not achieving the Full Year 2023/24 Financial Plan:	Risk scoring 12. (Previously scoring at 20)	Improved Financial Position.

Appendix 3 – Risks that scored 15+ during last report but have now closed/merged.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Reason for closure
High 16 4 x 4	6078	Trustwide	All Directorate	All Division	Keeping the base safe	There is a risk of being unable to provide sufficient appointment slots to manage demand. Due to an increase in referrals to services/reduced available capacity to manage demand.	Risk in relation to covid-risk closed as no longer relevant.
High 16 4 x 4	7678	Trustwide	All Directorate	All Division	Keeping the base safe	There is a risk of reduction in safe Medical staffing levels below the minimum required to maintain safety due to the impact of Covid 19 resulting in unsafe levels of patient care	Covid Risk no longer relevant

Appendix 4 – Risks that have increased in score (High Level):

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Risk Score
High	8121	Family & Specialist Services	Women's Services	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. This has resulted in increased numbers of patients waiting for appointments and increased waiting times resulting in in poor patient experience, potential of delays in diagnosis and a potential longer RTT pathways	16 4 x 4. (Risk increased from risk score of 12).
Very High	8528	Medical	Emergency Care	Accident & Emergency CRH/HRI	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 ED flow	20 4 x 5. (Risk increased from risk score of 15).

Keeping the Base Safe

19. Audit and Risk Committee Chair's Highlight Report

To Note

Presented by Nigel Broadbent

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Council of Governors

Committee Name:	Audit and Risk Committee (ARC)
Committee Chair:	Nigel Broadbent, Non-Executive Director
Date of meeting:	31 January 2024
Date of Board meeting this report is to be presented:	7 March 2024
ACKNOWLEDGE	• The Committee noted that 6 audit reports had been completed since the previous ARC meeting and all were significant or high assurance. • All 14 recommendations from the internal audit report on CHFT's Quality Structure have been completed and resulted in a high assurance opinion on the follow up audit. • Benchmarking information provided by Audit Yorkshire across their clients reflected positively on CHFT in terms of the proportion of recommendations completed.
ASSURE	• The Committee received a presentation on the implementation of the recommendations arising from the audit of the processes around Naso Gastric tubes and received assurances that most of these had been completed. An external review is planned and a follow up audit will be undertaken to provide additional assurance that the revised processes have been embedded. • The Committee reviewed the position more generally on audit report recommendations over the past 12 months. 85% of the recommendations have been completed, with 3 recommendations overdue, 6 recommendations overdue with revised target dates and 13 recommendations not yet due based on their original target dates. Colleagues were reminded of the need to ensure that there are no overdue recommendations at year end, if possible, and to be realistic about the deadlines set for completing recommendations, particularly those before 31 March. • The Committee received a presentation on a deep dive into the BAF risk in relation to the impact of the new partnership arrangements on decision making and capacity. ARC was assured that the experience over the first 12-18 months of the new ICS arrangements was sufficient to reduce the risk to a

	score of 8 but recommended that the risk should remain on the BAF until the system financial position for 2024/25 and the ICB response to the need to identify 30% efficiencies, became clearer. • The latest update of the Board Assurance Framework was considered by ARC prior to it being presented to the Trust board. ARC agreed the contents of the BAF and a reduction in the risk scores for partnership arrangements and nurse staffing, and a new risk in relation to midwifery staffing. The top three risks continue to be hospital reconfiguration, demand and capacity and financial sustainability. It had been agreed at Finance & Performance Committee that the risk score around financial sustainability would be reviewed further into the financial planning process for 2024/25. The BAF was also reviewed and triangulated against a benchmarking report of the key BAF risks in other trusts. It was agreed that the risks around business continuity would be considered in light of the EPRR report to ARC in April and the Audit Yorkshire thematic review. • The Committee agreed to undertake its annual self-assessment survey on effectiveness having reviewed how this is carried out in other trusts. • The Local Counter Fraud Specialist provided an update on progress against the annual counter fraud plan and highlighted the CHFT events which he had been invited to speak at. It was agreed that further consideration would be given to how awareness of fraud would be raised within Community services. • KPMG, the Trust's external auditors, presented their draft audit plan for the 2023/24 financial statements highlighting the main change which relates to the audit requirements around the introduction of IFRS16 on accounting for PFI contracts. Although the audit fees for 2023/24 will be increased in line with inflation, fees for the subsequent year (subject to contract extension) will need to be discussed at the April ARC meeting. In the meantime, discussions are taking place about how the Trust could help make the audit process more efficient and reduce the amount of time required from KPMG. A significant increase in the

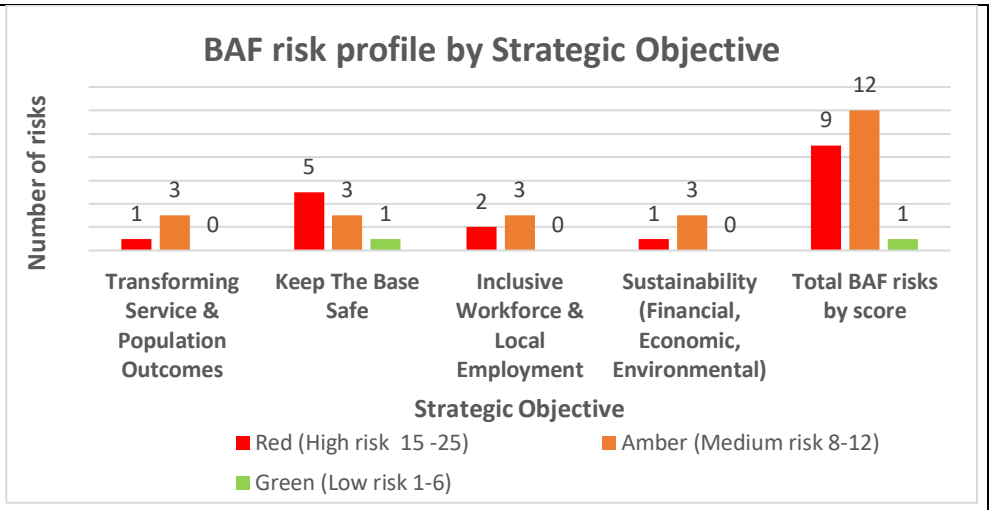
	audit fee for the Trust Charity had been proposed but the Charity Committee will be asked to consider alternative proposals.
AWARE	• A deep dive into the work on Information Governance and priorities over the next 12 months was undertaken. This identified that in addition to improvements to the processes for DSPT compliancy, data security awareness and embedding the use of Corestream, further awareness will be targeted at reducing incidents of inappropriate access to information. • The Committee noted the annual accounts timetable and the need for an additional meeting to sign off the accounts at the end of June. • The Committee considered the terms of reference of the Resilience and Safety Group and requested additions to the functions and scope of the Group. • The Committee discussed the scheduled deep dives in the work plan but also the potential to add further deep dives as risks emerged. It was agreed that ARC would undertake a deep dive (to be scheduled) into the risks around procurement e.g. around supply side vulnerability for key equipment/materials, changes in the legislative framework, the significant investment in reconfiguration and increasing collaborative procurement.
ONE CULTURE OF CARE	• Positive feedback from the meeting on the presentation of the Board Assurance Framework and the informative discussion around partnership arrangements.

20. Board Assurance Framework – Update 3

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 7 March 2024
Meeting:	Board of Directors
Title:	Board Assurance Framework Update 3 2023/24
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Audit and Risk Committee 31 January 2024
Purpose of the Report	This paper presents to the Board the third and final update of the Board Assurance Framework (BAF) for 2023/24 following review by the Audit and Risk Committee and recommendation to the Board. This final update of the BAF for the financial year to the Board will be reviewed by internal auditors to provide assurance that the Board of Directors understands the level and type of risk being taken with the Trust, understands the principal risks to the achievement of the Trust's strategic objectives and the BAF provides robust assurances over the controls in place or the action being taken to mitigate risks to an acceptable level within the Board's risk appetite. The internal audit review of the BAF will inform the Head of Internal Audit Opinion for 2023/24.
Key Points to Note	**Risk Profile by Strategic Objective** The Trust risk profile for risks to its strategic objectives as at 22 February 2024 is given overleaf, with a total of 22 risks which are scored: • 12 amber risks (54%) • 9 red risks (41%) • 1 green risk (5%) The Keeping the Base Safe goal has the greatest number of risks (9 of 22) and the highest number of red risk scores, at five of the 22 risks on the Board Assurance Framework (BAF). The Board and / or Board Committees have oversight for BAF risks within their remit. A list of which Committees have oversight for which risks has been added to the BAF.



Benchmarking of BAF Risks

The Trust has reviewed the risks on the BAF against a PWC report *"Managing Risk in the NHS - Risk Profile of NHS Organisations"* (July 2023), which reviewed the BAFs of 43 NHS organisations. An analysis of the Trust BAF risks compared to the ten common risks in the PWC report was presented to the Audit and Risk Committee. The Committee was assured that the Trust BAF had identified risks in all ten categories.

One of the less common risk areas in the PWC report was on business continuity. The Committee will receive the annual report on Emergency Planning and Preparedness at its meeting in April and, following that, will discuss whether there is a need to identify an overarching business continuity risk and if so whether this is an operational or strategic risk; currently the risk register has a number of business continuity risks related to specific services such as equipment and staffing.

Update 3

All BAF risks have been reviewed and updated by the lead Director and / or teams with updates shown in red font for ease of reference in the enclosed worksheets within the BAF. There have been some minor updates relating to actions / timeframes for gaps in controls and assurances since the Audit and Risk Committee on 31 January 2024 to risks 1/23 performance targets, 11/19 recruitment, retention and inclusive leadership, 6/19 quality and safety and 4/20 CC rating.

The Board has oversight of risk 3/23 Partnership arrangements. A deep dive of this risk was undertaken at the Audit and Risk Committee on 31 January 2024. The Deputy Chief Executive / Director of Transformation and Partnerships presented to the meeting a proposal that the risk score be reduced from 16 to 8 for the following reasons:

- the risk to delays in decision making due to partnership arrangements had not materialised
- the Trust has been actively involved in the new partnership working architecture required from the Health and Care Act 2022

- positive progress had been made across Calderdale and Kirklees in improving population health.

Whilst the target risk score of 8 had been met it was felt prudent to retain this risk on the BAF due to the fluidity of the operating environment.

Top Risks

The BAF shows three top risks for the Board spread across three of the Trust goals which are consistent with those reported to the Board in November 2023:

- Transforming Services and Population Outcomes - approval relating to hospital services reconfiguration, risk ref: 01/19, risk score of 20
- Keeping the Base Safe – demand and capacity (beds), risk ref: 1/23, risk score of 20
- Sustainability - risk 18/19 relates to the long term financial sustainability of the Trust and has a risk score of 16.

New Risks

There is one new risk proposed for addition to the BAF which relates to midwifery staffing, risk 6/23. This risk had previously been incorporated into the nurse staffing BAF risk, risk 10b/19 which was scored at 16. On reviewing the risk the Director of Nursing and colleagues felt that the risk score for the nursing element of the risk had reduced (see below) but the midwifery element remained at a risk score of 16. The new proposed midwifery staffing risk is scored at 16.

Risk Movement:

There has been movement in risk scores for two risks:

- 3/23 Partnership arrangements – risk score reduced from 16 (4x4) to 8 (4x2). As noted above the rationale for the reduction in the likelihood score from 4 to 2 for this risk is that the new legislative changes regarding system working and the provider licence have now been in place for 12 months and have not negatively impacted the Trust's capacity and delayed decision making.
- 10b/19 Nurse Staffing Risk – risk score reduced from 16 (4x4) to 12 (4x3). The rationale for the reduction in the likelihood score for this risk is due to progress with recruitment into vacant nursing posts and nursing staff (including international staff) having passed their preceptorship and now being included in the staffing numbers. The Safer Staffing report presented to the Board on 11 January 2024 noted a significant reduction against the band 5 nursing workforce vacancies which is our largest safety-critical resource.

Risk Exposure

Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate) this has been identified as a breach of the risk appetite.

In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of information and assurance on the management of risks with risk exposure.

As at 22 February 2024 there are six areas of risk exposure summarised below based on the risk appetite:

Strategic Goal: Transforming and Improving Care	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
7/20 Health Inequalities	12 =	Harm and safety	Low
Strategic Goal: Keeping the Base Safe	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
1/23 Demand and capacity (beds)	20 =	Harm and safety	Low
4/23 Performance targets	16 =	Regulation	Moderate
5/23 Cyber Security	15 =	Regulation	Moderate
Strategic Goal: Workforce	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
1/22 Workforce absence and retention	12 =	Workforce	Low
Strategic Goal: Sustainability	**Risk Score**	**Risk Appetite category**	**Risk Appetite**
18/19 Financial sustainability	16 =	Financial/Assets	Moderate

EQIA – Equality Impact Assessment	The BAF has a specific risk, risk 07/20, which relates to the Trust not reducing health inequalities for our most vulnerable patients. The Trust Board receives a report four times a year on progress with health inequalities actions at Board meetings. In terms of other risks, should any of the Board Assurance Framework risks materialise and impact people from different protected characteristics

	the risk owner is accountable for assessing these and determining any proposed actions to mitigate any equality impact arising from the risk.
Recommendation	The Board is asked to: i. **APPROVE** the updates to the Board Assurance Framework. ii. **NOTE** the top three risks to the achievement of the Trust's strategic objectives. iii. **DISCUSS** and confirm that the BAF is appropriately focused on the key risk areas that impact on the Trust's ability to meet its strategic objectives.

Update 3 - For 7 March 2024 Board
2023/24

Calderdale and Huddersfield
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2023/24 Update 3

Contents:

compassionate care

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming Services & Population Outcomes								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	7413, 8528	Strategic/ Organisational	Significant
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	15	**12 =**	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	12	**12 =**	9	RB	None	Innovation/ Technology	High
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	**12 =**	8	RA	None	Harm and safety	Low
Keeping the base safe - best quality and safety of care								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**15 =**	10	LR / DB	8528,7689,7994, 6079	Regulation	Moderate
04/19	Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations	12	**12=**	4	VP	None	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**15 =**	8	GB	7413, 8161,8562, 7955,8147	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	9	**6 =**	3	JH	. 7413	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of service due to failure to comply with quality statements resulting in a reduction of qualiy of services to patients and an impact on reputation.	12	**12 =**	6	LR	None	Regulation	Moderate
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	16	**20 =**	12	JH	8606, 8528	Harm and safety	Low
3/23	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	16!	8 ↓	8	AB	None	Strategic/ Organisational	Significant
4/23	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**16**	12	JH	8528, 8324, 8398,	Regulation	Moderate
5/23	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack	15	**15**	10	RB	None	Regulation	Moderate

Inclusive workforce and local employment								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	DB	7078,8508,8315 8509	Quality/Innovation & Improvement	Significant
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	12 ↓	9	LR	6345, 7994	Workforce	Low
6/23	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	LR	6911	Workforce	Low
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.	16	**12 =**	9	SD	None	Quality/Innovation & Improvement	Significant
1/22	Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change	12	**12 =**	4	SD	None	Workforce	Low
Financial, Economic and Environmental Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**12 =**	12	GB	None	Financial/Assets	Moderate
18/19	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash support.	25 =	**16 =**	12	GB	None	Financial/Assets	Moderate
06/20	Risk of climate action failure and not improving our environmental sustainability	16	**8 =**	8	SS	None	Strategic/ Organisational	Significant
2/23	Risk that the Trust cannot maximise its impact as an anchor institution in local communities to demonstrate social value	**9 !**	**9**	6	AB	None	Partnership	Significant

New risk
Area of risk exposure

REF	TOP RISKS	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
TRUST GOAL: TRANSFORMING SERVICES AND POPULATION OUTCOMES								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	8528, 7413	Strategic/ Organisational	Significant
TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE								
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	20	**20**	12	JH	7689, 8283, 8324, 8034	Harm and safety	Low
TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY								
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate

Area of risk exposure

CHFT RISK APPETITE STATEMENT - Revised September 2023

Risk Category	This means	Risk Appetite
Strategic / Organistional	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	Where required we will make difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, local and system impact, aiming to deliver our services within our ICS approved financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commercial	We explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients and colleaguessafe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety, appropraite staffing levels and promoting the well-being of our staff.	**LOW**
Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery.	**SIGNIFICANT**

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
High Likely (5)					
Likely (4)			02/20 Digital Strategy =	18/19 Long term financial sustainability = 4/23 National and local performance targets = 10a /19 Medical Staffing levels = **6/23 Midwifery Staffing levels =**	1/19 Approval of hospital reconfiguration outline business case and full business case = 1/23 Demand and bed capacity =
Possible (3)			2/23 Anchor institution & social value =	1/22 Absence and retention = 4/19 Patient & Public Engagement = 04/20 CQC rating = 14/19 Capital = 11/19 Recruitment and retention = 01/20 Clinical Strategy = 07/20 Health Inequalities = 10b/19 Nurse Staffing levels ↓	5/23 Cyber security = 9/19 HRI Estate fit for purpose = 6/19 Compliance with quality standards =
Unlikely (2)			16/19 Health & Safety =	6/20 Sustainability = 3/23 Partnership governance ↓	
Rare (1)					

= no change to risk score ! is a new risk ↓ reduced risk score

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES

Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024** **Risk category: Strategic** **Risk appetite: Significant**		
								Initial	**Current**	**Target**
1/19	Board of Directors / Transformation Programme Board	Deputy Chief Executive / Director of Transformation & Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE, WY ICS, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire Health & Care Partnership and Calderdale Cares Partnership and Kirklees Health and Care Partnership to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and Place based formal letters of support for the business cases. A Round Table Board is established that has members from NHSE, WY ICS, DHSC, Calderdale and Kirklees Places and meets quarterly to ensure system alignment and support for business case planning assumptions and development.	First line Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and the ICS, NHSE/ DHSC Second line Trust Board approval of business cases (SOC approved, March 2019). Reconfiguration OBC and FBC for new A&E at HRI approved by Trust Board in October 2021. Travel Plan approved by the TPB and the Green Plan by the Trust Board. Planning Permission for the new A&E at HRI was approved in September 2021. Planning Permission for the build of a Multi-storey car park and the new clincal buildings at CRH was approved by Calderdale Council in March 2022 Third line ICS and NHSE review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019. FBC for new A&E at HRI approved by NHSE Joint Investment Sub-Committee (JISC) in December 2021. Construction of the new A&E has completed and the date for opening is being planned. The Reconfiguration OBC was approved by NHSE Joint Investment Committee (JIC) on 25th February 2022. Reconfiguration OBC submitted for approval by Treasury.	• See below for further detail. 1. His Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 2. Agreement for development on the CRH site.	Work has been undertaken and presented to Transformation Programme Board (TPB) to define the skills and capacity needed for next stage of the programme to develop the Reconfiguration Full Business Case. Approval has been given to secure the necessary additional capacity / expertise. Project structures for the next phase of work have been implemented and progress is reported into the TPB each month.	5x5 = 25	5x4 = 20	5x2 = 10

Gaps in Control	**Timescales**	**Lead**
1.Trust and ICBs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH.	1. Discussions have taken place with YAS and activity modelling and clinical protocols have been agreed. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been negotiated and is progressing to completion -this will require Treasury approval. 4. Build of a Multi-storey car park at CRH to commence in 2024.	AB for all actions

Links to risk register from current service configuration:
8528 - ED operational performance
7413 - fire compartmentation risk HRI
Quarterly risk management report on the Reconfiguration Programme Risk Register to Transformation Programme Board

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to financial and workforce constraints, delivery of reconfiguration and agreed joint vision for clinical services resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk,18/19 financial risk, 10a/19 medical staffing risk	2024 refresh of current Clinical Strategy (2021-25) underway - describes Trust position on service development across West Yorkshire (WY) Transformation Programme Board - ensures estate is aligned with the clinical strategy, which informs decisions made to reconfigure services and ensure redesigned hospital model is fit for purpose (see BAF risk 1/19 reconfiguration) ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. Recruiting for additional Oncology staff to strengthen capacity CHFT Deputy Chief Executive chairs South sector implementation Board for Non Surgical Oncology (NSO) services across MYHT & CHFT. Project Manager support. Target Operating Models agreed. West Yorkshire & Humber Diagnostics Board (chaired by MYHT Chief Executive) reviews reports from workstreams on diagnostics (radiology, pathology). WY Imaging Collaborative reports to Diagnostics Board CHFT/ MYHT Partnership Board meets monthly to discuss fragile services and foster closer working relationships CHFT partner at Calderdale and Kirklees PLACE level clinical and professional forums,Quality Forum and PLACE Boards (sub group of ICB) to agree local health priorities and strategy. CHFT Medical Director appointed as SRO for South Pathology Network	**First Line** Plan for review and refresh of clinical strategy shared with WEB (12.12.23.). Update on NSO South Sector model to WEB 11.5.23. and 17.8.23.(re bed base). **Second Line (Board / Committee)** Refreshed Clinical Strategy July 2021 Board approved Lots 1 and 2 of Pathology Managed Service procurement approved by Board (6.7.23. Lot 1, 11.1.24. Lot 2) Pathology Partnership Update to January 2023 Board Transformation Programme Board highlight report and minutes to Board **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Diagnostics Board and Imaging Collaborative established across West Yorkshire WYAAT / PLACE meetings	Public engagment led by system partners on NSO service model ongoing. Industrial action impacting capacity to deliver clinical strategy LIMS (Laboratory Information System) implemetation delayed until 2025. WYAAT strategy to be approved by Board - March 2024 WYAAT and ICS system-wide approaches to reset. Performance of CHFT in relation to Covid backlog position remains focus of work CHFT reconfiguration delays impacts timescale for service transformation - action: progressing supporting elements where possible. Trust financial deficit position may limit development of new services -see BAF risk 18/19 long term financial sustainability	Review alignment of Trust clinical strategy with WYICB Joint Forward Plan (Delivering Our Integrated Care Strategy) Lead: David Birkenhead Timescale: September 2024. Review and refresh of clinical strategy to ensure it reflects CHFT and system ambitions. Lead: Medical Director / Associate Director of Strategy. Timescale: Board approval planned for September 2024	3x5=15	3x4=12	3x3=9

Action	**Timescales**	**Lead**
Monitor impact of industrial action on clinical strategy progress	Ongoing	Medical Director
Progress supporting elements of reconfiguration where possible as part of clinical strategy	Ongoing	Medical Director / Deputy Chief Executive and Director of Transformation and Partnerships
Review and refresh of clinical strategy	September 2024	Medical Director
Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone	September 2024	

Links to risk register: None

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk Category; Innovation/Technology Risk Appetite: High**		
02/20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund and deliver the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	Year 4 of 5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the next 5 year digital strategy Continued central funding available and committed capital funding from the Trust which will enable progression. Director of Digital Operations and Delivery role co-ordinating digital programmes and providing leadership whilst maintaining alignment toTrusts operational needs. Year 4 of the Digital Strategy (24/25 digital/EPR plan) focuses on improving on the digital basics and optimised use of existing systmes where funding may not be available. Governance via Digital WEB and Digital Operations Board.Digital Operations Board chaired by Chief Digital and Information Officer (CDIO), with reviewed terms of reference Monthly meetings with Chief Digital and Information Officer (CDIO) and Director of Finance reviewing progress with digital investment strategy. Divisional Digital Boards ensure appropriate spend of investment and report into the Digital Operations Board which has oversight of investment in line with strategy. EPR team restructured to ensure sufficient capacity and capability, with funding to support third Trust via project. CNIO and CCIO play a key role in the Digital Prioritisation Process (part of the Digital Health Team). COO, Chief Nurse,and Medical Director supporting the direction of digital developments in line with CHFT operational requirements. Clinical Change resource in place to help aid digital adoption and deliver benefits.	**First Line:** Digital Operations Board meeting bi-monthly, programme of work and progress presented at each meeting. **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2023/24 secured. 11 January 2024 Digital Strategy Progress and Update to Board with plan to 2025. 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS. Review 10 November 2022 Board. BCAG provides assurance that digital benefits are realised and digital business cases are aligned to the Trust Digital Strategy. **Third Line:** WYAAT &WYICS Chief Information Officer meetings ensures alignment of stategy on regional digital deployment as well as availability and eligibility for central digital funding. Good relationship with NHSE digital funding lead that has secured central funding in 2023/24 and expected to continue where available into 2024/25.		Availability of funding - continual monitoing of central funding available for digital investment. Lead: CDIO - ongoing	**Initial** **4x3 = 12**	**Current** **4x3 = 12**	**Target** **3x3=9**
Action					**Timescales**			**Lead**		
Links to risk register see linked 1/19 reconfiguration risk										

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2024
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
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								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Deputy Chief Executive	Risk of failing to respond to the health inequalities that exist within our populations due to lack of quality priorites to advance health equity, incomplete population health and patient ethnicity data, helthcare service delivery not matching patient needs in the most deprived areas or lack of resource allocation and programmes for health prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Deputy Chief Executive is the named Board Executive providing accountable leadership for tackling health inequalities. 2022-2024 Population Health and Inequalities Strategy approved at November 2022 Board with updates to Board throughout the year. Strategy focussed around four key areas of priority: Connecting with our communities and partners Access and prioritisation Lived experience and outcomes Diverse and inclusive workforce Health Inequalities Group, chaired by Deputy CEO, ensures oversight of all Trust workstreams in relation to health inequalities. Progress against delivery of Health and Inequalities Strategy reported regularly into the Trust Board. Equality impact assessment (EQIA) process for service and policy changes. Exploring actions to better recognise and address the impacts of poverty on health. Implementation of the Shadow Board - September 2023 Board Diversity Action Plan approved NHS EDI Improvement Plan - 6 high impact actions, one relating to members of Boards having an appraisal objective linked to EDI	**First Line** - Trust-wide health inequalities group meets monthly and oversees the organisations action plan and response to health inequalities. Health inequalities consideration and understanding included as a core element of all services supported by the development of data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. **Second Line** - Progress against delivery of Health and Inequalities Strategy reported formally into the Trust Board on a quarterly basis (July, November 2023. 12 month review of strategy presented at Board of Directors meeting January 2024 Approved Board succession plan seeks to ensure clear talent pipelines for each Executive and non Executive roles in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line** The Trust is working in collaboration as part of the West Yorkshire (WY) Integrated Care Board, WY Association of Acute Trusts and WY Community Collaborative, as well as continuing to showcase work nationally.	Continue to explore approach to diversity with WYAAT and ICB colleagues to ensure a regional approach. The Trust has delivered a number of successful interventions in respective of equality and diversity including the apprenticeship programme and Project SEARCH. Work continues overseen by the Trust's Inclusion group. Lead: Director of Workforce and Development Timescale: March 2024 Update in relation to use of patient level demographic information to prioritise clinical care - methodology current being trialled within cancer pre-habilitation service. Further plans to use the tool to identify those at higher risk of non-attendance at outpatient appointments. Lead: Deputy Chief Executive Timescale: March 2024 Population Health - continue to develop place-based approach to population health information to inform service planning and decision making. Deputy CEO and Managing Director of HIS leading on this work on behalf of CHFT Lead: Deputy CEO and Managing Director of HIS Timescale: March 2024	Population Health and Inequalities Strategy (2022-24) now in place. Progress against action plan underway. 2023 / 24 Annual Report will report on the required inequalities indicators and include additional narrative on the Population Health and Inequalities Strategy, our approach to addressing inequalities, and actions undertaken to reduce inequalities in line with NHS England requirements. Lead: Deputy Chief Executive June 2024	**4x4=16**	**4x3=12=**	**2x4=8**

Action	**Timescales**	**Lead**
Action Plan for more diverse Board and senior staffing consistent with local community and explore with WYAAT /ICBs	31/03/2024	Suzanne Dunkley
Development of tool to prioritise clinical care based on pateint demographic information to prioritise clinical care	31/03/2024	Rob Aitchison
Development of Place-based approach to population health information for service planning	31/03/2024	Rob Aitchison / Rob Birkett

Links to risk register: None

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk category: Regulation Risk appetite: Moderate**		
04/19	Quality Committee	Director of Corporate Affairs	**Risk** Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations **Impact** - poor patient experience - Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group (PEG) mandates the workplan and oversees progress and audit activity for public involvement and patient experience • Governor and Healthwatch are members of PEG •Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs •New Patient Experience and Engagement Strategy • Observe and Act patient observation tool as part of Journey to Outstanding reviews •Carer's Strategy approved March 2022, developed with service users and local voluntary sector organisations •Patient Story Process Map 2022 in place with a robust process for capturing, sharing, and learning through patient stories • Matron on Reconfiguration Team leads on patient experience • Complaints mapped to IMD (index of multiple deprivation) groupings • Director of Corporate Affairs Chairs Calderdale Place Communications, Involvement and Equality Group and have members on the Kirklees equivalent	**First line** Patient Experience Group Quarterly report on patient and public experience and equality to Quality Committee Examples of good practice on patient and public involvement including reconfiguration programme, children's services, carers etc **Second line** Patient Story to PEG, Quality Committee and Board Governor attends PEG Director of Corporate Affairs chairs Place Communications, Involvement and Equality Group reporting in to ICB Member of Place Based story tellers network PEG reporting to Quality Committee quarterly Keep carers caring presentation to Parliament **Third line** Quality Accounts, CQC rating of Good - report referenced positive examples of patient engagement. Healthwatch reports Recent external Government led review of accessibility of Trust website led to some actions which are now all complete	1. New Equality Delivery System 22 in place and not yet clear on the ask of providers versus that of Places. Clarity being sought with NHS England and Place lead 2. Work to do to improve compliance with Accessible Information Standard Director of Corporate Affairs to complete outstanding actions by March 2024. 3. Review of translation services contract required following patient feedback. Not clear if meeting KPIs.See action 3 below. 4. Need systematic way of capturing and reporting on patient and public engagement and its link to equality.Action:below. 5. Vacancy in Patient Experience post		**Initial** **3x4 = 12**	**Current** **4x3 = 12 =**	**Target** **1x4 = 4**
2023/24 Update 3					**Timescales**				**Lead**	
1. Complete actions to comply with Accessible Information Standard. 2. Procure new contract for translation services 3. Recruit to Head of Patient Experience 4. Develop databse of patient engagement 5. Implement new section 242 assessment into EQIA / QIA process					March 2024 March 2024 July 2024 July 2024 March 2024				Chief Nurse Head of Procurement Chief Nurse Head of Patient Exprience Head of Patient Experience	
Links to risk register: No risks on the high level risk register										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE											
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								Initial	**Current**	**Target**
06/19	Quality Committee	Chief Nurse/ Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Quality governance arrangements monitor quality and safety in line with as per our governance structure approved by the Board of Directors. • Quality and Safety strategy in place, currently under review, clinical division report into performance review meetings on delivery of of the quality priorities • Quality Committee scrutinises quality priorities with specific KPIs in place, and the Maternity Transformation Plan • Serious incident (SI) investigation process identifies recommendations to improve care with strong governance in place and process in place to address any immediate learning • Clinical Effectiveness and Audit Group (CEAG) reviews assurance on guidance and national audits • Clinical Outcomes Group monitors workstreams for patient safety and quality, reporting into Quality Committee • Risk management strategy revised and refreshed, strengthened risk management arrangements at divisional level. • Patient Safety Incident Response Framework (PSIRF) and draft investigation model that aligns with PSIRF framework being tested, with aligned and approved Incident Reporting Policy. • Board approved Infection Prevention Control (IPC) Board Assurance Framework (BAF) aligned with NHS England evidence-based framework •Compliance register refresh and scrutiny by Compliance Group • Focused Journey to Outstanding (J2O) programme • Ward assurance visits programme - clinical area quality dashboard reviewed at at Nursing and Midwifery Workforce meeting. Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry. • Care of the Acutely Ill Patient programme in place to improve mortality outcomes. • Nursing and Midwifery Strategy - enhanced quality dashboard monitored through nursing workforce meeting. • Children and Young Peoples Improvement Plan and Childrens Board has been established. • Learning from deaths programme and medical examiners office - processes in place to flag concerns and issues for further investigation. • Freedom to Speak Up process to support a culture for raising any safety concerns. • Participation in the national GIRFT Programme and national elective recovery programme.	First line Assessment of compliance with NICE guidance with increased oversight at CEAG. Performance against safety must dos reviewed at ward / matron level. HSMR & SHMI. Consistent mandatory and essential training compliance. Improved real time assurance on impact of safety staffing and quality - Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed with increased oversight at CEAG. Sub-groups report into Quality Committee as per governance arrangements and workplan. Maternity report to Quality Committee and Board - response to Ockenden review KPIs in Integrated Performance Report, PSQB reports to Quality Committee. 6 July 2023, Board report on Infection Control and progress with IPC BAF recommendations. June 2023 signifcant assurance opinion on IPC BAF following internal audit review, Board approved Risk Management Strategy September 2023 Monthly Quality report to Quality Committee which includes update on Serious Investigations (SI) progress and a lessons learnt section. Safer Staffing Hard Truths report to Board 10.11.22., 6.7.23. Maternity Services report to Quality Commitee and Board (March, May, July 2022) Complaints performance improved allowing time to focus on learning from complaints, with themes and trends identified and linked to Quality Priorities 2023/24. Ward to Board internal audit significant assurance opinion reviewed by Quality Committee (May 2023). 7.9.23. Board "True for Us" report in response to Lucy Letby case, Board development session quality and safety and PSIRF Freedom to Speak process reporting into Workforce / Quality and Board. Third line CQC maternity inspection report August 2023 - retained overall good rating. CQC rating of Good, regional Ockenden Assurance Visit (28.6.22.) CQC. Maternity Incentive Scheme - Inpatient, Children's and Young Peoples survey and urgent care survey 2023. Quality Account reviewed by stakeholder bodies for 2022/23 with positive feedback . Independent assurance on clinical audit strategy. Feedback through ongoing relationship with arms length regulatory bodies. CQC - Undertaken discharge review and Surgical Services visits. Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports and on site visits	• Recruiting to vacancies in revised quality and safety team structure Action: Complete recruitment March 2024 Lead: Deputy Chief Nurse/ Director of Corporate Affairs Quality priorities but gap re: Quality and Safety Strategy Action: Development of Quality and Safety Strategy Chief Nurse Timescale: April 2024 Variability in quality of divsional risk registers and understanding of their roles in risk management Action: Risk register training for divisional staff to support improved use of risk register to accurately identify risks to quality and safety of care Lead: Deputy Chief Nurse Timescale: March 2024 Ability to triangulate data to identify themes, trends and early warning signs of quality and safety issues Action: Developing phased project implementation plan for new risk management software with transition to new system by February 2025 Deputy Chief Nurse	Agree reporting arrangements for Divisional PSQB's into Quality Committee. Lead: Chief Nurse / Director of Corporate Affairs Timescale: March 2024 Internal audit further review of quality governance structure during 2023/24 Q3 Internal audit review of risk management processes Lead: Chief Nurse, Director of Corporate Affairs Timescale: March 2024 Gap in assurance re consistency in divisional management of quality and safety agenda Action: Quality Summit October 2023 which developed action plan for identified gaps in divisional processes - plan to confirm timescales. See above outcome. Inconsistent application of quality improvement (QI) methodology Action: Scope target audience and delivery method for QI training Lead: Deputy Chief Nurse Timescale: January 2024 Integrated Provision in the community: relative immaturity of Place-based quality and safety governance and assurance and regulatory/ statutory prvider framework for integrated care. Continue to develop Place based governance infrastructure Lead: Director of Operations Community.	3x5 = 15	3x5= 15 =	2x5 = 10

Action	**Timescales**	**Lead**
Recruitment to revised quality and safety team structure	March 2024	Deputy Chief Nurse
Quality &Safety Strategy	April 2024	Chief Nurse
Risk register training for divisional staff	March 2024	Deputy Chief Nurse
Risk management software phased project plan developed and delivered	February 2025	Deputy Chief Nurse

Links to risk register:
Also see BAF risk re clinical strategy 1/20, 10a/19 and 10b/19 relating to staffing
8528 ED operational performance, 7994 enhanced care nursing staff
6079 follow up out patient appointments

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

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04/20 July 2020	Quality Committee	Chief Nurse	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of services, due to failure to comply with quality statements resulting in a reduction of quality of services to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC Group with refreshed terms of reference meets monthly, oversee compliance with regulatory standards/ –and reports to Quality Committee, monitoring progress against 2018 must do and should do actions. Action plans in place re: must do and should do actions from 2018 CQC report, compliance with medical staffing in ED dependent on reconfiguration and GPICS standards on critical care. Regular engagement meetings with CQC and on site focus visits taking place Process for internal assessment against CQC standards (Journey to Outstanding) Dedicated CQC lead CQC action plan developed following CQC maternity inspection, monitored by CQC Group for Trust oversight, with local oversight by team Independent Well-led Governance development review completed. CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes (Journey to Outstanding) reviewed and updated, piloted and being rolled out. Journey to Outstanding (J20) implemented with increased breadth and depth of assurance - working towards business as usual model Focused Journey to Outstanding programme review of maternity services and community paediatric services. Reviewing J2O process against revised CQC framework.	**First Line:** Reports to CQC Group from divisions with increased scrutiny Journey to Outstanding results and action plan and findings shared with wards and presented to CQC Group . Also have focused J20 process Divisional review of must do and should do actions from 2018 CQC report, ongoing monitoring. **Second Line:** Quality Summit / Board Development Session (Well-led) CQC maternity inspection report presented to Board 7.9.23. Quality Committee reports from CQC Group and as part of Bi monthly quality report Quality Committee highlight report to each Board CQC well-led governance phase 2 report shared at Board workshop July 2021 Board Development Session 7 October 2021 on CQC effective domain. Maternity Services Update to Board 5.5.22. , review and assessment against East Kent Maternity report (10 November 2022) Caring Domain CQC Board Development Session 9.6.22. Update on CQC with Board at Board Development session, including review of quality statements February 2023 and new CQC single assessment framework 5 October 2023. **Third Line:** Formal engagement meetings with CQC and rolling programme of on site visits. Current CQC rating of "good" including well-led governance - maternity services rated as good overall in CQC maternity inspection report August 2023 Board well-led interviews undertaken by external reviewer as part of Board Development Programme CQC maternity review undertaken June 2023	New inspection frameworks for acute and community services published October 2023. Action: need to undertake assessment against new framework Lead: Director of Corporate Affairs	CQC maternity report August 2023 rating of requires improvement for safe Delivery of CQC action plan for 2 must do actions (training and qualified staffing levels) and 5 should do actions 2023 move to Single Assessment Framework for future CQC inspections and rating regime. Towards the end of 2023 CQC will gradually start to carry out assessments in the new way. This means a new approach to inspection and new assessment framework. In summer a new online provider portal will be lunched. This will be done in stages and provide support and guidance. In the first stage: Providers will be able to submit statutory notifications CHFT now have access to this portal and will submit notifications via this methodology for greater level of assurance Provider portal not yet published so unable to undertake review against information held	**Initial**	**Current**	**Target**
								4x3=12	**4x3=12**	**3x2=6**

Action	**Timescales**	**Lead**
Development of CQC action plan following maternity inspection	December 2023	Chief Nurse
Journey to Outstanding implementation underway via rolling programme including focused visits	12 month rolling programme	Chief Nurse
Development of PLACE level framework for system reviews with partners	March 2024	Chief Nurse
Assessment of compliance against newly published inspection framwork for Acute Hospitals and for Community Services to be undertaken and report to Board	January 2024	Director of Corporate Affairs

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

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								Initial	**Current**	**Target**
1/23 June 2023	Finance and Performance Committee	Chief Operating Officer	Risk that continued high acute demand, high patient acuity and shortfall in community provision leads to the requirement for additional beds over and above planned levels. This results in staffing and financial pressures.	Well Organised Ward programme and toolkit with four "must dos" to ensure consistency of fundamental actions at ward level by clincial teams. The Urgent and Emergency Care Delivery group (UECDG) is the overall assurance meeting for the delivery of Urgent and Emergency Care and reports to the Finance and Performance Committee and the Trust's Transformation Programme Board. It meets monthly to strategically review the performance of UEC delivery through the data dashboard and the improvement groups. The UECDG has two focused Improvement Groups: Same Day Emergency Care (SDEC) and Length of Stay (LOS). The Improvement Groups are supported by project individual Task and Finish groups, which provide monthly data-led updates into the appropriate Improvement Group for appropriate discussion, challenge and steer. The Improvement Groups report assurance of the delivery of UEC into the UECDG. Working with partners in Calderdale and Kirklees to agree target operating models for integrated community urgent and intermediate health and care models of care (with interfaces to single points of access and neighbourhood teams). Target operating models to frame effective use of business as usual and transformation based monies aligned with Place and wider system objectives. Agreement in principle with Calderdale partners on target operating model, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap. Sept 23 - Agreement in place to use allocated funding for discharge to enhance reablement which will support improved discharge of cohorts of patients on the transfer of care (TOC) list. Recruitment and roll out underway.	**First Line** Length of stay improvement group in place meeting monthly. Separate working groups in place with clear leads that report in to the improvement group. Same Day Emergency Care (SDEC) improvement group in place , which through september and october are being supported by the external CLEAR project team. Seperate working groups with clear leads that report in to the improvement group. ED improvement workstream led by ED directorate Senior Management Team which also reports to UECDG. **Second Line** Urgent and Emergency Care delivery group chaired by COO, meeting monthly, improvement workstreams report in to U and E CDG, against identified KPI's. U and E CDG reports in to Finance and Performance committee which reports in to Trust Board. Focus through Turnaround Executive on the financial savings linked to reduction in LOS and reduced bed base. **Third Line** NHS England (NHS E) monitoring and production of reports linked to Emergency Department and bed occupancy. Monthly meetings with COO and NHSE. Calderdale and Huddersfield U and E Care Board meets monthly with community teams, ICB and Local authority representation. CHFT UECDG reports updates on workstreams in to this.	Kirklees community provision and commissioning models for that provision . Action:ongoing discsussion with Kirklees partners Lead: Director of Operations Community Michael Folan, Deputy Chief Executive, Chief Operating Officer Transfer of care list for Kirklees and Calderdale running at high levels, 100-130. HIgher volume of patients requiring support on discarge and community provision not able to meet demand. Partner discussions continue which will form part of the planning discussions 2024/25 Lead: Director of Operations Community Michael Folan, Deputy Chief Executive, Chief Operating Officer	Absence of agreement in principle with Kirklees partners on target operating model to support increased discharge of patients on TOC list, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap analysis. Lack of assurance re capacity and provision of social care. Discharge run rate from the TOC list remains insufficient to reduce and maintain at a lower level, the overall number. This continues to form part of planning discussions 2024/25. Lead: Chief Operating Officer, Deputy Chief Executive, Director of Finance System-wide discussions regarding programme of work focused on Home First and move away from discharge to assess beds. CHFT to continue to work with partners. Lead: Chief Operating Officer, Deputy Chief Executive Development of and use of joint community dashboard to enable focus through system silver escalation meetings and to support focused action to enable sufficient capacity Lead: Chief Operating Officer and Deputy Chief Executive Timescale: 31/03/24	4 x 5 = 20	4 x 5= 20	4x3=12
Action:					**Timescales**			**Lead**		
Use of allocated 'pot 2' funding to enhance reablement for Calderdale. Roll out of programme in alignment with recruitment System wide discussions re Home First for Kirklees. Planning discussions with a focus on agreement with Calderdale and Kirklees regarding capacity to support reduction in TOC list					Ongoing to March 24 31 March 2024 30 April 2024			Chief Operating Officer, Director of WOD and OD, Chief Nurse COO & Deputy Chief Executive		
High level risks 8606 unable to reduce acute in patient bed base in line with reduction plan, 8528 ED operational performance										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

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								Initial	**Current**	**Target**
9/19	Transformation Programme Board	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Funding secured for ED HRI and MSCP CRH and in 2022/23 capital plan • Medical device and maintenance policies procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts •Premises Assurance Model (PAMs) illustrates to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, Plans in place to demolish DATs building to reduce backlog maintenance. Head of Estates and H&S lead from CHS now attend the Risk Group to align Trust and CHS risk registers • 6 monthly insepctions of cladding at HRI with report to CHS Board and Transformation Programme Board - programme of cladding works towards the end of the reconfiguration timetable supported by the Transformation Programme Board 19 December 2022 Capital has been secured to meet the 23/24 & 24/25 plan and requirements as agreed in the annual internal capital planning round.	First line • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS. Audits of routine checks, estates * Trust Health & Safety Manager with oversight of H&S across Trust & between partners. Audit of HTM Compliance to confirm appropriate control measures in place to manage the HRI and community estate completed Q1 2023. HRI A&E Build Assurance report delivered to reconfiguration core team with appendixed handover tracker and confirmation all life saftey systems commissioned & operational. * Implementation of ANPR at HRI & Acre Mill complete with full Go Live for staff permits of Feb24. *RAAC surveys completed and assurances provided from Leased In Properties. Second line Estates strategy (revised) approved at Board 2.9.21. H&S Update to Board: January 2022. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports. Assurance provided by HTM Compliance reports via external Authorised Engineers inspections against HTM standards. WEB reports on medical devices July 2019 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI. Latest 6 Facet survey to be undertaken late 2023, covering both HRI & CRH Third line CQC Compliance report.PAMS. HSE review of water management. Familiarisation visits by local operational Fire and Rescue teams. External assurance from authorising engineers for high voltage/ low voltage systems.PLACE assessment (Patient-Led Assessments of the Care Environment) undertaken October 2022 by Quality Performance and Service Manager	• Multi Storey Car Park - the Trust awaits the outcome of the business case review process with HM Treasury before further progress can be made. * 6 Facet survey has been undertaken with draft report expected mid Feb 24. Full report expected mid to late March 24. The 6 Facet Survey has covered HRI, CRH, Acre Mills & Broad Street.	*Development of new £15m HRI A&E currently going through Governance Assurances prior to confirmation of opening date	4x4 = 16	5x3= 15	2x4 = 8

Action	**Timescales**	**Lead**
Parking - ANPR to be introduced at HRI & Acre Mill+A59 6 Facet Survey report	Full Go Live February 2024 March 2024	Head of Estates

Links to risk register:
Risk 7413 - Fire compartmentation risk, HRI, 8161 CT scanning, 8562 Pathology, 7955 x ray, 8147 cath labs,

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk category: Regulation Risk appetite: Moderate**		
16/19 9/1/20	Audit and Risk Committee	Director Champion - Chief Operating Officer	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations resulting in harm to staff, patients, the public, visitors, potential regulatory failure, finanical risk and reputational damage	•Board approved 5 year H&S strategy NHS Workplace Safety Standards provides framework for H&S activity, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities (policy tracker written). The Strategy has been revised in early 2023 •General Health and Safety Policy (updated early 2023) clearly highlights the overarching roles and responsibilities and arrangements to achieve compliance. New lone working policy, and a new security policy written (December 2023), revised Violence & Aggression Policy with behaviour support cards, revised COSHH policy (second revision (April 2024) with clearer process for completing COSHH assessments by key stakeholders - both ensure CHFT can demonstrate legal compliance. • Individual health and safety policies under continuous review across 2022/23 and shared with CHFT Resilience and Safety Group Meeting - each policy with individual subject matter expert ownerships • SLA in place for CHS to provide Health and Safety Induction Training of on-site contractors and visitors • Executive Director Health and Safety Champion identified • Proactive Resilience and Safety Group Meeting firmly established. • Head of Health and Safety involved in all new sub committees to H&S committee. 8 H&S subgroups formed - maintains traction upon stakeholder responsibilities • Annual report on Health and Safety to Board which is to be a combined fire, security and health and safety risk paper and presented for 2023 submission • Health and Safety with updates to Board, Audit and Risk Committee oversight and attendance to present at Quality Committee every 6 months . • Health and Safety mandatory ESR training for staff (3 years). • Auditing and monitoring of compliance via new health and safety dashboard which is presented at each Resilience and Safety Group Meeting. Desktop meetings take place between the subject matter lead and the Head of Health and Safety across the year to ensure/seek assurance of continuous compliance.	First line Minutes of the Resilience and Safety Group Meeting evidence good level of engagement by all partners. Review of Resilience and Safety Group Meeting by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information . Policy approval via Resilience and Safety Group Second line Board joint responsibility for risk understood with Weightmans Solicitor Legal update given in 2023 WEB reports on mandatory training, health and safety training compliance -Resilience and Safety Group Meeting to Audit and Risk Committee, with annual deep dive. Quality Committee engagement planned for 2022, 18 October 2022 and then every 6 months with last update in early 2023yr. Audit Yorkshire January 2021 9 January 2020 external Health and Safety review presented to Board • 2021/22 Annual Health and Safety report and action plan to Board - 12 January 2023, May 2023 • Health and Safety Strategy revised September 2022, review of 2023 - 2028 Strategy by Audit and Risk Committee 31.1.23. Updates to Board on H&S 3 September 2020, 14 January 2021, 1 July 2021, 13 January 2022, Third line External health and safety review (Quadriga) 2019.	Development and implementation of NHS Workplace Health and Safety Standards - 90% achieved (10% left = Security compliance), Lead: Head of H&S Timescale: May 2024 Strenghtenning of assurance required for COSHH compliance. Cross-divisional engagement project planned for early 2024 to seek better compliance	Work continues upon the security compliance requirements, with a plan of action now written and working towards completion by mid-2024yr. The action plan is cross referenced against NHS Violence Reduction Standards and the NHS Workplace Health and Safety Standards.	**Initial**	**Current**	**Target**
								3x3 = 9	**3x2 =6 =**	**3x1 = 3**

Action	**Timeframe**	**Lead**
Development and implementation of NHS Workplace Health and Safety Standards (10% remaining to do) Formation of a cross divisional improvement plan to seek better compliance Delivery of security improvement plan	May 2024 Mid 2024 Autumn 2023 improvement plan completed and now stage 2 (implementation process - May 2024)	Head of H&S all actions

Links to risk register:
7413 fire compartmentation

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE											
Ref & Date added	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk category: Strategic**		
								Initial	**Current**	**Target**
3/23	Anna Basford, Deputy Chief Executie and Director of Transformation and Partnerships	Board of Directors	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	Ensuring we have a voice and influence at all levels within the region and places: -Chief Executive is the Chair of the West Yorkshire Association of Acute Trusts and a member of the West Yorkshire Integrated Care Board - Chair and Chief Executive attend ICS - Chair and Chief Executive members of Calderdale Place ICB - Director of Finance has role as Finance Lead for Kirklees Place - Chief Executive and Deputy Chief Executive members of Kirklees Place ICB - Other Director and senior leadership part of governance structures and workstreams at West Yorkshire and Place levels Directors in Senior Responsible Officer roles across Places Board discussions on system governance arrangements and direction of travel Round table arrangements in place for reconfiguration decision making involving regional and local partners	**First Line** • Chief Executive and Chair reports to Board • WYAAT Reports to Board • Round table discussions reported through Transformation Board **Second Line** • Trust members in Place and Regional decision making arrangements • Shared involvement in Place based reviews including safeguarding, Ofsted etc **Third Line** • Place review	ICB Operating Model published with 30% reduction in running costs by April 2025 may lead to disruption with ICB partners and individuals - outcome of impact of operating model for West Yorkshire awaited.	CQC system assessment framework not yet confirmed	4x4 =16	4x2=8 →	4x2=8

Actions	**Timescales**	**Lead**
Seek assurance on changes described in published operating model	December 2023	CEO

High Level Risk Register risks - none

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
4/23 Added September 2023	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets **Due to** Strike action; workforce gaps; partner responsiveness; activity pressures **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience -Elective recovery Funding - Reputational damage with stakeholders - clinician dissatisfaction	Clinical prioritisation of all patients on waiting lists to identify current priority status and a process for regular review of clinical need. Increased number of outcome metrics within performance reporting monitored through performance framework . WYAAT system approach to capacity management. Urgent Care System Board and ICS Discharge Forum with social care providers to plan / consider options Daily escalation of performance issues from divisional hubs into Bronze, Silver and Gold levels as appropriate. Access Delivery Group, Cancer Group, Urgent Care Delivery Group meet monthly to monitor recovery programmes, standards and waiting lists. Silver meeting has trajectory for reducing Transfer of Care list and is working through agreed actions Health Inequalities linked to elective recovery monitored at a divisional level. OPEL escalation arrangements reviewed and updated to provide clearer escalation process. Approved surge and escalation plan and implementation of full cpacaity protocol. Performance is discussed at the Finance and Performance Committee and any areas of under performance are considered in detail or as part of deep dives Comprehensive and robust planning meetings in for the new ED, supported by a transition plan led by the Head NUrse of ED. Testing taken place regarding the configuration of the new ED prior to the move.	**First line** Daily Bronze meeting and silver when required with process to enact GOLD if needed. New OPEL levels in place Trust feeds into weekly silver meeting with partners. All areas have access to KP+ Risk registers reviewed at Divisional PSQBs & PRMs. Performance bulletin issued regularly to stakeholders Integrated Performance report focus of one WEB each month for detailed scrutiny of recovery performance and activity. Integrated Performance Report overhauled and in place using statistical process charts and NHS Digital good practice for performance reporting Elective care transformation programme relaunched **Second line** Integrated Performance Report discussed at each Board sub committee and Board of Directors Assurance on overall performance discussed in detail at Finance and Performance Committee **Third line** Routine reporting to NHS England Comparison data nationally shows Trust as one of the best performers on elective recovery and one of four Trusts achieveing all three key cancer standards Prof Tim Briggs visit demonstrated good practice in elective position and shared as an exemplar nationally Awarded elective recovery hub and community diagnostic hubs	Not meeting diagnostic wait times in some modalities - action plan in place to address re neurophysiology and ECG COO - January 2024 Strike action impacting on delivery of elective, diagnostics, outpatients and non-elective activity - Strike planning meetings in place internally and with partners COO. There is a need to model impact to date and project potential impct going forward - Ongoing Impact of the opening of the new A&E and the actions of individuals on the use of A&E unknown but could impact performance at the HRI site and overall in the short term. Modelling to be completed and impact to be monitored COO - April 2024	Still not meeting A&E wait time target of 76% by March 2024. Lead: DOp Medicine, COO. 31st March 24 Annual Plan doesn't achieve 92% bed occupancy. CHFT agreed bed occupancy target 96%. Lead: Director of Ops Medicine, COO. 31st March 24 Transfer of Care list significantly higher than planned 50 by end of July 23. Lead: Director of Ops Community, COO, Deputy Chief Exec. 31st March 24 Reduction in outpatient follow-ups not yet being met. Lead: Director Ops FSS, COO. 31.3.24. Plan to meet no over 52 week waits for elective RTT not being met due to specific pressures within ENT. Lead: Directors of Ops Surgery, COO. 31.3.24. Not meeting DMO1 (6 week diagnostic) target for Cardiology and Neurophysiology. Lead: Director of Ops Medicine, COO. 31.3.24.	**4x5 = 20**	**4x4 = 16**	**4 x 3 = 12**

Actions	**Timescale**	**Lead**
Deliver action plan to address waiting times in neurophysiology and cardiology	January 2024	Chief Operating Officer for all
Strike action planning	Ongoing	
Undertake modelling of the impact of Industrial action on elective activity and model this going forward to enable projections	September 23	Respective divisional
Monitor impact of opening new A&E and model resulting performance	April 2024	Directorof Operations
Actions re: A&E target, bed occupancy, transfer of care list, out patient follow ups, 52 week waits	31.3.24.	

Links to risk register: 8528 Emergency Department operational performance , 8324 non-compliance with elective access policy (RTT validation), 8398 colorectal surgery

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE									
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024+A12 Risk category: Innovation/Technology Risk appetite: Moderate**	
5/23 November 2023	Audit and Risk Committee	Chief Digital and Information Officer	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack impacting on patients via exposure of patient records, inability of workforce to access / record patient care affecting quality and safety, financial and reputational risk . (Including but not limited to Cyber vulnerability, Social engineering, malware, ransomeware, phishing emails, loss of data and DOS attacks)	Significant internal and external security technical controls including: Vulnerability Management, Threat Management, Real time threat monitoring. Dedicated Cyber team monitoring and addressing threat notifications. Incident response and recovery - Business continuity plans (BCP) for clinical and non-clinical areas in the event of no digital provision. Monitoring via national ATP (Advanced Threat Protection) service. Programme of maintenance / replacement of digital systems ensuring up to date operating systems and configurations as per NCSC guidelines. Dedicated resource through cyber security team for management of cyber security issues, inlcuding an NSCS accredited lead. Policies on the handling and storage of data, and Data Protection officer: Information Security Policy, Network Security Policy (identity and access management) & Incident reporting system Essential training for staff on information security and cyber risks via ESR & Controls on supplier systems /supplier chain security	<u>First Line</u> Formal certification re cyber securtiy via ISO 27001 - Information Security Standard, ITSEC manager - Cyber advisor certified by NCSC, Data Protection Security Toolkit (DSPT) compliant, Cyber Essentials compliance. <u>Second Line</u> Deep dive on cyber security to Audit and Risk Committee July 2023 <u>Third Line</u> Compliance with NHS Digital / NHS Engalnd Data Security Protection Toolkit 2022/23 External 3rd party security testing at least annually	Testing of resilience and recovery plans, BCPs etc. Action: Discussion with Emergency Preparedness and Resilience lead re testing continuity plans: Lead Rob Birkett / Sarah Rothery The ever changing landscape/threat around cyber security Lead: Keith Redmond Ongoing	Further assurance required from partner organisation with connectivity with CHFT (techincal mitigation in place) Action: Seek assurance from WYAAT / ICS / Chief Digital Information Officers partners Lead: Rob Birkett Timeframe: March 2024	**Initial** **5 x 3 = 15**	**Current** **5 x 3= 15**	**Target** **5 x 2 = 10**

Action	**Timescale**	**Lead**
Testing of resilience plans Monitoirng of cyber threat Seek assurance re: cyber security from system partners	31/03/2024 Ongoing March 2024	Rob Birkett/ Sarah Rothery Keith Redmond Rob Birkett

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FERBUARY 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk Category: Workforce Risk appetite: Low**		
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to gaps in the clinical workforce (local and national challenges) **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver range of key performance indicators as defined by multiple organisations - Increased risk of litigation and negative publicity. - Poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	•Consultant Succession planning • "Grow our own" approach - through different methodologies. • CESR programme to increase Consultant workforce in appropriate specialties, Emergency Medicines scheme for oversease doctors with Royal College (Hybrid International Emergency Medicines) supports recruitment and retention. Global fellows in Radiology, •Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for Consultants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity (planning for April 2023/24 underway) • Recruitment and retention success, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals, use current staff effectvely - all new employees opted in to a bank contract (unless opt out). Elective and clinical attachment placements (attracts international colleagues) • WYAAT networking approach to pressured specialties, eg Non-Vascular Interventional Radiology, supporting MYHT with Non Surgical Oncology, Neurology • Ongoing medical staffing recruitment. Refreshed induction for trainees including EST completion, • Focus on alternative workforce models, allied health care professional roles – Physician Associates and Advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts • Medical Workforce Programme monthly meeting with wider group of stakeholders - provides an overview of the programme to ensure full visibility, shared view and tracking of all medical workforce based projects, with highlight reports from workstream leads. • Recruitment through external agencies for posts difficult to recruit to •New national contract launched for specialty doctors and specialist doctors enabling appointments at specialist level with more independence. Adopted SAS (Staff and Associate Specialists)doctor charter. •Refreshed engagement approach - eg Medical Director's Office created well-being talks, SAS Forum, Junior Doctor Forum, Consultant and SAS body informal catch up events. •SAS asdvocate appointed and new SAS tutor appointed - support more effective engagement with SAS cohort • Enhanced reporting data (eg sickness absence, staff in post by grade/specialty, turnover, vacaccy, retention) enabling a more robust view of medical workforce status. E-rostering provides understanding of rota gaps and workforce required, new e-roster lead in post, 2023/24 approach to Clinical Excellence Award discussed and agreed with Local Negotiating Committee to support retention of long standing Consultants Study leave policy approved, effective from April 2024, will give greater visibility of study leave taken and cost of study leave enabling better capacity planning and financial planning of medical staff	First line Staffing levels, training & education compliance reported and review through departmental and divisional governance structures. Industrial action planning has given us an understanding of baseline staffing levels.Escalation of any short term gaps to Bronze tactical meeting/ internal command arrangements. Weekly meeting between Divisional Directors and Medical Director's Office (with COO attending) to enable sharing of information. Roll out of new approach to sharing training data across Trusts for junior doctors IPR with key KPIs including sickness levels, and agency spend, with monitoring of spend. Weekly divisional medical staffing meetings to optimise fill rates. Medical workforce steering group meetings re-launched Significant Consultant recruitment across a number of specialities, especially within ED. Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – net recruitment gain of 39 wte medical and dental posts from September 2022 to September 2023. Turnover remains under 10% to August 2023 (7.73%) Medical Appraisal and revalidation report to Board, September 2023 Guardian of Safe Working Hours annual and quartely report to Board. Refresh of Recruitment Strategy Medical Workforce Programme Update to Workforce Committee Deep dive review of this risk at Workforce Committee 19.2.24. Third Line GIRFT benchmarking tool RAG rates workforce establishment position Plans discussed with NHS England Assurance process with CQC colleagues - feeback from relationship with arms-length bodies GMC Report on Junior Doctor Experience GMC Employer Liaison Meeting with Responsible Officer / Medical Director Local Negotiating Committee (with BMA in attendance) regular engagement to raise any concerns regarding medical workforce.	Progress recruitment for approved medical e-case rostering delivery team. Deputy Medical Director by June 2024 Dependence on HEE allocation of trainees. Continued junior doctor and Consultant body industrial action (independent and combined). Monitor outcome of indicative ballott for SAS cohort of doctors & referendum for government pay offer to Consultants. Action: Pre-strike planning including clinical activity risk assessment, responding to changing legal position (eg re use of agency staff), registers and contract notifications of deductions. Lead: Medical Director. Director of Workforce and OD/ Chief Operating Officer Review of job planning framework and implementation of a job planning consistency Committee to ensure a reduction in uwarranted variation between job plans. Deputy Medical Director by September 2024.	Short term sickness absence may be under-reported by medical staff. Action: Divisional directors to monitor and manage. Working Together to Get Results sessions to build on success of embedded Physician Associate scheme by providing development opportunities and additional support to junior doctor rotas and aid retention. Lead: Deputy Director of Medical Education Timescale: June 2024 Investigation of agency and bank spend and identification of potential for retraction by grade and service area Lead Deputy Medical Director April 2024	**Initial** 4 x 4= 16	**Current** 4 x4=16 =	**Target** 3 x 3 = 9

Action	**Timescales**	**Lead**
Industrial action planning, including clinical risk assessment and responding to changes in legal position Review of job planning framework and implementation of a job planning consistency Committee Investigation of medical staffing agency and bank spend	Ongoing September 2024 April 2024	Deputy Medical Director for all actions

Links to risk register:
7078 medical staffing, 8508 + 8509 Opthalmology, 8315 Paediatric Opthalmology

BOARD ASSURANCE FRAMEWORK
FERBUARY 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk Category: Workforce Risk appetite: Low**		
								Initial	**Current**	**Target**
10b/19 2021/22	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Senior nurse staffing meetings twice a day, 7 days a week provide an on the day repsonse to staffing position, responding to areas of escalation (red flags) and agreeing actions to mitigate the curent position. This meetings also determines the agree OPEL safer staffing postion. Clear esclations to the Associate Directors of Nursing rota and approval sought for Tier 3 agency to mitigate unresolved staffing position. Community nursing 7 day on call arrangements to manage staffing with escalation process. Executive oversight of twice yearly nrusing establishment review in line with NQB guidance •Senior nurse leadership rota provides ongoing visibility and dialogue across clinical areas, supporting staffing escalation • Adherence to best practice rostering processes. Preceptorship framework ensures standardised approach for new registrants who can fill shifts as registered nurse to support acheivement of workforce models and retention. OPEL safer staffing actions cards. •Internal pay enhancements profroma developed to support response to workforce pressures • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, •Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022. • Apprenticeship Strategy in place to support career pathways into nursing, AHPS • Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Role of the Clinical Site Matron and responsiblity for tactical command • Journey to Outstanding (J2O) processs, reviewers provided with information on staffing levels, eg ward information on vacancies and fill rates re; falls, pressure ulcers and friends and family test which will include an assessment of staffing levels. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes, People Strategy in place to support colleague health and well-being in line with national People Plan priorities • Quality and Safety oversight meetings in place for clinical areas where concerns exist on nurse sensitive indicators. • Safe staffing information presented to the Workforce and Quality Committee, • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitment and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. EQIA change process considers staffing position to avoid negative impact for staff and patients • Safe, Sustainable and Productive Staffing meeting meets alternative weeks which focuses upon the quality metrics associated with the staffing postion (Enhanced Dashboard Metric)	First line Twice daily staffing meetings . Alternative week review of the Enhanced Dashboard Metric that tracks CHPPD/FIll Rate and a number of staff metrics to track any potential harm as a result of staffing position Business Intelligence dashbaord provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. Review of workforce and quality metrics by Nursing, Midwifery and AHP Steering Group, with actions taken as needed Clinical Site Matron summary site reports which provide assurance of site staffing postion and action to respond to any concerns,. Second line Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM (remit for educational activities) Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Twice yearly report to Workforce Committee, Quality Committee and Board of Directors on safer staffing ?? for both oversight and scrutiny and assurance (January and July). Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. Add meeting dates Nursing and quality KPIs embedded in Integrated Performance Report. J20 reports presented to divsional PSQB provide opportunity for staff to feedback concerns re: staffing position to the division Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive - check date Dec QC Third Line Vacancy information reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies. Preceptorship framework approved by NHS England for newly registered nursing (December 2023)	At periods of operational pressure, insufficent workforce availability to meet demand above core bed base and in community services. Action: Ongoing use of bank and agency staff and derogated staffing models in place as per OPEL action staffing cards. Unable to control use of extra capacity wards Action: Engagement in length of stay improvement work and nursing representative at tactical meetings to manage staffing position Lead: Associate Director of Nursing Resilience, Acute Flow and Transformation Directorate	Understanding data re:vacancies at Band 6 and above to drive recruitment and workforce development Action: Understand turnover in band 6 staff and above and amend recruitment plan accordingly Lead: ADN Corporate Nursing, March 2024 Need for discussion on skill mix issues created by a combined effect of high proportion of new graduate nursing workforce and internationally educated nurses Action: Learning needs analysis and training and education delivery plan by March 2024 Lead: ADN Corporate Nursing	4x4 = 16	4x3 = 12	3x3 = 9

Action	**Timescales**	**Lead**
Implementation of CQC must do action for maternity re staffing	See action plan	Director of Midwifery
Use of bank and agency staff to meet demand	Ongoing	ADN Corporate Nursing
Length of stay improvement work and invovlement in tactical meetings re staffing	Ongoing	Deputy Chief Nurse
Understand turnover for Band 6 and amend recrutiment plan	March 2024	ADN Corporate Nursing
Learning needs analysis and training and education delivery plan	March 2024	ADN Corporate Nursing

Links to risk register:
Risk 6345 - nurse staffing risk, 7994 enhanced care nursing staff,

BOARD ASSURANCE FRAMEWORK
FERBUARY 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2024 Risk Category: Workforce Risk appetite: Low		
								Initial	Current	Target
6/23 January 2024	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Midwifery daily oversight and staffing meetings with ,maternity escalation plan to mitigate risk •Senior midwifery leadership rota provides ongoing visibility and dialogue across clinical areas, supporting staffing escalation • Adherence to best practice rostering processes. • OPEL safer staffing actions cards. • Role of the Clinical Site Matron and responsiblity for tactical command • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety • Internal pay enhancements profroma developed to support response to workforce pressures Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. 20% bank enhancements continues for maternity workforce to encourage uptake of shifts. •Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022. • Flexible approach to maternity staffing includes registered nurses working in maternity services •Maternity Transformation Programme Board has oversight of 3 year maternity delivery plan and associated actions to manage risk, including staffing •Apprenticeship Strategy in place to support career pathways into midwifery • International recrutiment of mdiwives and sysytem wide recruitment across local maternity system (LMS) • E-roster system in place • Journey to Outstanding (J2O) processs, provides opportunity for staff to feedback on staffing levels. • Quality and Safety governance meetings for monitoring metrics and standard KPIs, eg 1:1 care in labour, • Safe staffing information on midwifery presented to the Workforce and Quality Committee, with direct report from Director of Midwifery to Quality Committee • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitement and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. • Safe, Sustainable and Productive Staffing meeting meets alternative weeks which focuses upon the quality metrics associated with the staffing postion (Enhanced Dashbaord Metric)	First line Daily staffing meetings provide an on the day repsonse to staffing position, Business Intelligence dashbaord provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. The activity undertaken within the Nursing, Midwifery and AHP Steering Group which has a workplan focused upon responding to the insufficient staffing position by determing programmes of work related to recrutitment and retention and compliance with a number of metrics (as above) Clinical Site Matron summary site reports which provide assurance of site staffing postion and action to respond to any concerns,. Second line Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Twice yearly report to Workforce Committee, Quality Committee and Board of Directors on safer staffing (11.1.24),for both oversight and scrutiny and assurance (January and July)Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. KPIs embedded in Integrated Performance Report. J20 reports presented to FSS PSQB providing an assessment of the staffing position Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive Third Line Performance reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies Maternity CQC report from visit June 2023 confirms leaders had responsive approach for managing midwifery staffing shortages to mitigate risk. Maternity Voices partnership ensures regular patient feedabck on experience of care	National shortage of registered midwives impacting on staffing recuritment pipeline: Action: Commissioning use of the birth rate plus tool, revised workforce models in line with current birthrate, international recruitment Bid submitted to Business Case Approvals Group (BCAG) awaiting outcome- expect to reduce budgeted wte actions Nursing, Midwifery & AHP Steering Group to review this risk February 2024, lead Deputy Chief Nurse	CQC maternity report (August 2023)- requires improvement for safe domain. CQC action plan in response to safe "must do" re qualified staff for monitoring by Maternity Transformation Programme Board. Director of Midwifery	4x4 = 16!	4x4 = 16	3x3 = 9

Action	Timescales	Lead
Implementation of CQC must do action for maternity re staffing	See action plan	Director of Midwifery
Use of bank and agency staff to meet demand	Ongoing	ADN Corporate Nursing
Plan to re run birth rate plus tool to support review of WFM	March 24	Deputy Chief Nurse
Supporting newly recruited Midwives and international midwives through preceptorship and supernummerary periods - March 24		ADN Corporate Nursing
		ADN Corporate Nursing

Links to risk register:
6911 midwifery workforce

BOARD ASSURANCE FRAMEWORK
FERBUARY 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant**		
11/19	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale.	• Actions developed as part of the Colleague Retention Programme • Proposed approach for Board recruitment alongside Board Diversity Action Plan • Workforce Design and Transformation in AHPs leading to improved recruitment and retention • Expanded International Recruitment pathways for all AHPs • Workforce Planning for 2024/25 underway • Recruitment strategy embedded and forms part of People Strategy • Recruitment events in place for 2023/4 – 4 large scale events to take place • Review of social media approach • Initial review of inclusive recruitment processes undertaken • Internal career planning guidance document to support 'grow our own' being developed • Progressed into implementation phase for values based recruitment • OD Plan developed • Deployed a screening tool for values and behaviours as part of the onboarding process. • Board to agree Succession Planning approach which links to co-ordinated talent management pipeline programme including Empower programme and Enhance talent approach • Inclusive Leadership is one of the modules within our core Leadership Development programme. Each module is a three hour education session with action to implement practical application of the learning. Check in sessions will then be held to collate evidence of the application which will enable the organisation to monitor the growth of inclusive leadership. • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Refreshed our values and behaviours - to be incorporated in values based recruitment • Workforce design methodology developed to support with workforce remodelling and reconfiguration • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. • Further work undertaken to widen Trust welcome, induction and onboarding. This will be followed by further work to embed colleague journey after day one	<u>First line</u> • Clinicians leading of transformation programmes • Recruitment to key roles across the Trust - see BAF risk 10a • Values Based Recruitment • Workforce Design Hot House event programme developed for roll out • Revised Workforce Report to Workforce Committee to monitor key workforce indicators <u>Second line</u> Integrated Performance Report and Workforce Committee reports show Turnover of 7.65% Reduction in vacancies to 388.772 Revalidation report to Board. KP+ for workforce metrics live from February 2024 Colleague Retention Programme Paper taken to Workforce Committee on 18 December 2023 Deep dive of this risk at Workforce Committee 19.02.24. <u>Third line</u> GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT Trusts.	• Lack of comparative workforce data for medical and AHP staff groups compared to nursing, due to the delayed implementation of e-rostering. **ACTION**: Complete refreshed medical e-rostering roll-out by March 2024. Expand utilisation of e-roster across all AHP teams and development of reporting capability. • Review of inclusive recruitment approaches **ACTION**: further work to be undertaken to embed inclusive recruitment by March 2024.		**Initial**	**Current**	**Target**
								4x4 = 16	**3x4 =12 =**	**3x3 = 9**

Actions	**Action, Lead, Timescales**	**Lead**
Further work to be undertaken to embed inclusive recruitment	31/03/2024	Suzanne Dunkley
Complete roll-out of e-rostering for Medical and AHPs	31/03/2024	David Birkenhead/Lindsay Rudge

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FERBUARY 2024
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk Category: Workforce Risk appetite: Low**		
								Initial	**Current**	**Target**
1/22 June 2022 refreshed June 2023	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / Quarterly Pulse Survey	• 2024/25 Engagement Calendar created • Wellbeing Advisors will be more closely aligned to and embedded in divisional activity via a transfer into Division (Divisions will directly manage wellbeing activity/wellbeing advisors) • Launched CreditUnion • Launch of salary advance through WageStream in February 2024. • Enhancing our top up shop approach by engaging in a partneship with Neighborly • Workforce Psychologist training volunteers on peer support critical incident debriefing • Management fundamentals wellbeing section • New to manager programme wellbeing section • Appreciation week held twice a year • High impact action plan relating to staff survey • Employee Assistance Programme through CareFirst • Friendly Ear Service • 50 Health and Wellbeing ambassadors to engage with colleagues across all services areas as investing in employee wellbeing • Health and Wellbeing Risk Assessment available to all colleagues. • Development of Workforce Psychology offer • Weekly Wellbeing advisor walkarounds • Suicide prevention resource pack • Appraisal documentation with greater emphasis on health and well-being • Place-based funding for colleagues to access fast track MSK treatment. • 4 Hot Houses per year • Leadership conferences • External validation of our staff survey action plans and reflecting on results. • Colleague engagement focused on listening events, friendly ear and supportive events to engage colleague offering over difficult few years. A1 • Leadership visibility / walkarounds carried out by senior colleagues • Weekly Communication to staff by Chief Executive with Q&A session: operational update(Mondays), CHFT LIVE meeting (Wednesdays), Chief Exeutive Update (Fridays) • Freedom to Speak Up (FTSU) Guardian and ambassador network • CHuFT awards and monthly Star Award • One Culture of Care checklist to aid visibility visit and provide consistency • Colleague engagement groups, now expanded to include following networks: Women's Voices, Armed Forces, Carers, International Colleagues in addition to REN network, Colleague Disability Action Group, Pride. Network chairs meet regularly to share best practice. • Equality, Diversity and Inclusion events • Executive buddies assigned to staff survey hotspot areas • Appraisal workshops held • Activity being aligned to the NHS EDI Long Term Plan • EDI objectives now in appraisals	<u>First line</u> Monthly workforce monitoring meeting reviews all workforce data sets Monthly absence review meeting <u>Second line</u> Revised Workforce Report to Workforce Committee monitors key workforce indicators Sickness absence metrics reported to every Board meeting via the Integrated Performance Report. Quarterly metrics provided by CareFirst. PRMs monitoring roll out of staff survey actions Staff survey 2022 results and high impact actions presented to Board May 2023. Deep dive of risk to Workforce Committee People Heat Map <u>Third line</u> Quarterly People Pulse survey/ national staff survey Sickness absence benchmarking data through Model Health and Public View systems		Moving engagement and wellbeing activity to Divisions. Management have not received training yet. **ACTION** - Development tools and resources to upskill managers regarding engagement and wellbeing - 30 September 2024	**3x4 = 12**	**= 3x4 =12**	**1x4 = 4**

Action to address gap in control	**Action and timescale**	**Lead**
Development tools and resources to upskill managers regarding engagement and wellbeing	Sep-24	Head of Apprenticeships & Widening Participation

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024** **Risk Category: Financial / Assets** **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
14/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability not secured - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Business Case Approval Group, including forecasting and cash payment profiling. Prioritised capital programme agreed as part of 2023/24 financial plan including bring forward of items from 2024/25 into 2023/24. Historic delivery of the capital plan. Contingency set within annual plan Transformation Programme Board has oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience. Senior Finance participation in West Yorkshire Integrated Care System Capital Group which meets regularly to review capital forecasts from all partners to manage regional capital envelope and reports to ICS Finance Forum. Horizon scanning for external funding opportunities and bids for funding regularly submitted where these align with strategic objectives and managing risk.	First line Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes Second line Strategic outline case for reconfiguration approved by NHS E . Third Line Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Lead: Director of Finance Action: Representation to key bodies re: securing appropriate funding.	5 year capital plans submitted to ICS but longer term funding allocation process is still to be agreed by ICS partners. Lead: Director of Finance – Backlog maintenance costs will remain in excess of planned capital spend. Action: Internal capital spend is prioritised on a risk basis. Price not yet agreed for CRH reconfiguration works and remains subject to change. Progressing elements where possible. Construction partner presentations 22nd Jan 2024. Approval of Full Business Case Lead: Chief Executive, Director of Partnerships and Transformation and Director of Finance Treasury approval of reconfiguration business case . Action: Close monitoring of Treasury plans via NHS E on behalf of Trust	4x5 = 20	4x3 = 12	3x4=12

BOARD ASS

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through Finance &Performance Committee and Board	Ongoing	Director of Finance

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024 Risk Category: Financial / Assets Risk appetite: Moderate**		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash suppport. Whilst the Trust is developing a business case to support financial sustainability in the medium term, this plan is subject to approval and the release of capital funds **Impact** - financial sustainability not secured - increased regulatory scrutiny - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Place based recovery monitored at WY Finance and Performance Committee Budgetary control process with increased profile and ownership Turanround Executive (meets weekly, with Deputy Chief Executive Chair) monitoring cost improvement plan delivery in year and development of 5 year cost improvement plans. Accurate activity, income and expenditure forecasting Development of 25 year financial plans in support of Business Case Standing Financial Instructions set authorisation limits, Audit and Risk Committee in place to monitor key areas of compliance. Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes.	First line Reporting on financial position, cash and capital through divisional Boards, Performance Review meetings and Exec Board monthly. Capital Management Group meeting receives capital plan update reports Second line Scrutiny at Finance & Performance Committee & Board. Reports on progress with strategic capital to Transformation Programme Board. Board Finance reporting.ICS submitted balanced financial plan for 2023/24 with risks clearly articulated to NHSE. Internal audit report on efficiencies - significant assurance April 2022. WYAAT Board to Board event September 2022 re: efficiency identified themes for new WYAAT strategy. Third line NHSE deep dive of financial position 7.6.23. ICS Director of Finance assured re Trust financial management systems.–Action plan monitored through Finance & Performance Committee.Monthly return to NHS E and ICB. CRH Outline Business Case submitted November 2021	Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. PFI commercial negotiaition and approval required to progress. Action: Continued liaison with regulator and HM Treasury Lead: Chief Executive Limited additional revenue costs have been included for the development of the Reconfiguration Business Case. Inability to remove beds in line with annual plan resulting in additional financial pressures (from 4/23 targets).	PLACE based recovery plans still to be developed. Action: Development of plans to drive efficiences across the Kirlees and Calderdale PLACE Lead: Partnership reps, CHFT Director of Finance, Director of Transformation and Partnerships, Chief Operating Officer Timescale:April 2024 Inability to remove beds in line with annual plan resulting in additional financial pressures.	**5x5 = 25**	**4x4 = 16**	**3x4=12**

Action	**Timescales**	**Lead**
System financial recovery plans to be developed led by external resource	May-24	Director of Finance

Links to high level risk register risks: None
See BAF risks 10a/19, 10b/19 and 6/23 re workforce shortages

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

Ref & Date added	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2024 Risk Category: Strategic Risk appetite: Significant		
								Initial	Current	Target
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	Risk of climate action failure and not improving our environmental sustainability, including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS who is the Trust's lead for climate and sustainability. Connected into a range of West Yorkshire sustainability groups involving the WY Combined Authority, WYAAT and local Councils. System working - MD CHS Climate Commissioner for Kirklees Climate Commission to respond to the climate emergency across Kirklees and member of Calderdale Council Climate Action Group, developing a climate action plan for Calderdale. Green Plan approved and in place, aligned with ICS Green Plan, aims to reduce the impact of travel on the environment and reduce carbon emissions Green Planning Committee (meets monthly,attended by internal and external partners) chaired by MD CHS oversees delivery of sustainbility action plan, dashboard monitors the impact of the Green Plan, reports to Transformation Programme Board on quarterly basis. Travel Plan in place to support more active travel, less car use and more car sharing, Travel Co-ordinator monitors progress. Reconfiguration design and build principles led by a sustainability design brief and overseen by Transformation Programme Board. Green solutions - eg remote temperature monitoring at parts of HRI to reduce energy cost and carbon emission. Green solutions integral to HRI A& new build, eg air source heat pump for renewable energy, permeable paving, due to achieve excellent BREEAM sustainability rating Carbon Literacy Training of CHS senior management team. 100% energy bought from green sources and installation of LED lighting to reduce energy consumption. Light swtich off campaign. Signed up to NHS pledge to reduce plastic usage in hospital . Recycling awareness raising with staff to encourage correct waste disposal Asset tracking ensures live track of equipment and reduces wastage. Procurement Strategy ensures minimum 10% wighting for socal value wighting in all prucrement Funding bids to support sustainable activities by CHS, eg Salix Low Carbon Skills Fund for the development of the Trust's Heat Decarbonisation Plan. CHS awarded £46K to implement Coolnomix energy saving project at HRI, 5 22kw EV chargers installed as part of the ED development at HRI. 4 charging points at Acre Mill upgraded to integrate with the MER user app Digital Strategy supports sustainability - eg out patient transformation such as remote out patient appointments reduces travel, patient initiated follow up.	First line Monthly monitoring of the Trusts energy consumption Quarterly Update on progress with Green Plan and Sustainability Plan, via newly developed Green dashboard of key indicators to Transformation Programme Board. 44 of 47 travel plan actions complete. Green Plan - 163 of 206 actions complete. 12 month Trust-wide environmental calendar with focus on sustainable activities. Second line 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at 6 May 2021 Board meeting, following reviewed by Transformation Programme Board 8 March 2021. Green Plan shared with ICS. 2. Annual Board paper on sustainability/climate change, July 2023, May 2022 2022/23 Trust Annual Report details progress with sustanability. Third line:Share energy data records with NHS E on new NHS energy data platform	QIA sustainability impact assessment procedure to be reviewed along with business case applications for capital projects over £50,000 to ensure that sustainability is considered in business cases. Lead: Stuart Sugarman via Environmental Co-ordinator Timescale: June 2024 Lead: Stuart Sugarman Timescale to December 2024 Increase number Electrical Vehicle (EV) chargers at CRH: Lead: Stuart Sugarman Timescale: Multi Storey Car Park at CRH once built		4x4 = 16	4x2 = 8	4x2=8

Action	Date	Lead
12 month environmental calendar focsuing on sustianable activities	Jan - December 2024	Stuart Sugarman
Increased number of EV chargers	Once muli-storey car park at CRH built	Stuart Sugarman
Review QIA procedure and business case applications re sustainability	01/06/2024	Stuart Sugarman via
Green Plan to Overview and Scrutinty Committee	January 2024	Environmental Co-ordinator

No related risks on high level risk register

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2024
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2024** Risk Category: Partnership Risk appetite: Significant		
								Initial	**Current**	**Target**
2/23	Transformation programme Board	Chief Executive / Director of Transformation & Partnerships Deputy Chief E	**Risk** Risk that the Trust cannot maxiimise its impact as an anchor institution in local communities to demonstrate social value in employment, career and development opportunities from investments and use of resources due to competing priorities and lack of partnership working **Impact** unable to support broader economic and social development as required under new NHS Provider Licence	Transformation Programme Board has oversight of Trust work to support generation of social value and economic support in our local Places. The Trust has developed a social value action plan in relation to its major capital investments and is monitoring delivery against specific projects within the estate investment programme. Trust 1 and 5 year strategy aligned to ICS and 2 Place strategies, with specific strategic objectives re sustainability with progress reported to the Board quarterly . Trust Chief Executive and Chair are members of Calderdale and Kirklees Place based Integrated Care Boards. Director memebrship of Calderdale and Kirklees Health and Well Being Boards and therefore contribute to Place and WY ICS strategy. Strategic collaboration with Huddersfield University development of Health Academy for the local area - regulatr meetings and partnerhsip projects, e.g. Community Diagnostic Centre. Collaboration with Calderdale and Kirklees Further Education Colleges and voluntary sector to increase routes into employment in our local Places, e.g. T -Level Cadet Pathway. Widening Participation Team promote activities for disadvantaged young people, work experience placements, Project Search. Apprenticeship schemes. Work with the Purpose Coalition to tackle challenges facing patients, customers, colleagues and communiities and map Trust activities against the Purpose Goals.	**First line** Reconfiguration leadership team. HRI Project team manages social value for A&E delivery. Quarterly Updates on Trust Social Value actions and delivery reported to Transformation Programme Board. **Second Line** Transformation Programme Board highlight report to Board Progress report on strategic objectives to Board **Third Line** Updates to West Yorkshire ICS on social value generation via capital invetstment and use of local supply chain. Update to Calderdale Place-based Committee on social value quarterly. Levelling Up Impact Report from Purpose Coalition confirms Trust commitment to being a purpose-led organisation and plays a central role in its communities beyond healthcare service.	Communication and engagement of wider colleagues and partners of this work to inform and shape actions. Action: Share Levelling Up Impact Report and seek feedback on further opportunities to work with partners Lead: Deputy Chief Executive & Director of Transformation & Partnerships Timescale: March 2024 Stretch Trust performance as a local employer and anchor partner by implementing the recommendations of the Purpose Coalition. Lead: Oversight by Associate Director of Strategy Timeframe Update December 2023:	December 2023 update on progress with recommendations of the Purpose Coalition to WEB Lead: Associate Director of Strategy	**3x3 = 9**	**3x3 = 9**	**3x2= 6**

Action	**Timescale**	**Lead**
Share Levelling Up Impact Report and seek opportunities to work with partners. Implement recommendations of the Purpose Coalition as local employer (3) and anchor partner (2)	31 March 2024 March 2024	Deputy Chief Executive & Director of Transformation & Partnerships, Associate Director of Strategy
Links to high level risk register: None. See related BAF risk 3/23 re partnership duties, 6/20 sustainability, 7/20 health inequalities		

BAF Risks Review By Committee

REF	RISK DESCRIPTION	BOARD / COMMITTEE WITH OVERSIGHT
Transforming Services & Population Outcomes		
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	**Transformation Programme Board**
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	**Transformation Programme Board**
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	**Transformation Programme Board**
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	**Trust Board of Directors**
Keeping the base safe - best quality and safety of care		
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	**Quality Committee**
04/19	Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations	**Quality Committee**
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	**Transformation Programme Board**
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	**Audit and Risk Committee**
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of service due to failure to comply with quality statements resulting in a reduction of qualiy of services to patients and an impact on reputation.	**Quality Committee**
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	**Finance and Performance Committee**
3/23	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	**Trust Board of Directors**
4/23	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	**Finance and Performance Committee**
5/23	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack	**Audit and Risk Committee**

Inclusive workforce and local employment		
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
6/23	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	**Workforce Committee**
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.	**Workforce Committee**
1/22	Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change	**Workforce Committee**
Financial, Economic and Environmental Sustainability		
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	**Finance and Performance Committee**
18/19	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash support.	**Finance and Performance Committee**
06/20	Risk of climate action failure and not improving our environmental sustainability	**Transformation Programme Board**
2/23	Risk that the Trust cannot maximise its impact as an anchor institution in local communities to demonstrate social value	**Transformation Programme Board**

ACRONYM LIST

BAF	Board Assurance Framework
BTHFT	Bradford Teaching Hospitals NHS Foundation Trust
CCIO	Chief Clinical Information Officer
CNIO	Chief Nursing Information Officer
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
ASSURAN	Calderdale Huddersfield Solutions LTD
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HPS	Huddersfield Pharamcy Specials
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ICB	Integrated Care Board
ICS	Integrated Care System
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators

Outline Business Care
Overview and Scrutiny Committee
Private Finance Initiative

TMA	Transitional Monitoring Approach
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
DHSC	Department of Health and Social Care
IPC	Infection Prevention Control

	New risk
	Breach of risk appetite/ risk exposure
1-6	Low risk
8-12	Medium risk
15-25	High risk

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
JH	Jonny Hammond, Chief Operating Officer
RB	Rob Birkett, Chief Digital and Information Officer
AM	Andrea McCourt, Company Secretary
VP	Victoria Pickles, Director of Corporate Affairs
SS	Stuart Sugarman, Managing Director CHS
BB	Brendan Brown, Chief Executive
RA	Rob Aitchison, Deputy Chief Executive
LR	Lindsay Rudge, Chief Nurse
KA	Kirsty Archer, Deputy Director of Finance
ALL	All Board members

21. NHS Core Standards for EPRR – Progress Update on the EPRR Action Plan

Presented by Jonathan Hammond, Chief Operating Officer and supported by Sarah Rothery, General Manager, Resilience, Acute Flow and Transformation

To Note

Presented by Jonathan Hammond

Date of Meeting:	Thursday 7th March 2024
Meeting:	Board of Directors – Public Board
Title:	**NHS Core Standards for EPRR – An Update the Progress Against the Core Standards for EPRR Action Plan**
Author:	General Manager for Resilience, Acute Flow and Transformation
Sponsoring Director:	Chief Operating Officer
Previous Forums:	NHS Core Standards for EPRR Statement of Compliance was presented at Board of Directors on 11th January 2024
Purpose of the Report	The purpose of the report is to present to the Board of Directors in Public Board an update of the progress against the Core Standards for EPRR action plan. The report aims to indicate where progress has been made and highlight areas of concern.
Key Points to Note	NHS providers must plan for, and respond to, a wide range of incidents and emergencies that could affect patient health and delivery of care. Emergency Preparedness, Resilience and Response (EPRR) is a programme of work that is underpinned by a set of a Core Standards. Demonstrating compliance to the Core Standards gives assurance that the Trust is prepared to respond to incidents whilst maintaining critical services. **<u>Civil Contingencies Act (2004)</u>** CHFT is a Category 1 responder under the Civil Contingencies Action 2004 (CCA 2004) and so that it can perform its critical activities in the event of an emergency or business interruption, the CCA 2004 states Category 1 responders are required to: • Assess the risk of emergencies occurring and use this to inform contingency planning. • Put in place emergency plans. • Put in place a business continuity management led process to identify and mitigate risks. • Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform

and advise the public in the event of an emergency. Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

NHS Core Standards for EPRR Assessment 2023

Following a rigorous assessment process for the Core Standards for EPRR assessment in 2023, the statement of compliance was presented to the Board of Directors in January 2024, with an overall position of 'non-compliant'. Of the 62 applicable standards, 19 were assessed to be fully compliant, 43 partially compliant and 0 (zero) non-compliant.

An action plan was produced and under the assessment framework 2023, Trusts marked as non-compliant have a requirement to provide an update against action plan progress at the quarterly Local Health Resilience Partnership (LHRP) meetings and also provide updates to the Board of Directors.

Action Plan

A comprehensive action plan was developed using the Core Standards action plan template (Appendix 1). The assessment framework requires all standards assessed to be partially compliant or non-compliant to have an action(s) developed against them. This is notwithstanding the existing fully compliant standards which also require ongoing maintenance to maintain compliance.

At CHFT all partially compliant Core Standards have been put into an Action Plan and split into three categories:

- **Category 1** actions are locally controlled actions and should be completed by end of April 2024.
- **Category 2** actions are locally controlled actions which are expected to take at least 8 months to achieve and therefore should be completed by end of August 2024.
- **Category 3** actions have an interdependency with other organisations and therefore are, to some degree, reliant upon other organisation's action plans (i.e. the ICB or NHS England). These should be completed by end of August 2024.

The action plan was categorised according to the above criteria, and is shown in Table 1 below:

Table 1 – Number of actions per category

Category 1 Actions	16
Category 2 Actions	21
Category 3 Actions	6

Assurance

The Board of Directors can be assured that work to achieve compliance against the Core Standards is being prioritised within the EPRR function in the Resilience, Acute Flow and Transformation (RAFT) Directorate. The action plan is proving to be an effective tool to support the co-ordination of actions to ensure that progress is planned and monitored against each Core Standard.

It is the overall ambition of the Accountable Emergency Officer of the Trust to aim to achieve at least 77% compliance in the 2024 assessment. The action plan supports progress to be made against each Core Standard currently rated partially compliant before the end of August 2024. It is expected, but not yet confirmed, that the Core Standard assessment in 2024 will follow a similar rigorous process as that held in 2023. At time of writing, the submission deadline for 2024 is currently unknown and therefore our action plan is scheduled to run up to the end of August 2024. This is one month prior to the submission date that was in place in 2023 (29th September 2023) to mitigate risk of an earlier submission date, or equally provide a buffer.

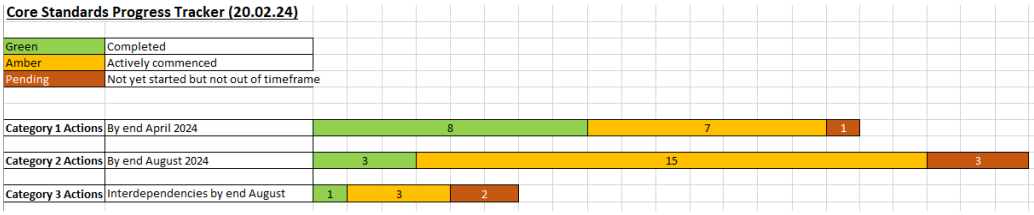
Progress of completion against each Core Standard as at time of writing is shown in Table 2 below:

Table 2 – Progress of Core Standards Actions (as at 20.02.24)

	Category 1	Category 2	Category 3
Complete	8	3	1
Active	7	15	2
Pending	1	3	2

Figure 1 shows the Core Standards position in an Action Tracker format. The Action Tracker can also be found at Appendix 2 to this report.

Figure 1 – Core Standards Action Tracker (20.02.24)



Areas of Concern

There are no actions are currently breaching the Category timeframe. All Category 1 actions have a timeframe for completion for the end of April 2024. The progress tracker shows that 50% of Category 1 actions have been completed. Whilst this demonstrates excellent progress, there is more work to do in the forthcoming weeks. Table 3 shows the Category 1 Core Standards that are currently an amber status (a review has commenced but not complete):

Table 3 – Category 1 Core Standards - Amber

Core Standard	Standard Title
Core Standard 7	Risk Assessment
Core Standard 14	Countermeasures
Core Standard 21	Trained On-call Staff
Core Standards 24	Responder Training
Core Standard 48	Testing and Exercising
Core Standard 52	BCMS Continuous Improvement
Core Standard 55	HAZMAT/CBRN Governance

Table 4 shows the Category 1 Standard that is currently pending to commence active review:

Table 4 – Category 1 Core Standards - Pending

Core Standard	Standard Title
Core Standard 61	HAZMAT/CBRN Equipment PPM

Actions are in place for all the above and at time of reporting there are no concerns that these Standards will not progress towards completion by the end of April 2024.

Some concerns relate to the Category 3 actions that have interdependencies with other organisations. A collaborative working group across WY providers has been established due to the unsustainable ask for the WY ICB to hold individual meetings with each provider who are rated as partially or non-compliant. The working group, attended by CHFT, is ICB-led and meets fortnightly with a Core Standard review schedule spanning November 2023 to June 2024. Some Core Standards that have interdependencies are scheduled for discussion in April / May 2024 which presents a time pressure for the Trust and is therefore factored into the action plan. Table 5 shows the Core Standards that have interdependencies and are currently amber (active review) or and Table 6 shows Category 3 standards pending an active review.

Table 5 – Category 3 Core Standards - Amber

Core Standard	Standard Title
Core Standard 13	New and Emerging Pandemics
Core Standard 15	Mass Casualty
Core Standard 19	Excess Fatalities

Table 5 – Category 3 Core Standards - Pending

Core Standard	Standard Title
Core Standard 39	Mutual Aid Arrangements
Core Standard 43	Information Sharing

EQIA – Equality Impact Assessment	Emergency Preparedness, Resilience and Response (EPRR), Fire Safety, Health and Safety and Security Risk Management are key Trust priorities to support the safety and security of staff, patients, visitors, and property. The delivery of high standards of emergency preparedness and safety ensures staff and organisational resilience. The EPRR Core Standards report aims to implement measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.
Recommendation	It is recommended that the Board of Directors: • **RECEIVE** and **NOTE** the Core Standards position presented (as at time of writing – 20th February 2024) • Is **assured** that an action plan is in place and being actively monitored.

Appendices

Appendix P2 – Supporting Slides
Appendix P3 – Core Standards Action Plan
Appendix P4 – Core Standards Action Tracker

NHS
Calderdale and Huddersfield
NHS Foundation Trust

NHS Core Standards for Emergency Preparedness, Resilience and Response

An Update on the Core Standards Action Plan

Board of Directors – Public Board

7th March 2024

Sarah Rothery

General Manager for Resilience, Acute Flow and Transformation

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Civil Contingencies Act (2004)

- NHS providers must plan for, and respond to, a wide range of incidents and emergencies that could affect patient health and delivery of care. Emergency Preparedness, Resilience and Response (EPRR) is a programme of work that is underpinned by a set of a Core Standards.

- CHFT is a **Category 1** responder under the Civil Contingencies Action 2004 (CCA 2004) and is required to:
  - Assess the risk of emergencies and use this to inform planning
  - Put in place emergency plans
  - Put in place business continuity led management led process to identify and mitigate risks
  - Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
  - Share information with other local responders to enhance co-ordination
  - Co-operate with other local responders to enhance co-ordination and efficiency

- Readiness to respond is assessed against a set of Core Standards for EPRR on an annual basis

Core Standards – Confirm and Challenge Findings

Calderdale and Huddersfield NHS Foundation Trust

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

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

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Action Plan

At CHFT all partially compliant Core Standards have been put into an Action Plan and split into three categories:

- **Category 1** actions are locally controlled actions and should be completed by end of April 2024
- **Category 2** actions are locally controlled actions which are expected to take at least 8 months to achieve and therefore should be completed by end of August 2024.
- **Category 3** actions have an interdependency with other organisations and therefore are, to some degree, reliant upon other organisation's action plans (i.e. the ICB or NHS England). These should be completed by end of August 2024.

Category	Number of Actions
Category 1	16
Category 2	21
Category 3	6

Assurance

- The Board of Directors can be assured that work to achieve compliance against the Core Standards is being prioritised within the EPRR function in the Resilience, Acute Flow and Transformation (RAFT) Directorate

- The Action Plan is proving to be an effective tool to support the co-ordination of actions to ensure that progress is planned and monitored against each Core Standard.

- The Action Plan supports progress to be made against each Core Standard currently rated partially compliant before the end of August 2024.

- This is one month prior to the submission date that was in place in 2023 (29th September 2023) to mitigate risk of an earlier submission date, or equally provide a buffer.

Action Tracker

Calderdale and Huddersfield NHS Foundation Trust

Core Standards Action Tracker (20.02.24)

Green	Completed
Amber	Actively commenced
Pending	Not yet started but not out of timeframe

Category 1 Actions	By end April 2024	8	7	1
Category 2 Actions	By end August 2024	3	15	3
Category 3 Actions	Interdependencies by end August	1	3	2

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Concerns

- There are no actions are currently breaching the Category timeframe.
- Seven Category 1 Core Standards (numbers 7, 14, 21, 24, 48, 52 and 55) are currently an amber status (a review has commenced but not complete) and one (number 61) is still pending review to commence
- Actions are in place for all the above and at time of reporting there are no concerns that these Standards will not progress towards completion by the end of April 2024.
- Some concerns relate to the Category 3 actions that have interdependencies with other organisations.
- A working group, attended by CHFT, that is ICB-led meets fortnightly with a Core Standard review schedule spanning November 2023 to June 2024, and covers the Category 3 Core Standards (numbers 13, 15, 19 and 39)

Ref	Organisation Name		Calderdale & Huddersfield NHS Trust	Final check & Challenge position	Accepted or Challenged	Action Category	Action to be taken	Lead	Timescale	Action Status	Comments
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	A	Accepted	1	**September 2023** - Agreement with AEO and Trust Secretary for a Resilience Statement to be included in the Trust Annual Report 2023/24, and onwards. **January 2024** - Core Standards submission informaiton was presented at Public Board (11.01.24). SR was asked to return for the March 2024 Public Board Meeting and provide an update against the Core Standards Action Plan. Annual Report 2023 produced for EPRR and Business Continuity. Working htrough governance - on track for Board May 2024	SR	In line with Board report publication timescales. Annual Report to go through governance from February 2024	G	**26.01.2024 -** AM to contact SR for narrative at the end of the financial year. **07.02.24** - Following on from ICB Core Standards Tracker Meeting. Good practice documents include. -Governance Structure with committees that receive papers -Terms of Reference for committees that receive reports -Minutes from meetings that receive reports -EPRR Policy with requirements around EPRR Board reporting and updates to committees. -Annual report and accounts with section on EPRR
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	A	**Secondary challenge**	2	Assessment of the ongoing (2024 onwards) workload and priorities of EPRR through development of comprehensive action plans Align the CHFT EPRR resource to the workload and priority assessment - highlight gaps if indicated EPRR resource for 2024/25 sign off at Exec Board (to take via WEB quarterly updates) Await the Board Statement from AJ. (Action from WY ICB Core Standards Tracker Meeting).	SR / KB (oversight - GB) SR (oversight - GB) SR	March 2024 Feb 2024 March 2024 Awaited	A	**December 2023** - Meeting arranged with KB and SR to begin workload and priorities assessment for 08.01.2024. **26.01.24** Not yet achieved - need GB input into the resource requirements **07.02.24** - AJ from LYPFT has agreed to support the development of a Board Statement on EPRR Resource for sharing. The statement will include contingencies for unexpected additional workload and will cover an assessment of capacity versus demand. This will be submitted to NHS E to approve and confirm compliance for all providers. To be adapted by CHFT. **18.02.23** - Booked on WEB 14/03/23 to provide an update. Take EPRR resource assessment
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	A	Challenge accepted by organisation	2	Update the current annual workplan to include actions and learning from exercises and incidents (lessons action tracker) Include the governance process by which identifying lessons from incidents and exercises takes place within the EPRR Policy in order to ensure that they are captured centrally and embedded across the organisation Report lessons learned to Board through the Annual Report (or more frequently, as required) Include a lessons learned standing agenda item on the Resilience and Safety Group meeting	KB SR SR (oversight JH - Board Report sponsor) SR	By end March 2024 May 2024 December 2023 (next Annual Report) November 2023 (next RSG)	G	**26.01.24** - Some work to do but expect to compliant in time. **07.02.24** - Following the ICB Core Standards Tracker Meeting. Note stating that there is a requirement for the continuous improvement process is to include a governance pathway to board. On track to full compliance.

7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	A	**Secondary challenge**	1	Work to align EPRR risks to the wider schedule of risks as set out on the National Risk Register and Community Risk Register (for West Yorkshire) Assess the scoring of local risks, in line with scoring of risks on the NRR and CRR Add the ICB Risk Management Process to our EPRR Policy	SR SR SR	March 2024 March 2024 March 2024	A	**08.12.23 -** Scheduled to SR diary for 14.12.23. **26.01.24** - SR to take proposed new risk scores to RSG - February 2024. **07.02.24** - Following ICB Core Standard Tracker Meeting - ICB and Locala were rated compliant for this standard (Consider adding the ICB Risk Management Process to our EPRR Policy (rated compliant)). ICB also attached NHSE Risk Managment Framework.
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	A	Challenge accepted by organisation	2	Review the Major Incident Plan in line with the EPRR Framework 2022 and best practice principles of Command and Control Take revised plan through governance Undertake a review of the roles and the associated action cards within the MIP Clarify the C&C arrangements across dual site Trust within plans (one C&C) Explain the role of the ICC better within the MIP Add loggists and transfusion to call cascades. Review call cascades in general Add process for using WhatsApp for cascade of mesaging	SR / KB (oversight - GB) SR (oversight - GB) SR / KB (oversight - GB) SR SR KB KB / SR	Aim for final draft - end April 2024 April / May 2024 April 2024 April 2024 April 2024 January 2024 April 2024	A	**26.01.24** - C&C Framework drafted. MIP to be reviewed following approval C&C Framework.
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	A	**Secondary challenge**	2	Make clear the management of arrangements for dealing with HCIDs within the IPC policies Meet with Belinda / IPC team to discuss process for managing this indicator Catch up in June for process made by IPC	Belinda Russell (IPC) KB / SR SR / KB / BR	March 2024 Meeting 08/01/24 Meeting 11.06.24	A	Email sent to Belinda 09.11.23 **January 2024** - Meeting arranged for 08.01.24 with belinda Russell IPC. **08.01.2024 -** KB sent through screen shot of evidence sent for the 2023 Core Standards and the Evidence Requirments Slide. SR forwarded comments received by NHSE following 2023 Submission. Deadline for BR is July 2024. **26.01.24** - KB to schedule meeting for beginning of June - arranged for 11.06.24

13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	A	Accepted	3	Pandemic Flu Plan reviewed by IPC and ED. Now working through governance. For sign off through required channels Await updated guidance from NHSE on pandemic flu guidance. ICB Core Standard meeting on this standard is scheduled for 15 and 22 May 2024	Belinda Russell (IPC)	December 2023 May 2024	A	Emailed BR on 08.12.23 asking if this was approved at IPC Board. **08.01.24** - BR confirmed Pandemic and New Emerging Pandemics was approved in October 2023. BR to send narrative of learning following live test during Dec 2023 / Jan 2024 Flu surge and to amend the plan in July 2024 to go through Governance August 2024. **26.01.24** - SR contacted BR for narrative of learning - still not received. Fortnightly ICB Meetings scheduled Pandemic Flu to be discussed on 15th and 22nd May. Meeting with BR arranged for 11.06.24
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	A	Challenge accepted by organisation	1	Training and Testing on countermeasures - requesting and receiving - to be undertaken by pharmacy Produce clear guidance for staff on how to activate Countermeasures and the requirement for mass countermeasures arrangements to include arrangements for administration, reception and distribution of mass prophylaxis in addition to mass vaccination - put these procedures into the MIP once agreed	Elisabeth Street (Pharmacy) Elisabeth Street (Pharmacy) and KB / SR	December 2023 March 2024	A	Email to Elisabeth Street 24.10.23 **January 2024** - SR forwarded the Countermeasures Reserve Stock Access Guidance NEY to Pharmacy. **26.01.24** - SR/KB to contact Northern Lincolnshire & Goole Trust and South Teeside Trust for their best practice procedure. **07.02.24** - Following the ICB Core Standards Tracker Meeting - LS sent the NHS E letter on Countermeasure (Contacts etc.). CHFT have insterted the informaiton into our HAZMAT Plan). **20.02.24 -** contacted Northern Lincolnshire & Goole - await reply
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	A	Challenge accepted by organisation	3	Revise arrangements to respond to mass casualty incidents which covers Burns, specific paediatric considerations and guidance on actions to be taken (letter details to be added to plans in review) Take Major Incident Plan (with mass casulaty response) through governance for sign off Await work from WY ICB on mass casualty dispersal and mass casualty plan ED MIP specific plan to include the mass casualty arrangements	Huw Masson (ED) SR (oversight - GB) WY ICB Huw Masson (ED)	By end April 2024 Commence May 2024 Awaited January 2024	A	**26.01.24** - Fortnightly ICB Meetings scheduled - Mass Casualty to be discussed on 15th and 22nd May **07.02.24** - Following ICB Core Standards Tracker Meeting - LS confirmed that NHSE Letter on Burns Arrangements details to be added to plans. **20.02.24** - ED draft Majax plan drawn up - to be reviewed within 8 weeks and rolled to other services when agreed
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	A	Challenge accepted by organisation	2	Revise Plan alongside revised national framework 2023 - https://www.england.nhs.uk/long-read/evacuation-and-shelter-guidance-for-the-nhs-in-england/ and in regards to transport arrangements Firm up arrangements with partners for transporting patients	SR / KB / KRawnsley SR / KB / KR	April / May 2024 April / May 2024	Pending	**26.01.2024** - not commenced review but not out of schedule

17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	A	Accepted	2	Update The Lockdown Plan to reflect the new ED at HRI and security controls at both sites Exercise the Plan Once reviewed liaise with Communications and IT regarding screensaver alerts notifying staff of a critical incident and lockdown.	Richard Hill (H&S) Richard Hill (H&S) Karen Bates (Resilience Support) Karen Bates and Sarah Rothery	By end March 2024 By end May 2024 Summer 2024	A	**December 2023** - KB Forwarded the Lockdown Plan to RH on 08.12.23. Meeting arranged to discuss requirements on 03.01.24. **26.01.24** - no update from RH - to follow up at next Action Plan review. **05.02.24** - RH confirmed Lockdown plan under review
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	A	Challenge accepted by organisation	2	Review the VIP Plan to include setting out a plan with regards to the estates, governance and security management arrangements for protected individuals (such as prisoners admitted as patients or high risk prisoners attending appointments) Then take through governance for sign off	Victoria Pickles (Corportate Affairs) and Richard Hill (Security)	By end March 2024 April / May 2024	A	**December 2023** - Meeting to be held between Wakefield Prison, SR and RH on 11.12.23 regarding risk assessment. Process to be added to the VIP IRP including Security Management and Governance. **26.01.24** - Another meeting scheduled regarding Prisoner Admissions on 08.03.24. At next Action Plan Review - remind VP to undertake VIP Plan. **12.02.24** - Airedale's Escorted Prisoner attending for treatment procedure added to our VIP Plan. Once receive SR comments, then forwarding to all services mentioned in the plan for their comments etc.
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	A	Challenge accepted by organisation	3	Await work from ICB on WY mass fatalities plan Include the following elements during the revision of the Major Incident Plan: specific expectations in managing psychosocial support for bereaved families associated with mass casualty incidents and the health role in dealing with mass fatalities. MIP to state activate the business continuity procedures for mortuary in a mass fatality incident	ICB (Awaited) SR / Huw Masson (ED) KB / SR	Awaited (may 2024 ICB meetings) April / May 2024 April / May 2024	A	**26.01.24** Fortnightly ICB Meetings scheduled Mass Fatalities to be discussed on 15th and 22nd May

20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	A	**Secondary challenge**	1	Conduct a modelling exercise to confirm On Call arangements are sufficient and effective - in C&C Framework To develop a Command and Control Framework document explicitly setting out the command structure in and out of hours and the responibilities - at all levels including role, frequency, phone availability, travel distance etc Explicitly describe the role and responibilities of On Call in the EPRR Policy (role, frequency, phone availability, travel distance etc) - can only be done after the C&C Framework is approved Align all IRPs to C&C Framework	GB (oversight - JH) SR SR KB / SR	By end December 2023 By end January 2024 April / May 2024 April / May 2024	G	**05.01.24 -** C&C Frameworek drawn up and sent to GB / KB / JH for comments **31.01.24** - Met with GB to confirm C&C arrangements and new edition produced **Feb 2024** - To present at WEB training session 21.03.24 and test in April
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	A	**Secondary challenge**	1	Subject to outputs from ICB Training Portfolio Working Group (CHFT are members) for the development of a TNA for incident responders - now shared with NHSE Regional team Continue to deliver incident response training Continue to promote mandatory attendance on the PHC Map training compliance against the TNA - developed with ICB - into portfolios	ICB SR / KB (oversight - GB) SR / GB SR / KB (oversight - GB)	Ongoing WEB training 21.03.24 and exercise 11.04.24 Ongoing (all attended) Launch - Delayed by NHSE - await new timescales and portfolio template	A	**26.01.24** - SR queried with Laura S on 12.01.24 if the draft TNA has been agreed by the regional team - awaiting response. ICB have informed that there is a meeting being rescheduled for w/c 29.01.24 with NHSE on training portfolios to agree new completion dates and when they are expecting to cascade the portfolios. WEB Training C&C Session booked for 14.03.24 - including attendance by YAS, WYP. PHC Training compliant - due to attend again 2025/2026 26.01.24 Fortnightly ICB Meetings scheduled Training to be discussed on 22nd May **20.02.24** - ICB informed on 21.02 that the mneeting for w/c 29.01 was not arranged and is now scheduled for 26.02.24. ICB have raised concerns about portfolios on behalf of providers (asked for a copy of the email - awaited). NHSE have dealyed the protfolio launch and timeframes - these are awaited. The portfolio template also awaited

22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	A	**Secondary challenge**	2	Subject to outputs from ICB Training Portfolio Working Group (CHFT are members) for the development of a TNA for incident responders Continue to deliver incident response training Continue to promote mandatory attendance on the PHC Strategic commanders must access & complete the courses on the TNA (where possible) Map training compliance against the TNA - developed with ICB - into portfolios (LHRP 24/11/23)	ICB SR / KB (oversight - GB) GB GB (oversight JH) SR / KB (oversight GB)	Ongoing WEB training 21.03.24 and exercise 11.04.24 Ongoing (all attended) By July 2024 Launch - Delayed by NHSE - await new timescales and portfolio template	A	**26.01.24** As above (CS 21) JH attended Legal Awareness. JH MAGIC Course requested. JH JESIP Course requested. GB attended JESIP. **26.01.24** Fortnightly ICB Meetings scheduled Training to be discussed on 22nd May **20.02.24** - Portfolios and TNA as per CS 21
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	A	**Secondary challenge**	2	Exercise debrief reports to inlcude a specific section for actions and learning to be documented Annual workplan to include testing and exercising action tracker showing actions / owners / timescales / completion for each exercise carried out Learning from exercises to be communicated into the Resilience and safety Group - standing agenda item Conduct communications tests every 6 months	KB KB KB KB / SR	Complete Complete Complete - November 2023 (next RSG) diaried for every 6 months going forward. Complete (April and October).	G	**26.01.24** - Tested new template of Post Exercise Report during Transport Exercise - 19.12.23. Annual workplan tab for action tracker - included actions for Transport Exercise Learning from Exercises standing agenda item on Resilience & Safety Group Meeting Scheduled to diaries every 6 months. **12.02.24** - Loggist Communication exercise carried out.
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	A	**Secondary challenge**	1	Subject to outputs from ICB Training Portfolio Working Group (CHFT are members) for the development of a TNA for incident responders Continue to deliver incident response training Continue to promote mandatory attendance on the PHC Strategic commanders must access & complete the courses on the TNA (where possible) Map training compliance against the TNA - developed with ICB - into portfolios (LHRP 24/11/23)	ICB SR / KB (oversight - GB) GB GB SR / KB	Ongoing 21.03.24 and 11.04.24 Ongoing By July 2024 Launch - Dec 2023 Completion - July 2024	A	**26.01.24** - As per CS 21

25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	A	Challenge accepted by organisation	2	Consider mandatory training on incident response as a Trust Also reliant on the outputs of the TNA development by ICB Log on risk register the gap in EPRR mandatory training requirements for ALL staff Update the EPRR Awareness leaflet Consider 6 monthly awareness leaflet circulation on Trust-wide email (decision to be made)	GB / JH ICB SR KB / SR KB / SR GB / JH	By end March 2024 Ongoing Complete (#8676 - pending approval) March 2024 March 2024	A	JH emailed J.Eddleston re mandatory training **26.01.24** - No progress.
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	A	Challenge accepted by organisation	2	Test the set up of the ICC Further develop the ICC set up instructions and room set up diagram - include in C&C Framework Check red sockets at CRH ICC Maps / diagrams to be put into the ICC Set Up (estates & facilities) Consider equipment for the ICC (telephone/radios etc) and reference use in the C&C Framework	KB / SR KB / SR KB KB / SR KB / SR	May 2024 January 2024 April 2024 December 2023 April 2024	A	Maps requested on 27.11.23 from Equans and Estates **28.11.23** Received and forwarded to SR to insert into Command and Control Framework. **26.01.24 -** Changed to a Priority 2 action. ICC Set up document drafted and will go to RSG in April 2024.
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	A	**Secondary challenge**	2	Loggists to be added to be call cascade Exercise contacting loggists in and out of hours for a response	KB SR	December 2023 February 2024	G	KB Completed and sent out to both Switchboard Managers / Hard copies printed and delivered to ICC's both sites on 23.11.23. Meeting arranged for 01.02.24 to arrange an in and out of hours communication test to Loggists. **12.02.24** - In Hours Loggist Communications exercise took place. An out of hours exercise arranged for Sunday 18.02.24.
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	A	**Secondary challenge**	1	Include the process for receiving, completing, authorsing and submitting SitReps as part of incident response within the C&C Framework Also include in the EPRR Policy Include a link to the C&C Framework in all IRPs (once complete)	GB / SR	January 2024 March / April 2024 March / April 2024	G	**26.01.24 -** Awaiting approval of C&C Framework. **07.02.24** - Received ICB Core Standards Tracker - Added AHFT Sitrep information into our EPRR Policy, MIP and C&C Framework.

33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	A	Challenge accepted by organisation	1	Create a Communication Plan that informs of communications in an incident response Include formal steer around warning and informing setting out access to 24/7 communications advice (e.g. through an on call rota) within the communications plan Document within the communications plan a process to log incoming requests, track responses to these requests and ensure that information related to the incidents is stored effectively Document communications in the EPRR Policy	SR with Comms Victoria Pickles (Corportate Affairs) Victoria Pickles (Corportate Affairs) SR	Feb / March 2024 Feb / March 2024 Feb / March 2024 March / April 2024	G	Meeting with VP and AC arranged for 29.11.23. Draft strategy forwarded on 29.11.23. SR to review - early December 2023. 08.01.2024 - Communication MI Strategy shared with ICB Media and NHSE Media. Comments received by ICB on 08.01.24 and implemented into the document. once approved, this document to be embedded into the MIP. **26.01.24** - Communications Major Incident Plan on a Page developed and also shared with ICB (received comments) and NHSE (awaiting comments). SR to take to RSG Meeting for comments and approval - February 2023.
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	A	Challenge accepted by organisation	2	Create a Communication Policy that informs of communications in an incident response Include formal steer around warning and informing setting out access to 24/7 communications advice (e.g. through an on call rota) within the communications policy Document within the communications policy a process to log incoming requests, track responses to these requests and ensure that information related to the incidents is stored effectively Document communications in the EPRR Policy Test the copmmunications incident plan	Victoria Pickles (Corportate Affairs) Victoria Pickles (Corportate Affairs) Victoria Pickles (Corportate Affairs) SR Amy Campbell?	Feb / March 2024 Feb / March 2024 Feb / March 2024 March / April 2024 April / May 2024	A	**26.01.24** - Changed to a priority 2 action - need comms work in CS 33 complete before developing into a process document.
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	A	Challenge accepted by organisation	2	Include in the communications policy bespoke communications guidance: Agreed media strategy and how this will be enacted during an incident Social media policy in order to track information on social media related to incidents and advice Protocols to support staff in effectively using social media to deliver authorised messages	Victoria Pickles (Corportate Affairs)	May 2024	A	26.01.24 - Changed to a priority 2 as per CS 34
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	A	Accepted	2	Media relations centre and holding points at both sites to be agreed Include details within all Incident Response Plans	Victoria Pickles (Corportate Affairs) SR	February 2024 March / April 2024	Pending	**26.01.24** - Changed to a priority 2. Not yet started

37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	A	Challenge accepted by organisation	1	Jonathan Hammond to attend all LHRPs throughout the year or delegate attendance to a nominated Deputy AEO who is a Board member	JH / Deputy AEO	From November 2023 (next LHRP) and through 2024	G	**November 2023** - SL confirmed that JH diary has been coordinated to allow him to attend all LHRP this year. **26.01.24** - Deputy AEO's identified who will attend LHRP if JH is absent. Rota in place for AEO cover in times of JH planned absence throughout the year
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	A	Challenge accepted by organisation	3	Await information on MOUs from ICB Include the process for requesting, receiving and managing mutual aid within the EPRR Policy (reference SCC)	ICB SR / GB	Awaited - ICB meeting 24.04.24 April 2024	Pending	**26.01.24** - ICB's have arranged fortnightly meetings - scheduled to be reviewed on 24.04.24 (CS 39).
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	A	Secondary challenge	3	Work with ICB to update the ICB held document - information sharing protocol	SR	Awaited - ICB meeting 24.04.24	Pending	**26.01.24** - ICB's have arranged fortnightly meetings - scheduled to be reviewed on 24.04.24 (CS 43).
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	A	Challenge accepted by organisation	1	Review and revise the BCMS Policy to align with the BCM Toolkit 2023 Align to risks, testing and exercising	KB / SR KB	Commenced - by end January 2024 March 2024	G	**29.12.23** - KB on track with reviewing the BCMS Policy. Following the SRG Meeting in December - BC Sub-Group Meeting attendance to be agreed. Meeting to be arranged between JH, GB, SR and KB to discuss implementation. **24.01.24** - KB and SR have reviewed the BCMS Policy - to go to RSG February 2024 - awaiting Procurement section, however, a meeting has been arranged for 06.02.24. 20.02.24 - Procurement information provided, BCMS policy went to RSG
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	A	Challenge accepted by organisation	1	Develop a strategic Trust BIA for critical activities (to be approved by Board) and align to the Trust BCP Document the governance process for completing BIAs and annual review - include in the revision of the BCMS Policy Reference to BCMS Policy better in the EPRR Policy	KB SR SR	By end February 2023 By January 2024 By February 2024	G	**29.12.2023** - Meeting arranged for 10.01.2024 to discuss (SR and KB). **26.01.24** - BIA Complete awaiting discussion with GB to approve Trust Critical Activities (meeting arranged for 31.01.24)- if confirmed will go to RSG February 2024. 20.02.24 - Agreed andwent to RSG in Feb.
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	A	Secondary challenge	1	Document the governance procedure for the testing and exercsing of BCPs on an annual basis (requires the input and supprt of services to test their BCPs) in BCMS Policy Improve the tracking of the BCP testing tracker on the workplan and log actions with owners and timescales Develop a standard template for post BCP exercise reports	SR KB SR / KB	January 2024 March 2024 January 2024	A	**29.12.2023** - Following discussion at RSG in December 2023. Agreed to implement a BCP Sub-Group Meeting with divisional reps. Arrange a meeting between JH, GB, SR and KB to discuss implementation. **26.01.24** - BCMS Policy reviewed RSG February 2024 if Trust Critical Activities are approved. **20.02.24** - BCMS policy went to RSG. Testing of plans is planned, but not all BCPs will be tested.
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A	Accepted	1	KPIs to be agreed and begin to compile 12 months of assessment Add as a standard agenda item to RSG	KB	Complete	G	**04.12.23** - KPI's added to the workplan with 12 month plan to show continuous improvements against KPI's. 20.02.24 - KPIs are reported at the RAFT GG and RSG

52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A	Challenge accepted by organisation	1	Document the process for governing the testing and review of BCPs in the revision of the BCMS Policy Develop the workplan to include tracking of learning and application Heading in Annual Report to include continuous improvement of BCMS To arrange an internal audit in 2024 and approach AY for an external audit 2025	SR KB SR	January 2024 Complete December 2023 Internal - by August 2024 External - 2025	A	**05.12.23** - Business Continuity Working Group to be established following the RSG Meeting. Group to work through a testing/exercising schedule and governance etc. **11.04.23** - to begin planning the internal audit. **13.02.24** - Internal Audit process planned out in preparation of BC Working Group implementation and will take place during latter end of February 2024. To update SR on 11.04.23 and plan for and approach WY Audit for 2025 audit request.
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	Challenge accepted by organisation	3	Work with CHS to cover requirements raised in confirm and challenge (action needs to sit with CHS) - Meeting 07/12/23 To document further actions following the meeting	CHS / SR / KB	Meeting 07/12/23	G	**07.12.23** - Meeting held. CG and AH to review presentation slide on what is required. Processes changing for Contract Management in 2024, so new process and governance arrangements to be added to the BCMS Policy. Next Meeting arranged 06.02.2024. **20.02.24** - Meetings held with CHS procurement. Information provided for BCMS policy. Changes made to tender questions, logging of BC on the system and a document will be produced and held by CHS to document the risk assessing of suppliers BC arrangements
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	A	Challenge accepted by organisation	1	Document the overarching governance processes of HAZMAT in the EPRR Policy Document the overarching governance processes of HAZMAT in the HAZMAT Plan Training requirements and schedule of work	SR SR ED Clinical Eductators	March 2024 March 2024 March 2024 (first meeting 10.01.24)	A	**February 2024** - TNA example provided to ED Clinical eductaors and sheet on the EPRR workplan to track compliance. HAZMAT Plan not yet commenced review
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A	Accepted	2	Detailed HAZMAT/CBRN risk assessments to be completed and signed off through division and RSG	ED Clinical Educators	February 2024 (meeting 10.01.24)	Pending	**February 2024** - Risk assessments not yet commenced but example from BTHFT received
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	A	Challenge accepted by organisation	2	Include guidance on when to use wet / dry decontamination in the HAZMAT Plan Plan exercises to test activating CDU's, management of contaminated waste, management of contaminated fatalities, continued delivery of ED services for non-contaminated patients Detail in HAZMAT plan detailing response arrangements aligned to risk assessments	ED Clinical Educators ED Clinical Educators ED Clinical Educators	February 2024 Ongoing through 23/24 and 24/25 May 2024	A	**04.12.23** - KB to add in guidance on wet/dry decontamination from slide 3 and slide 4 from decontamination slide pack and check with ED clinical educators.

61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	A	**Secondary challenge**	1	Write into the HAZMAT Plan the governance arrangements around the PPM Write into the HAZMAT Plan the governance arrangements around equipment repair and replacement	KB / SR KB / SR	March 2024 March 2024	Pending	**February 2024** - Not yet started
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	A	Accepted	2	HAZMAT TNA to be developed specific to roles and approved through division and RSG	ED Clinical Educators	May 2024	A	**February 2024** - Example TNA provided to ED Clinical Educators and sheet on EPRR Workpla. Need to determine the CHFT TNA for HAZMAT and receommended to take this to the next RSG ihn April
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	A	Accepted	2	HAZMAT TNA to be developed specific to roles and approved through division and RSG Training records to show approporiate training for roles identfied on TNA	ED Clinical Educators ED Clinical Educators / KB	March 2024 March 2024	A	**February 2024** - as per CS 63
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	A	Accepted	2	HAZMAT TNA to be developed specific to roles and approved through division and RSG Expected numbers of immediately deployable staff in any type of PPE has been established as part of TNA Safe systems of work documented alongside communication cascades to prevent unprotected staff exposure Training or plans for management of temporary staff who may need to be deployed or agency staff to be put into HAZMAT plan	ED Clinical Educators ED Clinical Educators ED Clinical Educators ED Clinical Educators	May 2024 May 2024 May 2024 May 2024	A	**February 2024** - TNA provided to ED Clinical Educators. Need to be adapting this for CHFT and using this to determine our HAZMAT deployable staff. To also be used for temporary staff. Need to present a TNA for CHFT at next RSG in Apil

66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	**Secondary challenge**	2	Post exercise report template with lessons learned section HAZMAT exercise lessons learned to be inputted into action plan on workplan with owners and timescales (following exercises)	KB SR / KB	Complete By Summer 2024 (to plan an exercise)	A	**February 2024** - Post exercise report template with lessons learned section now in place and used. When a HAZMAT exercise is undertaken, the lessons learned will be put int the workplan

Core Standards Action Tracker (20.02.24)

Green	Completed
Amber	Actively commenced
Pending	Not yet started but not out of timeframe

Category 1 Actions	By end April 2024	8	7	1
Category 2 Actions	By end August 2024	3	15	3
Category 3 Actions	Interdependencies by end August 2024	1	3	2

A workforce for the future

22. Guardian of Safe Working Hours Report – September – November 2023

To Note

Presented by David Birkenhead

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 March 2024
Meeting:	Public Board of Directors
Title:	Quarterly report (1st October to 30th Nov 2023) from the Guardian of Safe Working Hours, CHFT
Author:	Dr Liaquat Ali, Guardian of Safe Working Hours
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None
Purpose of the Report	The purpose of this report is to provide an overview and assurance of the Trusts compliance with safe working hours for doctors/dentists in training across the Trust, and to highlight any areas of concern.
Key Points to Note	1. Exception reports 2. Information about cover arrangements for out of hours rota gaps 3. Junior doctors strike
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 Sep 2023 to Nov 2023

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 Sep 2023 to Nov 2023.

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.

Numbers of the exception reports have increased (from 21 to 49) in significant numbers in this quarter; this is probably due to combination of winter pressure and increased work load. Substantial numbers of reports were initiated by FY1 doctors twice the figure by the FY2. This is expected as the junior doctors are in the first year of working within the NHS and are getting familiar with how the system works. Almost eighty percent were related to extra hours of working. Five exception reports were relating to immediate patient safety issues. Three ERs were related to service support available to the doctors and one was published due to missed educational opportunities. Allocate software indicates seventeen ERs as unresolved, however, after scrutiny, it appears that these were resolved but have not been fully closed on the software by mistake.

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): 263.76, Non -Training Junior Doctors: 205.5

Admin support is provided to the Guardian: The Medical HR team manage the payment for exception reports wherever this is agreed and create Allocate accounts for all those that need access. They also do initial prompts to clinical supervisors and educational supervisors regarding exception reports. There is a regular meeting scheduled with the GOSWH and the Medical HR manager for additional support if required.

The Medical Education team manage the invites, agenda, and minutes for the quarterly Junior Doctors Forum meeting.

Safety concern raised through Exception Report:

Five exception reports were recorded about immediate safety concern; three were relevant to minimum staffing level in the ward, two were about not having opportunity for lunch break.

These were resolved by additional payment to junior doctors and rota coordinator was informed to ensure adequate staffing level in the ward.

Work Schedule reviews:

There were no work schedule reviews during this period. But one of the educational supervisors agreed with trainee to consider work schedule review and provide additional support on call team at night.

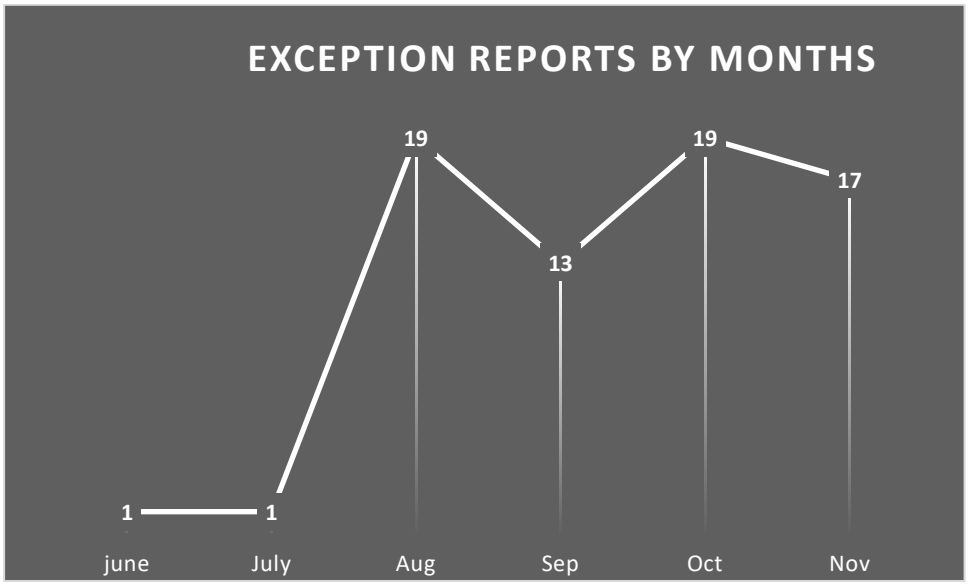
Exception Reports - details:

Total ER – 49

Distribution of exception reporting in relation to various reasons

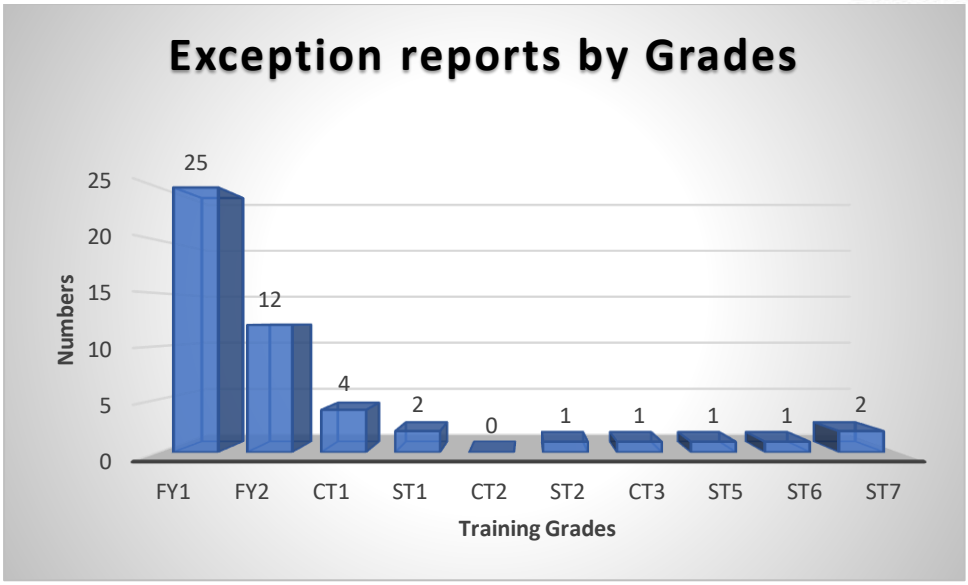
Out of these 49 reports, 40 were related to extra hours of working ,5 relating to immediate patient safety issues,4 related to service support available to the doctor and 4 was related to pattern of work. One was related to missed educational opportunities (missed training day)

Exception Reports (ER) from Sep 2023 to Nov 2023:



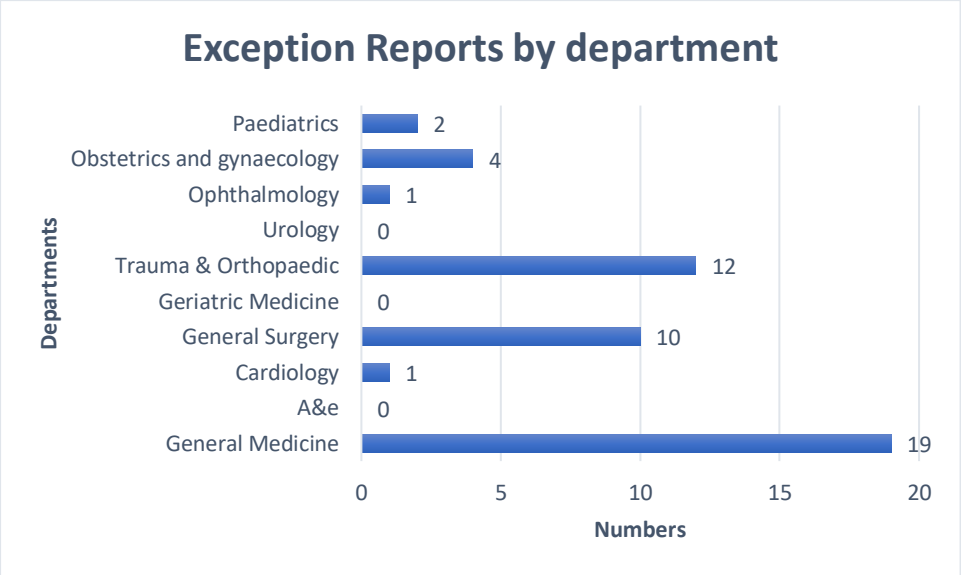
In total 49 reports were submitted. As we can see, the trend to submit ER is higher in Aug & October.

Exception report by Grade:



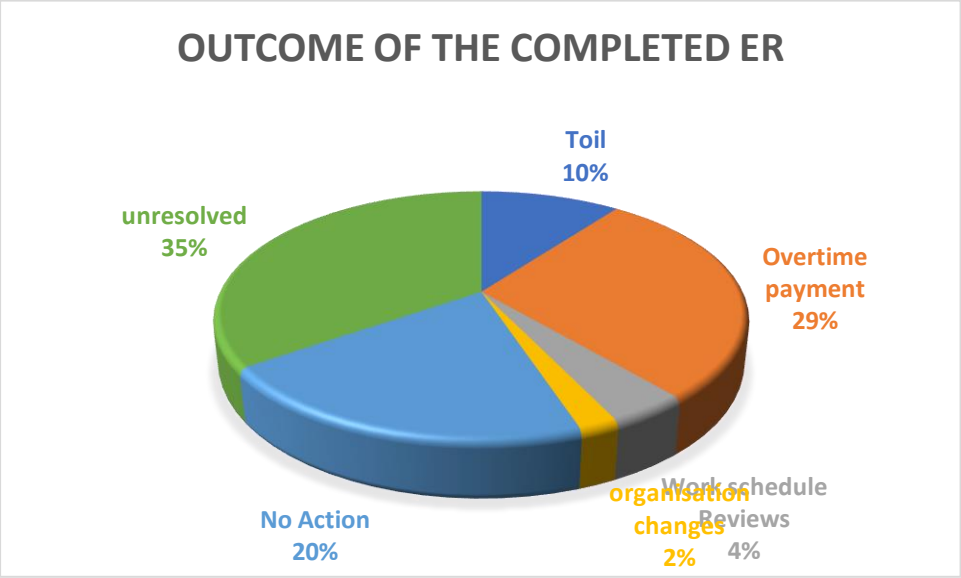
Most of the ER were from FY1 doctors. This is expected as the junior doctors are in the first year of working within the NHS and are still getting familiar with how the system works. I have noted ERs from senior trainees as well.

Exception reports by Departments:



We see that slightly more ER have been submitted in General Medicine as compared to General Surgery. This was other way round in the beginning of year.

Outcome of resolved exception reports:



Not all ER were resolved fully. Those shown as unresolved are the total number of exceptions where either no outcome has been recorded or where the outcome has been recorded but the doctor has not closed the record. Otherwise, all reports were fully resolved.

Steps from last Board meeting:

Fines:

There haven't been any fines issued in last three months.

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	Sep-23			Oct-23			Nov-23		
	Budgeted FTE	Actual FTE	Vacancies by FTE	Budgeted FTE	Actual FTE	Vacancies by FTE	Budgeted FTE	Actual FTE	Vacancies by FTE
Consultant	307.06	272.88	34.18	309.06	278.54	30.52	310.06	282.34	27.72
Foundation Year 1	49.00	55.62	-6.62	48.00	55.00	-7.00	48.00	55.00	-7.00
Foundation Year 2	37.00	34.33	2.68	37.00	35.33	1.68	37.00	36.04	0.96
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	132.56	88.02	44.54	132.56	85.05	47.51	134.56	84.02	50.54
Specialty Registrar	140.76	140.22	0.54	139.76	144.01	-4.25	139.76	143.28	-3.52
Staff Grade (Closed to new entrants)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Trust Grade Doctor - Foundation Level	32.00	20.00	12.00	32.00	19.00	13.00	32.00	17.00	15.00
Trust Grade Doctor - Specialist Registrar Level	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trust Grade Doctor - Specialty Registrar	32.94	46.36	-13.42	37.94	49.36	-11.42	37.94	51.36	-13.42
GP Trainees - Trust Based (Specialty Registrar)	40.00	44.59	-4.59	39.00	44.59	-5.59	39.00	44.59	-5.59
Total	**773.32**	**704.40**	**68.92**	**777.32**	**713.27**	**64.05**	**780.32**	**716.02**	**64.30**

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.

Bank and Agency fill rates by Division, September- November 2023			
	% unfilled hours	% filled Bank hours	% filled Agency hours
FSS	5.44%	89.19%	5.37%
Medicine	5.77%	79.91%	14.31%
Surgery and Anaesthetics	8.47%	88.83%	2.69%

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 which took place between 7am Wednesday 20 September to Saturday 23 September at 7am and co-ordinated joint strike action took place by both consultants and junior doctors on 2, 3 and 4 October.

Significant numbers of doctors participated in strikes as obvious by following data:

September IA Dates	Total presented for work	Total on IA
20	37%	63%
21	22%	78%
22	19%	81%
October IA Dates	Total presented for work	Total on IA
2	36%	64%
3	37%	63%

4	37%	63%
December IA Dates	Total presented for work	Total on IA
20	25%	75%
21	30%	70%
22	27%	73%

The Medical Director wrote to all medical and dental staff to confirm the details of the action, to remind colleagues to be respectful of others' views and to share a document with

frequently asked questions. Well-being support was available to all and regularly referenced in Trust updates.

The industrial action is confirmed as 'Christmas Day' levels of care. This means that emergency care will continue to be provided, although elective work may need to be cancelled. The medical team was supported by physician associates, pharmacists, trust grade doctors and training doctors who did not participate in the strike action. Fortunately, no unpredictable events took place. ER were recorded during strike action. Adequate support services were available in terms of: The Safari team was available to prescribe for TTOs (take home prescriptions), and a "Floater" prescriber was available as well as Microsoft TEAM setup (CHFT – Digital Support) to act as a central resource to facilitate any issues colleagues may have with Cerner, Blood TRACK, ABG machine access and prescribing. There was a significant level of support for industrial action with approximately 90% of those eligible going on strike.

Regional GOSWH conferences and webinars:

Dr Ali attended Yorkshire and Humber GOSWH Regional Meeting on 25th October and the Guardian of Safe working virtual national conference on 6th of Nov 2023 in his new role to liaise with other GOSWH.

Summary:

The trainees at CHFT have access to an allocate account to initiate exception reports and they have the provision if they want to raise any issue regarding safety concern, missed educational opportunities and extra work-outside their agreed rota. The rotas that are in the place are fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when changes may be needed.

Governance

23. Amendments to Constitution and Standing Orders of the Council of Governors

To Approve

Presented by Andrea McCourt

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 March 2024
Meeting:	Board of Directors
Title of report:	Amendments to the Trust Constitution and Standing Orders of the Council of Governors
Author:	Andrea McCourt, Company Secretary
Previous Forums	Council of Governors, 25 January 2024
Purpose of the Report	This report presents amendments to the Trust Constitution for approval. It also presents for approval an updated Standing Orders of the Council of Governors following a routine review for approval as required by the Trust Constitution. It is proposed that the Standing Orders of the Council of Governors and the Standing Orders of the Board of Directors becomes a separate document to the Trust Constitution, rather than annexes as currently as these are updated at different periods to the Constitution.
Key Points to Note	The Trust Constitution sets out the principles and processes that the Directors and Council of Governors follow. Any proposed changes to the Constitution require approval by both the Council of Governors and the Board of Directors as per section 44 of the Trust Constitution. The amendments proposed were approved by the Council of Governors at a meeting on 25 January 2024. The proposed changes to the Constitution and Standing Orders of the Council of Governors are: **Summary Changes - Constitution** • Section 20 /21 - removal of reference to Annexe of Standing Orders of Council of Governors and minor text amendments • Section 25.2 - clarification re: Deputy Chair and Senior Independent Non-Executive Director roles and ratification by the Council of Governors • Removal of section 25.8 (duplication of 25.2) • Section 32.1 - removal of reference to Annexe of Standing Orders of Board of Directors and minor text amendments • Annexes renamed Appendices and re-ordered more logically as follows: Appendix 1 Public constituencies Appendix 2 Composition of the Council of Governors Appendix 3 Roles and Responsibilities of Governors Appendix 4 Membership Further Provisions - addition of paragraph on disqualification as member for serious incident or violence The Constitution is enclosed with amendments in red text. Appendix 4 only is included as there are no changes to the other appendices apart from the appendix reference.

	Summary Changes – Standing Orders of the Council of Governors The main material changes are: ➢ Revisions to quorum, section 3.1 - proposed reduction in the quorum from ten to seven governors, comprising: - five publicly elected governors - one staff elected governor - one appointed governor ➢ Addition of written resolution at paragraph 10 Other non-material changes, shown in red text include: • Clarification of arrangements for chairing due to absence / disqualification -paragraph 5.2 • Addition of written resolution - paragraph 10 • Updated references to compliance with Fit and Proper Persons Policy – paragraph 17.12 • Addition of requirement for compliance with Code of Conduct for Governors – paragraph 17.13
Recommendation	The Board is asked to: • **APPROVE** the amendments to the Trust Constitution • **APPROVE** the amendments to the Standing Orders of the Council of Governors • **APPROVE** the Standing Orders of the Council of Governors and the Standing Orders of the Board of Directors will be stand-alone documents going forwards rather than form part of the Trust Constitution.

UNIQUE IDENTIFIER NO: G-1C-2017
Review Date: April 2026
Review Lead: Company Secretary

CONSTITUTION OF THE

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

(A PUBLIC BENEFIT CORPORATION)

Version:	2.0 Review and update including: - Expenses clarification - References to Monitor / NHS Improvement - Typographical amends 2.1 Addition of partner governor May 2019 *3.0 April 2021* 14.1.5 An elected governor who completes the maximum 6 year tenure may stand for re-election after a period of 2 years has elapsed since the end of their tenure 14.3 removal of reserve register Annexe 1 - addition of Rest of England constituency *4.0 13 January 2022* 25.4 Change to NED eligibility criteria 5.0 July 2022 24.0 Change to the Board of Directors composition to increase the number of Non-Executive Directors to up to 7 and the number of Executive Directors to up to 7. 6 April 2023 Amendments to reflect the Health and Social Care Act 2022, the NHS England Code of Governance for Provider Trusts (October 2022), application for membership and nomination as a governor, voting for removal of a governor. Version 7 25 January 2024 Re-ordering of Annexes and removal of Standing Orders for Council of Governors and Board of Directors, non-material changes

Approved by:	Council of Governors
Date approved:	Version 1 - 17 January 2017 Version 2 - 17 October 2019 Version 3 - 22 April 2021 Version 4 - 13 January 2022 Version 5 – 7 July 2022 Version 6 – April 2023 Version 7 – March 2024
Date issued:	7 July 2022 To update once approved (7.3.24)
Next Review date:	As required, as a minimum every three years (20276)

TABLE OF CONTENTS

CONSTITUTION FOR THE CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

1. Definitions

1.1. Unless otherwise stated words or expressions contained in this constitution bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Social Care Act 2022.

1.2. References in this constitution to legislation include all amendments, replacements, or re-enactments made.

1.3. Headings are for ease of reference only and are not to affect interpretation.

1.4. Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

1.5. In this constitution:

The Accounting Officer	is the person who from time to time discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.
The 2006 Act	means the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.
The 2012 Act	is the Health and Social Care Act 2012.
The 2022 Act	means the Health and Social Care Act 2022
Annual Members' Meeting	is defined in paragraph 10 of the constitution.
Appointed Governor Member	means those Governors appointed by the Appointing Organisations;
Appointing Organisations	means those organisations named in this constitution who are entitled to appoint Governors;
Areas of the Trust	the areas specified in Annexe 1;
Authorisation	means an authorisation given by NHS England

Board of Directors	means the Board of Directors as constituted in accordance with this constitution;
Code of Governance	means the NHS England Code of Governance for NHS Provider Trusts (October 2022)
Council of Governors	means the Council of Governors as constituted by this constitution and referred to as the Board of Governors/ Council of Governors in the 2006 Act;
Director	means a member of the Board of Directors
Elected Governor”	means those Governors elected by the public constituency and the staff constituency;
Financial year	means: (a) a period beginning with the date on which the Trust is authorised and ending with the next 31 March; and (b) each successive period of twelve months beginning with 1 April;
Integrated Care Board	An Integrated Care Board is a statutory organisation that brings NHS and care organisations together locally to improve population health and establish shared strategic priorities within the NHS
Integrated Care Partnership	An Integrated Care Partnership is a formal partnership of organisations working together to improve the health and care of the whole population they serve
Integrated Care System	An Integrated Care System (ICS) is a statutory partnership of organisations who plan, buy and provide health and care services in their geographical area. The organisations involved include the NHS, local authorities, voluntary and charity groups and independent care providers.
Local Authority Governor	means a Member of the Council of Governors appointed by one or more Local Authorities whose area includes the whole or part of the area of the Trust;

Member	means a Member of the Trust;
NHS England	The Health and Social Care Act 2022 has merged Monitor and the Trust Development Authority into NHS England and is now the Trust's regulator
Non-Executive Directors	means the Chair and Non-Executives on the Board of Directors;
NHS Trust	means Calderdale and Huddersfield NHS Foundation Trust;
Other Partnership Governor	means a Member of the Council of Governors appointed by a Partnership Organisation other than a Primary Care Trust or Local Authority;
Public Constituency	means those individuals who live in an area specified as an area for any public constituency;
Public Governor	means a Member of the Council of Governors elected by the Members of the public constituency;
Secretary	means the Board Secretary of the Trust or any other person appointed to perform the duties of the Secretary;
Staff Constituency	means those individuals who are eligible for Trust membership by reason of 8.5-8.9 of this Constitution are referred to collectively as the Staff Constituency;
Staff Governor	means a Member of the Council of Governors appointed by the Members of one of the classes of the constituency of the staff membership;
The Trust	means Calderdale & Huddersfield NHS Foundation Trust.

2. Name and status

2.1. The name of this Trust is “Calderdale and Huddersfield NHS Foundation Trust”.

3. Head Office and Website

3.1. The Trust’s head office for the purpose of this Constitution is at Trust Offices, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA, or any other address decided by the Council of Governors.

3.2. The Trust will maintain a website, the address of which is www.cht.nhs.uk or any other address decided by the Council of Governors.

4. Purpose

4.1. The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.

4.2. The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

4.3. The Trust may provide goods and services for any purposes related to:-

4.3.1. the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

4.3.2. the promotion and protection of public health.

4.4. The Trust may also carry out activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry out its principal purpose.

4.5. The Trust should be led by an effective and diverse Board that is innovative and flexible and whose role it is to promote the long term sustainability of the Trust as part of the ICS and wider healthcare system in England, generating value for members, patients and the public.

5. Powers

5.1. The powers of the Trust are set out in the 2006 Act.

5.2. All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

5.3. Any of these powers may be delegated to a committee of directors or to an executive director.

5.4. The Trust may do anything which appears to it to be necessary or desirable for the purposes of or in connection with its functions.

5.5. In particular it may:

5.5.1. acquire and dispose of property;
5.5.2. enter into contracts;
5.5.3. accept gifts of property (including property to be held on Trust for the purposes of the Trust or for any purposes relating to the health service);
5.5.4. employ staff.

5.6. Any power of the Trust to pay remuneration and allowances to any person includes the power to make arrangements for providing, or securing the provision of pensions or gratuities (including those payable by way of compensation for loss of employment or loss or reduction of pay).

5.7. The Trust may borrow money for the purposes of or in connection with its functions, subject to the limit published by NHS England from time to time.

5.8. The Trust may invest money (other than money held by it as Trustee) for the purposes of or in connection with its functions. The investment may include investment by:
5.8.1. forming, or participating in forming bodies corporate;
5.8.2. otherwise acquiring membership of bodies corporate.

5.9. The Trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its function.

6. Membership and Constituencies

6.1. The Trust shall have members, each of whom shall be a member of one of the following constituencies:
6.1.1. A public constituency
6.1.2. A staff constituency

7. Members

7.1. The Members of the Trust are those individuals whose names are entered in the register of members. Every Member is either a Member of one of the public constituencies or a Member of the staff constituency.

7.2. Subject to this Constitution, Membership is open to any individual who:
7.2.1. is over 16 years of age;
7.2.2. is entitled under this Constitution to be a Member of the public constituencies, or staff constituency; and
7.2.3. completes or has completed a membership application form in whatever form the Council of Governors approves or specifies.

Public Membership

7.3. There are eight public constituencies corresponding to the areas served by the Trust as set out in Annexe 1. Members of each constituency are to be individuals:
- 7.3.1. who live in the relevant area of the Trust;
- 7.3.2. who are not eligible to be Members of the staff constituency; and
- 7.3.3. who are not Members of another public constituency.

7.4. The minimum number of members of each of the public constituencies is to be 50.

Staff Membership

7.5. There is one staff constituency for staff membership. It is to divide into four classes as follows with five seats:
- 7.5.1. doctors or dentists (x1);
- 7.5.2. Allied Health Professionals, Health Care Scientists or Pharmacists (x1);
- 7.5.3. Management, administration and clerical (x1);
- 7.5.4. Nurses and midwives (x2).

7.6. Members of the staff constituency are to be individuals:
- 7.6.1. who are employed under a contract of employment by the Trust and who either:
  - 7.6.1.1. are employed by the Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or
  - 7.6.1.2. who have been continuously employed by the Trust for at least 12 months; or
- 7.6.2. who are not so employed but who nevertheless exercise functions for the purposes of the Trust and have exercised the functions for the purposes of the Trust for at least 12 months.

7.7. Individuals entitled to be Members of the staff constituency are not eligible to be Members of the public constituency.

7.8. The Secretary is to decide to which class a staff member belongs.

7.9. The minimum number of members in each class of the staff membership is to be 20.

Automatic membership by default – Staff

7.10. An individual who is:
- 7.10.1. Eligible to become a member of the Staff Constituency, and
- 7.10.2. Invited by the Trust to become a member of the Staff Constituency,

Shall become a member of the Trust as a member of the Staff Constituency without an application being made, unless he / she informs the Trust that he / she does not wish to do so.

8. Disqualification from membership

8.1 When applying to be a member, an online literature review will be undertaken to check that there are no known concerns regarding an individual that would suggest the person would act in a manner detrimental to the interests of the Trust. This decision as to whether an individual is likely to act in a way detrimental to the interests of the Trust will be made by the Council of Governors (as per section 8.2 of the Trust Constitution).

8.2 A person may not be a member of the Trust if, in the opinion of the Council of Governors, there are reasonable grounds to believe that they are likely to act in a way detrimental to the interests of the Trust.

9. Termination of membership

9.1. A Member shall cease to be a Member if:

9.1.1. they resign by notice to the Company Secretary;
9.1.2. they die;
9.1.3. they are disqualified from Membership by paragraph 7 and 8;
9.1.4. they cease to be entitled under this Constitution to be a Member of any of the public constituencies or the staff constituency.

9.2. Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annexe 3 – Further Provisions.

10. Annual Members' Meetings

10.1. The Trust is to hold an annual meeting of its members. The Annual Members Meeting shall be open to members of the public.

10.2. Further provisions about the Annual Members' Meeting are set out in Annexe 4 – Annual Members' Meeting.

11. Council of Governors - composition

11.1. The Trust is to have a Council of Governors which shall comprise both elected and appointed governors.

11.2. The composition of the Council of Governors is specified in Appendix 6 – Composition of the Council of Governors.

11.3. The composition of the Council of Governors, subject to the 2006 Act, shall seek to ensure that:

11.3.1. the interests of the community served by the Trust are appropriately represented;

11.3.2. the level of representation of the public constituencies, the staff constituency and the partnership organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs.;

12. Council of Governors – elections of Governors

12.1. Public Governors are to be elected by Members of the public constituencies, and Staff Governors by Members of the staff constituency.

12.2. The Election procedures including the arrangements governing nominations, the advertisement of candidates, rules regarding canvassing voting, and the election of reserves to fill casual vacancies are to be determined by the election rules, set out in Annexe 2 – Election Rules.

13. Council of Governors - appointed Governors

13.1. Local Authority Governors

The Secretary, having consulted each Local Authority whose areas includes the whole or part of the area of the Trust is to adopt a process for agreeing the appointment of Local Authority Councils Member with those Local Authorities.

13.2. Partnership Governors

The Company Secretary, having consulted each partnership organisation is to adopt a process for agreeing the appointment of Partnership Governors with those partnership organisations.

14. Council of Governors - tenure for Governors

14.1. Elected Governors:

14.1.1. shall hold office for a period of three years commencing immediately after the annual members meeting at which their election is announced;

14.1.2. subject to the next sub-paragraph are eligible for re-election after the end of that period;

14.1.3. may not hold office for more than six consecutive years or two terms;

14.1.4. cease to hold office if they cease to be a Member of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution.

14.2. An elected governor who completes the maximum 6 year tenure may not stand for re-election to ensure that they retain the objectivity and independence required to fulfil their roles. Appointed Governors:

14.2.1. shall hold office for a period of 3 years commencing immediately after the annual members meeting at which their appointment is announced;
14.2.2. subject to the next sub-paragraph are eligible for re-appointment after the end of that period;
14.2.3. may not hold office for longer than 6 consecutive years;
14.2.4. shall cease to hold office if the Appointing Organisation terminates their appointment.
14.2.5. cease to hold office if they cease to be a Member of the constituency by which they were elected, or if they are disqualified for any of the reasons set out in this Constitution.

15. Council of Governors - vacancies amongst Governors

15.1. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

15.2. Where the vacancy arises amongst the Appointed Governors, the Secretary shall request that the Appointing Organisation appoints a replacement to hold office for the remainder of the term of office.

15.3. Where the vacancy arises amongst the elected Governor, the Council of Governors shall be at liberty either:

15.3.1. to call an election within three months to fill the seat for the remainder of that term of office, or
15.3.2. where a vacancy arises within 6 months to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office to fill the seat until the next annual election, at which time the seat will become vacant and subject to election for any unexpired period of the term of office.
15.3.3. If the vacancy arises during the last 6 months of office, the office will remain vacant until it is filled at the next scheduled election term

16. Council of Governors – disqualification and removal

16.1. A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so if:
16.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;
16.1.2. they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;
16.1.3. they have within the preceding five years, been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

16.1.4. they are a Director or Company Secretary of this Trust, a Director of another NHS Trust or a Governor or Non-Executive Director of another NHS Foundation Trust;
16.1.5. they are under 16 years of age;
16.1.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;
16.1.7. their behaviour does not meet the Nolan principles / Standards of Public Life
16.1.8. they are a person whose tenure of office as the Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

17. Council of Governors - termination of office and removal of Governors

17.1. A person holding office as a Governor shall immediately cease to do so if:
17.1.1. they resign by notice in writing to the Secretary;
17.1.2. they fail to attend two meetings in any 12 month period, unless the other Governors are satisfied that:
17.1.3. the absences were due to reasonable causes; and
17.1.4. they will be able to start attending meetings of the Trust again within such a period as they consider reasonable.
17.1.5. in the case of an elected Governor, they cease to be a member of the constituency by whom they were elected;
17.1.6. in the case of an appointed Governor, the appointing organisation terminates the appointment;
17.1.7. they have failed to undertake any training which the Council of Governors requires all Governors to undertake;
17.1.8. they have failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the code of conduct for Governors;
17.1.9. they refuse to sign a declaration in the form specified by the Council of Governors that they are a member of a specific public constituency and are not prevented from being a member of the Council of Governors. This does not apply to staff members;
17.1.10. they are removed from the Council of Governors under the following provisions.

17.2. A Governor may be removed from the Council of Governors by a resolution approved by a 66% of the remaining Governors Members present and voting at a general meeting of the Council of Governors on the grounds that:
17.2.1. they have committed a serious breach of the code of conduct; or
17.2.2. they have acted in a manner detrimental to the interests of the Trust; and
17.2.3. the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor.

Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable.

18. Council of Governors – duties of Governors

18.1. The general duties of the Council of Governors are:

18.1.1. to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors;

18.1.2. to represent the interests of the members of the Trust as a whole and the interests of the public

18.1.3. to form a rounded view of the interests of the "public at large" to support collaboration and system working; this includes the population of the West Yorkshire ICS ;

18.2. The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

18.3. The Council of Governors shall appoint at a general meeting one of its public members to be Lead Governor of the Council of Governors.

18.4. The specific roles and responsibilities of the Council of Governors are set out in Annexe 5 – Roles and Responsibilities.

19. Council of Governors – meetings of the Council of Governors

19.1. The Chair of the Trust (i.e. the Chair of the Board of Directors, appointed with the provisions of paragraph 26 below) or, in the Chair's absence the Deputy Chair (appointed in accordance with the provisions of paragraph 26 below), shall preside at meetings of the Council of Governors.

19.2. Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

19.3. For the purposes of obtaining information about the Trust's performance of its functions or the directors' performance of their duties, the Council of Governors may require one or more of the directors to attend a meeting.

20. Council of Governors – standing orders

20.1. The Council of Governors shall adopt standing orders for the practice and procedure of the Council of Governors.

~~20.1.~~20.2. The Standing Orders shall specify the arrangements for excluding governors from discussion or consideration of any contract, proposed contract or other matter as appropriate. ~~which is attached at Annexe 8.~~

21. Council of Governors – conflicts of interest

21.1. If a Council of Governors has a pecuniary, personal or family interest, whether that interest is actual or potential, or whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the councillor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

21.2. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or the consideration of the matter in respect of which an interest has been disclosed. This should be in line with the NHS England guidance on Conflicts of Interest.

21.3. The Standing Orders for the Council of Governors are available on the Trust website.~~attached at Annexe 7~~.

22. Council of Governors - expenses

22.1. The Trust may pay travelling and other expenses to Governors at such rates as it decides. These are set out in the Standing Orders for the Council of Governors at Annexe 7 and are to be disclosed in the annual report.

22.2. Expenses claims must be submitted in line with the Trust's expenses policy.

22.3. Governors are not to receive remuneration.

23. Board of Directors – general duty

23.1. The business of the Trust is to be managed by the Board of Directors, who (subject to this Constitution) shall exercise all the powers of the Trust. The general duty of the Board of Directors and of each director individually, is to act with a view to promoting the success of the Trust as to maximise the benefits for the members of the Trust as a whole and for the public.

23.2. A third party dealing in good faith with the Trust shall not be affected by any defect in the process by which Directors are appointed or any vacancy on the Board of Directors.

23.3. The Trust will comply with the statutory requirements of the Code of Governance for NHS Provider Trusts issued by NHS England. Section A of this code details the principles and provisions relating to Board leadership and purpose.

24. Board of Directors – composition

24.1. The Trust is to have a Board of Directors. It is to consist of Executive and Non-Executive Directors.

24.2. The Board of Directors is to comprise:
- 24.2.1. a Non-Executive Chair;
- 24.2.2. up to 7 other Non-Executive Directors;
- 24.2.3. up to 7 Executive Directors.

24.3. One of the Executive Directors shall be the Chief Executive who shall be the Accounting Officer.

24.4. One of the Executive Directors shall be the Finance Director.

24.5. One of the Executive Directors is to be a registered medical practitioner.

24.6. One of the Executive Directors is to be a registered nurse or a registered midwife.

25. Board of Directors – appointment and removal of the Chair, Deputy Chair and other Non-Executive Directors

25.1. The Council of Governors shall appoint a Chair of the Trust.

25.2. The Board of Directors will appoint one Non-Executive Director to be Deputy Chair of the Trust. This individual may, through agreement with the Chair, take on the role of Senior Independent Non-Executive Director (SINED), however these can be separate appointments (one NED as Deputy Chair and a different NED as the SINED). Standing Orders of the Council of Governors state that the Council of Governors shall ratify these appointments made by the Board of Directors, at a general meeting.

25.3. The Chair and Deputy Chair will be the Chair and Deputy Chair of both the Council of Governors and the Board of Directors.

25.4. To be eligible for appointment as a Non-Executive Director of the Trust the candidate must demonstrate a commitment to the Trust are and the communities it serves and live within reasonable travelling distance.

25.5. The Council of Governors at a general meeting shall appoint or remove the Chair of the Trust and the other Non-Executive Directors.

25.6. Non-Executive Directors are to be appointed by the Council of Governors using the following procedure:
- 25.6.1. The Board of Directors will work with the external organisations recognised as expert in non-executive appointments to identify the skills and experience required

25.6.2. Appropriate candidates will be identified by the Board of Directors who meet the skills and experience required

25.6.3. A sub-committee of the Council of Governors (not exceeding four persons) including the Chair, will interview a short list of candidates and recommend a candidate for appointment by the Council of Governors.

25.7. Removal of the Chair or other Non-Executive Director shall require the approval of three-quarters of the Council of Governors.

25.8. ~~The Board of Directors shall appoint one Non-Executive Director to be the Deputy Chair of the Trust.~~

26. Board of Directors – Senior Independent Director

26.1. The Board of Directors will appoint one Non-Executive Director to be the Senior Independent Director.

26.2. The Trust has a detailed job description for the Senior Independent Director. The main duties include:

26.2.1. Being available to members of the Foundation Trust and to the Council of Governors if they have concerns that contact through the usual channels of Chair, Chief Executive, Finance Director and Company Secretary has failed to resolve or where it would be inappropriate to use such channels. In addition to the duties described here the Senior Independent Director has the same duties as the other Non-Executive Directors.

26.2.2. A key role in supporting the Chair in leading the Board of Directors and acting as a sounding board and source of advice for the Chair. The Senior Independent Director also has a role in supporting the Chair as Chair of the Council of Governors.

26.2.3. While the Council of Governors determines the process for the annual appraisal of the chair, the senior independent director is responsible for carrying out the appraisal of the chair on its behalf.

26.2.4. The Senior Independent Director should maintain regular contact with the Governors and attend meetings of the Council of Governors to obtain a clear understanding of Council of Governors views on the key strategic performance issues facing the Foundation Trust. The Senior Independent Director should also be available to Governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example.

26.2.5. In rare cases where there are concerns about the performance of the chair the Senior Independent Director should provide support and guidance to the Council of Governors in seeking to resolve concerns or in the absence of a resolution in taking

formal action. Where the foundation Trust has appointed a lead Governor the Senior Independent Director should liaise with the Lead Governor in such circumstances.

26.2.6. In circumstances where the Bboard is undergoing a period of stress the Senior Independent Director has a vital role in intervening to resolve issues of concern. These might include unresolved concerns on the part of the Council of Governors regarding the chair's performance; where the relationship between the chair and the chief executive is either too close or not sufficiently harmonious, where the Foundation Trust's strategy is not supported by the whole Board or where key decisions are being made without reference to the Board or where succession planning is being ignored.

26.2.7. In the circumstances outlined above, the Senior Independent Director will work with the chair, other directors and/or Governors, to resolve significant issues.

27. Board of Directors – tenure of Non-Executive Directors

27.1. The Chair and the Non-Executive Directors are to be appointed for a period of three years.

27.2. The Chair and the Non-Executive Directors will serve for a maximum of two terms.

27.3. In exceptional circumstances a Non-Executive Director (including the Chair) may serve longer than six years (two three-year terms). Any subsequent appointment will be subject to annual re-appointment. Reviews will take into account the need to progressively refresh the Board whilst ensuring its stability. Provisions regarding the independence of the Non-Executive Director will be strictly observed.

28. Board of Directors – appointment and removal of the Chief Executive and other executive directors

28.1. The Non-Executive Directors shall appoint or remove the Chief Executive.

28.2. The appointment of the Chief Executive requires the approval of the Council of Governors.

28.3. A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

29. Board of Directors – disqualification

29.1. A person may not become or continue as a Director of the Trust if:

29.1.1. they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged;

29.1.2. they have made a composition or arrangement with, or granted a Trust deed for, their creditors and have not been discharged in respect of it;

29.1.3. they have within the preceding five years been convicted in the British Islands of any offence, and a sentenced of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them;

29.1.4. they are the subject of a disqualification order made under the Company Directors Disqualification Act 1986;

29.1.5. they are a person whose tenure of office as a Chair or as a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

29.1.6. they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a health service body;

29.1.7. in the case of a Non-Executive Director they have failed to fulfil any training requirement established by the Board of Directors; or

29.1.8. they have failed to sign and deliver to the Secretary a statement in the form required by the Board of Directors confirming acceptance of the code of conduct for Directors and fit and proper persons test

30. Board of Directors - meetings

30.1. Meetings of the Board of Directors shall be open to members of the public unless the Board of Directors decides otherwise in relation to all or part of a meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public from a meeting of the Board of Directors if they are interfering with or preventing the proper conduct of the meeting.

30.2. Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

30.3. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

31. Board of Directors – standing orders

31.1. The Board of Directors shall adopt s~~S~~tanding orders for the practice and procedure of the Board of Directors~~. are attached at Annexe 8.~~

~~31.1.~~31.2. The Standing Orders shall specify the arrangements for excluding Directors from discussion or consideration of any contract, proposed contract or other matter, as appropriate.

32. Board of Directors – conflicts of interest of directors

32.1. The duties that a director of the Trust has by virtue of being a director include in particular –

32.1.1. A duty to avoid a situation in which the director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

32.1.2. A duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

32.2. The duty referred to in sub-paragraph 31.1.1 is not infringed if –

32.2.1. The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2. The matter has been authorized in accordance with the constitution.

32.3. The duty referred to in sub-paragraph 31.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4. In sub-paragraph 31.1.2, “third party” means a person other than –

32.4.1. The Trust, or

32.4.2. A person acting on its behalf.

32.5. If a director of the Trust has in any way a direct of indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors.

32.6. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7. Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8. This paragraph does not require a declaration of an interest of which the director is not aware or where the director is not aware of the transaction or arrangement in question.

32.9. A director need not declare an interest –

32.9.1. If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2. If, or to the extent that, the directors are already aware of it;

32.9.3. If, or to the extent that, it concerns terms of the director’s appointment that have been or are to be considered –

32.9.3.1. By a meeting of the Board of Directors, or

32.9.3.2. By a committee of the directors appointed for the purpose under the constitution.

32.10. Any Director who has a material interest in a matter as defined below shall declare such interest to the Board of Directors and it shall be recorded in a register of interests and the Director in question:
32.10.1. shall not be present except with the permission of the Board of Directors in any discussion of the matter, and
32.10.2. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

32.11. Any Director who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Directors.

32.12. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Director or their spouse or partner in any firm or company or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust, including private healthcare organisations and other foundation Trusts.

32.13. The exceptions which shall not be treated as material interests are as follows:
32.13.1. shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange.

33. Board of Directors – remuneration and expenses

33.1. The Board of Directors shall appoint an executive remuneration committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and Executive Directors.

33.2. The remuneration and allowances, and the other terms and conditions of office, of the Chair and Non-Executive Directors shall be decided by the Council of Governors at a general meeting. The Council of Governors may take advice from independent pay advisors whose Terms of Reference will be established and ratified by the Board of Directors and the Council of Governors.

33.3. The remuneration and allowances for Directors are to be disclosed in the annual report.

34. Secretary

34.1. The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director. The Secretary shall be accountable to the Chief Executive and their functions shall include:
34.1.1. acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

34.1.2. summoning and attending all members meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;
34.1.3. keeping the register of members and other registers and books required by this Constitution to be kept;
34.1.4. having charge of the Trust's seal;
34.1.5. publishing to members in an appropriate form information which they should have about the Trust's affairs;
34.1.6. preparing and sending to NHS England and any other statutory body all returns which are required to be made;
34.1.7. providing support to the Council of Governors and the Non-Executive Directors;
34.1.8. overseeing elections conducted under this Constitution;
34.1.9. offering advice to the Council of Governors and the Board of Directors on issues of governance and corporate responsibility.

34.2. Minutes of every members meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of meetings will be included on the agenda of the next meeting.

35. Registers

35.1. The Trust is to have:
35.1.1. a Register of Members showing, in respect of each Member, the name of the member, the constituency to which they belong and, (where the Council of Governors has decided that the Membership of the Public, or Staff constituencies shall be sub-divided for election purposes) any sub-division of that constituency to which they belong;
35.1.2. a Register of Members of the Council of Governors;
35.1.3. a Register of Directors;
35.1.4. a Register of Interests of Governors
35.1.5. a Register of Interests of the Directors.

35.2. The Secretary shall add to the Register of Members any individual who becomes a Member of the Trust or remove from the Register of Members the name of any Member who ceases to be entitled to be a Member under the provisions of this Constitution.

36. Documents available for public inspection

36.1. The following documents of the Trust are to be available for inspection by members of the public. If the person requesting a copy or extract under this paragraph is not a member of the Trust, the Trust may impose a reasonable charge for doing so.
36.1.1. a copy of the current Constitution;
36.1.2. a copy of the current Authorisation;
36.1.3. a copy of the latest annual accounts and of any report of the auditor on them;

36.1.4. a copy of the report of any other auditor of the Trust's affairs appointed by the Council of Governors;
36.1.5. a copy of the latest annual report;
36.1.6. a copy of the latest information as to its forward planning;
36.1.7. a copy of the Trust's Membership Strategy;
36.1.8. a copy of any notice given under section 52 of the 2006 Act (NHS England's's notice to failing NHS Foundation Trust).
36.1.9. The register of Members shall be made available for inspection by members of the public. Article 2(b) of the Public Benefit Corporation (Register of Members) Regulations 2004 allows for members to request their details are not published as part of the Register of Members.

37. Auditors

37.1. The Trust is to have an auditor and is to provide the auditor.

37.2. The Council of Governors at a general meeting shall appoint or remove the Trust's auditors.

37.3. The auditor is to carry out his duties in accordance with Schedule 7 to the 2006 Act and in accordance with any directions given by NHS England standards, procedures and techniques to be adopted.

38. Audit and Risk Committee

38.1. The Trust shall establish a committee of Non-Executive Directors as an Audit and Risk Committee to perform such monitoring, reviewing and other functions as are appropriate.

39. Accounts

39.1. The Trust must keep proper accounts and proper records in relation to the accounts.

39.2. NHS England may, with the approval of the Secretary of State, give directions to the Trust as to the content and form of its accounts.

39.3. The accounts are to be audited by the Trust's auditor.

39.4. The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

39.5. The following documents will be made available to the Auditor General for examination at their request:
39.5.1. the accounts;
39.5.2. any records relating to them; and
39.5.3. any report of the auditor on them.

39.6. The annual accounts, any report of the auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

39.7. The Trust shall:
39.7.1. lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and
39.7.2. once it has done so, send copies of those documents to NHS England.

40. Annual report, forward plans and non-NHS work

40.1. The Trust is to prepare an Annual Report and send it to NHS England.

40.2. The Trust is to give information as to its forward planning in respect of each financial year to NHS England. The document containing this information is to be prepared by the Directors, and in preparing the document the Board of Directors shall have regard to the views of the Council of Governors.

40.3. Each forward plan must include information about:-
40.3.1. the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and
40.3.2. the income it expects to receive from doing so.

40.4. Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 39.3.1 the Council of Governors must:-
40.4.1. determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions and
40.4.2. notify the directors of the Trust of its determination.

40.5. A Trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England may implement the proposal only if more than half of the members of the Council of Governors voting to approve its implementation.

41. Indemnity

41.1. Members of the Council of Governors and the Board of Directors and the Secretary who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

The Trust may purchase and maintain insurance against this liability for its own benefit and the benefit of members of the Council of Governors and Board of Directors and the Secretary.

42. Seal

42.1. The Trust shall have a seal.

42.2. The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

43. Dispute Resolution Procedures

43.1. Every unresolved dispute which arises out of this Constitution between the Trust and:

43.1.1. a Member; or

43.1.2. any person aggrieved who has ceased to be a Member within the six months prior to the date of the dispute; or

43.1.3. any person bringing a claim under this Constitution; or

43.1.4. an office-holder of the Trust; is to be submitted to an arbitrator agreed by the parties. The arbitrator's decision will be binding and conclusive on all parties.

44. Amendment of the constitution

44.1. The Trust may make amendments of its Constitution only if:-

44.1.1. More than half of the members of the Council of Governors of the Trust voting approve the amendments; and

44.1.2. More than half of the members of the Board of Directors of the Trust voting approve the amendments.

44.2. Amendments made under paragraph 4~~3~~.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3. Where an amendment is made to the constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust)

44.3.1. At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

44.3.2. The Trust must give the members an opportunity to vote on whether they approve the amendment.

44.4. If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

44.5. Amendments by the Trust of its constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Mergers etc. and significant transactions

45.1. The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

45.2. The Trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

45.3. The constitution does not contain any descriptions of the term 'significant transaction' for the purposes of section 51A of the 2006 Act (Significant Transactions).

46. Dissolution of the Trust

46.1. The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2006 Act.

APPENDIX 4 – FURTHER PROVISIONS - Membership

(From paragraph 9.2 of the Constitution)

Disqualification or Removal from membership

An individual may not become or continue as a member of the Trust (and the register will be amended accordingly) if in the last five years that person has perpetrated a serious incident of violence towards any facilities of the Trust or against any of the Trust's employees or registered volunteers, staff contracted to provide a service for the Trust , in association with their employment with the Trust or the Trust's patients or visitors as defined in the Trust Policy " Management and Prevention of Violence and Aggression Behaviour Policy" for the care of Individuals who are Violent or Aggressive" or any successor policy. Notwithstanding anything contained in this Constitution, no person who ceases to be a member of the Trust shall be re-admitted to membership except by a decision of the Board of Directors

Termination of Membership

1. A Member may be expelled by a resolution approved by not less than 66% of the full Council of Governors present and voting at a meeting of the Council of Governors – this may be either a public or an extra ordinary meeting as appropriate to the timeframe. The following procedure is to be adopted.

2. Any Member may complain to the Company Secretary that another Member has acted in a way detrimental to the interests of the Trust.

3. If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each Member's point of view is heard and may either:

   3.1. dismiss the complaint and take no further action; or
   3.2. arrange for a resolution to expel the Member complained of to be considered at either a public or extra-ordinary meeting of the Council of Governors.

4. If a resolution to expel a Member is to be considered at either a public or extra-ordinary meeting of the Council of Governors, details of the complaint must be sent to the Member complained of not less than one week before the meeting with an invitation to answer the complaint and attend the meeting.

5. At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the Member complained of may wish to place before them.

6. If the Member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

7. A person expelled from Membership will cease to be a Member upon the declaration by the Chair of the meeting that the resolution to expel them is carried.

8. No person who has been expelled from Membership is to be re-admitted except by a resolution carried by the votes of 66% of the Council of Governors present and voting at a general meeting.

~~ANNEX 7~~ – COUNCIL OF GOVERNORS – STANDING ORDERS

AS APPROVED AT COUNCIL OF GOVERNORS JANUARY 20243

A Public Benefit Corporation

STANDING ORDERS

COUNCIL OF GOVERNORS

Version:	5 – Updated and separation from Trust Constitution 2.0 Review and update including: - Expenses clarification - References to NHS England / NHS Improvement - Typographical amends 2.1 Addition of partner governor May 2019 3 April 2021 Integrated car system references added Addition of period after which governors may stand for re-election
Approved by:	Council of Governors / Board of Directors
Date approved:	17 January 2017 Version 2 17 October 2019 Version 3 22 April 2021 Version 4 20 April 2023 Updates for Health and Care Act 2022 and change from Council Member to Governor Version 5 25 January 2024 – update for quoracy, addition of written resolution, amendment to variation of Standing Orders and dispute resolution
Date issued:	~~17 October 2019 20 April 2023~~ TBC 7 March 2024
Next Review date:	In conjunction with the constitution but as a minimum every three years (2027)

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INTERPRETATION

In these Standing Orders, the provisions relating to interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning and, in addition:

"**The Act**" shall mean the National Health Service Act 2012.

"**Terms of Authorisation**" shall mean the Authorisation of the Trust issued by NHS England with any amendments for the time being in force.

"**Corporation**" means Calderdale & Huddersfield NHS Foundation Trust, which is a public benefit corporation.

"**Board of Directors**" shall mean the Board of Directors as constituted in accordance with the Trust's constitution.

"**Chair**" means the person appointed to be Chair of the Trust under the terms of the constitution.

"**Chief Executive**" shall mean the chief officer of the Trust.

"**Constitution**" shall mean the constitution attached to the Authorisation with any variations from time to time approved by NHS England.

"**Council of Governors**" shall mean the Council of Members as constituted in accordance with the corporation's constitution.

"**Council of Governors"** shall mean those persons elected or appointed to sit on the Trust's Council of Governors.

Deputy Lead Governor lead governor, act as deputy in the absence of the lead governor and share workload as required and act as a sounding board for the lead governor
"**Director**" shall mean a member of the Board of Directors as defined in section 13 of the constitution.

"Governor" shall mean a governor member of the Council of Governors as defined in section 12 of the constitution.

"**Lead Governor"** is the Public Council of Governor selected by the Council of Governors to act as a lead for the Council of Governors and to chair meetings in those circumstances where both the Chair and Deputy Chair have a conflict.

Integrated Care System (ICS) - is the West Yorkshire Health and Care Partnership.

"**NHS England**" is the previous name of the Independent Regulator for NHS Foundation Trusts. This changed to NHS Improvement on 1 April 2016and NHS England on 1 July 2022

"**Motion**" means a formal proposition to be discussed and voted on during the course of a meeting.

"**Officer**" means an employee of the Trust.

"**Deputy Chair**" means the Deputy Chair of the Trust pursuant to the terms of the constitution who will preside at meetings of the Council of Governors in the Chair's absence.

"**Secretary**" means the Board Secretary of the Trust or any other person appointed to perform the duties of the Secretary to the Board of Directors.

"**Written Resolution**" means a formal proposition to be circulated to governors to be voted on outside of a general meeting and returned as required – it allows a resolution to become effective without the need for a general meeting of the Council of Governors.

SECTION A: CONDUCT OF MEETINGS

1. Admission of the Public and the Press

1.1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with 12.24 of the Constitution."

1.2. The Chair (or Deputy Chair) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Council of Governors' business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the Council of Governors may resolve as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public in accordance with 12.24 of the Trust's Constitution."

1.3. Nothing in these Standing Orders shall require the Council of Governors to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without prior agreement of the Council of Governors.

2. Calling and notice of meetings

2.1. The Council of Governors is to meet at least three times in each financial year. Meetings shall be determined at the first meeting of the Council of Governors or at such other times as the Council of Governors may determine and at such places as they may from time to time appoint. Meetings may be held virtually or in person.

2.2. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least **ten working** days written notice of the date and place of every meeting of the Council of Governors to all Governors. Notice will also be published on the Trust's website.

2.3. Meetings of the Council of Governors may be called by the Secretary, by the Chair, by the Board of Directors or by eight Governors (including two appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request giving at least **ten working days'** notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chair or four Governors, whichever is the case, shall call such a meeting.

2.4. In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified on the notice.

2.5. All meetings of the Council of Governors are to be general meetings open to members of the public unless the Council of Governors decides otherwise in relation

to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds. The Chair may exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.

2.6. The Council of Governors may invite the Chief Executive or through the Chief Executive any other member or members of the Board of Directors, or a representative of the Trust's auditors or other advisors to attend a meeting of the Council of Governors. The Chief Executive and any Executive of the Trust nominated by the Chief Executive shall have the right to attend any meeting of the Council of Governors provided that they shall not be present for any discussion of their individual relationship with the Trust

2.7. The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting and count towards voting.

2.8. All decisions taken in good faith at a meeting of the Council of Governors, or of any of its committees, shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

2.9. Following notice of the meeting (as set out in SO 2.3) an agenda for the meeting, specifying the business proposed to be transacted at it shall be sent to every Governor, so as to be available to him/her at least **five working** days before the meeting.

2.10. The agendas will include all supporting papers available at the time of posting. Further supporting papers will be received no later than **three (3)** working days before the meeting.

2.11. Lack of service of the notice on any one person above shall not affect the validity of the meeting, but failure to serve such a notice on more than six Governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

3. Quorum

3.1. Seven Council of Governors members (including not less than five Public Governors, not less than one Staff Governor and not less than one Appointed Governor – in line with the Constitution) present in person or by proxy under arrangements approved by the Council of Governors shall form a quorum.

4. Setting the agenda

4.1. A Governor desiring a matter to be included on an agenda shall make the request in writing to the Chair at least **ten working** days before the meeting. Requests made less than fourteen clear days before a meeting may be included on the agenda at the discretion of the Chair or the Secretary.

5. Chairing of meeting

5.1. The Chair of the Trust or, in his/her absence, the Deputy Chair will chair meetings of the Council of Governors.

5.2. The Lead Governor will be appointed from the Public Membership at a general meeting. He/she will act as Chair of the meeting should the Chair and the Deputy Chair be in conflict. If the Lead Governor is absent or is disqualified from participating then the governors present shall choose by majority which Public Governor present shall preside for that part of the meeting. The Deputy Chair will hold the casting vote when he/she is acting as Chair.

6. Notices of motion

6.1. A Governor desiring to move or amend a motion shall send a written notice thereof at least **ten working** days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to preceding provisions.

7. Withdrawal of motion or amendments

7.1. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

8. Motion to rescind a resolution

8.1. Notice of motion to amend or rescind any resolution (or general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Governors who give it and also the signature of four other Governors, of whom at least two shall be Public Governors. When any such motion has been disposed of by the Trust, it shall not be competent for any Governor other than the Chair to propose a motion to the same effect within six months, although the Chair may do so if he/she considers it appropriate.

9. Motions

9.1. The mover of a motion shall have the right of reply at the close of any discussions on the motion or any amendment thereto.

9.2. When a motion is under discussion or immediately prior to discussion it shall be open to a Governor to move:

a) An amendment to the motion.

b) The adjournment of the discussion or the meeting.

c) That the meeting proceed to the next business. (*)

d) The appointment of an ad hoc committee to deal with a specific item of business.

e) That the motion be now put. (*)

1. [*In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Governor who has not previously taken part in the debate.]

9.3. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

10. Written Resolution

A written resolution is a formal written decision agreed after considering a motion. When the Chair or a governor desire that a resolution is passed by the Council of Governors, the Chair, Board Secretary or the governor (with the consent of the Chair) may circulate the resolution amongst the governors proposing that it is passed as a written resolution.

In terms of proposing Council of Governors Written Resolutions:

10.1 **The Chair, or seven (7) governors (including at least two (2) elected** governors and two (2) appointed governors) (5,1,1, as per quoracy) who give written notice to the Trust Secretary specifying the business to be carried out may propose a Council of Governors written resolution.

10.2 **Exclusions**

The following may not be passed as a written resolution:

- the removal of a Non-Executive Director or Chair
- removal of the auditor
- approval of a significant transaction.

10.3 A Council of Governors' written resolution shall be proposed by giving written notice of the proposed resolution to each governor. Notice by post, delivery in person, or email shall constitute written notice.

Notice of a proposed Council of Governors written resolution must indicate:

- the proposed resolution;
- how to signify agreement to the resolution; and
- the date by which it is proposed that the Council of Governors should adopt it.

A proposed written resolution shall lapse if not adopted by the 28th day from circulation.

References in this paragraph to eligible Governors are to members of the Council of Governors who would have been entitled to vote on the matter had it been proposed at a meeting of the Council of Governors.

A decision may not be taken in accordance with this paragraph if the eligible Governors would not have formed a quorum at such a meeting.

The resolution is deemed to have been passed when the required majority (simple majority, or 75% if a special resolution) as appropriate of eligible Governors have signified their agreement to it.

Where decisions of the Council of Governors are taken by means other than at a face-to face meeting or by written resolution, such decisions shall be recorded by the Trust Secretary in permanent written form.

Any written resolution that is so passed shall be noted at the next meeting of the Council of Governors.

11. Chair's ruling

11.1. The decision of the Chair of the meeting on the question of order, relevancy and regularity shall be final.

12. Voting

12.1. Questions arising at a meeting of the Council of Governors requiring a formal decision shall be decided by a majority of votes. In case of an equality of votes the Chair shall decide the outcome. No resolution of the Council of Governors shall be passed if it is unanimously opposed by all of the Public Governors.

12.2. All questions put to the vote shall, at the discretion of the Chair, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request, or the Secretary deems it advisable or necessary.

12.3. If at least one third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Governor present voted or abstained.

12.4. If a Governor so requests his/her vote shall be recorded by name upon any vote (other than by paper ballot).

12.5. In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

13. Minutes

13.1. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting

13.2. No discussion shall take place upon the minutes, except upon their accuracy, or where the Chair considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

13.3. Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust Website (required by the Code of Practice of Openness in the NHS).

13.4. The names of the Governors' present at the meeting and those who gave apologies for each meeting shall be recorded in the minutes.

13.5. Council of Governor Members' must make every effort to attend meetings of the Council of Governors where appropriate and practicable. Where is it's not possible for a Governor to attend apologies should be sent to the Corporate Governance Manager no later than three working days prior to the meeting.

SECTION B: COMMITTEES

14. Appointment of Committees

14.1. Subject to paragraph 40 below and such directions as may be given by NHS England, the Council of Governors may and, if directed to do so, shall appoint committees of the Council of Governors, consisting wholly or partly of Governors. In all cases, each committee shall have a majority of Public Governors.

14.2. A committee appointed under SO 13.1 may, subject to such directions as may be given by NHS England or the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

14.3. These Standing Orders, as far as it is applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Council of Governors.

14.4. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Council of Governors), as the Council of Governors shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

14.5. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Council of Governors.

14.6. The Council of Governors shall approve the appointments to each of the committees which it has formally constituted. Where the Council of Governors determines that persons who are neither Governors, nor directors or officers, shall be appointed to a committee, the terms of such an appointment shall be determined by the Council of Governors subject to the payment of travelling and other allowances being in accordance with such sum as may be determined by the Board of Directors or NHS England (in line with SO 20).

14.7. Where the Council of Governors is required to appoint persons to a committee or to undertake statutory functions as required by NHS England, and where such appointments are to operate independently of the Council of Governors or the Board of Directors, such appointment shall be made in accordance with the any regulations laid down by the Chief Executive or his nominated officer or any directions or guidance issued by NHS England from time to time.

15. Confidentiality

15.1. A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Council of Governors or shall otherwise have concluded on that matter.

15.2. A Governor or a member of a committee shall not disclose any matter reported to the Council of Governors or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Council of Governors or committee shall resolve that it is confidential and / or is discussed in private for all or part of a meeting.

15.3. In relation to patient confidentiality, the provisions at paragraphs 42 and 43 above for disclosure of information by Governors or members of committees established

by the Council of Governors shall not apply, and such information shall not be disclosed under any circumstances.

16. Appointment of the Chair, Deputy Chair and Non-Executive Directors

16.1. The Council of Governors shall appoint a Chair of the Trust. The Board of Directors will appoint one Non-Executive Director to be Deputy Chair of the Trust. This individual may, through agreement with the Chair, also take on the role of SINED (Senior Independent Non-Executive Director). The Council of Governors shall ratify the appointment of the Vice Chair at a general meeting.

16.2. Non-Executive Directors are to be appointed by a sub-committee (not exceeding four persons) of the Council of Governors using the procedures set out under paragraph 13 of the constitution.

SECTION C: REGISTER AND DISCLOSURE OF INTERESTS

17. Register and disclosure of interests

17.1. If Governors have any doubt about the relevance or materiality of an interest, this should be discussed with the Chair or the Secretary.

17.2. Any Governor who has a material interest in a matter as defined below and in the constitution shall declare such an interest to the Council of Governors and it shall be recorded in a register of interests and the Governor in question:

a) Shall not be present except with the permission of the Council of Governors in any discussion of the matter, and

b) Shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

17.3. Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

17.4. At the time the interests are declared, they should be recorded in the minutes of the Council of Governors. Any changes in interests should be officially declared at the next meeting as appropriate following the change occurring.

17.5. It is the obligation of a Governor to inform the Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the register upon receipt within three working days.

17.6. The details of Governors' interests recorded in the register will be kept up to date by the Secretary, and reviewed at each meeting of the Council of Governors.

17.7. Subject to the requirements of the Public Benefit Corporation (Register of Members) Regulations 2006 and the Data Protection Act 1998, the register will be available for inspection by the public free of charge and will be published on the Trust's website.

17.8. Copies or extracts of the register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the register.

17.9. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Governor, or their spouse or partner, in any firm or business which, in connection with the matter, is trading with the Trust, or is likely to be considered as a potential trading partner with the Trust.

The exceptions which shall not be treated as material interests are as follows:

a) Shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

b) An employment contract held by staff Governors;

c) A contract with their Integrated Care Board / Integrated Care System (ICS) held by a Place / ICS governor;

d) An employment contract with a Local Authority held by a Local Authority Governor;

e) An employment contract with any organization listed at paragraph 12.3.5 of the constitution.

17.10. If, in relation to 47, the Chair has a conflict of interest, the Deputy Chair will exercise the casting vote. If the Deputy Chair has a conflict of interest, the Deputy Chair will preside and exercise the casting vote, the nomination to be approved by a majority vote of those present at the meeting.

17.11. An elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the Council of Governors Charter as specified by the Council of Governors as to the basis upon which they are entitled to vote as a member. The Constitution provides guidance. An elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of elected Governors.

17.12. Members of the Council of Governors must meet the requirements of the Fit and Proper persons test as per section 4.1 of Section C of the Code of Governance for NHS Provider Trusts (Composition succession and evaluation) and comply with the Trust Fit and Persons Policy.

17.13. All members of the Council of Governors are required to comply with any Code of Conduct for Governors adopted by the Council of Governors or Board of Directors and with the Trust values and behaviours.

SECTION D: TERMINATION OF OFFICE AND REMOVAL OF GOVERNOR

18. Termination of office

18.1. A person holding office as a Governor on the Council of Governors shall immediately cease to do so if:

a) They resign by notice in writing to the Secretary;

b) They fail to attend two meetings in any Financial Year, unless the other l Governors are satisfied that the absences were due to reasonable causes, and they will be able to start attending meetings of the trust again within such a period as they consider reasonable;

c) In the case of an elected Council Governor, they cease to be a Member of the constituency by whom they were elected;

d) In the case of an appointed Council Governor, the Appointing Organisation terminates the appointment;

e) They have failed to undertake any training which the Council of Governors requires all Governors to undertake;

f) They have failed to sign and deliver to the Secretary a statement in the form required by the Council of Governors confirming acceptance of the Code of Conduct for Council of Governors Charter;

g) They refuse to sign a declaration in the form specified by the Council of Governors that they are a Member of a specific public constituency and are not prevented from being a Member of the Council of Governors. This does not apply to Staff Governors;

h) They are removed from the Council of Governors under the following provisions.

19. Removal of Governor

19.1. A Governor r may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting at a general meeting of the Council of Governors on the grounds that:

a) They have committed a serious breach of the Code of Conduct; or

b) They have acted in a manner detrimental to the interests of the Trust; and

c) The Council of Governors considers that it is not in the best interests of the Trust for them to continue as a Governor.

19.2. Where a person has been elected or appointed to be a Governor and he/she becomes disqualified for appointment, under SO 17.1 above, he/she shall notify the Secretary in writing of such disqualification.

19.3. If it comes to the notice of the Secretary that a person elected or appointed to be a Governor may be disqualified, under SO 17.1 above, from holding that office and the Secretary has not received a notice, under paragraph 59, from that person, the Secretary will make such inquiries as he/she thinks fit and, if satisfied that the person may be so disqualified, the Secretary will advise the Chair so that the Chair

can make a recommendation for disqualification to the Council of Governors. The recommendation will either be made to a general meeting or to a meeting called specifically for the purpose.

19.4. The Secretary shall give notice in writing to the person concerned that the Trust proposes to declare the person disqualified as a Governor. In this notice, the Secretary shall specify the grounds on which it appears to him/her that the person is disqualified and give that person a period of fourteen days in which to make representations, orally or in writing, on the proposed disqualification.

19.5. The Chair's recommendations and any representations by the Governor concerned shall be made to the Council of Governors. If no representations are received within the specified time, or the Council of Governors upholds the proposal to disqualify, the Secretary shall immediately declare that the person in question is disqualified and notify him/her in writing to that effect. On such declaration the person's tenure of office shall be terminated and he/she shall cease to act as a Governor.

19.6. A Governor whose tenure of office is terminated under paragraph 18 shall not be eligible to stand for re-election. ~~Any re-election would take into account time served as a Governor so that a maximum term would not exceed 6 years.~~

SECTION E: REMUNERATION AND PAYMENT OF EXPENSES

20. Remuneration

20.1. Governors are not to receive remuneration.

21. Payment of expenses

21.1. The return cost of travel from the Governor

a) The actual bus or rail fare using the most direct route.

b) Travel by private car or taxi at the Trust's usual pence per mile rate (currently 28p per mile) using the most direct route.

c) Necessary parking charges.

21.2. Governors claiming expenses may be required to provide tickets, receipts or other proof of expenditure alongside a completed and signed expenses form.

21.3. Expenses will be authorised through the Secretary's office and details of all expenses claimed by Governors will be recorded and published in the Trust's Annual Report and Accounts.

SECTION F: STANDARDS OF CONDUCT OF GOVERNORS

22. Policy

22.1. In relation to their conduct as a member of the Council of Governors, each Governor must comply with the same standards of business conduct as for NHS staff. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Governors are expected to be impartial and honest in the conduct of official business.

23. Interest of Governors in contracts

23.1. If it comes to the knowledge of a Governor that a contract in which he/she has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust, he/she shall, at once, give notice in writing to the Secretary of the fact that he/she has such an interest.

23.2. A Governor shall not solicit for any person any appointment in the Trust.

23.3. Informal discussions outside appointment committees, whether solicited or unsolicited, should be declared to the committee.

SECTION G: MISCELLANEOUS PROVISIONS

24. Suspension of Standing Orders

24.1. Standing Orders may be suspended at any general meeting provided that:

a) at least two-thirds of the Council of Governors are present, including at least six elected Governors and one appointed Governor, and

b) the Secretary does not advise against it, and

c) a majority of those present vote in favour.

24.2. But Standing Orders cannot be suspended if to do so would contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution.

24.3. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting and any matters discussed during the suspension of Standing Orders shall be recorded separately and made available to all members of the Council of Governors.

24.4. No formal business may be transacted while Standing Orders are suspended.

25. Variation and amendment of Standing Orders

25.1. Standing Orders may only be varied or amended if:

a) the proposed variation does not contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution;

b) unless proposed by the Chair or the Chief Executive or the Secretary, a notice of motion under paragraph 19 has been given;

c) ~~-thirds of the Council of Governors are~~ at least six elected Governors and one appointed Governor, and at least half of the Governors present vote in favour of amendment.

26. Review of Standing Orders

26.1. Standing Orders shall be reviewed bi-annually by the Council of Governors. The requirement for review shall extend to all and any documents having effect as if incorporated in Standing Orders.

APPENDIX A DISPUTES RESOLUTION

Dispute resolution procedure

Except where otherwise specified in the Constitution (paragraph 21) or the Standing Orders of the Council of Governors, questions of eligibility, procedure and administrative matters in relation to governorship or meetings of members or governors shall be determined by the Secretary. There will be a right of appeal to the Chair, whose decision shall be final and binding.

Except where otherwise specified in this Constitution, matters in relation to Directorship or meetings of Directors shall be determined by the Secretary, with a right of appeal to the Chair, whose decision shall be final and binding.

In the event of a dispute between the Council of Governors and the Board of Directors, the Council of Governors and the Board of Directors shall meet and attempt to resolve the dispute by negotiation. If agreement cannot be reached then the dispute shall be referred to the Chair, whose decision shall be final and binding.

In the event of the Council of Governors considering the Trust to be at risk of breaching its terms of authorisation, (likely to be an issue of Board leadership) such referral should be via the nominated lead governor to NHS England, if these concerns cannot be satisfactorily resolved (Appendix B, Council of Governors and the role of the nominated lead governor, section 4.49, Code of Governance for NHS Provider Trusts).

24. Fit and Proper Persons Self-Declaration Register

To Note

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 March 2024
Meeting:	Public Board of Directors
Title:	Fit and Proper Person Annual Assurance 2023/24
Author:	Andrea McCourt – Company Secretary on behalf of the Chair
Sponsoring Director:	Helen Hirst, Chair
Previous Forums:	None
Purpose of the Report	Within the context of good governance, the purpose of this report is to confirm that assurance has been provided to me as Chair on compliance with CQC Fit and Proper Person requirements and the NHS England enhanced framework for fit and proper persons, including completion of the annual fit and proper person self-declaration process for members and attendees of the Board of Directors. This item is presented to the Board to note in line with the Trust Constitution, the Standing Orders of the Board of Directors, the Fit and Proper Persons Policy and the Code of Governance for NHS Provider Trusts (Section C: Composition, succession and evaluation, paragraph 4.1).
Key Points to Note	The Care Quality Commission (CQC) introduced requirements regarding the 'Fit and Proper Person Test' for Directors in November 2014, which became law from 1 April 2015 and forms part of Regulation 5: Fit and Proper Persons Regulations (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The regulation requires NHS Trusts to seek the necessary assurance that all Executive and Non-Executive Directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role. The CQC holds Trusts to account in relation to FPPR through their well-led domain assessments and inspections. The Fit and Proper Persons Requirement (FPPR) ensures that providers only employ individuals who are fit for their role and to ensure that appropriate steps have been taken to ensure that they are of good character, are physically and mentally fit, have the necessary qualifications, competence, skills and experience for this role, can supply certain information (including a Disclosure and Barring Service (DBS) check and are financially sound. NHS England (NHSE) published a new Fit and Proper Persons Test (FPPT) Framework for Board members (non-statutory) on 2 August 2023

	alongside guidance for Chairs and for staff, with full implementation required by 31 March 2024. This follows on from 2019, when Tom Kark KC made recommendations to revise the existing Fit and Proper Persons Test process in his review into its scope, operation and purpose. The legislation has not changed and the core elements of the previous FPPT guidance remain. The new framework introduced some changes to the checks to ensure Directors satisfy the regulatory requirements. It also aims to situate the FPPT checks as part of the annual appraisal process. As Chair of the Board, I am accountable for taking all reasonable steps to ensure the FPPT is effectively implemented. This report confirms that a formal assessment of fitness and properness for each Board member has been undertaken and the Trust is effectively applying the FPPT. **Trust Fit and Proper Persons Policy** The Trust approved a Fit and Proper Person Policy to ensure that the Trust complies with the FPPR. This policy defines pre-employment checks made on appointment to Director-level roles. It also confirms the practice to assess on-going fitness, both through the annual appraisal process and through an annual self-attestation to confirm adherence with the FPPT requirements, including DBS (Disclosure and Barring Service) checks. There are two levels of FPPT checks, an enhanced check for Non-Executive Directors and Executive Directors and a routine check for non-voting Directors, the Company Secretary and deputies to Executive Directors. A local evidence folder is retained with information for each person on the register. Fit and proper person checks at recruitment were undertaken for those on the registers at the time of appointment. Assessment of on-going fitness is also undertaken via the annual appraisal process. The Chief Executive is responsible for appraising Executive members of the Board of Directors whilst the Chair is responsible for appraising the Non-Executive Directors and the Chief Executive. The Chair's appraisal is led by the Senior Independent Director. An annual self-attestation for Fit and Proper Person checks have been completed and a copy has been retained. All returns have been reviewed by myself and no issues have been identified that impact on the individual's ability to perform their duties as a member of the Board. Due checks of ongoing fitness have been made and dates of checks recorded in the individual evidence folders and summarised on the FPP register. The Board of Directors Fit and Proper Person Self-Declaration Register as at 22 February 2024 is attached at Appendix S2. The following groups of staff were required to complete an annual Fit and Proper Persons self-attestation: • Executive Directors (including the Chief Executive) • Non-Executive Directors (including the Chair) • Directors

	• Deputy Directors to Executive Directors (Finance, Medical, Nursing, Operations and Workforce and Organisational Development)
EQIA – Equality Impact Assessment	The content of this report does not adversely affect people with protected characteristics.
Recommendation	The Board is asked to **NOTE:** i. the confirmation of my satisfaction, as detailed in this paper, with arrangements for fit and proper persons checks, specifically the annual self-attestation process ii. that the Fit and Proper Persons Test has been conducted and that all Board members and those in scope within the Fit and Proper Persons Policy have completed an annual self-attestation and satisfy the requirements.

FIT AND PROPER PERSONS REGISTER 2023/24 AS AT 28 FEBRUARY 2024 ✓ denotes check is clear

Non-Executive Directors (NEDs)	DBS Check	Registering Professional Body	Date of Last Annual Appraisal	Training & Development	Annual Self Attestation signed	Disqualified Director Register	Insolvency Service Bankruptcy Register	Charity Trustees Register	Public Domain Search
Helen Hirst Chair	Yes	MCIPD [redacted]	21.06.2023	✓	✓	✓	✓	✓	✓
Nigel Broadbent	Yes	Member of the CIPFA [redacted]	13.06.2023	✓	✓	✓	✓	✓	✓
Tim Busby Chair CHS Limited	Yes	ACMA CGMA (Chartered Institute of Management Accountants)	30.06.2023	✓	✓	✓	✓	✓	✓
Karen Heaton, Senior Independent NED Finished 27.2.24	Yes	**N/A**	23 May 2023	✓	✓	✓	✓	✓	✓
Andy Nelson	Yes	**N/A**	03.07.23.	✓	✓	✓	✓	✓	✓
Denise Sterling	Yes	Health and Care Professionals Council [redacted]	21.06.23. 2022	✓	✓	✓	✓	✓	✓
Russell **Peter Wilkinson**		Member of the Royal Institution of Chartered Surveyors (MRICS) Ref No 0085230	22.06.23.	✓	✓	✓	✓	✓	✓
Jo Wass Commenced 732.24	Yes	CIPD [redacted]	N/A	Induction underway	✓	✓	✓	✓	✓

FIT AND PROPER PERSONS REGISTER 2023/24 AS AT 28 FEBRUARY 2024 ✓ denotes check is clear

EXECUTIVE DIRECTORS	DBS Check	Registering Professional Body	Date of Last Annual Appraisal	Training & Development	Annual Self Attestation signed	Disqualified Director Register	Insolvency Service Bankruptcy Register	Charity Trustees Register	Public Domain Search
Brendan Brown Chief Executive	Yes	RGN PIN [redacted]	10.05.2023	✓	✓	✓	✓	✓	✓
Rob Aitchison Deputy Chief Executive	Yes	N/A	14.04.2022	✓	✓	✓	✓	✓	✓
David Birkenhead Medical Director	Yes	General Medical Council [redacted]	13.08.2023	✓	✓	✓	✓	✓	✓
Gary Boothby Director of Finance	Yes	Assoc CMA [redacted] CIPFA [redacted]-CIP	06.11.23.	✓	✓	✓	✓	✓	✓
Kirsty Archer Acting Director of Finance (1.10.22. to 1.10.23.)	Yes	CIMA	20.06.23.	✓	✓	✓	✓	✓	✓
Suzanne Dunkley Director of Workforce and OD	Yes	FCIP [redacted]	17.08.23.	✓	✓	✓	✓	✓	✓
Lindsay Rudge Chief Nurse	Yes	NMC [redacted]	18.08.2023	✓	✓	✓	✓	✓	✓

FIT AND PROPER PERSONS REGISTER 2023/24 AS AT 28 FEBRUARY 2024 ✓ denotes check is clear

Directors & Company Secretary	DBS Check	Registering Professional Body	Date of Last Annual Appraisal	Annual Self Attestation signed	Disqualified Director Register	Insolvency Service Bankruptcy Register	Charity Trustees Register
Anna Basford Deputy Chief Executive / Director of Transformation & Partnerships	Yes	N/A	24.8.2023	✓	✓	✓	✓
Rob Birkett Chief Digital & Information Officer	Yes	N/A	18.08.2023	✓	✓	✓	✓
Jonathon Hammond Chief Operating Officer	Yes	Health & Care Professions Council [redacted]	21.08.2023	✓	✓	✓	✓
Victoria Pickles Director of Corporate Affairs	Yes	N/A	10.8.23.	✓	✓	✓	✓
Andrea McCourt Company Secretary	Yes	N/A	11.8.23.	✓	✓	✓	✓

FIT AND PROPER PERSONS REGISTER 2023/24 AS AT 28 FEBRUARY 2024 ✓ denotes check is clear

Deputies to Executive Directors	DBS Check	Registering Professional Body	Date of Last Annual Appraisal	Annual Self Attestation signed	Disqualified Director Register	Insolvency Service Bankruptcy Register	Charity Trustees Register
Neeraj Bhasin Deputy Medical Director	Yes	General Medical Council – Full Registration – [redacted] Royal College of Surgeons of England – Fellowship – [redacted] Institute of Leadership and Management – Membership – [redacted]	03.11.23.	✓	✓	✓	✓
Nikhil Bhuskute Deputy Medical Director	Yes	General Medical Council [redacted]	26.1.24.	✓	✓	✓	✓
Jason Eddleston Deputy Director of Workforce & OD	Post does not fall within the legal provisions that govern the processing of a DBS standard or enhanced check	N/A	18.04.2023	✓	✓	✓	✓
Joanne Middleton Deputy Chief Nurse	Yes	Registered General Nurse [redacted]	22.11.23.	✓	✓	✓	✓
Philippa Russell Deputy Director of Finance (1.10.22. to 1.10.23.)	Yes	Associate Chartered Management Accountant (ACMA), Chartered Global Management Accountant (CGMA) [redacted]	06.07.2023	✓	✓	✓	✓

25. Governance Report

a) Board of Directors Terms of Reference

b) Non-Executive Director Appointments

c) Board of Directors Declarations of Interest Register

d) Request for delegation for Annual Report and Accounts 2023/24

e) Request for delegation for Quality Accounts 2023/24

f) Use of Trust Seal

g) Board of Directors Workplan for 2024-2025

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 7 March 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) Board of Directors Terms of Reference b) Non-Executive Director Appointments and Board Committee Chair roles c) Board of Directors Declarations of Interest Register d) Request for delegation for Annual Report and Accounts 2023/24 e) Request for delegation for Quality Accounts 2023/24 f) Use of Trust Seal g) Board of Directors Workplan for 2024-2025
Key Points to Note	**a) Board of Directors Terms of Reference** The annual review of the terms of reference of the Board of Directors, which describes the role and work of the Board of Directors, is presented for approval and is enclosed as Appendix T2. Changes are shown in red font and include the following additions to responsibilities: • Leadership - sustainability, equality, diversion and inclusion and health inequalities • Culture - speaking up • Governance /Compliance – well-being (of employees) **RECOMMENDATION:** The Board is asked to **APPROVE** the Board of Directors terms of reference. **b) Non-Executive Director Appointments Update** The Council of Governors is responsible for the appointment of Non-Executive Directors for an initial period of three years. Recruitment to two Non-Executive Director roles, one a workforce related role and one a clinical role, has been underway since December 2023 with interviews having taken place at the end of January 2024. At the time of writing the completion of fit and proper persons tests, in line with

NHS England's enhanced framework, and other pre-employment checks are underway. Once these are complete a final ratification stage will take place by the Council of Governors at a general meeting.

The Non-Executive Director maternity champion role will be undertaken by the clinical Non-Executive Director once she has commenced in role. In the interim period Andy Nelson will take on the maternity champion role.

c) Board of Directors Declarations of Interest Register

The Trust is committed to openness and transparency in its work and decision making. As part of that commitment the Trust maintains and publishes a Register of Interests which draws together Declarations of Interest made by members of the Board of Directors which confirms the declarations are accurate and up to date.

All Board Directors and any other officers nominated by the Trust are required to declare interests which are relevant and material to the Board of Directors of which they are a member in line with:

- Schedule 7 of the National Health Service Act 2006
- NHS England's Code of Governance for NHS Providers (Section A2.10)
- Section 32 of the Trust's Constitution
- Section 5 of the Standing Orders of the Board of Directors
- Conflicts of Interest and Standards of Business Conduct Policy

System and place based partnerships have been on a statutory footing since the NHS Health and Care Act 2022 and declarations pertaining to these partnerships are included on the enclosed register for decision-making bodies.

The Trust has in place a Conflicts of Interest and Standards of Business Conduct Policy which notes the duty to ensure that dealings are conducted to the highest standards of integrity and helps staff and Non-Executive Directors manage conflicts of interest effectively.
On an annual basis the interests of members of decision-makers in the Trust, including the Board members are required to be updated.

In addition, at the commencement of each Board meeting, members of the Board are required to declare any interests. On an annual basis, as part of Fit and Proper Persons ongoing checks, Directors are required to confirm that their declarations of interest are up to date.

The Board of Directors Declarations of Interests Register as at 22 February 2024 is attached at Appendix T3.

For the purposes of the annual report and accounts the Executive Directors and Non-Executive Directors listed in the register are confirmed as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust.

The Board declarations of interest register is available to the public on the Trust website at the following address: https://www.cht.nhs.uk/publications/

Any changes in interests must be made using the online declarations system as soon as is practicable and notified to the Company Secretary.

RECOMMENDATION: The Board is asked to **NOTE** the Board of Directors Declarations of Interest Register.

d) Request for delegation for Annual Report and Accounts 2023/24

For the past four financial years the Board has agreed delegation to the Audit and Risk Committee for the end of year sign off processes for the approval of the annual report and accounts.

The Audit and Risk Committee noted the 2023/24 year end reporting timetable at its meeting on 31 January 2024. The 2023/24 annual report and accounts deadline is 28 June 2024 and does not align with the schedule of Board meeting dates. It is therefore requested that the Trust Board delegate to the Audit and Risk Committee the sign off of:

- 2023/24 audited annual accounts
- 2023/24 annual report.

The current date planned for the Audit and Risk Committee approval of the audited annual accounts and annual report is 25 June 2024, subject to Board approval for this delegation.

RECOMMENDATION: The Board is asked to **APPROVE** the delegation of authority to the Audit and Risk Committee to approve on behalf of the Board, at its meeting of 25 June 2024, the 2023/24 audited annual accounts and annual report.

e) Request for delegation of 2023/24 Quality Accounts

The Quality Account is no longer part of the Trust's Annual Report, however, there remains a requirement for Trusts to publish a separate Quality Account. The 2023/24 Quality Accounts require sign off by 30 June 2023, which does not align with the schedule of Board meetings.

As in previous years, it is recommended that the Trust Board agree delegation of authority to the Quality Committee for the approval of the 2023/24 Quality Accounts, with consideration of the Quality Account to take place at the Quality Committee meeting closest to this date, currently 3 June 2024.

RECOMMENDATION: The Board is asked to **APPROVE** the delegation of authority to the Quality Committee to approve on behalf of the Board, at its meeting of 3 June 2024, the 2023/24 Quality Accounts.

	f) Use of Trust Seal The Trust seal has been used on one occasion since January 2024 which related to a variation to the contract for The Clock House, Elland. Further details are provided in Appendix T4. **RECOMMENDATION:** The Board is asked to **NOTE** the use of the Trust Seal since January 2024 **g) 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 T5. **RECOMMENDATION:** The Board is asked to **APPROVE** the Board workplan for 2024/25.
EQIA – Equality Impact Assessment	The content of this report does not adversely affect people with protected characteristics.
Recommendations	The Board is asked to **APPROVE** the: • Board of Directors Terms of Reference • Delegation to the Audit and Risk Committee for the approval of the 2023/24 Accounts and Annual Report • Delegation to the Quality Committee for the approval of the 2023/24 Quality Accounts • Board of Directors workplan for 2024/25. The Board is asked to **NOTE** the following: • Use of the Trust Seal • Board of Directors Declarations of Interest Register.

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTITUTION

In accordance with its Constitution, the Trust has a Board of Directors, which comprises both Executive Directors, one of whom is the Chief Executive and Non-Executive Directors, one of whom is the Chair.

As set out in ~~Annex 8 of~~ the Constitution (section 31), the Trust has Standing Orders for the Board of Directors which describe the practice and procedures for the business of the Trust. Those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, information for the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees.

2. PURPOSE

The principal purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust will also work with local Integrated Care Boards and system partners, having regard to the triple aim of better health for everyone, better care for all and efficient use of NHS resources. It will promote effective dialogue with the local communities it serves.

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the Council of Governors and some decisions of the Board of Directors require the approval of the Council of Governors.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, which is a unitary Board, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, the Integrated Care System, PLACE level partner organisations including local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients, service users, and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision, strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.
- Reducing the impact on our environment to deliver sustainability
- Promoting equality, diversity and inclusion and addressing health inequalities

4.3. Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:

- Sets, maintains and oversees the implementation of the Trust's strategic vision, aims and objectives with reference to the West Yorkshire Integrated Care Strategy and the Trust's role within system and place-based partnerships, ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its

strategic objectives;
- Monitors and reviews management performance to ensure the Trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- Develops and maintains an annual plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

4.5. Culture

The Board:
- Is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Promotes a positive culture where people feel they can speak up, are confident their voice will be heard and are supported
- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction;
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation Trust business;
- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:
- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS England from time to time such as the Code of Governance for NHS Provider Trusts) and appropriate codes of conduct, accountability and openness applicable to Foundation Trusts and NHS Providers;
- Ensures that the Trust operates in accordance with its Constitution;
- Ensures that all elements of the Trust's licence relating to the Trust's governance arrangements are complied with;
- Ensures the Trust protects the health, well-being and safety of Trust employees and all others to whom it has a duty of care;
- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- Review and approve the Trust's Annual Report and Accounts - the Board may agree delegation of this to the Audit and Risk Committee if required to meet national timescales
- Review and approve the annual Quality Account or equivalent - the Board may

agree delegation of this to the Quality Committee if required to meet national timescales

- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account the lived experience of patients and carers;
- Ensures that all required returns and disclosures are made to the regulators and complies with all relevant regulatory, legal and code of conduct requirements, including Care Quality Commission fundamental standards for all regulated activities;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation Trust business;
- Agrees the schedule of matters reserved for decision by the Board of Directors;
- Ensures that the statutory duties of the Trust are effectively discharged;
- Acts as a corporate trustee for the Trust's charitable funds.

4.7. Risk management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services;
- Ensures there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining Committees of the Board of Directors with delegated powers as prescribed by the Trust's standing orders and/or by the Board of Directors from time to time and receiving reports from these Committees concerning work undertaken within their terms of reference.

4.9. Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its Governors, members, staff and the local community;
- Meets its engagement obligations in respect of the Council of Governors and members and ensures that governors are equipped with the skills and knowledge they need to undertake their role;
- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly, primarily via the Trust's website;
- Publishes an annual report and annual accounts which is submitted to NHS England and laid before Parliament

4.10. Finance

The Board:

- Ensures that the Trust operates effectively, efficiently, economically;
- Agrees the Trust's financial objectives and approve the financial plan;
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensures that the Trust achieves the targets and requirements of stakeholders within the available resources;
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and Council of Governors and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Council of Governors.

The Deputy Chair, a Non-Executive Director, will chair the Board in the absence of the Chair.

The composition of the Board is set out in the Constitution of the Trust (section 24) and the Standing Orders of the Board of Directors Those working with the Trust through Non-Executive Director development programmes or other development programmes (e.g. Shadow Board) may also attend meetings of the Board of Directors.

The Board may invite non-members to attend its meetings on an ad-hoc basis, as it considers necessary and appropriate, and this will be at the discretion of the Chair.

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chair and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors.

7. ACCOUNTABILITY TO THE COUNCIL OF GOVERNORS'

The agenda of the Board of Director meetings held in public shall be forwarded to the Council of Governors prior to the meeting.

After each Board meeting held in public, the Board of Directors will send a copy of the minutes to the Council of Governors.

The Non-Executive Directors are accountable to the Council of Governors for the performance of the Board of Directors. To execute this accountability effectively, the Non-Executive Directors ~~and Associate Non-Executive Director~~ will need the support of their Executive Director colleagues. A well-functioning accountability relationship will require the Non-Executive Directors to provide Governors with a range of information on how the Board has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the Trust. The Non-Executive Directors will need to encourage questioning and be open to challenge as part of this relationship. The Non-Executives also should ensure that the Board as a whole allows Council of Governors' time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS AND PROCEDURES

The Board of Directors will meet at least six times a calendar year in public on dates agreed with the Chair. Dates of forthcoming meetings held in public shall be posted on the Trust's website. Board meetings may be conducted virtually and, where this is the case, a recording of the Board meeting will be made available on the Trust website as soon as is practically possible after the meeting.

Agendas and papers for forthcoming meetings of the Board to be held in public, and minutes of previous meetings held in public, shall be posted on the Trust's website.

Urgent meetings shall be convened in accordance with section 3.4 of the Standing Orders of the Board of Directors.

Additional meetings of the Board may be held in private for consideration of confidential business.

Further details on the practice and procedure of the Board of Directors, including voting, can be found in the Standing Orders of the Board of Directors.

9. QUORUM

Six directors including not less than three executives, and not less than three Non-Executive Directors shall form a quorum.

If an Executive Director is unable to attend a meeting of the Board, an alternative may be appointed to attend that meeting or part of it, if so requested by the Chair. Any such alternative shall not be counted as part of the required quorum unless they have been formally been appointed by the Board as an Acting Director.

Non-quorate meetings may go forward unless the Chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the Company Secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the Council of Governors and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all Directors and others as agreed with the Chair and Chief Executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

The Board will review its effectiveness in the following ways:

Annual report with review of attendance records
Annual review of terms of reference
Annual reports from Board Committees
Board of Director Development Programme
Outputs from any Well-Led Governance Reviews
Internal./ external audit review

Date drafted: 13 February 2024

Date approved: 7 March 2024

Review Date: February 2025

DECLARATION OF INTERESTS – BOARD OF DIRECTORS
AS AT FEBRUARY 2024

Calderdale and Huddersfield NHS Foundation Trust

NON-EXECUTIVE DIRECTORS *

Date of Declaration	Name	Designation	Directorships, including Non-Executive Directorships held in private companies or public limited companies	Ownership /Part Ownership of private companies and businesses	Shareholdings and other ownership interests	A position of authority in a charity or voluntary organisation in the field of health and social care including membership of Partnership Meetings	Outside Employment (paid or non-paid) with a third party
14.11.23	Helen Hirst	Chair	Nil	Nil	Director of Helen Hirst Ltd. (management consultancy operating outside of West Yorkshire).	Member of West Yorkshire Association of Acute Trusts (WYAAT) – Committee in Common West Yorkshire NHS Chairs meeting Trustee and Chair of Wakefield Hospice Trustee of Staying Put Bradford (domestic abuse charity)	Interim Chair at Bradford Teaching Hospitals NHS Foundation Trust (6.11.23. to 2.3.24)
06.02.24	Karen Heaton	Non-Executive Director	Nil	Nil	Nil	Nil	Nil
13.02.24	Andy Nelson	Non-Executive Director	Nil	Nil	Nil	Nil	Nil
20.02.24	Peter Wilkinson	Non-Executive Director	Leeds Grand Theatre and Opera House Ltd – independent member of the Board and Trustee. A company limited by guarantee and a registered charity. Non-Executive Director Decipher Consulting UK Ltd. Consultancy business based in Manchester/Macclesfield	PW Advisory Ltd – own consultancy company based in Holmfirth	Nil	Nil	Nil

13.02.24	Denise Sterling	Non-Executive Director	Nil	Nil	Nil	Board Member for Race Equality Network (REN) Trustee Board Member for Bradford Diocesan Academies Trust	Nil
07.02.24	Tim Busby	Non-Executive Director	Director and Chair of Calderdale and Huddersfield Solutions Limited Director of Rosemont Pharmaceuticals and each of Primrose Group of Companies (Owners of Rosemont) Director of Busby Consulting Ltd.	Owners of Rosemont	Shareholder of Rosemont Pharmaceuticals	Nil	CFO for Rosemont Pharmaceuticals
06.02.24	Nigel Broadbent	Non-Executive Director	Nil	Nil	Nil	Vice Chair of the Audit Yorkshire Board	Nil

EXECUTIVE DIRECTORS*

Date of Declaration	Name	Designation	Directorships, including Non-Executive Directorships held in private companies or public limited companies	Ownership/Part Ownership of private companies and businesses	Shareholdings and other ownership interests	A position of authority in a charity or voluntary organisation in the field of health and social care including membership of Partnership Meetings	Outside Employment (paid or non-paid) with a third party
06.02.24	Brendan Brown	Chief Executive	Nil	Nil	Nil	Member of the West Yorkshire People Board (since 18.01.22) Partner Member (WYAAT) of West Yorkshire Integrated Care Board Member of Calderdale Cares Partnership Board Kirklees Integrated Care Board (ICB) Partner Member Chair of WYAAT Programme Board Chair of Kirklees & Calderdale Workforce Steering Group	Nil
30.01.24	Robert Aitchison	Deputy Chief Executive	Nil	Nil	Nil	Member of the West Yorkshire Community Health Services Collaborative	Nil
07.02.24	Dr David Birkenhead	Executive Medical Director	Benson Medical Services – Infection Control advice to the BMI Hospital, Huddersfield	Nil	Nil	Member of the WYAAT Medical Directors Group Member of the YWH Diagnostics Board Senior Responsible Officer of the New Pathology Partnership Member of the Kirklees Year of Music Board	Nil

22.01.24	Lindsay Rudge	Chief Nurse	Nil	Nil	Shareholdings of Chris Rudge Transport Services Limited	Nil	Nil
09.11.23	Gary Boothby	Executive Director of Finance	Director of Pennine Property Partnerships	Nil	Nil	Member of the West Yorkshire Association of Acute Trusts Finance Group Member of Integrated Care System Directors of Finance Forum Member of the Partnership Transformation Board Finance Lead for Kirklees	Nil
15.02.24	Kirsty Archer	Acting Director of Finance to October 2023	Nil	Nil	Nil	NEP Consortium Board Member	Nil
19.02.24	Suzanne Dunkley	Executive Director of Workforce & OD	Nil	Nil	Nil	Governor/Trustee of Calderdale College Workforce Sponsor Non Surgical Oncology Member of the WYAAT HRD group Member of the WY People Board	Nil

* For the purposes of the annual report and accounts the Executive Directors and Non-Executive Directors listed above are confirmed as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust.

DIRECTORS ATTENDING BOARD & COMPANY SECRETARY

Date of Declaration	Name	Designation	Directorships, including Non-Executive Directorships held in private companies or public limited companies	Ownership/Part Ownership of private companies and businesses	Shareholdings and other ownership interests	A position of authority in a charity or voluntary organisation in the field of health and social care including membership of Partnership Meetings	Outside Employment (paid or non-paid) with a third party
13.02.24	Anna Basford	Director of Transformation & Partnerships	Nil	Nil	Nil	Member of WYAAT Directors of Strategy Group and WYAAT Chief Operating Officers Group Non-Voting Member of Calderdale Health and Wellbeing Board	Nil
08.11.23	Robert Birkett	Chief Digital Information Officer	Nil	Nil	Nil	Member of WYAAT CDIO Group	Nil
08.11.23	Jonathan Hammond	Chief Operating Officer	Nil	Nil	Nil	Nil	Nil
17.10.23	Victoria Pickles	Director of Corporate Affairs	Nil	Nil	Nil	Vice Chair of Overgate Hospice and Overgate Hospice Support Ltd. Trustee of Mountain and Search Rescue England and Wales	Nil
13.11.23	Andrea McCourt	Company Secretary	Nil	Nil	Nil	Appointed Governor of South West Yorkshire Partnership Foundation Trust on behalf of CHFT.	Nil

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS – REPORT FOR THE 12 MONTH PERIOD FROM JANUARY 2024

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
01-24	5 February 2024	5 February 2024	The Trust signature and seal for a variation to extend the lease of the Clock House, Elland to 20 years by removing the break clause. This follows the discovery of additional asbestos at the site. The landlord has provided the Trust as tenant with capital monies to remove the asbestos. Also additional clause re fire safety alterations. Contract end date now 10 January 2042.	NAME: Suzanne Dunkley TITLE: Executive Director Workforce and Organisational Development NAME: Andrea McCourt TITLE: Company Secretary Date: 5 February 2024

Draft BOARD PLAN 2024/2025 – as at 26.02.24 V6

PUBLIC BOARD WORKPLAN 2024-2025

DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	5 September 2024	7 November 2024	9 January 2025	6 March 2025
Date of agenda setting/Feedback to Execs	31 Jan 2024	20 March 2024	21 May 2024	31 July 2024	TBC	TBC	TBC
Date final reports required	23 February 2024	19 April 2024	21 June 2024	23 August 2024	25 October 2024	27 December 2024	22 February 2025
STANDING AGENDA ITEMS							
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓	✓
Financial Update	✓	✓	✓ & Budget book	✓	✓	✓	✓
Health Inequalities	✓		✓		✓		✓
Quality Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓	✓
Finance and Performance Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓	✓
Workforce Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Chairs Highlight Report & Minutes			✓	✓		✓	
STRATEGY & PLANNING AGENDA ITEMS							
Strategic Objectives – 1 year plan / 5 year strategy	✓	✓ Year-end Quarterly Report	-	✓ - *2023-2024 Strategic Objectives Progress Report*	✓		✓
Digital Health Strategy						✓	

DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	5 September 2024	7 November 2024	9 January 2025	6 March 2025
Digital Update (Digital story and an update on the broader THIS work, not just the CHFT aspects)						✓	
Risk Management Strategy	✓		✓				
Charity Strategy					✓		
Annual Plan	✓	✓ for 2024/25					✓
Capital Plan	✓					✓	
Resilience / Surge & Escalation Plan					✓		
Green Plan (Climate Change)			✓				
Reconfiguration (commercial)				TBC			
QUALITY AGENDA ITEMS							
Director of Infection Prevention Control (DIPC) quarterly report	✓Q3	✓Q3	✓Q4	✓Q1	✓Q2		✓Q3
DIPC Annual Report			✓				
Learning from Deaths Quarterly Report	✓ Q2	✓ Q3	✓Q4 Annual Report		✓Q1		✓ Q2
Update on Maternity Reporting (invite Director of Midwifery)		✓	✓	✓	✓	✓	✓
Maternity Incentive Scheme						✓	
Safeguarding Adults and Children Annual / Bi-Annual Report			✓ Annual Report			✓ Bi-annual	
Complaints Annual Report			✓				
WORKFORCE AGENDA ITEMS							
Staff Survey Results and Action Plan		✓		✓			✓
Health and Well-Being				✓			
Nursing and Midwifery Staffing Hard Truths Requirement			✓ Annual Report			✓ Bi-Annual	✓
Guardian of Safe Working Hours Update	✓		✓	✓	✓		✓
Guardian of Safe Working Hours Annual Report		✓					

DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	5 September 2024	7 November 2024	9 January 2025	6 March 2025
Diversity					✓ Board Diversity Action Plan		✓
Medical Revalidation and Appraisal Annual Report				✓ Annual Report			
Public Sector Equality Duty (PSED) Annual Report		✓					✓
GOVERNANCE & ASSURANCE AGENDA ITEMS							
Emergency Planning Annual Report / EPRR Core Standards Submission		✓ Annual Report				✓ Compliance statement	✓ Annual Report
Freedom to Speak Up Annual Report				✓ Annual Report		✓ 6 month report FTSU themes and qualitative presentation	
Health and Safety Update (if required – routinely reports to ARC)		✓				✓	
Health and Safety Policy (May)		✓					
Health and Safety Annual Report			✓				
Board Assurance Framework	✓ 3		✓ 1		✓ 2		✓ 3
Risk Appetite Statement				✓			
High Level Risk Register	✓	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review (next review due March 2025 unless changes required beforehand)							✓
Trust Constitution - as required							
Non-Executive appointments	✓				✓		✓
Annual review of NED roles					✓		
Board workplan	✓	✓	✓	✓	✓	✓	✓
Board meeting dates			✓				
Use of Trust Seal	✓		✓		✓		✓

DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	5 September 2024	7 November 2024	9 January 2025	6 March 2025
Declaration of Interests & Fit and Proper Persons Declarations– Board of Directors (annually)	✓						✓
Attendance Register – (annually)		✓					
Fit and Proper Person Self-Declaration Register	✓						✓
Seek delegation from Board to ARC for the annual report and accounts 2021/22	✓						✓
BOD Terms of Reference	✓						✓
Sub Committees Terms of Reference	✓F&P ✓ NRC BOD	✓QC ✓ NRC CoG ✓ Workforce		✓ARC	✓ TPB review Sept		✓F&P ✓ NRC BOC
Constitutional changes (+as required)	✓	✓	✓	✓	✓	✓	✓
Compliance with Licence Conditions (final year 2022/23)		✓					
THIS Update						✓	
Huddersfield Pharmacy Specials (HPS) Annual Report				✓			
Fire Strategy 2021-2026		✓					✓
Annual Fire Safety Report						✓	
Audit and Risk Committee Annual Report 2022/2023			✓				
Workforce Committee Annual Report 2022/23			✓				
Finance and Performance Committee Annual Report 2022/2023			✓				
Quality Committee Annual Report 2022/23			✓				
Transformation Programme Board Annual Report			✓				
WYAAT Annual Report and Summary Annual Report						✓	
Kirklees ICB Committee Papers (Link)		✓	✓	✓	✓	✓	✓

DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	5 September 2024	7 November 2024	9 January 2025	6 March 2025
Calderdale Cares Partnership Committee Papers (Link)	✓	✓	✓	✓	✓	✓	✓

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 (see Review Room papers)

26. Review of Board Sub-Committee Terms of Reference

a) Finance and Performance Committee

b) Nominations and Remuneration Committee (Board of Directors)

To Approve

Calderdale and Huddersfield NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Version:	1.1 - first draft circulated for review to Chair / CE / DoF / DDof 1.2 - comments received OW / CB / AH 1.3 - Amendments from the Board of Directors 2.1 – Reviewed and updated for membership and to reflect planning cycle 3.1 – Reviewed and updated to include a Performance Delivery and Assurance Section 4.1 – Reviewed and updated – March 2019 5.1 – Reviewed and updated – June 2020 6.1 – Reviewed and section 5.3 added to allow for quoracy. November 2021 7.1 – Reviewed and section 5.1 attendees updates. June 2022 8.1 - Review of quoracy December 2022 9.1 - Scheduled review January 2024
Approved by:	Board of Directors
Date approved:	
Date issued:	
Review date:	

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee to be known as the Finance and Performance Committee. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

The Finance and Performance Committee has delegated authority from the Board to oversee, coordinate, review and assess the financial and performance management arrangements and providing assurance to the Board on these. This includes monitoring the delivery of the ~~5 Year Plan and supporting~~ Annual Plan and oversight of decisions on investments and business cases.

The Committee will ensure that Board members have a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

3. Authority

The Finance and Performance Committee is authorised by the Board, to which it is accountable, to investigate or approve any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request for such information.

4. Role and duties of the Committee

The Finance and Performance Committee will provide the Board with assurance that finance and performance is being monitored and managed across the organisation and that progress is being made in the implementation of the Annual Plan.

The duties of the Committee can be categorised as follows:

4.1. Finance and Financial Performance

- Provide assurance that the finance ~~-~~position and financial performance reporting systems of the organisation are robust through detailed review of the Monthly Financial Report. This includes noting the finance position at Place and System level
- Seek assurance that any appropriate management action has been taken to return the Trust's financial performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored.
- Provide assurance to the Board that cost improvement plans to support organisational changes are being delivered.
- Review the Trust's Long Term Financial Model and any national or regional submissions to test assumptions and provide assurance that the returns represent a true and fair view of the financial performance for the period under review.
- Review all significant financial risks on the high~~-~~level risk register and the Board Assurance Framework.
- Review the finance elements of the NHS Oversight Framework and Use of Resources metric.
- Examine any matter referred to the Committee by the Trust Board or one of the other assurance Committees.

4.2 Performance Delivery and Assurance

- Provide assurance that the performance reporting systems of the organisation are robust through detailed review of the Integrated ~~Performance Report~~Performance Report (IPR) on a monthly basis.

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

- Keep the content of the Trust's ~~IPR under~~IPR under review, ensuring that it includes appropriate performance metrics and detail of exceptions to provide assurance to the Board on all aspects of organisational performance against its strategic objectives.
- Seek assurance that any appropriate management action has been taken to return the Trust performance to plan and that any such actions or recovery plans that are in place are adequately resourced, implemented and monitored and that appropriate EQIA has been completed.
- Provide assurance to the Board that the performance of Clinical Divisions and corporate teams are in line with agreed annual plans and receive escalation where recovery plans do not resolve any adverse variance, with deep dives into specialties / issues as required.
- Review all finance and performance related risks on the Board Assurance Framework

4.3 Business and commercial development

- Ensure compliance with the Treasury Management guidance.
- Review the Trust's Annual Plan, ~~,~~ Capital Plans and Financial Model and recommend to the Board for approval.
-
- Approve the establishment of joint ventures or other commercial partnerships/relationships including the incorporation of start-up companies. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, etc. related to joint ventures, commercial partnerships or incorporation of start-up companies.
- Agree investment / dis-investment in services (with full understanding of financial and service implications of these decisions e.g. overheads)

4.4 Treasury Management

- Maintain an oversight of the Trust's Treasury Management activities, ensuring compliance with Trust's policies.
- Review borrowing arrangements and liabilities.
- Review and monitor the Trust's Treasury Management Policy *(approval is through the Audit & Risk Committee)*.
- Review the activities undertaken at Cash Committee

~~4.5 **Procurement**~~

- ~~Review the activities undertaken by Procurement and the contributions made along with performance against key national metrics.~~

5. Membership and Attendees

5.1. The Committee shall consist of the following 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
- ~~Director of Corporate Affairs~~

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

5.2. The Deputy Director of Finance and the Company Secretary will regularly attend. All Board members are invited to attend any assurance Committee.
5.3. Directors and other senior management staff may be required to attend discussions when the Committee is discussing areas of performance or operation that are their responsibility.
5.4. Two Governors will be invited to attend each meeting as observers.
5.5. If a Non-Executive Director or Executive Director is unable to attend a meeting, they should nominate a deputy, subject to the agreement with the Trust Chair and Chief Executive, and that deputy will be counted for the purpose of quoracy.

6. Attendance

6.1. Attendance is required by members at 75% of meetings. Members unable to attend should indicate in writing to the Committee secretary, at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances, any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

6.2. 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 jeopardies the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

7. Administration

7.1. The Committee shall be supported by the Secretary to the Executive Director of Finance, 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 issue to be carried forward;
- Advising the group on scheduled agenda items;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

8. Meetings

8.1. Meetings will be held on a monthly basis and arranged to meet the requirements of the corporate calendar;
8.2 Meetings could be held either in person or using virtually using digital technology
8.3 Items for the agenda must be sent to the Committee Secretary a minimum of 8 days prior to the meeting: urgent items may be raised under any other business;
8.4 An action schedule will be circulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers; and
8.5 The agenda will be sent out to the Committee members one week prior to the meeting date, together with the updated action schedule and other associated papers.

9 Reporting

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

9.1 The minutes of the Committee meetings formally recorded by the Committee Secretary will be submitted to the Trust Board when approved, together with a highlight report of the meeting(s) from the Committee Chair.

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

9.3 The Turnaround Executive, Capital Management Group, Business Case Approvals Group, the, Cash Committee, Huddersfield Pharmacy Specials, Joint Liaison Committee, PFI Quarterly Contract meeting, THIS Executive Board and , Access Delivery Group, Urgent and Emergency Care Delivery Group, Pennine Property Partnership Board will provide minutes of its meetings to the Committee along with reports as agreed.

10 Quorum

To be quorate at least three of the members of the Committee must be present, including at least two Non-Executive ~~Directors~~Directors.

If a quorum is not reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

11 Review

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

12 Monitoring Effectiveness

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 Board, 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~~ 4 were fulfilled~~;~~
- Members attendance was achieved 75% of the time~~;~~
- Agenda and associated papers were distributed 7 days prior to the meetings~~;~~
- The action schedule was circulated within 3 working days of the meeting, on 80% of occasions.

Calderdale and Huddersfield NHS Foundation Trust

NOMINATION AND REMUNERATION COMMITTEE (BOARD OF DIRECTORS)

TERMS OF REFERENCE

Version:	7 Draft 24 January 2024, 7.1 6 6 March 2023 5 10 November 2022 4 Board approved 3.3.22 3 Board approved 14.1.21 2 Board approved 5.3.20 1 Board approved 30.6.16
6	Board of Directors
Date approved:	Board 7 March 2024 TBC 6 March 2023 31 January 2024 Nominations and Remuneration Committee
Date issued:	7 March 2024 ~~6 March 2023~~
Review date:	March 2024~~4~~5

NOMINATIONS AND REMUNERATION COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Nominations and Remuneration Committee. The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

2.1 The Nominations and Remuneration Committee is constituted as a standing non-executive Committee of the 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.

2.2 The Nominations and Remuneration Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Nominations and Remuneration Committee.

2.3 The Nominations and Remuneration Committee is authorised by the Board of Directors to instruct professional advisors and seek information where required to support decision making. The Committee may also request the attendance of individuals and authorities from both within and outside the Trust with relevant experience and expertise if it considers this necessary to the exercise its functions.

3. Purpose

3.1 To be responsible for identifying and appointing candidates to fill all NHS Foundation Trust Executive voting and non-voting Director positions on the Board, and Director roles within Calderdale and Huddersfield Solutions Ltd (CHS). When appointing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006. When appointing the other Executive Directors, the Committee shall be the committee described in Schedule 7, 17(4) of the Act.

3.2 To determine the remuneration and other conditions of service of voting and non-voting Director positions on the Board and the Director positions within CHS.

The Committee will:

3.2 Regularly review the structure, size, and composition (including the skills, knowledge, experience, and diversity) of the Board and make recommendations to the Board regarding any changes in Executive and Non-Executive roles. When considering composition, the Committee will seek to reflect the Board's action plan to match the diverse composition of the overall workforce or community.

3.3 Consider and make plans for succession planning for the Chief Executive and other Executive Board Directors, taking into account the challenges and opportunities facing the Foundation Trust and the skills and expertise needed, to achieve the Strategy.

Consider and make plans for review and succession planning for the non-voting Director roles and Director roles for wholly owned subsidiaries established by the Board, taking into account the skills and expertise needed.

3.4 Keep the leadership needs of the Trust under review at Executive level to ensure the continued ability of the Trust to operate effectively in the health economy.

3.5 Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.

3.6 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the appointment. In identifying suitable candidates, the committee shall use open advertising or the services of external advisers to facilitate the search; consider candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria. The selection panel should include at least one external assessor from NHS England and / or a representative from a relevant ICB. (Code of Governance for NHS Providers Section C states FT should engage with NHS E to agree the approach)

3.7 Ensure that a proposed Executive voting and non-voting Director's other significant commitments (if applicable) are considered before appointment.

3.8 Be responsible for identifying and nominating a candidate for approval by the Board and the Council of Governors, in accordance with the Constitution, to fill the position of Chief Executive.

3.9 Ensure that proposed appointees comply with the Fit and Proper Persons Requirements and the Trust Fit and Proper Persons Policy and confirm their awareness of the circumstances which would prevent them from holding office and disclose any business interests that may result in a conflict of interest prior to appointment.

3.10 Consider any matter in line with Trust procedures relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Foundation Trust.

4. Remuneration role

4.1 Establish and keep under review a remuneration policy in respect of Executive voting and non-voting Directors of the Board.

4.2 Consult with the Chief Executive about proposals relating to the remuneration of Executive voting and non-voting Directors of the Board.

4.3 In accordance with all relevant laws, regulations, and Trust policies, decide and keep under review the terms and conditions of office of the Trust's Executive Directors and non-Board Directors including Director roles within wholly owned subsidiaries of the Trust, including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses; and compensation payments.

4.4 In adhering to all relevant laws, regulations, and Trust policies:

- Establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose and at a level which is affordable for the Trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of Executive Directors and non-Board Directors while ensuring that increases are not made where Trust or individual performance do not justify them.

- Be sensitive to pay and employment pay and conditions elsewhere in the Trust.

4.5 Monitor and assess the output of the evaluation of the performance of individual Directors and consider this output when reviewing changes to remuneration levels.

4.6 Advise on and oversee contractual arrangements for Executive Directors and non-Board Directors, including but not limited to termination payments (including redundancy), taking account of national guidance where appropriate, always ensuring that poor performance is not rewarded.

4.7 Delegate responsibility to the Chief Executive and Executive Director of Workforce and Organisational Development for the determination of the Trust's pay and reward strategy as it affects all other staff, working within national frameworks where required.

5. Membership and attendance

5.1 The membership of the committee shall consist of:

- The Trust Chair
- At least 3 other Non-Executive Directors on the Board (excluding the Chair of the Audit and Risk Committee)
- The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding his terms of condition and remuneration.

5.2 The Trust Senior Independent Non-Executive Director shall chair the Committee.

5.3 A quorum shall be three members which must include either the Trust Chair or ~~Trust Deputy Chair/~~Senior Independent Non-Executive Director. In the absence of the Trust Senior Independent Non-Executive Director, the Trust Chair will chair the meeting.

5.4 The Executive Director of Workforce and Organisational Development shall normally be invited to attend meetings in an advisory capacity but will withdraw from the meeting during any discussions regarding their remuneration and terms and conditions of service.

5.5 Other members of staff and external advisers may attend all or part of a meeting by invitation of the Committee Chair where required.

5.6 Members unable to attend should inform the Committee Secretary at least 7 days in advance of the meeting.

5.7 A register of attendance will be maintained, and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Company Secretary shall be the secretary to the Committee and will provide administrative support and advice. The duties of the Company Secretary in this regard include but are not limited to:

- Agreement of the agenda with the Chair of the 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 5 working days of each meeting; and
- Maintaining a record of attendance.

7. Frequency of meetings

7.1 Meetings shall be held as required but at least annually in each financial year, and whenever there is a need to consider matters relating to the appointment of Executive Directors. A meeting of the Committee may be called by the Company Secretary at the request of the Chair.

8. Reporting

8.1 Formal minutes shall be taken of all Committee meetings and ratified by the Committee at its next meeting

8.2 The Committee Chair shall prepare a report of each Committee meeting for submission to the next Board of Directors meeting in confidence unless it would be inappropriate to do so.

8.3 The Committee shall receive and agree a description of the work of the Committee, its policies, and all Executive Director emoluments in order that these are accurately reported in the Trust's Annual Report.

9. Review

9.1 The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually, with a prior review undertaken by the Committee before approval by the Board of Directors.

Date Approved by Nominations and Remuneration Committee: 31 January 2024

Review Date: March 2025~~4~~

27. Items to Receive

1. Minutes of Board Committees

- Finance and Performance Committee 02.01.24 & 31.01.24
- Quality Committee 20.12.23 & 15.01.24
- Workforce Committee 18.12.23
- Charitable Funds Committee 06.02.24

Partnership papers: Kirklees Health and Care Partnership Kirklees ICB Committee meetings - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk) and Calderdale Cares Partnership Meeting papers - 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 January 2024, 09.30am – 12noon
Via Microsoft Teams

PRESENT

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director
Rob Aitchison (RA)	Deputy Chief Executive
Gary Boothby (GB)	Director of Finance
Robert Birkett (RB)	Managing Director of THIS

IN ATTENDANCE

Rochelle Scargill (RLS)	PA to Director of Finance (Minutes)
Peter Keogh (PK)	Assistant Director of Performance
Philippa Russell (PR)	Assistant Director of Finance
James Houston (JHO)	Shadow Board
Arley Byrne (AB)	Shadow Board
Peter Howson (PH)	Commercial Director THIS - Item 6 only
Stephen Shepley (SS)	Director of Operations – FSS – Item 8 only
Kimberley Scholes (KS)	General Manager – FSS – Item 8 only.
Burrinder Grewal (BG)	Managing Director – HPS – Item 15 only
Stuart Baron (SB)	Deputy Director of Finance

OBSERVERS

Robert Markless (RM)	Public Elected Governor
Brian Moore (BM)	Public Elected Governor
Helen Hirst (HH)	Trust Chair

APOLOGIES

Kirsty Archer (KA)	Deputy Director of Finance
Andrea McCourt (AM)	Company Secretary
Anna Basford (AB)	Director of Transformation and Partnerships
Adam Matthews (AM)	HR Business Partner
Jonathan Hammond (JH)	Chief Operating Officer

ITEM

001/24 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting including members of the shadow board.

002/24 DECLARATIONS OF INTEREST

003/24 MINUTES OF THE MEETING HELD 28th November 2023

The previous minutes were approved as an accurate record.

004/24 MATTERS ARISING

005/24 ACTION LOG

The Action Log was reviewed as follows:

134/23 - 2022/23 National Cost Collection Pre-Submission the report was submitted on Friday 29th December. A final report will be sent to GB in the new year to sign and return. This will come to the February meeting.

191/23 – ENT and Cancer Deep Dive – ENT task and finish group action plan to be shared with the committee.

192/23 – IPR – Is the paediatric virtual ward included in the virtual ward offering? JH was not in attendance. To be deferred to the next meeting.

192/23 – IPR – What would the ambulance wait times look like without the new extra 8.5 minutes? A separate piece of work has been done and can be shared with the committee Then close action.

006/24 THIS COMMERCIAL STRATEGY PRESENTATION

Peter Howson gave a presentation that will be shared with the committee after the meeting. The commercial strategy will enable THIS to align their resources with the digital strategy. Approximately £1.3m of commercial income is contributed to CHFT each year. All CHFT operations are provided at cost.

Last year THIS were nominated for 4 Health Service Journal awards and there are 3 nominations being submitted this year.

Recruitment to specialist areas to meet customer needs continues to be a challenge particularly around project management. As a result, a pathway for in-house development has been put in place. Vacancies for two new account managers will be advertised later this month, following the promotion of two of the existing managers.

KPI's are in place to monitor if the commercial strategy is delivering as planned.

In summary:

- THIS continues to be on target to meet its commercial objectives.
- ICS changes and collaborative working is now becoming a reality offering opportunities for further work
- Commerciality vs Partnership working is coming more and more an important consideration and challenge as the ICB matures.

RB added that the strategy was very positive for THIS however, the committee should be aware the NHS organisations that THIS are selling services into, are having the same financial pressures as CHFT. There may be future commercial opportunities around data and business intelligence (BI) provision.

NB – Asked for clarification on the challenges around the ICS and how decision making and funding could be affected.

PH – THIS currently provide services to 4 out of 5 Places within the ICB. The ICB is appointing a new Chief Digital Information Officer (CDIO) who could potentially decide to move the services elsewhere. The team is working hard to meet all KPI's for the service provided and to complete any projects as efficiently as possible to position THIS as the provider of choice.
Amalgamation of the capital and financial teams means that decision making can be delayed as they decide who will make the decision and who will pay for it. Is it a singular invoice to one Place or is it split across the region? There has been an increase in the amount of activity provided which has incurred extra cost and despite notice being given seems to have been unexpected.

KH – There needs to be a balance between profit and delivering the service.
THIS are comfortable that the balance is correct. The focus is to ensure the teams are resourced effectively in order to provide more services. There are challenges as mentioned particularly around project management, but plans are in place to look at future provision.

KH asked if any business simulations exercises are carried out in relation to cyber security.
Unable to complete an exercise closing all systems down as it would prevent business as usual. Exercises are scheduled twice a year behind closed doors using tabletop exercises as well as physical infrastructure tests. These test backups, systems and software.
There is a new colleague in post as the Cyber Security Manager who is more experienced and will lead the team to complete everything that is a must do.

GB emphasised the challenge commercial and the ICS. There is a balance between THIS being commercially viable while remaining attractive as a supplier to partners.

RB finished the conversation by clarifying that a decision was made a few years ago to prioritise quality of service over profit. If THIS cannot deliver a requested service properly for the price, then the contract will not be taken on. THIS have said no on a couple of occasions to prevent risk to reputation etc. RB also explained that to maintain the ISO certifications, tabletop exercises must be completed which are then audited.

The Committee **RECEIVED** the THIS Commercial Strategy

007/24 PATHOLOGY MANAGER SERVICE CONTRACT

GB asked for approval of Lot 2 of the pathology manager service contract as discussed fully at a previous private meeting of this committee. The Lot has been through a complete tender process to determine the successful supplier. Lot 2 is of lower value than the previous Lot. The committee was asked to approve Lot 2 to go to the next Trust Private Board for approval.

The Committee **APPROVED** Lot 2 of the Pathology Manager Service Contract to go to Trust Private Board.

008/24 OUTPATIENT FOLLOW UPS DEEP DIVE

SS and KS presented an update following a full deep dive at a previous meeting of this committee.

The intention is not to reduce the number of patients to zero, but to return to pre-covid timescales. Patients can wait for 12 weeks before being seen of which 50% of the backlog fits within this timeframe. There are some specialities where patients have been waiting over 39 weeks.

KS listed the actions being undertaken to reduce the backlog including validation of requests which allowed 11,000 superseded requests to be removed. Targeted training has been carried out across all specialties to show colleagues the correct way to book a follow up appointment and ensure appointments are booked in order. Feedback has been very good.

The plan is to reduce the backlog to 24,000 by the end of the financial year, then with the impact of the booking training etc. taking effect, to reduce that number down to 16,000 by March 2025. The new Patient Portal will go live in March 2024 and it also expected to make a positive impact. Performance will be monitored through the Trust Access Delivery Group.

AB asked if there is an opportunity to see what others are doing? There is no benchmarking for follow ups and no national targets. Each organisation is submitting different information. That is why the decision was made to benchmark ourselves against pre-Covid performance.

JH enquired if there are any general actions that can be done to reduce errors or if they are speciality specific. There are general principles such as booking the appointments the correct way, but others have genuine capacity issues. Customer contact meetings with each speciality take place every fortnight.

AN asked if the longest waits are being dealt with first? In principle yes, but each speciality is different.

There is sufficient capacity to see all the follow ups as long as it is used in the right way.

NB If there is no national benchmarking is there anything that can be learned around process from other organisations? Some “Go See” visits have taken place, but they have not highlighted anything so far.

Internal audit days are being used to do some specific work around the booking process.

FINANCE & PERFORMANCE

009/24 MONTH 8 FINANCE REPORT

The Assistant Director of Finance presented the financial position as reported at Month 8, November 2023.

Story similar to previous months. At month end there was a £14.66m deficit which was around a £540k adverse variance to plan.. There has been some slippage within CIP schemes which is linked to bed capacity and length of stay. There were a number of additional capacity areas open in November.
It is worth noting that the ICS as a whole remains off track by £23m year to date.

The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £2.40m. Key drivers of this forecast deficit are £4.36m slippage on efficiencies, non-pay inflationary pressures, additional bed capacity and £0.71m forecast Strike costs for the recently announced Dec and Jan industrial action. The forecast improved by £3.5m in month compared with the position reported in M7. The ICS has allocated £2.1m additional funding to support YTD Strike costs and a further £1.6m of ERF funding is expected due to changes to Recovery performance targets. This improvement has been offset to some extent by an increase in forecast costs associated with winter bed capacity.

Capital is currently underspent £10.96m to date. There have been couple of changes including an additional £5m in plan for the expansion of Huddersfield Pharmacy Specials which will be funded by PDC. The forecast for the reconfiguration spend at Calderdale Royal Infirmary is now at £8.1m and expected to be funded internally.

Cash is ahead of plan with £31.3m in the bank which has delayed the expected draw down of PDC. The plan now is to draw down in February 2024 with a request of £15.3m to support the deficit.

GB asked the committee to note that, while the most likely position shows a variance from plan, West Yorkshire is suggesting they will deliver the plan subject to any additional strike costs. The intention is to negotiate a fair share for CHFT based on activity.

The mitigations within the forecast are now secured within the plan but most of them are non-recurrent. Timing of spend is favourably impacting the cash balance.

The committee were asked to note that the funding for HPS has not yet been awarded but has been forecast to be.
Any differences in CIP between the finance report and the TE report are as a result of the finance report reporting on the month end position and the TE meeting taking place weekly.

The committee **RECEIVED** the Month 8 Finance Report.

010/24 TURNAROUND EXECUTIVE 2023/24 CIP PROGRESS

The Deputy Chief Executive gave a brief update.

The committee were asked to note that while not all the identified schemes have delivered as expected, the highest level of CIP ever has been achieved this year. Deep dives have taken place into the schemes that have not delivered as expected. Planning has commenced for CIP for 2024/25, with some schemes already identified. This will link into the planning work.

NB questioned if there was any assurance that those schemes that were identified this year but did not deliver the efficiencies expected, would be given a challenge for the new year. This year's ED scheme is expected to deliver in full next year. The length of stay scheme is based on getting the bed base correct and this will be affected by other initiatives coming into use such as the virtual ward and SDEC.

The Committee **RECEIVED** the Turnaround Executive update

011/24 2024/25 FINANCIAL PLAN

The Assistant Director of Finance explained to the committee that as of this meeting there has been no national planning guidance issued. The guidance is expected at some point in January. No timetable has been received either.

The planning work is continuing and there are some assumptions such as the core funding allocations that were announced as part of the two-year settlement will stand but be uplifted for the 2023/24 pay settlements. It is yet unclear as to how this will be affected by inflationary pressures.

The expectation is to bring the annual plan to this committee on the 27th February but the timetable might change once the national guidance and timetable has been received.

Activity modelling will be completed by 12th January and planning for pressures, new developments and recovery plans by 19th January. The intention this year is to have a dragon's den style event similar to the ones held for capital planning to discuss pressures and developments.

Activity – the focus is still on reducing waiting lists within the financial constraints. The expectation is that mutual aid will continue and assuming it will be funded.

The local places will also be facing financial challenges next year with both Kirklees and Calderdale councils reporting deficits.

Last month the underlying position was reported as part of the medium-term plan. This was reported at £48.3m but this has now deteriorated to £53.3m. There will be an ICB convergence adjustment of around 1.2%.

£70m is the indicative plan currently absent any cost improvement plan. No target has been agreed for an efficiency target for 2024-25.

Capital has an indicative plan of £62m currently, £42m of which would be externally funded though the PDC and £20m as CHFT's share of the West Yorkshire capital fund. The capital schemes include the Community Diagnostic Centre, HPS expansion,

Calderdale Royal Plant Room expansion, Cath Lab and the Multi-storey car park at Calderdale.

The requirement for borrowing will continue into next year with a forecasted cash balance of £1.9m the beginning of the financial year.

The Committee **RECEIVED** the Planning update.

012/24 NHSE DEEP DIVE ACTION PLAN

The presentation was provided in the meeting pack. The update has come back to this committee for internal governance. We are on track to complete all the actions. Slippage is expected on the estates rationalisation plan. An external provider has been commissioned by West Yorkshire which is not expected to be completed until April or May.

The Committee **RECEIVED** the Deep Dive Action Plan

013/24 IPR

The Assistant Director of Performance highlighted the key points of the November IPR.

- Bed occupancy has been over 99% for the second month running.
- ED proportion of patients seen with 4 hours at 66% for the second month running.
- In general, elective recovery is going very well however ENT is affecting the 40-week position.
- There was one patient waiting over 65 weeks who has now been treated.
- Cancer performance continues to be strong with the faster diagnosis target being achieved for the third month running.
- Ambulance arrivals delayed over 30minutes remained high at 6.5% as expected inclusive of the key change of when the clock starts for measuring the delay.
- MUST assessment and complaints continue to see improvement.
- There were two never events in November.

A target of 76% for ED is in place to be achieved in March 2024.

GB noted that there has been very positive feedback from NHSE on the new IPR and the use of SPC charts. NHSE rated the IPR 5/5 and ranked CHFT at 12th out of 210 trusts. The question has been asked if they could be used for Finance. The financial information does not present as well in SPC format as it does currently and is not as easy to read.

RA highlighted that while this meeting was taking place, operational colleagues had not been able to join due to the pressures being experienced especially at the Calderdale site. The is mirrored across partners who are dealing with the same post Christmas and pre-strike challenges.

ACTION: AN to speak to PK outside of the meeting around other measures which have shown movement in the IPR Performance Matrix Summary.

The Committee **RECEIVED** the IPR for November

014/24 RECOVERY UPDATE

Assistant Director of Performance gave an update starting with the fact that CHFT is still performing well, is ahead of plan and performing better than all other trusts in WYATT.

Strike action has impacted the overall plan for 52 and 40 weeks. The plan for CHFT is to be as close to zero as possible for 52 week waits by the end of March. All specialities are reducing except ENT.

Diagnostics - Echo deteriorated October to November however, Neurophysiology has shown an improvement. JH has been in discussions with colleagues in Mid Yorkshire to explore the possibility of them carrying out work for CHFT. A group has been set up to look at creating a collaborative bank for Echo physiologists.

NB – Is there a possibility that ENT will prevent internal targets for 40 and national 52-week target being reached?

PR Yes there is. CHFT has had small numbers of 52-week waiters for a few weeks now. Strike action has also impacted this.

The Committee **RECEIVED** the Recovery Update

015/24 HPS BUSINESS CASE

The papers were shared prior to the meeting and comments have been submitted directly to RA.
RA shared a brief presentation. There was an opportunity for £15m of funding from the NHS England Infusions and Special Medicines Programme. One of the existing NHS manufacturers has been privatised and extra capacity is required in the market. CHFT already has a pharmacy manufacturing unit which operates as Huddersfield Pharmacy Specials.

Project delivery will be supported by Calderdale and Huddersfield Solutions (CHS) using external support as was the case for the new ED as well as support from HPS. The plan is to use the empty buildings next to HPS to expand and increase the footprint while allowing business to continue as usual.
The money is to be phased over the next two financial years. There may be some additional costs which are not yet known, for example medical records are currently housed in one of the buildings scheduled to be demolished. There will be no financial benefit to Trust until year 3. The majority of growth will come from newly licensed products.

BG – The main strategy for HPS is to licence manufactured products as the existing baseline specials business is in decline as fewer are prescribed. Capital investment is needed to deliver this strategy and manufacture in the volumes required. HPS will expand its footprint and improve the working areas.

KH asked if the £5m that is available 2023-24 can be flexed if we cannot spend it within this financial year? Stuart Baron has reached an agreement from ICB that CHFT can draw down less of the expected capital for reconfiguration this year and use the HPS money then reverse it next year.

HPS has a long history of manufacturing specials. Product lines will continue to sell but will be licensed lines instead of specials which will increase the market.

NB questioned if the business case would be monitored externally to ensure that the case is meeting the financial projections within the case? There is not expected to be any external scrutiny. The case does need CHFT board approval, but the money is being offered to provide resilience of the market. HPS is one of only 2 or 3 units nationally that could provide the NHS manufacturing service. KPI's have been requested as part of the internal governance and these will be monitored through the Transformation Programme board and following completion it will be built into the CHFT financial plans for a return in year 3 onwards. The numbers within the report are prudent based on the work done by Candesic so the benefits could be higher.

RA The worst-case scenario shows the costs of developing and running this development can be covered with an opportunity to provide increased contribution.

NB Earlier in this meeting the THIS commercial strategy spoke of charging a commercial rate for services. Is there any assurance that the kind of surpluses that are projected in the case would fit within the same principles?
BG Every time a medicine is priced it is done at a commercial rate comparing similar items in the market. The plan is based on that going forward. No-one has challenged the prices over the years.

AN Is there assurance that the project can be delivered within the costs quoted in the case?
BG Discussions are taking place with the Trust appointed architects who have provided written assurances that this can be delivered.

ACTION: BG to send metrics to AN.

AN noted that the level of contingency seemed low considering the size of the case. This has been set in line with national guidance but this should prove insufficient the development will be scoped accordingly

There will be some more details to include in the cover sheet and business case itself before it goes to Trust Board for approval. These will address any further detail points raised both within the meeting and in comments provided prior to it.

ACTION: AN/NB and RA to discuss and follow-up outside of the meeting.

The Committee **APPROVED** the HPS Business Case to go to Trust Board.

016/24 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Access Delivery Group
- Business Case Approval Group
- THIS Executive Board
- Urgent and Emergency Care.
- Capital Management Group
- HPS Board
- CHS/SPC Quarterly Meeting

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

017/24 WORKPLAN – 2023/24

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

018/24 ANY OTHER BUSINESS

-

019/24 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- THIS commercial strategy
- Outpatient follow-ups
- Positive performance themes and consistent challenges
- Approval of HPS business case

DATE AND TIME OF NEXT MEETING:

Tuesday 30th January 2024 09:30 – 12:00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on
Tuesday 30th January 2024, 09.30am – 12noon
Via Microsoft Teams

PRESENT

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director
Rob Aitchison (RA)	Deputy Chief Executive
Anna Basford (AB)	Head of Transformation and Partnerships
Kirsty Archer (KA)	Deputy Director of Finance
Jonathan Hammond (JH)	Chief Operating Officer

IN ATTENDANCE

Rochelle Scargill (RLS)	PA to Director of Finance (Minutes)
Peter Keogh (PK)	Assistant Director of Performance
Philippa Russell (PR)	Assistant Director of Finance
Adam Matthews (AM)	HR Business Partner
Christopher Roberts (CR)	Shadow Board
Tom Strickland (TS)	Director of Operations - Surgery

OBSERVERS

Brian Moore (BM)	Public Elected Governor

APOLOGIES

Andrea McCourt (AM)	Company Secretary
Gary Boothby (GB)	Director of Finance
Robert Birkett (RB**)**	Managing Director of THIS
Robert Markless (RM)	Public Elected Governor
Pam Robinson (PR)	Public Elected Governor
Stuart Baron (SB)	Deputy Director of Finance

ITEM

020/24 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting including members of the shadow board.

021/24 DECLARATIONS OF INTEREST

022/24 MINUTES OF THE MEETING HELD 2nd January 2024

The previous minutes were approved as an accurate record.

023/24 MATTERS ARISING

024/24 ACTION LOG

The Action Log was reviewed as follows:

134/23 - 2022/23 National Cost Collection Pre-Submission On the agenda. Close Action.

192/23 – IPR – Is the paediatric virtual ward included in the virtual ward offering? Currently testing models for paediatrics but are utilising the existing community resources district nurse and community therapy. Work in progress for the best model. Close Action.

013/24 – IPR- Conversation outside of meeting around ED measures – Close Action

015/24 – HPS Business Case –Close Action.

025/24 2022-23 NATIONAL COST SUBMISSION REPORT

The Deputy Director of Finance spoke briefly on the report included within the papers. The report has been brought to this committee to provide assurance that it has been submitted in line with expectations. As the committee is aware, there have been delays with the timetable provided by NHS England. All of the validations were passed, and we reviewed any material non mandatory validations. This information will feed into Model Hospital and other benchmarking tools. More of the data is now moving to patient level so more detail is required each time.

The submission was signed by Gary Boothby then for assurance brought to this committee before board.

JH asked if the data has applications in house e.g. CIP or TE. It compares activity and cost year on year.

The comparison in the appendix is misleading because of the re-categorisation of lines which were previously done at an aggregate level and is now done at a patient level.

AB asked if the data could be broken down further for instance, the outpatient spend, how much of it was discretionary activity?

The detail can be obtained whether through this process or separately from the information held.

The Committee **RECEIVED the National Cost Submission Report.**

FINANCE & PERFORMANCE

026/24 MONTH 9 FINANCE REPORT

The Assistant Director of Finance presented the financial position as reported at Month 9, December 2023.

The Trust is reporting a £17.54m deficit (excluding the impact of Donated Assets), a £1.80m adverse variance from plan. The in-month position is a deficit of £2.88m, a £1.26m adverse variance.

Key drivers of the adverse variance include a higher than planned bed capacity, strike costs of £2.4m and non-pay inflationary pressures. Strike costs are assumed to be fully funded through additional ICS allocations.

Overall Weighted Elective Recovery Position remains good at 109.4% despite Christmas and strike action.

Agency expenditure year to date was £7.89m, £1.62m lower than the Agency Ceiling, (3.7% of total pay expenditure) but £1.35m higher than planned. Agency costs have reduced since the start of the year, but bank expenditure remains above plan where we are seeing the biggest impact of the additional bed capacity and strike costs.

Continuing to see higher than planned insourcing and outsourcing.

Capital spend year to date is £16.25m which is £5.6m lower than planned. There is slippage in some schemes CT Scanner, Pharmacy Robot and Cath Lab. Still forecasting to spend £49m. Under IFRS16 the capitalisation of leases, the whole value of the lease comes at once. This along with large amounts for the CDC and reconfiguration projects will increase the amount of capital spend before year end.

Cash is above plan as a result of the slippage on capital. The balance at the end of December was £9.77m. An application for PDC support has been submitted and is expected to be required from February. Awaiting confirmation that it has been agreed.

Aged debt improved in month down to £3.2m, £750k of which belongs to one customer, Nitespharma, as discussed previously. The plan is to meet with debt advisors as to what we do next. This is the company that the Trust use to recover debt. They are subcontracting to a specialist solicitor. The remaining bad debt is primarily smaller debts that have been outstanding for some time e.g. overseas patients.

Better payment practice code was above target at 95.4%.

Forecast – continuing to report on plan with a likely case scenario of an adverse variance of £1.7m which is the same as last month. Discussions are ongoing with the ICS regarding potential further funding allocations to close the £1.7m gap.

KH asked if there was a possibility of any funding to assist with the increase in non-pay expenditure as CHFT will not be the only Trust to have experienced this. Under the block contract payment system, it is not possible to recover any extra costs incurred. We did receive additional inflation funding at the beginning of the year, but

it was not enough to cover everything. Conversations are taking place with the ICB around the allocations of resources where the link to activity can be evidenced for it to be recognised in the distribution of resource.

NB noted the Place and ICS information shows that most of the acute trusts are forecasting a slightly worse position than the original plan. Would any further allocations be expected to be made in this financial year?

The ICS as a whole still has a gap to find. There are still conversations taking place around the equal treatment on elective recovery funding and how strikes have a bearing on that.

The committee **RECEIVED** the Month 9 Finance Report.

027/24 TURNAROUND EXECUTIVE 2023/24 CIP PROGRESS

The Deputy Chief Executive gave a brief update.

Previously we have reported externally full achievement of the planed of £31.5m. From M8 we have accepted the shortfall of £3.9m in order to focus on planning for 24/25. We are now aiming to deliver savings of £27.6m with £27.5m currently forecast.

There is an interdependency with the 2024/25 planning process and the group are currently working through the impact of this years non-recurrent CIP. The aim is to produce a realistic CIP target for the new year with the expectation of the target being around £20-£25m.

Working through the portfolios to make sure they are sensible. There is a balance between housekeeping items and transformational ideas. All schemes to get to Gateway one by the 31st January.

More detail will be added to the schemes over the next few weeks as the teams come forward with their plans.

Recurrent CIP is the big focus for this year. To determine how much is transformational and how much is moving budgets around. As an example, the ED scheme around a changed staffing model has been a success. It has delivered a part year effect in 23/24, is a recurrent saving and will deliver a full year saving in 24/25.

The target for next year has to be realistic in order to get colleagues on board. The current unknown is the value of the pressures and developments requested but there is a session arranged for 9th February.

The Committee **RECEIVED** the Turnaround Executive update

028/24 2024/25 FINANCIAL PLAN

Currently following the internal planning timetable as there is still no national guidance available. Looking at the divisional plans and risks, opportunities for cost cutting across divisions and an aggregate view of elective recovery and bed capacity.

There have been some interim deadlines from the ICB and a submission was made yesterday to give a sense of scale of what some of our early planning is looking like which is not dissimilar to what has been described to the ICB previously. Initially prior to CIP there was a gap of £78.5m. CIP had to be declared and the decision was made to go with the higher estimate of £25m which then reduced the gap to £53.5m.

There is a lot of correspondence around the consistency of assumptions and presently there is no consistency across the ICB in the assumptions that organisations are expecting from the ICB.

The numbers will be more accurate after the pressures and developments day but to fund any developments at scale would worsen the position.

There is a funding expectation of 0.2% growth, but this is eliminated by the ICS conversion adjustment and inflationary pressures. The overall ICS allocations have increased by 1.8%.

NB talked about medium term financial planning. Across the system not just CHFT. Based on the deficit plan for this year, what would the position look like in 2025/26 based on the same assumptions. It would demonstrate that without greater funding the deficits will increase, and the system would be unsustainable.

The Committee **RECEIVED** the Planning update.

029/24 IPR

The Assistant Director of Performance highlighted the key points of the December IPR.

There are still small numbers of 52 week waits. Overall CHFT is in an excellent position both regionally and nationally.

The 40-week internal target will not be reached because of the challenges within ENT, although other specialties are currently expected to meet the target.
Diagnostics still have challenges with Echo and Neurophysiology, though it is expected that the trajectory for Neurophysiology will be reached in in the first quarter of 2024/25.

Ambulance arrivals delayed over 30 minutes reached 7.4% in December, but this has also been impacted by the change to the way the timings are measured.

Bed occupancy slightly reduced in December.

Cancer achieved all targets in December and reached the faster diagnosis target for the 4th month running.

Complaints completed in time reached 100% for the first time ever.

ED performance dropped slightly to 64%.

CR highlighted that there are a number of options being looked at as to how to address the high numbers of follow up backlog. Sharing ideas with other Trusts.

NB highlighted the gap between patients in ED waiting over 4 hours and those patients with learning disabilities. Lots of work is being done around health inequalities but are the correct performance measures in place to reflect this?

Work is being done on the detail for the metrics in relation to learning disabilities. The patient experience is the key factor. DNAs are also being reviewed and the reasons behind patient's DNAs across the organisation. It will take time to see the outcome of all the work.

BM commented DNAs appear to be going up and not down. The new patient portal is due to come online in the next few months which it is expected to be more patient friendly. The wording on the patient letters has also been reviewed to reduce confusion.

JH – The surge escalation plan was implemented through December as part of the full capacity protocol to help reduce the congestion in ED. This consists of three phases designed to free up space in ED and release clinicians to assess new ED arrivals. Other organisations have been doing this for a while and it proved to be a benefit when OPEL 4 was reached. There is a plan to do a focussed week at the beginning of March with the aim of supporting the improved timeliness of assessment in the ED.

The acuity of patients has changed year on year. Overall, there has been a 7% increase in the complexity of patients. More work is needed.

One of the well organised ward principles is do not try new things when the area is under pressure. Feedback from wards is that they are seeing the benefits of the well organised ward work.

The Committee **RECEIVED** the IPR for December.

030/24 RECOVERY UPDATE

The Assistant Director of Performance gave an update. The report this month includes a page from the Northeast and Yorkshire weekly long waiter report. This shows performance across the region and highlights CHFT as the top performing Trust in the region for capped theatre utilisation. With the exception of Leeds all other trusts showed a reduction in month except Leeds. However, CHFT, for the first time, showed an increase in month.

ERF funding 52-week waits have now been given some leeway as a result of the strike action. Internally the plan was to reduce these to being as small as possible. As

of last week, there were 41 patients waiting over 52 weeks, 33 of which are in ENT. There are plans for those patients to come in.

There was an increase in 40-week waits in December, but we are managing to reduce the numbers again. ENT contributed 594 of the 1194 patients waiting over 40 weeks. The internal plan is to reduce all other specialities to zero by the end of March 2024.

Outpatients new ASI's still big numbers and increasing.

JH – The challenges around ECHO are relating to staffing issues. There has been an internal training program, but it has been hard to retain staff. There are rumours that locum agencies are paying £80 per hour. Discussions have been taking place with other Chief Operating Officers across WYAAT, to create an Echo physiologist bank. The Echo physiologists across the region have said they would be on board with this idea if the pay was correct.

The Committee **RECEIVED** the Recovery Update

031/24 DEEP DIVE – ELECTIVE RECOVERY

TS gave a presentation around CHFT's approach to Elective Recovery. Starting with some background TS explained that during the pandemic CHFT made an informed decision to pause elective work for longer than the majority of other trusts across the region. At the same time worsening staffing levels were seen within theatres. At the peak of the back log in March 2021 there were 3970 patients waiting over 52 weeks.

There have been a multitude of tools and processes put in place to improve this position which now stands at very low figures waiting over 52 weeks. There has been a huge theatre staff recruitment campaign which has resulted in 60 new starters since the pandemic. New roles have been put in place and others have been restructured to provide a more consistent workforce. Theatres only reached full capacity 12 months ago. Resource has also been dedicated to theatre productivity and information boards have been created for all theatre suites which show the individual theatre utilisation. Whiteboards outside theatres give staff opportunity to feedback the highs and lows of each day.

The highest profile element of the theatre elective recovery is the cost per case system that has been implemented. Initially insourcing and outsourcing was being used to reduce the backlog, but this is an expensive choice, and both the clinical and operational teams were keen to bring the work back in house. Cost per case was rolled out from April 2022. The scheme is based on paying all theatre staff on the number of patients operated on rather than time worked. This scheme is strictly voluntary and runs only on weekends. Essentially all staff are awarded a 50% uplift for comparable weekend pay. Since April 2022, 1172, patients have been operated on the 149 weekend theatre lists. Other trusts have shown interest in the model. As of December 2023, CHFT was the top performing Trust for capped theatre utilisation at 84.8%.

Cost per case is now being rolled out across ENT and Ophthalmology which are some of the more pressured specialities. Going forward the plan is to reduce the number of cost per case lists and improve the utilisation of lists Monday – Friday. Two knee

surgery locums have been appointed with flexible PA's built into their job plan. They can then be allocated to lists in Orthopaedics where the theatre staff and list are in place, but the consultant is unavailable. This will reduce the need for insourcing at the weekend.

Arguably the biggest positive impact on performance is as a result of the improved tracking of patients on KP+. One of the slides demonstrated the increase in KP+ usage as more colleagues took accountability for their long waiters. THIS have also been instrumental in providing the data used in the access meetings. Everyone involved in the pathways has worked together to make this a success.

AB commented that she would be interested to know if any of the implemented improvements could be used as learning in other areas, for example, outpatients.

AN commented that culture and teamwork have been key to the success of elective recovery – TS agreed with this.

032/24 BAF RISKS

This committee are responsible for reviewing four risks on the register and if we are happy with the updates and the scores on the risks before they go to Trust Board.

The committee discussed risk 18/19 regarding the longer-term financial sustainability of the Trust. Does the score need to be increased? Currently at 16 but does the committee feel the risk is increasing? If the financial plan shows a growing deficit that the reconfiguration work won't improve, then the score would probably have to increase.
Historically this risk has been scored higher, but the score has gradually been lowered over the years.
Does the wording need updating as it is focussed on CHFT, but the position of the system can impact?
The risk description is about CHFT but contextually one of the issues is if there is a gap in the system it would be harder to achieve.

Financial planning for 2024/25 will be complete when the risks next come to the committee and the risk can be updated as required then.

The Committee **APPROVED** the BAF Risks to go to Board.

033/24 TERMS OF REFERENCE REVIEW

The committee noted the following:

- The numbering under point 9 is incorrect.
- Section 4.1 to be re-worded to cover the overview of the system and place position now provided to this committee.
- Section 4.2 to be changed to review all finance and performance risks on the register.
- Spelling error states Non-Executive director instead of directors.

- Section 4.5 refers to procurement, but it is not clear if this is something that is done by this committee. This has not been covered in the last 12 months but has been done historically. A conscious decision was made to stop receiving the procurement reports as procurement falls under the remit of CHS which is discussed in separate meetings.

AB - Where does the Trust owned procurement strategy sit? Who monitors it? CHS are responsible for owning the delivery but the Trust purchasing power could bring benefits to the local system.

KA commented that there is work going on across WYAAT looking at how procurement is handled and if there are and opportunities for structural changes and or efficiencies. Different options are being worked through.

AN – Is there something around the degree to which services are outsourced at CHFT that the committee should review?

AB – Capital spend. CHFT will be capital rich until 2031 and this comes with a big responsibility and a requirement to spend the money efficiently.

ACTION: AN to re-write section 4.5 in draft and bring back to next meeting.

034/24 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Access Delivery Group
- Business Case Approval Group
- THIS Executive Board
- Capital Management Group
- CHFT / CHS Joint Liaison Committee

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

035/24 WORKPLAN – 2023/24

The deep dive for next month is a follow up to the ED deep dive done in May last year.

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

036/24 ANY OTHER BUSINESS

-

037/24 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Committee looked at the Cost Collection Submission.
- Financial position is consistent with previous months but still forecasting to meet plan for 2023/24Financial plan to be reviewed before Board in March.
- Elective Recovery deep dive - key messages on what has been done well.
- BAF reviewed and financial sustainability risk discussed.

DATE AND TIME OF NEXT MEETING:
Tuesday 27th February 2024 09:30 – 12:00 MS Teams

QUALITY COMMITTEE
Wednesday, 20 December 2023

PRESENT

Karen Heaton **(KH)**	Non-Executive Director **(Chair)**
Nikhil Bhuskute **(NBhu)**	Deputy Medical Director
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Nick Gurbanov **(NG)**	Head of Risk
Jonathan Hammond **(JH)**	Chief Operating Officer
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Elizabeth Morley **(EM)**	Associate Director of Quality and Safety
Andy Nelson **(AN)**	Non-Executive Director
Victoria Pickles **(VP)**	Director of Corporate Affairs
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
Lindsay Rudge **(LR)**	Chief Nurse
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Lorraine Wolfenden **(LW)**	Governor
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

IN ATTENDANCE

Andrea Dauris **(AD)**	Associate Director of Nursing – Corporate **(item 216/23)**
Alison Edwards **(AE)**	Head of Safeguarding **(item 214/23)**
Alexandra Keaskin **(AK)**	Corporate Matron **(Observing)**
Mohammad Maqsood **(MM)**	Finance Manager – THIS & Surgery **(Observing from Shadow Board)**

Elizabeth Morley was welcomed to the meeting and her first week in the role of the Associate Director for Quality and Safety.

STANDING ITEMS

207/23 - WELCOME AND APOLOGIES

Neeraj Bhasin **(NBha)**	Deputy Medical Director
David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Sharon Cundy **(SC)**	Head of Quality and Safety
Denise Sterling **(DS)**	Non-Executive Director

208/23 - DECLARATIONS OF INTEREST

There were no declarations of interest.

209/23 – MINUTES OF THE LAST MEETING AND ACTION LOG

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

210/23 – MATTERS ARISING: GOVERNANCE ARRANGEMENTS FOR TRUST PSQB

Lindsay Rudge provided an update that following the Quality Summit, which was held on 11 October 2023, one piece of feedback provided was the duplication seen via divisional Patient Safety and Quality Board (PSQB) meetings and the Trust PSQB. Divisions previously reported directly into the Quality Committee on a quarterly basis and it was felt that this had

been diluted through the Trust PSQB. Divisions also fed back to the Summit that the monthly PSQB agenda was overwhelming, therefore, a rolling divisional PSQB agenda will cover a number of items during the quarter, as well as divisional specific issues, which will then be reported into the Quality Committee on a quarterly basis. Arrangements are being worked through with divisions as to what their quarterly report into the Quality Committee will look like; Groups / Committees which previously reported into the Trust PSQB will now report into the Quality Committee via a different format; and the Patient Experience and Involvement Group will be strengthened.

The last Trust PSQB meeting was held on Tuesday, 19 December 2023, and divisions will report into the Quality Committee either at the end of quarter 4 or the beginning of quarter 1.

A review will take place in six months' time, which will provide a summary of the new reporting into Quality Committee, and **DB** and **LR** will co-chair the Clinical Outcomes Group for better assurance and a better quality improvement process.

ACTION: Report on process to be provided into the next Quality Committee, as well as the inclusion of the updated governance structure.

SPECIFIC REPORTS

211/23 - UPDATE ON NASOGASTRIC (NG) TUBE ACTION PLAN

Joanne Middleton presented the update circulated at appendix C, highlighting the two Never Events regarding nasogastric (NG) Tubes inserted into adults; ongoing actions monitored through the Nutrition and Hydration Committee, with a combined action plan in place from serious incident learning and audit recommendations; a further Never Event declared on 10 November 2023 relating to an nasogastric (NG) tube inserted into a three-week-old baby despite being in the wrong position on Chest X-ray (CXR), and an external review of practice and approach commissioned by the Chief Nurse.

In relation to incidents and training, **KH** asked whether agency workers were still prevented from accessing lines. **JMidd** confirmed this as their training records cannot be confirmed.

OUTCOME: The Committee noted the update.

212/23 – ASSURANCE ON POSITION OF SEVEN DAY SERVICES

Nikhil Bhuskute presented the report as circulated at appendix D, highlighting assurance of compliance with the key standards for seven-day services.

An audit of a sample of 82 acutely admitted patients admitted in February 2023 was carried out, and as in previous audits, CHFT demonstrated continued compliance (90%>) with three standards (standard 2, 6 and 8), however, one standard (standard 5) was not fully met. The detail of the assurance was detailed in the report.

OUTCOME: The Committee approved the report.

SAFE

213/23 – QUALITY AND SAFETY STRATEGY

Lindsay Rudge provided a verbal update on the above.

Engagement is taking place with Aqua and the Improvement Academy in developing a quality and safety strategy. A review of the Clinical Strategy is currently taking place which the quality and safety strategy will align itself to. Updates have been provided to the Board Development

session with discussions on the high-level approaches. The development of the Quality and Safety Strategy is still a work in progress and is envisaged to be available in the new financial year.

214/23 – SAFEGUARDING COMMITTEE REPORT

Alison Edwards was in attendance to present the report circulated at appendix E, summarising key activities of the Safeguarding Team for the reporting period April 2023 to September 2023.

The report has been written in line with the Safeguarding Strategy, under the six key principles; Partnership; Protection; Accountability; Empowerment; Prevention and Proportionality.

The key points to note include:

- Significant progress made in relation to CHFT sharing information with the Local Authority to close Section 42 investigations improving outcomes for patients and their families.
- Further work required to embed the Burns, Bruises and Scalds protocol.
- Increase in activity in relation to serious practice reviews; safeguarding adult reviews and domestic homicide reviews which impacts on team capacity.
- Increasing compliance with receipt and scrutiny training.
- Safeguarding and Mental Capacity Act (MCA) / Deprivation of Liberty Safeguards (DoLS) training is fully compliant with the Intercollegiate Documents.
- Compliance with level 2 and 3 MCA / DoLS training has fallen to 87% for level 2 and 86% for level 3.
- Compliance with level 3 safeguarding children and adults training has fallen to 77% for adults and 69% for children.
- Working towards embedding trauma informed practice, and working toward increasing resources to support increasing safeguarding supervision compliance.
- Good assurance that DoLS applications are appropriate.
- A plan in place to ensure the child's voice and making safeguarding personal is embedded.
- Continuing to support the work around discharge improvement.
- A multi-agency response to improving the outcomes for Children Looked After.

In relation to training, **AN** asked what type of responses would be expected from colleagues dealing with safeguarding. **AE** responded that feedback from colleagues regarding training is positive. During the pandemic, there was a move to online training, however, now with the face-to-face, lunch and learn and supervision sessions, colleagues are finding an increase in the quality of safeguarding training. Early indications are that colleagues are feeling more confident, and it also needs to be recognised that there is now a junior workforce which will need to be supported.

In regard to food poverty and increasing mental health issues in young people, **AN** queried whether there is a greater demand for safeguarding issues. **AE** responded that there is an increase in financial abuse, which could be attributed to the cost of living crisis. This will be monitored going forward.

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

215/23 – MATERNITY AND NEONATAL OVERSIGHT REPORT

Gemma Puckett presented the above report, circulated at appendix F, highlighting the key points to note, which included:

- An increase in the midwifery workforce in October 2023, with newly qualified midwives who have now come to the end of their supernumerary introductory period, and now included in the numbers on the ward and settling in well, with positive feedback. A further

8.8 whole time equivalent posts have been offered to these students who are due to qualify in March 2023.

- The Saving Babies Lives care bundle have had two assessments since September 2023, and have reached the threshold of achieving 50% of each element and 81% of the bundle overall in place. This work continues and is one of the safety actions for the Maternity Incentive Scheme (MIS). There was positive feedback on the quality of the evidence provided. In conjunction with the business intelligence team, a saving babies lives dashboard is being developed which will allow data to be reviewed in an easier format and also on the Knowledge Portal +.
- The Local Maternity and Neonatal System (LMNS) assurance visit took place at the end of November 2023, which had positive feedback.
- Evidence for each action of the MIS is under review in a confirm and challenge process. In the last two weeks, it was identified that two cases were not reported to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) within the seven working day period. There is mitigation for one case, and a meeting has been arranged with NHS Resolutions regarding reviewing some technical guidance for the other case, however, there was no impact on safety and the cases were reported at 10 working days, rather than seven.

KH commented on the detailed report and asked whether the service is at risk in terms of the MIS. **LR** stated that there is a potential, however, there has never been a late case over the last four years. The worst case is there may be a review with the Board in terms of the technical guidance.

AN asked whether the BirthRate plus review has been scheduled. **GP** reported an initial meeting scheduled for January 2024, then data will be submitted.

With regard to the performance dashboard, **AN** asked about the red scoring bookings by 10 weeks indicator and why it is indicated on the dashboard. **GP** stated that the bookings by 10 weeks indicator is important as early access to midwifery care is better for pregnancy outcomes. There is an LMNS 'Speak to a midwife' campaign that the Trust is part of, regarding accessing maternity care early in pregnancy, and the LMNS have a dashboard which filters into locality and ward areas to see the age profile, ethnicity and location of women who are not accessing care, in order to target early bookings for the right interventions and discussions to take place. It can be challenging, due to cultural reasons or previous history issues. **LR** also stated that **GP** is on the Health Inequalities Group which can be influenced on what the workstream needs to focus on. **LR** also mentioned the deep dive report submitted to the Calderdale Care Partnership Quality Group and part of the Maternity report at the July 2023 Quality Committee meeting (Appendix C2), which also describes the work around access for women and children. Kirklees Place will also be completing a similar report.

In reference to the workforce data submitted to the LMNS and NHSE of 151.39 whole time equivalent midwives in September 2023, **MM** asked about the 13% gap against the new workforce establishment of 174.63 whole time equivalent midwives, and whether there were any problems that this may cause. **GP** stated that midwifery workforce is challenging and is mitigated with a robust escalation process, the utilisation of alternative roles, and looking at how maternity support workers can assist. There have been no serious harms as a result of workforce challenges. **LR** stated that the 174.63 whole time equivalent is the best case scenario and has been up to 190 plus in terms of the budgeted workforce model. It is important that there is a measure of what is accurate at CHFT between the 190 plus and 174.63 whole time equivalent in order to know what needs to be funded going forward.

Following a meeting with the Kirklees Quality Committee, **NBhu** asked whether the LMNS is cited and part of the planning and discussion regarding the ICB and Home Office plans for a potential large settlement of asylum seekers in Kirklees. **LR** stated that there is a strategic intent at West Yorkshire which needs to be understood at Kirklees Place.

As part of the next steps slide for the LMNS visit (appendix F8), **KH** asked about the next 12 months, and asked whether the development of the MVP should have been included, due to changes with the Chair and discussions with the Maternity Champions group. **GP** stated that it is part of the Ockenden immediate essential actions on how families are listened to as part of the three-year delivery plan and part of the MIS safety action 7.

Copies of the Q1 and Q2 Healthcare Safety Investigation Branch referral audit reports for the Ockenden submission; the Transitional Care Action Plan – July 2023; Action plan for Obstetric Workforce December 2023; Action plan for Neonatal medical workforce meeting BAPM standards; and feedback from the Local Maternity and Neonatal System (LMNS) visits were available as additional appendices to the report.

OUTCOME: **GP** was thanked for the update and the Committee noted the content of the report and the progress being made; the national issue with workforce, and the recruitment strategies in place.

216/23 - SAFER STAFFING

Andrea Dauris was in attendance to present the bi-annual report circulated at appendix G, providing an overview of CHFT Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance, for the reporting period of April to September 2023.

The key points to note include:

- Nursing and Midwifery vacancies remain challenging, with greater emphasis within the NHS Long Term Workforce Plan to grow domestic education, training and recruitment programmes. Overall, vacancies within nursing and midwifery remain aligned to the national position, however, a significant reduction is reported against the band 5 nursing workforce which is the Trust's largest safety-critical resource.
- As of September 2023, the vacancy position was at 155 full-time equivalents, which has been an improving position since the previous report. To note, the band 5 position was 42 full-time equivalents, however, this is anticipated to drop further to approximately 33 whole time equivalents. This has informed a decision to pause the international educated nurse part of the recruitment program temporarily, which will be appraised later in the year.
- A continued reliance on agency staffing, and a task action group looked at retracting high cost agencies across all areas, which was successfully achieved this year. There are some agency staff in areas, however, this is reducing.
- The intention to commission the BirthRate plus to ensure staffing reflects the activity and acuity.
- Monitoring of quality metrics, including the number of incidents reported against nursing and midwifery, and staffing-related incidents. During the reporting period, there were 184 nursing and midwifery incidents, 173 of these were reported as no harm, eight as minor harm and three as moderate. There was appropriate escalation and actions taken in response to those incidents.
- Achievement of the Quality Mark against the national preceptorship framework. This piece of work has been led by the Clinical Educator Team who went through quite a rigorous process to provide evidence and a self-assessment against 10 mandatory standards, of which they had to achieve 80% against each one of those standards. This puts the Trust in a good position and helps toward the retention agenda.
- Support for the Clinical Education Team, which has recognised the growth of the undergraduate workforce, which will continue to be significant going forward.
- The impact of patient experience and the quality agenda. The report details some quality metrics, such as pressure ulcers, Friends and Family Test (FFT) responses and falls.
- Overall good compliance against the developing workforce safeguards, which determines safe, effective and sustainable workforce models.

In relation to Community nursing, **AN** asked how the workforce felt about the demand and whether there was a challenge. **AD** reported that Community nursing used an evidence-based tool which described some pressures within the services and how to manage the growing demand. Whilst the recommendations are to run the evidence-based tool on two cycles before any changes are informed to workforce models within district nursing services, the evidence-based tool provided an opportunity about how to configure the workforce differently to manage those pressures. **EM** reported that an output will not be seen as yet, as this is a work in progress. Once the second set of data collection is completed, at that point, a decision will be made on the next steps, what has been input and how it has helped so far.

The report details the Nursing and Midwifery recruitment and retention strategies and the vacancy position of 155.86 full-time equivalents in September 2023, and potentially increasing by 70.58 full-time equivalents in 12 months' time. **AN** asked whether anything was driving a higher turnover, based on the projections. **AD** stated that the projections are based on the normal attrition rates in the Trust and need to better understand this. A strong piece of work has been done regarding the Band 5 colleagues as there have been a large number of students graduating and coming into the workforce, as well as the international educated nurse programme of work. Something is taking place outside of those grades, but equally, when reviewing the model hospital, colleagues under the age of 25 also have a high turnover, and CHFT are an outlier. There are a number of retention strategies that are nationally steered, however, a focus is required on the local strategies.

If the workforce is looked at as a profile of experience, **AN** asked whether there were any issues with the loss of experienced nursing colleagues. **AD** responded that during a review of the age profile in the report, there are some observations of a growing number of younger colleagues and a loss of experienced staff. Work is ongoing regarding using experienced staff and legacy mentoring to coach new starters, and also supporting the new workforce and developing their skills.

MM mentioned the graph on nursing agency expenditure versus the tier 3 agency retraction plan and asked whether the downward trend is a true reduction in cost, given the pressures in recruitment. LR stated that it is a significant cost reduction, as part of a detailed month on month plan, reported through the Turnaround Executive Group. It has been signed off as a cost improvement plan, is a true efficiency saving, with a better patient experience and patient safety position.

Copies of a presentation on the expansion of the Clinical Education Team and the Nursing and Midwifery Retention Plan were also available as additional appendices to the report.

OUTCOME: **AD** was thanked for the thorough report, and the Committee approved the report.

RESPONSIVE

217/23 - QUALITY REPORT

Lindsay Rudge presented the December report circulated at appendix H, highlighting:

- An improving position in the incident data, with a projected number of six open serious incident reports, after the serious incident panel taking place on Friday, with three of those reports in time. Thanks were conveyed to divisional teams for their efforts. This will allow for transition to the Patient Safety Incident Response Framework (PSIRF) principles around serious incidents. **LR** conveyed thanks to **JMidd** for leading the team and getting to this position.
- A better position with the medical division's backlog with their incidents.
- Continued improvement in response times for complaints.
- Some of the principles of Patient Safety Incident Response Framework (PSIRF) have now started to be adopted and tested, mostly to support improvement work within the medical

division and their backlog of incidents. Tools have been developed for Pressure ulcers, Falls and Infection Control issues. Further work is being done to test other learning responses in the surgical division, which will replace the root cause analysis templates which are currently being used for orange panel investigations, and a learning needs analysis has been completed for a comprehensive picture across divisions as to who requires which training. The Patient Safety Incident Response Plan (PSIRP) has been submitted to the Integrated Care Board for stakeholder consultation, and the current plan and Policy will be circulated following this meeting for comments. A go-live date is envisaged for the New Year.

- The Legal Services team are delivering business as usual, and also undertaking a number of other trustwide activities, against a backdrop of an increase in activity working through the coroners' backlog of inquests. The service is doing an amazing job and also had a benefit in year of a reduction in the Clinical Negligence Scheme for Trusts (CNST) premium as an organisation. **VP** reported that in addition, the service have also seen an increase in supporting and preparing colleagues through criminal cases. **LR** mentioned feedback received from colleagues on the support received from Sarah Mather (Head of Legal Services) through inquests, and work done over and above the usual service.
- Continued work with CQC partners and their new approach to regulation. **VP** mentioned that a slide on other issues of compliance and assurance across the Trust will be included moving forward.
- Quality Priorities: a continued increase in Malnutrition Universal Screening Tool (MUST) assessment compliance; a review of sepsis in the Emergency Department in terms of deteriorating patient, and an Acute Response Team will be going live during quarter 4
- Continued improvement with NICE guidance working with divisional leads.
- The plan for all policies to be reviewed and approved by October 2023 was not achieved, and escalated to divisional directors, along with the clinical repository backlog. It is envisaged that the Clinical Effectiveness post will be appointed to in the New Year, with the role having greater oversight and responsibility for these being kept up to date.
- Metrics from the Clinical Outcomes Group with several indicators still within the hit or miss column of the performance matrix, and continue to increase the dementia screening with a piece of work on person-centred care.

JMidd provided an update on approval to switch Datix, the incident reporting system, into a new system called InPhase, which aligns 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 will go live at the end of quarter 4, and will be run alongside Datix for 12 months in order to be confident with data migration.

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

218/23 - INTEGRATED PERFORMANCE REPORT

A copy of the report, circulated at appendix I, was available for information.

The pressures within the Emergency Department (ED) were noted and now signed off a full capacity protocol, which involves decompressing the ED and placing additional patients into some ward areas for a fixed number of hours, to ensure that patients coming through ambulances, GP, and community and making sure that every patient is treated. A pilot has been running this week and will hopefully be able to update at the next Committee.

ITEMS TO RECEIVE AND NOTE

219/23 - MINUTES

- Minutes from the 22 November 2023 Clinical Outcomes Group were circulated at appendix J, with no comments made.

- Minutes from the 12 October 2023 Infection Prevention and Control Committee were circulated at appendix K with no comments made.

- Minutes from the 12 October 2023 Medicines Management Committee were circulated at appendix L with no comments made.

- Minutes from the 13 September 2023 Calderdale Cares Partnership Quality Group were circulated at appendix M with no comments made

220/23 - ANY OTHER BUSINESS

Lindsay Rudge provided a verbal update on the Medicines and Healthcare products Regulatory Agency (MHRA) Valproate alert which was issued in November 2023.

There will be a change in legislation at the end of January 2024, and an internal task and finish group has been set up with Neurology, Paediatrics and Maternity to look at compliance with standards. An Integrated Care Board group has also been set up.

The biggest concern is capacity with the Neurology team, due to two different requirements within the alert for oral valproate medicines, meaning that:

- Valproate must not be started in new patients (male or female) younger than 55 years, unless two specialists independently consider and document that there is no other effective or tolerated treatment, or there are compelling reasons that the reproductive risks do not apply.
- At their next annual specialist review, women of childbearing potential and girls should be reviewed using a revised valproate Risk Acknowledgement Form, which will include the need for a second specialist signature if the patient is to continue with valproate and subsequent annual reviews with one specialist unless the patient's situation change

An action plan and audit will be completed, as well as working with Health Informatics colleagues on how to find annual risk assessments embedded in the Electronic Patient Record.

221/23 - BOARD TO WARD FEEDBACK

There was no feedback.

222/23 - MATTERS FOR ESCALATION TO THE TRUST BOARD

All items on the agenda will be commented on Trust Board.

223/23 - QUALITY COMMITTEE ANNUAL WORK PLAN

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

POST MEETING REVIEW

224/23 - REVIEW OF MEETING

There were no comments.

NEXT MEETING

Monday, 15 January 2024
2:30 – 5:00 pm
Microsoft Teams

ACTION LOG FOR QUALITY COMMITTEE

Position as at: 20 December 2023

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
20.12.23	210/23 - Governance arrangements for Trust PSQB	Lindsay Rudge	**ACTION**: Report on process to be provided into the next Quality Committee, as well as the inclusion of the updated governance structure.	15 January 2024	See agenda item 04/24	

MINUTES APPROVED BY QUALITY COMMITTEE ON 12.02.24

QUALITY COMMITTEE
Monday, 15 January 2024

PRESENT

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Neeraj Bhasin **(NBha)**	Deputy Medical Director
Nikhil Bhuskute **(NBhu)**	Deputy Medical Director
David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jonathan Hammond **(JH)**	Chief Operating Officer
Karen Heaton **(KH)**	Non-Executive Director
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Elizabeth Morley **(EM)**	Associate Director of Quality and Safety
Andy Nelson **(AN)**	Non-Executive Director
Victoria Pickles **(VP)**	Director of Corporate Affairs
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
Lindsay Rudge **(LR)**	Chief Nurse
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

IN ATTENDANCE

Renee Comerford **(RC)**	Assoc. Director of Nursing – Acute Pathway Transformation **(item 08/24)**
Thomas Ladlow **(TL)**	Head Nurse for Medicine **(item 07/24)**
Debbie Winder **(DW)**	Deputy Director of Quality - Calderdale Cares Partnership Board
Tracy Wood **(TW)**	Research and Development Lead **(item 10/24)**

STANDING ITEMS

01/24 - APOLOGIES

Jennifer Clark (JC)	Associate Director of Therapies
Sharon Cundy **(SC)**	Head of Quality and Safety
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board
Lorraine Wolfenden **(LW)**	Governor

02/24 - DECLARATIONS OF INTEREST

There were no declarations of interest.

03/24 – MINUTES OF THE LAST MEETING AND ACTION LOG

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

04/24 – MATTERS ARISING: GOVERNANCE ARRANGEMENTS FOR TRUST PSQB

See action log.

SPECIFIC REPORTS

05/24 - UPDATE ON NASOGASTRIC (NG) TUBE ACTION PLAN

Joanne Middleton presented the update circulated at appendix D.

It was noted that a new approach to secondary testing of position check has been successfully piloted on the Stroke Ward. Further pilot being rolled out on the Respiratory ward and Ward 17.

The Ph readers have not been piloted as previously reported, however, there is a plan to pilot from February 2024, when a training plan has been agreed.

With regard to the actions which are rated Red, **DS** asked if the position remained the same. **JMidd** stated that in relation to the training, there is now an agreed approach, however, this will be verified once compliance is confirmed; and in regard to the copy and paste function in the Electronic Patient Record, this is not being unique to Nasogastric tubes. **NBha** confirmed that this is an unintended consequence of the electronic system, and work ongoing with the Clinical Records Group.

OUTCOME: The Committee noted the update.

06/24 – RECRUITMENT TO EXPERTS BY EXPERIENCE AND PATIENT SAFETY PARTNERS

Lindsay Rudge provided a verbal update on the above proposal, which will be circulated to the Committee following this meeting.

The Proposal has been shared with the Patient Experience and Involvement Group in December 2023 and at the Patient Safety Incident Response Framework (PSIRF) Board last week. A short Task and Finish Group will be set up in January 2024 to move this forward, and will be comprised of colleagues from Communications, Volunteering and Resourcing.

The Patient Safety Partners are anticipated to be recruited by the end of March 2024.

Action: Report to be circulated following this meeting.

OUTCOME: The Committee were in support of the Proposal.

EFFECTIVE

07/24 – CLINICAL OUTCOMES GROUP FOCUSED ITEM: SEPSIS IN THE EMERGENCY DEPARTMENT (ED)

Thomas Ladlow was in attendance to provide a verbal update.

TL stated that there have been peaks and troughs across the year in terms of antibiotics in 60 minutes for patients. From December 2023, compliance against the target of 80% decreased to 36%, however, work has been ongoing with the Sepsis Lead Nurse and Clinical Educators.

It is known that new guidance will be published on 31 January 2024 which will detail how sepsis is flagged within the ED and also change some of the parameters in which antibiotics should be received. The guidance will be a generic approach, where patients will be assessed for sepsis against a National Early Warning Score (NEWS) score rather than different parameters, for example, a source of sepsis plus other issues which the patient may have presented with. This will hopefully provide some understanding between the nursing and medical teams on which patient will be seen as a priority for antibiotics. To improve the knowledge and understanding of the guidance across the department, the launch of a 'Perfect week' will take place in February 2024. The week will be run once a quarter, and will initially focus on ensuring that colleagues within the ED are aware of the new guidance, and also look at the use of different means of communication between teams to highlight patients that need to be seen as a priority. This will be done via the 'bubble' on FirstNet, which is an easy and visible way to communicate and track the time to antibiotic time for each patient. The department is also looking into changing their footprint as in what rooms are available for certain investigations and interventions earlier in the

patients journey, depending on their NEWS scores. Different pathways are also being looked into so patients can directly access resuscitation rooms or High Dependency Unit rooms within the ED depending on what their NEWS scores.

Work is ongoing with other organisations, and there were plans to carry out 'go sees' to other areas to find out what they do and how they manage patients with sepsis differently, however, this has been paused until receipt of the new guidance.

LR informed the Committee on being tasked with setting up the Task and Finish Group to support this work, and further actions on looking at data which could be tracked through quality elements, rather than performance.

LR stated that this will be one of the areas to consider as one of the quality account priorities moving forward.

OUTCOME: The Committee noted the update.

08/24 – CLINICAL OUTCOMES GROUP FOCUSED ITEM: DEMENTIA SCREENING

Renee Comerford was in attendance providing a presentation on dementia screening.

Current compliance with dementia and delirium screening was highlighted, as well as the challenges with screening.

The reality is that at present, the ask if for both medical and nursing teams to carry out a dementia screen. The advantage is that it enables all to carry out this assessment, however, the disadvantages are blurred responsibility; challenges created which cannot be resolved in the Electronic Patient Record related to tasks, and how each profession completes assessments.

Well Organised Wards (WOW) have been introduced which has seen an improvement in dementia screening of around 25%.

The response to move forward is whether an agreement is needed as to which profession completes this screening.

LR reported previously asking that this task moved to the nurses, and queried whether this had been transitioned. **RC** confirmed that both professions; Doctors and Nurses are carrying out this task, however, will ensure that this change is made from today. **LR** also asked that a hard stop takes place on the Acute Floors and that patients were not moved unless the assessment had taken place.

It was confirmed that the change will be made on the Electronic Patient Record, and raised at the Friday briefing with nursing teams.

OUTCOME: The Committee noted the report.

09/24 – Q2 LEARNING FROM DEATHS REPORT

Nikhil Bhuskute presented the report circulated at appendix E, highlighting an improved position of the initial screening reviews between quarter 1 and quarter 2. Following the initial screening reviews, some cases are identified for a structured judgement review.

44 out of 45 cases identified for a structured judgement review were completed during quarter 2, and one is awaiting an imminent second review.

Some examples of good quality of care were detailed in the report, and one theme of sub-optimal care around attention required for end of life care. Over the next few months, the objective is to improve ways to influence the outcome.

Submissions have been made to the regional learning from deaths team, on two themes: end of life care and improving the preventative care package for patients with bone health, and a task and finish group is being created to work with primary care.

AN mentioned the 50% target not being achieved, and asked whether the approach needs to be changed from chasing a target, as the themes are fairly consistent.

DB reported that a change in focus is required to look at the outcomes from reviews and ensure there are robust action plans. There has been a slight change with more reviews coming through as poor or very poor quality of care than previously, which will also require a focus.

In relation to the 88 initial screening reviews (ISRs) where there were four with very poor quality of care and six with poor quality of care, **DB** asked whether they came through serious incident reviews or whether they were discovered through the reviews. **NBhu** responded that they were from the ISRs or the orange panel rather than the medical examiner reviews. **DB** also commented on the 44 structured judgement reviews (SJRs), with 16 poor quality of care and four very poor quality of care, and stated that when this work started, most were already identified through with the serious incident process or the complaints process. **DB** asked whether this was still the case, to which **NBhu** confirmed it was.

DB stated that a paper will be taken through the Clinical Outcomes Group and into the Quality Committee on a different approach to reviewing these.

In relation to the structured judgement review theme on end of life care and DNACPR, **LR** asked whether the transition to Recommended Summary Plan for Emergency Care and Treatment will change the position. **NBhu** stated that it is a multi-variable issue, as the frailty of the out of hours palliative care team also contributes to this, however, the enhanced clarity of the ReSPECT programme may improve the position and have a positive influence, rather than a negative.

Action: Report to be provided to Quality Committee in March 2024 on different approach to structured judgement reviews

OUTCOME: The Committee noted the report.

WELL LED

10/24 – RESEARCH AND DEVELOPMENT REPORT

Tracy Wood was in attendance to provide an update, as circulated at appendix F, on the Trust's research activity and performance through the Research and Development Department.

In terms of the capacity issue, **AN** asked whether the commercial research is a potential route to growing funding and capacity, or whether extra funding is required. **NBha** stated that the commercial finding is non-recurrent, therefore, alternatives are being looked into to expand and restructure the governance team.

LR stated that the Research Committee come across significant challenges around any expansion or the substantive team being maintained on substantive contracts, due to the nature of the funding. Whilst this is a strategic priority and the Research Team constantly over-deliver for a district general hospital of this size, they are operationally challenged by getting the right level of support. **LR** and **DB** agreed to this as an action through the planning cycle corporately, to allow them to be sighted on the request.

LR mentioned **TW's** relationship with the national Nursing Director of Midwifery with the National Institute for Health and Care Research and acknowledged **TW's** national influence and profile.

OUTCOME: The Committee congratulated the team on the good news stories and innovative work, and noted the positive report.

SAFE

11/24 – MEDICATION SAFETY AND COMPLIANCE GROUP REPORT

Elisabeth Street presented the report circulated at appendix G, highlighting serious incidents and medication related Coroner's requests; Quality Improvement work; compliance with medication safety standards, and updates on national patient safety alerts, including an alert on Valproate, which is currently under review with a task and finish group between neurology, paediatrics, maternity and pharmacy.

There are new legislative changes in terms of the initiation of valproate to males and females under the age of 55, and also patients currently prescribed valproate. In terms of the annual review and risk assessment, to ensure that females on pregnancy prevention programme are fully informed. There are some gaps in governance, which is being supported by **NBhu**. An action plan for the alert is due for submission at the end of January 2024.

In relation to the e-medicine management audit, **KH** asked whether this would be re-audited. **LR** commented that a human factors inquiry needs to take place to understand the real cause of non-compliance and understanding the barriers to getting it right. **VP** also stated that the CQC Group will be focusing on this.

OUTCOME: The Committee noted the report.

12/24 – MATERNITY AND NEONATAL OVERSIGHT REPORT

Gemma Puckett presented the above report, circulated at appendix H, highlighting the key points to note, which included:

- *Maternity Incentive Scheme (MIS):* Year 5 was launched in May 2023 with a submission date of 1 February 2024. There is an area of non-compliance in safety action 1 element a. where 2 cases have been reported to MBRACE beyond the required 7 working days (appendix H). This was identified through checking processes.
- *Workforce*: Progress continues with recruitment, however, there is a negative benefit through requests for reduction of hours through flexible working. There has been recruitment from the newly qualified midwifery cohort due to start in April 2024. It is the first year in the region with double output from the university.
- *Funding*: This has been identified for two Consultant Obstetric and Gynaecology posts, which will be advertised shortly, and help to support progress to increase antenatal clinic capacity, which is a CQC must do action.
- *Neonatal staffing*: Qualified in Specialty (QIS) ratios are met and greater than 70% and maintained. The workforce in the unit is being looked into for the coming 6 to 12 months as there are colleagues coming up to retirement age which may impact the QIS ratio
- *Neonates*: This is being aligned under the midwifery portfolio and swapping into the Women's Directorate to join up governance and oversight and strengthen the perinatal working relationship.
- *Dashboard*: Third and Fourth degree tear rates flag as above the expected level, particularly, where there has been an instrumental and medically led delivery. A deep dive took place and is awaiting conclusion.
- *Local Maternity and Neonatal System (LMNS) Assurance visit*: This took place in November, and the report received in December 2023 (Appendix H3), which was positive with good feedback about how committed the team are and good areas to further develop.

LR was in support of the deep dive audit and requested that it returns to Quality Committee in March 2024.

DS commented on the positive Local Maternity and Neonatal System (LMNS) report and mentioned the two risks which have been open for over 12 months. **DS** asked if any support was required. **GP** stated that regular confirm and challenge meetings are set up in the division, as well as the divisional and Trust processes for risks, and feels confident that there is good oversight of the risk register and how it is managed.

LR mentioned that **GP** and her team submitted 'A year in midwifery' to the Nursing and Midwifery Leadership Briefing Forum, and suggested that it is also submitted to the Quality Committee. It highlighted the vast amount of work undertaken by the team in the last year.

LR also thanked **KH** for being an incredible Maternity Board Safety Champion.

OUTCOME: **GP** was thanked for the update and the Committee noted the content of the report.

13/24 – Q3 INFECTION PREVENTION AND CONTROL REPORT

David Birkenhead presented the report circulated at appendix I, highlighting the Clostridium difficile ceiling of 37, which has been breached. The cases are sporadic and not associated with outbreaks, however, the Trust, comparable to peer organisations, is still seeing higher rates of Clostridium difficile cases pre-Pandemic.

OUTCOME: The Committee noted the report.

14/24 – PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) UPDATE

Joanne Middleton presented the report circulated at appendix J, highlighting what will be changing; what it means for CHFT; progress made to date; the training plan; patient safety priorities, and the Trust's local and national priorities.

Colleagues were asked for any further comments on the Patient Safety Incident Response Plan (PSIRP).
Action: Deadline for comments extended to Friday, 26 January 2024

LR stated that a lot of work has gone into this and much more going forward, and acknowledged **JMidd's** contribution.

Due to the late circulation, the presentation is also available at the end of these minutes.

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

RESPONSIVE

15/24 - INTEGRATED PERFORMANCE REPORT

A copy of the report, circulated at appendix K, was available for information.

LR reported on the static performance of the safety metrics and the positive continued performance around complaints and the serious incident process, and incidents are now much improved. By the end of January, there should be no outstanding serious incidents that are out of time.

LR also reported on a concern of the operational indicator of patients with a learning disability seen within 4 hours in the ED, which is significantly lower than other patients seen within 4 hours.

Never Events also remain a concern in terms of the number and variance, and keen to undertake a review, particularly around human factors which may be contributing to those.

In relation to quality priorities, **DB** commented on the Care of the Acutely Ill Patient (CAIP) target of 'no more than 30% of patients scoring NEWS of 5 or more go on to score higher', which is seeing a deteriorating position. This may be related to pressure in the organisation and morbidity of patients, however, there is some focused work which will go through the CAIP programme.

JH reported that bed occupancy remains a significant challenge, at over 99% for the second month running. Transfers of care also remain high and is a continued area of focus.

A joint CHFT and Community dashboard is being pulled together across Kirklees and Calderdale to better see the pinch points in patient's pathways, and to understand where there are capacity shortfalls.

Risks are held with patients with long waits on the elective care pathways, and although elective care is well overall, there are some particular pinch points, for example, ENT patients waiting over 40 and 52 weeks. There is an action plan in place around ENT looking at capacity, ongoing recruitment and actively participating in the West Yorkshire programme and on ENT.

DS mentioned a statement on falls in relation to compliance and follow through with falls prevention measures that are not standardised across all wards, and asked whether the Well Organised Ward work will pick this issue up. **LR** confirmed that it would, but also stated that this will be monitored.

OUTCOME: The Committee noted the report.

ITEMS TO RECEIVE AND NOTE

16/24 – MINUTES FROM CLINICAL OUTCOMES GROUP

A copy of the minutes from Monday, 11 December 2023 were circulated at appendix L.

NBhu highlighted the Hospital Standardised Mortality Ratio position, which has slightly deteriorated due to 16 excess deaths in the pneumonia coding section in August 2023. A review of 10 cases which were low risk, did not identify any trends, however, a further deep dive into the excess deaths will take place for further assurance. The impact of the surge of deaths may see an elevated Hospital Standardised Mortality Ratio for a few months.

17/24 - ANY OTHER BUSINESS

Lindsay Rudge reported that proposed quality account priorities for the next year will be circulated for the next meeting.

Action: Proposed priorities to be circulated.

18/24 - BOARD TO WARD FEEDBACK

Good work from the Well Organised Ward (WOW) despite challenges, and good learning from discharge processes and knowledge around community services which are now available.

Processes have been adapted to bring people out of ED onto wards where there are discharges. Site and ward teams have responded very well to doing the right thing for patients and allowed a decongestion in the ED during busy times.

Despite industrial action, there has been positivity and the base kept safe with medical colleagues working alongside advanced practitioners.

19/24 - MATTERS FOR ESCALATION TO THE TRUST BOARD

- Focused discussion on sepsis in the ED
- Focused discussion on dementia screening
- Medication Safety and Compliance Group update
- Research and Development Committee Update
- Maternity and Neonatal Report update
- Learning from Deaths update
- Nasogastric tube action plan update

20/24 - QUALITY COMMITTEE ANNUAL WORK PLAN

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

It was noted that the workplan will change, due to upcoming amendments to the governance structure.

POST MEETING REVIEW

21/24 - REVIEW OF MEETING

Good meeting with very useful information provided.

NEXT MEETING

Monday, 12 February 2024
2:30 – 5:00 pm
Microsoft Teams

ACTION LOG FOR QUALITY COMMITTEE

Position as at: Monday, 15 January 2024

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
15.01.24	**06/24 – RECRUITMENT TO EXPERTS BY EXPERIENCE AND PATIENT SAFETY PARTNERS**	Lindsay Rudge	**ACTION - 15 Jan 2024:** Report to be circulated following the meeting *(see attached)*	Monday, 15 January 2024		Tuesday, 16 Jan 2024
15.01.24	**14/24 – PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) UPDATE**	All	**ACTION - 15 Jan 2024:** Comments on Patient Safety Incident Response Plan (PSIRP) deadline extended to Friday, 26 January 2024 See agenda item 26/24	Friday, 26 January 2024		
15.01.24	**17/24 - ANY OTHER BUSINESS: QUALITY PRIORITIES**	Lindsay Rudge	**ACTION - 15 Jan 2024:** Proposed Quality Account Priorities for 2024/2025 to be circulated See agenda item 33/24	Monday, 12 February 2024		
15.01.24	**09/24 – Q2 LEARNING FROM DEATHS REPORT**	David Birkenhead / Nikhil Bhuskute	**ACTION - 15 Jan 2024:** Report to be provided to Committee in March on a different approach to structured judgement reviews	Monday, 11 March 2024		
20.12.23	**210/23 - GOVERNANCE ARRANGEMENTS FOR TRUST PSQB**	Lindsay Rudge	**ACTION - 20 Dec 2023**: Report on process to be provided into the next Quality Committee, as well as the inclusion of the updated governance structure. **UPDATE - 15 Jan 2024:** Work still ongoing on final document. Report to be submitted in March.	Monday, 11 March 2024		

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE: HEALTH AND WELLBEING CHAPTER

Held on Monday 18 December 2023, 2.00pm – 4.30pm
VIA TEAMS

PRESENT:

Nigel Broadbent	(NB)	Non-Executive Director
Suzanne Dunkley	(SD)	Director of Workforce and OD
Karen Heaton	(KH)	Non-Executive Director (Chair)
Lindsay Rudge	(LR)	Chief Nurse
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Arley Byrne	(AB)	Shadow Board
Mark Bushby	(MB)	Workforce Business Intelligence Manager (for item 121/23)
Andrea Dauris	(AD)	Associate Director of Nursing (Corporate) (for items 138/23 and 139/23)
Laura Douglas	(LD)	Shadow Board
Laura Earle	(LE)	Sister, SAU and SDEC (for item 136/23)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Terry Gamble	(TG)	Staff Side Chair
Nikki Hosty	(NH)	Assistant Director of HR (for item 137/23)
Kam Khera	(KK)	Shadow Board
Simon Riley-Fuller	(SRF)	Associate Director of Nursing, FSS (for item 135/23)
Jackie Robinson	(JR)	Assitant Director of HR (for item 143/23)
Lis Street	(LS)	Clinical Director, Pharmacy
Beckie Yeates	(BY)	Workforce Psychologist (for item 133/23)

128/23 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting. The Committee noted Kate Wileman is a new Governor member.

12923 **APOLOGIES FOR ABSENCE**

David Birkenhead, Medical Director

130/23 **DECLARATION OF INTERESTS**

There were no declarations of interest.

131/23 **MINUTES OF MEETING HELD ON 17 OCTOBER 2023**

The minutes of the Workforce Committee held on 17 October 2023 were approved as a correct record.

132/23 **ACTION LOG – DECEMBER 2023**

The action log was received.

The December 2023 fire safety training figures had been circulated to Committee members to provide assurance that compliance remains on track.

133/23 **WORKFORCE PSYCHOLOGY**

BY provided an overview of the critical incident peer support debriefing, a new service developed by the team to provide a semi-structured approach to facilitate reflection on what happened, the effect on colleagues involved and how staff can approach coping individually and in their teams. She explained Critical incident stress management (CISM) debrief, a 90 minute group based meeting facilitated by two peer support debriefers, has become a widely used method of group debriefing. The Trust's charity is funding training for 14 peer support debriefers. The peer support debriefing services will be piloted in ED and maternity services between February and August 2024.

DS recognised the important work and asked how it aligns to PSIRF. BY explained the two frameworks will sit alongside each other and will be continually monitored during the pilot. NB noted the university research project and asked about outcomes of debriefs trialled elsewhere in the country. BY confirmed a control arm has been added to test effectiveness and CHFT will be the first trust to trial the improved design.

OUTCOME: BY was **THANKED** for the presentation and the Committee **NOTED** the new debriefing service.

134/23 **MEN'S HEALTH**

NH explained Dominic Bryan intended to attend the Committee meeting to share his personal circumstances however was unable to attend today. She shared DB's thoughts on how the Trust would benefit from a peer support network and resources dedicate purely to men's mental health. A task and finish group has been established to develop a framework for the peer support network.

OUTCOME: The Committee **NOTED** the efforts of the task and finish group and looks forward to hearing from the support network in 2024.

135/23 **FSS WELLBEING BOARD**

SRF began by providing background information to the FSS division. He explained the Division provides a broad mix of services via its 6 directorates and over the last two years has seen change of senior leaders particularly in the divisional management team. SRF described how the Wellbeing Board was established and its purpose to enhance colleague experience at work by providing opportunities that support colleagues to be proactive in supporting their own wellbeing and mental health. He shared examples of initiatives and next steps to scale up activity.

SD congratulated the FSS Division on the success of the Board. She recommended this as a case study to present to NHS England. KH agreed this is a real positive story.

OUTCOME: The Committee **THANKED** SRF for the presentation and **NOTED** the work of the Wellbeing Board.

136/23 **WELLBEING AMBASSADOR**

LE commenced at the Trust in 2011 as a staff nurse developing to a sister role in 2021. In 2020 LE took time off work as she faced a difficult time in her life, which led her to evaluate life. During this time she learnt many ways to imbed self-care into daily routine. LE developed a great passion for wellbeing and to champion her vision for everyone to be able to access resources and help with their own wellbeing. In 2021 she became a well-being ambassador.

LE doesn't want anyone to feel alone, she shares her experiences with colleagues and encourages others to talk. LE described the themes colleagues are currently experiencing and went on to give examples of support methods she promotes. She has seen enormous positive impact. LE now speaks about health and wellbeing at Trust preceptorship events.

SD highlighted understanding what people are going through before making a judgement is really important. SD has heard directly from colleagues this is really making a difference. The Committee recognised LE's compassion and resilience and thanked her for the brilliant work.

OUTCOME: The Committee **THANKED** LE for sharing her story.

137/23 **PEOPLE STRATEGY**

NH rounded up the health and wellbeing theme highlighting how Workforce and OD and local teams are working together to make initiatives a reality. She presented a spotlight on financial wellbeing and described the new initiatives to support colleagues.

NB asked for more detail on the WageStream initiative. WageStream is a bolt-on product to our rostering system that provides functionality for colleagues to draw down any money already earned. The package also provides functionality to track earnings to support financial planning. JE added there are safeguards so that the scheme works positively for colleagues.

NB asked how the Neighbourly scheme fits with community schemes already in place. NH confirmed there is no conflict with other arrangements such as food banks.

KH commented on the hard work making a difference, all contributing to one culture of care and hopes to see recognition in the staff survey.

OUTCOME: The Committee **NOTED** the overall progress made.

138/23 **NURSING AND MIDWIFERY SAFTER STAFFING REPORT**

AD presented the report to the Committee for its assurance and approval prior to submission to the Board of Directors. The key points were:-

- Greater emphasis within the NHS Long Term Workforce Plan (NHSE,2023) has been placed on growing domestic education, training and recruitment. Overall, Nursing and Midwifery vacancies at CHFT remain aligned with the national position, however a significant reduction is reported against the band 5 nursing workforce which is our largest safety-critical resource.
- A continued reliance on agency staffing across all clinical areas continues. However, the overall trajectory for 2023 continues to positively reduce and indicative of the strategic focus work being undertaken with agency expenditure.
- Staffing fill rates continued to fluctuate between 84% - 87% during the day. A position reflective of vacancies, ongoing sickness/absence and additional capacity areas.
- The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs.
- CHFT have recommissioned a New Birthrate Plus to be undertaken in quarter 4 to ensure that staffing reflects the activity and acuity and the changes to the national maternity agenda.
- During the reporting period 184 Nursing and Midwifery staffing related incidents were reported through the Datix reporting system. 173 of these incidents were reported as no harm to patients, 8 as minor harm and 3 moderate harms. There was appropriate escalation and actions taken at the time.
- Achievement of the Quality Mark against the national preceptorship framework
- The continued focused leadership to support this agenda.

- The Trust's commitment to recognise and support the growth in undergraduate activity through investment in the Clinical Education Team.
- The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas.
- The recommendation from the Chief Nurse is that there is good compliance with the Developing Workforce Safeguards.
- The Chief Nurse has confirmed they are satisfied that staffing is safe, effective and sustainable.

LR stated this is a pleasing report and highlighted the examples of significant improvements that will allow us to concentrate on 'grow your own'. Focus continues on newly qualified nurses and colleagues under 25 to manage turnover. DS recognised the outputs of the work and commented on the significant improvement in vacancies in AHPS, she had recently been fortunate to meet some newly qualified occupational health therapists.

OUTCOME: The Committee **NOTED** and **APPROVED** the Nursing and Midwifery Safer Staffing report for submission to the January 2024 Board of Directors.

139/23 **NURSING, MIDWIFERY AND AHP STEERING GROUP PROGRAMME UPDATE**

AD provided an update on the progress of strategic initiatives to establish safe and effective nurse, midwifery and AHP staffing. The key updates were:-

- 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 now reduced to quartile 2.
- Enhanced Dashboard Metrics are used to evaluate and monitor nursing quality.
- Successful International Recruitment Campaign.
- Decision to temporarily pause the International Nurse Recruitment programme.
- Ongoing Recruitment to Apprentice Trainee Nursing Associate programme.
- Ongoing Recruitment to Apprentice Registered Nurse Degree programme.
- The Clinical Placement Expansion Project (CPEP) programme is expanding.
- HCSW Recruitment Programme.
- E-Rostering effectiveness.
- Retention Strategies focussing on early career retention.

LR thanked Mark Bushby and the Business Intelligence team for their input to the programme. LR stated the national ask of recruiting 50K nurses has been achieved largely through international recruitment. Subsequently there is a national pause, however from an ethical point of view, LR highlighted CHFT's intention to continue to progress any job offers and also filter recruits into other organisations that may not have plans in place.

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

140/23 **FREEDOM TO SPEAK UP – PROGRESS REPORT**

This paper provides information to the committee in respect of the Freedom to Speak Up (FTSU) arrangements at CHFT and FTSU activity in the Trust from the 1 April 2023 to the 30 September 2023.

- The number of concerns raised in Q1 and Q2 2023 and the number of concerns raised as per the NGO's submission categories.
- The current priorities of the Freedom to Speak Up Guardian.
- The work being undertaken to create a culture where staff feel safe to speak up and make FTSU business as usual at CHFT.

The Committee is asked to note the contents of the report, the number of concerns raised in Q1 and Q2, 2023 and the work of the FTSU Guardian and Ambassadors. The report will be presented to the January 2024 Board of Directors. SD commented how proud she is of our processes. The Committee noted FTSU is transferring to the Chief Executive's Office. The FTSU Guardian will report to the Director of Corporate Affairs.

Andrea Gillespie, the FTSU Guardian was unable to attend the meeting. Any questions regarding the report should be emailed to Andrea.

OUTCOME: The Committee **NOTED** the report and number of concerns raised during the reporting period.

141/23 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) OCTOBER 2023 DATA**

MB presented the highlights:-

- Staff in post figures for headcount and FTE have seen in month increases by 47 and 46.35 FTE respectively. September/October intake of graduate/IR nurses mainly contributing to this.
- FTE increases to actuals and lower Turnover rates (7.5%) have seen a continued drop in overall Trust vacancies to 6.05%.
- Low numbers of Nursing Band 5 vacancies have led to a retraction of international recruitment in 2024.
- Recent recruitment has brought in month actuals closer to the planned position for 2023-24; Expected reduction in Bank/Agency FTE usage remains to be seen.
- Reconfiguration Target Operation Model activity is ongoing, further work is underway to translate changes into FTE/£'s.
- Operation planning for 2024/25 has been announced with guidance expected to be provided late December 2023 – initial early planning has commenced in preparation for the return.
- Turnover (rolling 12m) has seen a period of continued improvement between February 2023 (8.8%) and September 2023 (7.3%) and has since levelled out in October 2023 (7.5%).
- Actions within the AHP group have seen significant improvements to the group's turnover rate. Now the lowest turnover group at 4.8%. Actions to be shared across other groups for consideration.
- In month sickness increased by 0.37% in October 2023 to 4.73%. This is expected movement as we move in to winter. Long term sickness (2.93%) increased to just below the Trust target, while short term sickness (1.79%) is now just above the target of 1.75%.
- 17.3 Average FTE Lost per FTE, increase of 0.8 from October 2022.
- Top 3 reasons for absence during October 2023: Anxiety/Stress/Depression (30.7%), Cold/Cough/Flu (13.4%), MSK (10.9%).
- Actions to combat sickness absence are ongoing (Absence monitoring meetings, review of open cases, early escalation to Trust Psychologist of ASD cases, focus on MSK absence etc.)
- 67.6% of appraisals have been completed as at 31 October 2023, an increase of 7.5% from September 2023 (60.1%), this is 2.4% higher than the same point last year. However, at the time of reporting uptake was currently 12.4% behind the planned trajectory of 80%. Based on the current position it is unlikely the 95% target by end of December 2023 will be achievable.
- Continued overall strong Core EST compliance, improved position at 94.28%. However, Safeguarding Children has slipped just below 90%.
- Patient Safety compliance increased to 71.5%.
- Role Specific EST is undergoing work to cleanse target audiences, this will impact compliance rates as colleagues are added/removed; at the time of reporting compliance rates had seen a further declining position moving overall RST to 82.66%.

- National staff survey closed, preliminary response rate of 43.4%.
- Bank spend decreased by £0.26M in October 2023 to £2.94M. Bank spend continues to follow common cause variation around the mean.
- Agency spend dropped by £0.11M to £0.66M. October sees the sixth month of common cause in the variation; however, agency spend is currently at the lowest point seen in the last 24 months.
- Plan to review M&D Bank/Agency spend in early December 2023 which will allow for the development of a plan to retract.

ES commented on work being undertaken in Pharmacy in relation to workforce data and equality standards and noted the disparity in BAME colleagues at Bands 7 and 8. MB confirmed a similar picture in other staff groups in those bandings. JR stated the disproportion has been identified in the workforce data monitoring meetings and is being looked at as part of the retention programme work around both promotion and retention of colleagues. JE confirmed that in response to the national ED&I Improvement Plan there is a requirement from next year to look at pay gap analysis for ethnicity and disability and confirmed the Inclusion Group had commenced some initial analysis.

In terms of widening employment data, DS asked if the 75 residents employed at CHFT could be shown as a percentage of the overall group. MB confirmed this would be included in future reports.

NB asked if any link had been identified between MSK related sickness absence and RST for moving and handling. MB responded this is difficult to triangulate as not all colleagues complete the field to declare a work related MSK issue. JE took the opportunity to highlight the MSK injury physiotherapy service is attributing to reduction in sickness absence.

KH invited comments on the 7.5% turnover position. SD responded the overall figure is quite low and that overall 10% is optimal. She referenced the people heat map as a useful tool to triangulate data particularly against low turnover, high absence and low EST compliance. JE also recognised the importance of good appraisals and conversations between line managers and colleagues to identify personal and professional development needs.

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

142/23 **AGE PROFILE REPORT**

MB reported 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 31-45, a similar reduction in the age ranges spanning 46-55, and further slight increases in the proportion of colleagues remaining/returning aged 61+. The Trust has very few staff starting before age 21, though numbers have started to increase over the reporting period. The Trust continues to develop the Employability and Widening Participation programme, with schemes focused on new to work. Divisions are actively focussing on these actions to support 'growing our own', retention, skilling up, and succession planning as part of workforce planning.

LR stated the nurse related special class status that allows the pension to be taken at age 55 will end in the next couple of years. She also highlighted the current long day shift pattern may be a disadvantage to those wanting to carry on working and suggested a fresh eyes approach to working patterns.

ES asked what programmes are in place to attract young people into healthcare. JE will connect ES to Liam Whitehead, Head of Apprenticeships and Widening Participation. AB invited Pharmacy to join him at school visits.

NB commented on the high level of admin and clerical turnover. MB agreed turnover is high in the younger age group and this is more likely due to the easier access into these roles then used as a steppingstone to other careers. JR confirmed this area has been identified for further work. JE added the turnover may be advantageous as we move further towards electronic systems.

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

143/23 **QUARTERLY VACANCY DEEP DIVE (Q2)**

JR presented the report. The Trust turnover has decreased from 9.36% in September 2022 to 7.30% at the end of September 2023 (excludes Trainee Doctor rotations and employee transfers). The majority of the vacancies sit within the Medical division followed by FSS. HCSW vacancy position remains high despite progress in recruitment as turnover remains high offsetting progress. Expansion in the budgeted establishment for Medics has increased by 65 FTE posts currently showing as vacancies, however large volume of recruitment activity means we have a pipeline of new starters at consultant level within ED, Histopathology, Interventional Radiology, Urology and Neuro physiology all shortage specialties nationally. Nursing vacancy position has improved significantly with 32.34 B5 across the organisation, a further 10 are due to commence in January 2024.

An Admin and Clerical Trustwide review is underway which will look at any potential efficiencies to be made within this staff group. In other staff groups International recruitment has proved successful for Radiographers to support the CDC model with 7 offers made and a further 4 in the pipeline. Vacancies within Pathology are likely to increase given the on-going New Pathology Partnership NPP with Leeds and MidYorks.

KH thanked JR for the detailed report.

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

144/23 **COLLEAGUE RETENTION PROGRAMME**

JR presented a report that set out the Trust's current position and activity to support retention. The NHS People Promise describes the actions that Trusts should take to make the NHS a good, modern employer of choice and improve staff experience. The NHS Long Term Workforce Plan builds on the seven elements of the People Promise and sets out the strategic direction and the short to medium term actions to be undertaken. The CHFT People Strategy describes the workforce activity to support and retain our colleagues and deliver one culture of care. Through the People Strategy, we embed activity across the Trust which ensures that we are known as the best place to work, demonstrate one culture of care to our colleagues and support the health and wellbeing of colleagues.

To showcase all the good work described at today's meeting JE proposed a library of case studies is developed.

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

145/23 **EDUCATION COMMITTEE (EC) UPDATE**

The EC met on 7 December 2023. JE confirmed the EC has moved to monthly, face to face meetings from 2024. The terms of reference are being updated and will be shared with Workforce Committee for sign off.

146/23 **INCLUSION GROUP UPDATE**

At the meeting on 11 December 2023 the network chair and sponsor role descriptions were signed off. The next meeting will focus on delivery of the national improvement plan actions. JE highlighted this will be an ongoing programme of work that will span into 2024/2025/2026.

147/23 **WORKFORCE COMMITTEE TERMS OF REFERENCE**

An amendment had been made to the core membership.

AC highlighted that in removing the Director of Corporate Affairs from the membership, the Company Secretary will attend meetings. The terms of reference will be further amended to reflect this.

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

148/23 **2024 WORKFORCE COMMITTEE MEETING DATES**

OUTCOME: The Committee **RECEIVED** the 2024 meeting dates.

149/23 **2024 WORKFORCE COMMITTEE WORKPLAN**

NB queried there is only an annual review of the Workforce Strategy. KH responded the elements of the Workforce Strategy are reviewed on a rotation basis at each meeting.

OUTCOME: The Committee **REVIEWED** the 2024 Workplan.

150/23 **MEETING REVIEW**

SD stated the meeting had been a phenomenal meeting. Bringing in colleagues to tell stories and case studies is excellent. One culture of care ran all the way. KH commented on the high quality of reports.

151/23 **ANY OTHER BUSINESS**

No other business was discussed.

152/23 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

All items will be highlighted to the Board.

153/23 **DATE AND TIME OF NEXT MEETING:**

Workforce Committee Hot House:
6 February 2024 2.30pm – 4.30pm
Theme: Workforce Design

Workforce Committee:
19 February 2024, 2.00pm – 4.30pm
Chapter: Improvement

Minutes of the Charitable Funds Committee meeting held on Tuesday 6 February 2024, 10:30 am via Microsoft Teams

Present

Helen Hirst (HH)	Chair
Nigel Broadbent (NB)	Non-Executive Director
Lindsay Rudge (LR)	Chief Nurse
Gary Boothby (GB)	Director of Finance
David Birkenhead (DB)	Medical Director

In attendance

Vicky Pickles (VP)	Director of Corporate Affairs
Emma Kovaleski (EK)	Charity Manager
Sanna Samateh (SS)	Charitable Finance Officer
Zoe Quarmby (ZQ)	Assistant Director of Finance – Financial Control
Helen Rees (HR)	Director of Operations for Medicine (Deputy for Jonathan Hammond)
Amber Fox	Corporate Governance Manager *(minutes)*

01/24 WELCOME AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting and introductions were made, Sanna Samateh was welcomed into his first Charitable Funds Committee meeting.

Apologies were received from Lyn Walsh and Jonathan Hammond.

02/24 DECLARATIONS OF INTEREST AND INDEPENDENCE

All present declared their independence and there were no declarations of interest.

03/24 MINUTES OF THE PREVIOUS MEETINGS HELD ON 9 AUGUST 2023 & 11 NOVEMBER 2023

The minutes of the previous meetings held on 9 August 2023 and 11 November 2023 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meetings held on 9 August 2023 and 11 November 2023.

04/24 ACTION LOG

The action log was reviewed and updated accordingly.

VP explained the financial forecast will be influenced by a report expected from Gifted Philanthropy which will set out the next two years.
Action: Vicky, Nigel, Emma, Lyn / Sanna to meet to agree what the financial forecast should look like on the back of the Gifted Philanthropy report.

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

05/24 CHARITY STORY: CHILDRENS DIABETIC NURSING FUND

EK shared a charity story to highlight progress linked to the people behind the Charity and put a spotlight on the Children's Diabetic Nursing fund.

EK and her family have fundraised for years at HRI in aid of the children's diabetic fund and she shared some of her personal experience and key supporters of the fund, some of the key points to note were:

- Tree of Memories – Offered Gerry, a key supporter of the Charity a leaf on the Tree of Memories at CRH after all her support and donations of just over £8k, this was greatly received.

Lindsay Rudge joined the meeting.

- Annual Christmas Parties for patients and families are funded through the Charitable Fund, patients and families are fundraising to ensure the Christmas parties and other projects can continue.
- Another fundraiser, Jude, has registered for the skydive event in May 2024, to raise funds for the Children's Diabetes Team.
- Tickle Flex – able to use the donations to fund medical devices to support needle phobic children called Tickle Flex. This is having such an impact and they are looking at how to roll this out further to Acre Mills Outpatients.

The Chair thanked the Charity Manager for sharing the story relating to the Children's Diabetic Nursing fund.

The Director of Corporate Affairs highlighted the importance of creating relationships with businesses which can make a real difference and personal invitations or introductions into businesses works well for the Charity. The Chair highlighted partnerships are also important. EK explained they are looking at networks within the Trust as well as in the communities. EK attended the Chaplaincy team meeting and has been invited to the next monthly regional Mosque leaders meeting ahead of Ramadan and explained one of the mosques pro-actively fundraise for the Trust throughout Ramadan.

06/24 CHARITY MANAGER'S REPORT INCLUDING PROGRESS AGAINST STRATEGY

EK presented the report and highlighted it has been a successful year to date which has seen growth. She explained that fundraising has been increasingly challenging, and the Gifted Philanthropy report will be very insightful and will support future fundraising plans.

EK highlighted that operationally they have been stronger than ever before at the end of the year. A few points to note were:

- the majority of key performance indicators (KPIs) are on track and several fall in line with the development grant and plans to re-launch the charity in May 2024.
- CHFT Charity's activity shows a visual snapshot of what the Charity has achieved month on month which is positive.
- October was a positive month, hosted an event in partnership with Project Search to host a virtual balloon race, the Charity were also invited to host an engagement stand at the Huddersfield Town Football Club and Huddersfield Town continue to be supportive in raising the profile of the Trust Charity.
- Started developing a wellbeing garden at HRI for patients, colleagues and visitors with an aim to finish this by Spring at the re-launch of the Charity.
- In November, My Forever Boxes were funded by the Specialist Palliative Care Fund to help children process death - this was supported by the raffle and additional funds were able to be raised outside of the raffle, in support of the project.
- December was an incredible month which saw impact through experience with the Choir attending a ward and the main entrance.

Fundraising Projects include:

- **Orthopaedic Outpatients.** £35,000 to enhance the experience of children and young people who visit the Orthopaedic Outpatients department at HRI. The

Orthopaedic Outpatients Department are actively trying to rise these funds as a public appeal.

- **CAMHS patients.** £15,000 to enhance the inpatient experience for patients who require Child and Adolescent Mental Health Services, or support through the Paediatric Mental Health Liaison Nurse.
- **Dementia support.** £2,000 to enhance the waiting area and one dedicated cubicle in the A&E at Calderdale Royal Hospital.

EK described an exciting opportunity coming up to raise funds for cancer services. Several meetings have taken place with a local business who are looking at a significant contribution towards the cancer services team. This will be shared at the next meeting.

An analysis of where income is coming from has been undertaken and over the course of four years, an average of 59% of funds raised have been received through general giving and third party events. The Charity will be focused on raising the profile to uplift the funds raised through general giving, in memoriam and third party events.

The key performance indicators for 2024-25 have been drafted.

NHS Charities Together – two separate documents were circulated with the report. EK shared the NHS Charities Together grant intentions documents for this coming year and explained she will be submitting a proposal for an *innovation grant*. EK is keen to ensure the right project is supported for this application. EK has taken the decision not to apply for the Volunteering Health Fund.

GB explained they may be considering doing something different in orthopaedic outpatients and suggested a conversation takes place with operational colleagues before the Charity invest any funds. HR flagged that the orthopaedics location issue is at CRH.

GB asked if the two objectives for next year highlighted below were the same as if the charity delivered an income of £209k this would cover the operational and staffing costs.

1. Deliver all planned events to a target income of £209k.
2. Cover all operational and staffing costs, with an adequate and agreed surplus.

VP agreed that this should be a single number and the charity will manage the break down.
Action: EK to include one figure in the financial sustainable funding KPI.

NB suggested the charity agree a budget to set performance measures against, including the amount of income the Charity are hoping to raise through donations, grants, events and staffing costs for the year etc. HH agreed this would be a more useful way of presenting the finance report. VP agreed separating the finance report to the activity report.
Action: VP / EK / SS to work together to provide a separate finance report and activity report for the Charity.

07/24 FUNDING / FUNDRAISING REQUESTS

EK shared a funding request of £5,280 to continue the funding for the A&E care bags that has been an impactful project the Charity committed to previously. EK explained they will be looking at a funding and fundraising opportunity for these projects and the team are already planning fundraising later in the year.

GB agreed this is a good thing to do and expressed his support. He raised concern in the limited number of resources left.

NB asked if there was any evidence of the impact and the outcome of the first 100 care bags. EK agreed to pull this together and circulate.
Action: EK to circulate a document which shows the impact / outcome of the 100 A&E care bags.

LR suggested the request should be more explicit to look at what the demand is per year and how long they will last as it is not based on admission data from ED which states how many are required. She asked if there are any other specialised charities that would be willing to supply in this area with an application submitted which would free resources up to fund elsewhere.

DB suggested the charity invite applications into the Charitable Funds Committee to make a collective decision. He explained the ad hoc approach is not satisfactory and does not reflect the broader hospital community.

VP expressed her support for this request as it meets the Trust's strategic objectives and overall Trust objectives around health inequalities. She suggested charity material is included in the care bags to advertise they are funded by the charity.

VP asked that those who apply for funding attend future Committee meetings to support their application.

HH explained the Committee approved the funding in principle and requested further information to show the evidence and impact of the care bags.

HH suggested a bidding window could be introduced two or three times a year with a bidding window for the Committee to consider at its quarterly meetings. VP suggested that this could be linked with the timings of Dragons Den.

EK highlighted the new scheme of delegation and over course of the last two months, almost 100 funding applications have been processed through the charity through departmental funds.

From 1 April 2024, the steering group will be established with monthly meetings to review applications into both departmental and general funds.

HH asked the Charity to consider the general funds process and which funds are approved outside the charity in terms of their value. HH also suggested the funding form includes value versus impact and scale and what other funding has been explored.

NB highlighted under the new scheme of delegation, anything up to £50k can be agreed without coming to the Committee, he explained this creates a potential problem with how the Charity control the totality of funds and individual approval amounts. EK agreed to pick this up as part of the forecasting conversation i.e., only release x% of funds. EK asked for NB's support with this.

08/24 FINANCE REPORT – ACCOUNTS 2023/24 OVERVIEW

ZQ presented the Finance Report at Q3. The key points to note were:

- Fund balance has dropped by £2.6k - spent more income than has come in.
- Total income of £196k and spent £336k.

- Donations from Sovereign Health Care in December 2023, including the largest being £15k.
- To cover off some of the expenditure, had to liquidate some the investment which has seen the investment value drop.
- Revaluation loss as at Q3.
- Moved from £2.5m at year end, now at £2.2m, predominantly expenditure outweighing the income.
- Total of 822k approvals - some covering a few years
- Forecasting – understanding when this will be spent.
- Funds available with no approval against and are outstanding.

VP suggested it would be helpful to look at when approvals were made and how long they have been outstanding. VP highlighted there are a few posts in the report which need an exit plan e.g. MMD co-ordinator non pay costs.

NB asked for further information on the donation from Sovereign Healthcare. EK confirmed this is an annual donation from Sovereign Health care and is usually half this value. They recognised a special anniversary of the organisation and distribute funds to several charities across the region. EK confirmed that 50% went into the nursing fund and 50% went into the general fund. LR meets with Sovereign Healthcare every year and can update the Committee on what the spend is and explained the commitment this year is on patient experience and involvement.

VP asked Sanna to undertake a piece of work looking back historically which items have been paid for annually. i.e. hospital radio charity insurance for HRI and NHS retirement fellowship payment. This will then be reviewed to put a process in place and build in discipline and controls.
Action: Sanna Samateh to undertake an audit looking at which items are paid for annually across general purpose funds or all different funds.

09/24 COMMITTEE EFFECTIVENESS REVIEW

The Director of Corporate Affairs explained each Committee undertakes a self-effectiveness review to see if any improvements can be made and if the committee are meeting their terms of reference.

Committee members are asked to complete the checklist which will be circulated separately, by 29th February 2024. The feedback will be reviewed in March and will report back to the next meeting in May with an action plan on how to improve the effectiveness of the Committee.

10/24 FEASIBILITY STUDY FINDINGS REPORT

VP explained this report is part of NHS Charities Together assessment of the development of the Trust. The Trust commissioned a company called Gifted Philanthropy to undertake a stock take on where the Trust are and what the potential is for the charity moving forwards. Gifted Philanthropy have completed this with lots of NHS Charities, most recently Mid Yorks.

The report was due by December; however, the report was finished last week and includes lots of detail.
Action: Amy, Chief Executive of Gifted Philanthropy to present the findings of the report to the Committee in a separate session.

11/24 MINUTES OF STAFF LOTTERY COMMITTEE MEETING HELD ON 19TH DECEMBER 2023

The minutes of the Staff Lottery Committee held on 19th December 2023 were received for information.

12/24 ANY OTHER BUSINESS

Audit of the Annual Report and Accounts

ZQ explained following discussions with the external auditors, KPMG have significantly increased their audit fees. She explained VP shared information from Airedale who investigated whether an audit was required of their charity or if an independent examination could take place. ZQ confirmed the rules required for an audit and clarified the Charity would not require an audit for 23/24 and would need an independent examination. Previously the Trust paid £3.5k for an audit and the new set rate would cost £35k. KPMG explained if the Trust went back as new business they would be looking at around £50k to undertake an audit. ZQ confirmed the Trust will explore a local accounting firm to undertake an independent examination. In terms of timescale, the accounts will need to be submitted to the Charities Commission by January 2025.

NB commented that the proposal from KPMG is disproportionate with the scale of the charity and agreed with an independent examination route by a qualified accountant.

GB agreed with the proposal for an independent examination which would be better value for money due to the scale of the charity.

VP explained it was Airedale's auditors who recommended an independent route and supported Airedale with the process in how to do this.

EK is working with the League of Friends at CRH and engaging in discussion around a step-down plan for them. Recommendations have been made to their treasure and chair to set up a designated charitable fund called League of Friends (£325k). They would annually transfer a lump sum into the charitable fund and EK will liaise with them on a monthly basis to review any applications that would draw down from the League of Friends charitable fund. The Chair praised EK for this good way forward with the League of Friends at CRH.

EK shared feedback following a positive meeting with new general manager for reconfiguration, Sophie Box, where they are looking at how to maximise opportunities, for example supporting stroke rehab through power assisted wheelchairs.

DATE AND TIME OF THE NEXT MEETING

Tuesday 7 May 2024, 10:30 - 12:00, Meeting Room 3, 3rd floor, Acre Mills Outpatients or via Microsoft Teams.

Attendance Log 2023/24

	10 May	9 August	14 Nov	6 Feb	Total
Member					
Helen Hirst (Chair)	✔	✔	✔	✔	4/4
Nigel Broadbent	✔	✔	✔	✔	4/4
Kirsty Archer	✔	x	-	✔	1/2
Gary Boothby	-	-	✔	✔	2/2
David Birkenhead	x	✔	x	✔	2/4
Lindsay Rudge	x	✔	✔	✔	3/4

Adele Roach	✔	x	-	-	1/2
Jonny Hammond	-	-	-	x	0/1
Attendance					
Carol Harrison	✔	✔	-	-	2/2
Emma Kovaleski	✔	✔	✔	✔	4/4
Victoria Pickles	✔	✔	✔	✔	4/4
Zoe Quarmby	✔	✔	✔	✔	4/4
Helen Rees	-	-	-	✔	1/1

28. Date and time of next meeting

Date: Thursday 2 May 2024

Time: 10:00 am

Venue: Rooms 3 & 4, Acre Mills Outpatients

To Note

Presented by Helen Hirst