Public Board of Directors

Schedule	Thursday 11 January 2024, 10:15 — 14:00 GMT
Venue	Large Training Room, Learning Centre, Calderdale Royal Hospital
Organiser	Amber Fox

Agenda

10:15	1. Welcome and Introductions: To share a Digital Story: Louise Croxall, Chief Nurse Information Officer Andrea Gillespie, Freedom to Speak Up Guardian Rachel Westbourne, Public Health Lead Sarah Rothery, General Manager, Resilience, Acute Flow & Transformation Invited Public Governors: Brian Moore Gina Choy To Note - Presented by Helen Hirst	
10:16	2. Apologies for absence To Note - Presented by Helen Hirst	
10:17	3. Declaration of Interests To Receive	
10:18	4. Minutes of the previous meeting held on 2 November 2023 To Approve - Presented by Helen Hirst APP A - Chair Approved Minutes of the Public Board of Directors - 02.11.23 v4 (A).pdf	1
10:20	5. Matters Arising and Action Log APP B - Draft Action Log as at 02.11.23 (Public Board of	15

	Directors) (A).pdf	
10:22	6. Chair's Report To Note - Presented by Helen Hirst	
	APP C - Chair's Report - January 2024 (A).docx	16
10:27	7. Chief Executive's Report To Note - Presented by Brendan Brown	
	APP D - CEO Report - January 2024 (A).docx	19
	STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE	
10:37	8. Digital Story - Neonatal Intensive Care Unit and Badgernet EPR Presented by Louise Croxall, Chief Nurse Information Officer To Receive	
10:57	9. Digital Health Strategy and Update To Note - Presented by Robert Birkett	
	APP F - Digital Strategy - Annual Review BOD_ Jan 2024 (A).docx	28
11:07	10. Health Inequalities 12 month review Presented by Rob Aitchison and Rachel Westbourne, Public Health Lead To Note - Presented by Rob Aitchison	
	APP G1 - Board of Directors Cover Sheet - Health Inequalities update Jan 24 (A).pdf	38
	APP G2 - Board of Directors - Health inequalties update Jan24 (A).pdf	42
	APP G3 - CHFT Population Health and Inequalities Strategy 2023-24 action plan update (Board of Directors 110124) (A).pdf	49
	INTEGRATED PERFORMANCE	
11:17	11. Workforce Committee Chair Highlight Report To Note - Presented by Karen Heaton	

	APP H - Workforce and OD Committee Highlight Report - December 2023 (A).pdf	70
11:27	12. Quality Committee Chair Highlight Reports To Note - Presented by Denise Sterling and Karen Heaton	
	APP I1 - Chair Quality Committee Highlight Report - Oct 23- Nov 23 final (A).docx	72
	APP I2 - Quality Commitee Highlight Report - December 2023 (A).docx	75
11:37	13. Finance and Performance Chair Highlight Report To Note - Presented by Andy Nelson	
	APP J - Finance and Performance Commitee Chair's Highlights 3rd January 2024 (A).docx	77
11:47	14. Month 8 Financial Summary To Note - Presented by Gary Boothby	
	APP L1 - Board of Directors Cover Sheet Month 8 Finance Report_11 Jan 24 (A).docx	79
	APP L2 - Month 8 Finance Report for Board.pdf	82
11:52	15. Integrated Performance Report To Note - Presented by Jonathan Hammond	
	APP M1 - QWF_Performance narrative BoD_11th January 2024 final (A).docx	86
	APP M2 - IPR November 2023.pdf	89
12:02	16. High Level Risk Register To Note - Presented by Victoria Pickles	
	APP N1 - High Level Risk Register Front Sheet Board Jan 2024 (A).docx	167
	APP N2 - High Level Risk Register Extracted 12.12.23.pdf	170
	APP N3 - High Level Risk Register Appendices Jan 2024 (A).docx	178
	KEEPING THE BASE SAFE	

12:07	17.	Safeguarding Adults and Children Bi-Annual Report To Note - Presented by Lindsay Rudge	
		APP P1 - Cover Sheet - Board of Directors Safeguarding Bi Annual Report Apr 23 Sept 23 Final (A).docx	188
		APP P2 - Safeguarding Biannual report April 23 Sept 23 (A).pdf	190
		APP P3 - Board of Directors Safeguarding Bi Annual Report Apr 23 Sept 23 Final (A).docx	198
12:17	18.	Nursing and Midwifery Safer Staffing (Hard Truths Requirement) Bi-Annual Report To Note - Presented by Lindsay Rudge	
		APP Q - NM AHP Safer Staffing Report Board of Directors (A).docx	216
12:27	19.	Fire Safety Annual Report To Receive - Presented by Jonathan Hammond	
		APP R1 - Annual Fire Report 2022-23 Board of Directors Cover Sheet (A).docx	252
		APP R2 - Annual Fire Report 2022-23 Board (A).docx	254
12:32	20.	EPRR Core Standards – statement of compliance To Note - Presented by Jonathan Hammond	
		APP S1 - NHS Core Standards for EPRR Cover Sheet - Board of Directors 11 January 2023 FINAL (A).docx	261
		APP S2 - Board of Directors 11 Jan 2024 Slides v2.pptx	265
		APP S3 - NHS Core Standards for EPRR - Board of Directors 11 January 2023 FINAL Paper (A).docx	273
		APPENDIX 1 – STATEMENT OF COMPLIANCE.docx	279
		APPENDIX 2 - BoD Core Standards and Action Plan 2023.pdf	280
		APPENDIX 3 - LETTER FROM ANTHONY KEALY, LOCALITY DIRECTOR FOR WEST YORKSHIRE.docx	289
		APPENDIX 4 - NHS England EPRR Core Standards Overview for Boards.pdf	291
		Governance	

12:47	21.	Freedom to Speak Up Mid Year Report and Qualitative Presentation Presented by Andrea Gillespie, Freedom to Speak Up Guardian To Note	
		APP T1 - FTSU Mid Year Cover Sheet - December 2023 (A).docx	295
		APP T2 - FTSU Mid Year Board paper - December 2023 (A).docx	296
13:02	22.	Update on reinforced autoclaved aerated concrete (RAAC) in leased premises For Assurance - Presented by Stuart Sugarman	
		APP U1 - Cover Sheet - CHFT CHS RAAC In Leased Properties - January 2024 - to Board (A).docx	299
		APP U2 - CHFT CHS RAAC In Leased Properties - January 24 - to Board (A).docx	300
13:07	23.	Governance Report a) Updated Governance Structure b) Senior Independent Non-Executive Director and Deputy Chair arrangements c) Board Development Plan 2024 d) Board Workplan for 2024 To Approve - Presented by Andrea McCourt	
		APP V1 - Governance Report (A).docx	303
		App V2 - Governance Structure V32 (A).docx	306
		APP V3 - Board Development Programme 2024 draft.pptx	308
		APP V4 - Draft Public BOD Annual Workplan 2024 version 4 - 04.01.24 (A).docx	309
13:17	24.	Items to receive and note 1. Minutes of Board Committees - Finance and Performance Committee 25.10.23, 28.11.23 - Quality Committee – 23.10.23, 20.11.23 - Workforce Committee – 17.10.23 2. Partnership papers:	

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

To Note

13:19 25. DATE AND TIME OF NEXT MEETING

Date: Thursday 7 March 2024
Time: 10.00 – 1.00 pm
Venue: Boardroom, Learning Centre, Huddersfield Royal Infirmary

To Note - Presented by Helen Hirst

Chair Approved Minutes of the Public Board Meeting held on Thursday 2 November 2023 at 10.00 am, Forum Room 1A / 1B, Sub-Basement, Huddersfield Royal Infirmary

PRESENT

Helen Hirst	Chair
Brendan Brown	Chief Executive
Lindsay Rudge	Chief Nurse
Gary Boothby	Director of Finance
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
Andrea McCourt	Company Secretary
Neeraj Bhasin	Deputy Medical Director
Dr Liaquat Ali	Guardian of Safe Working Hours
Amber Fox	Corporate Governance Manager (minutes)

OBSERVERS

Brian Moore	Public Elected Governor
Tony Wilkinson	Public Elected Governor
Robert Markless	Public Elected Governor
Krish Pilicudale	Insight Development Programme
Gemma Puckett	Director of Midwifery and Women's Services
Arley Byrne	Senior Clinical Educator for Allied Healthcare Professionals
Ansah Jamil	District Nurse, Beechwood

137/23 Welcome and Introductions

The Chair welcomed everyone to the Board meeting held in public, including invited governors Brian Moore, Tony Wilkinson and Robert Markless as observers to the meeting.

The Chair introduced Krish Pilicudale, Director of Digital Information from the University of Huddersfield who is on placement with the Trust from the Insight Development Programme for aspiring Non-Executive Directors for nine months.

The Chair explained the Shadow Board is now part of the governance arrangements and Arley Byrne and Ansah Jamil 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.

138/23 Apologies for absence

Apologies were received from Rob Aitchison, Deputy Chief Executive and Stuart Sugarman, Managing Director for Calderdale and Huddersfield Solutions (CHS).

139/23 Declarations of Interest

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

TB declared an interest in item 160/23 in relation to the HPS Annual Report due to his Board member role for a pharmaceutical company which produces specials medicines. The Chair confirmed this was an item to note and there was no need to exclude TB from the discussion.

140/23 Minutes of the previous meeting held on 7 September 2023

The minutes of the previous meeting held on 7 September 2023 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 7 September 2023 as a correct record.

141/23 Matters Arising and Action Log

The action log was reviewed and updated accordingly.

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

142/23 Board Diversity (Non-Executive Development and Shadow Board), including Board Diversity Action Plan

Board Diversity

In introducing this item, the Chair welcomed the discussion on Board diversity, and emphasised the importance of all aspects of diversity and inclusion for the Trust, including diversity of thought, as without diversity across the workforce of the Trust, including the Trust Board, we will be unable to meet the diverse needs of the population we serve effectively. The Trust is targeting effort and energy to become a more diverse organisation which will benefit both patients and staff.

The Director of Corporate Affairs provided the national context and re-iterated the importance of Board diversity, which brings fresh ideas, greater challenge and enables robust decision-making and the Trust's desire to reflect the communities we serve. She gave a presentation on Board Diversity, and referenced NHS England's Equality, Diversity and Inclusion improvement plan which includes six high impact actions, with upcoming recruitment to two Non-Executive Director posts an opportunity to increase diversity. To date the Trust has developed a Board diversity action plan, been active in the development of leadership programmes at Trust, West Yorkshire and regional level focusing on people from a BAME background and was participating in the Insight Programme, which aims to give prospective Non-Executive Directors from under-represented groups first-hand experience of how Boards in the public sector work. The Insight Programme has been running since 2018 by Gatenby Sanderson. 64 people have participated in the programme, of which 31 have gone on to secure Non-Executive Director (NED) roles in the public sector. There are currently 25 people on the Insight Programme matched to organisations in the NHS.

Krish Pilicudale, participant in the Insight Programme working with the Trust, was invited to share his background. He shared that he came from India as an international student and had a background in retailing, banking and higher education. Krish is responsible for leading and delivering strategy for the University of Huddersfield and has an academic background. Krish was approached by Gatenby Sanderson about the programme and felt encouraged to be part of the Programme as he is compassionate about health care and the need for diversity. The Insight Programme offers placements in healthcare or housing and Krish was interested in healthcare. Shortlisted members are provided the opportunity to hear from the Non-Executive Directors who were previously part of the Programme and their experience. Krish feels encouraged to be part of the Insight Programme and thanked the Trust for the opportunity.

Robert Markless asked how people apply to be part of the Insight Programme. Krish explained there is a link on the Gatenby Sanderson website to complete an application and it follows a normal job application and interview process.

The aim is to have increased diversity on our Board and increased diversity in the pool of future leaders coming through.

Board Diversity Action Plan

The Director of Workforce and OD noted equality, diversity and inclusion is at the core of the Trust's People Strategy and reminded the Board that an Inclusion Committee and an Equality, Diversity and Inclusion action plan is in place, which also includes the Shadow Board programme. She presented an update on the Board Diversity Action Plan, which sets out the following actions:

1. Develop a clear approach to Board recruitment and selection, using competency assessment referenced in the Kark review.

2. Ensure Nominations and Remuneration Committees continue to consider all Board recruitment plans and approve all appointments. Plans to include ways to encourage diverse high-calibre candidates for Board level roles, candidates for Board appointments to be considered from a wide applicant pool and appointment 'long lists' to include diverse candidates.

3. Complete an annual evaluation of Board colleague skills/experience/knowledge in relation to Equality, Diversity and Inclusion (ED&I).

4. The Board succession plan to be updated annually at the start of each service year.

5. The Board will collectively champion diversity and support ED&I activity including participating in equality network meetings, attending ED&I events and challenging inappropriate behaviour.

6. Continue to grow the Shadow Board with a clear focus on ED&I and the diversity of senior leadership.

7. Support applications for/participation in national/regional Aspirant Director/Board development programmes.

The Trust position on the two NHS England targets on race and disability were shared:

- Workforce Race Equality Scheme data showed that BAME is under-represented on the Board with only 1 of 18 people attending the Board having a BAME background, compared to a Trust workforce of 24.8% with a BAME background and a BAME population in Calderdale of 13.9% and in Kirklees 26.4%.
- Workforce Disability Equality Scheme data showed Board membership in respect of declared disabilities is better than 85% and worse than 15% of Trusts, with 2 of 18 people attending the Board having a declared disability compared to 5.9% of the Trust workforce with a disability.

The Director of Workforce and OD reflected on the composition of the Board with regards to gender and noted that, although the workforce is 81% female, in line with the wider NHS, this is not reflected at the Board where 11 of 18 Board members are male and 7 female; this compares to a gender split of 49% male and 51% female in our communities.

Two Non-Executive Director positions being recruited to within the next six months and an Executive Director vacancy in late 2024 will provide an opportunity to seek applicants from a diverse background.

KH supported the work of 'growing our own' in the People Strategy and highlighted it is important to start at a young age and for the Trust to support their journey.

PW highlighted the gender split at the Trust overall and asked about the progression of women in relation to men. The Director of Workforce and OD stated discussion has taken place in Workforce and Organisational Development to understand how to bring more men into the workforce e.g. men's mental health support and apprenticeships.

TB highlighted the upcoming vacancies for the Board with the opportunity to make progress on ethnicity and gender. TB added the Board should also look at the age profile and the opportunity to seek or attract a different age profile. The Director of Workforce and OD agreed and stated the Shadow Board is of a younger age group, which is positive. TB suggested the Trust could take on a different approach to seek a Non-Executive Director with a different age profile to the current Board and the Director of Corporate Affairs responded the Trust have chosen not to use a search agency for the upcoming two NED posts and she recognised the Insight Programme attracts a younger age group.

The Chief Nurse described how an NHS Trust had appointed the first Chief Nurse from the Philippines in the country, however this took 20 years from the first intake of nurses and explained she will look at how to support those on the Shadow Board and younger colleagues in terms of development.

The Chief Executive re-iterated the need for people to grow into a Board role and draw on their experience and pay attention to dissenting voices.

Tony Wilkinson asked how the Trust can demonstrate to the wider public that diversity made a different to society. The Director of Workforce and OD responded there has been a growth of diversity in the workforce and the impact can be evidenced through feedback from patient surveys, performance of the Trust, such as A&E targets, cancer targets which all happen due to a diverse workforce and by representing the people the Trust is serving. She explained the performance speaks to the diversity of the workforce we are working alongside and how we give people in our communities a better experience.

DS stated it is essential to remain sighted on the talent pool and follow through with individuals once they have completed programmes. She highlighted secondment opportunities and projects can help support ongoing development and suggested starting these earlier in people's careers. The Director of Workforce and OD advised that work was happening on this amongst healthcare providers at Place level.

Krish suggested there is almost an expectation to have significant experience as a Non-Executive Director however promoting the culture alongside the role and not expecting significant healthcare experience broadens the pool to attract more diverse candidates.

OUTCOME: The Board **NOTED** the Board Diversity Presentation and Insight Programme and **APPROVED** the Board Diversity Action Plan.

143/23 Chair's Report

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

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

144/23 Chief Executive's Report

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

The Chief Executive stated there was immense pressure in the accident and emergency departments, elective recovery, and cancer; however, the Trust was still performing well in comparison to its peers, despite this pressure, which is a credit to colleagues at the Trust.

He noted a challenging post pandemic world, that the Trust was about to enter winter pressures and are seeing some levels of Covid and other infections which has impacted on workforce and absence levels.

The new Emergency Department (ED) is complete which is an exceptional building and acknowledged the leadership of the programme. The Deputy Chief Executive/Director of Transformation and Partnerships was working through the snagging issues.

The second CHuFT awards was taking place that evening (2 November 2023) with a record number of nominations and shortlisted colleagues.

Along with other organisations the challenging financial position was noted to be a concern. The Trust was forecasting to deliver the planned £20.80m financial deficit but this will be challenging given the recent strikes and the ongoing level of activity.

The Chief Executive thanked shadow Board colleagues for joining the meeting and re-iterated previous discussion about talent. The Deputy Chief Executive/Director of Transformation and Partnerships mentioned provided feedback from the shadow Board who welcomed the narrative in the Chief Executive report celebrating Allied Health Professionals (AHPs) and that more visible support would be really welcomed by health professionals if Board members could visit these colleagues and services.

Brian Moore fed back that he had recently attended the PLACE inspections at both hospitals and commended both hospitals for the ambience of the wards which was calm and clear and stated all staff were doing a fantastic job. The Chief Executive suggested governors could visit the Allied Healthcare Professional (AHP) workforce and Arley Byrne offered to show them around.

KH recognised the high numbers through ED into winter and highlighted the positive performance, commitment, and dedication of colleagues. KH explained the CHFT charity has been shortlisted for charity of the year in Calderdale.

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

145/23 Strategic Objectives Progress Report Q1, 2023/2024

The Deputy Chief Executive/Director of Transformation and Partnerships presented progress against the 2023/24 strategic objectives. Of the 15 objectives, 14 are reported as green on track and 1 reported as amber, off track with a plan. The amber objective relates to the delivery of the overall financial plan.

AN welcomed inclusion of the measures in the report which shows some really good progress with strong evidence it is on track.

NB recognised the objectives were all green apart from one and compared it to the IPR report where some areas are below target, such as health inequalities and asked what the Trust considers as on track. The Deputy Chief Executive/Director of Transformation and Partnerships responded that the metrics are a mix of both achieving a desired outcome and doing everything

that we have said we would, for example on health inequalities there is a measure to reduce health inequalities such as waiting list times but also a broader population health outcome.

The Director of Finance responded on the amber objective which relates to acute provider productivity metrics and explained month 4 is the latest data issued nationally and shows CHFT as the most productive provider in West Yorkshire and ahead of the national average. He explained the financial challenge relates to money moving around the system.

In response to a discussion at the previous Board about communicating progress on the strategy with colleagues across the Trust, the Director of Corporate Affairs explained they are looking to produce an infographic for wide dissemination.

OUTCOME: The Board **NOTED** the progress with the 2023/24 strategic plan.

146/23 Health Inequalities Update

The Deputy Chief Executive/Director of Transformation and Partnerships provided an update and explained a 12 month review on health inequalities will be presented on 11 January 2024 with Rachel Crossley, Public Health Specialist Lead in attendance.

The key updates were:

- Positive visit from national director from health inequalities – encouraged to share some of the metrics to the wider NHS.
- Health Inequalities Group focused on how to reduce the number of people who do not attend appointments which is higher for BAME and deprived communities.

Suzanne Dunkley, Director of Workforce and OD left the meeting.

TB stated the position is strong overall and the new areas of priority look positive and asked for an update on pop up clinics. The Chief Nurse responded these are community clinics where homeless or high intensity users might access services such as foot health rather than accessing services in more traditional ways and provides an opportunity to signpost these individuals to services.

AN explained the Happy Days charity run a winter shelter and include for example a wound clinic and chiropody as well as a list of other things that they can help with at these clinics. There is a challenge about the resources to expand this, but it is a huge opportunity to provide vulnerable users access to the care they need.

The Deputy Chief Executive/Director of Transformation and Partnerships explained they are presenting more detail in January on the wider impacts of poverty on the organisation and colleagues. The Director of Corporate Affairs added the Director of Public Health Report in Kirklees focused on poverty and asked organisations to consider their roles within this, which will also be included in the January report to the Board.

DS asked that although the Trust is a leader nationally in terms of health inequalities could we visit other organisations to identify opportunities for learning. The Chief Nurse stated a fresh eyes approach is used and gave a go see example of the new Head of Midwifery who is undertaking work to look at a Kirklees base for community midwives.

DS asked if the Trust are making use of “Making Every Contact Count” and how to make staff aware to ask the right questions e.g., screening and assessment, tools and support. The Chief Nurse confirmed they are focused on the making every contact count (e.g., smoking, dietary, alcohol) and the Digital team have been supporting getting this on an app. She explained Sarah

Wallwork, Matron is attending Executive Board to discuss this, and the training package is ready. The Chief Digital and Information Officer advised of further related work using the data to predict future patient activity.

The Deputy Chief Executive/Director of Transformation and Partnerships highlighted the opportunity for different organisations to share and showcase work and noted that the Trust had showcased its work with other organisations via NHS Providers. The Chair suggested we could strengthen our data to show the impact the health inequality work is having which would help us challenge ourselves, when discussing health inequalities further at the January 2024 meeting.

Robert Markless highlighted not everyone has access to public IT systems, due to lifestyle or age, and this should be built into the health inequalities approach.

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

147/23 Charity Strategy

The Director of Corporate Affairs presented the Charity Strategy for 2024-2026 to the Board as Corporate Trustee for the charity. The Charity Strategy was approved by the Charitable Funds Committee in August 2023.

As part of the national NHS Charities Together development fund, the Charity received grants for its development, recognising the need to professionalise the management and governance of NHS charities. This grant will be focused on two key things:

- A review of the structure, arrangements, development and fundraising potential of the Charity
- A refresh of the Charity's brand and positioning within the Trust

AN stated he was pleased to see the Charity partnering with others to share similar ideas as the challenge is charities could compete rather than collaborate.

DS expressed her full support and stated she is looking forward to more updates to Board and asked how the new branding be communicated. The Director of Corporate Affairs confirmed they are working in partnership, fundraising and funding within organisation and describing the real benefits. She explained the Charity provides a different route to the Trust for people who were not users of hospital services.

OUTCOME: The Board **APPROVED** the Charity Strategy as Corporate Trustee.

148/23 Finance and Performance Chair Highlight Report

AN presented the Finance and Performance Committee highlight report to the Board from the meetings held on 26 September and 25 October 2023. The key updates from the Committee were:

- Continued strong performance in cancer.
- Elective Recovery performance achieved 109%; however, now behind trajectory for 40 week waiters due to issues in ENT and strikes.
- Positive improvement in the MUST score now at 86%.
- The Trust have produced a strong and comprehensive response to an NHSE request on how we are protecting and expanding elective capacity.
- Received a detailed report on the actions being taken to address the problem of patients dropping off the national e-Referral System including mitigations CHFT have now put in place to avoid this problem re-occurring.
- Reviewed the Surge and Escalation Plan and the Resilience Plan; the latter replaces what used to be called the Winter Plan.
- Agreed the target for staff turnover to be changed from 11.5% to 10%.

- Appointment Slot Issues continues to be a concern, particularly in ENT.
- Excellent care provided in the Emergency Department despite the pressures being experienced, it was noted there will be an integrated flow hub in the new ED.
- Adverse variance to plan across the Integrated Care System was £40.8m YTD at month 6; and a forecast likely case of an £90m adverse variance to plan.
- Current expectation is that a gap of £6.7m will remain in the CIP programme despite further schemes being identified. We will need to finalise our forecast for the year at month 8.

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

149/23 Month 6 Financial Summary

The Director of Finance presented the financial position as reported at Month 6, which confirmed the Trust is forecasting to deliver the planned £20.8m deficit but the 'likely case' scenario is an adverse variance of £6.69m.

A workshop took place to work through opportunities subject to a quality impact assessment. The Trust are awaiting further guidance nationally on the elective recovery fund which is expected this week.

Performance targets had been adjusted as a result of the industrial action but only for April activity to date

It has been agreed across West Yorkshire Integrated Care Board (ICB) to revise the forecast, if necessary, between month 7 and 8 in line with national rules relating to financial forecasts going off plan, which does not align with the Board meeting timetable. The Board was therefore requested to approve delegation of authority to the Finance and Performance Committee to revise the financial forecast outturn to be actioned after month 7.

OUTCOME: The Board **NOTED** the Month 6 Financial position for the Trust as at 30 September 2023 and **APPROVED** delegation of authority to revise the forecast outturn after month 7 to the Finance and Performance Committee.

150/23 CT Scanner Business Case Approval

The Director of Finance presented the CT Scanner Business Case for approval for a fourth CT scanner for the Trust to be located at Calderdale Royal Hospital. The Trust has been awarded £2.266m from NHS England to fund a new CT scanner and the majority of the build works. The total capital cost is £2.643m and the Trust is being asked to pay the difference which is planned for the financial year 2023/24.

A scanner has been hired on site as a short-term solution to maintain performance and care for patients.

The Deputy Chief Executive/Director and Director of Transformation and Partnerships shared feedback from the Shadow Board who fully supported and welcomed the investments in a new CT scanner.

In response to a question from TB, the Director of Finance confirmed that the investment in the fourth scanner future proofs CT capacity, with there being a 15-20% growth in demand for CT scans.

NB thanked the finance team for the addendum to the business case which confirmed a 50% increase in capacity. He added the approval of the CT scanner Business Case needs to be reflected on the related risk currently on the high level risk register.

OUTCOME: The Board of Directors **APPROVED:**

1. the Business Case for £2.643m for the purchase of a CT scanner for CRH and the associated construction and infrastructure costs.
2. agreements or variations to documentation with the Trust's Private Finance Initiative partners that may be required to deliver the project and provide the Executive Directors with the authority to sign the relevant contracts with the PFI Partner.

151/23 Workforce Committee Chair's Highlight Report

KH presented the Chair's highlight report from the Workforce Committee meeting of 17 October 2023. The key points to note were:

- Last Committee focused on Workforce Design in the Emergency Department and Ophthalmology which resulted in the change they wanted and now need to make sure the change is embedded.
- EDI improvement plan is co-produced through engagement with colleague networks and senior leaders.
- The Workforce Race Equality Standard and Workforce Disability Equality Standard action plans 2023-2024 have the full support of our colleague networks.
- New revised IPR format was presented and whilst the format was better, further work was needed to make some targets clearer
- Deep dive took place on nurse staffing which is a challenging area and national issue.
- Lots of success in international recruitment.

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

152/23 Quality Committee Chair's Highlight Report

DS presented the Chair's highlight report from the Quality Committee meetings of 21 August 2023 and 25 September 2023.

- Learning from patient stories presented which focused on end of life experience and feedback from family members, feedback was to improve communication and involve carers in decision making sooner.
- An overview provided of the formation of a National Improvement Board and new CQC Operating Framework.
- How patient survey feedback will be used to develop a three-year Patient Experience Strategy.
- Maternity and Neonatal Oversight Report - the final report from the CQC maternity inspection has been published with the maternity service retaining a good status overall.
- Service reaccredited as a Baby Friendly Initiative (BFI) Gold service – one of very few maternity services to achieve this.
- Year 5 Maternity Incentive Scheme launched with a submission date of 1 February 2024 there are concerns regarding compliance with several actions - compensatory rest, new saving babies lives bundle and training compliance this has been added to the risk register.
- Medical Examiner Report - good progress continues to be made with the development of the service, by April 2024 this service will be rolled out to cover 56 practices, local hospices and the Mental Health Trust.
- Getting it Right First Time (GIRFT) achievements highlighted with CHFT being one of the higher performing Trusts on this which has been so impactful.
- Three open never events reported and a thematic review of incidents relating to NG tubes is underway.
- Quality Summit took place in October 2023 which had good engagement.

- Clinical Outcomes Group - Concern a number of workstreams have slipped to limited assurance which is linked to the impact of the industrial action.

The Medical Director confirmed an improving position on falls, pressure ulcers and infections. He noted a number of workstreams of the Clinical Outcomes Group had slipped from significant to limited assurance audit report and actions have been identified.

The Medical Director noted the Quality Summit had provided an opportunity to reset the quality programme going forward The Chief Nurse added the Quality Summit in October had good engagement across clinical and non-clinical teams, reviewed what is working and what needs to adjust and change and looked to re-focus the quality agenda across CHFT and reduce duplication for colleagues. Several groups have been brought together to align the improvement work e.g., Learning from Deaths, End of Life Group etc.

It was noted further discussion is taking place at the next Quality Executive Board on sepsis and the deteriorating patient.

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

Learning from Deaths, quarter 1 report, 2023/24
In respect of the Learning from Deaths quarter 1 report, 24% of deaths were reviewed compared to a 50% target of all deaths having a review, this is still a challenge.

The Medical Director commented that it was important to ensure time for undertaking improvement work as learning identified common issues.

OUTCOME: The Board **NOTED** the Learning from Deaths quarter 1, 2023/24 report.

Director of Infection Prevention Control (DIPC) Q2 Report 2023/34
DS highlighted the Trust's Clostridium difficile position has improved from previous years. The IPC Board Assurance Framework continues to be revised, the quality improvement audits and front line ownership audits are positive.

OUTCOME: The Board **NOTED** the Infection Prevention Control Q2 2023/24 report.

153/23 Integrated Performance Report
The Chief Operating Officer presented the Integrated Performance Report for September 2023. The key points to note were:

- The Trust is performing well nationally.
- Nominated for HSJ elective recovery award.
- Challenges remain in ENT.
- Strikes had a big impact with over 1k patient appointments affected and 4k follow ups.
- Trust remains ambitious with elective recovery 52 week target and pushing for 40 weeks which some specialities can achieve.
- Diagnostics are performing well; however, echo and neurophysiology are challenging in terms of workforce, the Trust has looked at mutual aid with Mid Yorks and what WYAAT can offer, these are the two specialties to focus on.
- Cancer targets for 28 day, plan to treat and 62 day referral to treatment were met in October which is really positive.
- Emergency Department – admitting fewer; however, more complex patients are being admitted which impacts on length of stay.
- Change of handover times with ambulances which starts from time ambulance pulls up and is a seven minute addition to our previous way of calculating handover times - this will impact on

performance, initial impact has been seen to the 30 minute target, but not the 60 minute target.
- One never event in September 2023.
- Sickness absence is the lowest ever since April 2021.

The Deputy Chief Executive/Director of Transformation and Partnerships shared feedback from Shadow Board which were:

- Finance and Performance Highlight Report – interested in the work the Trust are doing with partner organisations e.g., timely discharges.
- Finance and Capital Plans – The Trust is planning to spend £8.5m on the car park at the hospital and they asked why the Trust cannot spend this on staffing and clinical services. There was a discussion about capital and revenue and the need for reports / communications with colleagues explaining the limitations on how different pots of money can be used.
- Workforce – highlighted the success with international recruitment and asked if the Trust is retaining these colleagues and supporting them in the organisation, and with their long term careers.
- Absence - they asked if sickness absence can be broken down by Division to target where further action is needed.
- The Shadow Board supported the work on the Equality and Diversity Inclusion Plan.
- Quality report – query raised on the narrative for c. difficile levels which states is improving and doing well; however, the figure was 28 cases YTD against a target of 37 which is better than previous years. The Medical Director responded c. difficile position is significantly better than previous years and the general view is the ceiling targets set may not be realistic in the current circumstances and may be reset next year. He re-assured colleagues there were no outbreaks and these related to individual cases due to morbidity, age etc.
- The number of acronyms and abbreviations in papers were difficult for Shadow Board members to follow and greater care to these was requested.
- Finance – queried the consequences given the month 8 forecast was adrift to the plan. The Director of Finance responded any Trust that goes off forecast would introduce further measures and many other Integrated Care Boards are going off plan. The Trust was one of two across West Yorkshire that are green across all metrics.

TB asked if the root causes in the sustained increase in ED attendance could be influenced by the Trust and if anything else can be done in terms of transfer of care. The Chief Operating Officer responded there are virtual wards to help bring this volume down and there is a significant challenge around primary care. He explained the transfer of care list is significantly challenging and there is funding to enhance the urgent community response and the virtual ward teams are helping with this. AN agreed the Trust is doing everything it can and the funding will be a step forward. The Chief Nurse added this has been flagged as a quality and safety risk and will be escalated to both Places.

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

154/23 Audit and Risk Committee Chair's Highlight Report

NB presented the Audit and Risk Committee Chair highlight report from the meeting held on 24 October 2023. The key points to note were:

- Good progress in terms of implementation of recommendations from internal audit reports
- One limited assurance report related to Nasogastric tubes, the relevant lead is invited to the Committee in January 2024 to discuss the audit
- Two deep dives at the meeting focused on NASSIPS and LOCSIPS (safety standards for invasive procedures) previously a limited assurance audit report.
- Undertook a deep dive into the process for the Clinical Audit Programme

- Approved the Fire Safety Annual Report for 2022/23 with some changes to reflect the fact that additional capital funding had been approved for the current year.
- Reviewed the high level risk register and considered the latest version of the Board Assurance Framework and approved the new risk on cyber security at a score of 15
- New process for reducing the losses of personal effects.
- KPMG provided a verbal update on staffing, re-entering local government market and taking on 20 new trainees.

Tony Wilkinson asked for an update on the fire report which states the lifts at HRI do not meet the current standards. The Director of Finance confirmed there has been approved funding of £400k by the end of March 2024 which includes further spend on the lifts at HRI. The Fire Officer also works closely with the local fire departments to reduce any risk. The Chief Operating Officer confirmed there are mitigations in place to manage this risk.

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

155/23 Resilience Plan 2023/24

The Chief Operating Officer presented the Resilience Plan, the key points highlighted were:

- Surge and escalation plans sit alongside the Resilience Plan.
- The plan has been to the Emergency Care Board.
- Plan reflects assumptions to address challenges.
- OPEL scoring system is changing to a national system which shows 9 parameters and the majority are linked back to the Emergency Department rather than broader pressures. The Trust has spoken to other organisations and partners and will use the nine parameters for the national OPEL scoring from mid-November 2023.
- Triggers will lead to significant actions reflected in the CHFT Resilience Plan.

The Chair highlighted the local OPEL framework is still referenced on page 9 of the Resilience Plan under CHS and will need to be removed. The Chair explained the system wide plans were discussed at the Calderdale Cares and WYAAT meetings and the new OPEL scores were recognised.

AN confirmed the surge and escalation plan was reviewed at Finance and Performance Committee and was an excellent piece of work.

OUTCOME: The Board reviewed and **APPROVED** the Resilience Plan.

156/23 Guardian of Safe Working Hours Reports Covering the Period March – August 2023

The Guardians of Safe Working Hours reports covering the period March – August 2023 was presented by Dr Liaquat Ali, Guardian of Safe Working Hours who had taken on this role from the beginning of October 2023. The key updates were:

- Junior Doctors industrial action - The medical team was supported by physician associates, pharmacists, trust grade doctors and training doctors who did not participate in the action.
- Most exception reports were from Foundation Year 1 (FY1) doctors at 76%
- Rota gaps were filled by Trust doctors or locums.
- Almost 80% of exception reports were related to extra hours of working.
- 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.

The Board formally thanked Shiva Deep Sukumar who was the previous Guardian of Safe Working Hours and welcomed Dr Liaquat to his first Board meeting. The Board thanked Neeraj Bhasin, Deputy Medical Director for his support.

OUTCOME: The Board **NOTED** the Guardian of Safe Working Hours Reports.

157/23 Board Assurance Framework

The Company Secretary presented the second update of the Board Assurance Framework.

- All risks updated and no changes to risk scores
- Top three are reconfiguration, demand and capacity and financial sustainability
- New risk proposed on cyber security scored at 15

The Deputy Chief Executive/Director of Transformation and Partnerships shared feedback from the Shadow Board who asked how the top three risks are communicated more widely. There was discussion about linking this with sharing the overall Trust one year strategic objectives.

KH supported the addition of a cyber security risk.

NB suggested referencing ENT on the BAF risk 4/23 relating to failure to achieve performance targets under elective.

NB pointed out risk 16/19 around health and safety compliance and suggested referencing the additional capital expenditure to mitigate some of these risks.

NB pointed out there was no reference to the Resilience Plan as a form of control under the risk 1/23 regarding high demand and capacity.

OUTCOME: The Board **APPROVED** the updates to the Board Assurance Framework and the addition of risk 5/23 relating to cyber security at a risk score of 15.

158/23 High Level Risk Register

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

- Where there are deep dives in areas such as stroke, there was confirmation that these are included on the risk register; however, may have a scoring less than 15.
- Neurology risk has reduced.
- Looking at how to cluster some risks that relate to similar themes which are shown in the cover sheet e.g. staffing, demand and capacity
- Gained approval to purchase a new, more holistic risk, incident and performance system which will enable risk triangulation and provide clear, more comprehensive reporting to Board and Committees
- First meeting of the Corporate Risk Group took place in October to review corporate risk management.

AN commented the triangulation with the Board Assurance Framework is improving and it would be helpful to be explicit that the high level risk register does not include reconfiguration risks. He also commented that further information on gaps was needed.

NB commented the Audit and Risk Committee are looking at a potential future deep dive looking at the risks associated with partnership working and would discuss this further with the Deputy Chief Executive/Director of Transformation and Partnerships.

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

159/23 Governance Report

The Company Secretary presented the Governance report which contained:

a. **Annual Review of Non-Executive Director Roles**
b. **Revisions to Standing Financial Instructions and Scheme of Delegation**
c. **Use of Trust Seal**

Board Workplan - The Board is currently reviewing the flow of papers linked to the publishing of Integrated Performance Report which may impact the workplan.

d. **Board Committee Annual Reports:**

Huddersfield Pharmacy Specials (HPS) Annual Report

OUTCOME: The Board **NOTED** the annual review of Non-Executive Director roles (noting that DS was not the Wellbeing Champion) and Board participation in the Insight Non-Executive Director development programme, **NOTED** revisions to the Standing Financial Instructions and Scheme of Delegation have been approved on behalf of the Board by the Audit and Risk Committee, **NOTED** the use of the seal, **NOTED** the Board workplan for 2024 and **NOTED** the 2022/23 HPS Annual Report.

160/23 Review of Board Sub-Committee Terms of Reference

The terms of reference for the Transformation Programme Board were reviewed.

OUTCOME: The Board **APPROVED** the Transformation Programme Board Terms of Reference.

161/23 Items to receive and note

The following were provided for assurance:

- Finance and Performance Committee Minutes - 30.8.23, 26.9.23
- Quality Committee Minutes - 21.8.23, 25.9.23
- Workforce Committee Minutes - 23.8.23
- Partnership papers: Kirklees Health and Care Partnership and Calderdale Cares Partnership

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

162/23 Any Other Business

There was no other business.

163/23 Date and time of next meeting

The Chair formally thanked the Board of Directors, colleagues and governor for their attendance and closed the meeting at approximately 1.00 pm.

Date: Thursday 11 January 2024
Time: 10.00 am
Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 14.11.23

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
7.09.23 128/23	**Freedom to Speak Up Annual Report 2022/23**	Company Secretary	Andrea Gillespie, Freedom to Speak Up Guardian to be invited to the November 2023 Board meeting to provide a qualitative update. Due to availability now scheduled for 11 January 2024.	11 January 2024		11.01.24
6.07.23 93/23	**Integrated Performance Report**	Chief Operating Officer	Develop narrative summary report using non-SPC language and review within 3 months – Full review of IPR to be completed by end of November. The Chief Operating Officer explained the narrative reflects the SPC charts and further adjustments will be made with some feedback provided to Peter Keogh.	11 January 2024		

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public 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**

Straight after our last Board meeting a number of us had the pleasure of attending the annual ChuFT awards. What a show of talent from CHFT, across a range of areas and all demonstrating that magic ingredient that is CHFT's USP – One Culture of Care.

Just before Christmas I also attended the THIS Staff Awards which again demonstrated the expertise, talent and skills we have supporting not just our health informatics service but teams across West Yorkshire.

I finally managed to do my first set of consultant interviews! Speaking to candidates beforehand, I asked why they were seeking roles at CHFT – all mentioned our digital environment and one culture of care. The majority had worked here at some point and were keen to return as consultants.

The Council of Governors and the Board held a joint workshop covering the financial position, performance and preparations for winter. Feedback suggests that these sessions would be improved if they were face to face and had more opportunity for discussion which is something we can build in for the future.

Another Health Matters members event was held in November and was very well attended by younger people from local colleges who were keen to hear about robotics and what goes on behind the scenes in an operating theatres. A number stayed behind after the session, keen to hear about career opportunities.

Along with Paul Knight and Jayne Greenhalgh, I attended the Autumn Yorkshire Organ and Tissue Donation Collaborative in York. As always with these events, there are opportunities for learning and improvement as we heard about activities in other Trusts as well as celebrating our successes.

The Charitable Funds Committee held a short meeting in November to sign off the Annual Report and Accounts.

Our Board development session this month focused on reflection of our year's Board development. We recognised our strengths as a board in terms of relationships, quality of discussion and debate and our areas for improvement in respect of broader visibility and connection to operational services.

Quite a lot of time this last few weeks has been dedicated to many conversations with prospective Non-Executive Directors as we recruit to replace Karen and Andy. We have had a lot of interest, not just for the roles we have at the moment but interest for the future when vacancies arise.

Finally, the update covering December wouldn't be complete without mentioning the delightful Christmas walkabouts I've done with the Workforce and OD Team. We had a bit of a theme in mine to seek out the teams who work a bit more behind the scenes such as

research, phlebotomy, pharmacy, medical records and pathology. I was accompanied on one set of visits by Pam Wood who used to run the apprenticeships programmes – what a treat this was as former apprentices stopped and chatted about the roles they were in now, the experiences they'd had and how much they enjoyed working at the Trust.

2. Health and Care System

West Yorkshire ICS Partnership Board was held on the 5th December. It was in two halves – a formal meeting available to watch online and a development session where we discussed our collective and sector specific influence following the Autumn Statement. At the formal meeting where we were joined by West Yorkshire's Mayor, Tracey Brabin, we heard an update on and the ambition to address inequalities; the plans to reduce suicide by 10% and some interesting interventions from Leeds Health and Care Academy to reduce inequalities through inclusive recruitment.

A meeting of West Yorkshire NHS Chairs preceded the Board where we discussed the work, we are doing to support new chairs and NEDs recruitment and development, relationships between provider collaboratives and the thinking on separation of senior independent director roles from deputy chairs.

WYAAT CIC was held at the end of October and as well as our usual updates and assurances on WYAAT strategy and programmes of work we were joined by some of those who had participated in the WYAAT Senior Leadership Programme. Between them they gave an overview of the programme, how theory had translated into practice, how the placements had worked and what changes they would recommend following evaluation. The Committee also approved the Annual Report of the Collaborative and had a brief discussion about the changes to the EPRR compliance process.

As well as the routine business of the Board on quality, safety, performance and finance, Calderdale Cares Partnership Board this month had a specific focus on the future model of hospital care in Calderdale through a great presentation from Anna Basford.

3. National/other

I haven't attended any national events since the last report.

As Board colleagues are aware, I am currently the interim Chair at Bradford Teaching Hospital NHSFT. Interviews for the substantive position take place at the beginning of February 2024.

Helen Hirst
Chair
2 January 2024

Date of Meeting:	Thursday 11 January 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	• Throughout 2023, as an organisation we have managed significant demand, financial pressures, and a sustained period of industrial action. • Through it all, colleagues at CHFT have shown resilience, and an unwavering commitment to care for our patients, and each other. • During the Christmas period we have continued to see high levels of attendances at both of our hospital sites and across community services, while also managing the ongoing national industrial action by our junior doctor colleagues. • We continue to perform well in elective and cancer care and have received positive feedback from external reviews, including a regional review of our maternity services and NHS England's assessment of our Integrated Board Report. • Our colleagues and clinical services have been nominated, shortlisted, and received several awards recognising innovation and quality of care. • We are currently on track to deliver the forecast financial position, recognising that this may be impacted by further industrial action or increases in unplanned activity. Planning for 2024/25 has begun.
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 and **NOTE** this paper as assurance and progress against both the local and national agenda, and as an update against leadership responsibilities within the CEO portfolio.

Calderdale and Huddersfield NHS Foundation Trust
Chief Executive's Report
28 December 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. I am writing this report in the period between Christmas and New Year, which has given me an opportunity to look back over 2023 and what we can expect in 2024. As you would expect, I have been reflecting on the past 12 months – and on what a year it has been. It has been a challenging year both for the Trust and in wider society. The turbulent social, economic, and political context we are operating within are well documented and in many cases ongoing.

1.3. As an organisation we have managed significant demand, financial pressures, and industrial action. Through it all, colleagues at CHFT have shown resilience, and an unwavering commitment to care for our patients, and each other. It is important to remember that we have seen brilliant achievements daily, and as we start the year it is important I highlight just a few examples.

1.4. We have been recognised nationally for our performance on cancer targets – being the best performing Trust in the country – and equally importantly on elective recovery. Our new Rainbow Community Hub opened its doors in February and is already making a difference to many children and their families. We completed the build of our new Accident and Emergency Department at Huddersfield and will be opening it soon once final checks are complete.

1.5. Colleagues have featured on national and regional TV too many times to count, with the most recent appearance broadcast on Sky News on Christmas Day. Colleagues have been nominated and shortlisted for numerous awards including finalists in the Nursing Times Awards, Health Service Journal Awards, HSJ Digital Awards and Macmillan Excellence Awards, with our Prostate Cancer Exercise and Education Programme Team picking up Team of the Year Category at The British Association of Urology.

1.6. Internally, almost 700 nominations were made for our annual CHuFT Awards, The Health Informatics Service Awards, and monthly Star Awards, covering many talented teams and individuals. One of the most inspiring things about the internal awards is that colleagues make the nominations, for their colleagues, truly reflecting One Culture of Care.

1.7. We have held successful recruitment campaigns, into some roles that have been previously extremely hard to fill, and now have full establishment across many areas of the Trust, captured in our #TeamCHFT video.

1.8. It is important that we take some time to reflect on what we have achieved. The rest of this report will look forward to 2024 and what we know will be a challenging year ahead. There will continue to be external factors influencing what we do, our patients and our colleagues; the wars in the Middle East and Ukraine; the global economic situation and domestic cost of living pressures; a pending General Election and the consequent political uncertainty; continuing demand for services and the need to significantly reduce our backlog. I am confident that the people, culture, and communities that make up CHFT will ensure that we continue to be successful.

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

2.1. The Christmas and New Year period is historically when we see a reduction in attendances at our Accident and Emergency (A&E) departments and an increase in the number of available beds as patients are discharged to their homes. This year, however, we had one of our busiest weeks in the run up to Christmas and as I write this report we are at full capacity. As reported in the media, we have seen a significant increase in patients with respiratory illnesses, either respiratory syncytial virus in children or flu in adults. Our additional bed capacity has been included in the overall numbers as our baseline and we now only have access to what we refer to as 'super surge' beds. This is reflected in our performance against those metrics which are related to patient flow (four-hour ED target; ambulance handovers; bed occupancy; 12 hour waits) in the Integrated Performance Report, being presented at this meeting.

2.2. As a result, we have introduced our Full Capacity Plan. In line with our resilience plan, and in common with other trusts nationally, the Plan describes how we will safely support patients moving to ward areas ahead of admission, and how we will fully use our discharge lounges to ensure beds are made available as quickly as possible. The Plan has been piloted with clinical colleagues, patients, and their families. We have also been collaborating closely with partners to reduce the number of patients on the transfer of care list. Thanks to this collaborative commitment focussing on safe discharge this has fallen to around 80 patients and has remained below 100 throughout the Christmas period. Command and control arrangements with partners are in place to maintain this focus over January.

2.3. Cancer performance continues to be strong with the faster diagnosis target being achieved for the third month running. Sky News spent some time with us to film a piece, broadcast on Christmas Day, about how hospitals can use technology to speed up the diagnosis and treatment of cancer, using CHFT as an example of leading the way in the use of digital technology in patient care.

2.4. We continue to perform well in terms of elective recovery. ENT remains our most challenged specialty, impacting on the 40-week position. We will also need to assess and take stock of the impact of the latest rounds of industrial action on our cancer, elective, outpatient, and diagnostic performance.

2.5. Our three key risks remain unchanged, our financial position, with the uncertainty in relation industrial action and high levels of activity; staffing challenges in specific areas; and activity challenges impacting on patient flow.

2.6. As referenced in my last report, our maternity services received an Ockenden Regional Assurance visit from the West Yorkshire Local Maternity and Neonatal System on 28 November 2023. We have recently received the report of that visit, and the visiting team's overall conclusion was: 'The evidence submitted in advance was comprehensive and of a good standard. It demonstrated a commitment to safety, managing risk, learning and quality improvement. Staff were seen to be positive about their service and the care they gave to women and their families. They were proud to work at Calderdale and Huddersfield Trust and shared examples of how they were working hard to ensure services were the best they could be for the communities they serve. There was demonstration of commitment to team working and mutual respect, within the maternity services and neonates. There was a commitment to learning and improving and ensuring staff and service users were at the forefront of any change."

2.7. This is positive feedback and a real testament to the work of colleagues in maternity and neonatal services. Their commitment to providing high quality, safe care shines through as well as their demonstration of one culture of care for each other.

2.8. This latest visit follows our Care Quality Commission (CQC) rating of GOOD for maternity services. The CQC have recently published their new inspection and quality standards for the well-led framework. While these build on the previous key lines of enquiry, they do represent a significantly different approach, based on 'we statements' (what they expect of providers) and 'I statements' (people's experience of care). We have been strengthening how we capture our patient and public experience work to support our assessment. We will also be reviewing the new well-led quality statements which include new areas of focus including Freedom to Speak Up – the latest report of which is included on the agenda for this meeting; partnerships and communities – which will be the focus of our board development session in February; and environmental sustainability.

2.9. In December we became one of only 30 trusts in the UK to be awarded the distinction of Venous Thromboembolism (VTE) exemplar status by the National VTE exemplar network, led by Kings College, London. This milestone has taken more than 10 years of dedicated work with leadership and innovation led by the Trust Thrombosis team. The work has resulted in a significant improvement in our VTE risk assessment performance (consistently achieving >95% risk assessment); robust investigation of all hospital associated venous thromboembolism (HAT) incidents using a radiology database and real time feedback to the team. We have one of the lowest incidences of avoidable Hospital associated VTE in the country and have not had an avoidable VTE related death for more than two years. VTE Exemplar Centres were created by the Department of Health in 2007 as a way of recognising excellence in VTE prevention care and encouraging leadership and innovation in the field.

2.10. We are piloting the Oliver McGowan Mandatory Training on Learning Disability and Autism, which will be rolled out nationally next year. The Oliver McGowan Mandatory Training on Learning Disability and Autism is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better understanding and training. All colleagues in both patient facing and non-clinical roles will undertake the training which supports patients with autism and/ or learning disabilities to access services. The training

gives colleagues basic tools, awareness and understanding to help meet the needs of our patients with autism and/or learning disabilities.

2.11. Each quarter, NHS England (NHSE) undertakes a review of the 'segmentation' status of each NHS Trust and NHS Foundation Trust within the NHS Oversight Framework (NOF). The purposes of placing an organisation in one of four segments are to provide an overview of the level and nature of support required, to inform oversight arrangements, and to target support capacity as effectively as possible. For Q3, as expected we remain unchanged in segment 3. This is in relation to our financial deficit position.

2.12. During 2023 we made significant changes to our Integrated Performance Report, introducing statistical process control charts, in line with NHS Digital's Making Data Count best practice. NHS Digital recently reviewed our revised report rated it as 5/5, one of only 12 out of around 210 trusts nationally to have its report classed as exemplary. They particularly highlighted our focus on inequalities and the NHS England national inequality team used the report as a best practice example. The review included some suggestions for future improvement which will be implemented ahead of the new financial year.

3. Transforming services and population outcomes

3.1. Over the last few years, we have been working with the Infrastructure and Projects Authority (IPA) who were acting on behalf of His Majesty's Treasury (HMT) to agree with our PFI provider how to release the estate 'red line' (access to land) for development of the CRH site. We have now successfully negotiated a position that the IPA and HMT have advised aligns with government PFI policy. This should put us in a position to progress the enabling works early in the new year and begin the second half of our reconfiguration programme. This is a further significant step forward.

3.2. Early in the new year we will begin enabling works on the Calderdale Royal Hospital site as part of our preparations for the sizable clinical build. This will include some internal moves of services within the existing building, as well as starting on construction of the new learning and development centre on Dryclough Lane. We will also be working with colleagues and the public to look at options to mitigate the impact of the loss of car parking spaces while the construction of a new multi-storey car park takes place later in 2024 and into 2025.

3.3. As previously referenced, our approach to digital and innovative solutions to delivering care have continued to attract interest and we were featured on both Sky News and BBC national news. We also received a visit from Shadow Secretary of State for Science, Innovation and Technology and MP for Hove, Peter Kyle, who came to learn more about the work we are doing using Artificial Intelligence in the diagnosis of lung cancer.

3.4. Artificial intelligence is one element of our plans described in the annual review of our digital strategy which is included on the agenda for discussion at this meeting. The Strategy provides an excellent summary of how far we have come as a Trust and how we have achieved several national digital 'firsts' including the implementation of the electronic controlled drugs register and development of an electronic patient records (EPR) for same day emergency care over the past two years. As we move into year five of our Strategy we will be looking at how we continue to strengthen partnerships both across our local Places and with our neighbouring acute trusts. There are significant opportunities in a collaborative approach to digital leadership across the Calderdale, Kirklees, and Wakefield (CKW) elements of the Integrated Care Boards (ICB) through and with acute partners, especially

around driving further progress towards commonality/convergence of systems (e.g., Patient Portal, EPRs, Robotic Process Automation) as well as how we scientifically use data to improve services.

3.5. Our digital strength has been an important factor in the achievements we have made in addressing health inequalities. The recently published report from the King's Fund titled *Tackling health inequalities on NHS waiting lists* calls out the work we have done to analyse waiting list data to identify people with learning disabilities and implement a range of initiatives and extra support for these individuals.

3.6. The latest update on progress against our Population Health and Inequalities Strategy shows the progress against our four key priorities including collaborating with patients and the public to ensure our new Community Diagnostic Centre facilities meet the needs of underserved populations and are accessible; and making the best use of Making Every Contact Count. The actions have also focused on the impact we can make on poverty as a key anchor partner following a presentation to the wider executive and senior leadership team by the Director of Public Health for Kirklees on her annual report 'Poverty Matters'. I would encourage all Board colleagues to read this impactful and hard-hitting report. We have joined the Kirklees Tackling Poverty Partnership and the Calderdale Poverty Steering Group recognising that the way we deliver services, and how we operate as one of the largest employers in both towns can and should have a significant impact for the communities we serve.

3.7. We recently welcomed visitors from Monserrat and NHS England to explore opportunities to develop mutually beneficial partnership arrangements for nursing and midwifery colleagues. The visit enabled an exchange of ideas, and our teams highlighted the forward thinking and well led work they do. The next steps will be to explore how we begin to connect our teams here with those in Montserrat to share experiences and learn from one another.

3.8. On 10 January, we are hosting a visit by Professor Tim Briggs and the Getting it Right First Time national team on behalf of the West Yorkshire Association of Acute Trusts (WYAAT). This reflects the work we have been doing to address waiting list backlogs as we have been identified as an exemplar site by Professor Briggs' team. Any initial feedback from the visit will be shared at the Board meeting.

3.9. Our partnership arrangements at a West Yorkshire level continue to deliver changes and improvements in services. We are progressing the pathology partnership and the proposed managed service provider contract is on the agenda for the private board meeting in line with procurement rules. We are also making the necessary estates changes to enable us to care for non-surgical oncology patients for the South Sector in the new year.

3.10. From a partnership governance perspective all member trusts in WYAAT have agreed I will continue as Chair of the WYAAT Programme Executive and the acute sector representative on the Integrated Care Board. We are also members of the West Yorkshire Community Collaborative (WYCC), and Rob Aitchison, Deputy Chief Executive attends this on behalf of

CHFT. The governance documents for the WYCC are being developed and will come to a future board meeting for discussion.

3.11. Our partner on the Calderdale Royal site, South West Yorkshire Partnership Foundation Trust, will launch a public consultation on improving mental health care for older people on inpatient wards across Calderdale, Kirklees, and Wakefield. The consultation will ask people to share their views about creating a specialist inpatient service for older people with dementia, and dedicated wards for older people living with other mental health needs such as anxiety, depression, or psychosis, which are known as 'functional mental health.' They will be sharing more information in early January 2024, which will include details of the proposals and how people can give their views and we will be hosting information events at both our hospital sites.

4. Inclusive workforce and local employment

4.1. At the time of the Board meeting, the second period of industrial action over the Christmas period will have concluded: junior doctors are striking from 3 – 9 January. As ever we have supported the right of colleagues to participate in industrial action and I would like to take the opportunity to thank all those who were involved in planning for and supporting services during the strike action to maintain safety for our patients.

4.2. We are awaiting the results of the BMA vote on whether to accept the Government's pay offer to consultants which is due to close later this month.

4.3. While Christmas is a period of celebration, it can also be an exceedingly difficult time of year for some. As a Trust the health and wellbeing of colleagues remains a priority and you will see from the report from our Workforce Committee that there are new initiatives supporting this priority: a revised parental leave policy offering support to colleagues who have experienced miscarriage; a new men's mental health group starting in January aimed at destigmatising men's mental health; an expanded staff psychology service; and a peer support debrief service being piloted in our Emergency Departments and maternity services before being rolled out across the Trust using funding from the Trust Charity. This is in addition to our successful and well-supported existing networks.

4.4. Celebrating the work of our colleagues is also an important part of supporting their health and wellbeing. Many of you were able to join in the annual CHuFT awards on 2 November. As I said at the start of this report, the Awards were a lens into the innovation and compassionate care that is delivered across our services every day. There were some fantastic examples called out on the evening, including the way the Surgical Assessment Unit work together; the one culture of care shown by our Sexual Health Consultant Lindsay Short in addressing monkey pox; supporting people in pregnancy to stop smoking by our maternity health care support workers; and helping families of children at the end of life. This is a snap shot of the brilliance we saw across all nominated, shortlisted, and winning teams and individuals. The CHuFT awards provide an opportunity to shine a light on this innovation. It is important we use our discussions at Board to highlight and share this commitment and innovation as much as possible.

4.5. We also recently held our first 'in person' Long Service Awards since Covid. The awards are testament to the commitment of colleagues who work for us. Celebrating a collective combined service of more than 400 years with remarkable colleagues, we honour not only

their years of dedication but the profound impact they have made for our patients, their families, and our colleagues.

4.6. In January we will welcome the new cohort of University of Huddersfield student nurses for their first placement. We are expecting around 100 student nurses to start across our community and hospital sites in a range of settings; these may be wards but will also include departments and specialist nursing teams.

4.7. Colleagues in the Empower Class of 2023 graduated in December. The Empower Programme is for any colleague with an interest in investing time in their self-development. The inclusive programme is designed to help colleagues grow to empower themselves to be effective in their roles and community, as well as unlocking talent within the Trust.

4.8. We also held our latest leadership conference in December. Over 60 senior leaders across the Trust participated in a series of workshops on the theme of 'leading one culture of care', looking at supporting staff with resilience and through change.

5. Financial, economic, and environmental sustainability

5.1. The finance report at this meeting shows a £14.66m deficit, a £0.54m adverse variance from plan. The in-month position is a deficit of £0.52m, a £0.96m favourable variance.

5.2. Some of the key drivers of the adverse variance include factors already described in this report: higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £3.49m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.09m; and non-pay inflationary pressures. While the strike costs pre-December are being funded through an additional allocation from the West Yorkshire ICB, the position in relation to the most recent strike activity is unclear.

5.3. 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 for the most recent strike action.

5.4. While continuing to manage our in-year financial position, we have begun planning for the 2024/25 financial year. The national planning guidance, usually published before Christmas, has been delayed until the end of January. 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.

5.5. Our Huddersfield Pharmacy Specials service (the Trust's Pharmacy Manufacturing Unit) has performed better than plan in 2023/24 and at its meeting on 2 January the Finance and Performance Committee will be considering the business case for a significant capital build for the service around three core elements:

- delivering financial stability to the Trust by making a commercial return for CHFT
- improving and sustaining NHS supply chain resilience
- ensuring HPS can continue to meet regulatory requirements into the future.

6. Recommendations

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

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	5 Year Digital Strategy Annual Review (3rd year)
Author:	Rob Birkett, Chief Digital and Information Officer
Sponsoring Director:	Rob Birkett, Chief Digital and Information Officer
Previous Forums:	The Health Informatics Service (THIS) Divisional Board
Purpose of the Report	The CHFT Digital Strategy was approved by the Board of Directors in July 2020. In creating the Digital Strategy, we engaged with over 300 stakeholders through workshop sessions, digital hothouses and one to ones, this was with both internal and external colleagues. We are now going into the 4th year of the 5-year Digital Strategy, and this is the third annual review. We are proud of what has been achieved over this time, especially over the last 12-18 months. This update aims to provide the Board and colleagues with assurance on the digital teams' ability to deliver on our objectives and provide a forward view on what is around the corner. We will continue to build on our foundations to ensure that CHFT is recognised as one of the most digitally advanced Trusts in the country, digitally enabling our workforce and healthcare professionals to provide the best compassionate care to our patients and the people of Calderdale and Kirklees. Our vision continues to be "Together with our partners, we will deliver outstanding compassionate care to the communities we serve", with digital being the key enabler in supporting clinical and non-clinical colleagues to provide that care to all our patients, as well as digitally empowering patients to be involved in that care. It is fundamentally important that the Digital Strategy continues to align with "one culture of care", in that we support and empower patients and colleagues on their own digital journey. Whilst we have successfully delivered many projects, there is further work still to do in making sure our digital solutions are fully adopted by Trust colleagues. Digital continues to become mainstream for everyone and we need everyone to become an ambassador for digital, although, we feel that this is something that has moved forward significantly through 2023. Our core Digital Strategy principles are still valid today, we will aim to continue to: • Improve the reliability and quality of clinical care to support early discharge of patients • Improve adoption/optimisation of current systems • Make available an integrated care system • Give patients control over their care • Ensure our corporate divisions are digitally enabled to support compassionate care

- Support the sustainability agenda
- Support strategic systems decision making and future planning

What we said we would do:

In the Digital Strategy we laid out what our aims were around a number of priorities and the positive impact they would have for colleagues and patients. The key points outlined in this paper show the progress we have made in 2023.

Priorities	We will do this by	This will result in:
Digital technologies to improve the quality and reliability of clinical care	• Providing "real time" patient records and care plans • Reduce the number of standalone IT Systems • Remove the need for paper from board to ward	✓ All relevant clinical information single access points ✓ Right access; right information ✓ Effective alerting prompts acr pathways ✓ Improving patient safety
Digital technologies to support early discharge of patients	• Reviewing current systems/processes • Remote home monitoring	✓ Improve Patient Satisfaction ✓ Improving the quality of care patient
Adoption/Optimisation of current systems and hardware	• Showcasing areas of good practise • Supporting areas to adopt/optimise current systems	✓ Efficiency gains in utilising est digital offering ✓ Reduced reliance on face to fa and clinical interactions
Make available to our staff an integrated healthcare system across the Integrated Care System (ICS) and beyond	• Identifying opportunities to increase interoperability across systems	✓ Improved and more timely cli information ✓ Reduce patient risk
Giving patients control over their care and protecting privacy	• Enhancing Virtual Consultations • Promoting and enhancing access to the Patient Portal and self-care advice	✓ Improve Patient/carer's and re experience ✓ Improving quality and reduce
To ensure our corporate workforce are digitally enabled to support clinical care through responsive and up-to-date technology	• Utilising digital collaboration tools • Provide the necessary hardware to support • Review of our corporate systems	✓ Continue and Improve Agile W capability ✓ Reduction of travel between s
Support the sustainability challenge	• Use Artificial Intelligence to predict • Utilising collaboration tools for patients/colleagues • Review our finances, and workforce process and systems	✓ Reduction in travel amongst th communities we serve ✓ Protecting our environment ar carbon footprint ✓ Reduce pressure on our estate

Reconfiguration

All the work undertaken within the projects and programmes outlined in this paper is supporting the Trust in becoming digitally ready for reconfiguration.

Key Points to Note

Progress against the CHFT Digital Strategy: The key messages from 2023 are:

Infrastructure

WiFi Upgrade & Network edge device replacement – A solid infrastructure foundation is key to providing a platform on which to deliver digital solutions. We have modernised our WiFi provision through installing new hardware across both hospitals and community sites, upgrading our WiFi software to the latest secure versions and reducing the number of areas within our sites with a poor signal. Our physical edge network on which our WiFi and all other systems rely on, has also had its hardware replaced across both hospital sites, further improving resilience, reliability and security. We have secured capital funding to finalise this work by upgrading our core network (10-year cycle) in 2024, all designed with reconfiguration of services in mind.

Cloud Provision – Further work in utilising the Trusts connection to the CHFT instance within Microsoft Azure (Cloud) by resilient network connections from both hospital sites. This is continued foundational work and will give the Trust options in the future that don't require costly new data centres as part of the reconfiguration of services.

Zebra/Mobile Device upgrade – Our requirement for mobile access to clinical systems continues to increase. This software and hardware upgrade to our Zebra mobile devices will ensure we can continue to safely provide mobile

access for e-observations, Point of Care Testing (PoCT), Hospital at Night (HOOP) and alerts (NEWS scores). This mobile access supports direct entry of data to reduce the risk of transcription errors, improve data quality and real time bedside access to patient information. Our community division adopted a new zebra device using a Workforce Connect solution to improve colleague visibility and reduce their lone working risk.

Mobile Security (Intune) – Following the move to a web-based version of both email and teams, as well as common use of WhatsApp for communicating, the importance of mobile security continues to increase. The move to Microsoft Intune ensures that all communication through these methods and applications is via a safe portal. It also improves the experience for any colleagues who want to use their personal devices as the Intune portal separates work applications from personal applications resulting in CHFT being able to wipe only trust related data should the device be lost or stolen.

Digital Health

Electronic Controlled Drug Register (eCDR) – First of type nationally. The ordering of controlled drugs is processed and dealt with more accurately and efficiently resulting in the reduced risk of missed or delayed doses for patients. The solution is CQC compliant ensuring all errors are dealt with in a timely manner and enforces accurate documentation in the CD register. This work took away the requirement for a 'wet' signature which was supported by NHSE and will provide a way of working for other trusts to follow.

Same Day Emergency Care (SDEC) dedicated EPR build – First of type nationally. SDEC used Powerchart (Inpatient) to document patient care during their time in the department. The dedicated SDEC build within FirstNet (Emergency Department) will deliver a real time clinical overview of patients on Medical, Surgical and Frailty SDECs with Paediatrics planned for phase 2. This development will also enable the improved reporting both internally and centrally to NHSE. This build has been developed by CHFT and will now be available in Oracle Cerner model content platform for other trusts to utilise.

Virtual Ward built within TPP/S1 – The community Division has begun running a virtual ward for respiratory and frailty (over 65+). This is utilised to manage the caseload for patients who may have stayed in hospital but whom have been placed back at home or in their place of residence and remain under clinically led care. This enables patients to be discharged from hospital who would otherwise still need to occupy a bed.

NICU EPR (Badgernet) implementation - To ensure that CHFT's digital journey is Trust wide there has been a focus on tackling the last few departments and speciality's which remain in part on paper. This saw a project to put all the clinical documentation for NICU on to Badgernet. The department have used the system for some time but not for documentation and all patient care. This has now been completed with all medical records been digitally recorded. This is a huge benefit for staff as there is now a single source of the truth, clear reporting and patient transfers can be done quicker as photocopying is no longer required. As part of this move, we also saw a road map for getting diagnostic results directly feed into the system which will improve data quality and system utilisation.

Clinical Psychology – Similar to NICU there has also been a drive to digitalise the clinical psychology service also. This department, due to confidentiality required a secure environment in Oracle Cerner before they could begin to use the system. This year we have created a secure facility in our EPR which is solely for them with secure access and governance. This now means that the service is no longer reliant on password protect documents and shared drives.

It also provides a single source of the truth within EPR as well as the functionality to book patients in digitally saving time and reducing mistakes.

Nursing Documentation –This was a nursing led project to completely redesign nursing documentation within EPR in order to speed up and improve data capture. This was undertaken through significant engagement of all the professions who use the nursing documentation within EPR. At the elbow, sustained training was provided throughout the rollout with continued support from the process change team. The new documentation and process has now been live for over six months and the feedback has shown a significantly improved nursing workflow, the correct use of documentation and improved data quality.

Automation: RPA – Now into its second year, the RPA 'bots' are working on several large, automated processes on a routine basis, these are listed below. Through this automation, the time saved by the bots equates to around 10,000 hours (approx. 6wte) in 2023. This has only been achieved by developing the team capability, increasing capacity through internal development and the onboarding of a senior RPA developer. Following a review by WYAAT we are now one of only two main development teams across West Yorkshire. We are also starting to see some commonality of RPA platforms across the ICS.

- Referrals eRS into EPR
- Radiology scan acceptance
- Radiology plain film booking
- Outpatient procedure coding
- Waiting list validation - future outpatient appointments

Oracle/Cerner EPR instance and contract – As of November 2023 we are now up to date in terms of required upgrades to our Oracle Cerner EPR instance. This enables us to take advantage of more recent functionality as well as improving the security of the system. We also enacted our 5year contract extension early in order to maintain pricing and secure a reduced inflation forecast based on CPI. Our EPR contract now runs until March 2030 supporting longer term developments. In relation to this, Airedale are expected to join the CHFT/BTHT instance of EPR in September 2024.

Business intelligence and Data Science

Waiting list validation – Using a data driven approach to pull the requests into three cohorts, identifying duplicates, past date appointments and required future appointments. This targeted approach has resulted in a reduction to the outpatient waiting list, removing over 10,000 unnecessary appointment requests with a cost avoidance potential of around £1.5m through a reduction in cancellations and Did Not Attends (DNA's), driving a more efficient use of clinical and admin resource. The benefit to the patient is significant with a reduction in unnecessary appointments as well as enabling patients to be seen quicker overall, whilst prioritising in line with our approach to health inequalities. As backlogs are now reducing, this process will be extended to more waiting lists, aiming to apply data driven validation to the whole of CHFT's waiting list backlog. We have also applied robotic Process Automation to the model to drive further efficiency.

HR Adult cohort (Canterbury) – Taking learning from a 3rd party working in a partner organisation, our in-house business intelligence team used a data science approach to identify a cohort of high-risk patients who disproportionally added to our Length of Stay (LOS), despite not having any comorbidities. Our response to this has been to add flags in our EPR for early identification of these patients, followed by collaborating with partners to plan how we align our services to support early intervention and enabling the right treatment and support to be put in place, to reducing or avoiding admissions where possible.

The reasoning being that this cohort account for the greatest proportion of bed days with no reason to reside, therefore supporting them to be at home will help with flow and improve experience and outcomes.

Integrated Performance Report (IPR) - The Business Intelligence teams have played a significant role in shaping the areas of focus for both clinical and operation staff by using SPC (Statistical Process Control) to present Trust data. This is highlighted in the work completed on supporting the challenges of elective recovery and emergency patient flow with senior analysts providing a wealth of expertise in supporting these areas.

The report has recently been reviewed by NHS England and they have rated us 5/5, one of only 12 trusts (out of 210 they have reviewed) nationally. They have described the report as exemplary and commented on the use of SPC, summary icon tables and matrix to guide discussion/action. They commented on the analytical narrative supported by a clear and concise action focused narrative, as well as the use of re-calculations. They also singled out the focus on inequalities and the national inequality team will be using the report in their analyst network as a best practice example.

The report has now been in use for over 6 months and is embedding well with minor improvements being made over this time.

Cyber Security

The threat of a malicious cyber-attack is ever present and therefore we have continually adapted our methods of protection and prevention, to reduce vulnerabilities and mitigate the risk as far as possible. We have maintained the fundamentals through replacing firewalls and updating software to the latest versions including next generation/AI network security.

We have strengthened the security of our mobile devices through the rollout of Intune Mobile Device Management (MDM) security software as well as ensuring we have implemented best practice around software and vulnerability patching across the wider infrastructure (Servers and Network).

We continue to actively scan and monitor the infrastructure for any suspicious activity and automatically prevent thousands of potential attacks per year. We have also sought assurance through external infrastructure testing from a 3rd party specialist resulting in significant assurance being awarded.

We have maintained our Cyber Security Essentials certificate as well as ISO27001 (Information Security Management), DCB1596 Secure Email (NHS England) and significant assurance through internal audit (Audit Yorkshire).

CHFT have yet again submitted a Data Security Protection Toolkit position of Compliant as well as achieving over 97% of colleagues completing Data Security Awareness (DSA) training.

This position was reached through a collaborative approach between the Information Governance and Cyber security teams, both of which have had structure changes and additional capacity introduced in 2023, including the addition of a National Cyber Security Centre (NCSC) Cyber Adviser, One of only a few in the UK. Both teams support the wider system including GPs/Primary Care which gives a broader knowledge base through economies of scale as well as a wider view of threats and responses.

A Cyber security update and presentation were delivered to Risk and Audit Committee as well as to a Digital Weekly Executive Board in Aug; the update was well received at both forums.

Education Training and Development

As CHFT continues its digital journey, optimising the use of existing systems and implementing new and innovative ways of working, the requirement for sustained education and training has increased both in importance and scope. 2023 has seen the development of a multi-method approach to ETD in relation to EPR and associated clinical systems. This includes:

- Focussed redesign of training for FY1/2 doctors
- Complete revision of Nursing documentation including re-education in correct use
- Development of a Digital Change Team with operational or clinical experience
- Digital Nursing and AHP placements in partnership with University of Huddersfield
- Re-learning opportunities through revised e-Learning, Bitesize and Self Led education

All of the above are a significant step forward in terms of how we intend to deliver education in the future however it is early days and further work will be required throughout 2024-25 for remaining substantive colleagues alongside developing a method of measuring impact.

A report to Quality Committee in November 2023 received positive feedback and gave assurance of the approach.

Governance and Assurance:

The governance as described in the strategy is in place and working.

Attendance and ownership have improved across the Divisional digital boards, further embedding digital within the divisions. These Divisional Boards continue to feed into the CHFT Digital Operations group with clinical and operational colleagues helping direct prioritisation of developments in line with divisional and trust strategy. Whilst recognising this is an improvement, we acknowledge there is further progress to be made.

Investment decisions are supported by robust business cases and key stakeholders from across the Trust. All business cases are now approved and monitored through the Business Case Approvals Group (BCAG) and the annual capital planning process.

We were once again able to submit a return of compliance to the Data Security and Protection Toolkit (DSPT). As the toolkit had tightened its requirements this year, some capital investments played a part in us being able to achieve this.

CHFTs Digital provision also recertified to 5 key standards again in 2022-23:

- Cyber Essentials – National Cyber Security Centre
- ISO9001 (Quality Management)
- ISO20000 (IT Service Management)
- ISO27001 (Information Security Management)
- DCB1596 Secure Email
- Internal Audit (Audit Yorkshire) – High and Significant assurance across the plan

Working with our partners

CHFT has an increased digital footprint within the ICS via THIS digitally supporting four of the five ICB places (Calderdale, Kirklees, Wakefield and Bradford), as well as a number of other regional/system partners including

Spectrum CIC, Community providers, Hospices, prison health and the 3rd Sector.

We continue to be involved in the regional Laboratory Information Management System (LIMS) including hosting the WYAAT Head of Pathology Systems and Interoperability role within CHFT. We remain involved in the Enterprise Integrated Clinical Environment solution (ICE) as well as providing a support service for regional LIMS and CDCs as they come into service.

Through the CHFT CDIO role we lead the Calderdale place digital board and have a presence on the Kirklees digital board as well as WYAAT, ICS and national CIO Forums.

CHFT is engaged with the Yorkshire and Humber Care Record (YHCR – Interweave) as both a provider and consumer of data. Also working alongside the regional team to integrate YAS Transfer of Care data into our EPR. The further benefits of this will develop as more of our boundary provider partners join the record.

The relationship around our joint Electronic Patient Record (EPR) with Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) has been successful and continues to develop and deliver benefits, one of which is the joint approach to bringing Airedale NHS Foundation Trust (AFT) onto the shared Oracle Cerner EPR instance (system) in Sept 2024.

We have overcome some digital barriers in the provision of Non-surgical Oncology services in a joint approach with Mid Yorkshire NHS Teaching Trust (MYTT), such as visibility of our EPR lists in MYTT, supporting our oncologists. We have also collaborated with MYTT on a data science approach to identifying a high-risk patient cohort with joint learning around a system based co-ordinated response.

We are exploring further the benefits and opportunities in a collaborative approach to digital leadership across the Calderdale, Kirklees and Wakefield (CKW) elements of the ICB through CHFT and MYTT, especially around driving further progress towards commonality/convergence of systems (e.g. Patient Portal, EPRs, RPA) and the further use of data to inform how we improve services across CKW.

Secured central funding:

There is a risk on the board assurance framework risk relating to the potential lack of funding limiting progress of the Digital Strategy. During 2022-23 the Digital Strategy has once again been well supported through CHFT capital programme ensuring the must do's are done (infrastructure) and developments, especially those relating to efficiencies or patient flow, can be delivered.

In addition to this we have been successful in securing significant central funding. This success is due to two things, our ability to respond quickly to available funding and a good track record of delivery.

This central funding includes:

<u>Digital Diagnostic Capability Programme (DDC)</u> - £3.3m total

22/23 - £1.6m for HRI Edge Network Refresh

23/24 - £0.9m for HRI Edge Network Refresh, enablement of CDC Spoke and network security.

24/25 - £0.8m TBC: Expected to enable final technical connectivity for CDC Hubs

Cyber Security Fund

22/23 – £60k – Next generation network security

Frontline Digitisation fund

22/23 - £100k – Staff Facing Whiteboards

Patient Experience Portal

22/23 - £450k for Implementation and licencing

22/23 - £80 for Integration into EPR

Licencing costs centrally covered for 2024/25.

Forward view:

Whilst we have made good progress against our 5-year Digital Strategy, there remains some key areas of focus as we move into 2024. A key part to some of the digital successes of 2023, was aligning our digital roadmap with the needs of clinical and operational colleagues across the Trust, we aim to continue that into 2024. Four key focus areas for 2024 are:

Patient Experience Portal (PEP) – Following a successful procurement process, 2024 will start with a swift implementation of a new patient portal provided by DrDoctor and Patient Knows Best (PKB), two of the leading providers of PEPs nationally. The initial implementation needs to be completed quickly in order to replace some existing services prior to contract renewal, however the development of functionality will progress throughout the year.

This software will fundamentally change and improve how we remotely interact with our patients including letters, appointment booking, remote consultation and remote monitoring. It will also positively change how they interact with us, both with the services we provide and also their own patient information/data.

Artificial Intelligence (AI), Machine Learning and Automation – We have explored and tentatively implemented a number of aspects of AI, machine learning and automation over the past year with positive outcomes. We intend to develop this further over the coming year with the potential to increase the use of AI within diagnostics whilst ensuring the governance is there to underpin the technology.

We will build on our use of predictive analytics and modelling, using our data science approach to help reshape services, aiding flow and improving outcomes. Further progress will be made around the use of automation technology including RPA, in order to drive efficiencies, reduce risk and increase capacity.

Health Information and Management Systems Society (HIMSS) – We aim to achieve HIMSS level 6 in 2024. HIMSS are a global organisation providing an NHS recognised framework for the measurement of digital and data maturity within a trust. The benefit of using HIMSS is that it measures how well embedded digital processes are directly in relation to the delivery of patient care with a specific focus on improving patient safety and outcomes. HIMSS Electronic Medical Record Adoption Model (EMRAM) works on a framework of 7 levels (1-7), with level 7 only being achieved by the most digitally mature trusts across the world. CHFT self-assessed at level 5 with a strong ambition to progress to level 6 within 2024.

HIMSS visited the Trust to conduct a gap assessment late last year, resulting in some clear recommendations around improving patient interaction (Patient Portal) and further development around closed loop prescribing, specifically the

	scanning of drug doses at the bed side, both of which are in the plan for early 2024. Given CHFTs positive position around the use of data, we also intend to assess ourselves against the HIMSS Adoption Model for Analytics Maturity (AMAM) framework, to further improve our use of data within the Trust and across the system. Airedale NHS Foundation Trust (AFT) / Oracle Cerner – Whilst not directly related to CHFTs Digital Strategy, the onboarding of AFT onto our shared instance of Oracle Cerner will involve our digital teams. Our shared EPR team has already been working collaboratively on the program with some of the new functionality being available to CHFT post go-live in Sept 2024. The shared model will continue post go-live with the team providing support services across all three trusts post go-live. The program itself will have some impact on the development of CHFTs EPR, as we go through a number of EPR change freezes throughout the build up to go-live, however our plan is flexible enough to continue to deliver around these issues. This will result in increased commonality/convergence of core systems across 3 of our 5/6 WYAAT Trusts. **Summary** There is a lot for CHFT to be proud of digitally this year. The teams are proud to have not only made good progress against the Digital Strategy, but also delivered on a number of national firsts as well as developing models and applications that can be used by other Oracle Cerner Trusts. The teams were finalists in 4 HSJ digital award categories alongside clinical and operational colleagues, for a range of projects including Pharmacy Integration and waiting list validation through data science. As we move forward, we will keep pushing the progress on all our digital programmes through to completion. We will further develop partnerships with our suppliers whilst remaining challenging of the services we receive from them. We will continue to develop our own people alongside securing skilled capability in order to keep CHFT in strong position when it comes to digital maturity and national influence. Through our approach to data science, we will continue to take advantage of the wealth of data that can help address some of the pressures and health inequalities across our patient populations, with a focus on how we distil and use this data to support patient care, aid safe discharge and improve outcomes, both at a Trust and at system level. Now is a good time to look further forward and commit to starting to understand what the future holds in relation to a new Digital Strategy in 2025. Given what we have achieved so far, and our plans for the next 12 to 18 months, this new strategy will have a strong focus on Data Science, the use of Artificial Intelligence, Machine Learning and Automation as well as a shift from the implementation of systems, to digitally and data enabled service redesign, complimenting, and enabling the overall ambitions of CHFT.
EQIA – Equality Impact Assessment	The Digital Strategy aims to promote inclusivity as part of the wider work on health inequalities. CHFT are progressing well in this space and will continue to work locally, regionally and nationally on addressing health inequalities including but not exclusively around learning disabilities, using our data and technological capabilities to understand our patient populations.

	We want to continue to push the boundaries of interoperability using the Health Information Exchange and Medical Interoperability Gateway software as well as regional and national offerings such as Yorkshire and Humber Care Record and the Yorkshire Ambulance Service Transfer of Care Project. We will do this by working with partners around data sharing agreements so we can ensure information is available at the point of care so those patients that don't have digital access to the information can get the appropriate care and information when meeting their health care professional. CHFT have a Digital Strategy that supports continued improvement, making sure people are fully adopting the technology we have. Whilst the technology provides the enablement, engagement with workforce/people/patients is critical and we need to make sure this is ongoing under the umbrella of "one culture of care". We have and will continue to support engagement sessions around the Digital Strategy including patients, relatives and workforce colleagues so they can continue to contribute to our strategy. Digital needs to be seen as mainstream not as an add on, 'people first-then technology'. Promoting digital inclusivity as part of the wider work on health inequalities is critically important and continues to be a digital strategy focus via our EQIA governance. The pandemic allowed us to implement technology that has enabled us to connect with patients, relatives and our workforce, it has introduced a way of working that has become the norm. There is more to do to ensure we expand our reach across the whole system and patient populations. The introduction of a modern patient portal will take this forward in 2024.
Recommendation	The Board is asked to **NOTE** the good progress that has been made against the commitments laid out in the Trust 5-year Digital Strategy for 2023.

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	Health Inequalities Update and 12-month review
Author:	Rachel Westbourne, Public Health Specialist Lead
Sponsoring Director:	Rob Aitchison, Deputy Chief Executive
Previous Forums:	Trust Health Inequalities Group
Purpose of the Report	The purpose of this report is to update the Board on progress against the actions set out in the Trust's Health & Inequalities Strategy (2022-24)
Key Points to Note	**NHSE Health Inequalities Information Requirements** On 27 November 2023, NHS England published the Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006). There is an expectation that integrated care boards, trusts and foundation trusts should use the statement to identify key information on health inequalities and set out how they have responded in their annual reports. As a trust, there are specific indicators that we are expected to monitor and report on. We are reviewing the reporting requirements to ensure we can meet these for our 2023 / 24 Annal Report, and our initial review suggests we will be able to do so. We already monitor a range of inequalities indicators (including in the Integrated Performance Report) that go beyond the scope set out in the new guidance. To meet the requirements set out by the new guidance, our 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. **Action Plan update and priorities for 2024** During Q3 of 2023-24, we completed the first review and refresh of the Health Inequalities Action Plan, which sits alongside and supports delivery of the strategy. The action plan functions as a live assessment of key

actions and activities taking place to progress work in the Trust to address health inequalities and promote population health. The action plan is owned by the Health Inequalities Group (chaired by Rob Aitchison) who will maintain oversight of and responsibility for the action plan. The Action Plan was updated to reflect work completed and achievements over the previous 12 months. New actions were added to reflect new work and priorities for the following year. We will continue to present regular updates on progress and key developments to Board throughout the year.

An updated copy of the Population Health and Inequalities Strategy with the refreshed action plan is appended. The accompanying slides and presentation highlight the priority actions for the next year under the four priority areas outlined in the strategy:

- **Connecting with our communities and partners**
  - Continue delivery of the BLOSM service (including the Trauma Navigator pilot) in ED and compile and present service evaluation data.
  - Build on the work of community pop-up clinics in Calderdale to improve access to health services for socially vulnerable populations, improving identification of socially vulnerable patients and improving access and care pathways.
  - We have joined the Kirklees Tackling Poverty Partnership and Calderdale Poverty Steering Group and are setting out our role as a place partner in addressing poverty as a health issue.

- **Equitable access and prioritisation**
  - Targeted work to reduce DNAs, particularly amongst patients from the most deprived communities.
  - Further piloting and rollout of the Health Inequalities Vulnerability Matrix. There is currently an ongoing pilot in cancer prehabilitation. A Clinical Reference Group and plan for engagement and governance will be established to ensure appropriate consultation, input into development, and governance.
  - Project to improve patient communication and letters – including new outpatient templates and considerations of accessible information standards and health literacy.

- **Lived experience and outcomes**
  - Work to promote poverty aware practice and poverty proofing pathways within our services (to explore including this within the refreshed Trust Clinical Strategy).
  - Embedding best use of a Making Every Contact Count approach (to explore including this within refreshed Trust Clinical Strategy).

- Continue to support work in priority areas for lived experience: learning disability, maternity, and mental health.

- **Diverse and inclusive workforce**
  - Support the continued development of the new Shadow Board including a specific development session on Health Inequalities
  - Continued delivery and promotion of: One Culture of Care values and behaviours; EDI awareness and education programme, Root out Racism Programme, the Widening Participation channels and apprentice programmes to support inclusive recruitment, the staff equality networks

New area for inequalities action: Poverty

The Health Inequalities Group and Executive Board recently welcomed presentations from Kirklees Council on 2023's Kirklees Annual Director of Public Health Report, which was focused on experiences of poverty in local communities and the impacts on health and wellbeing.

Many of our patients and workforce will be experiencing poverty and struggling financially; poverty rates locally are significantly higher than the national average. Poverty and health are inextricably linked. Living with poverty and financial insecurity impacts a broad range of physical and mental health outcomes and is a key driver of health inequalities. Addressing poverty is a therefore an important health intervention.

Implications for CHFT

The impact of poverty and financial insecurity on our patients and workforce can contribute to:

- Increased sickness absence and presenteeism amongst the workforce
- Worse health outcomes for both the workforce and patients
- Increased DNAs due to barriers to access – our DNA rate for patients from the most deprived quintile is 10.3% (compared to 4.4% for least deprived), representing 41% of all our DNAs
- Increased emergency attendances and unplanned admissions (due to increased health risks and struggles to access health care early)
- There is some evidence that poverty and financial insecurity can reduce the efficacy of treatment.

We are exploring what action we might take as a Trust to better recognise and address the impacts of poverty on health. This includes:

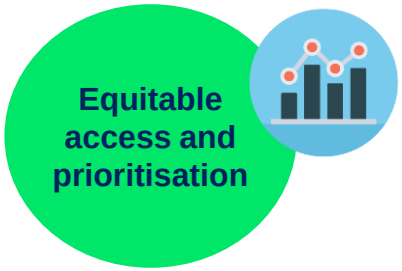
	• Joining the Kirklees Tackling Poverty Partnership and the Calderdale Poverty steering group to build on our role as a place partner in addressing poverty. • Inclusion of poverty and low income as a category that must be considered when undertaking Equality Impact Assessments. • Promotion of the NHS Low Income Scheme. • Plans to hold a Poverty Aware Masterclass for managers to increase awareness, understanding, and confidence in this area. • Exploring embedding poverty aware practice and poverty proofing pathways in our services.
EQIA – Equality Impact Assessment	The Trust's approach to Health Inequalities plays an important role in reducing the impact that inequalities have on access to, experience of, and outcomes from care. Specific initiatives within this work will continue to be reviewed to ensure they do not disadvantage individuals or groups negatively and that wherever possible actions maximise positive impact on protected characteristic groups.
Recommendation	The Board is asked to **NOTE** the Health Inequalities Update and 12-month review.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Progress update against the Trust's Population Health & Inequalities Strategy

11th January 2024



compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

NHSE Health Inequalities Reporting Requirements

NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)

27 November 2023

Integrated care boards, trusts and foundation trusts should use this statement to identify key information on health inequalities and set out how they have responded to it in annual reports.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

NHSE Health Inequalities Reporting Requirements

- The large majority of the data reporting required is at ICS rather than Trust level
- We are reviewing the reporting requirements and ensuring we can fulfil these – initial review suggests we will be able to do so
- We also already monitor a wider range of indicators than those required by the new duty (including in the Integrated Performance Report)
- Our 2023 / 24 Annual Report will report on the required inequalities indicators, and include additional narrative on the Health Inequalities Strategy, our approach to addressing inequalities, actions undertaken to reduce inequalities and impacts

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

The Health Inequalities Group and Strategy Review

- The Group continues to meet on a monthly basis with representation from across the Trust.
- Feedback suggests the meetings are positive and productive, with opportunities to share learning, present projects, and establish new actions to address inequalities.
- During Q3 of 2023-24, we reviewed the Population Health and Inequalities Strategy and updated the Action Plan to reflect work completed and achievements over the previous 12 months. New actions were added to reflect new work and priorities for the following year.
- Every quarter, those with named actions on the Action Plan will review and update on their actions where appropriate.
- A review and refresh of the whole strategy will be undertaken in 2024 (the current strategy covers 2022-24 – we anticipate this will only need to be light touch.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Updated Plan on a Page

Headline actions under the priority areas have all been reviewed and refreshed. New actions are highlighted.

CHFT Population Health and Inequalities Strategy

Connecting with our communities and partners

Harnessing our role as an anchor institution and key partner in the local health and care system, we will work to address inequalities in the wider determinants of health in our local communities, deliver social value, and work with system partners to identify and deliver shared priorities to improve population health.

- Work with partners across the local health and care system to take a collaborative and strategic approach to reducing inequalities
- Continue delivery of the **BLOSM service in ED** for vulnerable patients – evaluation to be completed and funding to continue delivery to be secured
- Build on the work of the pop-up clinics to improve access to services and health outcomes for **socially vulnerable populations**

Equitable access and prioritisation

We will reduce inequalities in access to care by removing barriers, improving access for the most vulnerable groups, and moving towards a more holistic approach to prioritisation where a broader range of risk factors are considered.

- Pilot use of the **"Health Inequalities Vulnerability Matrix"** to support a more holistic approach to prioritisation
- Monitor and proactively respond to **key inequalities indicators:** waiting times, Did Not Attends, unplanned admissions
- Improving **patient communications** and **targeted work to reduce DNAs**
- Ensure that the **upcoming Community Diagnostics Centres** meet the needs of underserved populations

Lived experience and outcomes

We will address disparities in experience of care to improve patient outcomes. We will focus on improving the lived experience of patients, particularly those known to be most at-risk of experience inequalities and poor outcomes. We will take a holistic and compassionate approach, recognising the importance of behavioural and wider determinants of health.

- Explore embedding **action on poverty and poverty aware practice across services.**
- Look at making best use of a **Making Every Contact Count approach**
- Continue building on good work in focus areas for improving patient experience and outcomes: **Maternity Learning disability Mental health**

Diverse & Inclusive Workforce

We are committed to ensuring our workforce reflects the diverse populations we serve and that we take action to promote equality of opportunity. We will promote colleague health and wellbeing and create a compassionate and inclusive environment in which all our workforce feels valued in line with our One Culture of Care approach.

- **Support development of the Shadow Board**
- **EDI Awareness and Education Programme,** EDI module in leadership development for managers
- Growing inclusive recruitment through the **Widening Participation** channels, growing the **apprenticeship programme**
- Promote, support and engage with the **Equality Networks**

Ways of working: data and intelligence, collaborative working, leadership

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Priorities for the next 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 in order to secure recurrent funding for the service beyond 24/25.
- Build on the work of community pop-up clinics to **improve access to health services for socially vulnerable populations**, improving identification of socially vulnerable patients and improving access and care pathways.
- 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.

- Targeted work to **reduce DNAs, particularly amongst patients from the most deprived communities.**
- Further piloting and rollout of the **Health Inequalities Vulnerability Matrix.**
- Project to **improve patient communication and letters** – including new outpatient templates and considerations of accessible information standards and health literacy.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Priorities for the next year

- Work to **promote poverty aware practice and poverty proofing pathways** within our services (to explore including in refreshed Clinical Strategy).
- Embedding best use of a **Making Every Contact Count approach** (to explore including in refreshed Clinical Strategy).
- Continue to support work in priority areas for lived experience: **learning disability**, **maternity** and **mental health**.

Lived experience and outcomes

Diverse & Inclusive Workforce

- Support development of the new **Shadow Board.**
- Continued delivery and promotion of: **One Culture of Care** values and behaviours; **EDI awareness and education** programme, **Root out Racism** Programme, the Widening Participation channels and apprentice programmes to support **inclusive recruitment**, the staff **equality networks**.

Calderdale and Huddersfield
NHS Foundation Trust

Calderdale and Huddersfield NHS Foundation Trust

Population Health and Inequalities Strategy, 2022 - 24

Executive Summary

CHFT is on a journey to expand its role and impact in improving population health and addressing health inequalities in the communities we serve.

Health inequalities are avoidable and unjust differences in health experienced by different groups. There is a wealth of evidence showing that certain groups in our communities (e.g., those experiencing social deprivation, ethnic minority communities, people with a disability) experiencing poorer health outcomes, and poorer access to and experience of health and care services. The Covid-19 pandemic exposed and exacerbated these long-standing inequalities, particularly among ethnic minority communities and for communities living in the most deprived areas, highlighting the need for the NHS to take urgent action in response.

CHFT responded by establishing a Health Inequalities Group to oversee development and delivery of workstreams and actions to address health inequalities. This work has included, for example: reviewing waiting list data to identify and address any inequalities; ensuring high priority care for patients with a learning disability; work on health communication and improvement in maternity services; promoting a diverse and inclusive workforce; and ensuring we use our role as an anchor institution to deliver social value and work with our partners on local priorities.

This work to date has shown that we can achieve significant impact. We must now ensure this progress is sustained and built on.

This strategy sets out CHFT's approach to improving population health and reducing inequalities in the communities we serve. The strategy presents the Trust's vision and principles for our role in population health and inequalities, the priority areas in which we will take action, and an action plan for how we will deliver this.

The Strategy outlines the four priority areas for action:

- Connecting with our communities and partners
- Access and prioritisation
- Lived experience and outcomes
- Diverse and inclusive workforce

These priority areas recognise the different responsibilities and areas of influence where CHFT can take action to promote the health and wellbeing of our local population and address the inequalities in health they experience. We recognise, as the local response to the pandemic and the inequalities it highlighted showed, that taking action on these issues requires using data and intelligence to understand the problem and evaluate impact, alongside working collaboratively with partners to achieve change and ensuring we have strong ambition and leadership to enable change.

Progress on this strategy will be regularly reviewed by the CHFT Health Inequalities Group and reported on to the Executive Board and Trust Board.

Background

Health Inequalities and Population Health

Many of our local communities experience poorer health and wellbeing than communities living in other parts of the country. We also know that within our local population there are significant disparities in health, with some groups and communities at greater risk of experiencing poor health outcomes, and the conditions which lead to them, than others. These inequalities in health are long-standing and systemic, driven by social, economic, and environmental inequalities. Crucially, they are also preventable.

What are health inequalities?

Health inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions (known as the wider determinants of health) influence how we think, feel and act and can impact both our physical and mental health and wellbeing (The Health Foundation, 2018).

When we talk about health inequalities, we often think of this in terms of inequalities in health outcomes and status, but it is important to also recognise the inequalities in access to and experience of health care. Often, people at the greatest risk of experiencing health inequalities due to their socioeconomic and environmental conditions are also those most likely to experience challenges in accessing care (Tudor Hart, 1971; Marmot, 2018).

Health inequalities can include (The King's Fund, 2022):

- health status (for example, life expectancy and prevalence of health conditions)
- access to care (for example, availability of services or ability to access services)
- quality and experience of care (for example, levels of patient satisfaction)
- behavioural risks to health (for example, smoking rates)
- wider determinants of health (for example, quality of housing).

Health inequalities are often analysed and addressed across four factors (The King's Fund, 2022):

- socioeconomic factors (for example, income or social deprivation)
- geography (for example, region or whether urban or rural)
- specific characteristics including those protected in law (for example, sex, ethnicity, or disability)
- inclusion health groups (people who are socially excluded, for example, people experiencing homelessness)

These factors and groups are not homogenous. People will experience different combinations of these factors and the ways in which these factors interact with each other and influence an individual's health and the inequalities they are likely to experience will vary.

Taking action on these inequalities has always been important, but the impact of the Covid-19 pandemic has made this more urgent by exacerbating and highlighting these inequalities. The stark inequalities seen during the pandemic were not created by Covid-19; they existed long before and will continue to persist and worsen now if purposive action is not taken.

What is population health?

Population health is about improving physical and mental health of people, whilst reducing health inequalities, across an entire population. Reducing health inequalities requires taking action at a population as well as an individual level, in order to address those factors which result inequity between different groups. Recognising the importance of population health means thinking about how actions we take can influence the health of the whole of the population we serve, not just individual patients. Population health also has a focus on preventing ill health, shifting the focus towards preventative and proactive rather than responsive care taking action on the wider determinants of health that are known to play the greatest role in determining health outcomes.

Our local population

CHFT serves a diverse population of approximately 460,000 across the local authority areas of Calderdale and Kirklees, with around 14% of the population from a BAME background. The population is socially and economically diverse with areas of high deprivation and other areas of relative affluence, as shown on the map below. There are significant inequalities both between the local population and other areas of the country, and within the local population.

Men and women in both Calderdale and Kirklees experience significantly lower life expectancy than the England average, and higher rates of premature mortality due to preventable causes (*Public Health Outcomes Framework*, OHID). Both areas also experience relatively high levels of deprivation. Out of the 317 local authorities in England, Calderdale is ranked as the 66th most deprived and Kirklees as the 82nd most deprived (Indices of Deprivation, 2019). Both areas have significantly higher levels of child poverty than the national average, with around 1/5th of children growing up in a low-income household (*Public Health Outcomes Framework*, OHID).

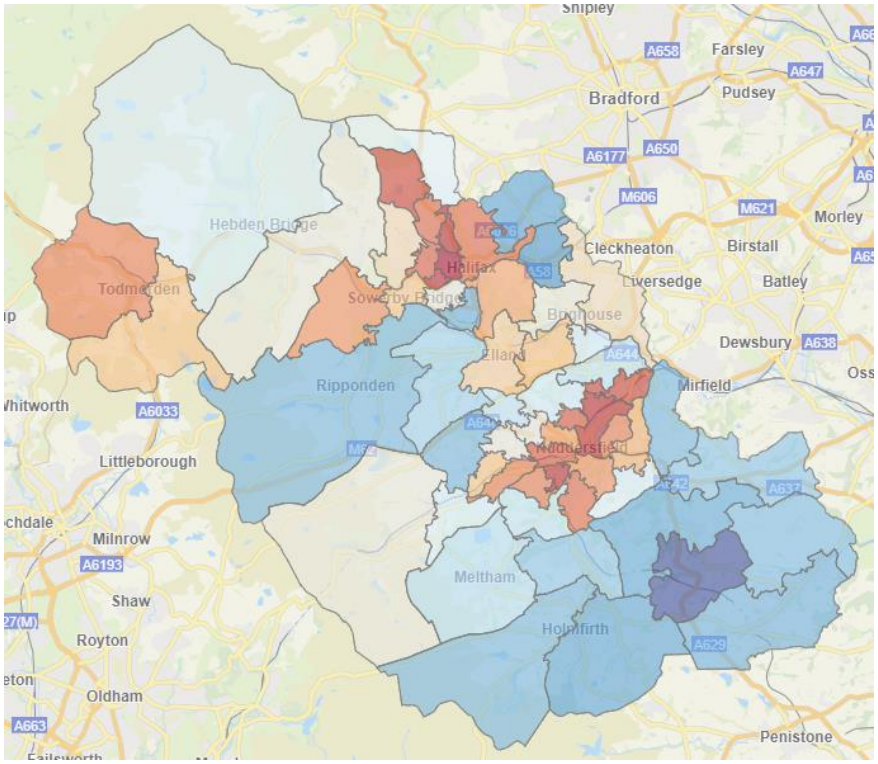


Figure 1: CHFT catchment area showing relative deprivation levels by ward (dark red being areas that are the most deprived through to dark blue being the least deprived).

There are also significant health inequalities that exist within the local population, with a clear social gradient in life expectancy and health: i.e., the more deprived a local area is, the worse the health outcomes are and the lower the life expectancy. For instance, those living in the most deprived areas in our local population have lower life expectancy and spend more years in poor health compared to those living in the most affluent areas (*Public Health Outcomes Framework*, OHID).

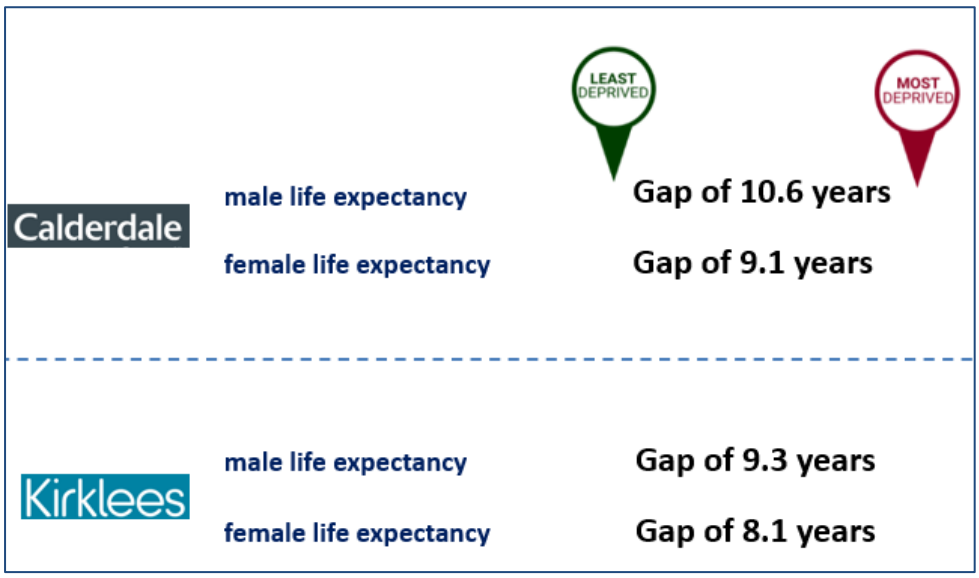


Figure 2: Life expectancy inequalities by deprivation in Calderdale and Kirklees

More information on the health of our local population and the inequalities they experience can be found at:

The Calderdale Joint Strategic Needs Assessment

The Kirklees Joint Strategic Assessment

Our role in addressing health inequalities

Context

As outlined above, health inequalities are not inevitable; they are preventable. These inequalities can be reduced but doing so requires deliberate and sustained action from all parts of society and public services, not least the NHS.

Reducing health inequalities has been a prominent feature of health policy in England at least since the 1990s, and yet many inequalities only appear to be widening, seen, for instance, in the stalling and in some cases falling gains in life expectancy for those living in the most deprived areas (The King's Fund, 2022). Recent analysis has also shown that there are consistent and growing inequalities in access to planned care, which must be addressed through removing barriers to access, prioritisation of care, and addressing the wider determinants of health which also contribute to these inequalities (The Strategy Unit, 2021).

Tackling health inequalities is not only a matter of fairness and population health, but a matter of optimal service delivery with health inequalities contributing to unscheduled hospital activity and increased demand on health services. For instant, recent analysis suggests that increasing access to elective care for those in the most deprived areas is likely to lead to reductions in emergency care overall and to inequalities in levels of emergency care (The Strategy Unit, 2021).

We have a responsibility to ensure that access to and experience of our services is equitable, and that our decision-making and service delivery considers impact on population health and inequalities and opportunities to promote population health and reduce inequalities.

The national context

The NHS Long-Term Plan (2019) committed to taking a more concerted and systematic approach to reducing health inequalities and unwarranted variation in care, as well improving prevention of avoidable illness and its exacerbations.

Since then, specific guidance and requirements for the role of NHS organisations in addressing health inequalities has been published, particularly in light of the health inequalities that were highlighted and exacerbated by the Covid-19 pandemic.

In developing this strategy and our four aims and priority areas, we have particularly sought to address the five key priority areas set out by NHSE to guide action on health inequalities and consider the Core20PLUS5 approach to reducing health inequalities.

The five priority areas are:

- restoring NHS services inclusively
- mitigating against digital exclusion

- ensuring datasets are complete and timely
- accelerating preventative programmes
- strengthening leadership and accountability.

The Core20PLUS5 approach particularly highlights the importance of focussing on communities within the 20% most deprived areas and other groups known to be at increased risk of experiencing health inequalities in your local population.

The NHS Oversight Framework (latest version 2022/23) sets out NHSE's approach to oversight and includes metrics to be measured at an ICS and Trust level within five national domains of oversight, with one focused on preventing ill health and reducing inequalities: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability. Each of these domains is also considered in this strategy.

Further detail of these are set out in **Appendix 1**.

The local context

Internal links:

The Population Health and Inequalities Strategy links to delivering the Trust's strategic objectives, specifically:

- We will have an optimal configuration of services and demonstrated improved outcomes for local people
- Working with partners we will regularly use population health data to address health inequalities

The Strategy also has links to the Digital Strategy and Workforce Strategy, recognising there are shared priorities and interdependencies.

External links:

The West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System) brings together partners across the West Yorkshire footprint, including CHFT as a care provider and the **Kirklees and Calderdale Integrated Care Boards**, to support the local system in furthering action on health inequalities and health improvement. The Partnership's priorities are set out in Better health and wellbeing for everyone: Our five year plan.

The West Yorkshire Association of Acute Trusts (WYATT) is an agreement between the six Hospital Trusts of West Yorkshire to work together so we can deliver more joined up, high quality, cost effective care for our patients, including through sharing learning and collaborating on approaches to addressing health inequalities.

Calderdale Health and Wellbeing Strategy

Kirklees Health and Wellbeing Plan

Our vision and priorities

Our **vision** for population health and inequalities is:

"CHFT will play a leading role locally in improving population health and tackling inequalities, taking bold action, and working with our partners to deliver impactful change for the communities we serve. We will ensure equitable access and excellent experience of care to improve outcomes for everyone."

Addressing health inequalities is a complex issue which requires a multi-pronged approach and sustained action and progress over a long period of time. As such, it will be necessary to set long-term priorities and establish the incremental actions which will work towards achieving them.

There are four key **aims** of this strategy:

1. To harness our role as an anchor institution and **connect with our communities and partners** to promote health and equity in the local population.
2. To reduce inequalities in **access** to care and ensure **prioritisation** promotes equitable access and outcomes.
3. To ensure all patients **experience** high-quality, compassionate, and holistic care to improve **outcomes** and reduce inequalities.
4. To promote a **diverse and inclusive workforce** which reflects the populations we serve and where everyone feels valued.

Taking action

Priority areas for action

To deliver the aims of this strategy, action will be focused in four priority areas.

Connecting with our communities and partners
Harnessing our role as an anchor institution and key partner in the local health and care system, we will work to address inequalities in the wider determinants of health in our local communities, deliver social value, and work with system partners to identify and deliver shared priorities to improve population health.

Access and prioritisation
We will reduce inequalities in access to care by removing barriers, improving access for the most vulnerable groups, and moving towards a more holistic approach to prioritisation where a broader range of risk factors are considered.

Lived experience and outcomes
We will address disparities in experience of care to improve patient outcomes. We will focus on improving the lived experience of patients, particularly those known to be most at-risk of experience inequalities and poor outcomes. We will take a holistic and compassionate approach, recognising the importance of behavioural and wider determinants of health. Areas of focus will include patients with a learning disability, maternity services, and mental health.

Diverse and inclusive workforce
We are committed to ensuring our workforce reflects the diverse populations we serve and that we take action to promote equality of opportunity. We will promote colleague health and wellbeing and create a compassionate and inclusive environment in which all our workforce feels valued in line with our One Culture of Care approach.

An action plan setting out specific priorities and actions to be progressed under each of these areas has been developed to ensure effective implementation of this strategy. These areas build on workstreams already progressed as part of our existing work on health inequalities, following work to evaluate our progress on health inequalities so far and identify future priorities.

Ways of working

Achieving these aims and implementing successful action in the priority areas will require embedding three enabling principles into our ways of working:

- **Using data and intelligence to inform implementation and evaluation**
  Data and intelligence will be an enabler for all our work on population health and inequalities. We will maximise the collection and use of data to understand and address inequalities, continuously monitoring key indicators of inequality and measuring the impact of our actions. We will use evidence-based approaches and share our learning to increase impact.

- **Working collaboratively as part of place partnerships**
  Addressing health inequalities is complex and requires joined-up action across; we will work collaboratively with partners across the local health and care system to achieve this.

- **Organisational leadership and governance to promote action**
  There will be a shared vision and ambition for reducing health inequalities across the organisation, regularly communicated by leadership to the workforce so that everyone understands their role in this. Systems must be in place to ensure that the impact on health and inequalities is considered in all decision-making, policies and service delivery.

Governance

The Health Inequalities Group will ensure oversight of this strategy, the action plan, and all workstreams resulting from it. The Group meets monthly and will regularly review progress against the strategy.

It is proposed that regular updates be provided to the Trust Executive Team, and quarterly reports on progress presented to the Trust Board.

Action Plan – Updated for 2023 / 24

The action plan sets out specific priorities and actions to be progressed in order to deliver the four key aims of the Population Health and Inequalities Strategy.

The action plan has been developed by the Health Inequalities Group, following evaluation of progress to date and identification of future priorities. The plan will be updated and edited over time to reflect progress in implementation and any appropriate changes.

Priority area: Connecting with our communities and partners

What have we achieved so far?

- Established and led a multi-agency working group to reduced inequalities in asthma within a Primary Care Network Area (Greenwood PCN, Kirklees).
- Created a new service called BLOSM within our emergency departments to tackle health inequalities and engage with vulnerable service users attending ED (BLOSM stands for Bridging the Gap, Leading a change in culture, Overcoming adversity, Supporting Vulnerable People, Motivating Independence and Confidence)
- Rolled out trauma-informed practice training to ED staff. ED now has its own bespoke safegurading level 3 training package delivered through the BLOSM team to all new starters.
- Implemented robust process and governance for including Equality Impact Assessments as part of any service changes.
- A refreshed assessment of the Equality Impact Assessment (EQIA) and Quality Impact Assessment (QIA) impact of the proposed service changes and estate developments at CRH and HRI has been undertaken.
- The Trust has worked with the Social Value Portal (SVP) to support the Trust in measuring and reporting the delivery of social value from our estate investments.
- The Trust's construction partner for the new A&E has met all targets set across the different aspects of Social Value.
- Supported the delivery of the Calderdale BAME Action Plan. The Group was Chaired by CHFT's Director of Transformation and Partnerships.

Going forwards

Director Sponsor: Anna Basford

Action	Output	Impact	Timescales	Action owner
Continue delivery of the BLOSM service (including the Trauma Navigator pilot) in ED and compile and present service evaluation data.	Evaluation of impact of the new service and the trauma navigator pilot.	Increased early intervention and support for vulnerable users attending ED.	Ongoing.	Jason Bushby / Alistair Christie
Use the output from the Social Value Assessment to inform implementation plans for the estate developments.	Ensure the investment secures wider social benefits that are targeted to reduce health inequalities.	Estates investments maximise social value impacts.	Business as usual.	Anna Basford
Build on the work of the pop-up clinics to improve access to	Improved identification of and	Improved access and health	2024	Sarah Wilson

health services for socially vulnerable populations.	pathways for socially vulnerable patients.	outcomes for socially vulnerable patients.		

Priority area: Access and prioritisation

What have we achieved so far?

- Analysed waiting list data through an inequalities lens and reduced gaps in waiting times seen between White and BAME patients, and patients from the most and least deprived communities.
- Developed a “Health inequalities vulnerability matrix” to identify patients at increased risk of experiencing inequalities and take a holistic approach to prioritisation and care. The tool is being piloted within cancer prehabilitation services.
- People with learning disabilities were prioritised under the reset and recovery programme, with all known people with a learning disability on existing waiting lists having their surgery.
- Continued work with partners on Outpatient Transformation. This includes remote appointments project, and implementation of patient-initiated follow-up (PIFU) pathways. Specific actions relating to digital inclusion, and the development of referral information required to identify where reasonable adjustments may be needed to enable equitable access have been progressed.
- Completed an audit of readmissions of patients with a learning disability within medical division.

Director Sponsor: Jonathan Hammond

Action	Output	Impact	Timescales	Action owner
Continue to monitor and proactively respond to inequalities in waiting times.	KP+ dashboards with relevant data maintained. Data regularly reviewed and responded to where appropriate.	Equity in access to planned care is achieved and maintained.	Business as usual.	Rob Birkett / Jonathan Hammond
Analyse data on unplanned admissions, emergency attendances, and “Did Not Attend”s through an inequalities lens (and where possible, triangulate with	Identification of any inequalities and options for actions to address these.	Improved access to services and reduction in inequalities in access.	Ongoing.	Rob Birkett / Jonathan Hammond

discovery work).				
Monitor data quality of inequalities indicators, including completeness of ethnicity data.	Data quality regularly reviewed.	Ensures we have appropriate data to continue monitoring and responding to inequalities.	Business as usual.	Rob Birkett / Peter Keogh
Development and piloting of the health inequalities vulnerabilities matrix as a predictive risk identification tool to support a more holistic approach to prioritisation and care.	A tool to test and pilot within medical division.	A more holistic approach to patient care and prioritisation and increased awareness of patient risk factors for harm and inequalities.	Piloting and refinement of the tool ongoing. Wider rollout expected in 2024.	Rob Birkett / Jonathan Hammond
Development and implementation of the Digital Inclusion Strategy (to ensure outpatient referral pathways and new ways of delivering outpatient services such as telephone and video appointments do not exclude people or widen inequalities).	Digital Inclusion Strategy developed to take account of potential impact on inequalities (linked with reasonable adjustments work)	Digital pathways are inclusive and patients are offered the most appropriate appointment type based on their need, recognising different needs and barriers.	Ongoing.	Lisa Williams

Priority area: Lived experience and outcomes

What have we achieved so far?

- Launched “My Pregnancy Notes”, a “single point of access” patient interface enabling online booking for pregnancy care and access to maternity notes.
- Undertaken discovery interviews in Maternity to gain insight into women’s experiences of care and engage those less likely to send in feedback.
- Pilot of English as a Second Language pregnancy antenatal classes.
- Improved language accessibility of maternity services, including welcome signs produced in top 10 local first languages and mapping of multi-lingual resources available.
- Carried out a staff survey on cultural competence with maternity staff and piloted rollout of a cultural competence training package.
- Smoking in pregnancy research undertaken and published.
- Vitamin D / Healthy Start Scheme being promoted by Midwifery teams to increase uptake of Vitamin D and access to healthy food ‘vouchers’ for pregnant women and new mothers on very low incomes to spend on veg, fruit and milk.
- A wide programme of work has taken place to improve the experience of patients with a learning disability, with an enhanced task and finish group established to take this forward, to ensure that patients with a learning disability were prioritised on the waiting list and their care access and experience improved
- Rollout of essential learning disability e-learning across the Trust – as of August 2023 95% of staff had completed this.
- Reasonable adjustment audit takes place monthly and is reported to Care of the Acutley Ill Patient (CAIP). To become quarterly and report to Clinical Outcomes Group.
- Implemented the Long-Term Plan smoking cessation pathway for all inpatients.
- Established referral pathway and pilot with the University of Huddersfield Health and Wellbeing Academy to offer six support sessions on goal setting to all Trust patients to aid transition from secondary care to self-management.
- Delivered teaching sessions with practitioners, community nurses, and allied health professionals on use of the Whooley questionnaire to screen for depression and refer to services as appropriate.

Director Sponsor: Lindsay Rudge
Trust wide

Action	Output	Impact	Timescales	Action owner
Explore embedding action on poverty and poverty aware practice across services.	Action plan and implementation of interventions to improve access, experience, and outcomes for patients living in poverty.	Improved access and care for patients living in poverty to improve health outcomes and reduce inequalities.	2024	Rachel Westbourne

Maternity

Action	Output	Impact	Timescales	Action owner
Ongoing action under 5 workstreams: - Organisation of care - Communication with mothers, families and carers - Culturally aware services - Use of population data - Accessible information standards		Improved access, experience, and outcomes for patients accessing maternity services.	Ongoing	Gemma Puckett / Joanne Machon
Following a new lead taking over the work, review the health inequalities maternity workstream and establish action plan.	Maternity health inequalities work plan.	Improved access, experience, and outcomes for patients accessing maternity services.	To be established in the first half of 2024	Gemma Puckett / Joanne Machon

Learning Disability

Action	Output	Impact	Timescales	Action owner
Progress a pilot of use of robots technology to automate and improve identification of patients with an LD flag.	Better identification and navigation of care pathways for patients with an LD.	Improvement in care pathways, patient experience and outcomes for patients with LD.	2024	Amanda McKie
Undertake audit of outpatient DNAs for patients with an LD.	Completion of audit with report of findings and any recommendations	Improvement in access and care pathways for patients with LD.	2024	Amanda McKie

Mental Health

Action	Output	Impact	Timescales	Action

				owner
Continue rollout of support sessions on goal setting with the University of Huddersfield to aid transition from secondary care to self-management and undertake evaluation once sufficient data is available.	Sustained delivery of support sessions and evaluation.	Improved patient empowerment and self-management.	2024	Ian Noonan
Develop webpage and Mental Health intranet site.	Webapage / intranet site	Increased staff awareness and referrals into programme	2024	Ian Noonan
Whooley questions (screening for depression) incorporated in to safety part of admission assessments. When this is live, add Whooley screening to MH KPIs for CO group to demonstrate completion and target any areas for improvement in use.	Whooley questions incorporated into safety part of admission assessment	Improved holistic and compassionate care.	2024	Ian Noonan

Priority area: Diverse and inclusive workforce

What have we achieved so far?

- Established several Colleague Voice equality groups.
- Guidance developed to include engagement with all internal network groups and links to engagement team as part of Equality Impact Assessments for service design/
- Embedded process for previewing all cases of racial discrimination in disciplinaries & complaints prior to progress through formal stages.
- New recruitment strategy developed and launched, including bold and ambitious statements for equality of opportunity.
- Inclusive talent toolkit and framework developed and embedded in People Strategy.
- Incorporated EDI and wellbeing discussions into annual appraisals. Results from the Staff Survey indicate that this approach is valued.
- The Trust launched it's first Shadow Board in September 2023. The 10 colleagues that will form the Shadow Board met for the first time, on 15 September 2023, for an introduction to each other and to hear the details of how the Shadow Board will operate in practice going forward. The Shadow Board will meet monthly, alternating between meetings shadowing our Public Board, and developmental sessions. The developmental sessions will focus on topics including 'Strategy and Governance', 'Strategic Finance and

Risk' and 'People Leadership and Culture'. The first meeting shadowing the Public Board meeting took place in October 2023.

- Completed a 12 month inclusion events programme which received very high engagement and positive feedback.

Director Sponsor: Suzanne Dunkley

Action	Output	Impact	Timescales	Action owner
One Culture of Care values and behaviours implemented into recruitment.	One Culture of Care values and behaviours referenced in all recruitment processes.	One Culture of Care embedded throughout organisation and into all recruitment processes.	Ongoing / business as usual.	Nicola Hosty.
ED&I Awareness and Education Programme (face to face for managers and e learning for colleagues)	Enhance understanding of difference, improve relationships between colleagues and improve services for patients	Informed decision making, placing ED&I at the forefront of thinking and delivery of service	Ongoing.	Nicola Hosty.
Leadership development for managers. ED&I Module dedicated to increase cognisance of difference and how managers can be an inclusion ally	Enhance understanding of how they need to flex their style to support the diversity of the members in their team and they teams they work closely with – role modelling the change we want to see in the Trust	Challenging inappropriate behaviours, improving colleague engagement, make equitable decisions, ggrow talent and promoting development opportunities.	EDI education and awareness suite now available with dedicated sessions for managers – rollout and feedback in 2024.	Nicola Hosty
Root out Racism programme	Aims to tackle structural and institutionalise d racism, as well as addressing health and social inequalities	Take action to address bullying and harassment	Ongoing.	Nicola Hosty

	across the area			
Utilise the Widening Participation channels and apprentice programmes to support inclusive recruitment.	Increased inclusive recruitment and development offering opportunities to communities traditionally underrepresented in the workforce.	Increased employment opportunities for local communities and a workforce that is reflective of our communities.	Ongoing / business as usual - Equality Networks outputs and impact will be reviewed by the Inclusion Group on an annual basis.	Nicola Hosty
Continue to promote, support, and engage with the Equality networks.	Equality networks continue to grow, creating space to think, learn and make improvements	Equality networks provide a supportive space for engagement, improvements, enhancements and make an impact on the way the Trust does things around here, taking into account different views/experiences	Ongoing / business as usual - Equality Networks outputs and impact will be reviewed by the Inclusion Group on an annual basis.	Nicola Hosty

Appendix 1: National Policy Context

The five priority areas for tackling health inequalities:
https://www.england.nhs.uk/wp-content/uploads/2021/03/B0468-implementation-guidance-21-22-priorities-and-operational-planning-guidance.pdf

The five priority areas were outlined in the 2021/22 Operational Planning Guidance. Should these be updated as updated guidance is released, we will continue to ensure that our approach to health inequalities aligns with any updated national priorities and requirements.

Priority 1: Restore NHS services inclusively
At national level, the decline in access amongst some groups during the first wave of the pandemic broadly recovered in later months. Insight work has, however, highlighted that in some cases pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic. It is therefore critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.

Priority 2: Mitigate against digital exclusion
Systems are asked to ensure that:

- providers offer face-to-face care to patients who cannot use remote services
- more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups
- they take account of their assessment of the impact of digital consultation channels on patient access.

Priority 3: Ensure datasets are complete and timely
Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.

NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, e.g. for people experiencing post- COVID syndrome.

Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes
Uptake of the COVID and flu vaccination has increased significantly across all groups, but inequality has also widened, particularly by deprivation and ethnicity. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021.

Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including:

- Ongoing management of long-term conditions
- Annual health checks for people with a learning disability
- Annual health checks for people with serious mental illness
- In maternity care, implementing continuity of carer for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population as a whole.

Priority 5: Strengthen leadership and accountability
Systems and providers should have a named executive board-level lead for tackling health inequalities. and should access training made available by the Health Equity Partnership Programme."

The Core20PLUS5 approach: https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS

PLUS population groups we would expect to see identified are ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation hidden amongst relative affluence; people with multi-morbidities; and protected characteristic groups; amongst others.

Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

5

The final part sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

1. Maternity: ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.
2. Severe mental illness (SMI): ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).
3. Chronic respiratory disease: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.
4. Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028.

5. Hypertension case-finding and optimal management and lipid optimal management: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The NHS Oversight Framework and NHS Oversight Metrics for 2022/23: https://www.england.nhs.uk/nhs-oversight-framework/

The NHS oversight framework for 2022/23 replaces the NHS system oversight framework for 2021/22, which described NHS England and NHS Improvement's approach to oversight of integrated care boards (ICBs) and trusts.

This framework outlines NHS England's approach to NHS oversight for 2022/23 and is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance.

The framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports our ambition for system-led delivery of integrated care in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: next steps to building strong and effective integrated care systems across England and the government's white paper on integration – Joining up care for people, places and populations.

A set of oversight metrics has been published, applicable to integrated care boards, NHS trusts and foundation trusts, to support implementation of the framework. These will be used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS oversight framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

References

The Health Foundation (2018). "What makes us healthy? An introduction to the social determinants of health." Available at: https://www.health.org.uk/publications/what-makes-us-healthy

The Kings Fund (2022). "What are health inequalities?" Available at: https://www.kingsfund.org.uk/publications/what-are-health-inequalities

The King's Fund (2022). "What is happening to life expectancy in England?". Available at: https://www.kingsfund.org.uk/publications/whats-happening-life-expectancy-england

Marmot, M. (2018). "An inverse care law for our time". *BMJ* 2018;362:k3216. DOI: https://doi.org/10.1136/bmj.k3216

English Indices of Deprivation 2019 (2019). Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

NHS England (2021). NHS Operational Planning and Contracting Guidance Available at: https://www.england.nhs.uk/operational-planning-and-contracting/

NHS (2019). The NHS Long Term Plan. Available at: https://www.longtermplan.nhs.uk/

Office for Health Improvement and Disparities (OHID). Public Health Outcomes Framework. Available at: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data

Office for National Statistics (ONS) (2022). Life expectancies. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies

The Strategy Unit (2021). “Socioeconomic inequalities in access to planned hospital care: causes and consequences.” Available at: https://www.strategyunitwm.nhs.uk/publications/socio-economic-inequalities-access-planned-hospital-care-causes-and-consequences

Tudor Hart, J. (1971). "The Inverse Care Law". *The Lancet*. 297 (7696): 405–412. DOI: https://doi.org/10.1016/S0140-6736(71)92410-X

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:	18 December 2023
Date of Board meeting this report is to be presented:	11 January 2024
ACKNOWLEDGE	The following points are to be noted by the Board following the meeting of the Committee on 18 December 2023 where the strategic theme was Health and Wellbeing. • The Committee received presentations on workforce psychology, men's health, the role of a wellbeing ambassador and the role and impact of the FSS Wellbeing Board. The presentations were all informative and powerful and demonstrated colleague commitment to health and wellbeing and the positive impact this has on our colleagues contributing to realising our One Culture of Care. We have made genuine progress with this strategic theme and await the results of the latest staff survey. The work will continue to embed this level of care across the Trust. • Health and Wellbeing is one of the priority areas of our People Strategy and the Committee received an update on the financial planning and support now available to colleagues. This is aimed at encouraging staff o manage their finances in a cost-of-living crisis and minimise their debt. • IPR-The revised format was welcomed by the Committee, and it was noted that the EDI data is now included. It was also noted that the number of colleagues undertaking fire safety training has improved . Turnover has reduced and WOD will keep a watch on this as turnover can be both positive and negative . • Changes to the Terms of Reference in relation to membership of the Committee was approved. • The quarterly vacancy (Q2) deep dive reflected the decreasing level of turnover and the improving recruitment position although the challenges in nursing and medical remain. • The Freedom to Speak Up report was available to the Committee and will be presented to the next meeting of the Board of Directors.

ASSURE	• The detailed Nursing and Midwifery Safer Staffing Report was presented to the Committee providing assurance that we are not out of line with the national picture and in some areas we are stronger. Our recruitment processes have been successful despite the national shortage of midwives, and we have been able to encourage some potential leavers to stay. The report reflected the complexity of managing staffing levels and meeting service needs in addition to the rigour applied to managing this challenging situation. A review using the Birthrate Plus toolkit is to be commissioned. The Board should also note the achievement of the Quality Mark against the national preceptorship framework. An update on the Nursing, Midwifery and AHP Steering Group Programme was received. A comprehensive dashboard has been developed which combines the use of retrospective data to demonstrate the trend of the impact of recruitment strategies. The detail now available provides valuable understanding of the workforce position at an organisational and service level. Following a review of the international nurse arm of the recruitment programme it was decided to pause recruitment until May 2024.There will continue to be a focus on growing our own. It was noted how strong AHP recruitment had been, and turnover had decreased significantly to approximately 4% from 13% - a real success story and worthy of putting forward as a national case study.
AWARE	• The Committee also received an annual report on the Trust's age profile which has not changed significantly and requested that colleagues consider how best to present this in future, so areas of concern are highlighted. • The Trust's has a detailed retention strategy and work continues on this to ensure that learning from experiences is shared across the Trust as well as utilising nationally available tools.
ONE CULTURE OF CARE	One Culture of Care is considered as part of the workforce reports and in discussions.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	23rd October 2023, 20th November 2023
Date of Board meeting this report is to be presented:	11th January 2024
ACKNOWLEDGE	• Ratified terms of reference for the Medicine Management Committee, Clinical Outcomes Group, Safeguarding Committee. • Learning from patient story, an overview was given of a good patient journey though the hospital until discharge and how the journey was enabled and the learning.
ASSURE	• Medicines Management Committee (MMC) a detailed report was provided on the work of this committee including new project requests, updating of the Trust guidelines and the Trust Medicines Code; work on drug shortages and drug recalls; updates on the Trust's antibiotic usage; updates from the Electronic Patient Record team; and compliance with NICE guidance. There was a previous concern from the MMC regarding the migraine service not providing some of the treatments which were recommended by NICE, this has now been resolved with a Neurologist in place who is providing the new treatment. • Received and noted the Maternity and Neonatal Oversight report. The terms of reference of the Maternity and Neonatal Transformation Board have now been approved and will have oversight of delivery of the 3 year delivery plan for maternity and neonates. • Quality and Safety Strategy - The feedback and recommendations from the recent Quality Summit is now being utilised to further develop the refreshed Quality and Safety Strategy, which will strengthen the approach to quality assurance and quality improvement. The draft Quality and Safety Strategy will be brought into the next Quality Committee meeting. • The Naso Gastric tube assurance report October 2023 - in response to the two never events (Jan/April 2023) was received and it provided a thorough overview of the actions taken and the ongoing work that includes the recommendations from the internal audit that provided limited assurance in relation to the key risks outlined in the audit. Daily reviews are being provided by Matrons and Clinical site matrons of all patients who are receiving NG feeds. A re-audit will take place in quarter 4 of 2023-2024, to ensure that actions taken have made an improvement. Committee noted

	the November update and the further NG never event reported on 10th November. • An update of the Board Assurance Framework Risks overseen by the Quality Committee was presented and the actions taken since the last update. - 6/19: Compliance with quality and safety standards - 4/20: CQC Rating - 4/19: Public and Patient Involvement - 3/19: Seven day services, this risk has been removed from the BAF. The standards are still in place, national reporting is no longer a requirement. Audits of progress against the standards will continue to be reported and monitored by the Quality Committee. • The Quality report – there are two Never Events that remain open– wrong eye injected (July 2023) and medication administrated via wrong route (declared in September 2023). A deep dive is being carried out in the Surgical Division and a report is expected on actions undertaken. Currently there are four National Patient Safety Alerts, leads have been identified and plans being created to achieve the completion dates. CQC group update provided and progress with the CQC Road map. • IPR in relation to performance CHFT remains challenged, extra capacity wards are now open and there are also challenges around the delivery of the acute service. • The NHS adult inpatient survey 2022 benchmark report was presented and it is a generally positive report. CHFT being in the top five for a number of indicators. The key area results are to be developed into an action plan and into the Patient Experience and Caring Group. • Report received on the progress of training and digital solutions from the follow up appointment concerns. The committee was impressed with the progress and the innovative work being done and fully supported the multi method approach being used for digital clinical systems education, training and development. • CHFT continues to make good progress with compliance of the 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 violence and aggression policy with an escalation process has been written and it was raised in committee the importance of this policy being actively promoted across the organisation. • The Patient Safety and Quality Board report was noted and actions in place for the items escalated to Quality Committee. • A report was presented on the review of three neonatal deaths on the Neonatal Unit in November 2022. The 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 that an external audit now takes place.

	• Report received on the refreshed approach to Patient Experience and the key areas of focus.
AWARE	Update provided on Martha's Rule, which would give all patients in NHS hospitals in England (and those acting on their behalf) the legal right to request a second opinion from a senior clinician in the same hospital, if a patient is deteriorating rapidly but it appears concerns are not being taken sufficiently seriously by medical staff. CHFT considering the next steps and what changes if any should be made.
ONE CULTURE OF CARE	Committee acknowledged and discussed the results of the inpatient survey and the impact of the investment placed in colleagues, their health, their wellbeing.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Karen Heaton
Date(s) of meeting:	19 December 2023
Date of Board meeting this report is to be presented:	11 January 2024
ACKNOWLEDGE	The following points are to be noted by the Board following the meeting of the Committee on 19 December 2023. • There was one matter arising on the Governance Arrangements for the Trust PSQB. This has involved a review of the Divisional and Trust reporting structure, and a revised structure will be trialled in the New Year with Divisional PQSBs meeting quarterly. A diagram showing the new reporting structure will be provided to the next meeting of the Committee. • Assurance was given to the Committee that the Quality Strategy was being updated and would be brought back to the Committee at a suitable future meeting. • A detailed bi-annual Safeguarding report was presented. It was noted that considerable progress had been made with sharing information with local authorities to close S42 investigation and thereby improving outcomes for patients and families. Compliance with receipt and scrutiny training is increasing and safeguarding and MCA/DoLS training is fully compliant with the Intercollegiate documents. It was also noted that there was an increase in activity in relation to serious practice reviews which impacted on team capacity. However, all responses have been within the required timescale. The work around discharge improvement continues.
ASSURE	• An update on the NG tube action plan was provided and the Committee welcomed the fact that an external review to be commissioned in the New Year would be welcome. There had been three never events- two involving adults and one involving a three-week-old baby. Training had been enhanced and face- to -face training welcomed by colleagues. • A report covering compliance with the key standards relating to seven-day service was

	presented. Clinical Standards 2,6 and 8 are met and Clinical Standard 5 is partially met. Work is underway to remedy this. • A comprehensive and detailed Maternity Safety and Neonatal Report was presented to the Committee highlighting the ongoing and positive work from colleagues within the service. The recent assurance visit by the LMNS had been very positive with some welcomed suggestions for continual improvement. There was recognition of the commitment to continuous improvement and the commitment of colleagues in a challenging environment. A review of the evidence in relation to the Maternity Incentive Scheme is underway. One item for escalation to the Committee for awareness which is neonatal cot capacity challenges across the region due to a reduction in cots in some neonatal services and the impact for CHFT. • The Safer Staffing Report was presented to the Committee emphasising that the national picture remains challenging. Staffing fill rates continue to fluctuate throughout the day and the Committee were assured that a robust process was in place for managing the situation. CHFT has commissioned a new Birthrate Plus review to take place in Q4 to ensure that staffing reflects the activity and the changes to the national agenda. The Chief Nurse confirmed they are satisfied that staffing is safe, effective, and sustainable.
AWARE	• The Committee also received the Quality Report and noted that improvements to responding to complaints is ongoing and the legals service has been under an increasing workload driven by coroners' activity. The service provided has not diminished. There are a number of external assurance visits which take place at any given time throughout the year and it was agreed that it would be helpful if the Committee had sight of these to provide a more rounded over view.
ONE CULTURE OF CARE	• One Culture of Care is considered as part of the workforce reports and in discussions.

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:	28 November 2023 and 2 January 2024
Date of Board meeting this report is to be presented:	11 January 2024
ACKNOWLEDGE	• Continued strong performance in Cancer with all key targets being met and a positive news item on Sky News • Recovery performance also remains strong and the best in the West Yorkshire ICS (see table below). We now have no patients waiting over 65 weeks and just 27 52-week waiters. We have delivered 108% of our elective recovery plan in the year to end November although we are behind our trajectory for 40-week waiters due to issues in ENT and the impact of the strikes. • Quality indicators showing quality of care holding up well despite operational pressures albeit there were 2 never events in November. • Our financial position has improved since our last Board meeting in November. At that time, we were projecting a likely case of a £6.7m adverse variance to plan – this has reduced to £2.4m and we are forecasting to deliver the plan for the financial year.

ASSURE	• At our January meeting we:
	  ○ Reviewed and approved the business cases for Lot 2 of the Pathology Managed Services contract and for the investment in Huddersfield Pharmacy Specials
	  ○ Were assured of the progress being made on the action plan following the NHSE Financial Plan Deep Dive
	  ○ Had a follow-up deep dive on the work being done to reduce the backlog of Outpatient Follow-Ups. This showed some encouraging progress with a key area of action being booking in order which is expected to have a significant impact on the backlog. More generally Internal Audit are conducting a review into our booking processes
	• At our November meeting we did a 'deep dive' into Cancer and the changes made in the key performance indicators. As noted above our cancer performance continues to be strong.
	• The committee received a presentation on the THIS Commercial Strategy which showed excellent progress being made in delivery of the strategy.

AWARE	• The 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. • 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 and the costs of strike action • At month 8 we are reporting a £14.66m deficit which is a £0.54m 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 2024/25 programme. • The adverse variance to plan across the ICS was £23m YTD at month 8; a significant improvement from month 6 and the ICS is now forecasting to meet plan.
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.

Provider	40 Week Waits	52 Week Waits	65 Week Waits	78 Week Waits	104 Week Waits
Airedale	1,763	827	212	7	0
Bradford	1,877	502	74	0	0
Calderdale and Huddersfield	1057	27	0	0	0
Leeds	9,954	4,149	1,178	177	2
Mid Yorks	5,360	2,006	497	30	0

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	Month 8 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 8 (November 2023)
Key Points to Note	**Year To Date Summary** The Trust is reporting a £14.66m deficit, (excluding the impact of Donated Assets), a £0.54m adverse variance from plan. The in-month position is a deficit of £0.52m, a £0.96m favourable 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), £3.49m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.09m; and non-pay inflationary pressures. YTD Strike costs will now be funded through an additional ICS allocation and this benefit is included in the YTD position. Other pressures are offset to some extent by additional Elective recovery Funding, early delivery of other efficiencies 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 £10.37m. • 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 108.0%.
- The Trust has delivered efficiency savings of £16.70m, £0.89m lower than planned.
- Agency expenditure year to date was £7.08m, £1.37m lower than the Agency Ceiling, (3.7% of total pay expenditure) but £1.34m higher than planned.

Key Variances

- Income is £7.06m above the plan. Clinical contract income is 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) and there is also a favourable variance on Provider to Provider contracts. This additional income supports higher than planned costs in the year to date position.
- Pay costs were £4.04m higher than the planned level. Pay pressures are linked: to higher than planned bed capacity (£3.49m) - £0.80m surge capacity, plus £2.70m 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 (£2.09m impact YTD); supernumerary overseas nurses (£0.84m). These pressures have been offset to some extent by early delivery of other (non-recurrent) efficiencies and 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 £6.61m 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 (£1.13m 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 £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. 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. <u>Attached:</u> Month 8 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 30th November 2023.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Nov 2023 - Month 8

KEY METRICS

	M8				YTD (NOV 2023)				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)	(£1.48)	(£0.52)	£0.96		(£14.12)	(£14.66)	(£0.54)		(£20.80)	(£20.80)	(£0.00)	
Agency Expenditure (vs Ceiling)	(£1.06)	(£0.80)	£0.25		(£8.45)	(£7.08)	£1.37		(£12.67)	(£10.88)	£1.79	
Capital	£2.23	£0.54	£1.69		£19.47	£8.51	£10.96		£34.00	£48.81	(£14.80)	
Cash	£19.78	£31.31	£11.53		£19.78	£31.31	£11.53		£2.19	£1.90	(£0.29)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	91.6%	-3%		95.0%	93.4%	-2%					
CIP	£3.30	£2.39	(£0.91)		£17.59	£16.70	(£0.89)		£31.50	£27.05	(£4.45)	
Use of Resource Metric	3	3			3	3			3	3		

Year To Date Summary

The Trust is reporting a £14.66m deficit, (excluding the impact of Donated Assets), a £0.54m adverse variance from plan. The in month position is a deficit of £0.52m, a £0.96m favourable 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), £3.49m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.09m; and non-pay inflationary pressures. YTD Strike costs will now be funded through an additional ICS allocation and this benefit is included in the YTD position. Other pressures are offset to some extent by additional Elective recovery Funding, early delivery of other efficiencies 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 £10.37m.
- 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 108.0%.
- The Trust has delivered efficiency savings of £16.70m, £0.89m lower than planned.
- Agency expenditure year to date was £7.08m, £1.37m lower than the Agency Ceiling, (3.7% of total pay expenditure) but £1.34m higher than planned.

Key Variances

- Income is £7.06m above the plan. Clinical contract income is 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) and there is also a favourable variance on Provider to Provider contracts. This additional income supports higher than planned costs in the year to date position.
- Pay costs were £4.04m higher than the planned level. Pay pressures are linked: to higher than planned bed capacity (£3.49m) - £0.80m surge capacity, plus £2.70m 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 (£2.09m impact YTD); supernumerary overseas nurses (£0.84m). These pressures have been offset to some extent by early delivery of other (non recurrent) efficiencies and 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 £6.61m 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 (£1.13m 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 £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.

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 30th Nov 2023 - Month 8

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M8

CLINICAL ACTIVITY

	M8 Plan	M8 Actual	Var
Elective	3,124	3,103	(21)
Non-Elective	35,890	34,831	(1,059)
Daycase	33,631	34,946	1,314
Outpatient	292,839	305,567	12,728
A&E	116,514	118,120	1,606
Other NHS Non-Tariff	1,329,093	1,462,274	133,180
Total	**1,811,092**	**1,958,840**	**147,748**

TOTAL GROUP: INCOME AND EXPENDITURE

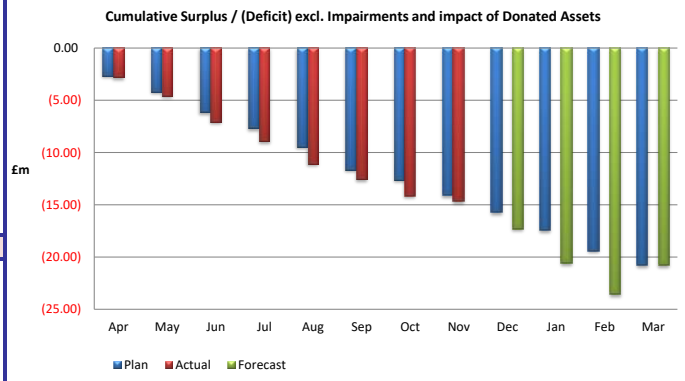
	M8 Plan	M8 Actual	Var
	£m	£m	£m
Elective	£11.93	£12.62	£0.68
Non Elective	£84.30	£85.76	£1.47
Daycase	£24.27	£25.88	£1.61
Outpatients	£29.71	£32.34	£2.62
A & E	£21.00	£22.04	£1.04
Other-NHS Clinical	£145.29	£139.72	(£5.58)
CQUIN	£0.00	£0.00	£0.00
Other Income	£36.68	£41.90	£5.22
Total Income	**£353.19**	**£360.25**	**£7.06**
Pay	(£233.00)	(£237.05)	(£4.04)
Drug Costs	(£31.84)	(£31.08)	£0.75
Clinical Support	(£22.68)	(£22.51)	£0.16
Other Costs	(£43.26)	(£50.54)	(£7.28)
PFI Costs	(£10.79)	(£11.05)	(£0.25)
Total Expenditure	**(£341.57)**	**(£352.23)**	**(£10.66)**
EBITDA	**£11.62**	**£8.02**	**(£3.59)**
Non Operating Expenditure	(£25.74)	(£22.68)	£3.06
Surplus / (Deficit) Adjusted*	**(£14.12)**	**(£14.66)**	**(£0.54)**

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

DIVISIONS: INCOME AND EXPENDITURE

	M8 Plan	M8 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£69.59)	(£69.29)	£0.29
Medical	(£89.41)	(£95.14)	(£5.73)
Families & Specialist Services	(£62.91)	(£62.68)	£0.23
Community	(£21.70)	(£21.25)	£0.45
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£37.79)	(£37.57)	£0.22
THIS	£0.90	£0.85	(£0.05)
PMU	£0.82	£1.58	£0.76
CHS LTD	£0.46	£0.38	(£0.08)
Central Inc/Technical Accounts	£266.40	£269.01	£2.62
Reserves	(£1.30)	(£0.55)	£0.75
Surplus / (Deficit)	**(£14.12)**	**(£14.66)**	**(£0.54)**

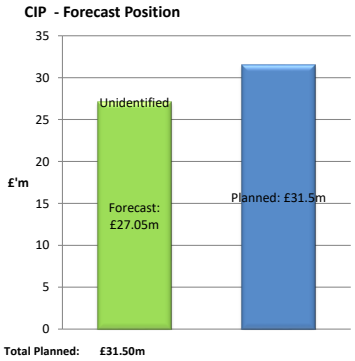
TOTAL GROUP SURPLUS / (DEFICIT)

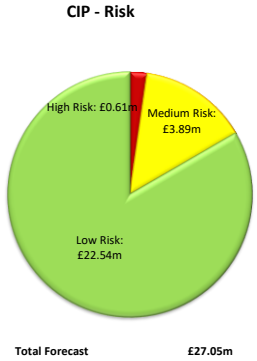


KEY METRICS

	Year To Date			Year End: Forecast			
	M8 Plan	M8 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£14.12)	(£14.66)	(£0.54)	(£20.80)	(£20.80)	(£0.00)	
Capital	£19.47	£8.51	£10.96	£34.00	£48.81	(£14.80)	
Cash	£19.78	£31.31	£11.53	£2.19	£1.90	(£0.29)	
Invoices Paid within 30 days (BPPC)	95%	93%	-2%				
CIP	£17.59	£16.70	(£0.89)	£31.50	£27.05	(£4.45)	
	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	4,671	35
Non-Elective	53,866	52,253	(1,613)
Daycase	49,935	52,142	2,208
Outpatient	434,259	454,976	20,718
A&E	174,293	176,696	2,403
Other NHS Non- Tariff	1,975,197	2,173,219	198,022
Total	**2,692,185**	**2,913,958**	**221,772**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£17.69	£19.05	£1.36
Non Elective	£125.90	£128.08	£2.17
Daycase	£36.01	£38.69	£2.68
Outpatients	£44.01	£48.23	£4.22
A & E	£31.42	£32.97	£1.55
Other-NHS Clinical	£219.67	£212.36	(£7.30)
CQUIN	£0.00	£0.00	£0.00
Other Income	£55.28	£62.82	£7.53
Total Income	**£529.98**	**£542.20**	**£12.22**
Pay	(£350.38)	(£354.86)	(£4.49)
Drug Costs	(£47.98)	(£46.79)	£1.18
Clinical Support	(£33.68)	(£33.75)	(£0.07)
Other Costs	(£63.83)	(£75.34)	(£11.51)
PFI Costs	(£16.19)	(£16.57)	(£0.38)
Total Expenditure	**(£512.06)**	**(£527.31)**	**(£15.25)**
EBITDA	**£17.92**	**£14.89**	**(£3.04)**
Non Operating Expenditure	(£38.72)	(£35.69)	£3.03
Surplus / (Deficit) Adjusted*	**(£20.80)**	**(£20.80)**	**(£0.00)**

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

DIVISIONS: INCOME AND EXPENDITURE

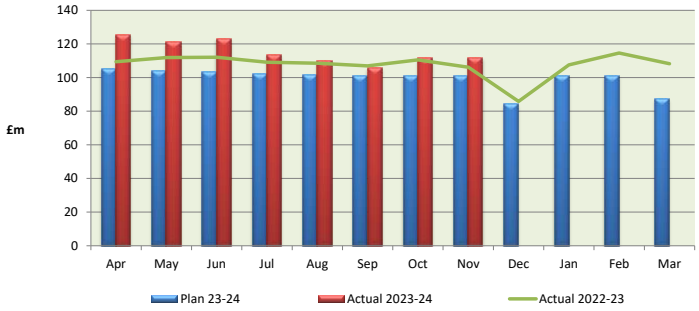
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£103.73)	(£104.65)	(£0.91)
Medical	(£136.89)	(£143.96)	(£7.07)
Families & Specialist Services	(£94.68)	(£95.10)	(£0.42)
Community	(£33.11)	(£32.67)	£0.45
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£56.26)	(£55.97)	£0.29
THIS	£1.36	£1.36	£0.00
PMU	£1.20	£2.00	£0.80
CHS LTD	£0.71	£0.63	(£0.09)
Central Inc/Technical Accounts	£402.11	£403.86	£1.75
Reserves	(£1.51)	£3.69	£5.20
Surplus / (Deficit)	**(£20.80)**	**(£20.80)**	**(£0.00)**

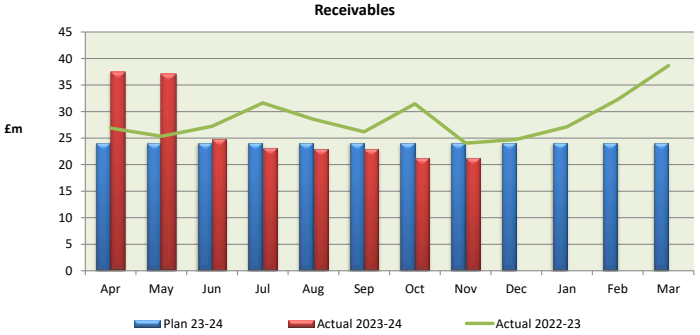
Total Group Financial Overview as at 30th Nov 2023 - Month 8

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

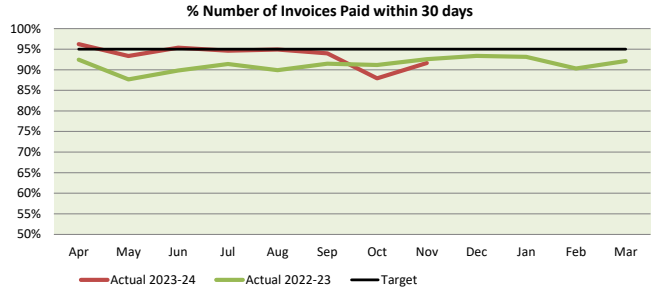
WORKING CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Payables (excl. Current Loans)	(£100.79)	(£111.79)	£11.00	
Receivables	£24.04	£21.31	£2.73	



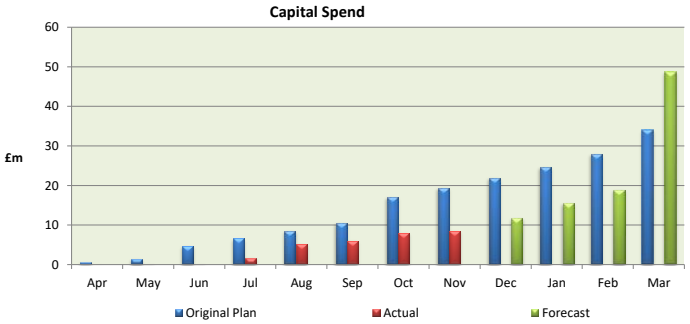


BETTER PAYMENT PRACTICE CODE



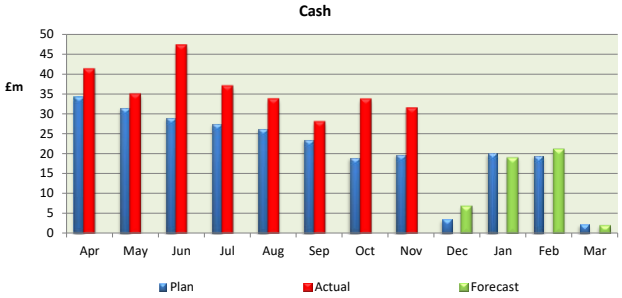
CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Capital	£19.47	£8.51	£10.96	

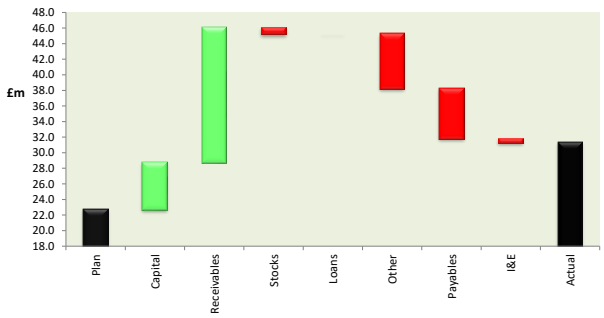


CASH

	M8 Plan £m	M8 Actual £m	Var £m	M8
Cash	£19.78	£31.31	£11.53	
Loans (Cumulative)	£13.25	£13.25	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust is reporting a £14.66m deficit, (excluding the impact of Donated Assets), a £0.54m adverse variance from plan.
- Year to date the Trust has incurred higher than planned costs due to: higher than planned additional bed capacity of £3.49m (including slippage on associated CIP); Strike costs of £2.09m; and non-pay inflationary pressures. YTD Strike costs will now be funded through an additional ICS allocation of £2.1m and other pressures were offset to some extent by the early delivery of other efficiencies 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 £10.37m.
- Overall Weighted Elective Recovery Position as a percentage of plan was 108%.
- The Trust has delivered efficiency savings of £16.70m, £0.89m below the planned level.
- The Trust has a cash balance of £31.31m, £11.53m more than planned.
- Capital expenditure is lower than planned at £8.51m against a planned £19.47m.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3, as planned, with all metrics as planned.

NOTES

- 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 c.£3.5m in month compared with the position reported in M7 due to the additional ICS allocation to support YTD Strike costs and an assumed additional £1.6m of ERF.
- Forecast assumes full receipt of £16.66m of Elective Recovery Funding (ERF), £1.63m more than planned.
- The Capital forecast is to spend £48.81m, £14.80m more than planned. Additional PDC funding has been awarded to support the Community Diagnostic Centre and HPS expansion. Internally funded capital is forecast at £22.22m, £5.19m 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. The increase in the capital expenditure plan means that the Trust is now forecasting to drawdown £15.30m of Revenue Support PDC to support the deficit, with associated additional revenue costs.
- 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

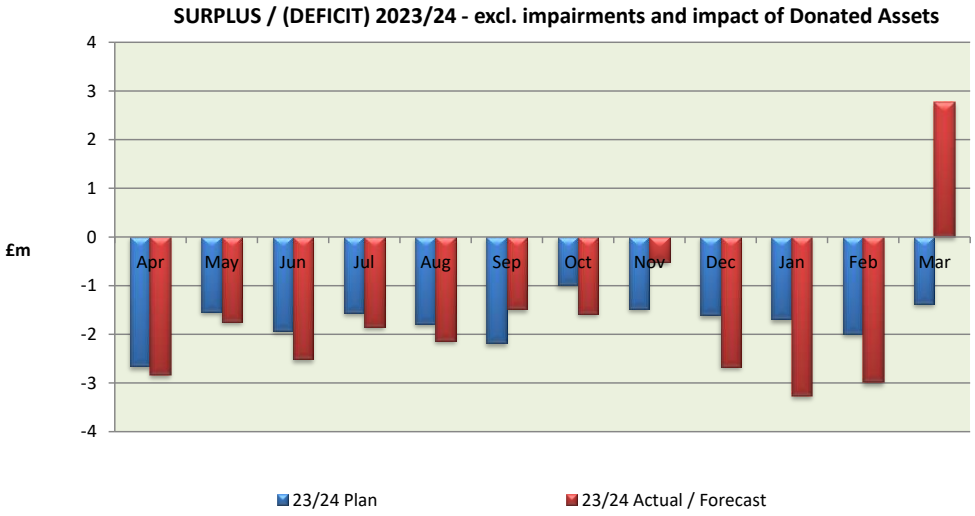
FORECAST 2023/24

23/24 Forecast Position (31 Mar 24)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m	
Income	£530.07	£542.38	£12.31	
Pay expenditure	(£350.38)	(£354.86)	(£4.49)	
Non Pay Expenditure	(£161.68)	(£172.45)	(£10.77)	
Non Operating Costs	(£39.15)	(£36.31)	£2.84	
Total Trust Surplus / (Deficit)	**(£21.15)**	**(£21.25)**	**(£0.10)**	
Deduct impact of:				
Impairments & Revaluations (AME)[1]	£0.00	£0.00	£0.00	
Donated Asset depreciation	£0.43	£0.62	£0.19	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.18)	(£0.09)	
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 £23.20m, £2.40m worse than planned. Key drivers of this forecast gap are £4.36m slippage on efficiencies, non-pay inflationary pressures, additional bed capacity and £0.71m of 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 of 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 for winter bed capacity and the associated impact on planned efficiences.

The worst case scenario is a £10.29m 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 perfromance, additional 'Surge' bed capacity during the winter months; ongoing pressures due to supernumerary overseas nurses, mobile CT requirements; Radiology outsourcing; 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.
- The 'likely case' forecast includes expected costs for the upcoming Junior Doctor Strikes. 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 not incur any additional expenditure and will be contained within the planned cost envelope agreed for Elective Recovery.
- Forecast assumes that the Trust will have access to sufficient funding to cover any costs incurred through provision of the Community Diagnostic hubs.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	Quality and Performance Report
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Jonathan Hammond, Chief Operating Officer
Previous Forums:	Finance and Performance Committee
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 November 2023.
Key Points to Note	**Performance Matrix Metrics Changes** To note changes in the matrix are now highlighted in a different colour (dark green improvement, purple deterioration). • **Total Patients waiting >40 weeks (IMD 1 and 2)** – impact of ENT numbers. • **Staff Movement (Turnover)** – target has reduced from 11.5% to 10%. • **Non-site-specific cancer referrals** – referrals have remained steady at just below target. • **Hospital Discharge Pathway Activity** – a peak in length of stay for pathway 0 patients at 4.5 days. • **Bed Occupancy** – over 99% for the second month running. • **Transfers of Care** – remains high at 123. • **% of patients that receive a diagnostic test within 6 weeks (IMD 1 and 2)** – impact of Echocardiography and Neurophysiology. • **ED Proportion of patients seen within 4 hours** – second month at 66%. **Performance Summary** For November 2023 we continue to perform well in terms of **elective recovery** 65/52/40 weeks although there continues to be further impact on the > 40-week position due to the ENT ASI position. There was 1 patient (ENT) waiting > 65 weeks at the end of November who has now been treated.

	For **diagnostics** we still have challenges in Echo and Neurophysiology with the trajectory now stretching out to June 2024 for Neurophysiology and ongoing concerns regarding recovery in Echo. The plans to reduce **follow-up** backlog via an improved booking process will reduce the numbers to below 20,000 by the end of March 2024. Deep dives are being 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 was started in December 2023 and will continue into January 2024. The impact will be reviewed to identify any further training needs. **Cancer** performance continues to be strong with faster diagnosis target being achieved for the third month running. We have agreed to allow Sky News to film a pre-recorded news package about how hospitals can use technology to speed up the diagnosis and treatment of cancer. • CHFT is an innovative Trust leading the way in the use of digital technology inpatient care. • Digital and data play an important role in helping us shape how we provision the healthcare services of the future. • There are many innovative/pioneering digital solutions in place at CHFT that have already improved patient experience and outcomes. **ED** performance for November remained around 66% with continuing pressures around numbers of patients and acuity. We have seen a small reduction in the number of patients waiting over 12 hours in ED and bed occupancy was above 99% for the second month. Proportion of **ambulance arrivals** delayed over 30 minutes remained high at 6.5% in November as expected. The key change is the use of arrival destination as the trigger for when the clock starts which removes any notify times previously used. We have also started to see a small number of 60-minute delays however it is worth noting that 2 of the 4 seen in one evening in early December were < 8.5 minutes over, which is the recognised time difference caused by the change in ambulance drop-off. The target of 95% of adult patients to receive a **MUST** assessment within 24 hours of admission/transfer to the ward has been particularly difficult challenge for the Trust however we continue to achieve above 80%. There were 2 **never events** in month which are being investigated. % of **complaints** closed on time (target 95%) was 90% in November which continues the excellent progress. **Feedback from NHS England's recent review of CHFT's IPR:** • The report is looking fantastic, what a transformation! The difference compared to the report in 2022 is astounding. We rated your new

	report as 5/5. We only rated 12 out of c.210 Trusts as 5/5 and therefore CHFT is one of our exemplary reports. Well done to you and all involved! • The focus on inequalities is again great to see. The national inequality team also used your report in our recent analyst network as a best practice example. • In summary, the report is excellent, and it is driving meaningful conversation.
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 is asked to **NOTE** the narrative and contents of the report for November 2023.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report November 2023

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

ASSURANCE

VARIANCE	PASS	HIT or MISS	FAIL
SPECIAL CAUSE IMPROVEMENT	• Core EST Compliance • Staff Movement (Turnover)	• Total Patients waiting >40 weeks • Total Patients waiting >52 weeks • Diagnostic activity undertaken against activity plan • Non-site-specific cancer referrals • Total Patients waiting >40 weeks (IMD 1 and 2)	• Total Patients waiting >65 weeks
COMMON CAUSE/NATURAL VARIATION	• Patients dying within their preferred place of death • % of incidents where the level of harm is severe or catastrophic	• Total Patients waiting > 62 days for cancer treatment compared with February 2020 • Proportion of patients meeting the faster diagnosis standard • Stillbirths per 1,000 total births • Proportion of Urgent Community Response referrals reached < 2 hours • 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 • E. Coli Infection Rate • Number of Serious Incidents • % of complaints within agreed timescale • % of episodes scoring NEWS of 5+ going on to score higher • % of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward. • Proportion of patients meeting the faster diagnosis standard (LD) • % of patients that receive a diagnostic test within 6 weeks (LD) • 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 that receive a diagnostic test within 6 weeks • Early Cancer Diagnosis • ED Proportion of patients seen within 4 hours • Proportion of ambulance arrivals delayed over 30 minutes • % of beds occupied by patients who no longer meet the criteria to reside • ED Proportion of patients seen within 4 hours (LD) • % Outpatient DNAs (IMD 1 and 2) • Total Patients waiting >40 weeks (LD)
SPECIAL CAUSE CONCERN	• No KPIs	• Total RTT Waiting List • Proportion of patients spending more than 12 hours in ED • Hospital Discharge Pathway Activity • ED Proportion of patients seen within 4 hours (IMD 1 and 2) • % Outpatient DNAs (LD)	• Bed Occupancy • Transfers of Care

Not included in table – Finance, Virtual Ward, 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

Elective Care:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >40 weeks to start treatment	November 2023	913	0			-	-	-
Total Patients waiting >52 weeks to start treatment	November 2023	13	0			-	-	-
Total Patients waiting >65 weeks to start treatment	November 2023	1	0			-	-	-
Total RTT Waiting List	November 2023	35,324	31,586			32,368	29,889	34,847
Total elective activity undertaken compared with 2023/24 activity plan	November 2023	104.4%	100%	-	-	-	-	-
Percentage of patients waiting less than 6 weeks for a diagnostic test	November 2023	81.9%	95%			86%	80%	93%
Diagnostic Activity undertaken against activity plan	November 2023	15,542	14,547			13,287	11,376	15,199
Total Follow-Up activity undertaken compared with 2023/24 activity plan	November 2023	99.7%	100%	-	-	-	-	-

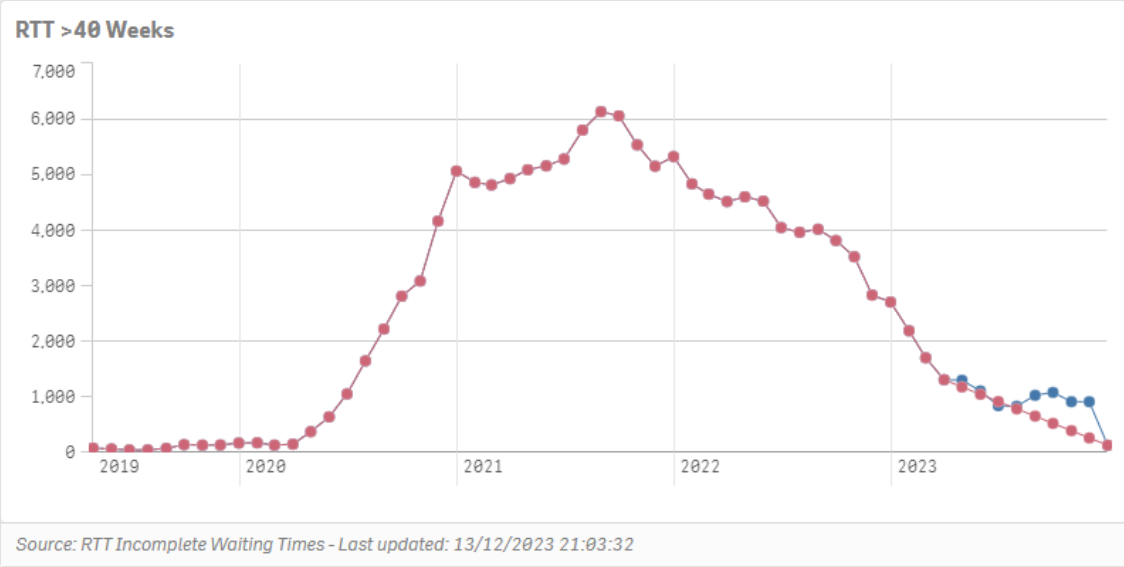
Total Patients waiting more than 40 weeks to start consultant-led treatment

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 913 at the end of November against the target trajectory of 262.
- Most of our remaining patients who are waiting over 40 weeks are in ENT (428), Max Fax (62), Urology (54), General Surgery (108), Cardiology (48). Of those specialties listed, only ENT is increasing.

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

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

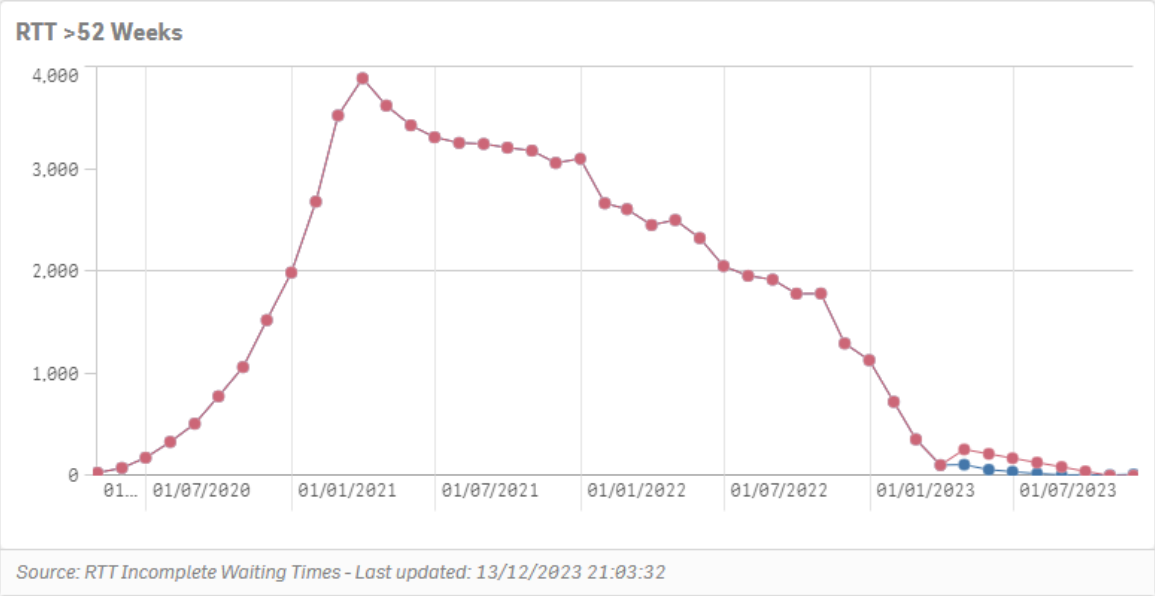
Total Patients waiting more than 52 weeks to start consultant-led treatment

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 13.
- There are 141 patients (down from 283) waiting between 46 and 52 weeks, including General Surgery (19), Urology (10), ENT (77), Max Fax (10).
- 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 December 2023.

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

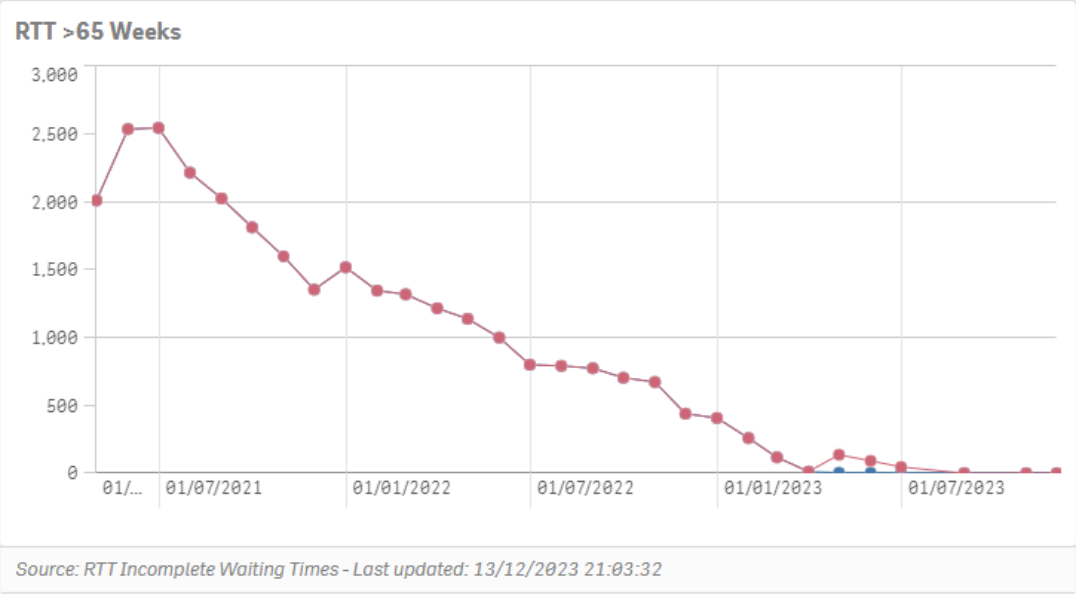
Total Patients waiting more than 65 weeks to start consultant-led treatment

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 November there was 1 patient waiting over 65 weeks (ENT). This patient has now been treated.

Underlying issues:
- We have an increasing number of over 52/40 Week ENT patients, this has resulted in 1 patient waiting over 65 weeks at the end of November.

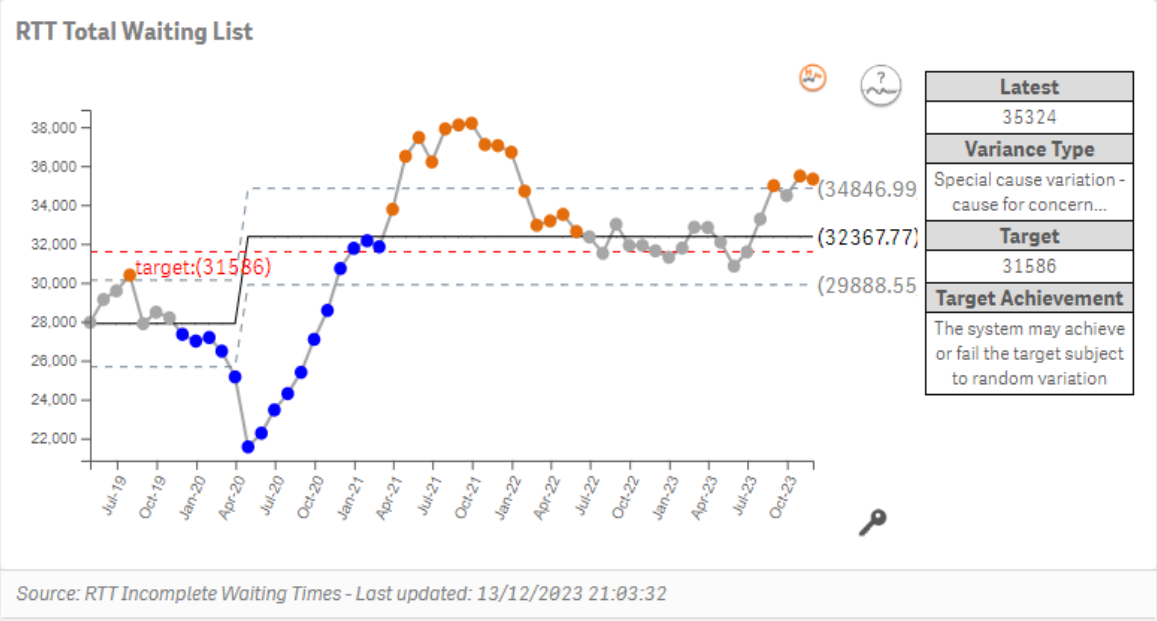
Actions:
- ENT Task and Finish Group concluded with actions in place.

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:
- After a fall in September, the list remains high despite a small reduction from the October position and stands at 35,324 at the end of November.

Underlying issues:
- We currently have a relatively stable RTT Waiting list position, although it has reached the abnormally high threshold 3 times in the last 4 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 6 of the 8 months compared with the 2023/24 activity plan.
- Performance in November 2023 has increased to 104.4% in month.
- Both Day cases and electives were above the planned position for November.
- The YTD performance for the elective activity overall remains above the planned position and currently stands at 104.6%, which is a total of 1,417 spells more than the plan at this stage.
- Day case activity continues to track above 100% against the planned position YTD.
- Elective activity has dropped slightly below the 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.
- We are working to ensure Capped theatre utilisation is tracked via Model Health and are currently showing as the 3rd highest in the region with the aim of consistently meeting the 85% national target.

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

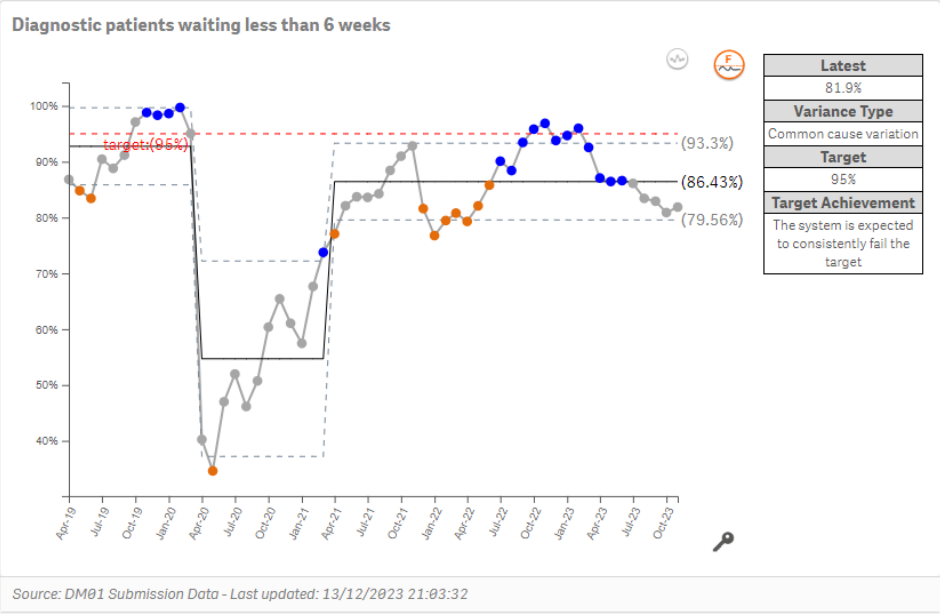
Calderale and Huddersfield NHS Foundation Trust

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 (41.5%) and Neurophysiology (54.2%).

Actions:

Echocardiography
- Slight reduction in 6-week breaches but remain high at 1,296 w/c 18th December.
- Additional clinics in line with ERF plan having a negative impact on ability to recover position.
- One of the trainees is now accredited and can run clinics independently.
- Plan for internal team to deliver 100 additional reports per week and ~170 additional TTE scans per month once reporting backlog is cleared.
- Had discussions with COO at Mid-Yorks for their Echo staff to do some work for CHFT.
- A group has been set up looking at a collaborative bank for Echo Physiologists across West Yorkshire to progress in the next quarter.

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 end December 2023
- Band 6 Physiologist – recruited for January 2024
- Band 7 Physiologist – recruited for 1st April 2024

Total Diagnostic Activity undertaken against the activity plan

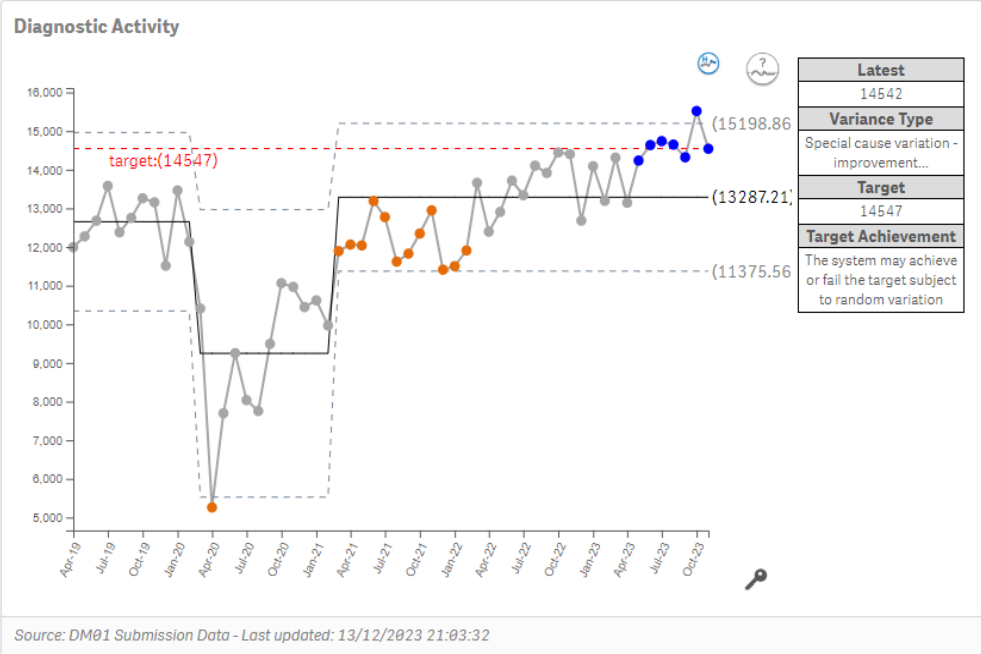
Calderdale and Huddersfield NHS Foundation Trust

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 may achieve or fail the target subject to random variation.
- Performance can be expected to vary between 11,376 and 15,199. Activity is similar to pre-Covid levels.

Underlying issues:

- Overall, we are now 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 under plan and we are materially off target against 95% of patients being seen within 6 weeks.

Actions:

Echocardiography

- Slight reduction in 6-week breaches but remain high at 1,296 w/c 18th December.
- Additional clinics in line with ERF plan having a negative impact on ability to recover position.
- One of the trainees is now accredited and can run clinics independently.
- Plan for internal team to deliver 100 additional reports per week and ~170 additional TTE scans per month once reporting backlog is cleared.
- Had discussions with COO at Mid-Yorks for their Echo staff to do some work for CHFT.
- A group has been set up looking at a collaborative bank for Echo Physiologists across West Yorkshire to progress in the next quarter.

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 end December 2023
- Band 6 Physiologist – recruited for January 2024
- Band 7 Physiologist – recruited for 1st April 2024

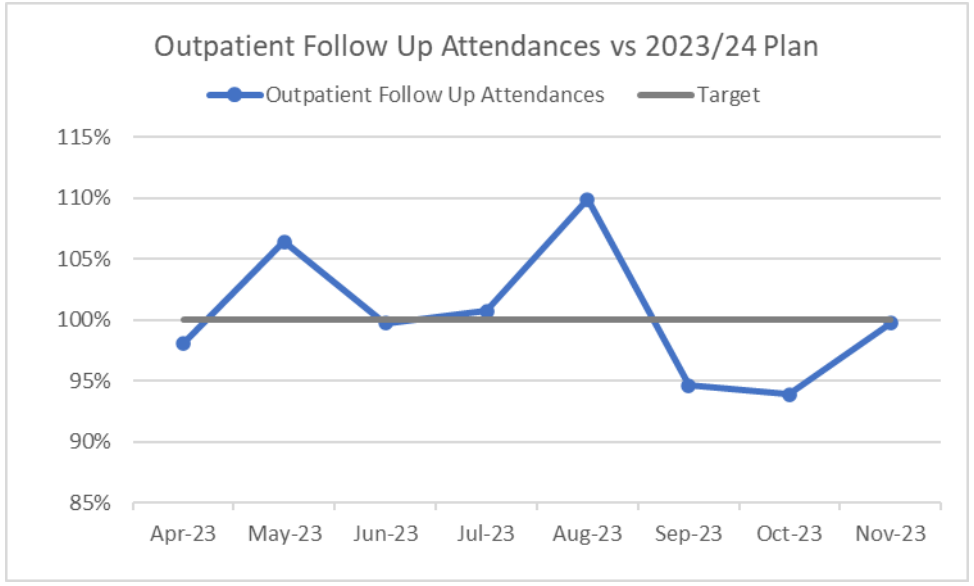
Total Follow-Up attendances undertaken compared with 2023/24 activity plan

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 improved for month 8 and CHFT achieved 99.7% of the planned position in-month for follow-up attendances.
- The YTD position remains above the planned levels standing at 100.4%.

Underlying issues:
- Although the national target for follow-up activity is 75% of 2019/20 activity, due to a significant follow-up backlog (26,131), CHFT have not taken this up.
- 50% of the backlog has been waiting less than 12 weeks.
- Industrial action has had an impact on follow-up attendances in September and October, this is anticipated to impact again in January 2024.

Actions:
- There are currently 10,181 (of the 26,131 backlog) records that are awaiting a clinical prioritisation within CHFT's MPage system, this is an increase of 1,000 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 26,131 follow-up patients past see by date and this is gradually increasing weekly.
- Deep dives are being 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 was started in December 2023 and will continue into January 2024. The impact will be reviewed to identify any further training needs.

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	11th Dec 2023	32	35			35.08	20.98	49.18
Proportion of patients meeting the faster diagnosis standard	November 2023	81.19%	75%			76.77%	66.97%	86.57%
Non-Site-Specific Cancer Referrals	November 2023	21	25			18.68	5.85	35.44
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	November 2023	57.6%	75%			48.87%	34.09%	63.65%

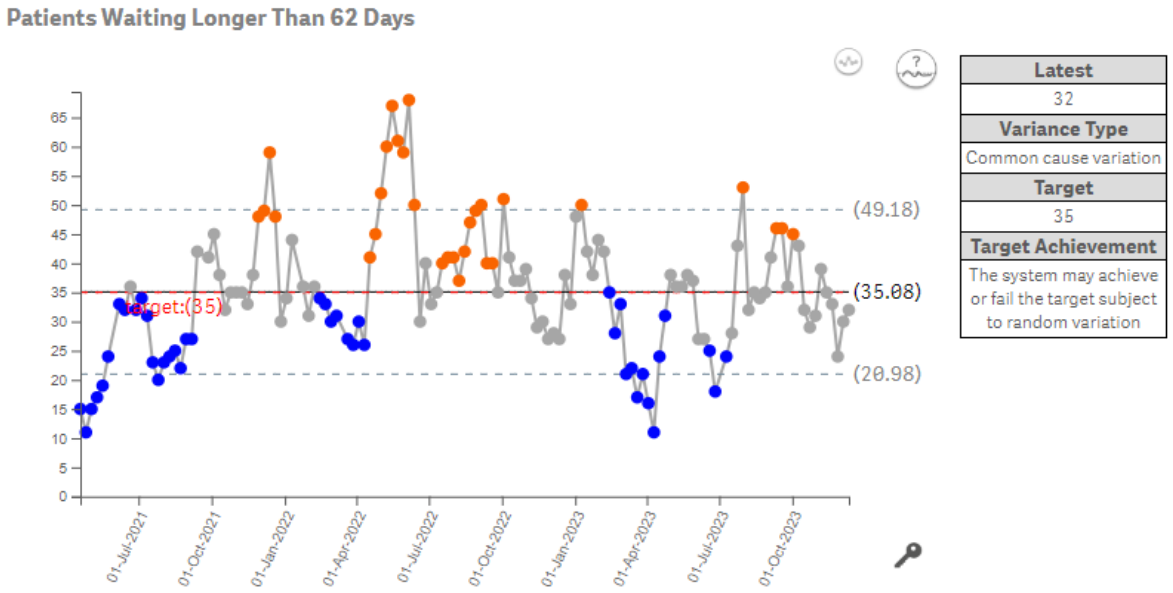
Total Patients waiting over 62 days to begin cancer treatment compared with February 2020 baseline

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.



What does the chart show/context:
- As of Monday 11th December there were 32 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:
- Over 62-day waiters continuing to be escalated to divisional teams where appropriate

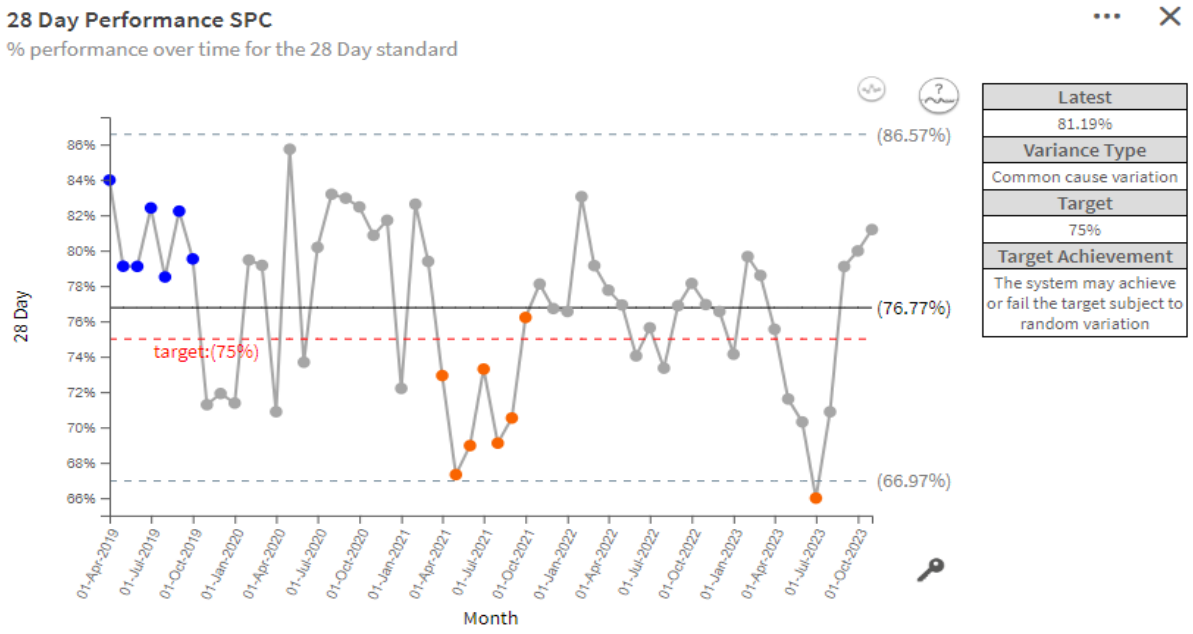
Proportion of patients meeting the faster diagnosis standard

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%.



What does the chart show/context:
- Latest monthly performance stands at 81.19%.
- 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 Non-Site-Specific are also not meeting the 28-day target.

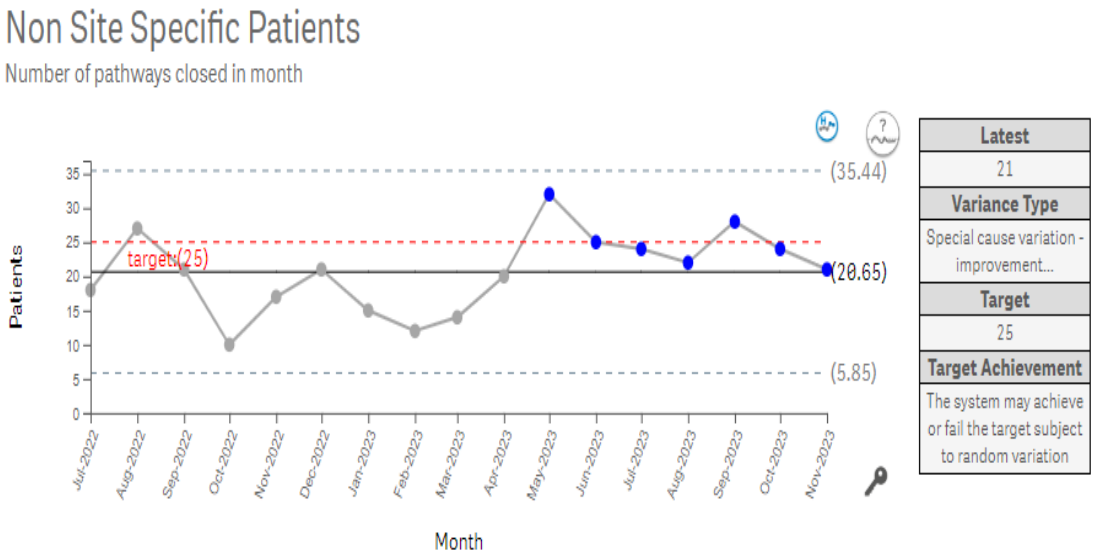
Actions:
- Skin have reverted back to their face-to-face clinics, Skin and the overall 28-day target have improved as a result.
- Pathway navigator in place for Lower GI and Upper GI to support patients to engage with the pathway.
- NSS actions include, proforma to be used by physicians associate and 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.
- Head and Neck, request for mutual aid from other Trusts.

Non-Site-specific Cancer Referrals

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

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

Target: 25 as per activity plan – March 2024



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 5 and 35.
- Referrals have remained steady this month at 21 with a minor decrease on the projected number (25).

Underlying issues:
- Referrals continue to be variable.

Actions:
- Share quarterly NSS referrals data with PCNs, continuing to raise the NSS service profile.
- Rolling out into a second PCN in Calderdale.
- Presenting to A&E in December to encourage in-house referrals.

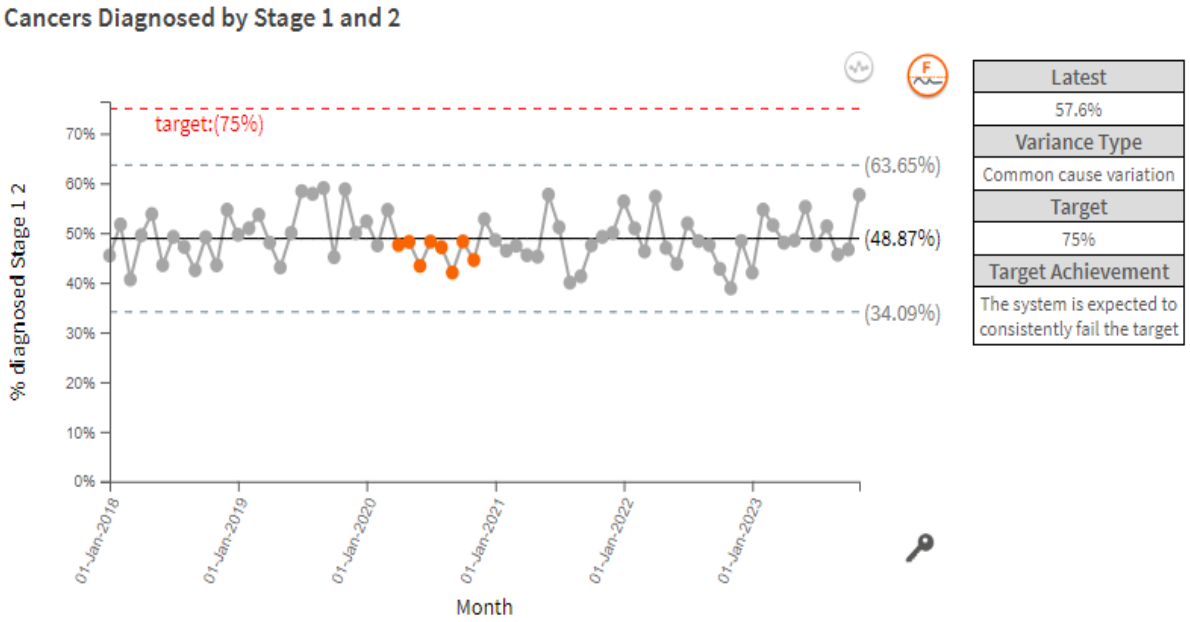
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028

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.



What does the chart show/context:
- The Trust is expected to consistently fail the target of 75%.
- Performance can be expected to vary between 34% and 64%.
- Nationally this metric stands at 52%

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	November 2023	66.71%	76%			68%	61%	76%
Proportion of ambulance arrivals delayed over 30 minutes	November 2023	6.5%	0%			4%	1%	7%
Proportion of patients spending more than 12 hours in an emergency department	November 2023	5.41%	2%			3%	0.5%	5.1%
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	November 2023	99.5%	96%			98%	96%	100%
% of beds occupied by patients who no longer meet the criteria to reside	November 2023	23%	14.21%			22%	18%	26%
Hospital Discharge Pathway Activity – AvLOS pathway 0	November 2023	4.5	4.1			4.03	3.62	4.43
Transfers of Care	November 2023	123	50			90	51	132

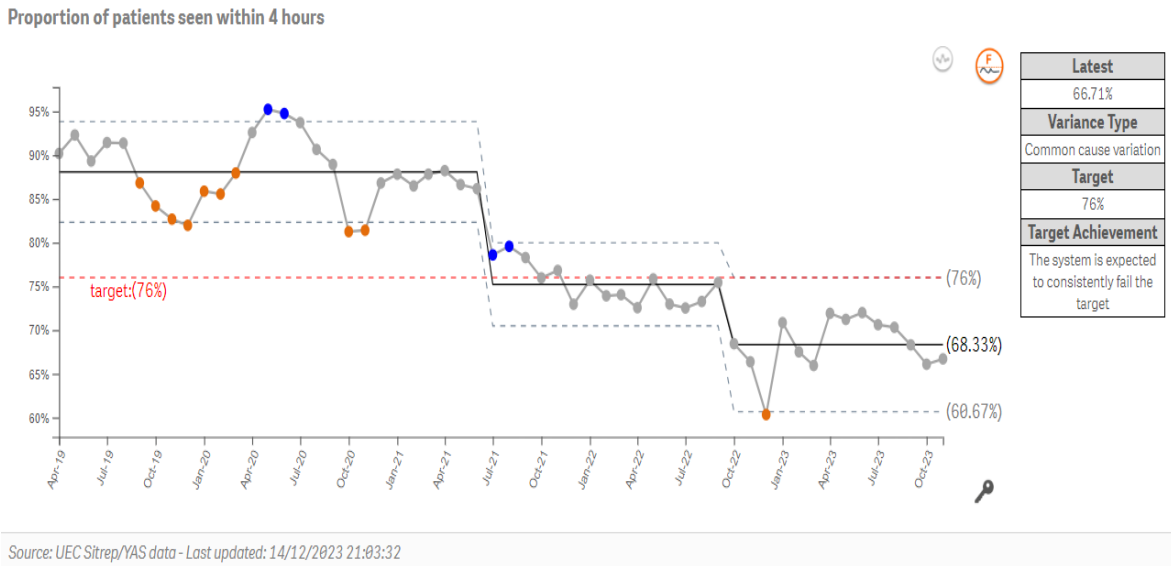
Proportion of patients seen within 4 hours

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 76%.
- The performance for November was 66.71%.
- Big drop in admitted performance.

Underlying issues:

- Increase in occupied beds - long wait for beds
- Increase in acuity
- Increase in TOC now at 123 for November compared to an average of 105 for the first 6 months of 2023/24.

Actions:

- Recruitment into Medical WFM at interview stage, 4 locum consultants appointed and 2 substantive consultants.
- 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.

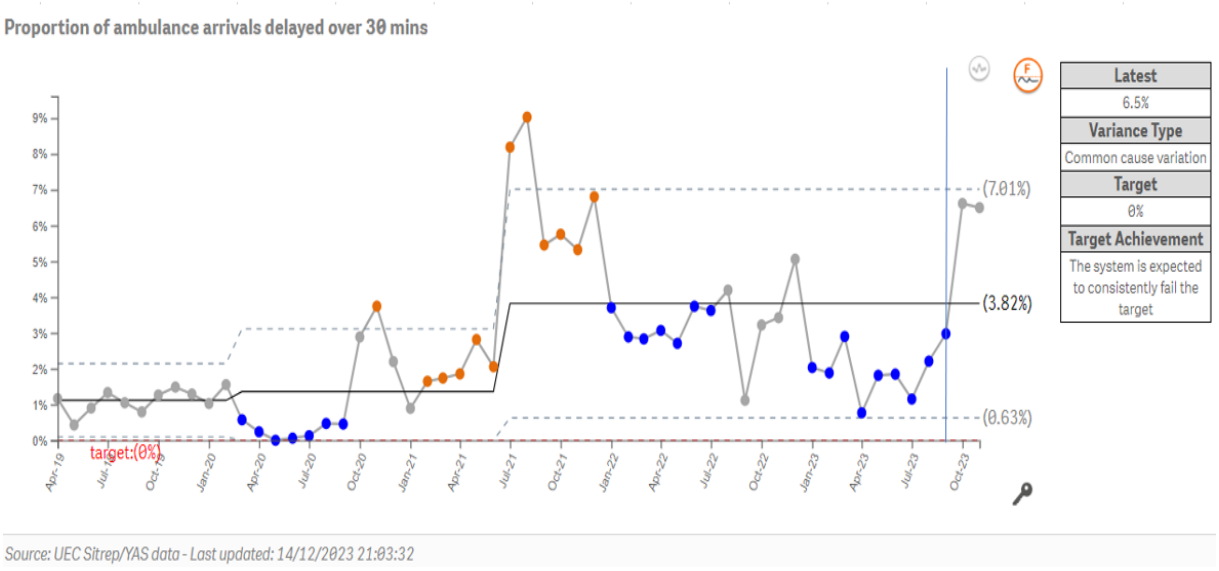
Proportion of ambulance arrivals delayed over 30 minutes

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).



What does the chart show/context:
- The performance for November is 6.5%.
- 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. SOP brought in to improve performance on these at the start of April.
- 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)
- YAS - the overall demand for A&E operations service to early October was 9% higher when compared to the same period last year and was 16% higher for category 1 calls (the most serious conditions).

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.

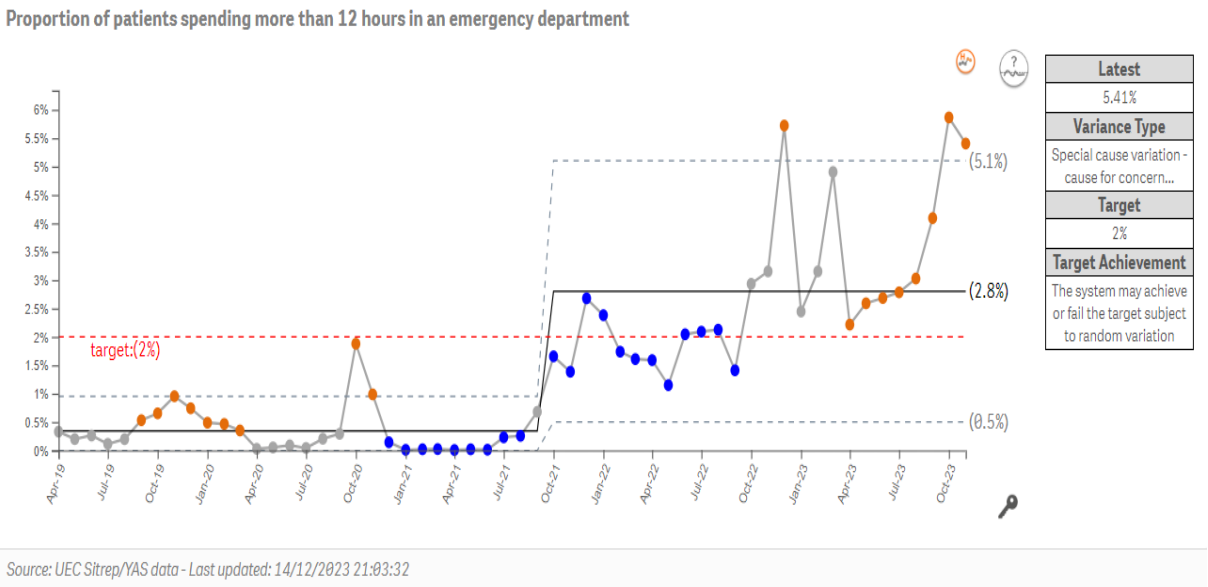
Proportion of patients spending more than 12 hours in an emergency department

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 November the performance was 5.41% with 780 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 0.5% and 5.1%.

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

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

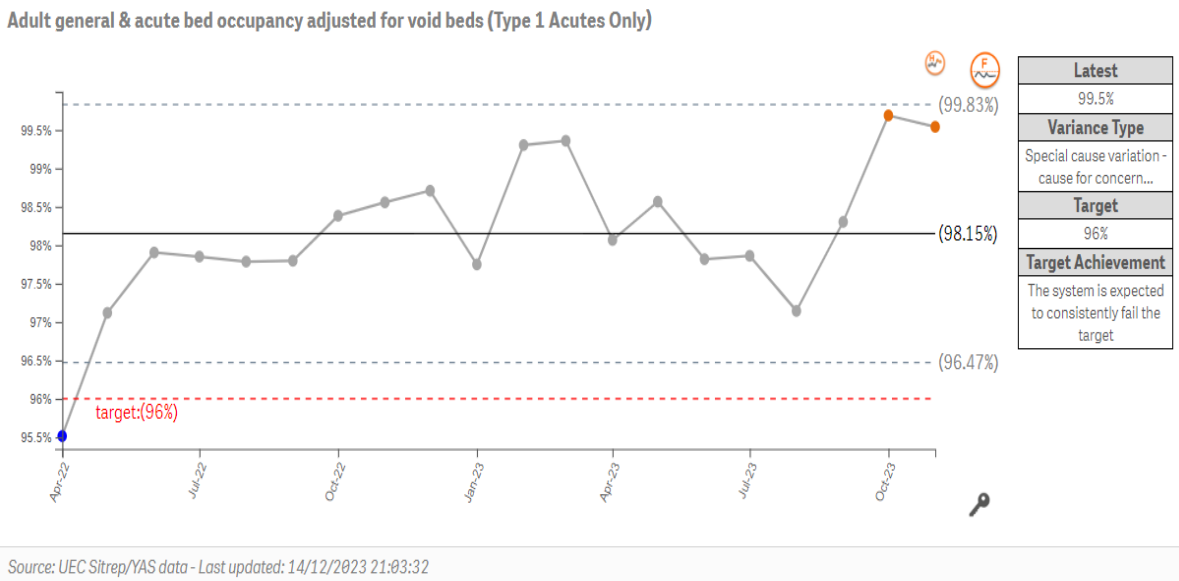
Adult general & acute bed occupancy adjusted for void beds (Type 1 Acutes Only)

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: 14/12/2023 21:03:32

What does the chart show/context:
- Adult bed occupancy increased in November and was very high at 99.5%. 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 and Respiratory floors.
- 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.

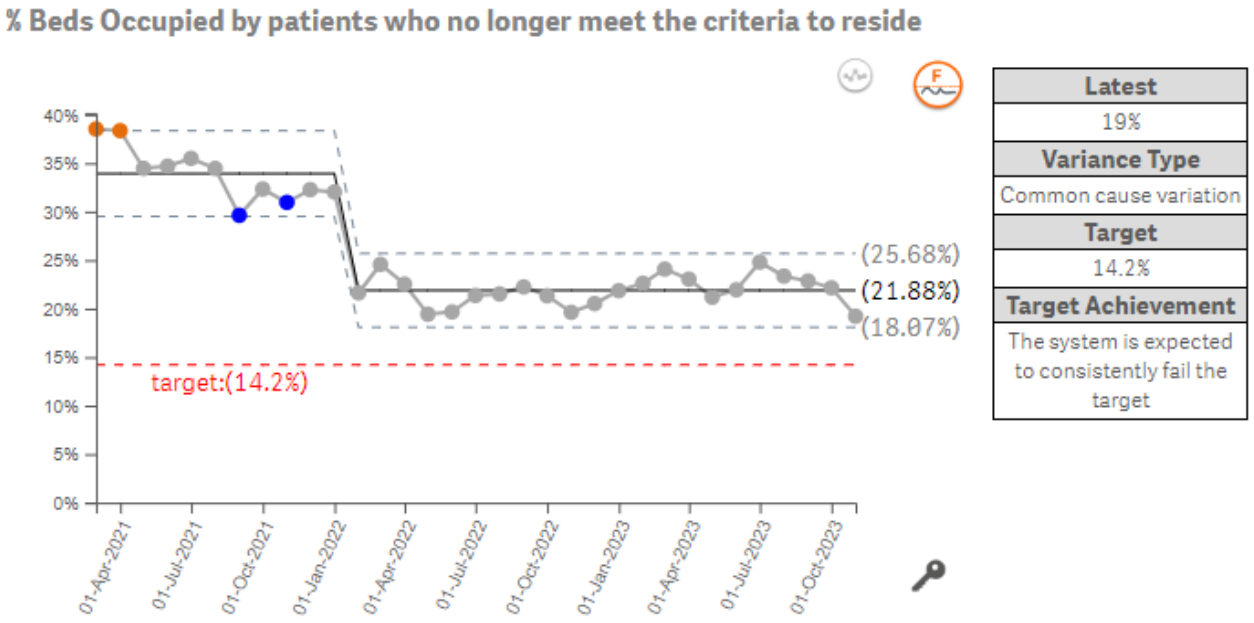
Percentage of beds occupied by patients who no longer meet the criteria to reside

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: David Britton 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: 05/12/2023 21:03:31

What does the chart show/context:
- In November 19% of patients had no reason to reside.
- Slightly less beds were occupied in November, but this was still in line with the number of patients with no reason to reside, hence the percentage remaining similar to previous months.
- November'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:
- Well Organised Ward (WOW) has now been launched and a trajectory will be combined with the digital board roll-out plan.
- 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.

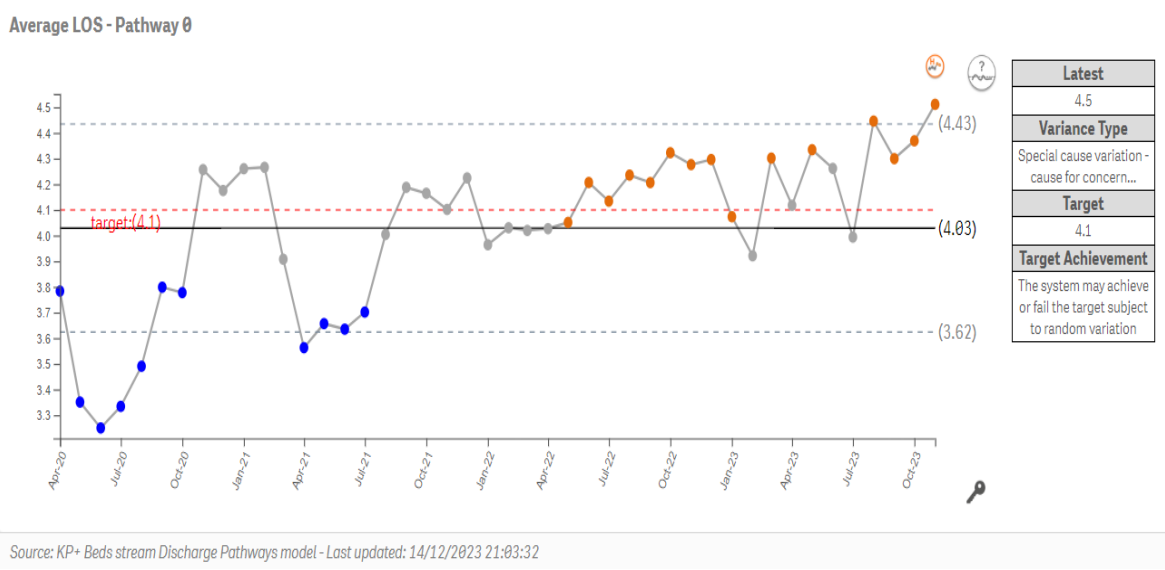
Hospital Discharge Pathway Activity

Calderdale and Huddersfield NHS Foundation Trust

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 November average length of stay was 4.5 days.
- Performance can be expected to vary between 3.62 and 4.43 days.

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

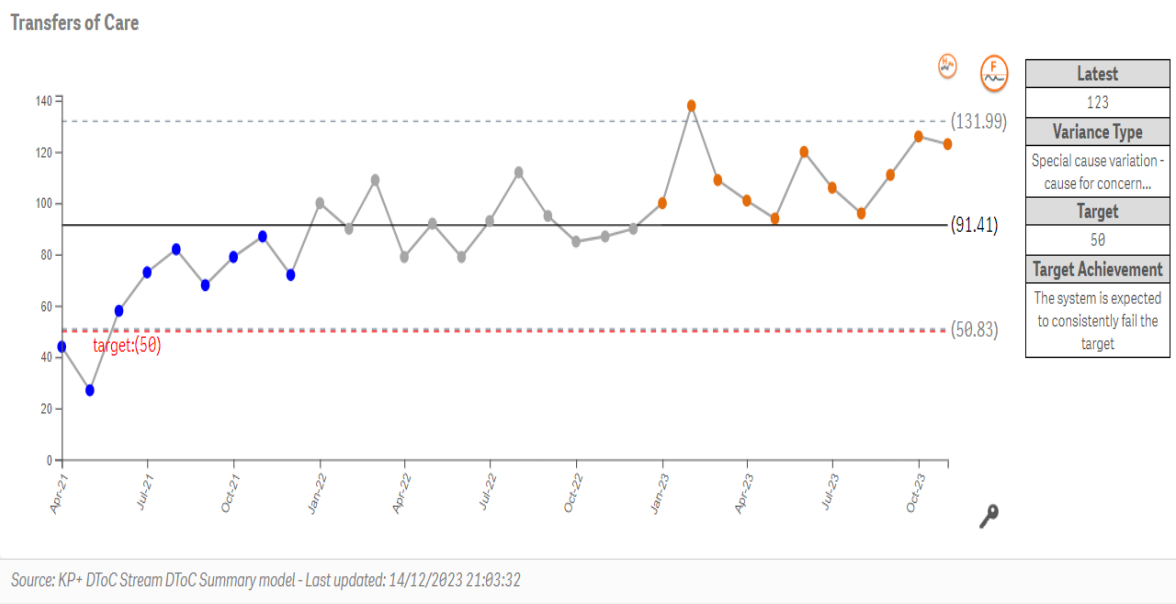
Actions:
- Improvement groups continue with PMO support to develop and improve groups.
- Launch of the Well Organised Ward Programme.
- Approval of funding to reablement and trusted assessors.
- New LOS pack launched in October 2023.
- Governance structures defined within the divisions and through PRMs.

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 November was 123 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:

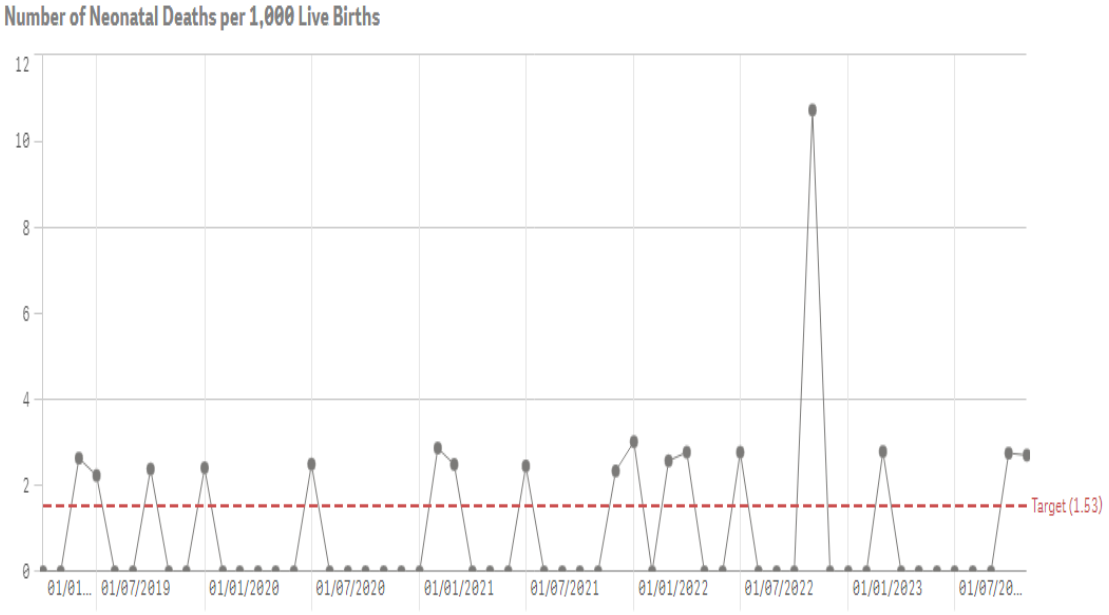
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Neonatal deaths per 1,000 total live births	November 2023	2.71	1.53	-	-	-	-	-
Stillbirths per 1,000 total births	November 2023	2.70	3.33			3.68	0	13.08

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)



Source: Maternity Dashboard - Last updated: 18/12/2023 21:03:32

What does the chart show/context:
- There was 1 neonatal death in November

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

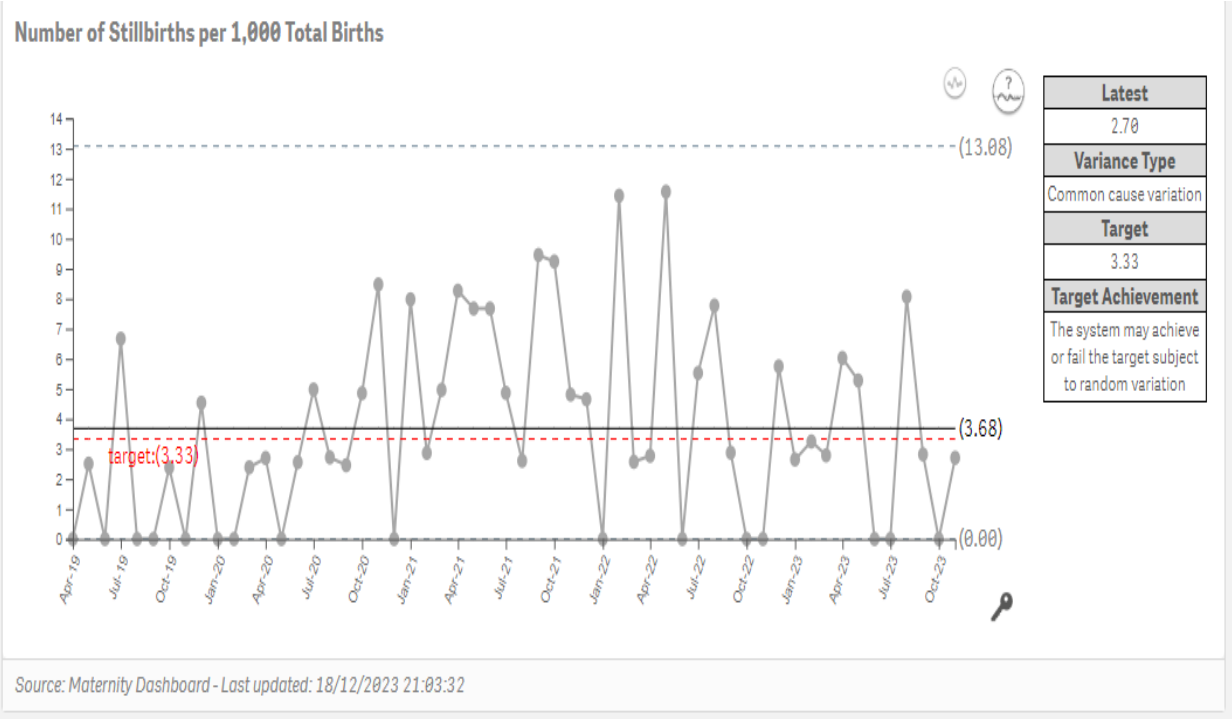
Actions:
- All early neonatal deaths reviewed at Orange Panel and weekly governance meeting
- All neonatal deaths MDT PMRT (perinatal mortality review tool) completed
- All early neonatal deaths referred to MNSI (The Maternity and Newborn Safety Investigations Programme)
- Regular quarterly stillbirth/neonatal audit undertaken
- Responsive review of neonatal deaths was undertaken due to increase in 2022, this would be repeated where significant rise or concerns were identified
- Audit discussed at Maternity Health Equalities Workstream
- Monthly Saving Babies Lives Group
- MDT with tertiary fetal medicine centre for known fetal anomalies

Stillbirths per 1,000 total births

Executive Owner: David Birkenhead Clinical Lead: 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 total births. MBRRACE-UK



What does the chart show/context:
- There was 1 stillbirth in November.

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.

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	November 2023	64.2%	70%			68.8%	51.1%	86.5%
Community Waiting List	November 2023	6,512	4,387 (end 23/24)		-	5950	5641	6259
Virtual Ward	November 2023	138%	80%	-	-	-	-	-
Patients dying within their preferred place of death	November 2023	97.7%	80%			92.6%	81.2%	103.9%

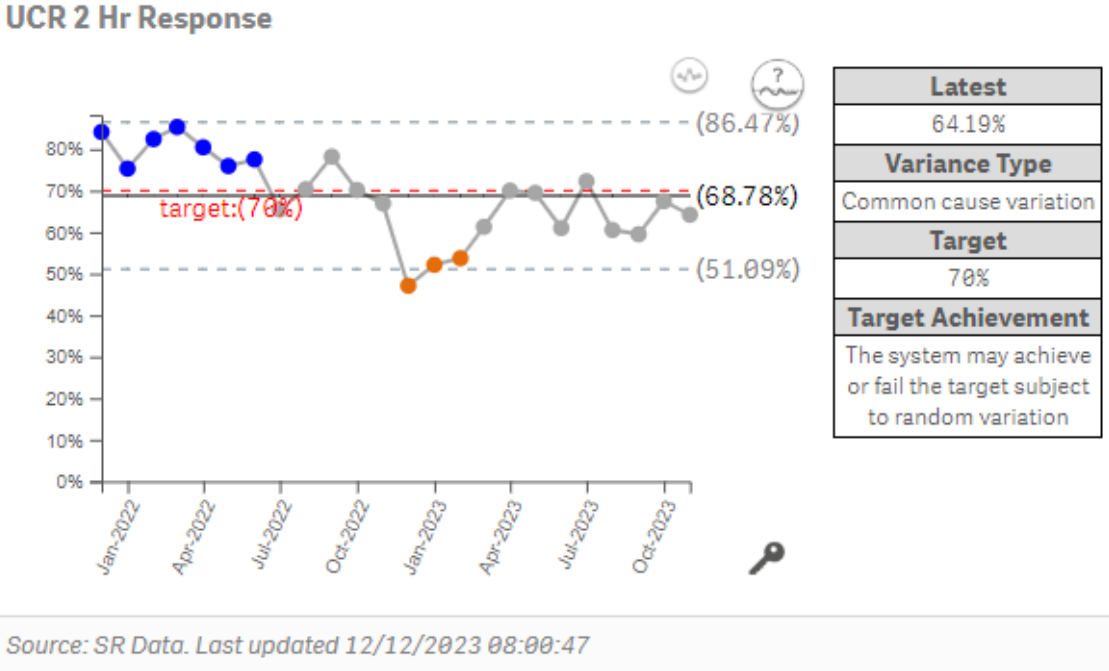
Proportion of Urgent Community Response referrals reached within two hours

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Clinical Lead: Hannah Wood Business Intelligence Lead: Gary Senior

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

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



Source: SR Data. Last updated 12/12/2023 08:00:47

What does the chart show/context:
- Current position for November 2023 is at 64.2%.
- 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).

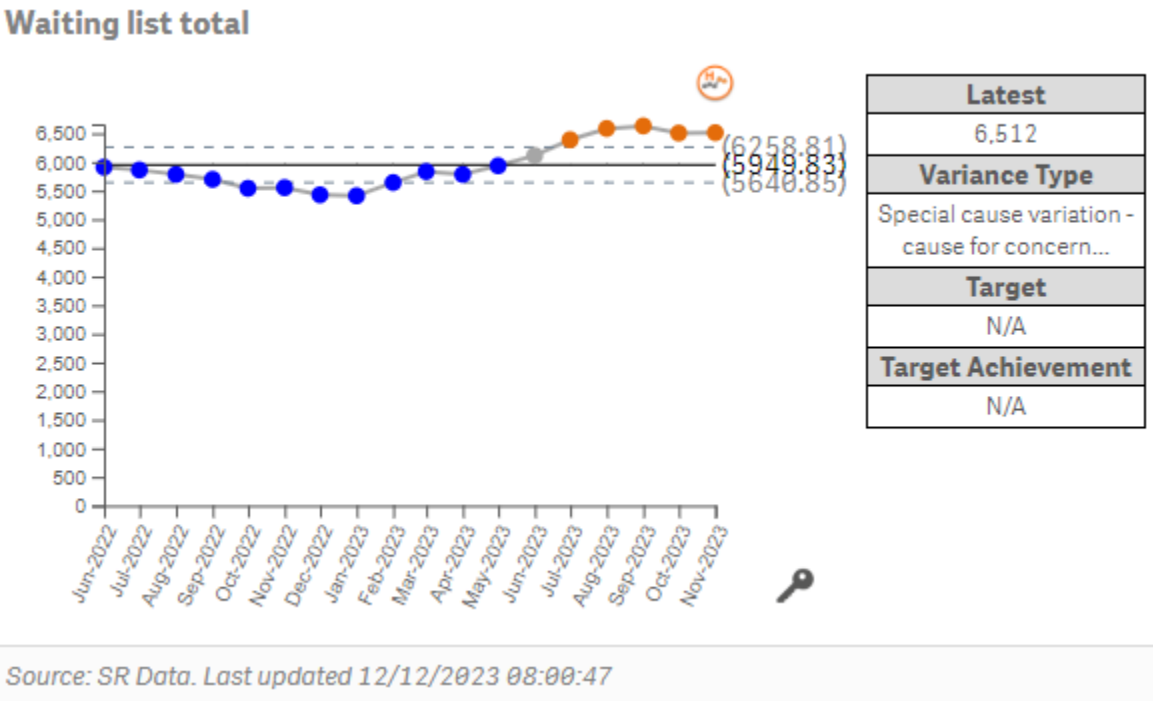
Actions:
- Communications to service leads around accurate data recording.
- Ongoing cases where 2 hrs time is taken by LCD to triage due to their processes therefore is out of the 2hr window prior to reaching UCR.
- Manual audit being completed to examine the different elements of the 2-hour response.

Community Waiting List

Executive Owner: Rob Aitchison Operational Lead: 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 12/12/2023 08:00:47

What does the chart show/context:
- 6,512 total in November 2023.
- Nationally and Regionally MSK, Podiatry and Children's SALT waiting lists are increasing.

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 2 wtes on maternity leave.
- 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.

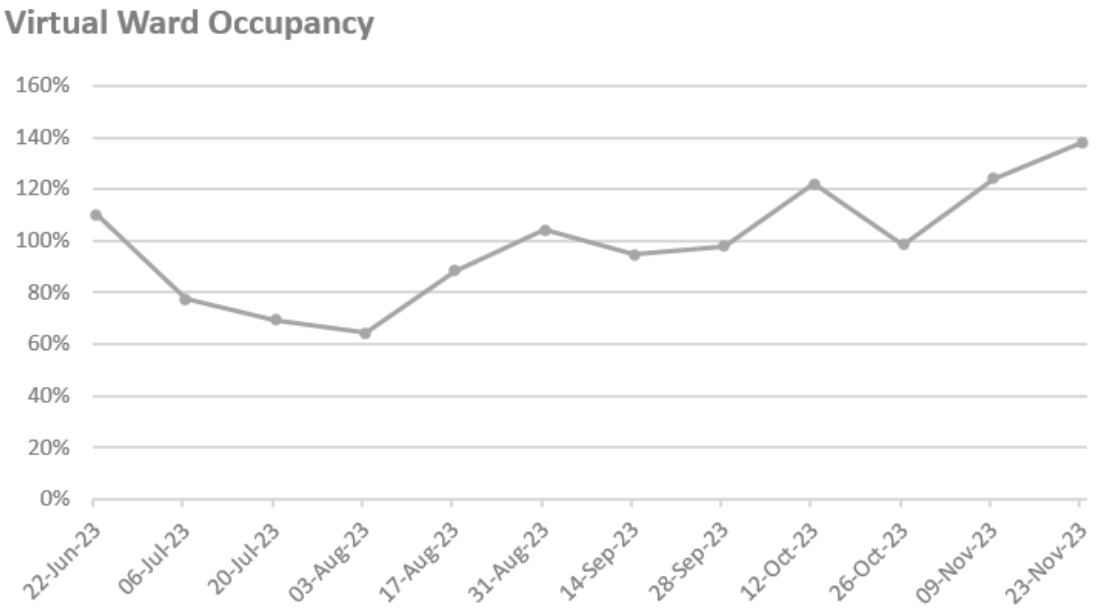
Actions:
- SALT recruitment pressures have reduced with 1.2 wte Band 6 left to recruit to, but a locum in post to support in interim.
- Professional Lead SALT recruited from Children's SALT who will start in role in January 2024.
- Transition to new SALT service structure will begin from December 2023 with information gathering calls currently taking place to families on waiting list.
- 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

Executive Owner: Rob Aitchison Operational Lead: 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 30 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%.



What does the chart show/context:
- Current combined position for November 2023 is 138%

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.

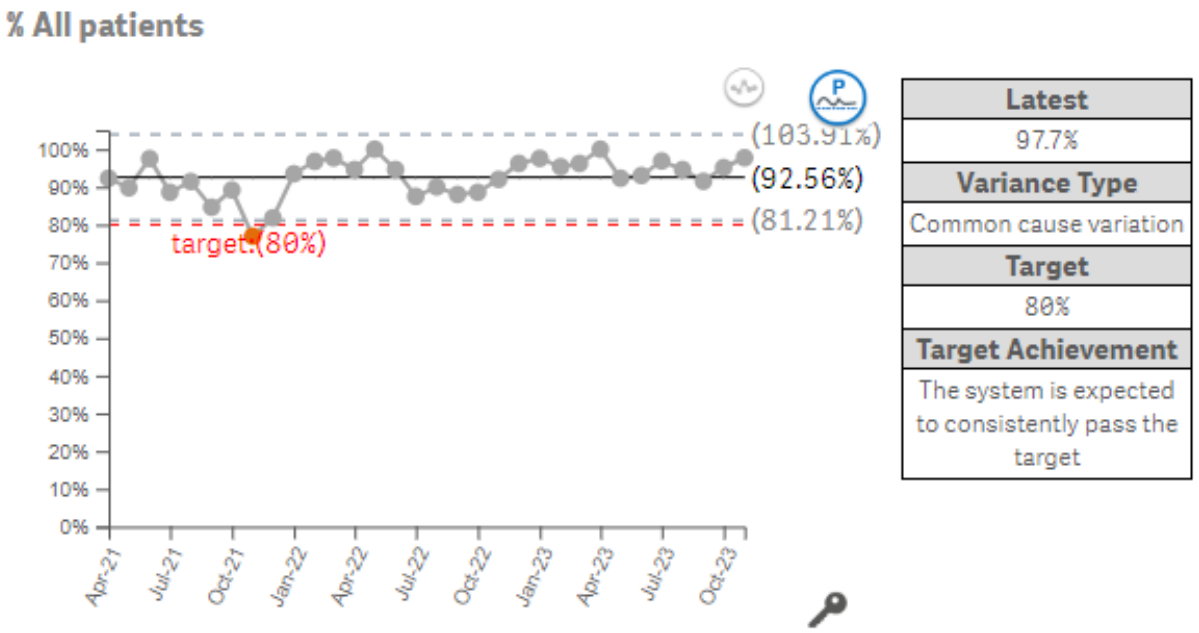
Actions:
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care 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: Jonathan Hammond Operational Lead: Abbie Thompson Business Intelligence Lead: Gary Senior

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

Target:
80%



Source: SR Data. Last updated 15/12/2023 10:52:45

What does the chart show/context:
- SPC chart shows Common Cause Variation.
- Consistently above 80% target (exception November 2021).
- Current month combined 97.7% (EOL 100% and Palliative 96.2%).
- Palliative patients – 96.4% patients died at home – November 2023.

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.

Safe, High Quality Care

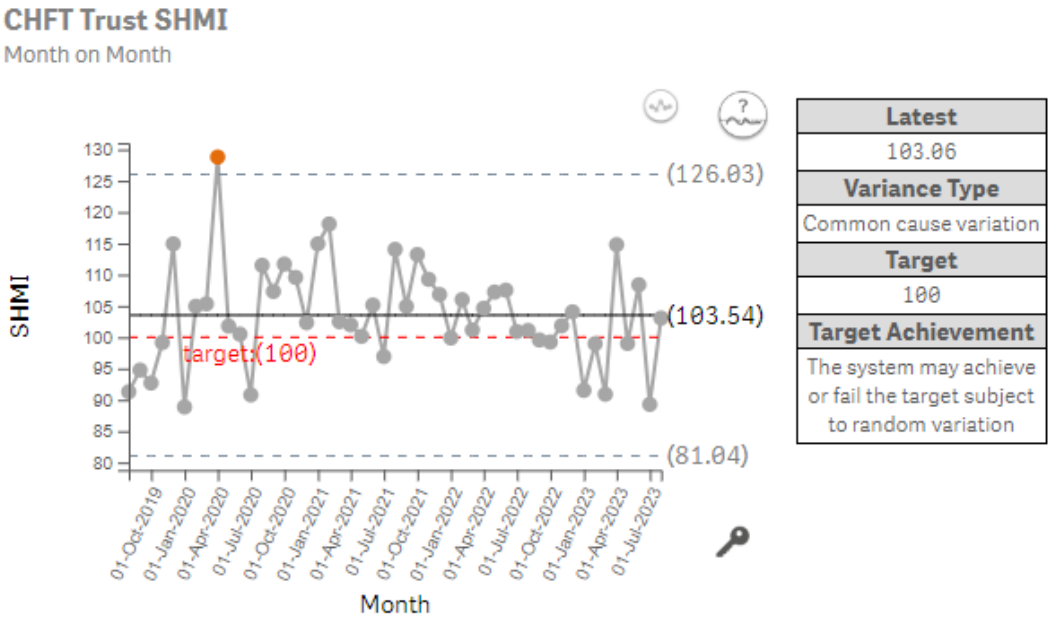
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator	August 2023	99.89	100			103.54	81.04	126.03
Care Hours Per Patient Day (CHPPD)	November 2023	7.8/8.6	-	-	-	-	-	-
Falls per 1000 Bed Days	November 2023	8.2	7.02			7.69	5.35	10.03
CHFT Acquired Pressure Ulcers per 1000 Bed Days	October 2023	1.9	1.76			1.70	0.90	2.50
MRSA Bacteraemia Infection	November 2023	0	0			-	-	-
C.Difficile Infection	November 2023	6	3.1			3.2	0	9.36
E.Coli Infection	November 2023	2	5.6			3.4	0	8.58
Number of Never Events	November 2023	2	0	-	-	-	-	-
Number of Serious Incidents	November 2023	2	0			3.31	0	9.32
% of incidents where the level of harm is severe or catastrophic	November 2023	0.81%	2%			0.8%	0%	1.91%
% of complaints within agreed timescale	November 2023	90%	95%			89.78%	74.61%	100%

Summary Hospital-level Mortality Indicator

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

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

Target:
100



What does the chart show/context:
- CHFT SHMI performance has remained stable in the latest 12 month rolling release and shows performance of 99.89 and remains below the 100 mark.
- Month on Month performance has deteriorated in August with performance standing at 103.06.
- Performance remains within the expected range in the latest release.
- The latest national SHMI position stands at 98.99 and CHFT now sits very slightly above this national position however remains comfortably within the expected range nationally.

Underlying issues:
- The sepsis team reviewed a cohort of notes to understand if there could be a more accurate initial diagnosis e.g. urinary tract infection/infective exacerbation of COPD, rather than a more generic first admission documentation of ‘sepsis’, as the generic description would drive up sepsis mortality indicators.
- The notes review showed there could be significantly more specific diagnoses which would reduce the alerting.
- From February 2023 sepsis deaths have had some additional validation by members of the sepsis team to determine if a more definitive diagnosis could be coded and therefore improve accuracy of recording.
- Sepsis performance has improved significantly and has dropped below the 100 mark which is the best performance since 2021.

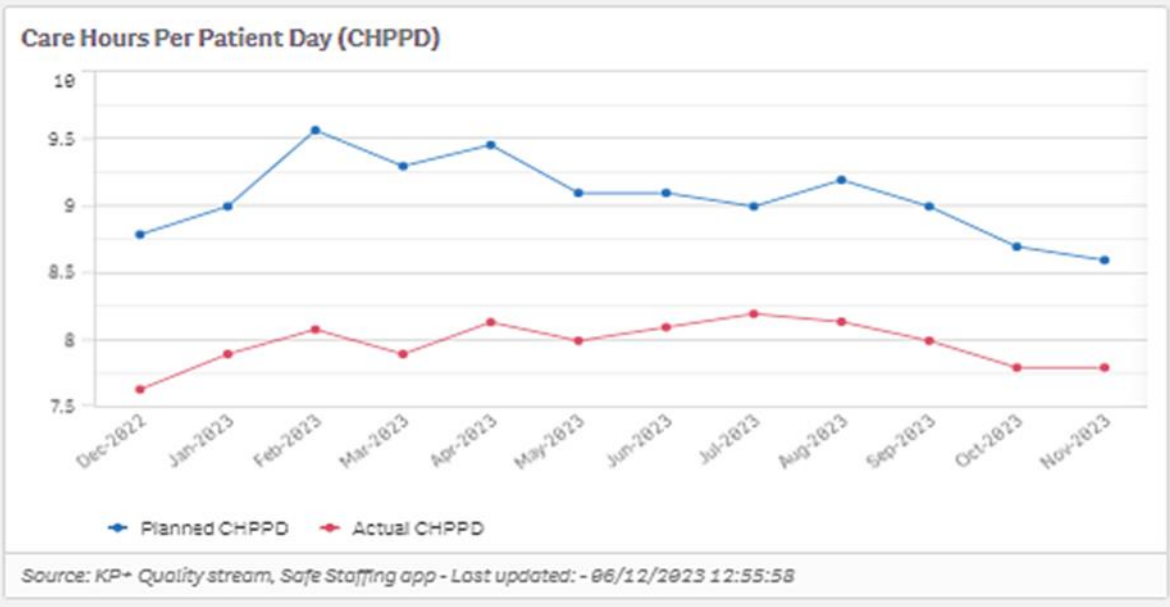
Actions:
- Clinical Lead has contacted all mortality leads in all specialties to communicate the need to increase the level of mortality reviews being carried out on a monthly basis and the timeliness of these reviews being improved.
- The Trust target is for 50% of deaths to be reviewed using the initial screening review methodology, currently performance is not meeting these levels.

Care Hours Per Patient Day

Executive Owner: Lindsay Rudge Clinical Lead: Andrea Dauris Business Intelligence Lead: Charlotte Anderson

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

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



What does the chart show/context:
- The actual CHPPD is less than the planned by a deficit of 0.8 care hour per patient day.
- The latest data in Model Hospital is from September 2023 when CHFT reported providing 8.0 CHPPD against a peer median 8.6 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.
- Reducing the CHPPD deficit is dependent on having the right workforce to meet the patient requirements.

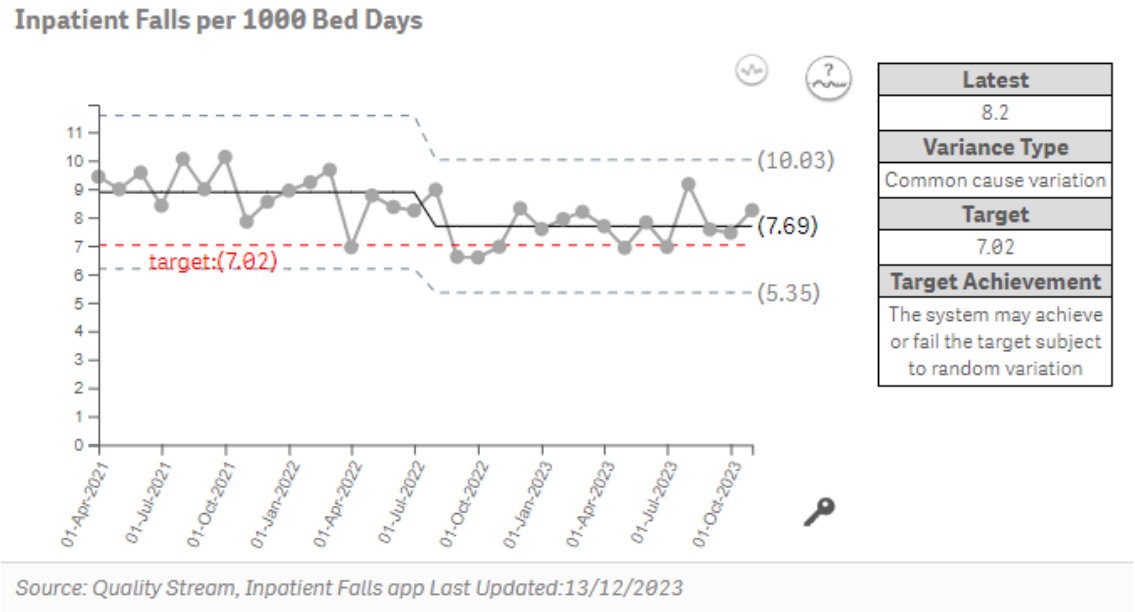
Actions:
- Undertake bi-annual Safer Staffing review. This process provides assurance of the correct workforce models based on an evidence-based methodology. The next bi-annual review is scheduled for March 2024.
- Ongoing monthly reviews of recruitment strategies, including employment of new graduates, 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: Rhiann Armitage

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

Target:
10% reduction from 2022/23



Source: Quality Stream, Inpatient Falls app Last Updated:13/12/2023

What does the chart show/context:
- The rate of inpatient falls for November was 8.2.
- Currently performance can be expected to vary from 5.34 to 10.01.
- A step-change has been added to the chart from July 2022, which has changed the upper and lower control limits.

Underlying issues:
- The Falls Collaborative has now been reformatted and attendance has much improved.
- Enhanced care team issues with 1-1 cover for areas inconsistent.
- Inconsistencies in wards using falls prevention measures e.g. bay tagging, co-horting.

Actions:
- Relook at the TOR of the falls collaborative.
- Falls link nurses to be allocated and invited.
- Continuing with reconfiguration plan around the enhanced care team.
- Education as part of the revamped Enhanced Care team processes and assessments.
- We have now joined a WYAAT falls collaborative and attended the first meeting. We are arranging go sees and going to work as a region to look at ways to reduce falls.
- Bed rails assessment is being reviewed due to concerns it is not reflective of what we need for safe practice.
- The SOP for retrieving patients off the floor now has a final draft and is awaiting ratification.
- The Falls policy is going to be reviewed in the coming months.

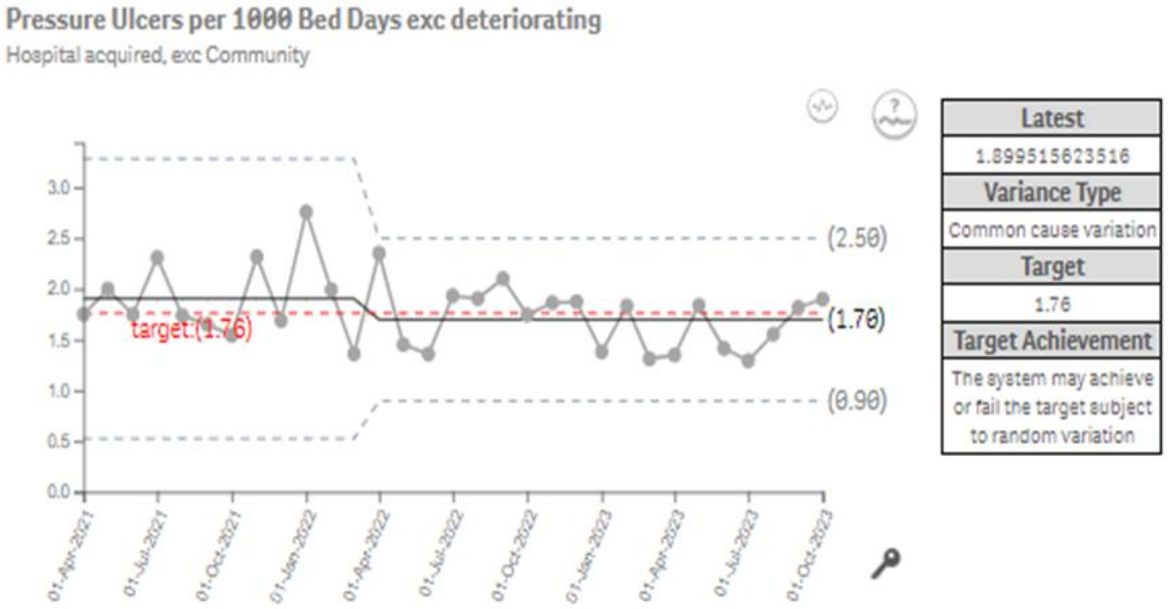
Hospital Acquired Pressure Ulcers per 1,000 Bed Days

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Lindsay Rudge Clinical Lead: Alison Ward Business Intelligence Lead: Charlotte Anderson

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

Target:
10% reduction from 2022/23.



What does the chart show/context:
- The incidence of Hospital acquired PU excluding deteriorating PU.
- The incidence of Hospital Acquired PU for October 2023 was 1.9
- The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month.
- Currently performance can be expected to vary from 0.90 to 2.50

Underlying issues:
- Performance for all inpatient settings in October 2023, according to ward assurance data is 49% for PU risk assessments being completed within 6 hours of admission.
- CQUIN data for Q1 identifies that Criteria 1 (risk assess within 6 hours) requires improvement.
- 3% of CHFT acquired PUs for October 2023 are PUs which have deteriorated, this includes deterioration of PUs originating outside CHFT.

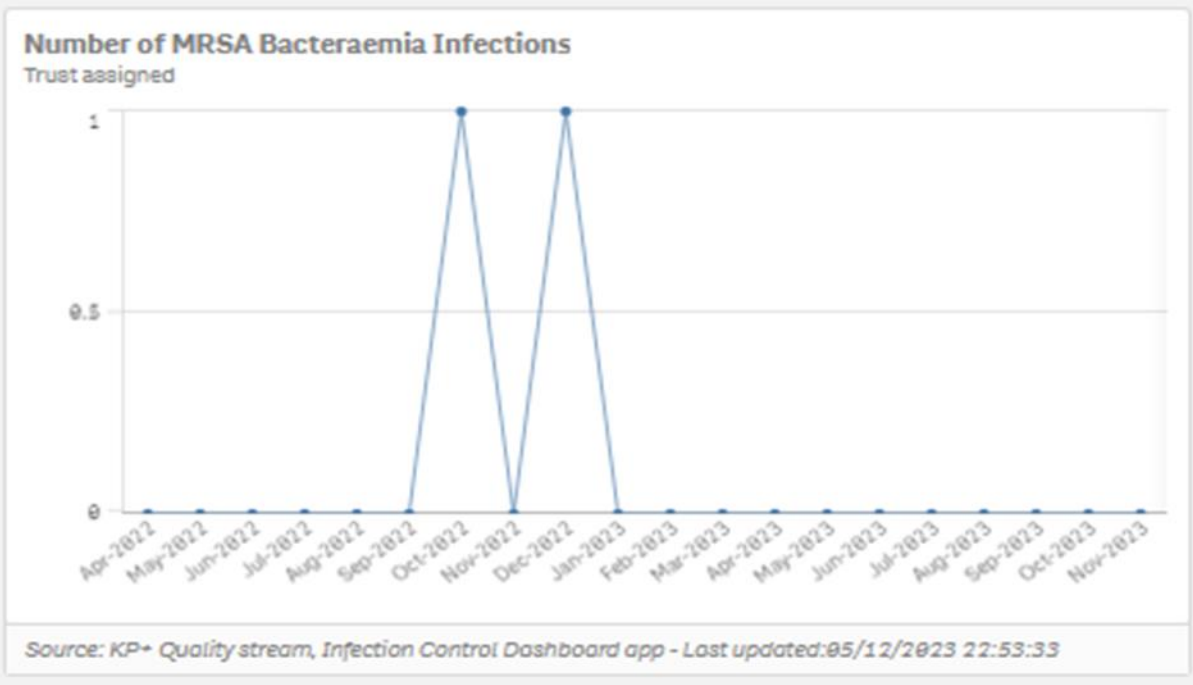
Actions:
- PU risk assessment within 6hrs of admission/ward transfer is now captured on Live Assessment data within KP+.
- The top performing wards for risk assessment compliance are HRI ward 18 at 86%, ward 5 at 84% and CRH ward 7C at 85%. Targeted improvement is planned for the low performing wards.
- Audit of risk assessments planned for December 2023.
- SSKIN bundle review completed, and changes submitted to the EPR clinical analyst in collaboration with BTHFT and Airedale.
- Processes for PU investigations and learning are being reviewed as part of PSIRF.
- After Action Review template for PU is being rolled out across the Medical Division.
- Review of PU Collaborative meeting is ongoing from December 2023.

MRSA Bacteraemia Infections

Executive Owner: David Birkenhead Clinical Lead: Belinda Russell Business Intelligence Lead: Charlotte Anderson

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

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



What does the chart show/context:
- There were no MRSA Bacteraemia case infections in November.
- 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.

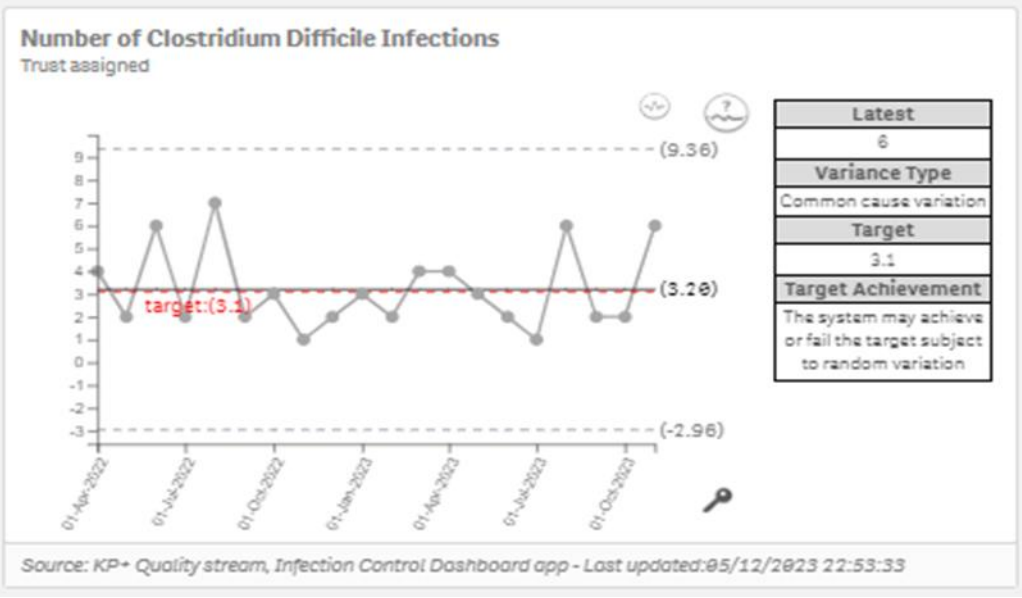
Actions:
- MRSA screening data cleanse has been completed and improvements seen. A further piece of work is underway with FSS to be completed by the end of November.
- Colonisation suppression visual user guides have been provided to patients to ensure correct application.
- Mandatory training to be 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: Charlotte Anderson

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

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



What does the chart show/context:
- There were 6 C.Difficile infection in November.
- The Trust is unable to consistently meet the 3.1 objective and may achieve or fail subject to random variation month to month.
- Currently performance can be expected to vary from 0 to 9.36.
- YTD 2023/24 - 26

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.

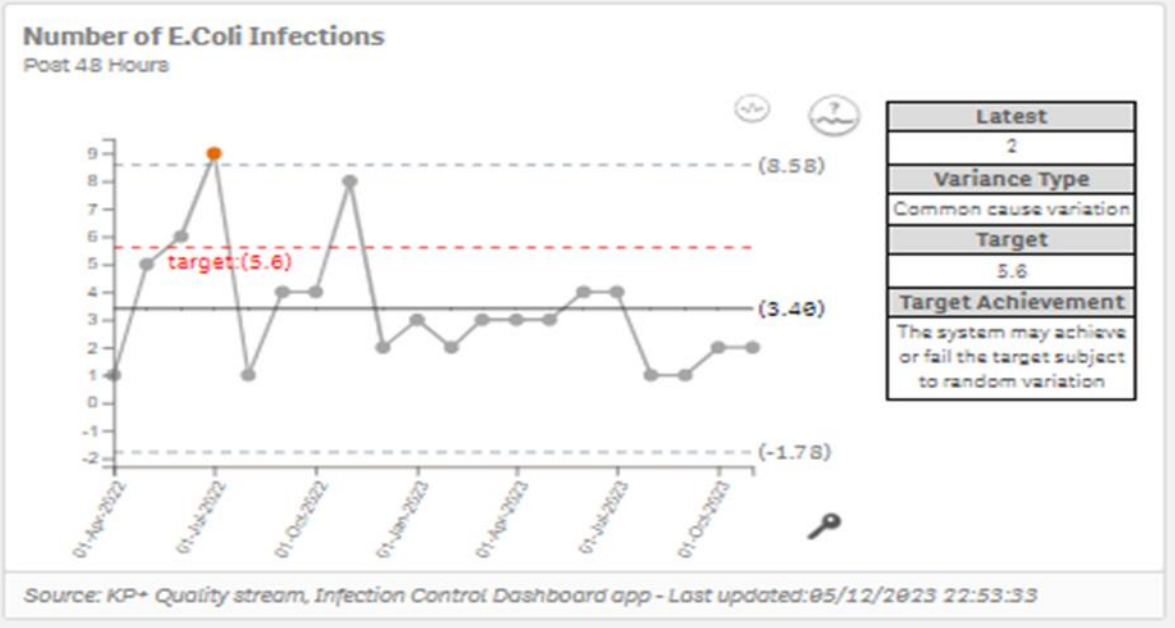
Actions:
- The Trust has implemented an improvement plan including a programme of HPV deep cleaning (to be agreed).
- C.Diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases.
- NHSEI carried out a support visit in March, with positive feedback. Their recommendations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

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

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



What does the chart show/context:
- There was 2 E.Coli infection in November.
- The Trust is unable to consistently meet the 5.6 objective and may achieve or fail subject to random variation month to month.
- Currently performance can be expected to vary from 0 to 8.58.
- YTD 2023/24 – 18.

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.

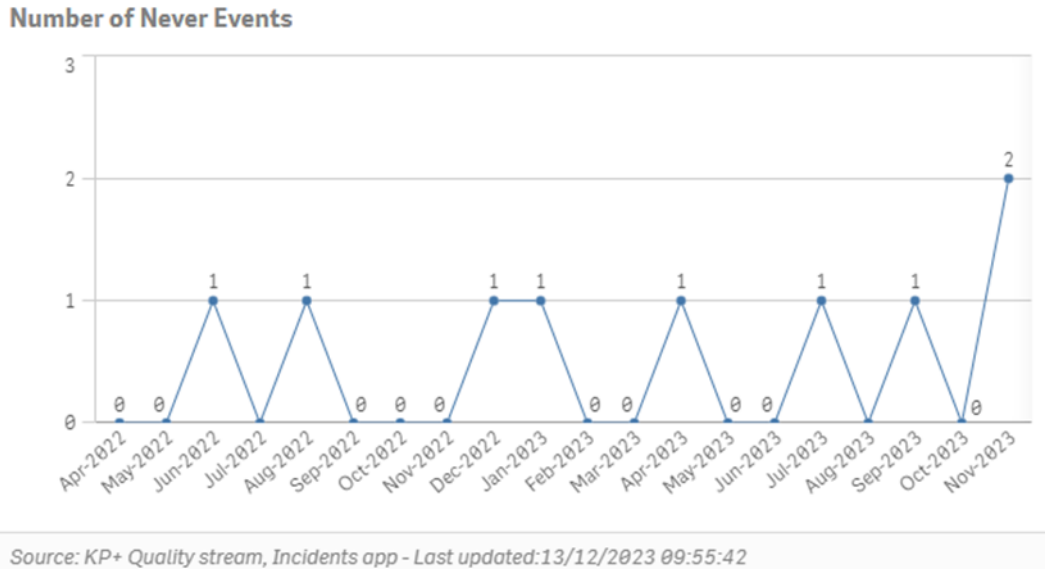
Actions:
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working 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 2 never event reported in November 2023.
- The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month.

Underlying issues:
- Initial learning and actions identified following SWARM huddles.
- Both very different cases however theme captured in relation to training and competencies.

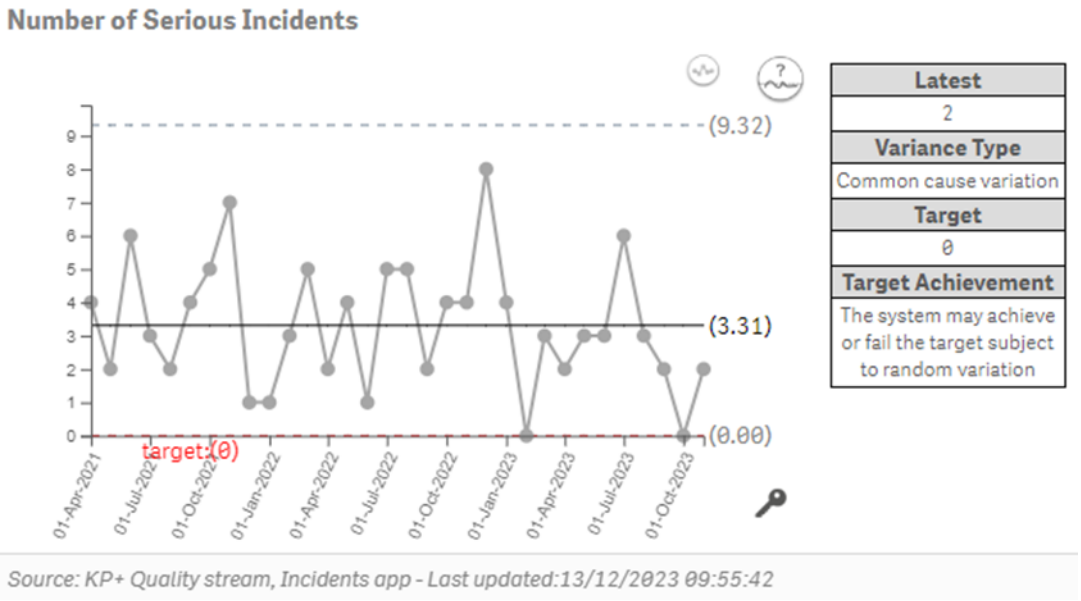
Actions:
- The Trust will continue to hold SWARM huddles as required to ensure learning is identified to keep our patients and staff safe.
- Initial actions completed and SI investigations ongoing.
- Never event notification process is being reviewed.

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 November 2023.
- Currently performance can be expected to vary from 0 to 9.32.

Underlying issues:
- 2 never events reported being investigated as serious incidents.

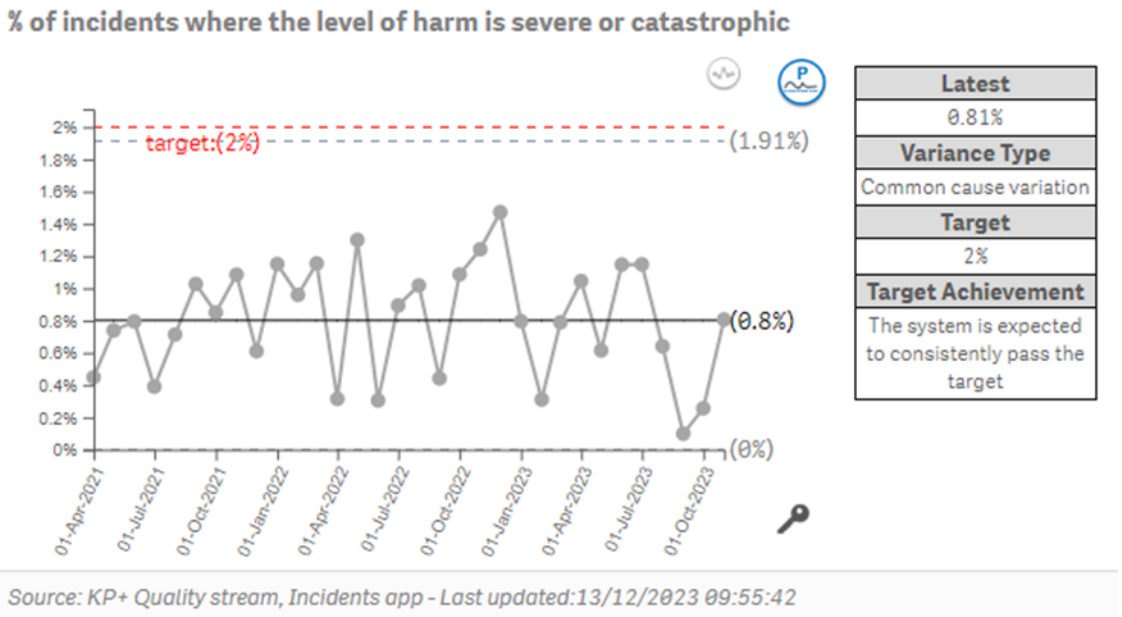
Actions:
- SWARM held to identify learning and immediate actions.
- Them identified relating to training, supervision and competencies – initial actions implemented awaiting investigation outcome for further learning.

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

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

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

Target:
2% or less



What does the chart show/context:
- The percentage of incidents where the level of harm was severe or catastrophic was 0.81% in November.
- The Trust may achieve or fail the target subject to random variation on a month-by-month basis.
- Currently performance can be expected to vary from 0% to 1.91%.

Underlying issues:
- Continue to validate serious incidents through the divisional teams and executive panel.
- Transitioning across to new incident reporting system to support identification of themes and trends.

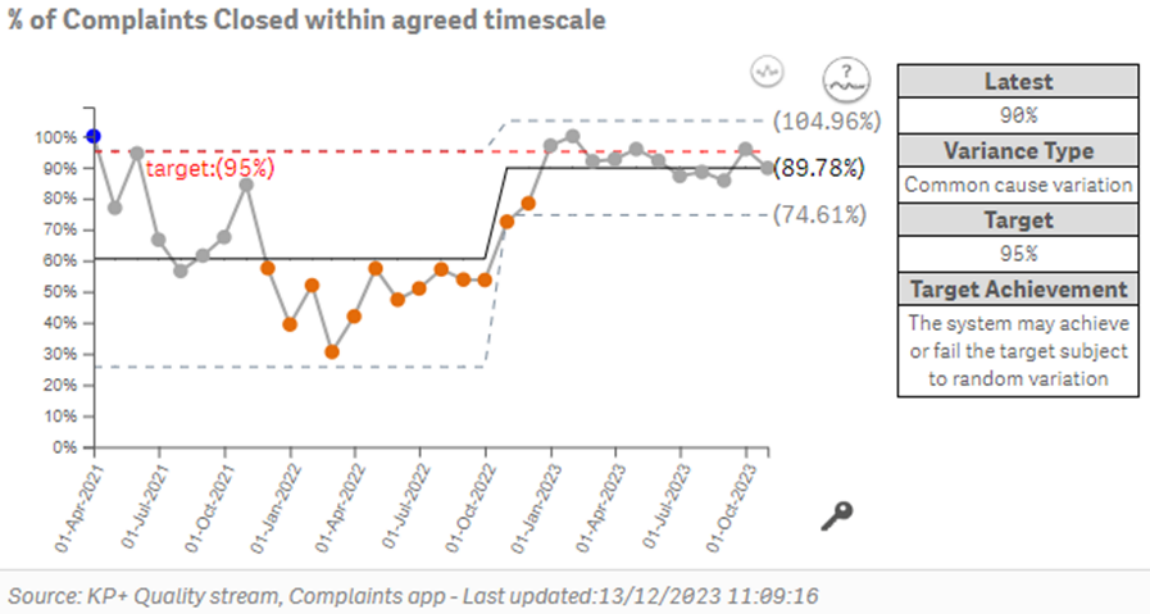
Actions:
- The Quality and Safety team continue to have oversight of all Trustwide incidents to identify themes and organisational learning.
- To continue to monitor the trend within the upper controls limits to ascertain reasons for variation.

% of complaints within agreed timescale

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

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

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



What does the chart show/context:
- In November 90% of complaints were closed within the agreed timescale
- Currently performance can be expected to vary from 74.61% to 100%.
- Performance is subject to common cause variation.

Underlying issues:
- The Trust's target of 95% has not been met this month however 90% is still a consistent and positive performance.
- Operational demands and pressures have taken priority.

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 as this has been particularly challenging.
- Continue to monitor Trust performance daily and meet with Divisions on a weekly basis to maintain oversight of performance.

Quality Priorities:

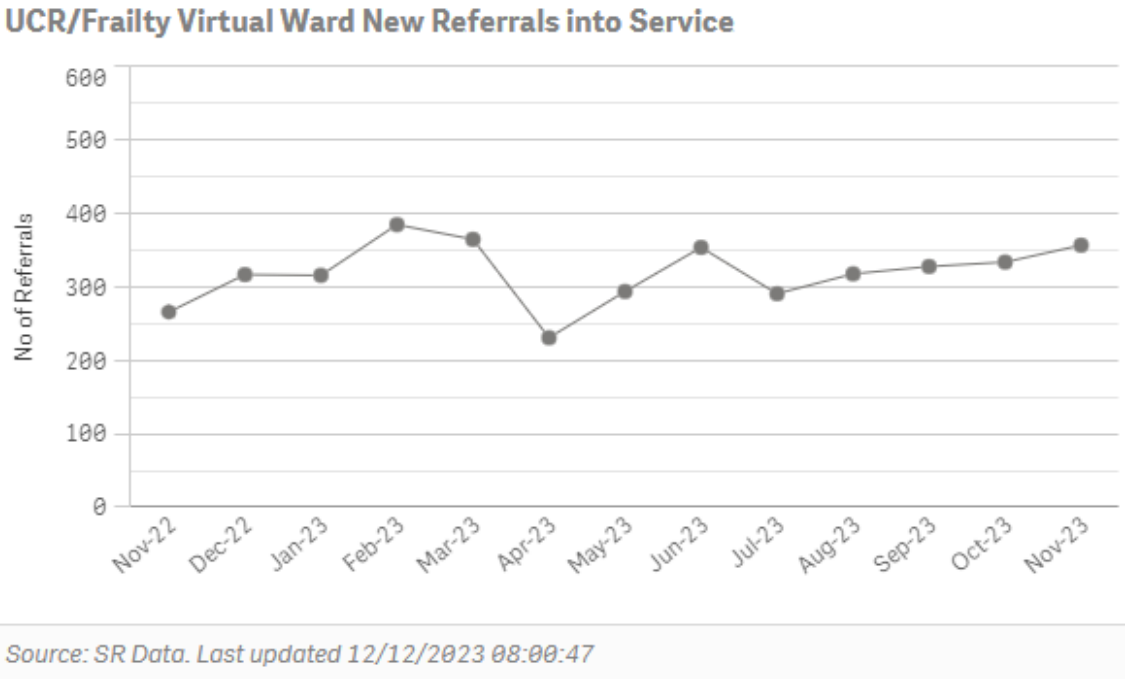
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Alternatives to Hospital Admission – Number of referrals into the Frailty service	November 2023	357	TBC	-	-	-	-	-
% of episodes scoring NEWS of 5 or more going on to score higher	November 2023	34.4%	30%			32.66%	28.66%	36.67%
% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward.	November 2023	81.29%	95%			77.42%	54.71%	100%

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.



What does the chart show/context:
- New referrals into service for the whole Urgent Community Response / Frailty Virtual Ward service.
- Average of 320 per month for all. 357 for November 2023.

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.

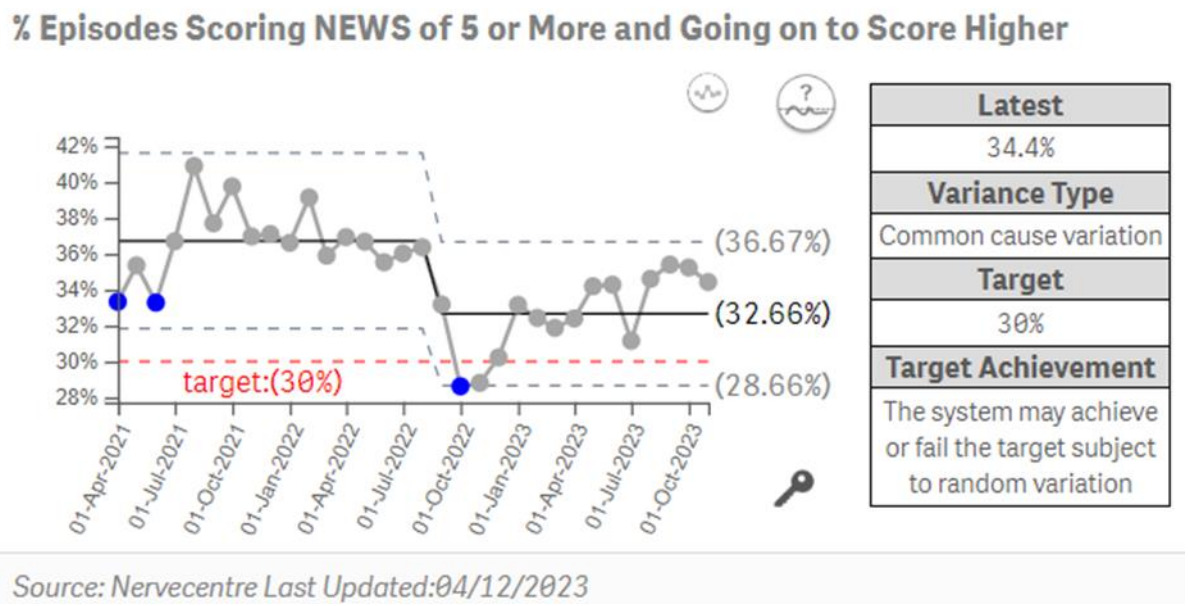
Actions:
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care 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: Lindsay Rudge Clinical Lead: Cath Briggs/Elizabeth Dodds Business Intelligence Lead: Charlotte Anderson

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

Target:
No more than 30% of patients scoring NEWS of 5 or more go on to score higher.



What does the chart show/context:
- Performance was 34.4 % in November.
- The Trust is unable to consistently meet the target of 30% and may achieve or fail subject to random variation.
- Currently performance can be expected to vary from 28.66% to 36.67%.

Underlying issues:
- Doctors do not carry NerveCenter devices "in hours".
- Observations not carried out on time, or failure to escalate appropriately in line with policy or escalations.
- Consideration for ceiling of care and resuscitation decisions are not always documented.
- Data is not regularly reviewed by ward areas.
- No identified lead nurse for deteriorating patient.

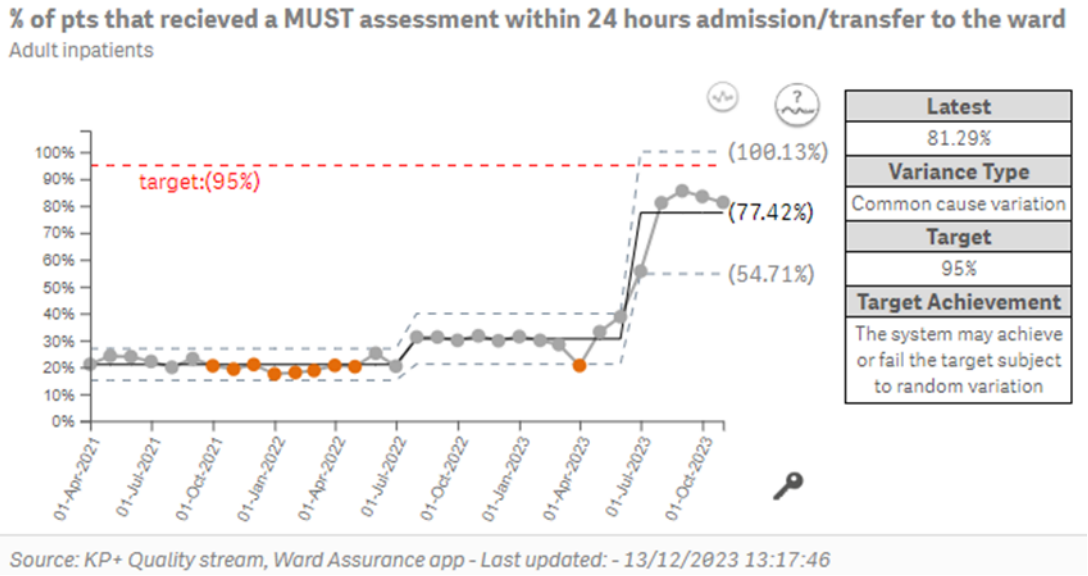
Actions:
- A new dashboard is being developed to ensure data is available easily – now available on KP+.
- A snapshot review of patients' records is being undertaken - any further actions to be fed through Deteriorating Patient & Sepsis collaborative at December 2023 meeting.
- Deteriorating Patient CQUIN audit focusing on NEWS2 records and escalations for patients with unplanned admissions to critical care. This will highlight any further actions to be fed through Deteriorating Patient & Sepsis collaborative. This will be presented quarterly.
- As more data becomes available and learning from the above audit comes to light, further actions will be identified within the workstream.

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 November performance was 81.29%.
- Performance is in common cause variation and improvements are being sustained.
- Currently performance can be expected to be between 54.71% and 100% and therefore may achieve or fail the target subject to random variation.

Underlying issues:
- Continuing to work through the identified actions from the never events.
- Food and drink strategy delayed due to medical photography not able to support.
- NGT policy awaiting sign off from the nursing and midwifery expert group.
- MUST assessment training compliance has improved and is now at 73.7%.
- MUST assessment completion within the first 24 hours of a patient's admission remains stable at 83.45%, this needs to be at 90% by December and 95% by the end of January.

Actions:
- There needs to be a continued push on the MUST assessment completion and training. This will be a focus for the month of December and will include walk rounds, posters and screen savers.
- Food and Drink Strategy is in the process of completion.
- NGT policy has been sent for approval.
- The group have developed a MUST dashboard on KP+ to aid compliance with the MUST assessments. This is working really well and we have seen significant improvements.
- The training compliance for NGT is now visible on KP+ and health roster to assist the ward managers and matrons to monitor compliance.
- A trial of a new CO2 pod has been completed on ward 17 and Stroke floor successfully (CO2 pod is a device that is used to confirm the placement of an NGT), this will not replace the PH & NEX check but would be an additional safety measure.

Health Inequalities: Learning Disabilities

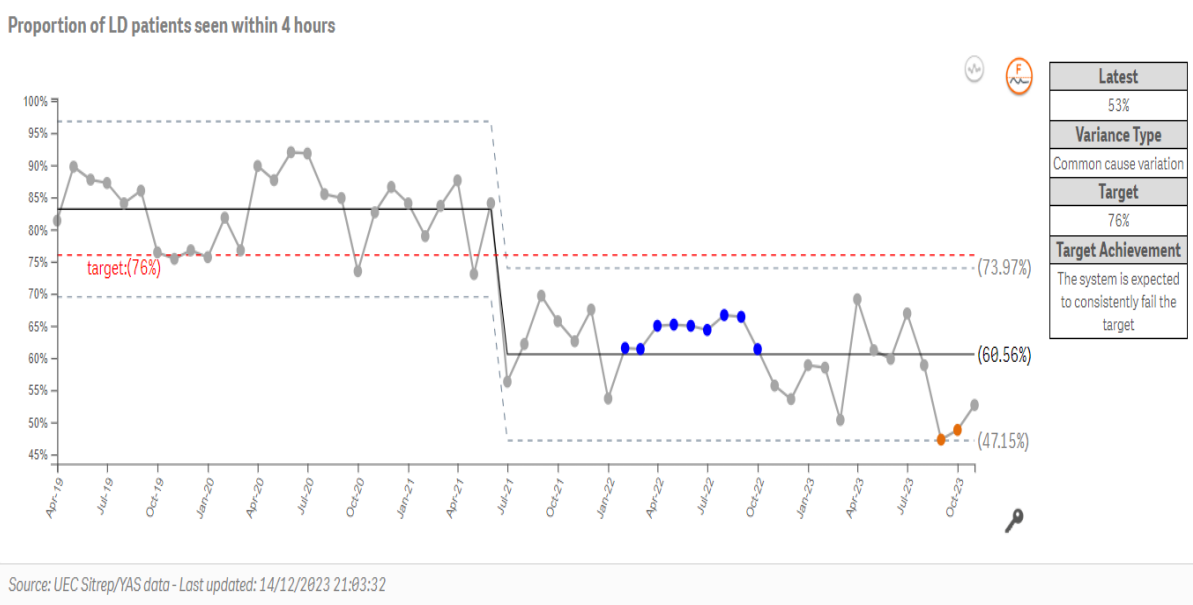
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Emergency Care Standard	November 2023	50%	76%			61%	47%	75%
Outpatients DNAs	November 2023	8.7%	3%			9.01%	3.08%	14.93%
Cancer Faster Diagnosis Standard	November 2023	83.3%	75%			63%	0%	100%
% of patients waiting less than 6 weeks for a diagnostic test	November 2023	81.1%	95%			87.38%	73.87%	100%
Patients waiting more than 40 weeks to start treatment	November 2023	3	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 November was 53% which is considerably lower than the overall Trust 4-hour standard.

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 LD 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.

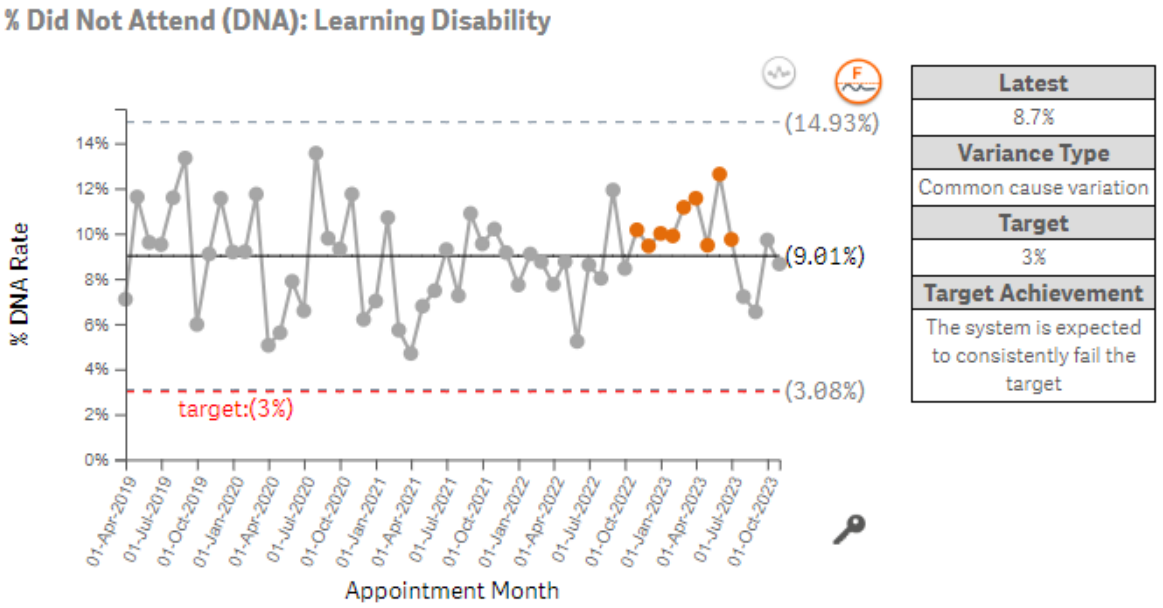
Actions:
- Results from audit to be taken to PSQB for discussion and agreement on any required actions

% Did Not Attend (DNA): Learning Disability

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

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

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



Latest
8.7%
Variance Type
Common cause variation
Target
3%
Target Achievement
The system is expected to consistently fail the target

What does the chart show/context:
- The current DNA rate for appointments for patients with a Learning Disability improved in November 2023 and stands at 8.7%.
- 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 6.9% for November 2023.

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.

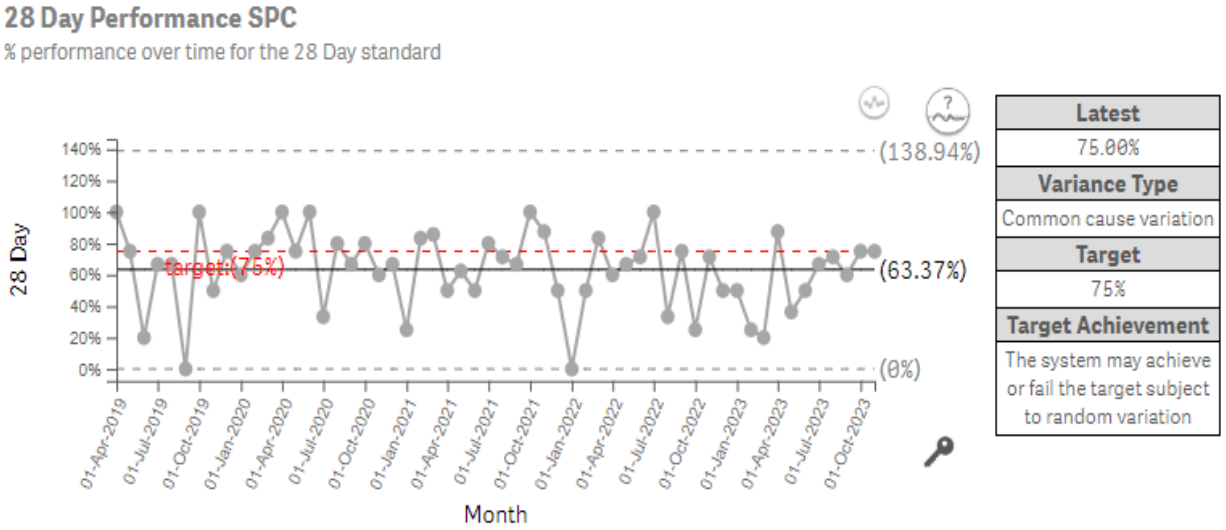
Proportion of patients meeting the faster diagnosis standard: Learning Disability

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 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:
- Audit of patients to understand reasons for high level of breaches to be done January/February 2024.

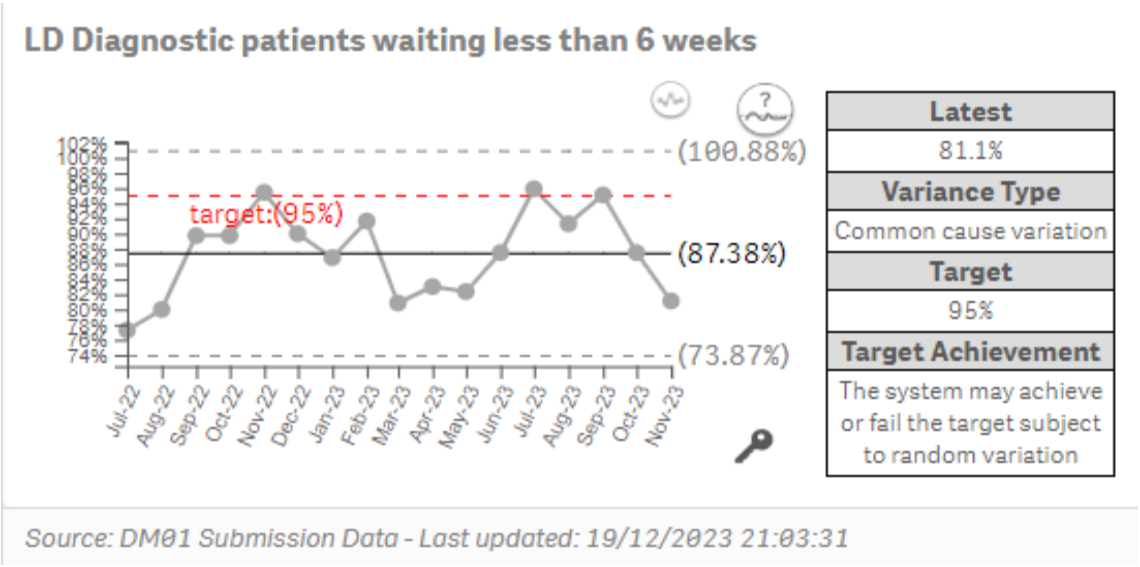
Percentage of patients waiting less than 6 weeks for a diagnostic test: Learning Disability

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 81.1% which does not meet the NHSE target of 95%. In-month performance is in line with in-month CHFT overall performance which is 82%.
- 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.

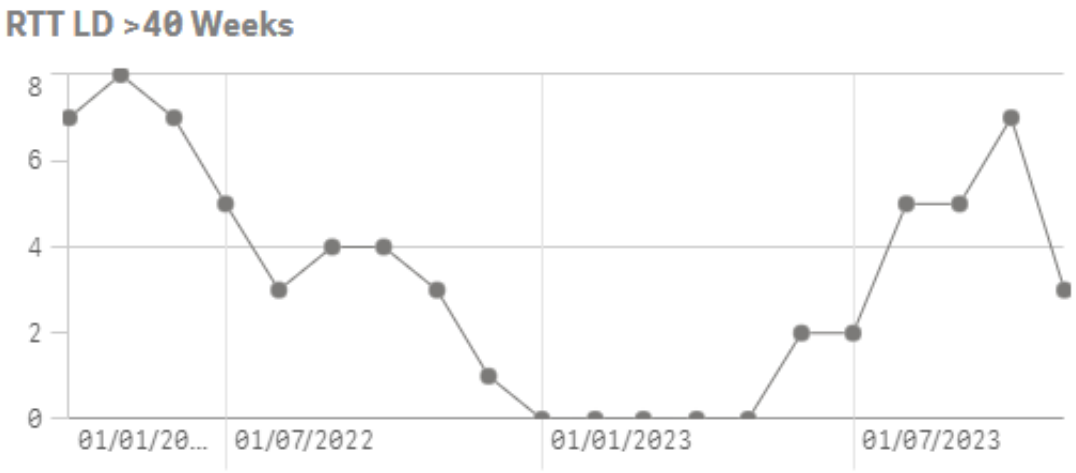
Actions:
- Audit Learning Disability breaches to check no other reasons for breaches other than capacity – to be done January/February 2024.

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

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

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

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



Source: RTT Incomplete Waiting Times - Last updated: 20/12/2023 16:20:35

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 patient with a Learning Disability who have waited more than 40 weeks

Underlying issues:
- Learning Disability patient performance reflects CHFT performance

Actions:
- None required

Health Inequalities: Deprivation (IMD 1 and 2)

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Emergency Care Standard	November 2023	64.8%	76%			72%	65%	78%
Outpatients DNAs	November 2023	9.9%	3%			9.61%	8.08%	11.15%
Cancer Faster Diagnosis Standard	November 2023	79.8%	75%			75.86%	63.01%	88.71%
% of patients waiting less than 6 weeks for a diagnostic test	November 2023	79.9%	95%			86.92%	73.04%	100%
Patients waiting more than 40 weeks to start treatment	November 2023	290	0			-	-	-

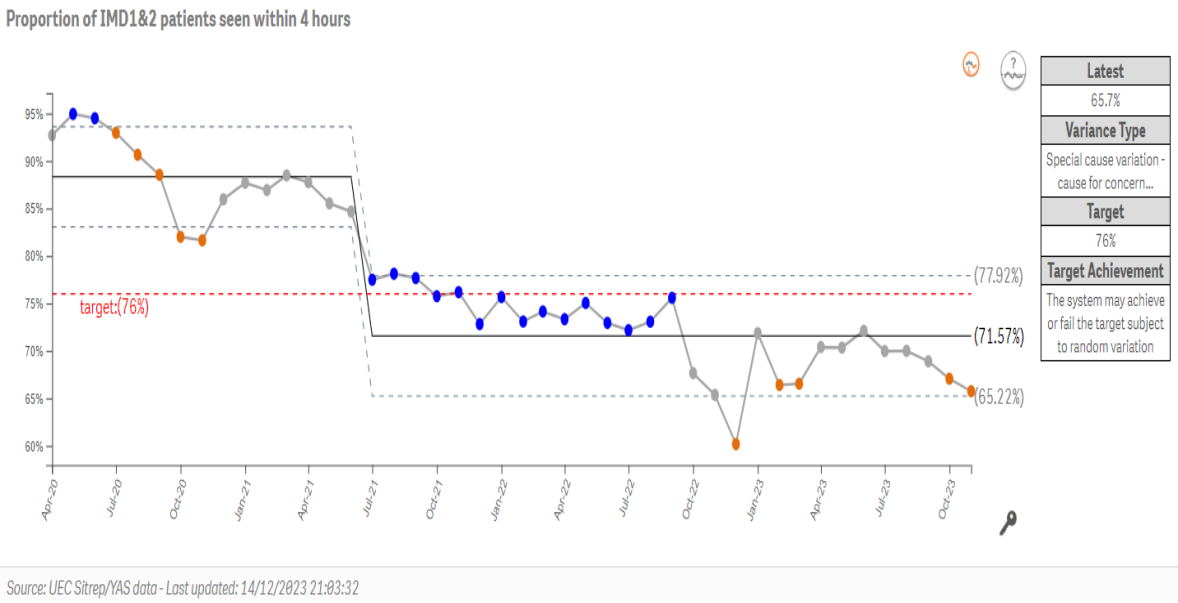
Emergency Care Standard: Deprivation (IMD 1 and 2)

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 November 65.7% which is in line with the overall Trust performance for all ED attendances.

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

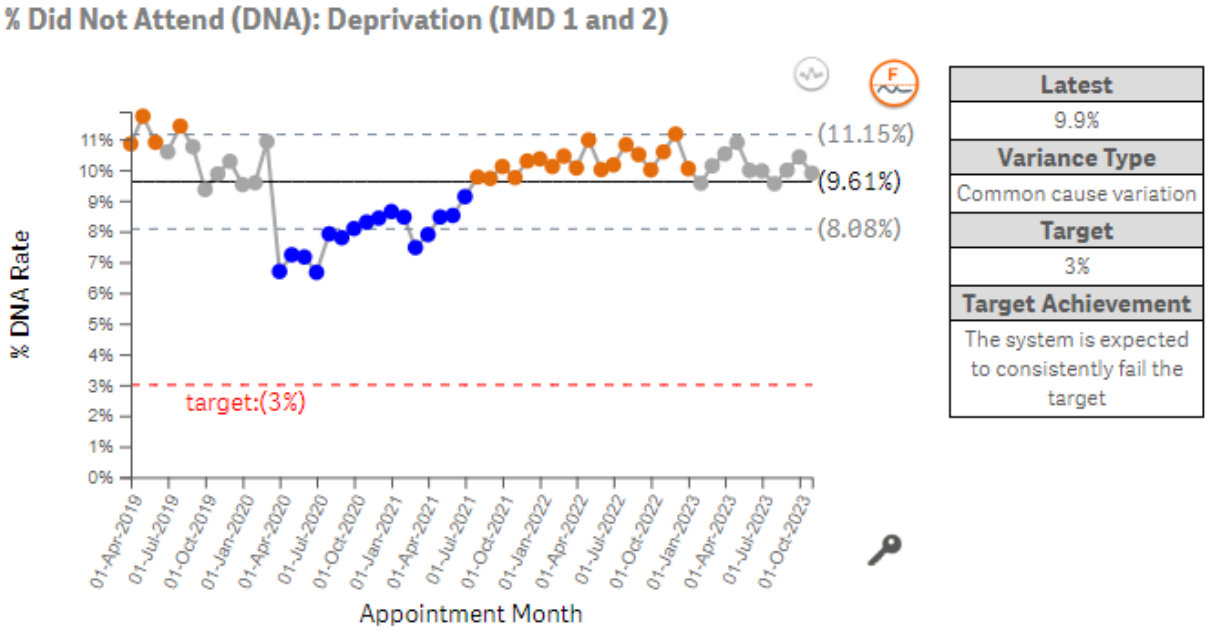
Actions:
- Recruitment into Medical WFM at interview stage, 3 locum consultants appointed.
- Evenings into nights is problematic and breach review identifies poor skill/seniority mix in employed medical workforce. Now addressed with 2 ST4+ on nights and evening consultant staying on until department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

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

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

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

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



Latest
9.9%
Variance Type
Common cause variation
Target
3%
Target Achievement
The system is expected to consistently fail the target

What does the chart show/context:
- The current DNA rate for appointments for patients from the IMD 1 and 2 groups stands at 9.9% for November 2023.
- 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 6.9% for November 2023.

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

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.

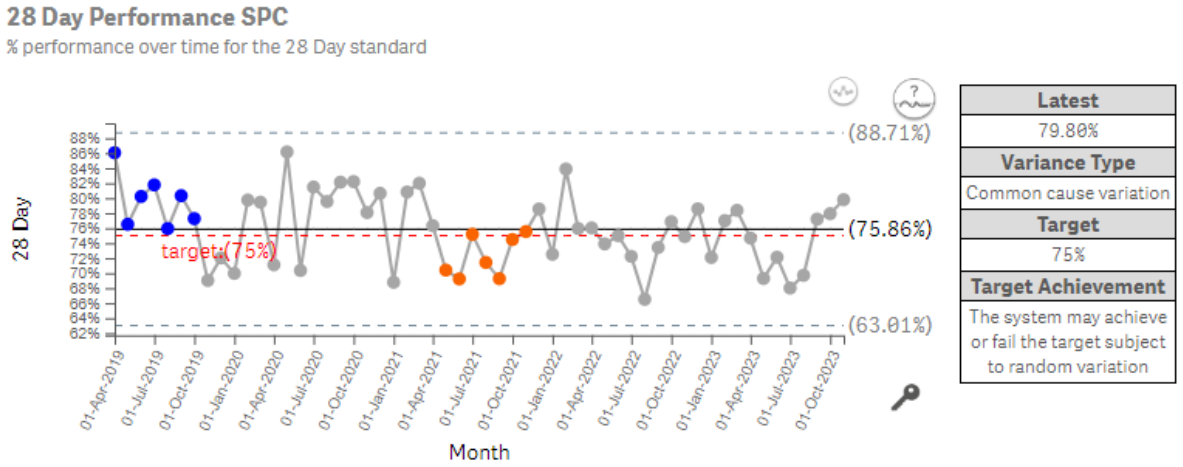
Proportion of patients meeting the faster diagnosis standard: Deprivation (IMD 1 and 2)

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Maureen Overton Business Intelligence Lead: Rebecca Spencer

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

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



What does the chart show/context:
- Latest monthly performance stands at 79.8% which is above the NHSE target. Performance for this group of patients is about the same as 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.

Actions:
- Skin have reverted back to their face-to-face clinics; Skin and the overall 28-day target has improved as a result.

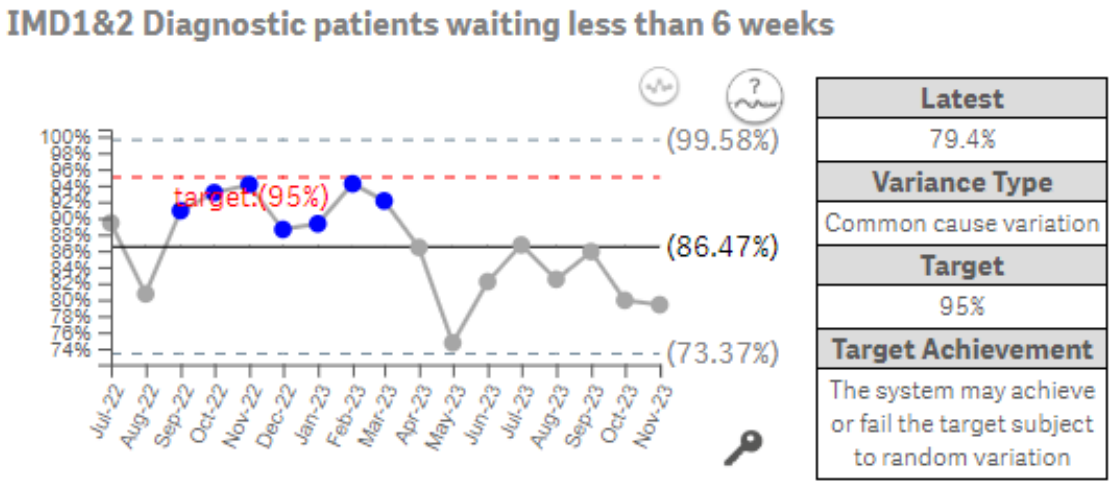
Percentage of patients waiting less than 6 weeks for a diagnostic test: Deprivation (IMD 1 and 2)

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: 19/12/2023 21:03:31

What does the chart show/context:
- Latest monthly performance stands at 79.4% which is below the NHSE target and CHFT performance.
- 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 73.37% 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.

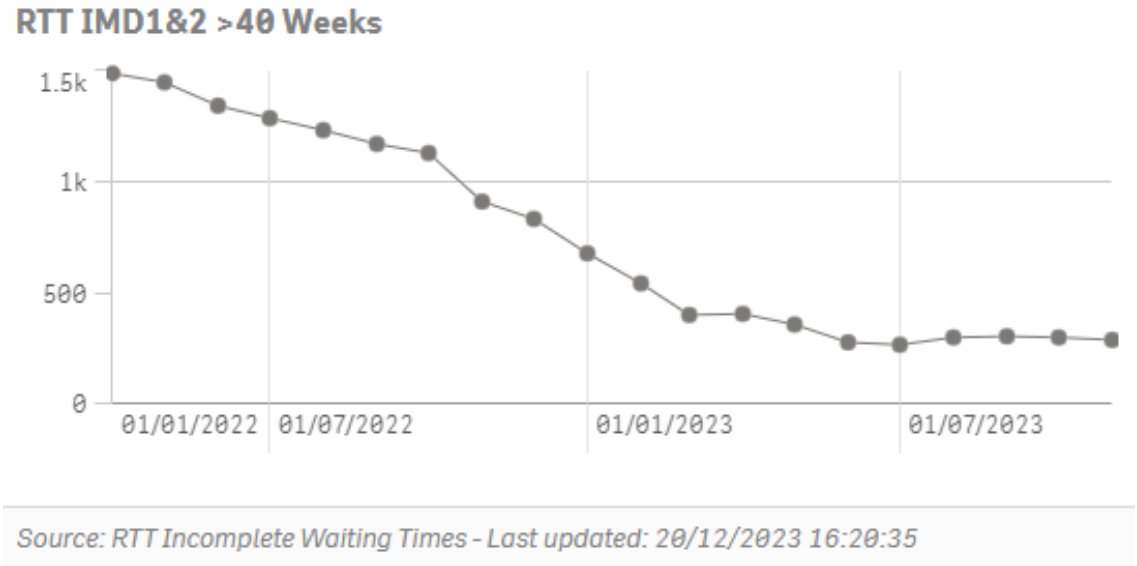
Total Patients waiting more than 40 weeks to start consultant-led treatment: Deprivation (IMD 1 and 2)

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Thomas Strickland Business Intelligence Lead: Mark Butterfield

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

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



What does the chart show/context:
- This chart shows the number of patients on the RTT Incomplete Pathways list who have been waiting more than 40 weeks to start treatment.
- The aim is to show progress towards 0 patients waiting more than 40 weeks by January 2024 (internal target).
- Our 40-week position has been reducing rapidly between April 2022 and April 2023 and has since started to level out.
- We are now down to 290 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.
- 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:

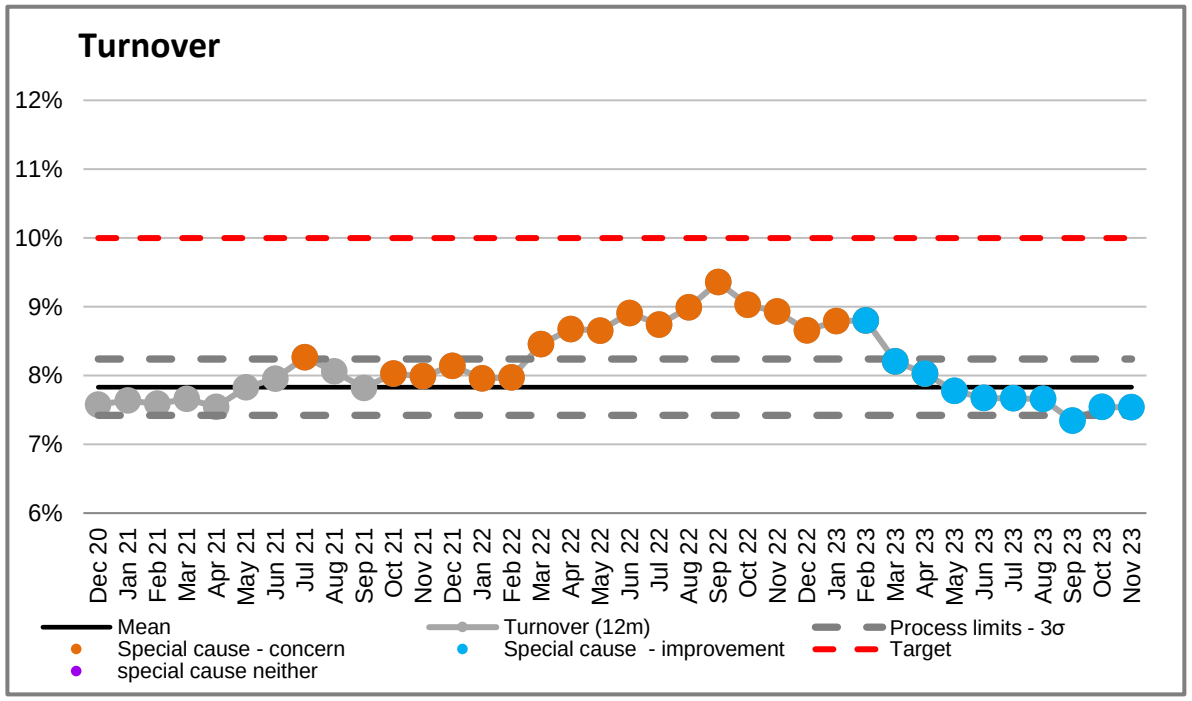
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	November 2023	7.54%	10.0%			7.83%	7.42%	8.24%
Sickness Absence (Non-Covid)	November 2023	4.80%	4.75%			4.83%	4.19%	5.46%
Appraisal Compliance (YTD)	November 2023	73.53%	95.0%	-	-	-	-	-
Core EST Compliance	November 2023	94.34%	90.0%			92.96%	91.87%	94.04%
Bank Spend	November 2023	£3.53M	-			£3.19M	£1.54M	£4.85M
Agency Spend	November 2023	£0.80M	£0.53M			£0.88M	£0.58M	£1.18M

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: 7.54%**



What does the chart show/context:
- The Trust's turnover ceiling has been reduced from 11.5% to 10.0% to reflect the consistently low turnover rates.
- 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 with 7.54%.
- Turnover has shown a downward trend between February-September 2023 and has remained below the mean average from May 2023 to present.
- The Trust benchmarks well against other WYAAT organisations.

Underlying issues:
- Directorates with turnover above the 10% ceiling include FSS Management (19.4%), Outpatients and Records (15.1%), and Pharmacy (14.3%).

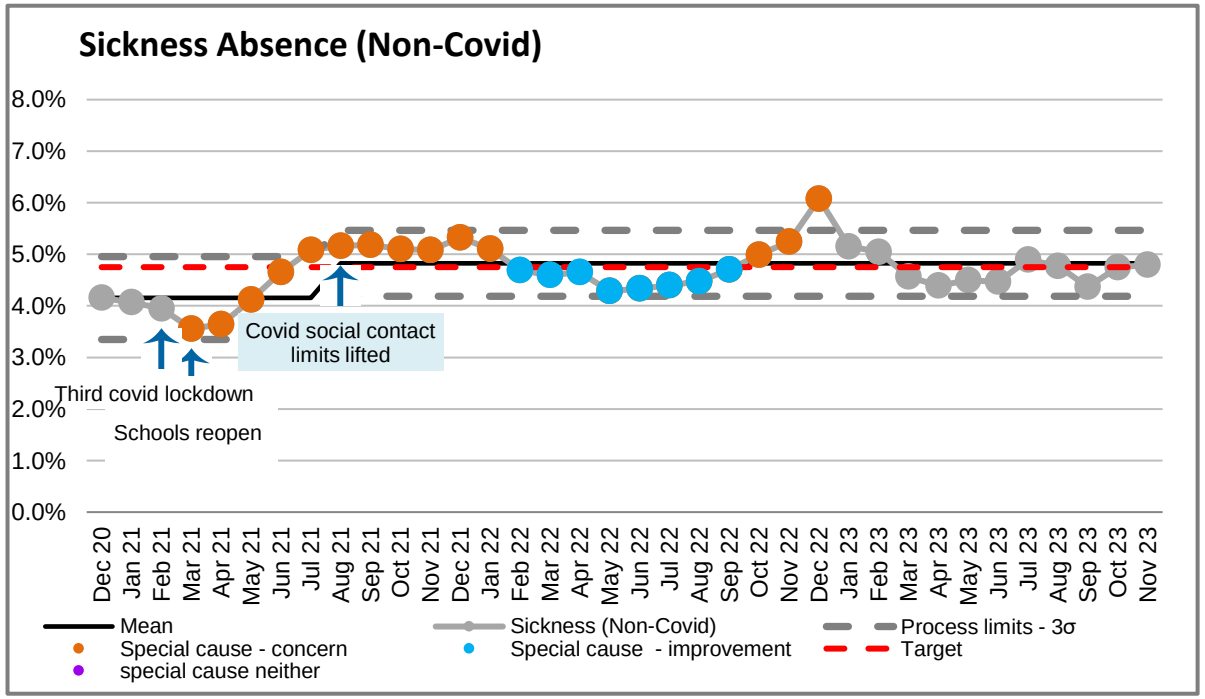
Actions:
- A Colleague Retention Programme paper was presented at Workforce Committee on 18th December 2023.
- Turnover data is reviewed in the Workforce and OD Directorate bi-monthly Workforce Monitoring meeting.
- HRBPs will work with any hotspots identified to work through any issues.

Sickness Absence (Non-Covid)

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

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

Target: 4.75%	**Current:**	**Total**	**4.80% (in month)**	**4.81% (12m)**
		Long	**2.68% (in month)**	**3.06% (12m)**
		Short	**2.12% (in month)**	**1.76% (12m)**



What does the chart show/context:
- The mean and target for absence are very similar causing compliance to be hit and miss on a monthly basis.

Underlying issues:
- Top 3 reasons for sickness in November 2023 – Anxiety/Stress/Depression, Gastrointestinal Problems and Cold, Cough, Flu - Influenza

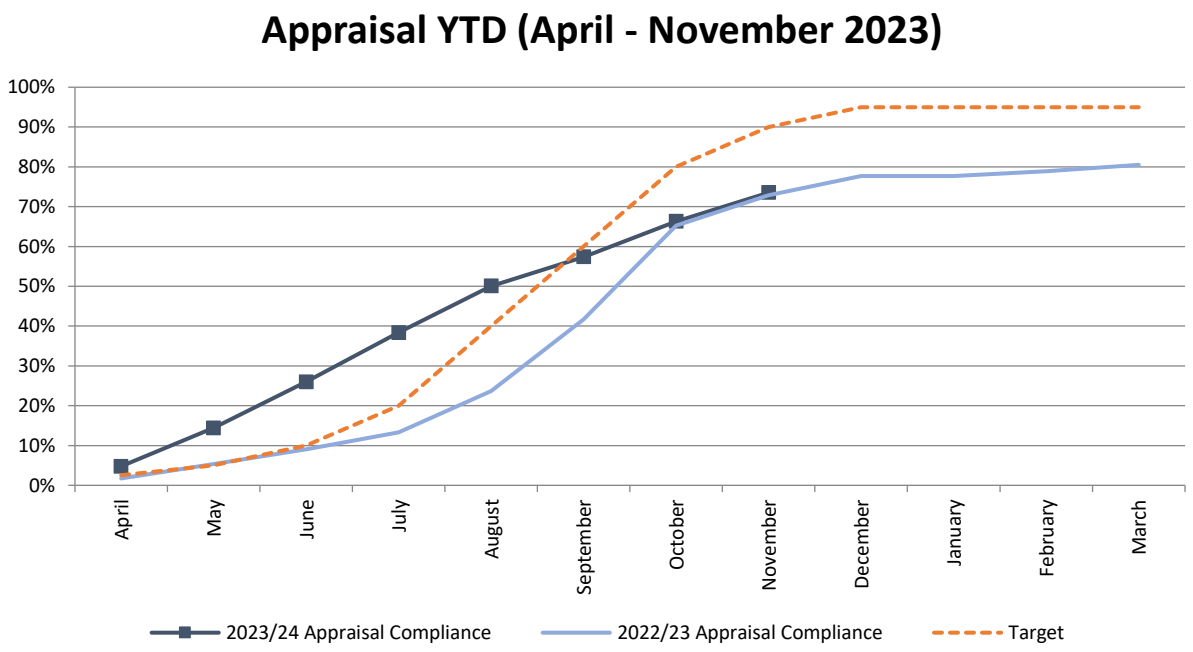
Actions:
- Winter vaccination is underway with ongoing promotion within divisions with the aim of reducing colleagues becoming seriously ill with chest and respiratory issues over the winter months.
- Work continues within hotpots for age/gender group to reduce absences, identify and themes or trends and options for supporting colleagues.
- Promotion of self-referral physio provision for all MSK absences. Reporting in place to triangulate where absences prevented/reduced in length as a result of MSK intervention.
- Continued promotion Menopause policy and support available.
- HRBPs working closely with the Workforce Psychologist to ensure all support on mental health issues are available to colleagues with clear pathways to access services.
- Exploring the possibility of Health MOTs for colleagues given the high level of absences in the 50+ age group of colleagues.
- HRBPs working with divisions to hold appropriate deep dives into hotspot areas. HR Team holding monthly meetings to discuss every long-term absence case and ensure an appropriate management plan is in place.
- Absence data to be presented at Executive Board meeting on a regular basis to ensure focus on reducing the level of absence.
- Management guidance developed to support manager with reasonable adjustments and how to utilise Access to Work for colleagues with underlying health conditions or a disability.

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), 90.0% (in month) **Current: 73.53% (in month)**



What does the chart show/context:
- Total compliance where Appraisals have been completed in the current appraisal season.
- Appraisal compliance has continued to be below the in-month planned position at 73.53%.
- Appraisal compliance is performing just above the rate of the previous year at the same point in time.
- It is unlikely the Trust will achieve its target of 95% appraisals by the end of December 2023.

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.

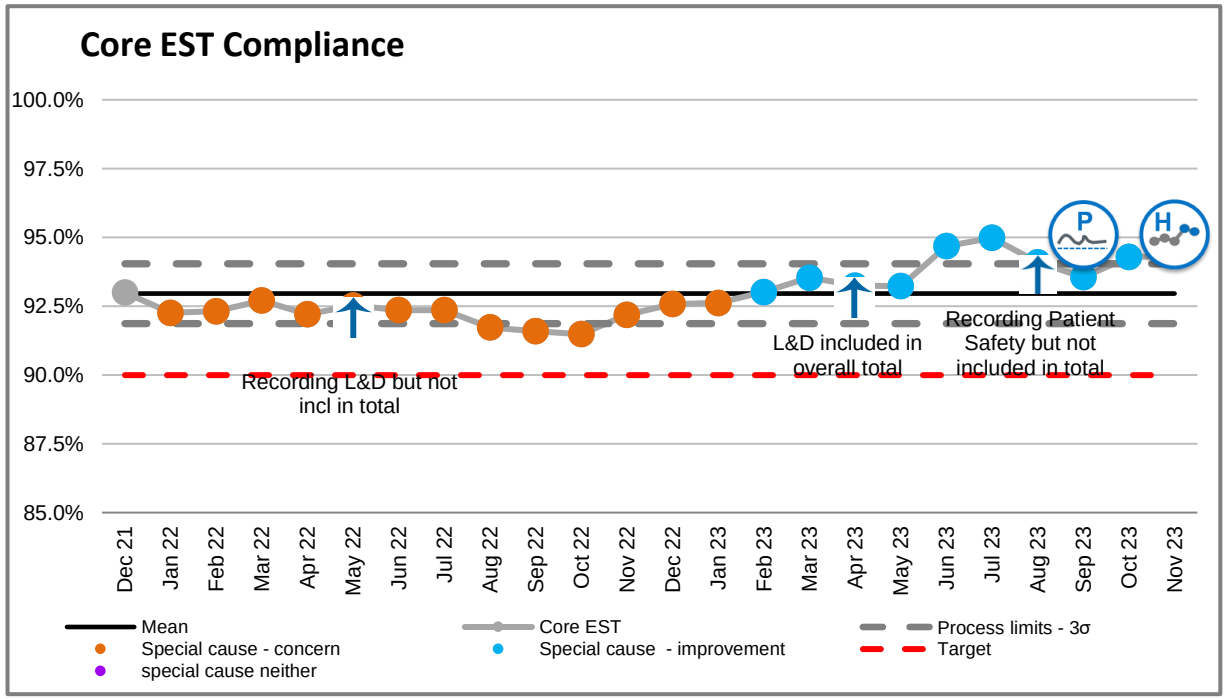
Actions:
- ‘How to’ guide to appraisals video now available as part of our management fundamentals offer, to make it a more people centred conversation.
- New to manager programme launch features appraisals in content
- ESR recording guidance produced to support managers to ensure all activity is captured.
- Targeted approach to support hot spot areas including Connect & Learn sessions (managers and appraisee’s guides) to improve the quality of conversations.
- Connect & Learn sessions ongoing with recent session attended by 25 managers on 31st August 2023, 58 attendees in October and 41 attendees in November. Additional sessions planned.
- 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: 94.34%**



What does the chart show/context:
- The Trust is consistently achieving the 90% target; however the EST compliance is slightly under the 95% stretch target at 94.34%
- Compliance in November 2023 remains above the mean and above the process limits indicating further special cause improvement
- From April 2023 Learning Disability Awareness is now included in the overall EST compliance rate

Underlying issues:
- No current issues.

Actions:
- Compliance rates are shared with Directorates on a weekly basis.
- Enhanced divisional accountability.
- Local campaigns to focus on mandatory learning in divisions.

Bank Spend

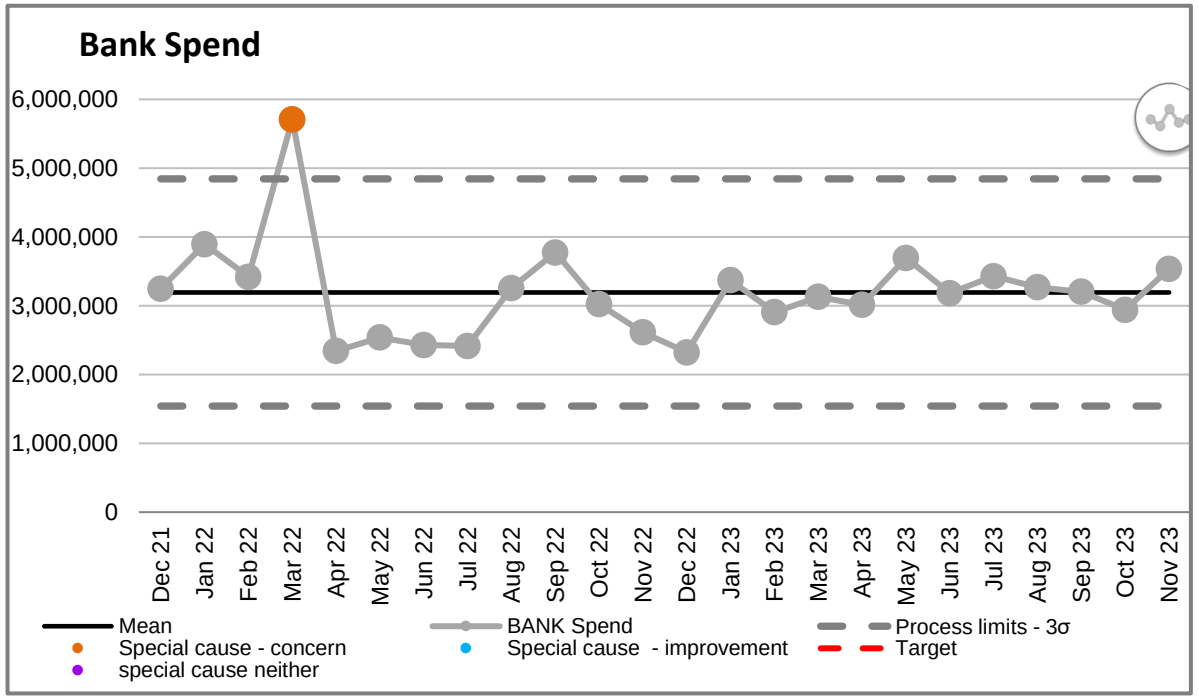
Executive Owner: Suzanne Dunkley Bushby

Lead: Samuel Hall

Business Intelligence Lead: Mark

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: £3.53M



What does the chart show/context:

- From April 2022 bank spend is following common cause variation, since January 2023 bank spend is on or near the mean
- 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 and May 2023
- Bank spend is currently £3.53m in November 2023, an increase from £2.94m in October

Underlying issues:

- There is a reliance on bank usage to cover unplanned unavailability and to support the recovery programme.
- There is also a dependency on Bank to support the running of extra capacity areas that flex open and closed.
- Increase in Bank spend due to opening of multiple extra capacity areas to manage flow.

Actions:

- Plans being developed to operationalise transition out of 20% premium for Nursing and ODP colleagues.
- Medical Bank and Agency spend reviewed and regular Agency users to be sent to divisional colleagues to confirm plan to remove/recruit to positions.

Agency Spend

Executive Owner: Suzanne Dunkley Bushby

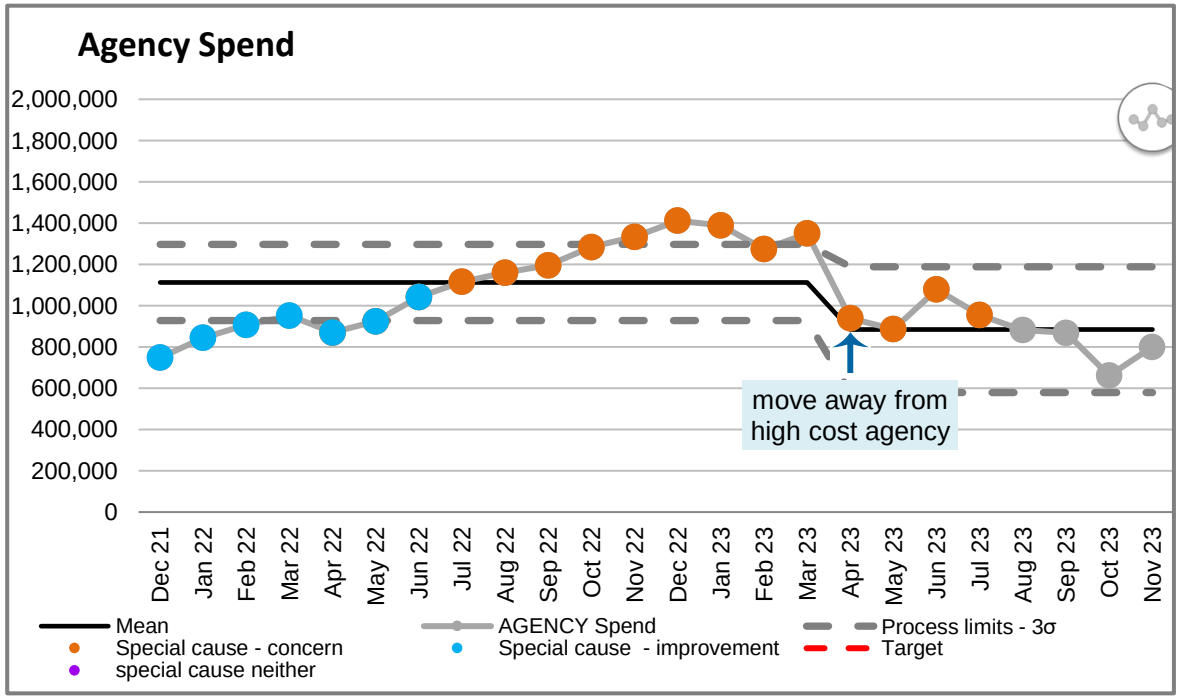
Lead: Samuel Hall

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: £0.80M



What does the chart show/context:

- There had been an increasing trend in monthly Agency spend from April 2022 with a peak in December 2022.
- 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 August 2023.
- Spend in November at £0.80m.

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.
- Volume of shifts cascaded to agency still remains high.
- Step up in agency usage in November due to extra capacity areas flexing open when required.

Actions:

- Nursing Agency lead time reduced to 21 days in October 2023.
- 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).
- Director approval is required for all agency usage.
- Long-term Medical Agency usage to be reviewed in January 2024 with MDO colleagues.

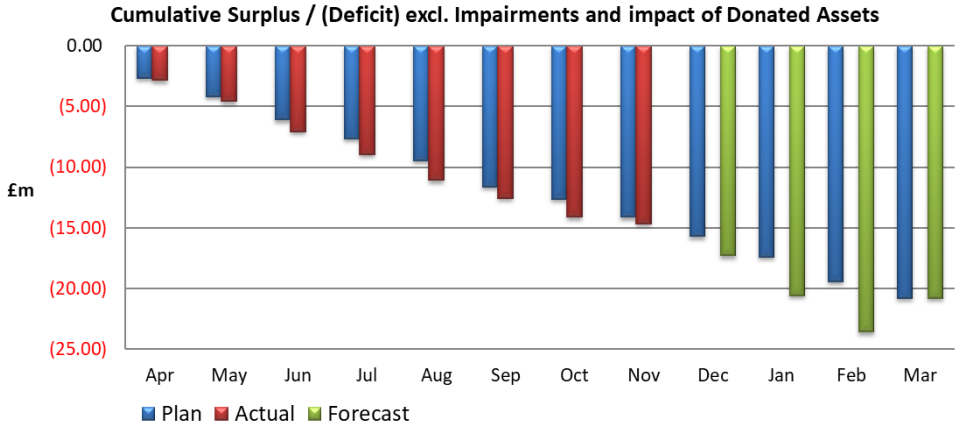
Finance:

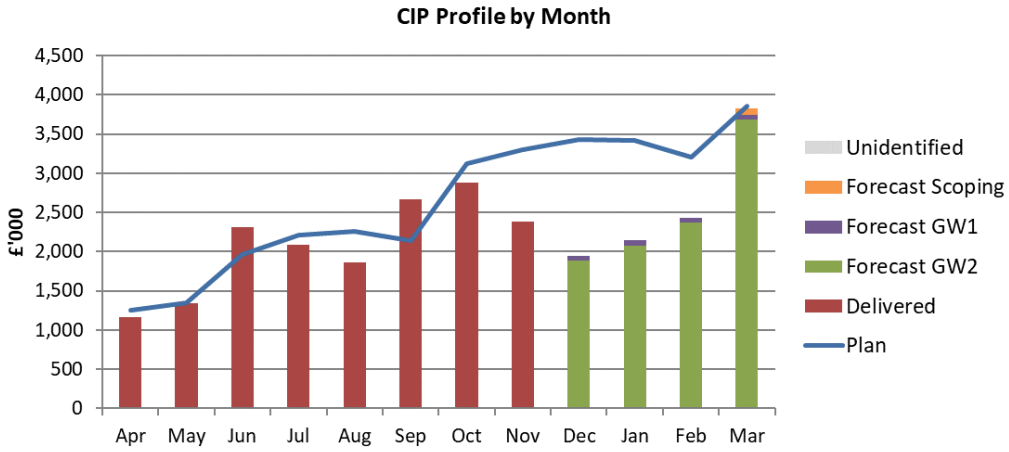
- Cumulative Surplus
- CIP Profile
- Capital Spend
- Cash Balance

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 £14.66m, a £0.54m adverse variance from plan. The forecast is to deliver the £20.80m deficit as planned.
- The Trust has delivered efficiency savings of £16.70m year to date, £0.89m lower than planned, and is forecasting a £4.4m shortfall in delivery of CIP.

Underlying issues:

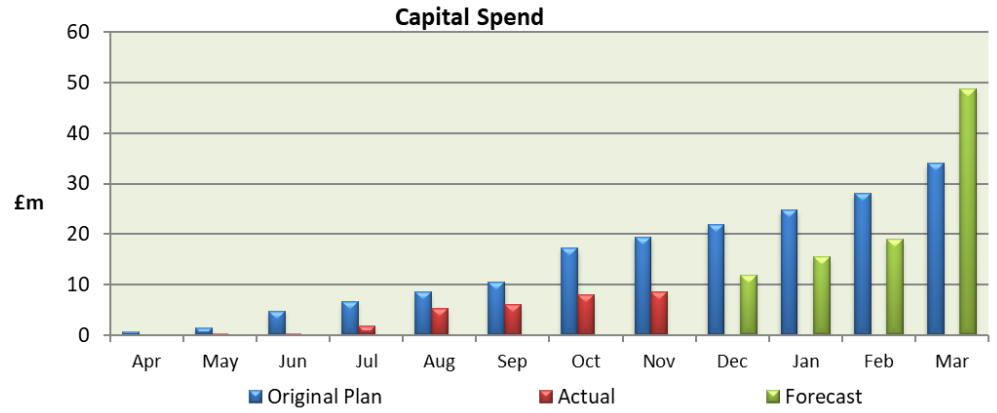
- Key drivers of the adverse variance included: higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £3.49m pressure due to impact on associated efficiency plans and surge capacity; Strike costs; and non-pay inflationary pressures. These pressures were offset by early delivery of other efficiencies and higher than planned commercial income. YTD Strike costs of £2.1m have now been funded.
- 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 are £4.4m slippage on efficiencies, non-pay inflationary pressures, additional bed capacity and £0.7m forecast Strike costs. The forecast improved by c.£3.5m this month due to the allocation of £2.1m funding for Strike costs and a further £1.6m of Elective Recovery funding expected due to Recovery performance.

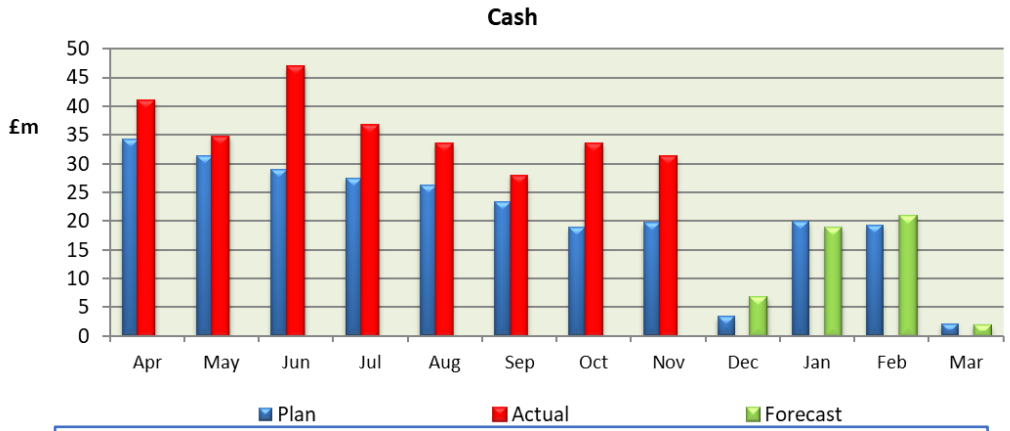
Actions:

- Further opportunities and potential mitigations are currently being considered at both Trust and System level with the aim of closing the remaining 'likely case' gap.

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 £8.51m on Capital programmes year to date, £10.96m lower than planned. Capital Forecast is to spend £48.81m, £14.80m more than planned: including additional Public Dividend Capital (PDC) funding awarded to support the Community Diagnostic Centre and HPS expansion; and an increased capital allocation for Reconfiguration. At the end of November, the Trust had a cash balance of £31.31m, £11.53m higher than planned. Use of Resources (UOR) stands at 3, as planned, with all metrics as planned.

Underlying issues:

- The Capital underspend is due to delays in the Pharmacy Robot project, HRI Reconfiguration, Cath Lab and CT Scanner. Leases are also underspent.
- The increase in the capital expenditure plan means that the Trust will now need to drawdown £15.30m of Revenue Support PDC to support the deficit, £5.80m more than planned.

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. 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.

Appendix B (ii) – Metrics Rationale and Background

Calderdale and Huddersfield NHS Foundation Trust

Metric	Details
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	Cancer is one of the biggest contributors to inequalities in life expectancy with people from the most deprived communities more likely to get cancer, be diagnosed at a late stage for certain types of cancer and to die from the disease. Early presentation, referral, screening and diagnosis are key to addressing this.
Proportion of patients seen within 4 hours	Monitor waiting times in A&E. Longer waits associated with poorer patient outcomes. NHS Objective to improve A&E waiting times so that no less than 76% (80% local target) of patients are seen within 4 hours by March 2024 with further improvement in 2024/25.
Proportion of ambulance arrivals delayed over 30 minutes	Proportion of ambulances which experience a delay (by more than 30 minutes) in transferring the patient over to the care of ED staff. Patients arriving via an ambulance should be transferred over to the care of hospital staff within 15 minutes of arrival at an Emergency Department (ED). Handover delays can be detrimental to the health of the patient and can have a knock-on impact on the ambulance service (crews are unable to attend to other potentially life-threatening calls). Such delays at the front door of ED can also be a sign of potential overcrowding within the ED.
Proportion of patients spending more than 12 hours in an emergency department	To monitor long waits in A&E which could indicate overcrowding in ED and can cause poor patient experience. The number of patients that spend more than 12 hours between arrival and admissions, transfer or discharge, as a proportion of total attendances.
Neonatal deaths per 1,000 total live births	The Long-Term Plan committed the NHS to accelerate action to achieve the national maternity safety ambition of 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. The number of neonatal deaths is influenced by a number of factors, including the quality of care delivered to the mother and baby and appropriate surveillance for all women. The rate of deaths within 28 days of birth per 1,000 live births. A neonatal death is defined as a live born baby born at 24 weeks gestational age or later, or with a birthweight of 400g or more, who died before 28 completed days after birth.
Stillbirths per 1,000 total births	The focus of this indicator is to measure progress in reducing the rate of stillbirths against the trajectory towards the 2025 ambition. Measures the rate of stillbirths per 1,000 live births and stillbirths. A stillbirth is defined as a baby delivered at or after 24 weeks gestational age showing no signs of life, irrespective of when the death occurred.
Staffing fill rates against funded establishment for maternity staff	Ensure there are sufficient numbers of staff in maternity services to support delivery of the Long-Term Plan. Appropriate staffing levels are also required to implement continuity of care for patients.

Appendix 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 - LD	To monitor waiting times in A&E for patients with a learning disability to ensure equity across all patient groups
Outpatients DNA's - LD	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 - LD	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 - LD	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 - LD	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)

Date of Meeting:	Thursday 11January 2024
Meeting:	Public 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 or a significant number of patients or colleagues. Risks are identified and added to the risk register by colleagues across the Trust. 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 the service, patient care or colleagues 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 is problematic in terms of being able to report on, 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 in the new year. This new system will enable risk triangulation and provide easier, clearer, more comprehensive reporting to Board and its committees in line with the new Patient Safety Incident Reporting Framework. A project plan is currently being developed to support 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.

	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. In addition, as an executive team we are refreshing the divisional performance review meetings, to include a discussion on any emergent or current risks resulting from the triangulation of performance, workforce, quality, and finance. This will identify any risks that are currently on the risk register but that may not be scoring high enough to be included on the HLRR. **Current risk profile** Currently there are 34 high scoring risks on the Trust risk register (see details at the end of the report): • 8 are scored as very high. • 26 are scored as high. • All risks have been recently reviewed and the mitigations (progress) updated. • Of the 34 risks, four have had their risk scores increased. • Since the last report in November 2023, there has been a total of 16 risks that have had their risk score reduced. Of the 16 risks that have reduced in score, 15 risks in total are now below 15 and are no longer included in the high-level risk report because of this. • Since the last report there has been a total of 3 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: • Financial sustainability: - Risk of not achieving the Full Year 2023/24 Financial Plan • 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. – Several risks are 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: - 12 risks related to staffing, either in relation to fragile services or recruitment challenges in certain staff groups.

	- 12 risks are in relation to demand and capacity, particularly in outpatient specialties and some diagnostic services. - 4 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 January. The transition to the new incident reporting system in the new 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. Training has been developed to further support this process and will be delivered by the risk team.
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.

Risk	Dir	Dep	Opene	Status	Objecti	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Curren t	Risk Change	Target	Action Plans	Progress Update	Review Target	Toleran t	RC	Exec Lead
Very High	Corporate	Medical Director's Office	Oct-2017	Active	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing, 2827 A&E middle grade, 7454 radiology, 5747 interventional radiology) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to difficult to recruit to Consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology, and dual site working which impacts on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives	Medical Staffing Job planning established which ensures visibility of Consultant activity. E-rostering roll out commenced to ensure efficient use of Consultant time Establishment of staff bank to ensure vacant posts filled WYAAT networked approach to pressured specialties Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) - HR resource to manage medical workforce issues. - Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Risk of pensions issue impacting on discretionary activity National shortage in certain medical specialties Regional re-organisation could potentially de-stabilise the workforce E-rostering partially implemented for doctors (expected by Sept 2020) - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	no change	9 3 x 3	• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	**Current Update:** December 2023**:** Medical e-case rostering delivery team business case to Business Case Approvals Group. Deputy Medical Director and risk owner to review risk score once the upcoming Drs strikes which are due to take place in December 2023 are over. Dependence on HEE allocation of trainees. Continued junior doctor and Consultant body industrial action (independent and combined). Monitor outcome of indicative ballot for SAS cohort of doctors. 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 Office.	Jun-2023 Jun-2023		WF	David Birkenhead	Pauline North
Very High	Trustwide	All Divisions	Mar-2020	Active	Keeping the base safe	There is a risk that patients may have to wait for outpatient appointments, diagnostic tests or routine operations Due to cancellations of routine surgery and rescheduling of clinics Resulting in their condition deteriorating, potential impact on treatment options available and a less positive outcome	EPR booking and validation processes Urgent fast-track processes in place Risk assessment for re-prioritisation of appointments Virtual appointments commenced in some prioritised areas	Unable to meet target KPI's for RTT and diagnostics, and that patients will wait longer than is best practice for outpatient appointments with an increase in the ASI list and holding list.	20 4 x 5	20 4 x 5	no change	4 2 x 2	Clinical review and prioritisation of essential patients Medicine: risk assessment of booked and due, consider remote or delay 3-6 months. Working up CAS model and recovery plan. Incident reporting for identifying patient harm or impact on prognosis or outcome Complaints and PALS Team logging enquiries and concerns re waits for appointments, and patients not wishing to attend for appointments	**Current Updated**: December 2023 : Risk linked to cancelations through covid period and impact of this. Elective work no longer being cancelled due to this reason and CHFT is performing well on planned activity overall. Where specialties hav challenges, this is being picked up in divisional risk registers. At the time of writing this report this risk was open, however will now appear closed in the next report.	Mar-2023 Oct-2022		NA	Jonny Hammond	Tom Strickland
Very High	Corporate	Finance and Procurement	May-2021	Active	Financial sustainability	Risk of not achieving the Full Year 2023/24 Financial Plan: The Trust is planning a deficit position of £20.80m for 23/24. There is a risk that the Trust fails to achieve this plan due to: - a challenging efficiency requirement of £31.5m which equates to 6.3% of operating expenditure, including an additional £6.5m stretch target. - mechanism for allocating Elective Recovery Funding (ERF) remains subject to final approval and planned deficit assumes full receipt of this funding. - risk that additional funded bed capacity is insufficient to meet demand due to DTOC, Covid-19 or winter pressures. - risk of further strike action resulting in increased costs and impacting elective recovery. - Inflationary pressures exceed planned levels. - risk that any Pay Award above the 2% planning assumption is not fully funded.	Business As Usual Controls: Standing Financial Instructions set spending limits Project Management Office in place to support the identification of efficiencies. Turnaround Executive (TE) meets weekly to drive forward identification of efficiencies, monitoring of progress and potential mitigation for any slippage. Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Accountability guidance and escalation process for budget holders. Controls around use of agency staffing. Approval process for new investments and ongoing scrutiny of expected KPIs through Business Case Approvals Group (BCAG) Elective Recovery Funding in place to support expenditure required for Recovery, subject to delivery of planned Waiting List times.	Uncertainly regarding penalties associated with not achieving agreed Waiting List performance. Capacity planning challenges linked to Transfers of Care and Length of Stay - including impact of external pressures. Financial impact of Strike action - no additional funding currently identified to support additional costs incurred and impact on activity performance. Uncertainly regarding funding for pay awards for Medical Staff. Inflationary pressures above the funded level.	20 5 x 4	20 5 x 4	no change	12 4 x 3	The Trust is engaging with both Place Partners and the ICS to understand the drivers of the deficit position and work collaboratively to address Patient flow and the impacts on Emergency Department demand and Bed Capacity. • Weekly programme through TE to ensure all efficiency schemes are on track and find mitigation for any shortfall. • Strong focus on budget holder accountability with a number of Exec level meetings taking place as part of the escalation process. • Medium term planning underway to consider more cost effective ways of delivering Elective Recovery. • Reviewing NHSE Expenditure Controls to ensure that existing governance arrangements are sufficient. • Additional Exec lead focus on vacancy control, vacancy management and agency expenditure through the Workforce CIP group • Active engagement with the ICB on development of the mechanisms for Elective Recovery funding allocations	**Current Update**: December 2023: Year To Date the Trust is reporting a deficit of £11.08m, a £1.61m adverse variance to plan. 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), £1.85m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £1.43m; and non-pay inflationary pressures including Utilities. These pressures were offset to some extent by early delivery of other efficiencies and higher than planned commercial income (HPS). The position assumes full receipt of variable Elective income / Elective Recovery Funding, but this remains a risk. £27.84m of CIP schemes are at Gateway 2 / Delivering (fully developed and Quality Impact assessed where appropriate), with £2.99m unidentified - the level of unidentified CIP has increased in month due to slippage on 2 schemes (bed closures associated with LOS reduction / TOC & Emergency Department revised rotas), for which mitigation is yet to be found. The AfC Pay Award for 23/24 has been paid since June and indications are that sufficient funding will be allocated to cover the cost, but there remains uncertainty regarding som elements of the funding mechanism for the Medical Staff pay award. Ongoing Strike action is driving a financial pressure in the year to date position and is likely to continue to do so for at least the next couple of months. No additional funding is currently available to support this expenditure.	Mar-2024 Oct-2023		FPC	Gary Boothby	Philippa Russell
Very High	Corporate	Planned Access and Data Quality	Jul-2022	Active	Keeping the base safe	There is a risk of non compliance with the Trust Elective Access Policy, due to high volume of outstanding clinical outpatient validation and prioritisation on Mpage, resulting in the inability to identify next steps in patients pathways causing clinical delays. Prior to clinical review these patients have already been admin reviewed which on average removes 50%. There are currently a total of 15,841 patients awaiting clinical review and prioritisation on Mpage. This comprises several patient cohorts: Cancelled appointments with requests (CAWRs) - 585 Holding List (12 weeks overdue) - 8,715 Incomplete Orders (IOs) - 6,541 9,054 patients have been waiting more than 90 days with the longest wait being 546 days. There are several risks of not clinically reviewing these patients 1. A proportion of patients won't need a clinic appointment therefore by not reviewing them we are missing the opportunity to remove them from the backlog and could have an appointment booked in the meantime which would waste valuable capacity. 2. A proportion of patients could be urgent but will be delayed in receiving an appointment, therefore the Trust carries a level of unknown risk. 3. The incomplete order patients do not have an order within EPR therefore will never receive an appointment unless they are clinically assessed and prioritised. In addition to this we currently have 3,402 P rated patients on the holding list that are now overdue due to insufficient capacity. Due to the many conflicting	Full reporting in KP+ at patient, clinician and specialty level. Reviewed at customer contact meetings. Auto generated email to clinicians when they have 20+ validations to complete	Insufficient clinic time available to review patients in a timely manner	20 4 x 5	20 4 x 5	no change	6 3 x 2	New Access Committee launched in May 2022 and meets on a monthly basis. The target is for no patient to wait more than 30 days for clinical assessment.	**Current Update:** December 2023 There are currently a total of 17,348 patients awaiting clinical review which is a small decrease since the last update. Of this 9,707 patients have been waiting more than 90 days. In addition to this we currently have 3,182 P rated patients on the holding list that are now overdue due to insufficient capacity which is a slight decrease. 2239 follow up requests are more than one year overdue. We continue to highlight outstanding validation and capacity issues and customer contact meeting with emphasis on IO patients. Further training sessions have been undertaken with specialities on the correct way to book follow up appointments. We continue to offer training on validation as requested. The Trust RPA is currently being programmed to perform a number of validation tasks which will thereby increase the amount of validation the central team can complete. The validation team continue to use the low hanging fruit model to maximise resource keep outpatient PTLs as clean as possible. 18,647 records have been validated in total and 10,213 have been closed which gives an average closure rate of 54.8%. The two biggest areas for outstanding clinical review of IO's remains Colorectal on 742 and Cardiology on 484. These patients are effectively lost to follow up as they will never get an appointment until they are clinically reviewed for a decision on next steps. There have been several red and orange incidents were the patient was sat on the IO list.	Feb-2024 Jan-2024		PCB	Jonny Hammond	Kimberley Scholes

Very High	8508	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Feb-2023	Active	Keeping the base safe	There is a live current risk to CHFT being unable to provide a Consultant Glaucoma Service due to no Consultant in post at CHFT. Resulting in not providing the required supervision and training to specialty doctors required for the royal college of ophthalmology standards impacting standards of care, staff development, delays and clinical outcomes for patients.	Advert out for x2 locum consultant - 1 success and due to start 8/5/23. 1 post still out to advert AHP's providing new patient clinics. Technicians providing diagnostic clinics Agreed Agency Consultant to take on glaucoma standard capacity. Trust Drs protected glaucoma slots. Regular meetings with failsafe team re pending lists, ASI's and HLs WLIs for virtual appointments. IPT trabeculectomies to neighbouring trust WYAAT / regional involvement Escalation to Aletta Carbone (CD H&N) and Thomas Strickland (DOp S&A)	No substantive consultant leading service - Not having a Consultant is preventing the glaucoma service to run as clinics require a lead resource. Current workforce have been asked to take on this, however due to not specialising within the area there has been no success to create these resources at a complex level. Not having substantive resources is causing instability within the service and is in turn affecting recruitment and retention due to lack of support for current workforce. Repeated attempts to recruit have been unsuccessful National shortage of glaucoma specialists No locum consultant able to perform surgical intervention Risk to agency / bank giving last minute notice.	20	4 x 5	20	4 x 5	no change	6	2 x 3	Advertise Glaucoma Consultant vacancy Business case for Speciality doctor Collaborative working amongst AHP's regarding service improvement in screening and stable clinics Review of the pathway / AHP and nursing training Quality assurance systems to ensure patients are seen by the right clinician at the right time Opportunities to work differently to optimise capacity 90 clinics required to review all 719 patients past their end date. 5 super red clinics required for the 30 patients currently validated as requiring interventions. However not all patients requiring F2F review have been validated therefore the total number of high risk patients has not been identified. (Datix will need to follow to capture the harm) To look at competencies and JPs with each ACP. However this will be a future provision not an intermin help.	**Current Update:** December 2023 - locum consultant withdrawn, back out to advert. Remedy contract approved and waiting start date for remedy consultant for virtual work. 2/10/2023 Update - locum glaucoma consultant accepted post, under HR process. Contract agreement written for Remedy outsourcing with procurement to finalise. 1/9/2023 - approval from exec team to implement outsourcing company Remedy to support backlog. This is in discussions with procurement, finance. Approval for Specialist Dr. Shortlisted and looking for interview dates. 28/6/2023 - Agency Consultant withdraw application. Escalated in GM meeting with TS. Will go back out to advert for a Locum and a Substantive post. Escalated resignation of optom in Surgical PSQB 26/6/2023. Asked for glaucoma risk to continue to be escalated to Trust PSQB 08/06/2023 resignation of optometrist specialising in glaucoma currently supporting new patient service. Adds to fragility of service. ? new risk to report as now single point of failure to all new patients or increase current risk to service. Escalated to TS. 24.05.23 - Discussed at Risk Group agreed risk score of 20. Recommendation from COO's is that there is a WYAAT service wide review for glaucoma.	Jan-2024			Natalka Dragan PSQB	Emma Griffiths
Very High	8509	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Feb-2023	Active	Keeping the base safe	There is a risk of significant harm due to insufficient glaucoma appointments available to cope with demand due to increasing patient numbers and inability to recruit substantive consultant. This will result in long delays, multiple rescheduling of existing routine patients having to be moved to accommodate more urgent appointments on a weekly basis. Many appointments falling outside the recommended guidelines due to capacity issues. Delays in treatment could result in loss of sight and could lead to irreversible blindness, in turn leading to a potential influx in litigation with financial implications due to patients who have not been seen in the right place at the right time.	Risk stratification of waiting lists Micromanagement of clinics and utilisation of slots by existing consultant and failsafe Pathways to ensure efficient and correct requests Agency consultants and WLI Discussions with WYAAT and ICBs to look at community pathways and primary care solutions IPT agreements with neighbouring trusts 4462 pts on holding list, 719 past end date, 200 Red Longest waiter 17 weeks past end date, 495 Amber. Longest waiter 27 weeks past end date (one outlier 116 wks past end date) 30 patients have been validated as Super red requiring intervention to limit sight loss.	Lack of medical staff, AHP support, clinical capacity and clinical space to see the required demand resulting in an increase in holding lists. Clinics being stood down to enable staffing of gaps in emergency/ acute and MR services Single point of failure to service if agency consultant were to leave. Further cancellation of clinics to enable theatre sessions. Lack of consultant able to offer complex surgical intervention for high risk patients Increase in virtual review not desirable to medical workforce. Accepted risk already for increased incomplete outcomes (monitored via access meetings) due to increased virtual pathways	20	4 x 5	20	4 x 5	no change	6	2 x 3	Job advert for additional substantive or locum consultant with a special interest in glaucoma Business case for additional specialty doctor position Identify and develop areas that may be suitable for diagnostic or virtual pathways (already in place, impact on virtual pathways as limited virtual review resource available)	**Current Update:** December 2023 - locum consultant withdrawn, back out to advert. Remedy contract approved and waiting start date for remedy consultant for virtual work.	Jan-2024			Aleta Carbone PSQB	Emma Griffiths
Very High	8528	Medical	Emergency Care	Accident & Emergency CRH/HRI	Mar-2023	Active	Transforming and improving patient care	There is a risk of a reduction in 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. National target is 76% of all patients to be seen, treated, admitted or discharged within 4 hours. There are also other quality associated measures as part of this such as ambulance handover times (less than 30 mins, 30-60 mins and greater than 60 mins), time to triage etc.	Workforce models for both Medical and Nursing including vacancy levels constantly monitored and reviewed to ensure the ED has the best opportunity in dealing with this extra activity. Use of the Urgent Care Hubs co-located within the ED as a service to see and treat low acuity patient. Use of Local Care Direct as a service to see and treat low acuity patient out of hours. ED long waiter SOP and the use of ED nursing rounding to ensure long waiting patients are cared for whilst waiting bed placement. Frailty Nurses present within the ED 5 days per week.	A clear escalation plan within the organisation to decant patient from the Emergency Department (ED) who have a prolonged waits for an inpatient bed. Lack of Medical Same Day Emergency Care provision at the Calderdale Royal Hospital resulting in the ED been unable to stream patients away from the department. Lack of robust SDEC referral process to streamline suitable patient into SDEC service from the front door of the ED.	16	4 x 4	20	4 x 5	no change	6	2 x 3	Continue to promote the use of the Urgent Care Hub and Local Care Direct as services to see and treat low acuity patients. Promote ED consultant at the front door at times of increased congestions. Continue to collaborate with divisional colleagues in relation to SDEC pathways and the streaming of patients. Continue to collaborate with divisional colleagues in relation to re-opening a medical SDEC at the CRH site.	**Current Update**: November 2023: - discussed at corporate risk review meeting. Addition of reduction of quality and safety in the risk description. Also, increased to a score of 20. Approved	Jun-2024 Jan-2024			David Britton DB	Tom Ladlow
Very High	8669	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Nov-2023	Active	Keeping the base safe	There is a risk of delayed diagnosis, treatment for cancer patients. Due to one H&N cancer consultant on long term sickness absence and the fixed term contract of 1 doctor having expired resulting in poor patient experience and potential to impact on the Trusts Cancer metrics	Support from general ENT team in seeing FT and carrying theatre diagnostics Daily micromanagement and tracking of all high risk patients	Theatre capacity with only 1 consultant H&N surgeon available for theatre and clinics National recruitment in ENT ad H&N is challenging Risk of higher stress levels for the current locum H&N consultant with heavy workload which could lead to further sickness in the team Risk to ENT long wait patients if lists become overrun with P2 and FT diagnostics	20	4 x 5	20	4 x 5	New Risk entered in Nov 2023	4	2 x 2	6 month locum has to return to his parent hospital but CHFT are engaging to understand if a further secondment/FTC opportunity would be available To advertise for a locum post should the above not prove fruitful Working to see how the current CNS team can support "good news" patients to free up specialist time for the H&N consultant to focus on complex patients .	**Current Update:** November 2023: Discussed and approved at a risk score of 20 at PSQB in November. 14.11.23 locum 12 month post added to TRAC .	Jan-2024 Jan-2024			Thomas Strickland PSQB	Aleta Carbone

High	8562	Family & Specialist Services	Pathology	Blood sciences	May-2023	Active	Keeping the base safe	Risk Proposal Accepted at Path Board - RP-083 Risk of - Enforced removal of Siemens Track within the Biochemistry Department Caused By - Delays in the procurement of new equipment via the WYAAT MSC Resulting In - Inability to use the Siemens Track post September 2023. Inability to automate the centrifugation / de-capping/ delivery of samples to the chemistry and Immunoassay analytical equipment and the tracking of all samples.	Currently using the track until September 23 when Siemens will remove it. New MSC currently underway, however there has been a legal challenge against the winning supplier which will cause serious delays to the awarding of the MSC. Siemens have been approached to provide a potential solution for the department to extend the existing contract between 12 months and 3years (3 years remaining on existing contract)	Existing instrumentation is not capable of dealing with current workload without the track and has no facilities for pre and post analytics once track has been removed e.g. centrifugation, tracking, de-capping etc. This will have an enormous impact on patient safety / care with the inability to meet TAT's for all patients or provide a workable solution without additional equipment provided by Siemens Insufficient staffing levels / capacity to manually perform workload. Pre and post analytical equipment required including centrifugation.	16 4 x 4	16 4 x 4	no change	4 4 x 1	Interim plan required for Siemens to provide a workable solution so that CHFT can provide a clinical biochemistry service to CHFT's primary and secondary care patients. CHFT to provide alternative workload process to deal with current demand Urgent decision required as validation and verification of all new equipment can take approximately 6 months for completion - required for UKAS accreditation,	**Current Update:** December 2023- Track is having numerous issues, including 1 x centrifuge has now failed. Delivery date for new equipment is week commencing 18th Dec, European resource arriving wk commencing 8th Jan. Current staffing levels will impact on the implementation of the new equipment plans. Conveyancer report completed - no concerns raised.	Jan-2024			PSQB	Stephen Shepley	HAYLEY BAKER
High	8606	Medical	All Directorates Medical	All Departments/Wards Medical	Aug-2023	Active	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 The set bed reduction plan is as follows: • 30 bed reduction in May (RF and AF reduction and close 4d) • 48 bed reduction in June (RF, AF reduction, close 4d and down to 24 beds on 6ab) • 60 bed reduction in July (RF, AF reduction, close 4d and down to 12 beds on 6ab) To retain the 60 bed reduction for the rest of the financial year. The divisions Loss CIP target is £3.4m which we will not meet this year.	• Admission avoidance through the Emergency Department and Ambulatory areas • Trust wide work on discharge planning - plan for every patient, R2R and WoW work • Linking with Community colleagues to support earlier discharge and TOC list • Developing clinical pathways to support outreach clinical service (Covid Community clinics) • Roster/WFM compliance checks • Ward/department budget management meetings	• Capacity in Community services • Workforce gaps • Continued increase in acute demand • Increased acuity of patients impacting on LOS	16 4 x 4	16 4 x 4	no change	6 2 x 3	• Continued review of recovery plans in the event that acute pressure increases • Balance of workforce distribution to elective and acute work • Continued review of bed base to best manage demand • Clear bed plan worked up which includes the order of retraction out of extra capacity beds • Continued pipeline of substantive staff into extra capacity areas to reduce the need for bank and agency	**Current Update:** December 2023 - current position is that we have 8b fully open, 11a fully open. CRH SDEC has been successfully opened this week but yet to determine staffing resource which currently will be impacting on finances. Discussed at Medicine PSQB 15/09/2023.. Risk accepted.	Jan-2024	Mar-2024		PSQB	Helen Rees	David Britton
High	8609	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Aug-2023	Active	Keeping the base safe	There is a risk of prolonged waiting times for patients within ENT (many of these patients still awaiting clinical triage) Due to multifactorial elements including an increase in referrals over the last 6 months, inability to return to pre-covid levels of activity resulting in potential to negatively impact patient outcomes, compromised patient care, increased patient dissatisfaction, and potential health complications arising from extended waiting periods.	Working with Pioneer Healthcare who provide weekend outpatient capacity using CHFT estate Task and finish group concluded identified solutions ands improvements that can be made in both primary and secondary care - an action tracker will be discussed monthly with the consultant body and the senior leadership team	the T&F has identified that with Pioneer and CHFT capacity the Organisation is approximately 70 slots/week short In October 2022 we ceased working with Omnes this was a decision based on risk analysis (insourcing) and since that time we have seen a steady climb (prior to that ASI's stood steady around 1600-2000) There is a risk that increased new appointment slots may have an adverse effect on the holding list this will need to be tracked	16 4 x 4	16 4 x 4	no change	4 2 x 2	The T&F has lead to the development of an action plan which will be managed through a monthly meeting with the consultant body Capacity to review the referrals in the RAS - internal/external , build a standard criteria for acceptance Increase capacity looking at standardised slot times and clinic lengths Improve referrals from primary care to ensure they meet a basic standard and that current referral guidelines are adhered to prior to referrals	**Current Update:** November 2023 - after 2 trial periods with Consultant Connect we are progressing with their triage of the A&G and RAS for all ENT patients (ASI 4872 with 2262 over 18 weeks). Recruited to 2 middle grade posts awaiting recruitment checks . ASI action plan is drawn up and monitored weekly	Dec-2023	Dec-2023		PSQB	Thomas Strickland	Sharon Berry
High	8161	Family & Specialist Services	Radiology	CT	Sep-2021	Active	Keeping the base safe	Objective: Service Delivery Risk Risk: Risk of being unable to provide a CT scanning service in the event of a fatal breakdown of the CT scanner at CRH. Cause: • Age of equipment (9 years old) • Lease due to expire 2022 Effect: Inability to scan patients Impact: • An increase waiting times for imaging and delays to diagnosis. These delays would need to be considered by clinical teams to ascertain patient impacts. • Failure to meet national standards (i.e. Stroke).	- Scanner regularly serviced - Maintenance and Service contract in place - Support of additional mobile scanner - Ability to scan patients at HRI if needed	- Our staff are not trained to use the mobile scanner (the scanner is provided by a private company and is manned by their staff). - Support provided by mobile scanner is limited, they cannot do perfusion scans which are required for some stroke patients (thrombectomy). - From January 2024 we will no longer be support for some replacement parts/cannot guarantee repairs.	9 3 x 3	16 4 x 4	no change	4 2 x 2	- CT scanner to be included within the new MES - To utilise the mobile unit where ever possible - To transfer to HRI, if appropriate. - CHFT staff now training to use the mobile scanner. - Replacement scanner included in equipment replacement scheme planning.	**Current Update:** December 2023: Risk remains the same as last month. November 2023 Update: Risk gaps updated to include inability to scan some stroke cases on the mobile scanner and inability to source/replace parts from January 2024. Risk score also considered and do not feel that the score can be reduced at this stage as the scanner could have a fatal breakdown at any time. Whilst we have had limited downtime, this cannot be guarantee for any future issues. October 203 Update: Plan to replace this scanner after the installation of the new 4th scanner (currently underway). Confirmation of funding of continuation of use of mobile CT scanner awaited.	Jan-2024	Mar-2024		PSQB	Stephen Shepley	Lucy Thomson
High	8219	Family & Specialist Services	Pathology	Blood sciences	Dec-2021	Active	Keeping the base safe	RISK OF : Loss of Cross-Site Biochemistry Service 24/7 CAUSED BY: 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) RESULTING IN: Potential for failure of service out of core hours	Offering current temporary trust bank rate (+50%), overtime and shift swaps Moved maintenance off nightshifts and weekends to day shifts to try alleviating pressure and improving shift attractiveness. Review of tactical options to cover Christmas weekend. Plans in place	Lack of resilient structure to maintain 24/7 service in light of reducing ability to recruit and retain qualified Biomedical Scientists	16 4 x 4	16 4 x 4	Risk increased from risk score of 12.	4 4 x 1	Exhaust all short term mitigations to enable staff to deliver service locally rather than enacting current BCP and referring work. (Continue to run take top exercises of BCP) Determine resilient structure to maintain 24/7 service in light of reducing ability to recruit and retain qualified Biomedical Scientists	**Current Update:** December 2023 - Rota currently 1:9, number of vacant shifts to cover due to loss of staff and sickness, with no volunteers. A VO order is being submitted to try and encourage volunteers. Recruitment is in progress but all staff will need a substantial amount of training prior to joining the 24/7 rota. BCP is being re-written to include action cards. Nov 15/11 - Current Turn over rate is 18.63% lost 5 BMS in 5 months. Oct31/10 - Further resignation of a qualified BMS, resulting in the loss of 5 BMS in 5 months. This will have a negative impact on the ability to maintain a 24/7 service across two sites and the ability to cover all 24/7 shifts. Propose to increase risk from 12 to 16 due to the increase in likelihood of not being able to cover all shifts.	Mar-2024	Oct-2024		PSQB	STEPHEN SHEPLEY	HAYLEY BAKER

High	8098	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Jul-2021	Active	Keeping the base safe	There is a risk of clinic cancelation, delays and reduced capacity in all areas of ophthalmology due to macular injection staff shortages resulting in permanent sight loss for patients, cancellations of non emergency capacity and increased holding lists.	Utilising medical workforce to provide injector roles where the rota allows. Cancellation of non emergency clinics to release staff. Continue to provide WLI macular capacity on a Saturday to support the delivery of a timely high risk service to patients.	Lack of resilience and adaptability within the workforce to cover this subspecialty Continual rise in demand for capacity Length of time to train injectors (6 months +)	16 4 x 4	16 4 x 4	Risk Increased from risk score of 9.	2 1 x 2	Reconsider the workforce. Ensure surplus staff trained to cover clinic in event of sickness, annual leave and pregnancy	**Current Update:** December 2023 - further 2 resignations totalling 5. significant risk remains. mitigated by securing agency Dr to support injections and putting injector role out to advert. October 2023 3x Injectors resignation- increase risk 07/06/23 2x injectors pregnant and not injecting due to risk, mat leave cover in recruitment stage. Will require training 09/02/23 Training ongoing, barriers to training schedule due to gaps in workforce. Staff sickness creating further gaps and strain on remaining injectors.	Nov-2023	Feb-2024	PSQB	Aleeta Carbone	Emma Griffiths
High	7955	Family & Specialist Services	Radiology	Main X-Ray	Dec-2020	Active	Keeping the base safe	Objective: Service Delivery Risk Risk: Inability to deliver plain film services from three plain film rooms at Calderdale Royal Hospital (CRH) Cause: The rooms becoming obsolete due to their age (these rooms are 20 years old and are beyond their normal life span and no longer have maintenance cover) and due to • Lack of parts • Lack of qualified engineers Effect: The rooms no longer being in use. Impact: Disruption to all acute (including the Emergency Department) and main x-ray services. The equipment includes, for example, the rooms, the retrofit units and peripheral kit such as printers, CR readers and consoles. Also refer to risk 7581 in relation to the financial impact of a breakdown.	- Maintenance cover*. - Datix reporting of breakdowns. *Whilst we have maintenance cover we are experiencing difficulties in sourcing replacement parts. On a previous occasion a replacement part has had to be made as the part was no longer available. This is resulting in longer periods of downtime and eventually parts will not be able to be replaced.	- Continued maintenance cover due to age and lack of available parts.	12 4 x 3	16 4 x 4	no change	4 2 x 2	- Equipment on the 5 year capital plan.	**Current Update**: December 2023 Unable to reduce to 12 at this time as Room 1 is yet to be complete. Still aim to reduce once the works are complete . November 2023 Update: The ED room has been replaced, replacement of Room 1 to be completed by end of 2022-23. This will leave two rooms to be replaced (Room 2 and 3). To reduce the risk to 12 once Room 1 is complete (there will be a risk until this point as there will be reduced capacity whilst Room 1 is being replaced) which will add strain to the two remaining old rooms (Room 2 and 3). To review the risk once Room1 has been complete to assess remaining risk and risk rating. October 2023 Update: CRH ED room has been replaced and will re-open within next few weeks. Funding has been approved at BCAG to replace CRH Room 1 (this financial year). Risk score to remain the same at this time as there are issues with our current rooms (unable to supply replacements tubes and two rooms require new tubes). To consider reducing the score once Room 1 is complete. Risk Confirm & Challenge 25/10/23 Attendees: SS, CG, GE, SD, LR, JE, SRF, GH .	Jan-2024	Mar-2024	PSQB	Stephen Shepley	Emma Hurst
High	7970	Community Healthcare	Out Patient Therapies	Childrens Therapy	Dec-2020	Active	Keeping the base safe	There is a risk that delays in availability of videofluroscopies for Children could result in harm from aspiration. Due to the lack of trained personal within the trust or a formal arrangement with a regional centre for paediatric videofluroscopy. This service was previously provided by radiology until the retirement of the radiologist who was trained to perform, interpret and report on these. Resulting in increased aspiration risk and delayed implementation of appropriate treatment for these children. There are currently 15 children on the waiting list.	12 children a year (one a month) can be referred to Leeds for service.	12 referrals annual is not sufficient to address the back log or meet demand.	12 3 x 4	16 4 x 4	no change	3 3 x 1	June 2021 - CHFT Finance and CCG are in negotiation to agree tariff with Leeds to provide the service Meeting between Children Therapies, Paeds, Radiology and Leeds service in early January to explore solution 17/01/22; NG and MF to brief CCG and ICS re inequity of provision across WY@H. Waiting list initiatives to also be explored.	**Current Update**: December 2023 - risk remains the same until recruitment into post Jan 2024 Sept Update from lead - Clinical Lead for dysphagia has finished with Trust. recruitment taking place. This means that clinical management of high risk patients is being supported by bank and less experienced staff only. 11 currently on wait list for VF at Leeds. Leeds not in a position to offer more slots. Risk rating revised in line with Clinical Lead vacancy. Risk upgraded to 16 September - lead not in attendance to give an update. MH to contact and add to next risk agenda April 2023 - risk remains the same. Further updates are expected from Leeds in the new financial year. Trust dysphagia lead is managing the risk in community more so than the team were doing previously (prior to her being in post) so the urgency and number of referrals for VF has plateaued for now. feb 6th 2023 - risk discussed - further update once Leeds have confirmed additional support Nov 22 - risk remains the same June 2022 - Agreement in place with Leeds to see 1 patient per month. 19 patients on the waiting list- risk remains the same March 2022 - risk remains the same Jan 22 - Leeds have given access to see one patient per month. Risk remains the same until alternative solution is in place 11/10/21 - Issue escalated to COO and COO to COO conversation taking place to find some resolution.	Jan-2024	Jan-2024	PSQB	Debbie Wolfe	Carly Hartshorn
High	8009	Medical	Integrated Medical Specialties	All Departments	Feb-2021	Active	Keeping the base safe	There is a risk of outpatient capacity not being sufficient to ensure timely appointments for both new and follow up patients across IMS. This is exacerbated by the restriction of face to face appointments that are required although this is partially mitigated through video and phone clinics. For specialties such as Neurology physical examination is more likely and face to face appointments required following an initial telephone appointment or video call and therefore adding additional pressure to already stretched capacity. This risk is due to the size of the backlog that has built up during the covid pandemic. This is resulting in delayed appointments and ultimately the risk of not diagnosing a patient and seeing and treating then within the 18 week RTT pathway.	CAS clinic and advice and guidance to manage referrals into the trust	Capacity to deliver against the demand due to the backlog built up over covid As at 21st May 2023 Neurology ASI's - 837 Follow up past due to - 3064 Haematology ASI - 119 Follow up past due to - 7 Dermatology ASI - 232 Follow up past due to - 1383 Nephrology ASI - 72 Follow up past due to - 117 Rheumatology ASI - 216 Follow up past due to - 2701	16 4 x 4	16 4 x 4	no change	2 1 x 2	Looking to increase the medical workforce where budget allows and as short term mitigation increasing the number of clinics run through waiting list initiatives. To continue to aid recovery the directorate are continue to maximize the use of recovery funding to deliver WLI clinics both internally and externally with a focus on reducing patients on an open RTT pathway to under 40 weeks initially with a further push to get below this based on capacity and available funding.	**Current Update:** December 2023: ASI numbers have dropped in neurology with other areas remaining static or increasing. This was anticipated as additional resource and capacity was focused on those patients on an open RTT pathway to ensure they are waiting no longer than 40 weeks by the end of March 2024	Jan-2024	Mar-2024	PSQB	Helen Rees	Chris Roberts
High	6078	Trustwide	Appointment and Records	Appointments Service	Aug-2014	Active	Keeping the base safe	There is a risk of being unable to provide sufficient appointment slots to manage demand. Due to an increase in referrals to services/reduced available capacity to manage demand. Resulting in: - poor patient experience - increased administration (reliance on spreadsheets to track capacity requirements) - risk to failure of RTT targets - impact on contract income targets	Process: Fortnightly communication to Clinical Divisions highlighting capacity requirements. Regular communications with Ops managers / GMs. KP+ system allows for real time monitoring of slots, waiting lists and canx/DNA rates. All GP referrals are now referred via ERS. Worklists include ASIs, enabling review of the referral prior to offering appointment including the use of CAS/RAS in some services.	Variations in capacity and demand plans. Consultant vacancy factor. Not all services review referrals prior to offering an appointment. Lack of monitoring of no AC relevant slot utilisation	16 4 x 4	16 4 x 4	no change	3 3 x 1	Monitor ASI position at customer contact meetings. CAS/RAS service operating in some services. Insourcing work on-going to help reduce ASI numbers.	**Current Update:** December 2023; Risk linked to cancelations through covid period and impact of this. Elective work no longer being cancelled due to this reason and CHFT is performing well on planned activity overall. Where specialties have challenges, this is being picked up in divisional risk registers. At the time of writing this report this risk was open This risk will appear closed for next report.	Dec-2023	Dec-2023	PCB	Jonathan Hammond	Nicholas Buckley

High	6079	Trustwide	Appointment and Records	Appointments Service	Aug-2014	Active	Transforming and improving patient care	Follow-Up Appointments – A risk of being unable to provide sufficient appointments for patients requiring OP follow-up. Resulting in delay in patient care, poor patient experience, caused by capacity & demand issues post covid.	Validation of Holding List both admin and clinical to provide p values for patients and to remove duplicate requests. Clinical Assessment of all patients waiting >12 weeks from appointment due date. Monitor holding list & clinical validation position at customer contact meetings.	Insufficient slots to manage demand Variable clinical engagement in clinical assessment process Clinical vacancies. Complex and convoluted booking rules. Lack of monitoring of no AC relevant slot utilisation	16 4 x 4	16 4 x 4	no change	4 4 x 1	May 2021 - CHFT Clinical prioritisation and recovery plan (post COVID) being held monthly with COO support. Fortnightly customer contact meetings on-going. On-going admin validation.	**Current Update:** December 2023: remains a risk due to the high volume of follow ups overdue appointment. A programme of work is underway focused on improving the booking of appointments in date order. In addition, an audit is being undertaken to look in more detail at booking processes, which will nable the planning for a longer term piece of work, depending on the findings. Transformational work is focused through the Elective Transformation board on improving clinical pathways in conjunction with primary care and on the further faster GIRFT programme and the use of patient initiated follow ups	Dec-2023	Dec-2023	PCB	Jonathan Hammond	Nicholas Buckley
High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Active	Keeping the base safe	There is a risk of: insufficient Trust employed Nurses, Midwives, and HCSW to deliver safe and compassionate care on a shift-by-shift basis, as defined by the agreed Workforce Models or Care Hours Per Patient Day (CHPPD) Due to: an inability to fill vacancies, the requirement to staff additional capacity areas and/or excessive unplanned staff absence Resulting in: • patient harm (inc. but not limited to: serious incidents, failure to detect deterioration, falls, pressure ulcers, medication incidents, infections) • poor patient experience • reduced staff morale • increased sickness and attrition of staff • reduced staff competence (due to inability to attend training) • increased financial pressure (due to use of bank and agency) • poor learner experience (due to inadequate supervision)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Hard Truths Process and monitored by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least twice times each 24 hour period using the Safer Care tool with actions instigated by Matrons to mitigate any shortfall. Formal escalation to Deputy Chief Nurse or their delegate to agree mitigating actions requiring agency bookings. - staff redeployment where necessary - nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream - active recruitment activity, including international recruitment - Introduction of new roles eg Nurse associate - Identification and training of volunteers to meet and additional surge demand - Implementation of NHSE Winter Planning Guidance and Associated Assurance Framework, including OPEL escalation triggers and actions, and twice daily ADN-led safer staffing meeting.	Low numbers of applications to nursing posts across grades and specialities National shortage of Registered Nurses	16 4 x 4	16 4 x 4	no change	9 3 x 3	• Local/domestic recruitment • International recruitment project • Nursing associate role development and deployment of graduating cohorts • Workforce transformation (NA's, TNA's and ACP's) • Developing nursing retention strategy • Use of flexible workforce • Utilisation of nursing workforce using safe care live • Response to the NHS interim people plan - significantly grown the number of undergraduate Health students to improve the pipeline of nurses to recruit	**Lastest Update**: December 2023: no change to staffing risk impact or liklihood. Improved vacancy position. Interntational recruitment now paused. Further progression with agency retraction plan. Greatest risk now manifests from the need to staff additional capcity areas. Twice daily staffing meetings continue to assess and mitigate any risks. This includes reviewing all red flags.	Nov-2023	Dec-2023	WF	Suzanne Dunkley	Janet Youd
High	6596	Corporate	Corporate Quality	Governance and Risk Quality	Jan-2016	Active	Keeping the base safe	There is a risk of not complying with the national SI framework March 2015 due to not conducting timely investigations into serious incidents (SIs) resulting in delays to mitigate risk, to realise learning from incidents and share the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Scheduling of SI reports into orange divisional incident panels to ensure timely divisional review of actions. - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Investigator Training - to update investigator skills and align investigations with report requirements. - Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Risk Team support to investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning - Investigation Pack and plan for each SI investigation, with initial and midpoint meetings with Risk to monitor progress	1. Operational pressures and impact on capacity to undertake investigations in a timely way, further exacerbated by Covid 2. Sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation, particularly doctors. 4. Lack of access to documents on EPR to non clinical investigators. 5. Operational pressures impacting on time for conducting investigations 6. Requirement to undertake SI investigations is not in Consultant job plans 7. delivery of RCA training workshop suspended due to Covid	16 4 x 4	16 4 x 4	no change	4 4 x 1	Increase number of trained investigators Be clear in delivering training there is a requirement to participate in SI investigations - complete Learning Group to develop approach on learning and a learning event - Quality Priority for 2020/21 Paper with options for investigators - complete Use of staff who are shielding to support investigations Quantify volume of Covid incidents meeting threshold for investigation in accordance with SI Framework Update sept 23 trajectory set to ensure that outstanding SIs are completed by December 23 Weekly meetings in place to monitor progress against the tracker Support to investigators from risk team	**Current Update**: December 2023 The regular review of the SI tracker continues with a significant improvement to less than 15 ongoing. A number of the outstanding old SIs have been closed however concluding the final outstanding SIs has proven to be challenging (information not gathered at the time of incident, investigators leaving, for example) however Risk continues to work closely with the Division February 2020 - Discussion with Director of Nursing regarding written communication to line managers of investigators regarding their involvement in serious incident investigation to reduce withdrawal rates.	Nov-2023	Dec-2023	QC	Lindsey Rudge	John Tyrer

High	6911	Family & Specialist Services	Women's Services	All Departments	Jan-2017	Active	Keeping the base safe	There is a risk of not meeting current midwifery workforce models due to current vacancies and periods of increased absence (maternity / long term sickness), resulting in the inability to provide safe staff and timely care across the maternity footprint. Overarching risk linked to: 8454 - induction of labour 8455 - Maintaining 1:1 care 8457 - Meeting maternity triage time 8458 - birth centre experience 8097 - ability to deliver Continuity of care 8456 - community caseload size	Right staff in the right place - twice daily staffing meetings Twice yearly review of workforce models with Director of Nursing, Deputy Director of Nursing and Head of Midwifery Maternity Escalation Policy Use of NICE approved safer staffing tool - Birth Rate Plus Active recruitment - LMNS wide, localised and international recruitment Sickness/ Absence Management: Monthly staffing forecast to support recruitment and rotation planning Daily monitoring of delays and escalating for mutual aid as required Feed in to tactical meeting All unfilled shifts escalated to bank / agency for shift fill Maternity bleep holder to offer leadership and oversight Use of incentive schemes to aid bank pick up at periods of heightened absence Workforce revised to support skill mixing	Midwifery bank predominantly made up of CHFT midwives, limiting cover Inability to predict activity for on the day planning National shortage of registered midwives, impacting on staffing recruitment pipeline	9 3 x 3	16 4 x 4	no change	2 1 x 2	Daily staffing reviews and review of rosters Quarterly analysis of shift fill in line with Birth Rate Plus Monthly analysis of shift fill in line with UNIFY Safer Staffing Requirements Monthly analysis of 1:1 care in established labour and supernumerary coordinator status Use of NICE Safe Staffing Red Flags Quarterly review of community midwifery caseload size Monitoring of bookings and births to support workforce planning Revise workforce models in line with current birth rate - presented to Hard Truths May 23 awaiting approval Recruitment and retention working party with strategy to follow	**Current Update**: December 2023: review LD, GP and GH - Score reviewed following recruitment of newly qualified midwives and international midwives. Continue with vacancy of around 23wte but continue to experience challenges from supernumerary status and high levels of sickness. Score adjusted and reduced to 15, hope for further reduction of score following additional recruitment in March. November 2023:Confirm & Challenge Risk Meeting - 1/11/23 Attending: GH,GP,FA,JE,LR,MW Risk has stayed the same, sickness summits taken place across Directorate, work required on sickness notice. Delayed inductions - further info to add by risk owners. Sept 2023 - Review LD, GH, MW - Risk reviewed and no change to score. Further reduction in WTE registered workforce, continue with action plan and mitigations to maintain safety. On going recruitment continues. Supernumerary coordinator status maintained at 100% and 1:1 care in labour. July 27/7 - Confirm & Challenge Risk Meeting Attending: SS, JE, GH,FA, DT, LD, AF, LR, NB Reduced from a score of 20 to 16 due to all mitigation's in place, which are keeping us safe, reflecting the new score, attended Womens Forum and PSQB to confirm. New recruitment and lower birth rate would look to reduce the score further. July 2023 reviewed GH LD risk discussed at both Maternity forum and PSQB agreement that current mitigations allow the risk to be reduced to a score of 16	Dec-2023	Mar-2024	NWG	Gemma Puckett	Laura Douglas
High	6949	Family & Specialist Services	Pathology	Blood sciences	Mar-2019	Active	Keeping the base safe	Risk Of: The inability to deliver a two site Blood Transfusion / Haematology service Caused By: The inability to recruit and retain sufficient numbers of HCPC Biomedical Scientists to maintain two 24/7 rotas. Resulting In: Serious disruption to the blood transfusion service, impacting on various clinical services that rely on this department. This is due to insufficient staffing and an inappropriate workforce model for the service. The department is unable to provide a back up rota at present due to the current staffing levels and in the event of not being able to provide a two site service would implement BCP. Concerns have been raised from A/E, Acute floor and gastro regarding the BCP currently available.	1. Substantive Biomedical Scientists are working additional shifts to cover gaps in the rotas, also utilising Bank staff where available. 2. Staff development plan in place for training Biomedical Scientists 3. Existing business continuity plan in place Locum has been approved, but currently unable to identify a suitable locum.	1. Substantive Biomedical Scientists are working additional shifts on a voluntary basis with no obligation to provide cover and over a sustained period of time with no imminent resolution. Good will and overtime. Only finite number of shifts staff members can physically perform. 2. Delay in recruiting locums due to length of time taken to approve Business case. 3. Staff development plan for trainees is compromised and time scale lengthened, due to reduced levels of trainers present during core hours as a result of additional shift commitments. 5. Business continuity plan has not had a recent test with relevant stakeholders - Desk top exercise required 6 Stakeholders have raised concerns regarding the current BCP	10 5 x 2	15 5 x 3	Risk decreased from a score of 16.	5 5 x 1	July PSQB - Risk increased from a 12 to 16. JE to liaise with biomedical team regarding the context, gaps and mitigation of the risk Action plan relating to Gaps in control number 3. Understand blockers to the recruitment process and determine options to expedite the process. Completed and posts filled Action plan relating to Gaps in Control number 5. Organize a test for Business continuity plan with relevant stakeholders. Update 12/1/2018- BCP test planning meeting arranged for 15th Jan. Planning actual test for last week Feb 2018. Further tests of BCP included in lab audit calendar.	**Current Update**: December 2023 - Increased levels of sickness is putting strain on the 2 x 24/7 rosters, causing difficulties in finding volunteers to cover shifts. Nov 15/11 - Department still trying to locate a suitable locum, all vacancies have been filled but not with qualified BMS due to lack of suitable candidates, staff will require training and supervision.	Jan-2024	Jan-2024	DB	STEPHEN SHEPLEY	HAYLEY BAKER
High	7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Fire committee has been established in November 2019 where fire safety is discussed and any risks escalated. Chief Operating Officer, is the nominated executive lead for fire safety Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher	Number of areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 5 x 3	15 5 x 3	no change	1 1 x 1	May 2021 The fire strategy has been produced by outside consultants and a work plan is being developed. The fire policy is ready to be approved by the fire committee. Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trusts reconfiguration plans. Fire Committee to review fire risks. July 2019: NHSI capital bid for 19/20 June 2019: Fire risk assessments, installation of sockets May 2019: Delivery of fire training Feb 2019: Walk around on wards between CHS, CHS Fire Officer and Matrons with the aim of de-cluttering wards to ensure a safe and effective evacuation. Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard.	**Current Update**: December 2023: Funding for fire allocated for 23/24 is £200,000. Compartmentation survey have now been completed. CHS to appoint a contractor to undertake remedial's. CHS working with procurement to tender works. Once finalised, a decision to be made regarding priority of works and the operational impact on services.	Dec-2023	Jul-2024	FIREC	Jonathan Hammond	Keith Rawnsley
High	7874	Family & Specialist Services	Women's Services	Gynae OPD HRI/CRH	Oct-2020	Active	Keeping the base safe	Risk merged with risk 7762 Due to a number of factors (Covid recovery and changes in the national screening programme in relation to HPV) 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.	prioritising patients on a fast track pathway Current low grade clinics in place Colposcopy nurse in training	Insufficient capacity to meet demand Inability to predict nurse training completion	12 4 x 3	15 3 x 5	no change	3 3 x 1	escalated to ADN re nurse staffing Matron working with service to identify staffing CD working with Medical staff estimated 12 additional sessions would put the service back to normal wait times case for Mysure to support additional hyst being undertaken in an opd setting Case put forward to NHS England screening programme for funding for additional equipment Escalated to division and directors	**Current Update:** December 2023: Confirm & Challenge Risk Meeting - 1/11/23 Attending: GH,GP,FA,JE,LR,MW. Risk could be reduced potentially to a 12 score, consider current position if KPI at 8 weeks. Oct 23 - funding received improved position down to 19 weeks wait for low grade - plan for further clinics - to review next month in view of reducing score	Dec-2023	Dec-2023	PSQB	stephen shepley	Gill harries

High	7994	Corporate	Corporate Nursing	Enhanced Care Team	Jan-2021	Active	Transforming and improving patient care	There is a risk of not being able to deliver individualized patient centered care for our most vulnerable patients who require a higher level of enhanced care due to the current number of vacancies within the team and inability to fill staff bank requests to provide this service , resulting in increased falls poor and patient experience	Existing referal process to the ECSW lead provides a stepped approach to patient care interventions prior to referral to the team for 1;1 care requirements. Each patient following referral has a assesment by the lead or delegated RN to determine existing interventions ,care planning and support that can be initiated at ward level to support patient safety and experience. Utilisation of existing ward workforce to maintain patient safety by cohorting patients to maximise visibility and care delivery.utilisation of engagement support workers. keep carers caring initiative to support care of these patients Escalation to ward matron to review staffing requirements and available staffing against acuity and dependancy through daily safecare and workforce meetings. Ability to utilise bank HCA if available if unable to cover patient demand within existing ECSW workforce. care plan developed in EPR that supports person centred care and guides interventions use of equipment such as falls alarms	There are periods when demand does not match capacity in terms of 1:1 provision equipment is not always utilised person centred care plans not completed consistently to support care delivery delays in discharge process increase risk of harm and deterioration Lead Dementia post currently vacant Safe care does not provide clear picture of true demand and pressures	10 2 x 5	15 3 x 5	no change	6 2 x 3	Sept 23 Review provision on Enhanced care team and consider new approach based on best practice and Go Sees - RC Dec 23 Continue to have daily oversight of patients with enhanced care needs through daily staffing meeting with support and intervention from the team and ward matron - ongoing Develop person centred care strategy and delivery plan - RC Jan 24 Attempt recruitment into lead dementia post - RC Dec 23 develop acuity measure through safe care to provide clear oversight - AD / RC Feb 24 support provided through other nurse specialists for management of complex patient and weekly complex MDT established - complete reiterate through hard truths process and daily matron visits the requirement to organise care delivery to cover 1:1 shifts when required even if additional support isnt available - ongoing JAN 2021 Recruitment to vacancies currently wte 8.36 (@ 24.1.21) ongoing. Scope use of therapy assistants on staff bank to support service during day Scope use of potential medical students to work on bank Scope high user areas (care of elderly) to rotate into ECSW team for 6 months alongside recruitment process of HCA's Capture data from wards with ESW in place in relation to providing 1 to 1 care versus number of referrals. Review JD for ECSW post in line with HCSW Recruitment Strategy.	**Current Update** December 2023**:** The enhanced care team have now recruited into their vacancies. The dementia post has been appointed and she is due to start around March 2024. The demand for the service remains high due to: -High number of patients with complex needs -High number of patients staying on the caseload due to fewer allocations of new placements for people with learning difficulties and complex needs This risk currently needs to remain and the service is undergoing a full review	Dec-2023	Mar-2024		WF	Lindsay Rudge	Renee Comerford
High	8147	Family & Specialist Services	Radiology	Interventional Radiology	Aug-2021	Active	Keeping the base safe	Service Delivery/Equipment /patient Safety Risk: Objective: Service Delivery/Equipment/Patient Risk: There is a risk of being unable to use the pressure injectors within both intervention labs (@ CRH/HRI) Cause: Fatal breakdown of the injectors (due to age) • Age of equipment • Inability to source replacement parts Effect: Patients requiring alternative non-invasive imaging for diagnosis. Impact: Inability to diagnose the source of a bleed in a time critical situation. In the event of a failure on both sites the patients would be required to be emergency transferred to Bradford/Leeds Hospital. RCR Guidelines require that every Cath Lab should have an injector.	- Only able to perform on the HRI site.	- In the event of a breakdown we are unable to source alternative parts which would result in that element no longer being able to be used.	6 3 x 2	15 3 x 5	Risk Increased from risk score of 9.	3 3 x 1	- Maintain locally in good order - Quotation form supply chain - on multi purchase deal £20,520 (incl. VAT) for both - all pressure injectors across all modalities are being added to the MES contact tender - To be included within the Radiology equipment replacement plan.	**Current Update**: December 2023: Awaiting installation of the injector, to close once in place. November 2023 Update: Funding for one injector (£20k) approved at Dragon's Den in October 2023. It is on order with a 6 week delivery lead time. Risk score to remain the same until the injector is installed. To closed once installed and kit running again (likely January 2024). October 2023 Update: Business case written (£20k), to be presented at Dragons Den (October 2023).Risk Confirm & Challenge 25/10/23 Attendees: SS, CG, GE, SD, LR, JE, SRF, GH Now approved, once in place risk will close, new one if required .	Jan-2024	Mar-2024		PSQB	Stephen Shepley	Amreet Uppal
High	8398	Surgery & Anaesthetics	General and Specialist Surgical Services	Colorectal	Aug-2022	Active	Keeping the base safe	There is currently a risk of high volumes of patients awaiting a follow up appointment within Colorectal surgery due to increased referrals post covid and historical patients waiting for their appointments, resulting in patients waiting longer for their appointments which will delay treatment and care for these patients.	Clinicians have prioritised work to ensure long waiters have been treated for surgery, along with the cancer patients. Currently as of 16/08/2022 922 patients are over due appointments, of which 118 patients are overdue 52 + weeks and 141 overdue 39+ weeks	There has been a 30% increase in demand with no increase in resources to see more patients. There is no failsafe officer.	15 3 x 5	15 3 x 5	no change	6 2 x 3	Clinicians have sight of the patients that are overdue , to implement plans to mitigate and clinically validate these patients as not all patients require follow up appointments. To write a business case for an additional Colorectal Consultant.	**Current Update**: December 2023: Volume of patients has maintained at 736 from October to date, therefore some of the learning already embedded is showing an improvement in the position. To review again in January 2024 in light of overall numbers in view to reducing the risk. 03/10/2023 Update - With the strikes we have not seen an improvement as originally anticipated. The department have set up a working group with key stakeholders to improve the data quality and system process that is causing the issues.	Nov-2023	Nov-2023		PCB	Thomas Strickland	Laura Cooper
High	8504	Family & Specialist Services	Women's Services	Yorkshire Fertility (was ACON)	Jan-2023	Active	Keeping the base safe	There is a risk of delayed fertility treatment due to a current 16 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.	Escalated to General Manager for pathology and Lead Andrologist to see what can be done to improve wait times Lead Andrologist to look at the andrology diary and audit DNA rates for their service	Both Fee pay and NHS patients are unable to have their IVF treatment as waiting for the test to plan appropriate treatment it will have an impact on patient satisfaction and experience as many couples will be unhappy with the wait.	15 3 x 5	15 3 x 5	no change	1 1 x 1	Offered MY services to help with data analysis met with Pathology - to look at additional clinics and capital scheme to go to dragons den	**Current Update:** November 2023 Confirm & Challenge Risk Meeting - 1/11/23 Attending: GH,GP,FA,JE,LR,MW How do we benchmark if no national standard? Improvements implemented, score seems high - Understand the risk and possibly describe under a financial risk, also bench mark against average length of test time. GH Take to YF Business meeting for discussion. Oct 23 - times have plateaued out but no reduction in wait times, Currently working with andrology for costs assessment	Nov-2023	Dec-2023		PSQB	Gill Harries	Helen Gibbons

High	8315	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2022	Active	Keeping the base safe	There is a risk of significant of increasing waiting lists and delays to new and follow up appointments in the ophthalmology paediatric service as well as delays in improvement, quality assurance, staff development and pressure on the service due to not having enough substantive Paediatric Consultants. This could result in catastrophic or significant harm to the patient.	One FT substantive consultant with 3x Paeds sessions a week Job to be advertised for substantive paediatric consultant Collaboration with locum consultants Utilisation of existing orthoptic and optometry skills Links with admin staff regarding pending lists, ASI's Regular validation	Lack of capacity Lack of additional substantive consultant Lack of speciality middle grade	15	5 x 3	15	5 x 3	no change	6	2 x 3	Validation of waiting lists Advertise attractive substantive Paeds Consultant vacancy Collaborative working amongst AHP's regarding service improvement and working differently Service improvement Review of the pathway / AHP and nursing training Paediatric leads orthoptic/ optom and also Paediatric ACP Quality assurance systems to ensure patients are seen by the right clinician at the right time Opportunities to work differently to optimise capacity	**Current Update**: December 2023- delay in locum starting. awaiting start date. 01/09/22 Locum Paeds consultant to start 2 days a week in October, Job advert out for substantive position. 2/10/2023 - Still awaiting for payment agreement and HR to confirm start date for Locum paeds consultant.	Jan-2024			PSQB	Aletta Carbone	Natalka Drapan
High	8344	Family & Specialist Services	Women's Services	Maternity	Jun-2022	Active	Keeping the base safe	There is a risk of human error in transcribing information, due to the lack of maternity reporting software resulting in misinterpretation of doppler waveforms.This may lead to an error in identifying women at risk of severe growth restriction or incorrect management of growth restricted fetuses - both of which may result in stillbirths	Doppler waveform results are produced on the scan report and staff have to manually plot using a ruler and then make a decision of care based on this result Increased clinician awareness Qualified staff member to review /plot the result	Lack of capacity for independent second check of result plotting Reliance on process to identify abnormal doppler results	15	5 x 3	15	5 x 3	no change	4	4 x 1	1.review of current software provision 2. develop a case for maternity scanning reporting software.- due to increased costings, further business case completed for BCAG June/July 23 - update case to go through Dragons Den in Oct 23 3. SGA quarterly audit 4. Raise at digital board	**Current Update**: November 2023: Review LD - Awaiting procurement to complete purchase of software and then installation before risk can be closed. Confirm & Challenge Risk Meeting - 1/11/23 Attending: GH,GP,FA,JE,LR,MW Dragons Den funding approved but no date as yet, target risk rating change to a 5 score Oct 23 case presented at Dragons Den - Case approved to review in next few months regarding reducing score	Mar-2024 Dec-2023			HSC	Gill Harries	Emma Burbidge
High	8361	Surgery & Anaesthetics	Critical Care	Pain Clinic	Jul-2022	Active	Keeping the base safe	There is a risk of disruption to services in the pain clinic due to impending retirement of Band 6 CNS in January 2024, and potential retirement of Band 7 (CNS) at some point (turned 55 in October 2021) resulting in only one experienced Band 6 Clinical Nurse Specialist leaving a gap in knowledge and a risk to patient care, as there will be limited resources to review patients on the wards and nurse clinics would have to stop.	Continue to offer show and tell sessions to staff if asked Continue to support students	No vacancies to recruit into to train someone up to take over CNS role	9	3 x 3	15	3 x 5	Risk increased from risk score of 12.	1	1 x 1	try and obtain support for a development post, so that we can train someone to take over when CNS posts become available	**Current Update:** December 2023 2 x CNS off sick New CNS still in training New staff nurse starting early December but will need supervised practice Potential for limited ward cover during the next couple of months	Jan-2024 Dec-2023			NWG	Ruth Lush	Christina Knight
High	8627	Family & Specialist Services	Appointment and Records	Health Records	Sep-2023	Active	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. Resulting in negative impact patient experience, and a poor service, compromising patient safety, as there is a risk of not being able to provide sufficient new and follow up outpatient's appointments for those patients requiring urgent reviews. This situation is also resulting in negative staff morale and negative wellbeing.	We are prioritising certain areas over others.i.e main Outpatient areas. Putting notices/signage to inform patients that they may have to seek another desk for assistance if they require to speak to a receptionist. Patients can still use the check in screens and seek directions from main desks and the Security desk at HRI.	Patients may not be mobile enough or able to move from the closed reception area to another.	15	3 x 5	15	3 x 5	no change	1	1 x 1	To keep monitoring all areas and manning the desks where the majority of flow of patients are. To recruit and train new reception staff as quickly as possible.	**Current Update**: December 23 2 vacancies were not recruited to as anticipated. one going back out to advert, one still awaiting a outcome. 0.40 was filled by an internal candidate, 1 wte was authorised for an Apprentice , however the apprentice interviewed was not suitable, so still waiting for this post to be filled. 1.80 wte has gone to redeployment and although this has been chased up several times, no one has been put forward from redeployment? So risk still stands	Dec-2023 Dec-2023			DB	Stephen Shepley	Jacqueline Sellars
High	8637	Surgery & Anaesthetics	Head and Neck	Audiology	Sep-2023	Active	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.	Children at this age are usually tested at birth via to the NHSP so bilateral hearing is ascertained at this stage and any concerns of a unilateral loss or patients not tested by the NHSP are not discharged until bilateral hearing levels can be confirmed either via OAE testing or further reviews until they reach he age that headphones can be used.	The sound proof rooms which are used for testing are too small to accommodate a bilateral system. Not having capacity to keep all patients on review until 2-3 years old means than theoretically a patient who passed NHSP but has no unilateral concerns could be discharged by service with unilateral loss this would be solved by larger rooms to house full VRA setup	15	5 x 3	15	5 x 3	no change	1	1 x 1	To get a new bilateral VRA system to install in one paediatric soundproof room then using the two unilateral systems we have to create one bilateral system for the other site. Submitted a bid to dragons den to complete the estate works required to increase the size of the sound proof rooms.	**Current Update:** December 2023. This is a risk that has been managed and accepted in the past however learning from the Lothian Report means that as an organisation we have to address this in order to future proof the service when new regulations are introduced and audited	Oct-2024 Dec-2023			DB	Will Ainslie	Nathan waite

Appendix 1 – All Risk scoring 15 or more.

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Current Risk Score
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	7689	Trust wide	All Divisions	All Departments	Keeping the base safe	There is a risk of longer waiting times for outpatient appointments, due to cancellations of routine surgery and rescheduling of clinics	20 4 x 5
Very High	8057	Corporate	Finance and Procurement	Trust wide Finance	Financial sustainability	There is a risk of not achieving the Full Year 2023/24 Financial Plan:	20 5 x 4
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	7678	Trust wide	All Divisions	All Departments	Keeping the base safe	There is a risk of reduction in safe medical staffing levels below the minimum required to maintain safety.	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.	
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	7092	Trust wide	All Divisions	All Departments	Keeping the base safe	There is a risk of incorrect prescription details due to selection errors, untrained users in EPR (Electronic Patients Records).	16 4 x 4
High	6078	Family & Specialist Services	Appointment and Records	Appointments Service	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.	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	6596	Corporate	Corporate Quality	Governance and Risk Quality	Keeping the base safe	There is a risk of not complying with the national SI framework due to competing timely investigations resulting in delays to mitigate risk and sharing findings with those who have been affected	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	7970	Community Healthcare	Outpatient Therapies	Childrens Therapy	Keeping the base same	There is a risk that delays in availability of video fluoroscopies for Children, due to the lack of trained personnel (within the trust) resulting in increased aspiration risk and delayed implementation of appropriate treatment for these children.	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	7874	Family & Specialist Services	Women's services	Gynae	Keeping the base safe	The risk of delayed diagnosis of due to waiting times of 17 weeks for colposcopy and 10 weeks wait for histology resulting in potential harm to patients	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	8344	Family & Specialist Services	Women'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.	15 5 x 3
High	8528	Medical	Emergency Care	Accident & Emergency CRH/HRI	Transforming and improving patient care	There is a risk of a reduction in the operational performance within the Emergency Department (ED) and the maintenance across all Emergency Care Standards due to prolonged patient length of stay within the ED and the impact this has on ED flow.	15 3 x 5
High	8504	Family & Specialist Services	Women's Services	Yorkshire Fertility (was ACON)	Keeping the base safe	There is a risk of delayed fertility treatment due to a current 10.5 week wait for Yorkshire Fertility patients to have a semen analysis.	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
High	6949	Family & Specialist Services	Pathology	Blood Science	Keeping the base safe	The inability to deliver a two site Blood Transfusion / Haematology service due to the inability to recruit and retain enough HCPC Biomedical Scientists to maintain two 24/7 rotas.	Risk currently scored at 15. Reduced from risk score of 16.
Moderate	7454	Family & Specialist Services	Radiology	Main X-Ray	Keeping the base safe	There is a risk to service provision due to a reduction in consultant capacity.	Risk currently scored at 12. Reduced from risk score 20.
Moderate	8072	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Keeping the base safe	There is a risk of service being compromised due to staffing vacancies in the paediatric and neonatal medical teams	Risk currently scored at 12. Reduced from risk score 20.
Moderate	8283	Family & Specialist Services	Radiology	All Radiology	Keeping the base safe	There is a risk of demand outstripping capacity across all areas of radiology due to an increase in patient demand.	Risk currently scored at 12. Reduced from risk score 20.
Moderate	8490	Medical	Integrated Medical Specialties	Neurology	Keeping the base safe	There is a risk of in-patient reviews being delayed due to a reduced medical workforce.	Risk currently scored at 12. Reduced from risk score 20.
Moderate	8537	Family & Specialist Services	Children's Services	Children's Community Nursing Team	Keeping the base safe	There is a risk of special needs schools not having enough nurses to support the schools due to staffing.	Risk currently scored at 9. Reduced from risk score 16.
Moderate	8277	Medical	Integrated Medical Specialties	Neurology	Keeping the base safe	There is a potential risk to patient care and treatment as not sustaining the day-to-day delivery of the Neurology service due to staffing.	Risk currently scored at 12. Reduced from risk score 16.

Moderate	8416	Family & Specialist Services	Radiology	All Radiology	Keeping the base safe	There is risk of an increase in expenditure relating to reporting of images due to a significant increase in the imaging department requiring reporting (linked to increase in demand) and the increased cost in reporting costs.	Risk currently scored at 9. Reduced from risk score 16.
Moderate	7479	Family & Specialist Services	Children's Services	Children's Ward CRH (3)	Keeping the base safe	There is a risk that young people with acute mental health care needs will not be met due to a national shortage of inpatient provision for young people with acute mental health issues.	Risk currently scored at 12. Reduced from risk score 16.
Moderate	7640	Family & Specialist Services	Pharmacy	Pharmacy	Keeping the base safe	There is a risk that patients do not receive appropriate medication because of the current staffing which results in a lack of assurance that patients are receiving an appropriate level of pharmacy input.	Risk currently scored at 12. Reduced from risk score 15.
Moderate	8453	Family & Specialist Services	Pharmacy	Pharmacy	Keeping the base safe	There is a risk that patients may receive incorrect or delayed medicines due to a shortage of Pharmacist and Pharmacy Technicians and Pharmacy Assistant Technical Officers.	Risk currently scored at 12. Reduced from risk score 15
Moderate	8259	Family & Specialist Services	Women's Services	Maternity assessment centre	Transforming and improving patient care	There is a risk of not meeting the required triage times of women attending our Maternity Assessment Centre for emergency assessment and treatment due to the lack of dedicated obstetric medical cover.	Risk currently scored at 9. Reduced from risk score 15.
Moderate	8568	Family & Specialist Services	Radiology	Medical Illustration	Keeping the base safe	There is a risk of being unable to provide a full medical illustration service due to a reduction in the Medical Illustration clinical photography staff by 50%.	Risk currently scored at 12. Reduced from risk score 16.
Moderate	8429	Medical	Medical Specialities	Cardiology	Keeping the base safe	There is a risk that delays will occur in PCI waiting times for PCI and angiogram patients.	Risk currently scored at 12. Reduced from risk score 15.

Moderate	8595	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Keeping the base safe	There is a risk of not being able to replace the fluoroscopy equipment due to there not being any dedicated allocated funding resulting in a limited service being provided/reduced capacity.	Risk currently scored at 9. Reduced from risk score 15.
Moderate	8006	Family & Specialist Services	Women's Services	All Departments	Keeping the base safe	There is a risk of patient harm and poor outcomes across obstetrics and gynaecology, due to an inability to cover the required rota at tier two level due to a result of rotation vacancy.	Risk currently scored at 8. Reduced from risk score 16.

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	8384	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of disruption to transfusion service due to staffing levels.	Merged with Risk 6949
High 16 4 x 4	7637	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Keeping the base safe	The is a risk of delivery of safe care for the Paediatric and Neonatal unit, due to regular sickness and isolation across the Tier 1 and Tier 2 medical staffing rota.	Following new rotation in September 2023 the allocation of trainees has been significantly improved, resulting in this risk being closed.
High 15 3 x 5	8468	Family & Specialist Services	Pharmacy	Pharmacy	Keeping the base safe	There is a risk of being unable to supply timely medication to the organisation due to pharmacy staffing not being sufficient to cover the additional beds opened during heightened operational pressures.	Merged with Risk 8453

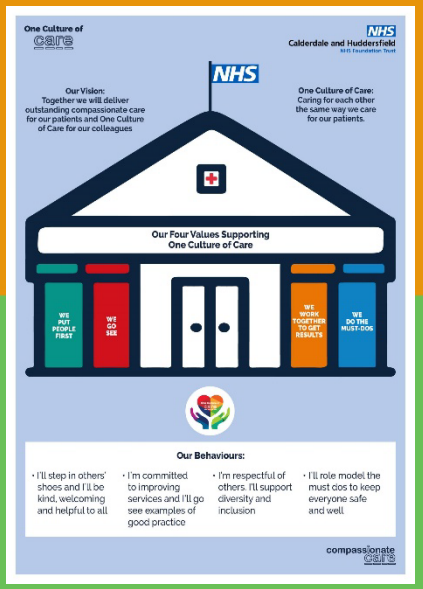
Appendix 4 – Risks that have increased in score (High Level):

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Risk Score
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 reduction in qualified BMS, inability to recruit and reduced ability to retain qualified staff.	16 4 x 4. (Risk increased from risk score of 12).
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 resulting in permanent sight loss for patients, cancellations of non-emergency capacity and increased holding lists.	16 4 x 4. Risk increased from risk score of 9).
High	8147	Family & Specialist Services	Radiology	Interventional Radiology	Keeping the base safe	There is a risk of being unable to use the pressure injectors within both intervention labs (@ CRH/HRI) due to the age of equipment.	15 3 x 5. (Risk increased from risk score of 9).
High	8361	Surgery & Anaesthetics	Critical Care	Pain Care	Keeping the base safe	There is a risk of disruption to services in the pain clinic due to impending retirement of a member of staff in January 2024, and potential retirement of another staff in 2023 resulting in only one experienced Band 6 Clinical Nurse Specialist to review patients on the wards.	15 3 x 5. (Risk increased from risk score of 12).

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	Safeguarding Adults and Children - Biannual Report
Authors:	Andrea Dauris, Associate Director of Nursing Alison Edwards, Head of Safeguarding
Sponsoring Director:	Lindsay Rudge, Chief Nurse
Previous Forums:	Safeguarding Committee Meeting - 6th December 2023 Quality Committee - 20th December 2023
Purpose of the Report	The purpose of this report is to provide the Board of Directors with an overview of Safeguarding activity within Calderdale and Huddersfield NHS Foundation Trust and how this meets our statutory safeguarding responsibilities under the Children Act 1989/2004; the Care Act 2014 and the Mental Capacity Act 2005. The report is aligned to the Safeguarding Strategy 2022-2024 and focuses on the six safeguarding principles. Safeguarding sits corporately within the Trust and the Named Executive Director is the Chief Nurse. As part of our multi-agency commitment to Safeguarding Adults and Children; Calderdale and Huddersfield NHS Foundation Trust is represented on both Kirklees and Calderdale Safeguarding Adults Boards/ Children's Partnership arrangements by the Associate Director of Nursing Corporate Services / Head of Safeguarding. The Trust Safeguarding Committee reports to and links directly into the Quality Committee on behalf of the Trust Board with a requirement to provide an annual and biannual report.

Key Points to Note	• Significant progress made in relation to CHFT sharing information with the Local Authority to close S42 investigations improving outcomes for patients and their families. • Further work is required to embed Burns, Bruises and Scalds protocol. • There is an increase in activity in relation to serious practice reviews; safe guarding adult reviews and domestic homicide reviews which impacts on team capacity; however, our response has been within timescales. • Compliance with receipt and scrutiny training is increasing. • Safeguarding and MCA/ 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. • We are working towards embedding trauma informed practice. • We are working towards increasing our resource to support increasing safeguarding supervision compliance. • We have good assurance that DoLS applications are appropriate. • We have a plan in place to ensure the child's voice and making safeguarding personal is embedded. • We continue to support the work around discharge improvement. • There is a multi-agency response to improving the outcomes for Children Looked After.
EQIA – Equality Impact Assessment	Equality impact assessment forms the basis of much of the work of the Safeguarding Team. The role of the team is to ensure that our most vulnerable people in society are protected from harm.
Recommendation	The Board is asked to **NOTE** the key activity of the Safeguarding Team for the reporting period April 2023 - September 2023.

Safeguarding Adults and Children Biannual Report April 2023- September 2023



compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Partnership

- Significant progress with S42 feedbacks to the Local Authorities
- Work ongoing to address the gap in knowledge with the multi-agency Burns; Bruises and Scalds protocol in non-mobile infants
- Providing information and supporting the learning from multi-agency safeguarding reviews
- 21% increase in compliance with receipt and scrutiny training
- Focus on increasing awareness around ICON

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Protection

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

compassionate care

Accountability

Calderdale and Huddersfield NHS Foundation Trust

- Audit of DoLS applications
- Slight decrease in MCA/ DoLS training compliance
- Decrease in Safeguarding Adults/ Safeguarding Children compliance
- Development of a refusal pathway for CLA/ Care Leavers

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Empowerment

- Child's Voice
- Lived Experience
- Making safeguarding personal
- Youth Forum is progressing

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Prevention

- Difficulties in meeting the statutory timescales for IHA's in Kirklees/ Increasing complexity in children becoming looked after
- Challenges for CLA placed from external Local Authorities in Calderdale
- Several initiatives introduced to improve accessibility for CLA
- Safeguarding continue to support ongoing work around unsafe discharges

compassionate care

Calderdale and Huddersfield NHS Foundation Trust

Proportionality

- Managing Allegations Policy has been reviewed
- Working group looking at our missing's process with West Yorkshire Police

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Safeguarding is Everyone's Responsibility

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS

11 JANUARY 2024

SAFEGUARDING BI-ANNUAL REPORT

1. INTRODUCTION

This report is the Safeguarding Biannual Report for the Quality Committee, for the reporting period April 2023 – September 2023.

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

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

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

We have previously reported delays with meeting the statutory timescales for section 42 investigations led by the Local Authority and requiring CHFT to investigate or provide information that ensures we are meeting our responsibilities under the Care Act 2014 and our safeguarding adult's policy. The impact of this has been a delay in timely feedback to our patients; their families and carers. Since April 2023, work has progressed at pace resulting in reducing the backlog of information required by the Local Authority to close these investigations. A new process has been developed to support this going forward and improve outcomes for patients, families, and carers. This has been on the safeguarding risk register, scoring 12 for a substantial period, however due to the progress made a proposal will be taken to the Safeguarding Committee in December 2023 to reduce this risk.

In response to the findings from the safeguarding practice reviews for Star Hobson and Arthur Labinjo Hughes, CHFT have submitted a response to the request from both Safeguarding Children's Partnerships to review our response to safeguarding children. Feedback from the partnerships confirmed CHFT are part of an effective multi-agency response to safeguarding children and no new actions were identified for the Trust.

CHFT have also provided a response relating to the Healthcare Safety Investigation Branch (HSIB)- Non-Accidental Injury in Infants attending the Emergency Department - April 2023. We have demonstrated compliance with some of these recommendations, however this has identified the following area for improvement:

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

Response:

- work has commenced to establish an automated electronic format as a new process to the current Electronic Patient Records (EPR).
- a Standard Operating Procedure (SOP) is being developed.
- a communication strategy is being developed.
- targeted work continues with wards, and departments as measures are adopted to improve CHFT compliance.
- BBS continues to form part of the Safeguarding Level 3 Safeguarding Children Training, as well as the ED Bespoke package.
- The improved offer for the Calderdale GPs to refer directly into CHFT has been embedded, and work is ongoing to mirror the offer within Kirklees.

Safeguarding Week took place between the 19th – 23rd June this year. This helped raise awareness of the positive work of many agencies across the locality to support our most vulnerable people in society. This year, aligning with our partners in Calderdale and Kirklees we have focussed on financial abuse/ cost of living crisis/ trio of vulnerabilities and taking a trauma informed approach/ hidden males and significant others/ Mental Capacity and the use of advocacy by promoting four personalised stories. The Safeguarding team have also developed a video to share what safeguarding means to us at CHFT. We dedicated time to meeting staff in the acute/ community services, including Children Looked After to promote safeguarding by sharing information, pens, badges, and lanyards. Safeguarding week, particularly the video received positive feedback from staff and next year we will be asking staff across the organisation what safeguarding means to them. **Appendix 1 – poster of Safeguarding Week**

During this reporting period we have received two new requests for information relating to domestic homicide reviews and both these requests have been fulfilled within timescale. The Safeguarding Team continue to support the safeguarding review process and the number of ongoing serious practice reviews has reduced from twelve to five; safeguarding adult's reviews from seven to six and domestic homicide reviews from seven to six. The key themes from these reviews are trauma informed practice, hidden males and significant others/ Mental Capacity Act including executive functioning and advanced management plans, self-neglect, professional curiosity, infant crying and how to cope and information sharing. The learning from these reviews continues to influence our approach to training and safeguarding practice.

CHFT continues to work in partnership with SWYPFT formally through the service level agreement and clinical working protocol. There are monthly meetings between SWYPFT's Mental Health Act office, CHFT and the wider partnership to discuss issues and good practice relating to the detention of patients under the Mental Health Act to support learning and the development of practice in relation to this to ensure we meet the needs of our patients. We have seen a 21% increase in our compliance with Receipt and Scrutiny training up to the end of September 2023.

	31.03.23					30.09.23					
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	92	92	61	31	66.30%	109	109	95	14	87.16%	20.85%
Key											
Aspirational Target >95%											
On target 90% - 94.0											
ear Target 85% - 89.9%											
Below Target<85%											

CHFT have been involved in a recent Kirklees challenge event to review our action plan and commitment to children, and young people at risk of Honour Based Violence (HBV) and Forced Marriage (FM). The feedback from the partnership was positive and provided the Partnership with assurance our staff could respond appropriately to concerns relating to HBV and FM. The panel were particularly keen to hear about the interactive training packages (SLIDO) that have been developed and the plan to develop our programme of lunch and learn sessions in 2024.
The following case study demonstrates effective partnership working between CHFT, the Police and Karma Nivarna charity:

A person attended ED with urinary retention in the early hours of the morning, This person was admitted to SAU with a catheter. During the admission, the patient made a disclosure to SAU that they were being forced to travel to Pakistan the next day to marry thier 1st cousin, and then they attended ED to escape. The Safeguarding team were promptly called by the ward, and the Named Professional Adult/Deputy Head of Safeguarding attended.
One to one safeguarding intervention and support followed between the Safeguarding Team and the patient, resulting in good engagement, trust and rapport built. There was effective Multi Agency working between the Police, Karma Nivarna charity, the Safeguarding Team and the ward staff. Enabling the patient to have their passport restricted so that they were unable to travel unwillingly, placed in secure accommodation, supported to report the crime to the police and ongoing to support and guidance from Karma Nivarna.
The patient was able to escape the situation, and is now studying at university.

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

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

CHFT have also been involved in several learning events in Kirklees to case audit children and young people at risk from exploitation and the outcome from these learning events is yet to be shared.

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

- support with induction; apprentice and the internationally educated nurses training sessions.
- are starting to encourage students to have short placements with team members to support their learning in relation to safeguarding.
- Delivery of training for Junior Doctor's on MCA and Safeguarding.

The Domestic Abuse Specialist Practitioner has also:

- visited The Gathering Place to network and improve the visibility of the domestic abuse services and the CHFT safeguarding team. This has led to attendance at the Health in Health Inequalities forum, aiming to raise awareness of barriers to accessing health care for vulnerable victims and perpetrators.
- was a key speaker at the Domestic Abuse Networking Event attended by over 150 multi agency workers from across Calderdale which has helped to highlight the

importance of the health role within the daily risk assessment multi-agency meeting (DRAMM).

A plan is in place for the Paediatric Liaison Sister to work from both ED areas on a bi-weekly basis to support with visibility and to provide support across the departments.

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

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

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

Following the Joint Targeted Area Inspection relating to Child Sexual Exploitation/ Criminal Exploitation in 2022 there has been good progress on the learning identified for CHFT. Three outstanding actions are progressing slowly, and anticipated completion date is March 24. These are:

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

Response
The template has now been redeveloped and shared across the organisation for comment. The feedback received has supported a decision not to progress this as a joint children / young people and adult template, and to focus on this being for children and young people only as it was felt that this would not improve current safeguarding adult processes and that the focus needs to be on improving professional curiosity and risk assessment of children and young people. We are now in the final stages of embedding this proforma across our ED departments, Paediatrics and Maternity services.

- *Scoping exercise to review how CHFT can flag children and young people at risk of Child Criminal Exploitation (CCE) and / or Child Sexual Exploitation (CSE) who live out of area.*

Response
This has been delayed due to barriers in obtaining information from the partnership. A scoping exercise is now being conducted.

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

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

3.1.1 – Domestic Abuse
CHFT continue receive funding for our Independent Domestic Violence Advisor (IDVA) from the Ministry of Justice (MOJ) and provide midyear reports and end of year reports for the Ministry of Justice. The midyear report for 2023-2024 shows the role has supported/ contacted 100 victims or suspected victims of domestic abuse.

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

The following comments have been received from our staff:

“Thank you for helping me. As a staff member it was hard for me to disclose that I am a victim of abuse, I was fearing that my colleague would find out, but you were very professional and dealt in a confident manner. I felt at ease when I spoke with you. You were understanding and not judgemental. You explained the process of accessing help and encouraged me to seek support”.

“I was referred to you by my manager. You were helpful and supported me. You were with me at my every step and soon I was able to leave my partner and move out. After leaving my relationship I was feeling down and felt useless, especially because when I was in an abusive relationship, I was constantly doing things and cleaning my house all the time as my ex-partner did not like it if I was doing nothing and now, I don’t know what to do with myself and I feel more useless now than ever before. I remember calling you and you were able to meet on the same day. You had got me hot chocolate and piece of cake, we chatted for some time and talked about options and support available for me. I did not feel that I was taking to a member of staff, you were brilliant and most importantly I knew I can come and see you if I ever felt down and needed a chat. The hospital needs more of you”.

Following a ‘go see’ visit to Pinderfields Trust to look at Domestic Abuse practice within the emergency department, we were able to take some key learning for our departments moving forward. Following this visit we are also now working towards a non-fatal strangulation pathway for the Trust, which will give a clear guidance on the medical and safeguarding interventions required when these cases present.

3.1.2 – Female Genital Mutilation (FGM)

Our FGM training data demonstrates our compliance remains below our 90% target.

	31.03.23					30.09.23					
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
372|LOCAL|Female Genital Mutilation|	578	578	519	59	89.79%	601	601	530	71	88.19%	-1.61%

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

Response

CHFT Safeguarding team have adopted a targeted approach with staff required to complete FGM training to increase compliance of this. This will continue to be monitored by the safeguarding operational group and safeguarding committee.

The table below represents the data CHFT share with NHS digital in relation to identified cases of FGM. Our data helps provide a national picture about the nature and prevalence of FGM, and how services can respond to the needs of women who have experienced violence, which includes how we address this harmful practice and its potentially negative consequences for

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

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

To date CHFT have only reported one child who has presented and has been noted to have had FGM completed when on holiday in Iran. This was reported to children's social care and the police as per safeguarding protocol.

This reporting period includes a person who had accompanied her pregnant mum to an antenatal appointment. Her mum was asked about FGM and the person stated that she was "7 or 8 when they had it done" but when probed further the person declined having ever had FGM. However, in line with verbal disclosure mandatory procedure this was reported to the police and children's social care.

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

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

FGM-IS – number of records CHFT have created.

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

A trust wide FGM policy has now been developed which is currently awaiting ratification and replaces the previous maternity FGM guideline. This also includes the Department of Health FGM risk assessment tool, which standardises our risk assessment process and supports a consistent response to those at risk.

3.1.3 Prevent

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

CHFT's Safeguarding team continue to respond to information requests and share these with partner agencies. Over the reporting period there has been 35 requests for information.

A plan to increase Prevent training to a three yearly requirement was approved by the Education Committee in May 23. However, as some concerns about the content of the Prevent training and Islamophobia have been raised by the Race Equality Network previously, the Prevent Lead Calderdale and the Head of Safeguarding, met with the network to discuss this plan and how the Prevent lead was supporting to ensure these concerns had been voiced both regionally and nationally. This change will be implemented in October 23. The initial impact of this will see a third of our workforce become non-compliant. Our Communications team have shared information Trust wide, and this has also been shared across Divisional Patient Safety Quality Boards for managers to support staff to complete this training.

The Prevent Policy was reviewed and ratified in August 23.

Our compliance within the reporting period has remained within our compliance target.

	31.03.23					30.09.23					
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
NHS|MAND|Prevent WRAP - No Renewal|	6344	6344	5958	386	93.92%	6454	6454	6053	401	93.79%	-0.13%

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

3.1.4 Trauma Informed Care

We are working together with BLOSM towards becoming a fully Trauma Informed Emergency Department (ED) and have made real progress over the reporting period. We have delivered our new ED Bespoke Safeguarding session to over 100 nursing colleagues across our departments and embedded within these sessions the principles of Trauma Informed Practice, linking this to previous case examples and introducing external agencies into the sessions who have brought a different perspective and encouraged debate and discussion between ED staff and external partners. We are looking at including our senior medical colleagues at these meetings moving forward which will further allow us to implement the approach across our departments.

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

We are proud to be part of the West Yorkshire Adversity, Trauma and Resilience network and as part of this our BLOSM project lead is currently undertaking a fellowship in Adversity, Trauma and Resilience which has supported the opportunity to work alongside colleagues across West Yorkshire from a range of different sectors all focused on the same goal. We have been chosen as a pilot site to check our readiness to become a Trauma Informed trust and as part of that have linked in with senior colleagues to start planning what needs to be put in place to make that possible.

We are committed to continue to work with BLOSM towards implementing a trauma informed approach across our departments and improving outcomes for service users. The social pathways developed by the BLOSM service continue to support how we embed our learning from local safeguarding reviews.

A policy to support children and young people with their mental health needs was introduced in 2021, with an update undertaken in October 2023. The Risk Assessment and Care Plan for Children and Young People with a Mental Health concern was also introduced as part of this policy that requires completion following admission for any children and young people who present with mental ill health.

3.1.5 Children and Young People with Mental Health Needs

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

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

Work remains ongoing to improve SDQ scores and consistency of reporting for Children Looked After (CLA). There are further meetings between the CLA team and Local Authority to improve these. The CLA Nurses contribute to the assessment in relation to the suitability of Calderdale Therapeutic Services Intervention.

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

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

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

- 214 urgent referrals
- 139 extension requests
- 161 applications have been cancelled due to no longer being required.
- of these, only 1 application has resulted in a Best Interest Assessor attending the ward to approve a standard DOLS authorisation.

The Designated Nurse for Safeguarding Adults West Yorkshire Integrated Care Board (ICB) questioned the number of DoLS applications made by CHFT which do not progress to standard authorisations and if we are considering the Ferreira Judgement in relation to DoLS applications. Our response is outlined below which provided assurance that CHFT have robust processes in place.

<u>Response</u>

A random sample of 8 DOLS applications were selected from the last 6 months practice and reviewed by our Named Professional Safeguarding Adults/Deputy Head of Safeguarding, Nurse Consultant Learning Disabilities, Nurse Consultant Mental Health and Head of Legal Services. Of the 8 applications reviewed, all participants in the investigation agreed that 6 of these were appropriate DOLS applications, with an appropriate level of restriction in place to warrant an urgent DOLS authorisation. There were 2 applications where there was a low level of restriction in place. Both patients were a documented falls risk and there is evidence in the

notes to suggest intermittent close supervision. Both patients became acutely unwell and were commenced on the end-of-life care pathway, offsetting the need for a DOLS to be in place. However, this was not a predicted outcome for both patients on admission and so the use of DOLS was still viable.

Further enquiry demonstrated that of the last 6 months, no DOLS applications have been rejected by either Kirklees or Calderdale.

From a legal perspective, the overall agenda is to ensure the appropriate framework surrounds these patients both in terms of standard and urgent authorisation, in which following the audit we can be confident that we are following. Moreover, given that the authorisation office has rejected none of CHFT applications, suggesting these are appropriate, CHFT are confident that appropriate process and paperwork is completed when indicated.

Overall compliance with MCA/ DoLS training remains within target however over the reporting period there has been a slight drop in compliance with staff requiring level 2 and level 3 training. This will continue to be monitored via the safeguarding committee and is in response to review of training requirements earlier in the year.

	31.03.23					30.09.23					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	6344	24703	22941	1762	92.87%	6454	25243	22797	2446	90.31%	-2.56%
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
NHS|MAND|Mental Capacity Act - 3 Years|	263	263	249	14	94.68%	295	295	269	26	91.19%	-3.49%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3357	3357	3054	303	90.97%	3406	3406	2993	413	87.87%	-3.10%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	875	875	843	32	96.34%	920	920	800	120	86.96%	-9.39%
Key											
Aspirational Target >95%											
On target 90% - 94.0											
ear Target 85% - 89.9%											
Below Target<85%											

Our Future Plan:

1. DOLS applications continue to be monitored and quality assured by the Safeguarding Team before they are sent to the Local Authority for review.
2. The introduction of an online form for DOLS application is to be introduced soon. DOLS notifications to CQC are now only required when there has been a standard DOLS authorisation. This will alleviate some administration pressure on both staff on the ward and within the Safeguarding team. Having a more streamlined process and automated dashboard will reduce the risk of human error and increase time we can spend on patient care.
3. The Safeguarding team will continue to increase knowledge and confidence throughout the Trust through training, support, and guidance with MCA and DOLS.
4. The Safeguarding team will use data collection to monitor themes and trends from a Trust perspective with regards to DOLS applications and use this information to recognise gaps in knowledge that will steer training focus for the future.
5. An external audit of MCA is planned for Winter 2023.
6. The Best Interest Decision making form is to be added to EPR for ease of access, with supplementary training to be provided to support staff in utilising this tool.

4.2 Safeguarding Training.

The Safeguarding Children's/ Adults/ MCA/ DoLS training packages for level2 and level 3 have now been reviewed and include a hybrid approach of e-learning and face to face sessions.

This ensures compliance with the safeguarding Children and Young Peoples: Roles and Competencies for Healthcare Staff (2019), the Looked After Children: Roles and Competencies for Healthcare Staff (2020) and the Safeguarding Adults: Roles and Competencies for Healthcare Staff (2018).

The adult face to face safeguarding training now supports more bespoke packages for acute, community and ED staff. Our new face to face packages are evaluating positively amongst staff.

We have noted that compliance in relation to safeguarding Adults and Safeguarding Children level 3 training has dropped by 19% and 20% retrospectively since the end of March 2023. This coincides with the reintroduction of the face-to-face training. To support an improvement in compliance the Safeguarding Team have increased the availability of face-to-face sessions over recent months, and this is being monitored by the Safeguarding Committee.
The Level 3 children's training package has been enhanced and re-developed with the content having been updated to reflect local learning. An improved offer has been provided and will be embedded by December 2023.

Following the maternity CQC inspection in May 2023, the Safeguarding Team have met to review the allocated safeguarding requirements of staff across the organisation. This will ensure staff are allocated the correct level of skills and knowledge equating to the requirements of their role.

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

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

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

	31.03.23					30.09.23					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	6344	24703	22941	1762	92.87%	6454	25243	22797	2446	90.31%	-2.56%
Competence Name	**Assignment Count**	**Required**	**Achieved**	**Outstanding**	**Compliance %**	**Assignment Count**	**Required**	**Achieved**	**Outstanding**	**Compliance %**	**% Deviation**
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1754	1754	1693	61	96.52%	1773	1773	1731	42	97.63%	1.11%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3901	3901	3623	278	92.87%	3952	3952	3532	420	89.37%	-3.50%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	576	576	561	15	97.40%	629	629	489	140	77.74%	-19.65%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1751	1751	1695	56	96.80%	1768	1768	1726	42	97.62%	0.82%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3928	3928	3624	304	92.26%	4012	4012	3608	404	89.93%	-2.33%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	553	553	500	53	90.42%	570	570	397	173	69.65%	-20.77%
372|LOCAL|Safeguarding Supervision|	731	731	561	170	76.74%	754	754	574	180	76.13%	-0.62%
Grand Total	**6344**	**24703**	**22941**	**1762**	**92.87%**	**6454**	**25243**	**22797**	**2446**	**90.31%**	-2.56%

Key

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

Additionally, both the Paediatric Liaison Sister, and the Safeguarding Paediatric and Maternity Advisor, are working closely with the training department, and the Paediatric Clinical Educator to improve the safeguarding induction package for new paediatric starters within the Trust to provide a bespoke offer.
Safeguarding supervision compliance remains below our target of 90%. However, to support improving this the following steps have been taken.

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

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

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

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

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

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

We continue to develop our safeguarding champions network as this is instrumental in supporting our staff and over the next few months plan to develop this further by identifying our community based safeguarding champions.

Some of the Safeguarding Champions have taken on an additional role as a Safeguarding Supervision facilitator to support with ward and departmental compliance, and a recent request has been sent to establish Champions with a keen interest in PREVENT to establish a cohort of PREVENT champions within the network. **Appendix 2** Safeguarding Champions poster

4.3 Audit

All audits identified in the safeguarding audit plan have been completed or are underway apart from the Paediatric liaison and Management of patients not brought to appointments audit. These have been delayed due to the ongoing work relating to the number of safeguarding reviews. There has been no detrimental impact of these audits being completed as processes are in place for both these areas.

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

4.3.1 Transfer of Antenatal/Postnatal information to the neonatal EPR record from Athena audit

This was a planned re- audit to ensure the process for recording birth and safeguarding information from the Athena electronic maternity record to the neonatal EPR Power chart record is embedded in practice.

The audit concluded that there has been a significant improvement in the transferring of information from Athena into babies EPR records from 33.6% in the initial audit to 74.5% in the re-audit.

A further smaller dip sample of records will be undertaken to ensure the process of transferring information from Athena into babies EPR is embedded in practice.

4.3.2 ICON audit

ICON training was rolled out to Midwives in 2020.

The aim of the audit was to assess if ICON was discussed and recorded in the Athena Maternity EPR record at the following touch points:

Touch point 1 community-based intervention (antenatal) - The audit has identified that ICON discussions are not being recorded in the antenatal period in the Athena EPR records.
Touch point 2 hospital-based intervention (before discharge home after the baby is born) - The audit has identified that ICON discussions are taking place and being recorded in the coping with crying section on Athena. It is not recorded though if male parents/caregivers are provided with ICON information.
Touch point 3 community-based intervention (postnatal period) - The audit has identified that ICON discussions are not always recorded in the Athena.

Our Named Midwife is working with Maternity services to address the findings of the audit.

As part of standard practice SOPS are reviewed in light of any changes at the time of coming into effect. The Paediatric Liaison SOP has been updated in line with changes following partner discussions with Locala and in response to CHFT changes to process.

Paediatric Liaison Notification SOP has also been updated following the introduction of an electronic form and automatic referral into the safeguarding team.

A refusal pathway has been developed to ensure that young people refusing their health assessment are placed into a vulnerable caseload followed up at regular intervals to try and engage them in a health assessment.

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

The voice of the child and the lived experience is a golden thread that runs through the work undertaken across the Trust. BLOSM has since launched across both the Emergency Departments in January 2023. The reaction to the pilot has been positive and the exemplary work can be demonstrated following the most recent nomination for a Nursing Times Award in London 2023. In response to the work undertaken and the recent nomination the development of a presentation was undertaken by the BLOSM team to present to the Nursing Times Awards judges. The presentation included a patient story representing the voice of a young person who has positively highlighted the great work BLOSM is undertaking and the

impact that this has had on their life and well-being, this has since been incorporated into the Safeguarding Children Level 3 Training package.

Child M is a young person who attended the ED following a suspected episode of self-harm, Child M denied this and stated that the overdose had been unintentional, and routine follow up was completed at this point by the Paediatric Liaison service. Child M subsequently represented with a further episode of ingestion of medication, at this point, they disclosed that there was an intent to end life following an incident in school. Following on from this Child M presented following an assault in school at which point the BLOSM pilot had commenced in Trust and with consent gained from Child M, a referral into service was completed. At this point Child M had relayed the positive outcomes achieved following the work the BLOSM care navigator have been able to deliver. Child M had been through service pre-BLOSM and was able to communicate the difference it had made. They stated that because of the work provided they were in a much better place and felt that they had been well supported and helped. Since then, there have been no further incidents of self-harm recorded on records and school have initiated a package of support through school.

As part of the BLOSM data collection process, BLOSM continues to collate feedback from young people based on their experiences of working with the BLOSM youth workers, this includes asking the young person how their interaction with the youth work team has improved their experience within the department. The key element of the BLOSM evaluation is to ensure that the views and thoughts of the young person is captured and utilised as a method to shape services moving forward.

The Youth Forum continues to be progressed and there have been two additional events that have since taken place. The first event was in April 2023 relating to Children and Young People's experiences of attending the Emergency Departments, the second most recent session in September focused on experience relating to taking blood tests. There are plans for two young people to meet with CHFT governors to share their personal experiences.

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

The Working Together to Safeguard Children guidance and the Information Sharing Advice for Safeguarding Practitioners was released for consultation and CHFT submitted its response to these in September 2023. Once the final version of these documents is available, CHFT will need to update the Safeguarding Children Policy to ensure any changes are reflected in our operational policy.

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

There has been some targeted work regarding discharge within the Trust, focusing on poor discharge and safeguarding implications with regards to this. This is an opportunity to look at poor discharge from a Safeguarding perspective and the themes and trends that surround these cases. There is a safer discharge working group which the Safeguarding team attend, and safe discharge now forms part of the Adult Level 3 Safeguarding training.

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

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

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

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

In Calderdale the total number of CLA was 351 and in addition 222 CLA have been placed in Calderdale from other areas. During this period 92% of IHA's were completed within timescale and 82% of RHA's were completed within timescales in quarter 1. In comparison the total number of CLA was 357 and in addition 228 have been placed in Calderdale from other areas. During this period 58% of IHA's and 88% of RHA's have been completed within timescale.
Factors impacting on completion of IHA's:

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

Within Kirklees and Calderdale, we are seeing an increase in complexity of CLA due to an increasing number of children who are becoming looked after and unaccompanied asylum-seeking children (UASC). It is anticipated that the number of (UASC) will continue to increase, and this picture is also being mirrored across West Yorkshire.

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

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

The Calderdale CLA team continue to offer drop-in sessions at the Orange Box once a month which provide support to Care Leavers with health advice and signposting. This has also improved communication and collaborative working with the Pathways service.
The following case study illustrates the positive impact of the CLA nurses supporting Care Leavers at the Orange Box:

Care leaver presented at the Orange Box with a diagnosis of epilepsy managed with medication. CLA nurse reviewed the health records and there was no information regarding the diagnosis or medication. GP contacted to arrange for a review of epilepsy. CLA nurse advised the appointment would need to be made via the online portal. This was actioned by the nurse and a face-to-face appointment requested. The young person was provided with information for mental health support.
The young person was again seen by the CLA nurse 2 months later reporting an increase in seizures. The GP had made a referral to neurology. Poor sleep, increasing use of energy drinks, anxiety, depression, and reduced cannabis use reported. Referral was made to the epilepsy nurse and pathways worker contacted in relation to mental health support. A discussion took place between the CLA nurse and young person in relation to lifestyle choices and options.
The following month the CLA nurse received communication from the epilepsy nurse detailing an appointment date and communicated this with the Care Leaver and pathways worker. Later that month a date for a CT scan was received however there was some confusion regarding the date of the scan, and when the CLA nurse contacted the Consultants secretary it was established this had been missed. The CLA nurse contacted Radiology and the scan was rearranged for the next day. This was communicated with the Pathways worker who is supporting the care leaver.
The following month the CLA nurse received communication from the Pathways worker detailing that the young person had sustained an eye injury. CLA nurse contacted the relevant department and appointment made. The young person missed the appointment however the CLA nurse contacted the GP requesting a re referral to the appropriate service. Further contact from the Pathways worker later that month requesting for a change to the EEG appointment. The CLA nurse has contacted the relevant department who are sending details of a new appointment.

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

- Introduced the friends and family test to support gathering regular feedback from children and young people which will support the voice of CLA and Care Leavers.
- Devised a child friendly information leaflet that explains the role of the CLA team, the health assessment process and support services available in Calderdale.
- Secured the use of the new Rainbow Child Development unit from January 2024 to complete initial health assessments. This provides a child friendly environment with colour, play and distractions to support a positive experience in what is an unsettling time for the child.

- Following identifying that the main group of children refusing dental care are aged 15-17 years, the CLA team have worked with the Oral Health team to supply supplies and education with the Pathways workers to increase awareness about oral health. In addition, for young people who are not registered with a Dentist they are signposted to dental practices which are signed up to dental flexible commissioning services scheme which is a scheme designed to improve access to dental care for vulnerable groups.
- Attending the Pathways service Walk and Talk events, which provides an opportunity to meet with young people in a more formal way, to support positive relationships and trust and the opportunity to discuss any health related if they want to.

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

Following the audit of compliance with the Allegations of Abuse Against Staff Policy earlier this year, there has been several briefings to support staff with their understanding of their responsibilities under this policy. The policy has been reviewed and was ratified in August 23 and now includes a flow chart to clarify individual responsibilities. Between April 2023 – September 2023 there has been 23 allegations made against our staff, eighteen relating to adults and 3 relating to children. The Assistant Director of Human Resources; Associate Director of Nursing Corporate and Head of Safeguarding meet monthly to discuss and provide safeguarding oversight with staff members who are being managed under this policy.

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

Our Named Professional/Deputy Head of Safeguarding is conducting a piece of work with our security/health and safety teams to increase knowledge and expertise in least restrictive practice with regards to patients that are subject to a DoLS.

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

<u>Response</u>
Our Named Professional Adult Safeguarding/ Deputy Head of Safeguarding is leading a task and finish group to look at our organisational response to this. The Missing Persons Policy will be updated with the Police later this year.

APPENDIX 1 - poster of Safeguarding Week

APPENDIX 2 - Safeguarding Champions poster

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	Nursing, Midwifery and Allied Health Professional Bi-annual Safer Staffing Report
Author:	Andrea Dauris (Associate Director of Nursing – Corporate)
Sponsoring Director:	Lindsay Rudge – Chief Nurse
Previous Forums:	Quality Committee 20th December 2023 Workforce Committee 18th December 2023
Purpose of the Report	The purpose of this report is to provide the Board of Directors with an overview of Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance within Calderdale and Huddersfield NHS Foundation Trust in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce Safeguards guidance. This is supported by an overview of staffing availability over the reporting period, progressing with assessing acuity and dependency of patients on ward areas and the quality impact upon nurse sensitive indicators. This data collection has been used to inform the Nursing and Midwifery establishment reviews for 2023-2024. It is a national requirement for the Board of Directors to receive this report bi-annually.
Key Points to Note	The following details that are considered the key points to note: • The national picture for nursing and midwifery vacancies remains tumultuous therefore 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 as we move through 2023 with several additional winter capacity areas remaining operational beyond predicted time frames. 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. Benchmarking from the Model Hospital suggests at a Trust level CHFT sits in quartile 2 at 8.2. The Trust median position sits at 8.5 slightly less than our peer's median of 8.7. • CHFT have recommissioned a New Birthrate+ 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.
EQIA – Equality Impact Assessment	Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non-English speakers and being a member of a social minority (e.g. migrants, asylum seekers, and travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing, midwifery or allied healthcare professional staff required to provide safe care. Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the scoping document. Evidence shows us a direct correlation between quality, safety and patient experience and nurse staffing levels. Failure to have staffing in place that meets the care needs of patients means there is a potential risk of poor outcomes for all service users. Should this be the case then people from protected characteristic groups could have been disproportionally impacted given the evidence to suggest a less favourable experience for people from these groups across all NHS services.
Recommendations	The Board is asked to: • Receive and **NOTE** this report and note the on-going plans to provide safe staffing levels within nursing, midwifery and AHP disciplines across the Trust. • **NOTE** the ongoing recruitment plans to support each service • **NOTE** the maternity staffing position and the local position which is common with the national profile. • **NOTE** the compliance against the triangulated approach that underpins the Trust's establishment processes and the ongoing quality of data it provides.

NURSING, MIDWIFERY AND ALLIED HEALTH PROFESSIONAL BI-ANNUAL SAFER STAFFING REPORT

CONTENTS

1.0. INTRODUCTION

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

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

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

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

- Evidence based tools and data
- Professional judgment
- Outcomes

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

This report describes CHFT's position in response to the national guidance for the reporting period 1st April – 30th September 2023.

2.0 SAFER STAFFING

2.1 Nursing and Midwifery Establishment reviews.

Since the last establishment review, the Trust continues to approach the setting of nursing and midwifery establishments as set out in NQB standards. This includes the implementation of the Safer Nursing Care Tool (SNCT), an evidence-based workforce planning tool that provides patient acuity and dependency intelligence, which has informed the Trust establishment setting process. SNCT and Community Safer Nursing Care Tool (CSNCT) are objective tools that utilise levels of care to support workforce planning and have been recognised for supporting safe staffing across in-patient wards and district nursing services.

During the reporting period the Safer Care Nursing Tool (SNCT) data collection was undertaken in June. This was followed by six divisional panels presented to the Chief Nurse which completed in November 2023.

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

The table below summarises the changes which were approved: -

Division	Area	Current WTE	Agreed WTE	Comments	23/24 Cost (£'000)	Proposed Funding method
Medicine	Ward 12	39.92	54.07	Part of the south sector non-surgical oncology (NSO). Service to be provided across Ward 12 and Ward 11b. Resulting in 4 additional inpatients beds on Ward 12 and 4 inpatient beds and 6 assessment areas on Ward 11b Approved by Matron and ADN	£609,384	Subject to NSO funding agreements
Surgery	Maxio-facial Unit	10.28	10.28	Convert B6 to B7 to support nurse leadership. Approved by Matron and ADN	£11	Divisional budgets
Surgery	SDEC	10.79	10.42	Increase of ward clerk hours from 7.5hrs to 10hrs to support flow of activity through department. Offset by a reduction in HCSW hours on Sunday shift. Supported by SNCT data, professional judgement. Approved by Matron and ADN.	0	Cost Neutral

Division	Area	Current WTE	Agreed WTE	Comments	23/24 Cost (£'000)	Proposed Funding method
Surgery	8c	18.53	20.24	Increase in HSCW role across late and weekend shifts. Supported by SNCT data, professional judgement. Approved by Matron and ADN.	£58	Divisional budgets
Community	Ageing Well Service	6.0	5.0	A reduction in 1WTE B7 practitioner. Approved by Matron and ADN. This was a non-recurrent project funded by the ICB	£158	ICB funding agreed for 6/12
Community	Bladder and bowel service	4.71	5.91	Increase in B6 paediatric service and B3 HCSW. Informed by professional judgement. Approved by Matron and ADN	£70	Identified through divisional pressures and developments
Families and Specialist Services (FSS)	Radiology Nursing	8.79	9.96	Increase in HCSW to release B7 management time. Approved by Lead Nurse and ADN.	£35	Approved subject to confirmation of divisional funding.
Total					**£941**	

2.2 Community Nursing Services

The Community Healthcare Division presented an appraisal of their current establishments, which, following a review of current services made recommendations which have been summarised earlier in the report. The overview of services continued to highlight the diversity of service provision. The division successfully completed data collection within District Nursing Services using the new evidence-based Community Nursing Safer Staffing Tool (CNSST). Given this was the first round of data collection, as per guidance, there were no changes recommended to the workforce model.

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

2.3 Maternity Services

As identified in previous safer staffing reports the midwifery vacancy position was determined following commissioning of Birthrate Plus who undertook a full baseline assessment for the period 1 April 2019 – 31 March 2020, providing the Trust with a report in November 2020. Birthrate Plus methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and has been endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.

More recently due to the decrease in birth activity the workforce model was recalculated using the 1:24 ratio as recommended in the Birthrate Plus report, this will overestimate the staffing required as it covers all ante, intra and postnatal care. This proposed a new establishment which was agreed at the previous safer staffing Chief Nurse panel in May 2023 including a proposal to apply a 90/10 skill mix between midwives and non-midwifery support staff, allowing for a flexible and sustainable service. The skill mix included maternity support workers working in community, on the transitional care pathways and staff nurses providing postnatal care on both the labour ward and postnatal ward.

A further commissioning of Birthrate Plus has been agreed to take place in quarter 4 of 2023-2024 reflective of the tools recommendations to repeat 3 yearly.

As part of this round of safer staffing panels no further changes were proposed to workforce models within the services.

Table 1: Vacancy levels September 2023

	Births	Planned WTE (MW and RN)	Actual WTE	Planned Leavers (to end Sept 23)	Midwives and RN in recruitment pipeline
CHFT	4313	198	138.8	4.41	19.08

There continues to be challenges in recruiting to the current vacancies (table 1) which is reflective of the regional and national position. The service has continued to develop its recruitment and retention strategy, holding recruitment events to attract newly qualified and existing midwives to the service. Vacancy has been further compounded by sickness, and maternity leave however a repeat Birthrate Plus will enable a reset vacancy against current birth rate and acuity and support identification of a more accurate position for reporting once completed. To ensure the safety of women and babies, and in accordance with guidance from NHSEI, the maternity service has prioritised provision of 1:1 care for women in established labour and supernumerary status of the labour ward coordinator (table 2). This has contributed to decisions for the continued suspension of services at Huddersfield Birth Centre and the continued suspension of the roll out of maternity continuity of carer.

Local exit interviews undertaken by the Director of Midwifery suggest the main reasons midwives are leaving continue to be due to leaving the midwifery profession, promotion, relocation, and retirement. The maternity recruitment and retention working party has developed a recruitment and retention strategy, which also includes stay

interviews hosted by the Deputy Director of Midwifery and Matrons with discussions around options of flexible or alternative working to support colleagues. The maternity services Deputy Director of Midwifery and Band 7 lead on workforce with clinical educators who work clinically with the newly qualified midwives to provide support. Previously the clinical educators were funded from NHSE but having realised the benefits of clinical support a permanent full-time band 6 clinical educator has been recruited.

The maternity service continues to be involved in LMNS regional recruitment for student midwives who qualified in September 2023. In preparation for this CHFT maternity services held two recruitment events to showcase the service and to meet the teams. Both events were well attended with student midwives from both CHFT and other local Trusts. Further recruitment events for student midwives who qualify in March 2024 have been held in October as well as participation in the Trust wide recruitment event. Formal application and interviews will take place in November 2023.

The Trust received external funding to support recruitment to 5 international midwives, with the target that the international midwives will have passed their English Language and NMC Computer Based Test and arrived in England between 1 August 2022 and 31 December 2023. CHFT has welcomed 2 international midwives who have both completed their OSCE assessments and are now waiting for addition to the NMC register. A further 3 international midwives have been recruited and been welcomed to CHFT. They will be undertaking their OSCE assessment in November 2023.

Despite these challenges women continue to be offered three choices of place of birth in line with the aspirations of Better Births: home birth, midwife led alongside birth centre and consultant led unit. Calderdale Birth Centre has introduced a responsive model in May 2023 where staff follow the women rather than staffing a building.

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

Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. NHS Resolution's Maternity Incentive Scheme states that the midwifery coordinator in charge of labour ward must have supernumerary status, which is defined as having no caseload of their own during their shift to ensure there is an oversight of all birth activity within the service. 1:1 care in labour has remained consistently above 98% over the last six months and the coordinator remaining supernumerary has remained consistently at 100% over the last 5 months (Table 2).

Table 2:

Month	April 23	May 2023	June 2023	July 2023	August 2023	September 2023
Supernumerary status of labour ward coordinator	100%	100%	100%	100%	100%	Not yet reported
1:1 care in labour	100%	100%	98.6%	100%	100%	99.7%

2.4 Nursing and Midwifery Forward Planning

There has been updates to the Safer Nursing Care Tool (SNCT) for both inpatient and acute inpatient services. These changes include updates to current multipliers and incorporation of new categories. The Associate Director of Nursing and Head of Nursing and Midwifery Workforce and Education will update the current training programme to reflect these changes with the intention of implementation at the next round of data collection in January 2024.

2.5 Allied Healthcare Professional (AHP) Establishment reviews.

For this reporting period, the Chief Nurse held the first AHP safer staffing panel meeting. The principles that provide the framework for all safer staffing panel meetings were adhered to and reflected those identified within the Developing Workforce Standards (2018).

Unlike nursing and midwifery services, there are no evidence-based tools that can used or single guidance to inform safe staffing levels required in services provided by Allied Health Profession (AHPs) with the exception being for stroke https://www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines (RCP, 2016) and critical care https://www.ficm.ac.uk/sites/ficm/files/documents/2021-10/gpics-v2.pdf (GPICS, 2019). In the absence of specific guidance, a West Yorkshire approach reflective of that undertaken Airedale NHS Foundation Trust was agreed and coordinated with AHP leads.

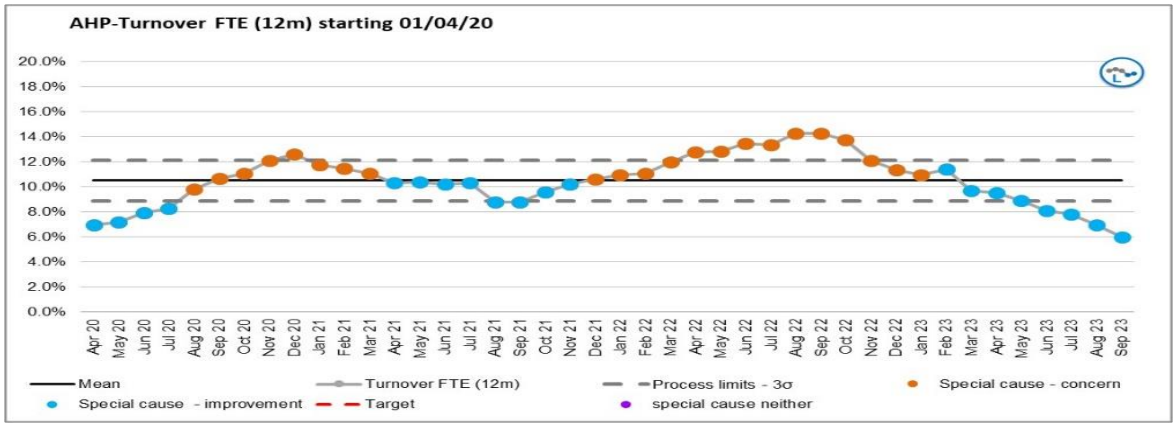
NHSI have mandated all AHP roles have electronic job plans in place. This project is almost complete with radiographers expected to be fully job-planned by March 2024. AHPs within Community Division are 100% compliant and are now working to meet level 3 attainment compliance.

The Chief Nurse panel was presented with workforce modelling and gap analysis against establishments for inpatient physiotherapy, occupational therapy, speech and language therapy and dietitians. Whilst no changes were requested the work identified a case of need around supporting the delivering of a 7-day services and a response to the growth in activity and acuity of patients.

The Community Division continues to employ an AHP workforce manager to embed the recommendations from Health Education England's (HEE) AHP Workforce Strategy including the associated recruitment initiatives. This post provides leadership to the AHP Clinical Educators who are now in post to improve the experience and

development of the support workforce, students and registered workforce to optimise patient care. The team are also responsible for recruitment and retention initiatives with qualitative and quantitative data demonstrating a significant benefit. The AHP workforce team are all employed on fixed term contracts.

The work of the Nursing, Midwifery and AHP Workforce Steering Group, has commissioned the development of an AHP recruitment and retention tracker. This tracker provides projections based on current turnover rates to determine and provide oversight of potential clinical hotspots. This is monitored monthly and informs the AHP workforce team of where focus is required. Since the employment of the AHP workforce team the turnover rate of AHPs has reduced from 12% (November 2022) to 6% (September 2023) with a downward trend evident (figure 1).



(Figure 1)

Over the last 6 months the AHP workforce team have focused on the following successful initiatives. These have been attributed to the reduction in the turnover rate. These projects were embedded within teams which at the time of the last report had the highest vacancy rates.

<u>International Recruitment</u>

- The successful recruitment of 2 overseas OTs and 1 Radiographer (with an additional 10 Radiographers planned to support CDC).

<u>Apprentices</u>

- 6 x staff completing the Physiotherapy apprentice degree.
- 4 x staff completing the OT apprentice's degree.
- 2 x staff due to start Dietitian apprentice degree in May 2024.
- 1 x staff due to start SALT apprentice degree in September 2024.
- 8 x staff completing level 5 apprentices.
- 12 x staff completing level 2 apprentices.
- Consistent presence at all trust recruitment events and apprentice interview days.

<u>Preceptorship:</u>

- AHP Preceptorship established across AHPs
- 38 AHPs within community division now enrolled on the preceptorship.

- 14 new starters due to start on the programme in the next 3 months.
- AHP preceptorship at CHFT is gaining regional and national attention.
- Will be applying for accreditation once this is available for AHPs.

Support Workers

- Over 150 hours of face-to-face training provided to AHP support workers.
- 8 support workers completing Florence Nightingale Leadership Award
- 8 staff completing Level 5 Associate Continuing Healthcare Practitioner Apprenticeship.

Rotation expansion

- Pilot of band 5 physiotherapy rotation in research.
- Band 5 OT rotations available in collaboration with SWYFT within an inpatient mental health setting.
- Work ongoing to create a further OT rotation within Overgate Hospice.

Student Capacity

- 25% increase in student capacity across physiotherapy and OT.
- Increasing to 40% by January 2024.
- Digital and leadership placements now on offer within the AHP Workforce Team.
- Collaboration with the CET to improve NETs score across AHPs ongoing.

As a result of the above, areas who had high vacancy rates at the time of last reporting have seen significant improvements in vacancy rates.

Vacancy Rate

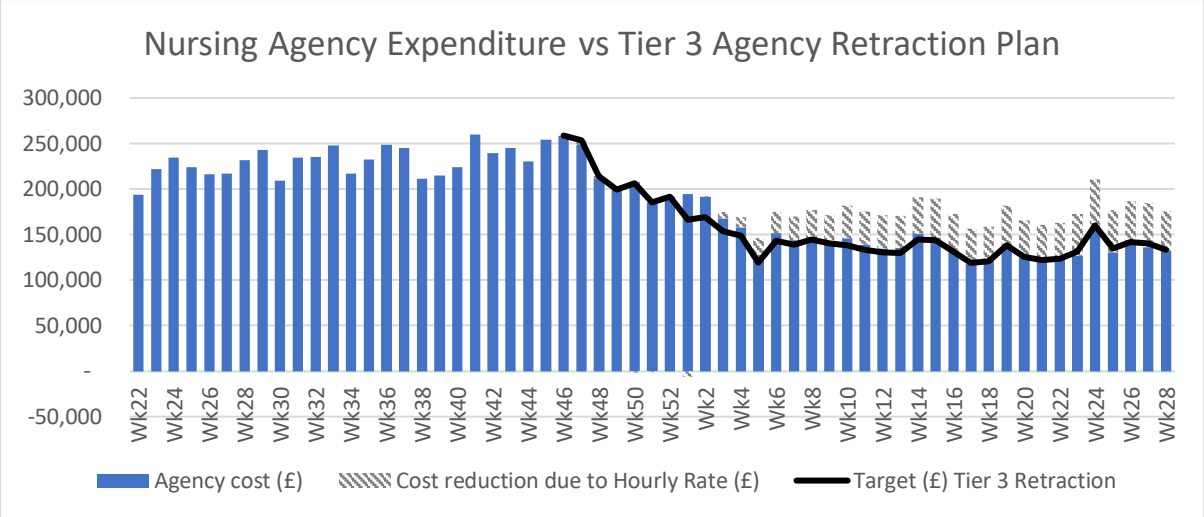
Profession	March 2023	September 2023
Physiotherapy	10%	0.73%
Occupational Therapy	5.49%	0

2.6 Agency Usage

CHFT introduced a high-cost Agency Retraction plan in February 2023. As part of the plan, visibility of vacant shifts to Tier 3, which are the most expensive agency option available was reduced. As a result of this, Tier 3 Nursing Agency bookings reduced steeply from mid-April into May 2023, subsequently ceasing entirely as of 10 July 2023. Due to very limited visibility of available shifts, 4 out of 5 Tier 3 agencies agreed to review their rates and align themselves with Tier 1 rates, which offers supply at a substantially reduced cost to CHFT.

Figure 2 shows the reduction in cost due to the improved average hourly rate position costs for temporary Nurse staffing in comparison to the previous financial year (2022/23).

However, the volume of agency activity whilst demonstrating a downward trend has remained relatively stable through 2023/24. The current volume of activity is impacted through the vacancy position and additional capacity areas.



(Figure 2)

3.0 NATIONAL COMPLIANCE

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

As part of this cycle of establishment reviews the Chief Nurse hosted the first AHP panel, further strengthening compliance with this document.

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

4.0 SICKNESS AND ABSENCE LEVELS

Figures 3 - 6 show the sickness level at the Trust during the reporting period.

During the reporting period total absence continued to be a challenging position with peaks in December for both workforce groups. The top 3 reasons for absence are anxiety, stress and depression, musculoskeletal and cold, cough, flu. Whilst Covid absence has generally dropped throughout the year, a slight increase can be seen as winter approaches.

In response, the health and wellbeing support available at CHFT continues to be refined and tailored to support the diversity of our people and remains a critical response to supporting the health and wellbeing of nursing, midwifery and AHP colleagues. In addition to a calendar of scheduled events, financial wellbeing is a particular focus where colleagues can gain advice and support via the Employee

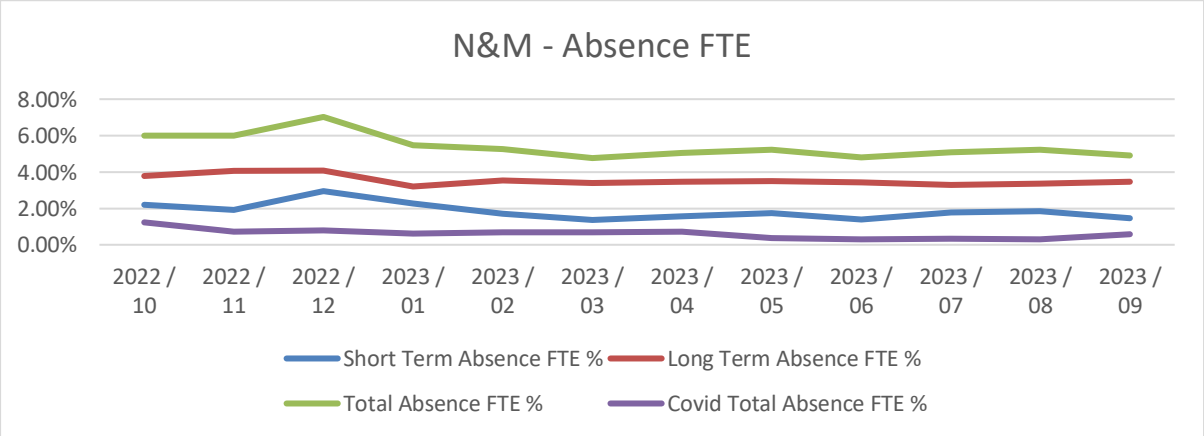
Assistance Programme. CHFT also has top up shops at each hospital site where people can pick up and drop of as and when they need things like non-perishable items, sanitary products, toiletries and recycled clothes. Schwartz rounds continue where all colleagues clinical and non-clinical come together to discuss the emotional and social aspects of working in healthcare.

CHFT's psychologist team are currently training a pool of trauma debriefers who are volunteers from the organisation, in addition to the psychologist being EMDR trained. This means colleagues can access therapy that treats mental health conditions that happen because of memories from traumatic events in their past. Its best known for its role in treating post-traumatic stress disorder (PTSD)

Qualified Nursing & Midwifery

Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Covid Short Term Absence FTE %	Covid Long Term Absence FTE %	Covid Total Absence FTE %
2022 / 10	1,160.73	1,988.92	3,149.65	52,500.97	2.21%	3.79%	6.00%	0.93%	0.30%	1.23%
2022 / 11	984.69	2,088.75	3,073.43	51,359.69	1.92%	4.07%	5.98%	0.44%	0.29%	0.74%
2022 / 12	1,564.82	2,164.49	3,729.32	53,100.08	2.95%	4.08%	7.02%	0.49%	0.29%	0.79%
2023 / 01	1,206.05	1,709.62	2,915.67	53,413.13	2.26%	3.20%	5.46%	0.32%	0.29%	0.62%
2023 / 02	829.47	1,728.81	2,558.28	48,733.54	1.70%	3.55%	5.25%	0.39%	0.29%	0.68%
2023 / 03	736.10	1,835.65	2,571.74	53,992.45	1.36%	3.40%	4.76%	0.42%	0.28%	0.70%
2023 / 04	823.72	1,804.01	2,627.72	52,254.86	1.58%	3.45%	5.03%	0.44%	0.29%	0.72%
2023 / 05	935.57	1,898.05	2,833.63	54,230.92	1.73%	3.50%	5.23%	0.13%	0.25%	0.38%
2023 / 06	719.94	1,795.55	2,515.49	52,497.69	1.37%	3.42%	4.79%	0.09%	0.22%	0.31%
2023 / 07	969.08	1,780.79	2,749.87	54,135.70	1.79%	3.29%	5.08%	0.10%	0.22%	0.32%
2023 / 08	997.89	1,817.91	2,815.81	53,909.26	1.85%	3.37%	5.22%	0.14%	0.16%	0.30%
2023 / 09	756.81	1,820.54	2,577.36	52,430.72	1.44%	3.47%	4.92%	0.39%	0.18%	0.56%

(Figure 3)

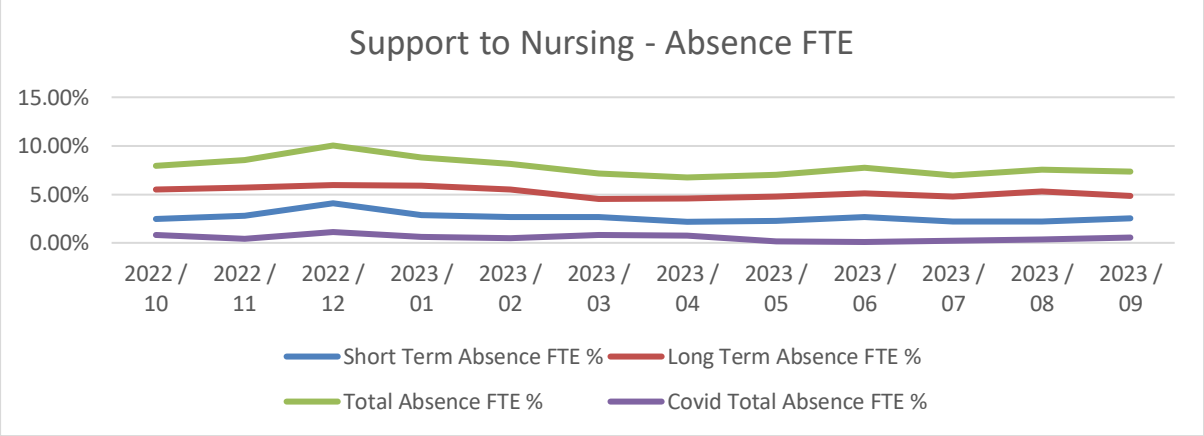


(Figure 4)

Nursing support

Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Covid Short Term Absence FTE %	Covid Long Term Absence FTE %	Covid Total Absence FTE %
2022 / 10	636.13	1,433.59	2,069.72	26,147.13	2.43%	5.48%	7.92%	0.68%	0.13%	0.81%
2022 / 11	704.29	1,441.67	2,145.96	25,192.44	2.80%	5.72%	8.52%	0.29%	0.13%	0.42%
2022 / 12	1,052.29	1,536.33	2,588.62	25,805.61	4.08%	5.95%	10.03%	0.98%	0.13%	1.11%
2023 / 01	737.32	1,518.82	2,256.14	25,707.66	2.87%	5.91%	8.78%	0.46%	0.13%	0.59%
2023 / 02	616.12	1,272.64	1,888.76	23,245.47	2.65%	5.47%	8.13%	0.37%	0.13%	0.51%
2023 / 03	677.72	1,162.39	1,840.11	25,709.14	2.64%	4.52%	7.16%	0.65%	0.16%	0.80%
2023 / 04	535.49	1,126.57	1,662.07	24,671.41	2.17%	4.57%	6.74%	0.57%	0.20%	0.77%
2023 / 05	584.76	1,212.15	1,796.91	25,577.46	2.29%	4.74%	7.03%	0.08%	0.05%	0.13%
2023 / 06	662.92	1,272.29	1,935.21	25,067.56	2.64%	5.08%	7.72%	0.04%	0.05%	0.09%
2023 / 07	544.13	1,195.67	1,739.79	24,979.19	2.18%	4.79%	6.96%	0.15%	0.05%	0.21%
2023 / 08	553.05	1,342.12	1,895.17	25,223.66	2.19%	5.32%	7.51%	0.29%	0.05%	0.34%
2023 / 09	621.56	1,183.36	1,804.92	24,490.93	2.54%	4.83%	7.37%	0.50%	0.05%	0.56%

(Figure 5)



(Figure 6)

5.0 SAFER STAFFING (HARD TRUTHS) DATA

Safer staffing reviews are a process initiated by NHS England and the Care Quality Commission (CQC) (2014). It combines the robust Trust annual and bi-annual staffing reviews with a commitment to greater openness and transparency by publishing data regarding nursing, midwifery, and care staff levels. This data is provided through the monthly Trust report to NHSEI, detailing both registered nursing and midwifery staffing numbers and unregistered support staff numbers. The data also includes the Trust provision of care hours per patient day (CHPPD). This data for all acute Trusts is now published on NHS Model Hospital.

CHPPD is the national benchmark measure for safer staffing and provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by totalling the number of hours worked by registered nurses, nursing associates, and in some cases allied health professionals, as well as healthcare support worker on each ward for the 24-hour period, then dividing by the number of patients on the ward each day at midnight.

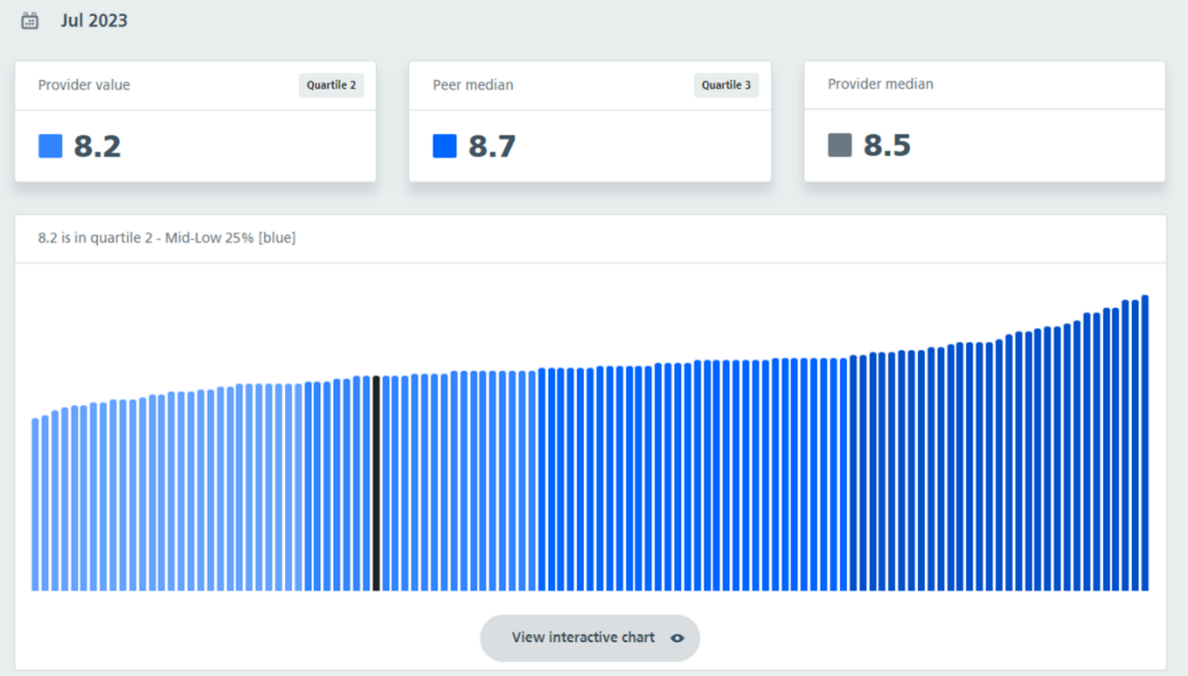
Due to the way it is calculated, actual CHPPD is influenced not only by numbers of staff on duty, but also the bed occupancy. Therefore, wards with fewer patients, or with high numbers of day-case patients who are discharged prior to midnight, demonstrate significantly higher CHPPD. It should be noted that **CHPPD reveals the total nursing and support worker hours available per patient on the ward at midnight**. It does not reflect the actual hours required to meet the care needs for these patients, which could be significantly more for those with high acuity or dependency, or fewer for patients with low acuity and who are independent in self-care.

Required care hours are calculated separately, using real-time patient acuity and dependency data which is recorded on the Safecare application. The required hours can then be compared with available hours. This is used to inform the twice daily staffing meetings to ensure deployment of staff according to care demand at the time

The Model Hospital platform https://model.nhs.uk is used to benchmark the CHFT nursing workforce data against the national average, as well as 'Peer Hospital' data. This data is generally updated quarterly, the analysis of which is reported to the weekly Safe, Sustainable and Productive Staffing Meeting as part of the group workplan.

There is no 'correct' number of CHPPD to be achieved. However, significant variation from the national average or the 'peer group' average, should warrant further investigation. CHPPD significantly higher than average could indicate inefficiencies in staffing. CHPPD significantly lower than average could indicate too few staff and associated patient safety risks.

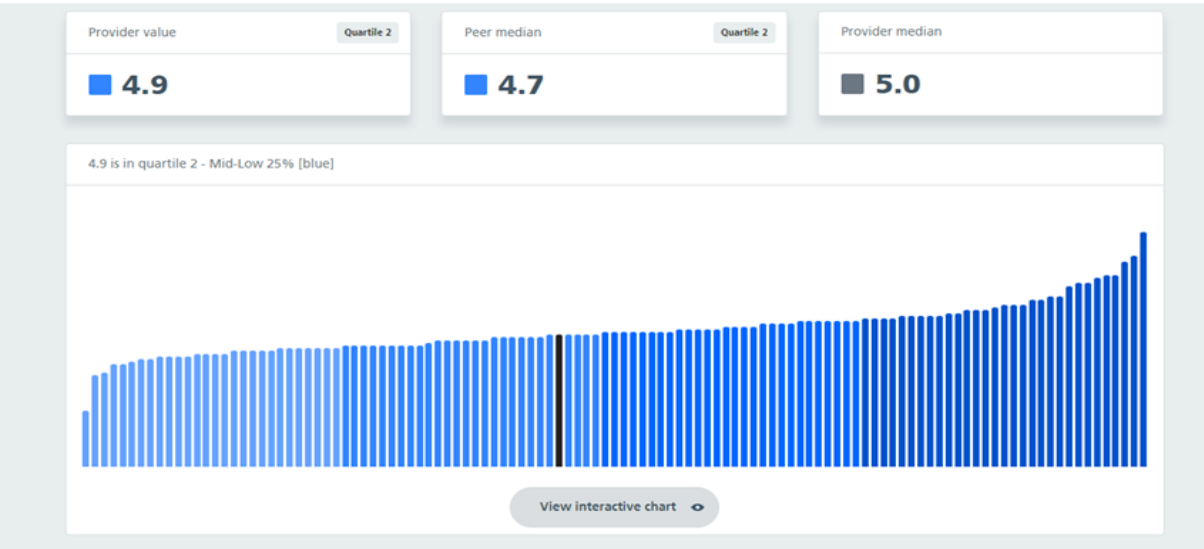
The latest information from Model Hospital on CHPPD is from July 2023. Review of this data reveals CHFT to be in the quartile 2 providing 8.2 CHPPD at Trust level (figure 6). The national median CHPPD for July 2023 was 8.5 CHPPD with the Peer Median being 8.7 CHPPD. Four peers provide more CHPPD than CHFT (highest 9.1), with the remaining 4 peers providing fewer CHPPD (lowest 6.4). This latest data shows a static benchmark position of CHFT for CHPPD since the previous report which outlined the January 2023 position.



(Figure 7)

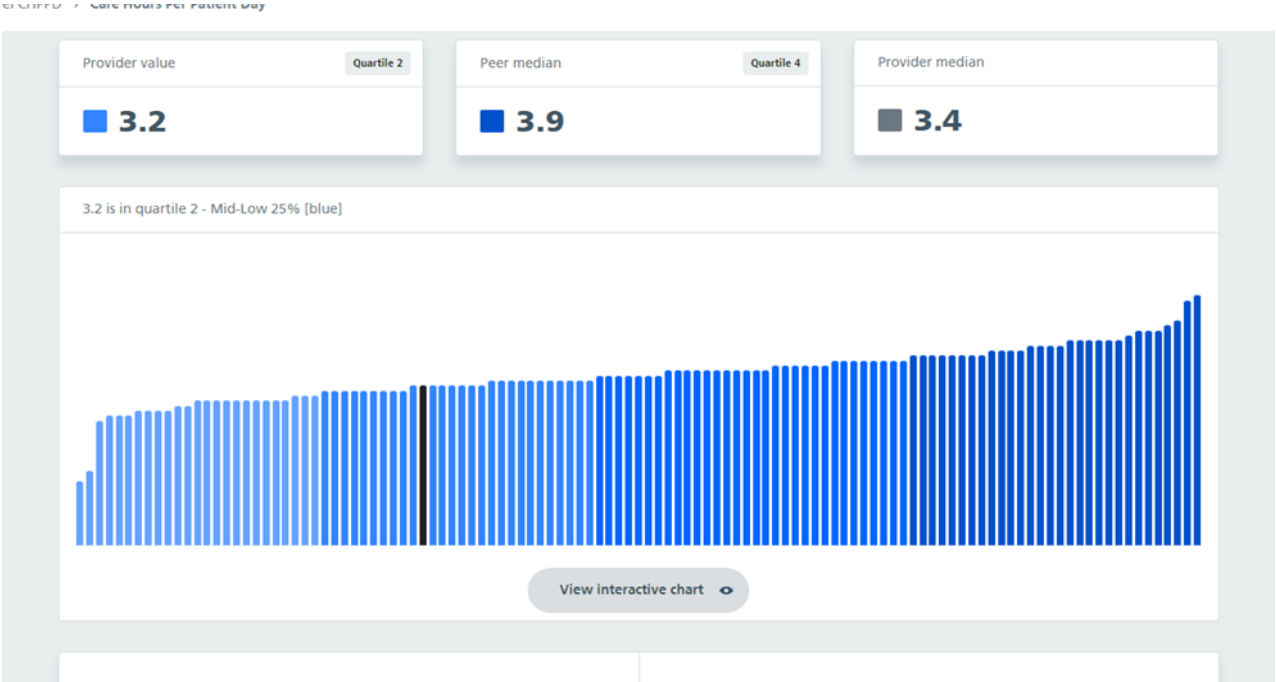
In addition to Trust-wide total CHPPD the Model hospital can be used to benchmark the care hours provided by Registered Nurses and Midwives compared to the CHPPD provided by Healthcare Support Workers, thereby giving an indication of the CHFT benchmark with respect to skill mix.

Review of the latest Model Hospital data (July 2023) revealed the CHPPD hours provided by registered nurses and midwives was 4.9, this compared to a national median of 4.7 and a peer median of 5.0 (figure 8).



(Figure 8)

CHPPD provided by healthcare support workers at CHFT was 3.2. This compared to a national median of 3.4 hours and a peer median of 3.9 hours (figure 9).



(Figure 9)

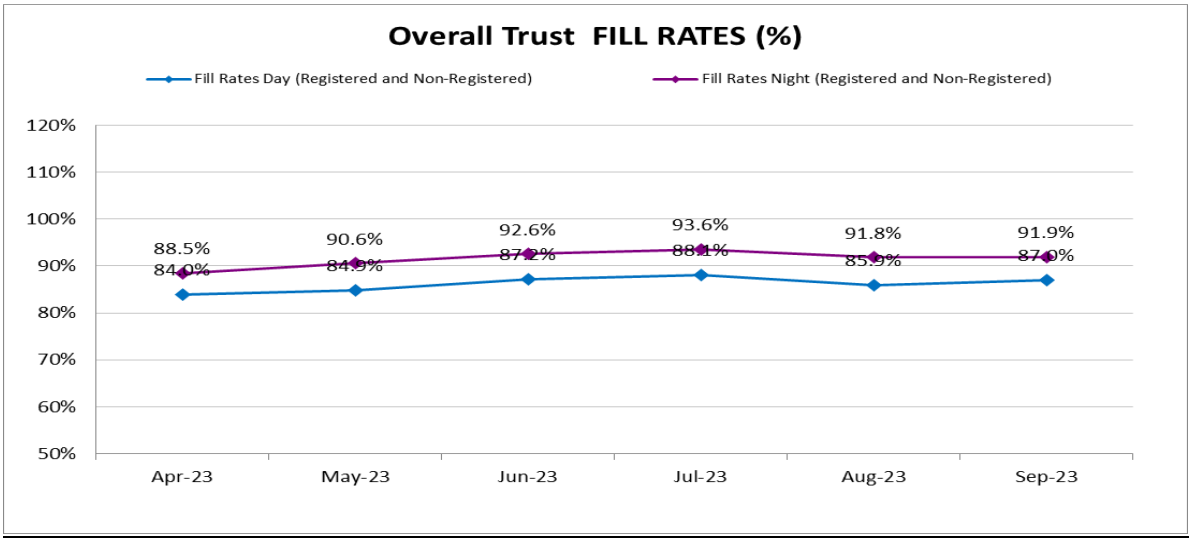
Review of this latest Model Hospital data gives no indication that CHFT is an outlier with respect to total CHPPD, or to the CHPPD skill mix provision.

Fill rates.

Whilst fill rates are no longer a reporting requirement to NHSEI they continue to be a useful measure for analysis. Fill rates are calculated by comparing planned hours against actual hours worked for both registered nurses (RNs) and health care support workers (HCSW). Factors affecting fill rates include:

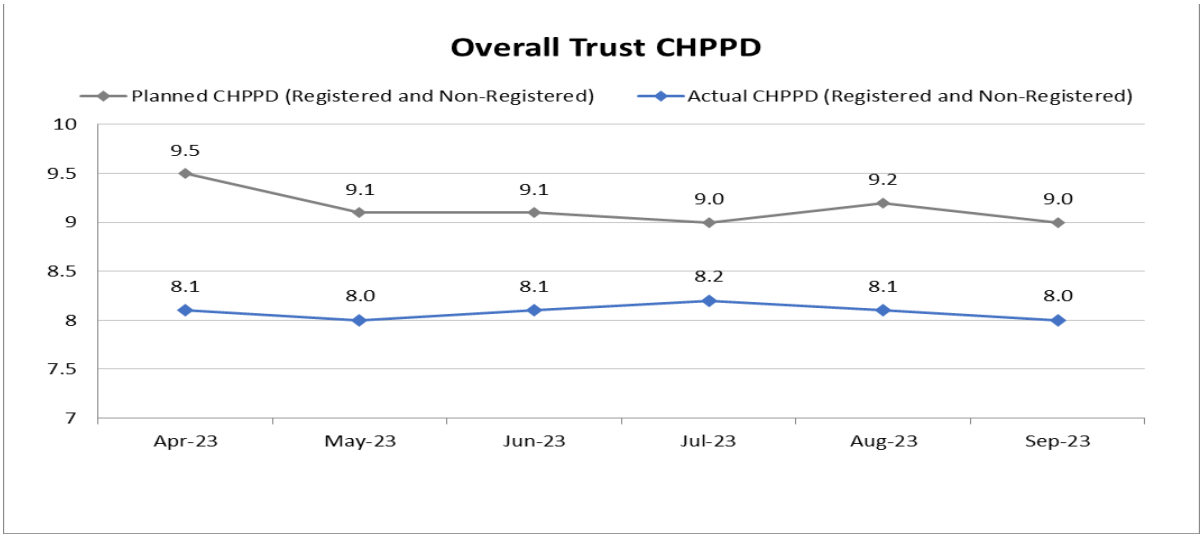
- Sickness (lower if not filled)
- Vacancies (lower if not filled)
- Enhanced Care Support Worker requirements, otherwise known as 1:1 observation (when additional staff above agreed WFM are rostered on to support)

For the reporting period, fill rates continued to fluctuate between 84% - 87% during the day (figure 10).



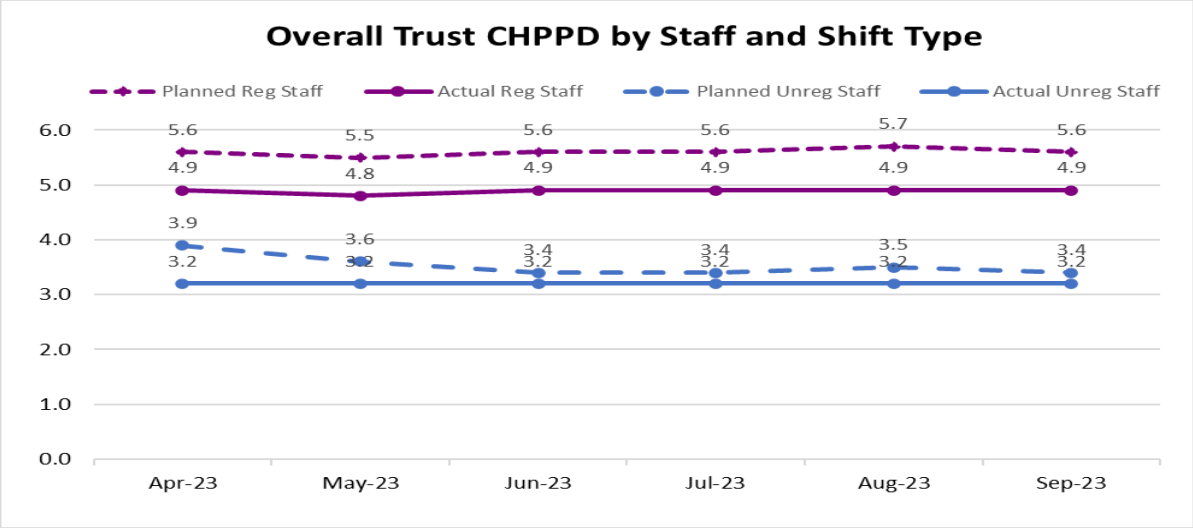
(Figure 10)

This position continues to impact on the overall Trust CHPPD position with an ongoing shortfall reported between planned and actual care hours during the reporting period (figure 11). This is reflective of the ongoing challenging sickness/absence position, opening of additional escalation areas, in addition to supporting enhanced service delivery in some areas.



(Figure 11)

In recognising the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), figure 12 breaks down the CHPPD by staff groups, which highlights the most challenging gap can be seen within the RN workforce.



(Figure 12)

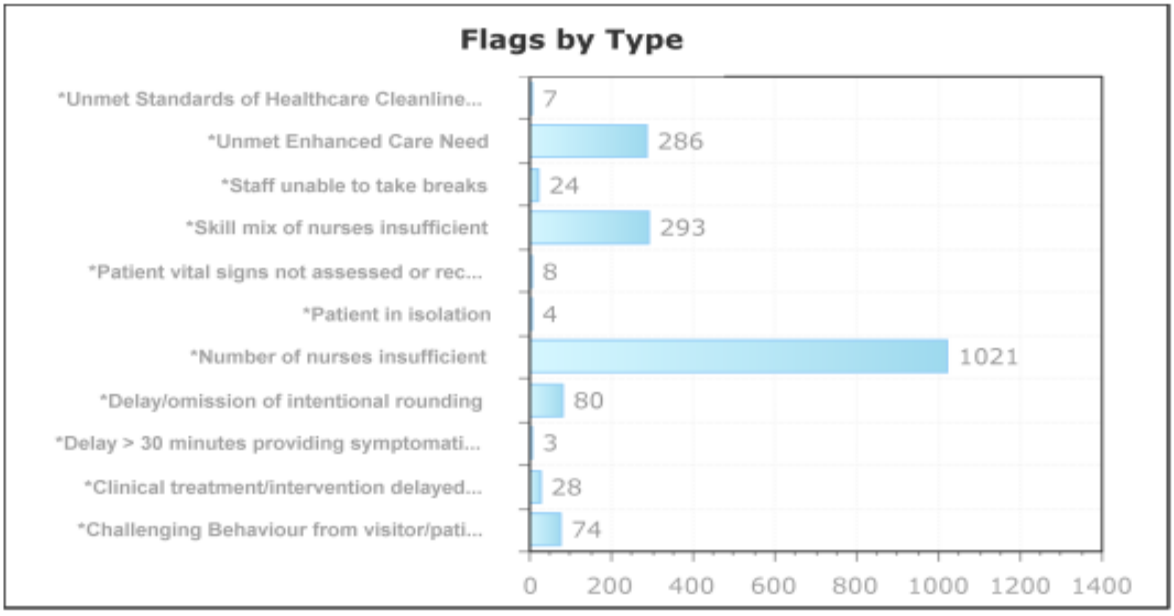
Addressing the shortfall is managed through divisional team rostering processes and twice daily staffing meetings which are chaired by divisional Matrons. These processes support the staffing resource being safely flexed to meet patient demand, activity, and acuity and the continued effort given by our teams to ensure service provision remains outstanding.

5.1 Red Flag Escalation

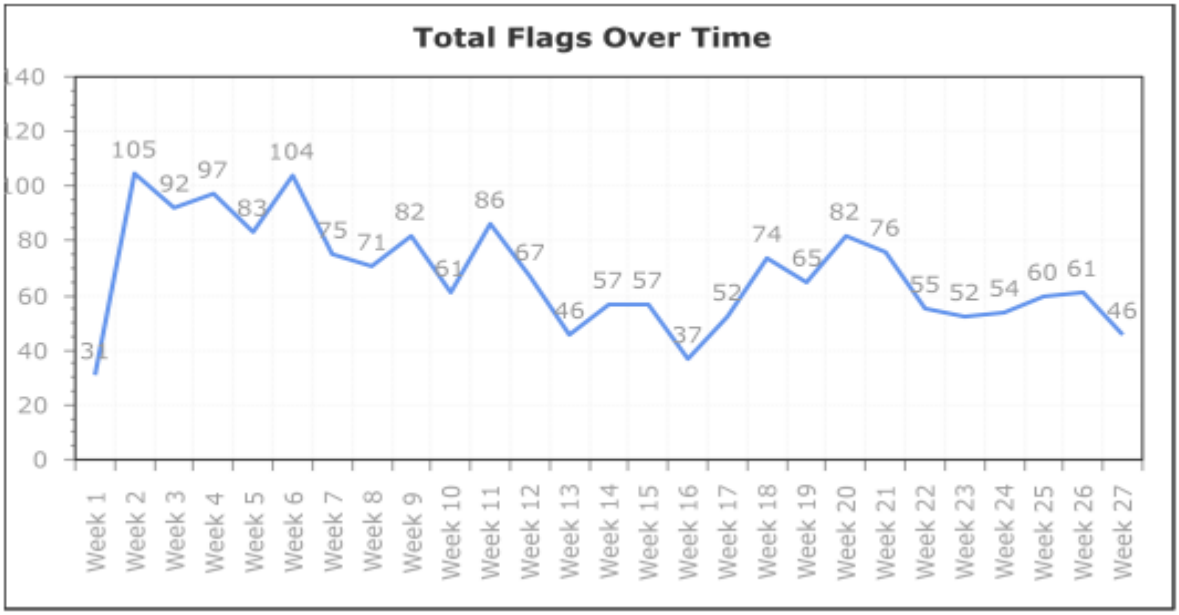
To supplement the process of rating the status of staffing requirements within the roster system, a system of red flag escalation has been developed in line with NICE (2014) guidance. Nursing red flags are events that have an impact on the way care is delivered to patients, therefore requiring a prompt response by the Nurse in Charge or a more senior nurse to mitigate patient safety concerns. Nursing red flags can be raised at any point during a shift.

The red flag process forms a key part of the governance arrangements and ongoing monitoring of the staffing position. The reporting of red flags is identified and responded to within the twice daily staffing meetings.

Figure 12 provides a breakdown of red flags for the reporting period 1st April 2023 – 30th March 2023, with insufficient number of nurses, the most reported category.



(Figure 13)



(Figure 14)

A downward trend in the reporting of Red Flags is demonstrated in figure 14 which may be related to the improving Band 5 vacancy position. This position correlates to the stepping down of the OPEL (Operational Pressures Escalations Levels) safe staffing score from an OPEL 3 to OPEL 2.

In isolation this data does not provide a clear understanding of the actual impact upon patient experience or the workforce in delivering patients' care. It is recognised that despite no adverse clinical outcome, delays in care have the potential to negatively impact the overall experience of patients and colleagues.

5.2 Quality

There is a well-established correlation between staffing levels, safe care and patient experience.

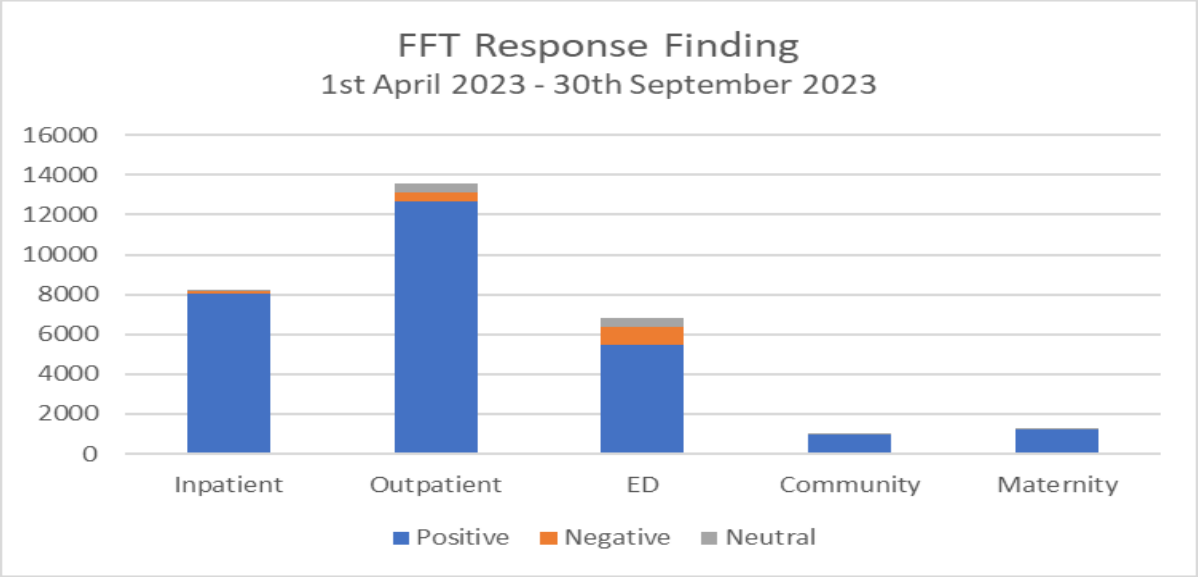
As such it is important for any staffing review to take into consideration the quality of the care provided using nurse sensitive indicators. For this report three recognised nurse sensitive indicators have been used: Friends and Family Test, falls and pressure ulcer data.

The Enhanced Dashboard Metric has been fully integrated into clinical practice and was reported against during divisional safer staffing panel meetings, supporting the triangulation of several quality metrics against the acuity and dependency data, thereby informing establishment reviews.

Additionally, the Enhanced Dashboard Metric is reported into the Safe, Sustainable and Productive Staffing meeting monthly. Data within this report is analysed through divisional teams to determine actions required to respond to data triangulation and mitigation against any impacts. Initial engagement with NHSEI has indicated positive feedback in the work that is being led within the Trust.

5.2.1 Friends and Family Test (FFT)

Between 1st April 2023 and 30th September 2023, the Trust received 30,849 completed Friends and Family Tests (FFT) responses. 91.9% of patients, carers and family members reported a positive experience whilst receiving care and treatment within the Trust. 5% reported it to be negative, and 3.1% described their experience as neither good nor bad.



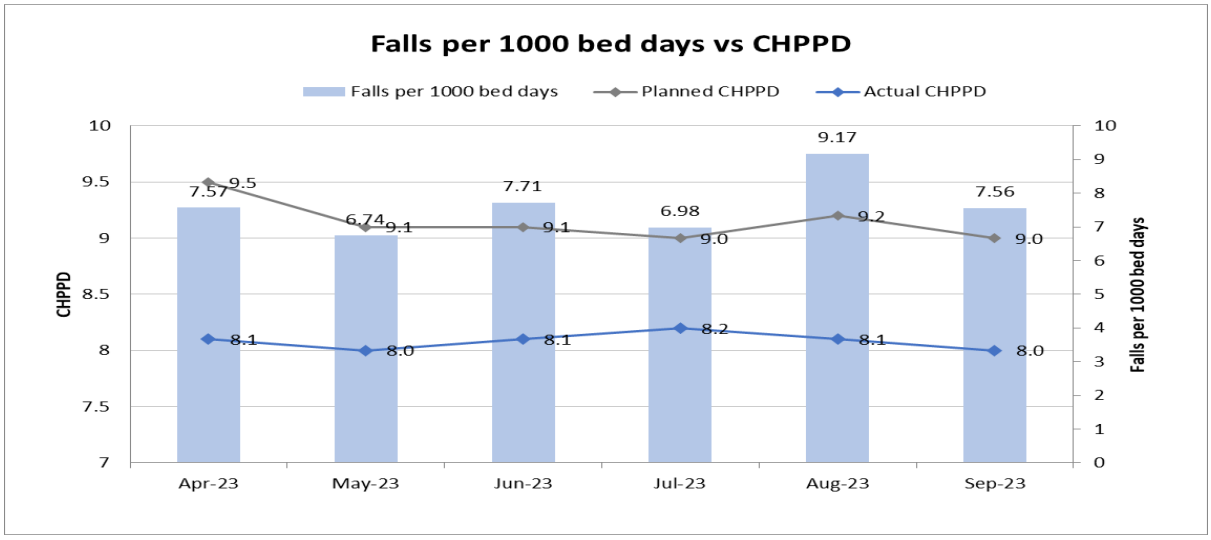
Microsoft Forms are now being used to ensure data is captured more robustly and the data collated filters into KP+.

5.2.2 Falls and Pressure Ulcers

The charts below provide an overview of the reporting of incidents related to falls per 1000 bed days (Figure 15) and ulcers per 1000 bed days (Figure 16).

Falls

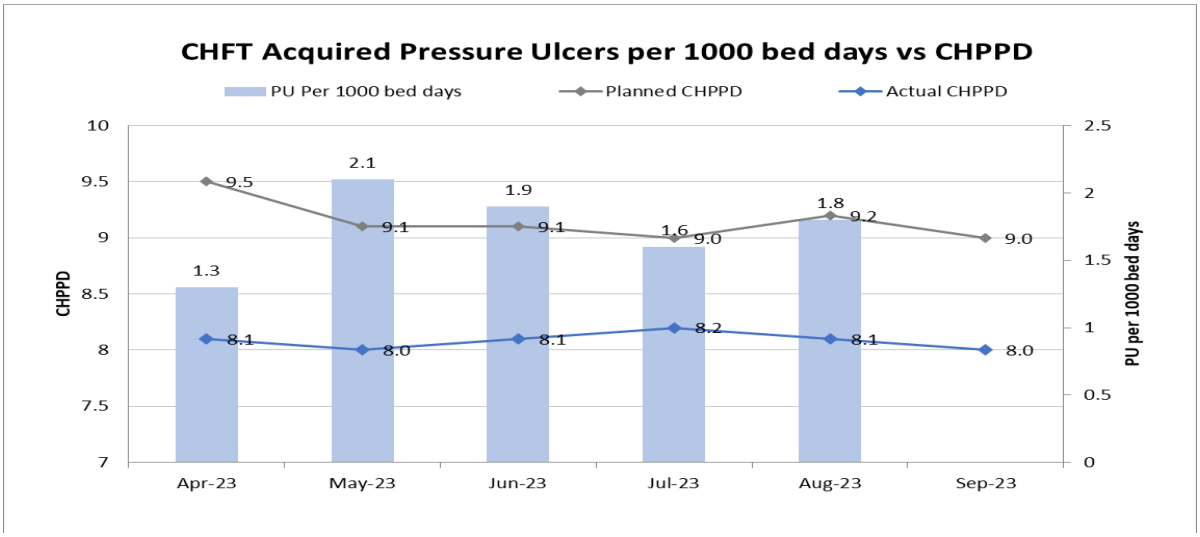
Throughout the reporting period there is a shortfall between the planned and actual CHPPD which fluctuates between 0.8 and 1.4, with the incidence of falls peaking in August where the CHPPD gap is at 1.1 (figure 14). Interestingly, the gap in CHPPD is 1.1 also in May where the lowest incidence of fall is reported.



(***Figure 15)***

Pressure Ulcers

Due to validation processes for the purpose of the reporting period of this report pressure ulcer data is only available up until August 2023. Data for pressure ulcers per 1000 bed days demonstrates a fluctuating position with the highest incidence identified in May where CHPPD demonstrated an overall gap between planned and actual of 1.1. The lowest incidence of pressure ulcers occurred in April when CHPDD reported a 1.4 deficit position between the planned and actual.



(Figure 16)

Analysis of the data indicates variability in the incidence of the two nurse indicators that may be attributable to the gap in planned and actual CHPPD.

Analysis of the gap in CHPPD continues to be identified as the most challenging for the RN workforce (figure 12).

Given the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), it is reasonable to suggest the impact of ongoing enhanced delivery of some services, additional capacity, current vacancy position and the impact of staff sickness absence continue to impact upon patient experience.

5.2.3 Incident Reporting

There was a total of 184 Nursing & Midwifery staffing related incidents that were reported through the Datix system during the period 01 April 2023 to 30 September 2023. Women's services reported the highest staffing incidents with 130 incidents (125 no harm and 5 classed as minor harm) relating to staffing reported. Of the 184 staffing incidents, 173 incidents were recorded as no significant harm to patients, 8 minor harm and 3 moderate harms. There was appropriate escalation when the incidents occurred, and this is recorded within the incident records.

There continues to be a strong theme around staff being redeployed to support other areas and the impact of this. This is now being monitored within the Safe, Sustainable and Productive Staffing meeting with ongoing engagement via a survey to those staff that are redeployed.

The Risk Management Team along with the Quality Governance Leads for each division review all incidents daily and highlight any themes and trends so that learning can be collated, and improvements made. In addition to this, the Quality & Safety team hold a weekly MICCI (Mortality, Incidents, Complaints, Claims and Inquests) meeting to ensure triangulation of all areas (including risks and audit). This meeting along with daily oversight of all incidents provides oversight and scrutiny within the Quality & Safety team.

CHFT'S RESPONSE

6.0 ESCALATION AND REPORTING ARRANGEMENTS FOR QUALITY AND SAFETY

Safe Staffing is a key area of focus and remains one of the Trust's Must Do priorities. Led by the Senior Nursing Team a range of actions remain in place to manage any associated risk. This includes but not limited to:

- A monthly safe, sustainable and productive meeting
- Monthly nursing, midwifery and AHP Steering Group
- Twice daily Nursing and Midwifery Staffing meetings chaired by divisional matrons which are in operation 7 days a week.

The purpose of staffing meeting is to review the real-time safer staffing assessments and agree actions required to respond to short-term staffing escalations and changing acuity and dependency to assist with staff deployments.

Real-time staffing is provided through Safecare which gives a live view of the nursing staffing position measured against the acuity and dependency of our patients, facilitating comparisons of staffing levels and skill mix to the actual patient demand to maintain safe staffing across the Trust as a whole. Safecare LIVE plays a pivotal role in these meetings providing visibility across wards, transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards patient safety.

In addition, Safecare allows the nursing team to assist the ward manager with real-time roster management to ensure we have the right person, in the right place, at the right time to inform operational decisions to maintain safer staffing Trust wide.

Decision making within this forum is informed by an appraisal and risk assessment of the divisional information presented and any staffing shortfalls are mitigated against.

7.0 RECRUITMENT AND REGISTERED NURSE TRAJECTORY

The NHS Long Term Plan has set a target of reducing nursing vacancies by 5% by 2028 and the Trust remains committed to driving down the vacancy position at CHFT. The national picture for nursing vacancies remains tumultuous therefore greater emphasis within the NHS Long Term Workforce Plan has been placed on growing domestic education, training and recruitment.

This will be addressed by a comprehensive, multi-pronged Recruitment Strategy with ongoing alignment to the NHS People Plan and NHS Long Term Workforce Plan. This includes specific commitments around:

- **Looking after our people** – with quality health and wellbeing support for everyone.
- **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face.
- **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience

- **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return.

This is supported by the Trust's People Strategy and Recruitment Strategy 2022-2025. The Recruitment Strategy includes a detailed action plan which is underpinned by several principles including:

- International recruitment across all staff groups
- Values based recruitment.
- Learning from the pandemic and developing a flexible, adaptable workforce
- Valuing development for all
- Growing our own and retention of our workforce

Below provides further detail surrounding of the Trusts related activity:

7.1 International Nurse Recruitment

During this reporting period 38 internationally educated nurses have arrived in the UK for employment at CHFT. 31 nurses have taken the NMC competency test and registered. 7 are at different stages of their training with exams booked in November. The national delay reported to test availability is improving and tests can be booked during a preferred date range and chosen test centre. There continues to be a lower first-time pass rate than previous years, nationally the first-time pass rate for Q1 was 34% (there is no data available for Q2). Adjustments to the internal training programme and reduced numbers on cohorts has seen CHFTs first time rate increase and it is 42% for this reporting period. Length of programme and continued low first time adversely effects timeframe for NMC registration.

All nurses are supported to transition into life within the UK, in addition to a robust training package and wrap around pastoral support that has seen positive results with 0% attrition during the 2023 programme.

Pastoral support has been at the centre of this project since its inception and recognised by NHSE as imperative to making international recruitment work. CHFT pride themselves on a programme of pastoral support which includes:

- IR Facebook page for social engagement before and after arrival.
- Access to CHFT's international recruitment specialist who guides recruits through the whole process from interview to taking their test. Assisting with transport, accommodation, visas, registering with GPs, shopping and the local area, booking tests including travel to Ireland.
- A welcome session and booklet that includes information about the UK, the local area and also the NHS including its background and the role of a nurse in the UK today.
- An open-door policy where during working hours all candidates past and present can drop in for support.
- Clinical support and orientation.
- Welcome packs and meet and greets (we are the first people recruits meet when they arrive).
- Support with NMC registration.

During 2022 the NHS Pastoral Care Quality Award was introduced, to achieve this award a set of standards for best practice pastoral care need to have been met. This is an opportunity for the CET to have work recognised and to demonstrate the Trust's commitment to supporting internationally recruited staff at every stage from recruitment and beyond. The Trust recently applied for the quality award and are currently awaiting the outcome.

During this reporting period the impact of this approach can be measured against the attrition which currently sits at 2% in first year of employment.

The outstanding 6 nurses who formed part of the 2022 targets arrived in country in early Q1 and confirmation has been received from the National team that the target was successfully met. The Clinical Education Team are now working towards completing recruitment to our revised 2023 target of 35 following a further bid to NHSE in Q1. It is expected a small number, <3 nurses, may be delayed, with the intention that they will arrive in the UK by end of Q4.

Work has continued with colleagues from the family and specialist services division when it was agreed that 2 international nurses will be recruited to work in paediatric areas. The preparation and support need of these nurses will be different and scoping work has been completed, it is expected that these staff will need to be supported to attend an external programme to prepare them for their NMC OSCE test. This work has allowed for collaboration with the West Yorkshire Integrated Care Board and Keralan government and the development of a Trust partnership including a visit to CHFT.

Work with Locala to support their programme of international nurse recruitment into Community Services has completed. This work has been valuable as it has allowed Locala to share learning which could inform future recruitment into our community services.

Recruitment of internationally trained midwives gained traction during this period and all 5 midwives have arrived in the UK ahead of the revised December deadline. 2 have successfully passed their NMC competency tests with the other 3 awaiting their exam dates. Attention will now turn to supporting them to further develop and thrive in their careers at CHFT.

The AHP NHSE target has also been met and 3 staff have been recruited and started employment. The CET and AHP educator worked collaboratively to ensure there was a robust pastoral and training offer for their arrival in the UK. Further AHP employment is planned with a total of 10 radiographers to support an expansion of services in the development of the community diagnostic centre. This recruitment is progressing with 7 people currently under offer and further interviews planned.

As the numbers of internationally educated nurses have increased over the last few years, attention has turned towards professional development opportunities and revalidation support. This is integral in ensuring the Trust has a valued and supported workforce. Activity has included linking with regional and national groups to benchmark CHFT against other organisations. As part of NHSE stay and thrive

initiative CET was successful in securing a bid to support the delivery of an international educated development day. This event was attended by around 100 nurses who found it inspiring, motivating, and provided generally positive feedback.

7.2 Recruitment of Newly Qualified Nurses

Regular recruitment events and advertising continued through 2023 for both experienced and graduate staff to build a pipeline into Trust. We continue to be an attractive employer for our local HEI with most graduates being a University of Huddersfield student. Through Q2 activity was adjusted with a focus on transitional support for the applicants including scoping their preferred work areas. September position resulted in 55 nurses joining the Trust. A further 33 are expected to start employment across October and November due to personal choice or academic delays. All graduates were supported with a welcome event and enrolled in role specific induction and preceptorship programmes which enhances competence and in turn confidence with the aim of retaining those recruited.

Benchmarking against the national preceptorship framework has now completed, work has been undertaken by the CET to ensure CHFT are fully compliant with the framework. Following a recent submission to NHSE, the team have been informed the Trust has been awarded the quality mark for the programme. This serves as a national gold standard, with the potential to influencing prospective employees as to where they would look to secure this first role.

CET have been successful in securing a NHSE bid to develop and deliver a reversed supernumerary concept which is expected to increase graduate confidence whilst shortening the supernumerary period required. Recruitment to a CE post to support this project and a project plan is in place. There has been slippage in the progress of the project due to recruitment and sickness challenges. The timeline has been adjusted in agreement with the regional RePair lead and will be trialled in January 2024.

An additional graduation point in January-February means there is a further pipeline of graduates totalling 28. Attracting our final year students remains a priority however the vacancy position has changed and collaborative work with the recruitment team is taking place to establish an approach to managing the 2023/24 pipeline ensuring our recruitment remains aligned to our workforce need and Trust values and priorities.

7.3 Nursing Associate Apprenticeships (TNAs)

11 apprentices successfully registered as Nursing Associates (NAs) in 2023, these have been allocated to vacant RN/NA positions across the Trust. A further 16 are due to complete in the early part of quarter 4 following the completion of cohort 7's training. Work is currently being undertaken with divisional leads around deployment plans and it expected that they will transition into NA roles in January 2024.
There are 4 active cohorts of Trainee Nursing Associates (TNAs) (52 apprentices in total, of which 16 are due to qualify in January 2024). Business case approval was granted securing the programme until 2024 when a further business case will be required, this translates into a further 40 places across 2024. Recruitment activity for cohort 11 commenced in quarter 2 and there are 21 applicants moving through

recruitment checks and University enrolment. They will commence the course in January 2024 and plans are being confirmed to support their induction and base training areas.
As Nursing Associate numbers grow attention has started to turn to professional development opportunities and revalidation support. Staff attended a national celebration event in March 23 which allowed for the sharing of good and innovative practice across the first quarter of the year. Furthermore, a Clinical Educator and Registered Nursing Associate attended the inaugural NA conference in Birmingham in September, which focused on the development of the role. The information gained from these activities will inform and strengthen the support offer and future development of the role. Various workforce planning events have also taken place with divisions to consider utilisation, governance and how the role can be embedded further into our clinical teams and services.

Our NA workforce are making a difference to patient care and services across most divisions, and this was further highlighted during this year's University of Huddersfield Apprenticeship Awards when one NA won their category for TNA of the year. The organisation was also shortlisted for large employer.

7.4 Registered Nurse Degree Apprenticeships

The 2 apprentices on the full 3-year apprenticeship have moved into their final year (qualifying in January 2024). Deployment and transitional plans have been confirmed to support the apprentices into their registered nurse roles in quarter 4.
A significant milestone was achieved in July-October 23 when the 5 Nursing Associates on the 2-year shortened RN apprenticeship successfully completed the course and moved into RN roles. They have subsequently been enrolled into the relevant preceptorship groups and support will continue to ensure they successfully continue to transition into their new role.
A small cohort of 2 NAs were recruited and started the programme in February 2023 this has been supported by the community division, with agreement for a further cohort of 7 N/As. These posts have been recruited to and 7 apprentices commenced the course in October 2023.

Work has commenced with divisional colleagues to ensure they are enrolled into preceptorship and supported to transition into an RN role.
Business case approval was granted for 2024 securing a further 5 opportunities for NAs which to top up to RN. Ambitions for beyond this are being explored within Trust and with partner Universities.

7.5 Return to Practice Nurses

4 nurses returned to practice in this reporting period. 2 have completed the course and registered with the NMC. 1 nurse is due to complete the course in quarter 1. The next cohort is due to commence in January 2024 and recruitment is ongoing. In response to the low number of applicants across recent years, a review of the current strategy continues which includes new recruitment materials, opportunities for other professional groups and exploring alternative training opportunities in collaboration with Workforce and Organisational Development, NHSE Project Team and local course providers.

It should be noted that section 7.1 – 7.5 reflects activity that is led by the Clinical Education Team, which has grown significantly over recent years to support the recruitment agenda. In response to this and the ambitions set out in the NHS Long Term Workforce Plan, the undergraduate work has been supported through a business case application to access student tariff monies.

7.6 Retention initiatives

In response to a national rise in registered nurse attrition since the start of the pandemic, NHSE launched a national retention strategy in July 2022: NHS England » Looking After Our People – Retention .

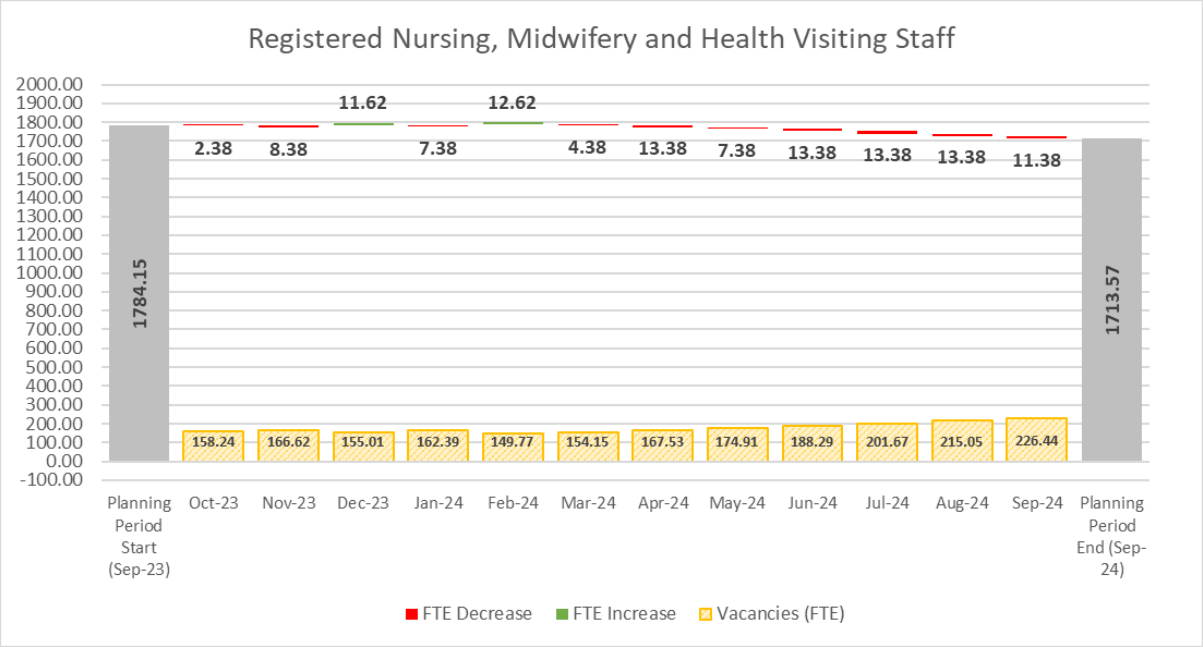
The strategy focusses on 5 high-impact interventions to improve the experience of nurses and promote retention of staff.

- Implementation of Legacy Mentoring
- Implementation of the National Preceptorship Framework
- Guidelines and Policies for Menopause Support
- Encourage Staff to Access Simplified Pensions guidance and Explore Flexible Retirement Options
- Complete the Retention Self-Assessment Checklist

The self-assessment toolkit was populated in October 2022, and action plans developed to ensure CHFT are implementing appropriate retention strategies. The work is overseen by the Nursing, Midwifery and AHP Workforce Steering Group (Appendix 1).

7.7 Summary position

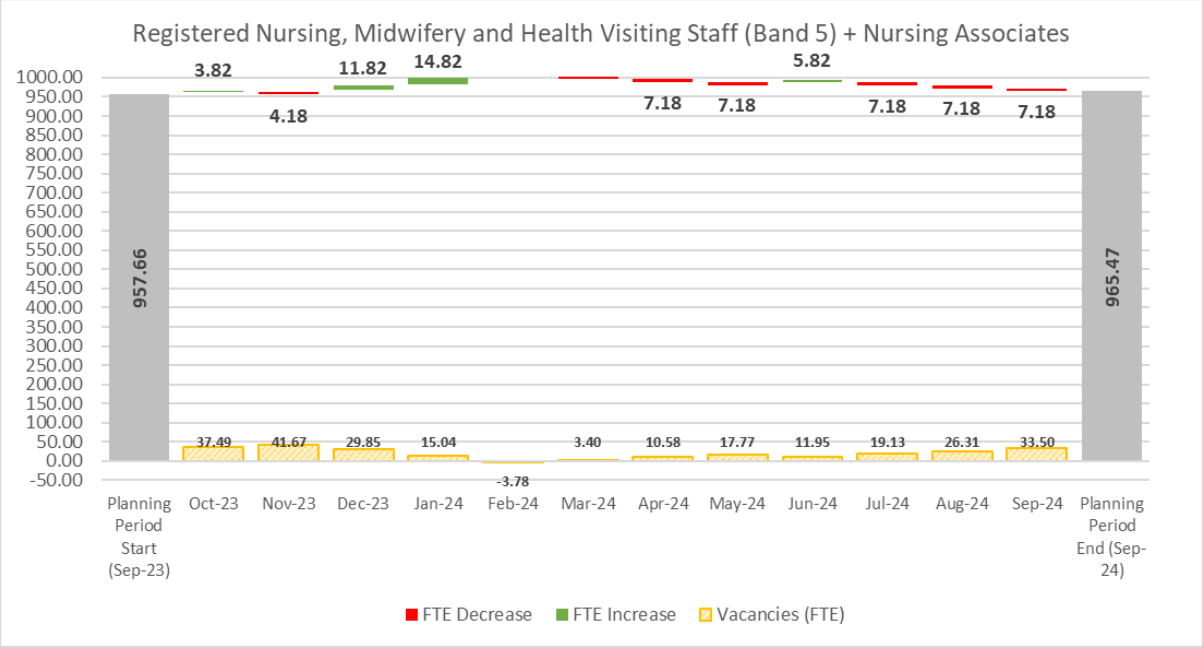
Based on the current Nursing and Midwifery recruitment and retention strategies, September 2023 vacancy position sits at 155.86 FTE an improving position since the previous report. With an assumed turnover rate of 9% and applying planned recruitment movement, 226.44 FTE vacancies would remain in September 2024, an increase of 70.58 FTE over the next 12 months.



(Figure 17)

The deep dive commissioned following the July 2023 safer staffing board of directors' report identified a favourable vacancy position across Band 5's (figure 18) indicating 41.31 FTE vacancies across B5 and NA roles, which would drop to 33.50 FTE in September 2024 a decrease of 7.81FTE.

In developing a clear position associated with the B5 vacancy position, attention is now focused upon understanding vacancies associated across the B6 and above roles. Early findings suggested the actual vacancy position across these areas may be less than that which is reported.



(Figure 18)

7.8 Health Care Support Workers (HCSW)

The National ‘Zero HCSW Vacancy’ campaign continues into 2023, with an overall aim of growing the Healthcare Support Worker (HCSW) workforce in line with demand, ensuring inclusive and sustainable recruitment while reducing the attrition of existing HCSWs.

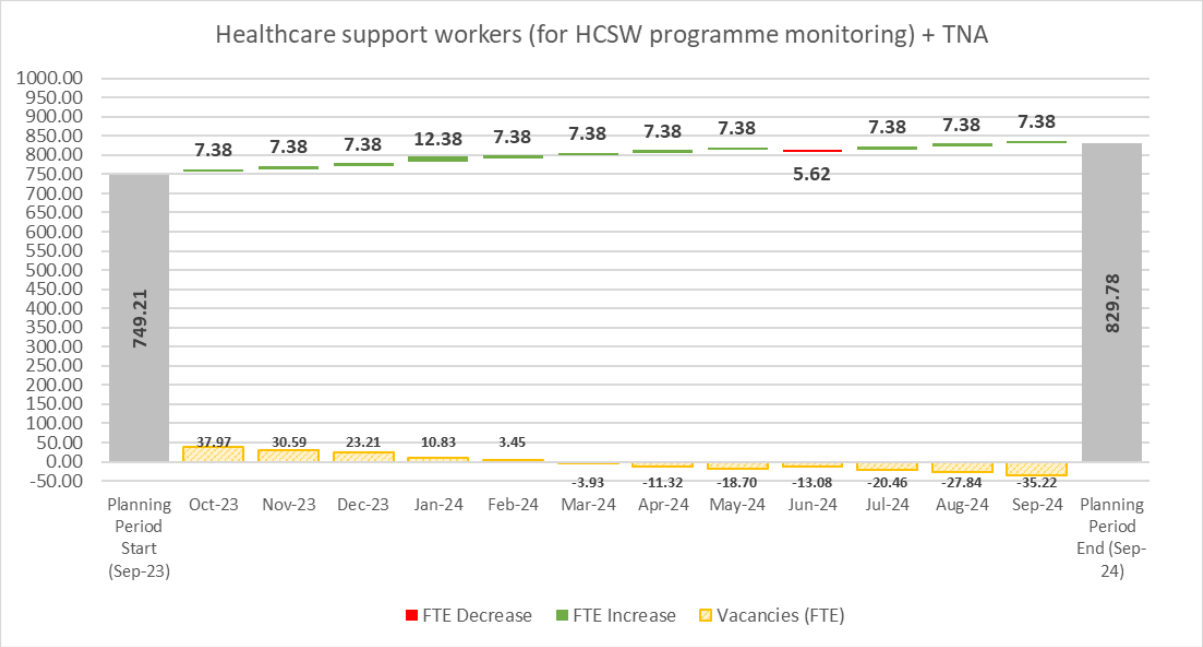
The key principle of the 2022 programme was adopting a ‘new to care’ model and this principle remains a key focus in 2023. The programme has shown that introducing a ‘new to care’ model of recruitment is reducing the destabilisation of other health and social care providers whilst creating a sustainable workforce and increasing representation of the local community. This has been evidenced within various ‘go-see’ exercises carried out by the HCSW Recruitment Team.

At the start of the 2023 financial year NHS/E made the decision to terminate funding associated with the HCSW Programme and stated an expectation that Trusts should now absorb the financial responsibility, because of this the HCSW Recruitment Team were disbanded and the recruitment of HCSWs was placed back into divisions. Recently, CHFT have seen an increase in the recruitment of HCSWs with divisions such as Medicine continuing with the centralised recruitment approach, completing large scale recruitment campaigns, and allocating to departments on appointment.

The labour market for HCSWs nationally remains a tight market and CHFT have not only suffered a reduction in applications per advert over the last year but also a reduction in applicants meeting the set CHFT criteria, this has prompted a review of the entry requirements for Band 2 and various options presented to Nursing, Midwifery & AHP steering group with a decision yet to be reached.

The NHS Long-term workforce plan estimates that 47,500 – 56,500 additional HCSWs will be required over the next 15 years, as a result a plan to stabilise the workforce is being explored within CHFT. An expression of interest has been submitted to NHS England HCSW Programme to request funding progress “new to care” and to create and coordinate additional training at induction, provide pastoral support to aid in retention and support the completion of HCSW core competencies.

As of September 2023, HCSW including TNA identified a combined vacancy position of **45.35 FTE** (figure 19) with turnover rate standing at around 8.39%.



(Figure 19)

7.9 Widening Employment at CHFT

Over the last 12 months, the Apprenticeship & Widening Participation Team have continued to innovate and further establish a range of entry pathways for local people to access work readiness and employment opportunities here at the Trust. This includes creating progression opportunities into entry clinical and nonclinical employment including apprenticeships, volunteering, work experience, T Level pathways and pre-employment routes such St John's Cadets, the Prince's Trust, Sector Work Based Academy (SWAP) and general aspirational raising activities. These pathways and progression routes into the workforce have helped support and recruit over 65 new colleagues into clinical and nonclinical areas.

The team have also successfully embedded an adult skills training provider into CHFT who offer colleagues free Maths and English functional skills qualifications to support personal development and internal progression.

One of the main objectives of this work is to help "grow our own", with particular focus on supporting underrepresented groups from across our local communities. The development of a range of external partnerships and removal of some of our own internal barriers has been pivotal in the success so far as CHFT strive to:

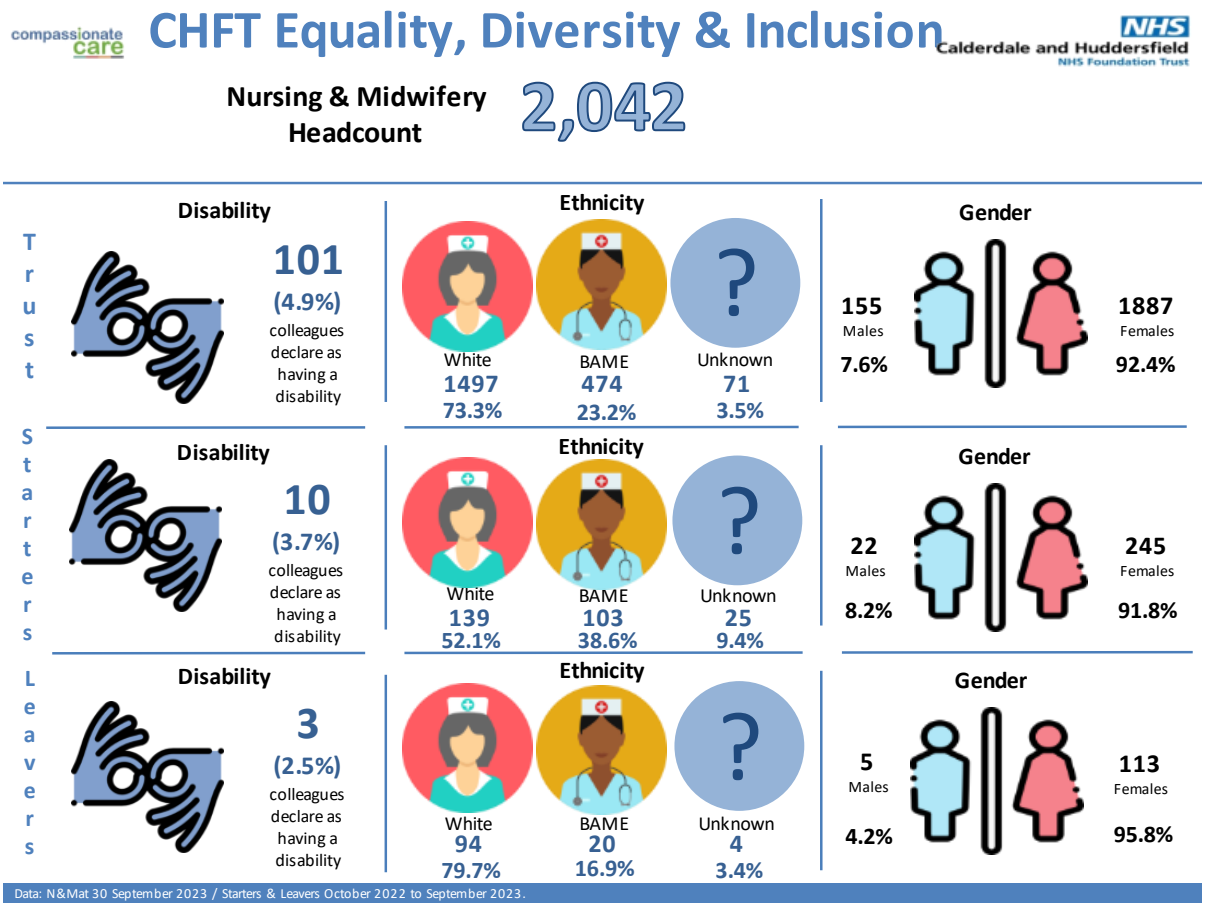
- Harness and leverage the power and commitment of local people whilst retaining the very best local talent in our local communities.
- Be the local apprenticeship "employer of choice" in Huddersfield and Calderdale.
- Ensure the staff base is representative of the people we serve. Of those recruited from our projects 47% are of an Ethnic minority background, in comparison to 24% of CHFT's headcount. 32% are male participants, in comparison to 19% of CHFT's headcount.

- Ensure promotion of the hugely important role of “pre-employment pathways” and progression into paid bank, substantive entry roles and apprenticeships. T Level recruitment is enabling the team to test this progression out even further.
- Encourage and support CHFT colleagues to follow a career path that suits them and their life making full use of resources such as the apprenticeship levy and the continued offer of “in work support” including careers advice and guidance, maths and English etc.

Through CHFT’s “grow our own” strategy, Widening Participation activity is helping CHFT prepare for the Future NHS Long Term Workforce plan and support the trust to help tackle staffing supply issues across the Nursing, Midwifery and AHP workforce.

8.0 NURSING AND MIDWIFERY WORKFORCE

8.1 Equality Diversion and Inclusion



(Figure 20)

The current qualified nursing and midwifery workforce comprises of 2042 staff, 101 (4.9%) of which have declared a disability, comparable to CHFT as a whole at 5.5%.

474 (23.2%) of all registered nurses at CHFT are of BAME ethnicity, this is below the reported overall CHFT figure of 24.1%, while 3.5% have not declared their ethnic origins.

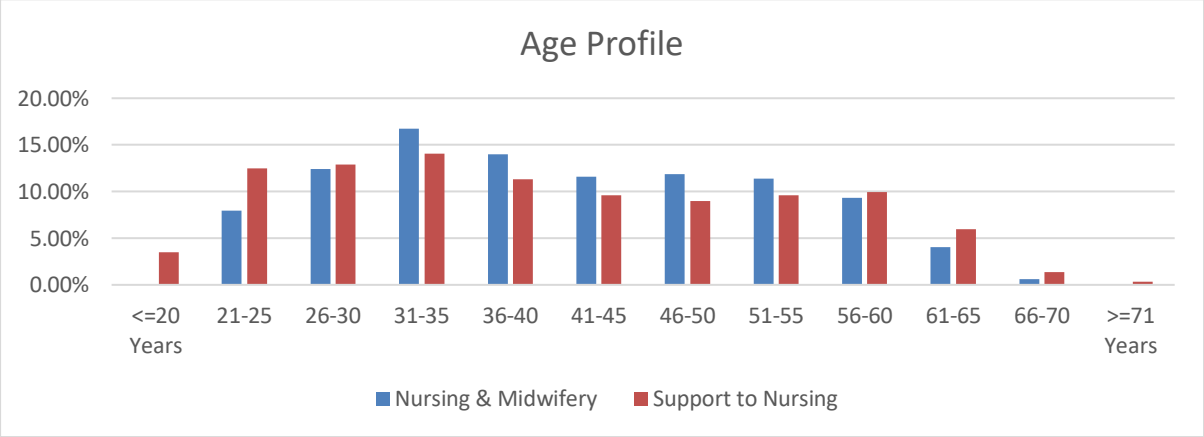
The majority (92.4%) of RNs are female, this is above the Trust whole workforce gender split of 79.1% female, 20.9% male.

Over the reporting period for Nursing and Midwifery there has been a net:-

- …increase of 7 disabled colleagues.
- …decrease of 12 white staff.
- …increase of 39 BAME staff.
- …increase of 15 staff of unknown ethnic origins.
- …increase of 9 males.
- …increase of 34 females.

Figure 21 provides a breakdown of the age profiles of both nurses, midwives and support to nursing roles.

Age Profile



(Figure 21)

8.2 Revalidation

Revalidation is the process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). Revalidation promotes continual development and reflection in practice and is a requirement to undertake every three years.

Currently the Trust has 2,042 nursing and midwifery staff and 68 nursing associates. Of these. approximately 592 who are due to revalidate within the next 12 months (57 of these are due in 2023)

The NMC provides a comprehensive suite of resources which support registrants through the process of revalidation. This is signposted through CHFT intranet page which also provides additional information to support the process.

8.3 Nursing and Midwifery Council (NMC) referrals

There are currently 11 active cases of which 5 cases were new referrals to the NMC during the reporting period.

9.0 SUMMARY

During the reporting period establishment reviews have been undertaken as set out within national guidance, based upon the principles of the safer staffing triangulation approach. This approach has informed the changes that have been approved.

10.0 RECOMMENDATIONS

The Board of Directors is asked to: -

- Receive this report and note the on-going plans to provide safe staffing levels within nursing, midwifery and AHP disciplines across the Trust.
- Note the ongoing recruitment plans to support each service
- Note the maternity staffing position and the local position which is common with the national profile.
- Note the compliance against the triangulated approach that underpins the Trust's establishment processes and the ongoing quality of data it provides.

Appendix 1: Retention Initiatives

Career Stage	Link to NHSE Toolkit	Action	Lead
All Stages	Leadership and Teamwork	Collate themes from exit interviews and monitor attrition through business intelligence	S-RF/ MB
Late Career	Pride and Meaningful Recognition	Explore Legacy Mentoring	JY
Late Career	Health and Wellbeing	Ensure Menopause Policy Refreshed if required	JR
Mid Career	Professional Development and Careers	Establish Career Framework- linked to Talent Management Framework	AD/CL /JC
All Stages	Professional Development and Careers	Expand Professional Nurse Advocacy Programme and Strengthen Implementation	JY
Early Career	Professional Development and Careers	Create guidelines for structured supernumerary period in clinical setting to complement induction/preceptorship framework	VD
Early Career	Pride and Meaningful Recognition	Achieve Pastoral Care Award for international recruits implement Stay and Thrive strategy	VP

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	Annual Fire Safety Report
Author:	Keith Rawnsley, Trust Fire Officer
Sponsoring Director:	Jonathan Hammond, Chief Operating Officer
Previous Forums:	Audit and Risk Committee – 24 October 2023
Purpose of the Report	The purpose of this report is to provide the Board of Directors with the Fire Officer's Report for the period 1st April 2022 – 31st March 2023.
Key Points to Note	Fire Safety is a key Trust priority to ensure the safety of patients, staff and public. The delivery of a high standard of fire safety is critical to ensuring that our premises remain as safe as possible, and staff are trained to be able to deal with any emergency situation that may arise. Healthcare providers have a duty of care to ensure that appropriate governance arrangements are in place and are managed effectively. The Health Technical Memorandum (HTM) series provides best practice engineering standards and policy to enable management of this duty of care. Calderdale and Huddersfield NHS Foundation Trust (CHFT) is committed to improving and protecting the environment for those who access our services and for those who provide our services and is guided by the HTM series. The contents of this report reflect the commitment of the Board to achieving the safest possible environment from which to deliver high quality health and care services. It details the work conducted by the Fire Safety team in collaboration with other members and teams within the organisation for the period 1st April 2022 to 31st March 2023.
EQIA – Equality Impact Assessment	The Annual 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	The Board is asked to **RECEIVE** and **NOTE** the Annual Fire Report.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

11 JANUARY 2024

ANNUAL FIRE SAFETY REPORT - 1ST APRIL 2022 – 31ST MARCH 2023

1. INTRODUCTION

This report has been prepared by the Trust Fire Officer to provide the Calderdale and Huddersfield NHS Foundation Trust (CHFT) Board of Directors with a comprehensive review of the management and activities relating to fire safety for the period of 1st April 2022 to 31st March 2023. The report includes a workplan forecast into 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.

Individual responsibilities of designated persons in relation to fire safety are outlined in the Trust Fire Safety Group Policy. The Chief Operating Officer is the Executive Director with delegated strategic responsibility for fire safety across the organisation and assumes responsibility at Board level for all Fire Safety Policy matters.

The Trust employs a Fire Officer who is supported by a Trainee Fire Officer to work as a team to carry out the operational requirements of fire safety activity across the organisation. The Fire Safety Response Committee met monthly with a broad membership including colleagues from Trust partners, Calderdale and Huddersfield Solutions Ltd (CHS), and Equans.

The Trust has continued to make good progress over the last 12 months in terms of fire safety however there is further work required to implement the actions within the Fire Strategy to ensure full compliance. Covid 19 caused some ongoing delays and made progress with some capital projects quite challenging. Access to ward areas has been the biggest challenge over the last few years as Covid restrictions coupled with operational pressures has meant high occupancy levels and some access restrictions. This has resulted in Calderdale and Huddersfield Solutions (CHS) being hindered in carrying out the sub-compartmentation works that require an empty ward area.

2. EXECUTIVE SUMMARY

The Regulatory Reform (Fire Safety) Order (RRO) provides the legal framework for the implementation of fire safety in organisations and the HTM (Health Technical Memorandum) provides guidance on how to manage fire safety in healthcare premises, detailing the responsibilities placed upon the Trust and its employees. Fire safety advice, support and training is provided by the Trust's Fire Officer and Trainee Fire Officer. The Trust also commissions independent advice from a formally appointed Authorising Engineer (AE) Fire, as required by HTM 05 – Managing Healthcare Fire Safety.

An additional piece of Fire Safety legislation also came into force on the 23rd of January 2023 which requires information to be available to the Fire Service.

A 5-year Fire Strategy commissioned in 2020 and signed off by the Trust Board in March 2021 confirms the understanding and direction that has been recommended by the Trust Fire Officer and the Fire Safety Response Committee.

Work on the new ED at HRI is progressing, and several large projects have been completed within the reporting period, namely the refurbishment of the MRI area at Calderdale Royal Hospital (CRH) and The Rainbow Community Children's Hub at Elland is now occupied. A few smaller projects such as the demolition of the houses to make way for the new Learning Centre at CRH has commenced and the Fire Alarm upgrade is progressing.

In 2022-23 associated funding of £250,000 was allocated for fire related projects and spent on the development of plans, a feasibility study, new fire doors, compartmentation and improvements on ICU at Huddersfield Royal Infirmary (HRI). Some additional capital projects also added to an improvement in fire safety in some areas across the Trust. Capital works over the last two years have included:

- Fire remediation works completed as part of the Ward 18 refurbishment and subsequent remedials to Ward 15 as part of a £3.2m investment in late 2020. These works included new fire door sets and compartmentation.

- Circa £500,000 in 2022/23 on a sprinkler system for the new Accident & Emergency department, which also included fire compartmentation works to the former Trust HQ building and the new link corridor.

- In 2022/23, £250,000 on a minor refurbishment of ICU which included new fire door sets and compartmentation.

- In 2022/23, installed 14 sets of new fire doors costing in excess of £15,000 (fitting only).

- In 2022/23, £12,000 renewing all our fire plans for HRI and community buildings and a further £31,000 on 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.

- Fire Lift upgrades including fire stopping to the shafts took place in 2022/23 at a cost of £55,000.

- A feasibility study for the smoke control vent for Ward Block 1 sub-basement corridor also completed at a cost of £12,000, which was a recommendation from the Mott MacDonald Fire 5 year Strategy report.

Capital has been identified for 2023/24.

Compartmentation is the sub-division of a building into smaller sections or units in order to withstand or limit the growth or spread of a fire, through the use of fire resisting construction such as fire doors. Architectural plans have been drawn to give the Estates Department an understanding of the sub-compartmentation requirements in comparison to the current position. These plans are anticipated to identify gaps in compliance.

An in-depth survey of the HRI site and community premises commissioned to identify weaknesses in compartmentation has been undertaken with the report currently awaited. This report is expected to give an understanding of the work required to address compartmentation weaknesses, with a subsequent tender process required to understand the associated costs of improvement works. Clarity around the areas due for demolition within the Trust's reconfiguration plans is required to ensure funds and resources to improve compartmentation can be allocated most effectively. Compartmentation at Calderdale Royal Hospital (CRH) is

to a good standard.

A feasibility study to assess if smoke extraction from the sub-basement of ward block 1 is achievable is near completion. Once the results of this study are received, associated costings can be developed and a decision taken as to whether the improvement scheme will go ahead.

The lifts at HRI are not currently compliant with modern day standards and therefore improvement works are underway to improve the fire safety standards of some lifts. One lift per ward block will be a firefighting lift however these lifts cannot accommodate a bed.

The upgrade of the fire alarm panels at HRI over the last few years has seen improvements in the system and, as a consequence, has delivered less disruption to staff and patient care due to the zonal capabilities of the alarm sounds.

The fire alarm system at CRH is being upgraded as part of the life cycle program. The majority of the site is complete with the exception of block N (ISS/ Med Engineering/ Old Ward 3) which is programmed to be replaced later in 2023.

Fire training was delivered during 2022-23 using the online e-learning package accessed on the ESR. The package was outdated in its content however there were difficulties experienced when trying to update it. A new piece of software was procured which enabled an updated package to be developed meaning improved content for all users. Annual Fire training in 2023-24 will be a blended approach between face-to-face classroom sessions or online e-learning. In additional to mandatory annual fire training, evacuation training and regular visits to wards and departments are carried out. Face to face Fire Warden training along with fire extinguisher training has also taken place and the Trust now has over 1000 Fire Wardens trained covering 90% of departments. Fire warden duty is monitored on E-Rostering for clinical departments.

Oxygen enrichment has given cause for concern during the Covid pandemic however the risk of this has reduced over the course of 2022-23 as the number of Covid patients requiring high levels of oxygen has started to reduce. Education on the dangers of oxygen enrichment have been uploaded to the intranet and is now also incorporated into Fire Warden and mandatory training. It has also been placed into the new revised annual training package.

Concerns regarding the placing of combustible materials such as beds, chairs, stores crates in corridors have been raised by the Fire Officers due to the increase in fire loading and the dangerous impact it can have on evacuation procedures. Steps have been taken to try and reduce this issue, with education as to the dangers given where needed. Departments have been notified when areas of concern have been identified, with both Fire Officers and Heads of departments working closely to mitigate this risk. Standards are not currently where they should be and therefore this risk has been documented on the risk register having being raised at both the Fire Committee and Health and Safety Committee.

Staff working from home has had an impact on the number of Fire Wardens available on site. Additional checks have been carried out and where gaps were found, contact was made with managers of relevant areas to address and put mitigating actions into place. Additional Fire Warden training courses were delivered to assist in the recruitment of new Fire Wardens. Education on home fire safety is addressed in the new annual fire training e-learning package and face to face classroom sessions.

3. FIRE SAFETY – ANNUAL PERFORMANCE

3.1 Fire Risk Assessments

Fire Risk Assessments (FRA) are a legal requirement and have been carried out for all CHFT

premises and community premises. The Authorising Engineer (Fire) undertakes the FRAs for the Trust by doing this it enables an independent overview on how well the Trust is progressing with fire safety. The Trust Fire Officer is in regular contact with the Trust Authorising Engineer (Fire) on related matters. Each FRA is reviewed by the Trust Fire Officers and then reviewed by the Fire Safety Response Committee.

One of the main areas for improvement is the 30 minute fire compartmentation works at HRI. Other common findings include concerning storage of items including beds, mattresses, consumables and other equipment being located in inappropriate areas such as corridors. Electrical risks include insufficient electrical socket outlets resulting in the use of extension leads which can be dangerous. The NHS has a policy of one plug, one socket. Where electrical concerns are identified, the Trust Fire Officers are asking department managers to ensure the safe use of electrical sockets which may require a reduction in the number of electrical appliances being used. Or the advice to request for the installation of additional sockets which will incur a departmental cost. Wedging open of fire doors is another concerning issue and funding is needed to allow some doors to be held on 'hold open' devices linked to the fire alarm.

The movement of departments and staff to different locations does not always necessitate the need for a review of the fire risk assessment.

Fire Risk Assessments are followed up with an action plan and a review.

3.2 Fire and Fire Alarms

No major fires occurred during the reporting period.

3.3 False Alarms

The Trust is required to monitor fire alarm activations to ensure they are kept to a reasonable level and determine the reason for the activation putting in actions or to prevent a reoccurrence.

An unwanted fire signal (UFS) is a fire alarm where the fire service attend site and there is no fire. West Yorkshire Fire and Rescue Authority charge organisations £450 for each UFS. Their objective is to reduce the number of UFS thus ensuring fire tenders/appliances are available for actual fire calls. CHFT's Fire Officer and Authorised Engineer continue to work closely with the Fire Authority, Estates and Facilities, Engie and ISS to ensure, where possible, we manage UFS internally and are not charged.

Table 1 Fire Alarms Statistics – Huddersfield

Table 1 shows the number of fire alarm activations at HRI over the last two years: 2021-22 and 2022-23.

Year	Location	Actuations	Fires	False Alarms	Unwanted Fire Signals
2022 /23	HRI	31	0	19	0
2021 /22	HRI	21	0	20	0

There were 10 actuations caused by toasters, which accounts for the increase in activations.

There was 1 activation at Acre Mill ODP, which was a false alarm and 3 false alarms at HPS.

Table 2 Fire Alarms Statistics Calderdale

Table 2 shows the number of fire alarm activations at CRH over the last two years: 2021-22 and 2022-23.

Year	Location	Actuations	Fires	False Alarms	Unwanted Fire Signals
2022 /23	CRH	25	0	22	0
2021 /22	CRH	29	1	28	0

In addition to these there were also 14 activations within the Dales at Calderdale Royal Hospital.

3.4 Mandatory Fire Safety Training

The annual mandatory fire safety training target was achieved during 2022-23 with an overall 90.39% achievement.

Table 3 Fire Training Statistics

Table 3 shows the number of staff trained in mandator fire safety training and Fire warden training.

Year	Fire Safety Training	Fire Warden Training
2022/23	5731	1016
2021/22	5361	488

The numbers above account for Trust and CHS staff. It is estimated that around another 600 staff trained in Fire Safety in ISS, Engie, Renal, Locala, Social Services, etc.

3.5 Fire Warden Training

Fire Warden training continued throughout 2022-23 with improved attendance due to monitoring of E-rostering which identifies the gaps, enabling targeting those areas with lower numbers of Fire Wardens.

3.6 Fire Response Team Training

This training was reduced due to Covid however security and porters at HRI have had additional training on the dry risers.

3.7 Trust Induction Training

Induction training is carried either by online training or by using MS Teams dependent on

who the induction is for.

3.8 Fire Evacuation Training

This is carried out at our offsite premises and where possible scenario training is carried out within the hospital.

Evacuation training using the evacuation aids has also been undertaken when requested, using Evacpads and the Bariatric devices.

The Fire Officers and the EPRR team are working closely to deliver future business continuity and Fire exercises for 2022/2023.

4. GOVERNANCE

4.1 Fire Safety Response Committee

The reporting of the Trust's fire safety compliance with current fire legislation, fire safety regulations and the Trust Fire Safety Group Policy was structured through the Fire Safety Response Committee which met monthly throughout 2022-23. The Trust Fire Committee did report to the Trust Health and Safety Committee however both of these meetings have been consolidated into one for 2023-24.

4.2 Fire Policy

The CHFT Fire Policy has also been reviewed and updated to reflect the Fire Strategy and ensure the content is accurate and up to date.

5. CAPITAL WORKS

CRH does not have the same level of building deficiencies as HRI because it is a newer building and secondly because the building is covered by a lifecycle maintenance and repair programme.

No major compartmentation work has been completed this year at HRI, apart from on Ward 2 (ICU). One of the next major steps will be the 30-minute sub compartmentation, but this will require access to wards and would take weeks per ward to achieve. Compartmentation works remain on the risk register until a decision is made which allow access and the finance for works to be conducted on the wards.

There are also some risers within the hospital at HRI that have Asbestos Containing Materials (ACM). These require serious maintenance however until access is granted work cannot commence. This major task will involve vacating the wards to give access to allow specialist cleaning of the riser. Once cleaned and made safe (no ACMs) a survey will need to be undertaken to assess the work needed both in terms of compartmentation and other services such as mechanical or electrical services.

Major building work has commenced at HRI with the building of the new ED. The buildings works is being closely monitored by the Fire Team as not to compromise the current means of escape in block 1. Measures have been put in place to ensure staff safety.

6. West Yorkshire Fire & Rescue Service/Building Control

There is a sustained and open dialogue between the Trust Fire Officer, the AE Fire and West Yorkshire Fire and Rescue Service both in terms of building works and in conjunction with building control. The Fire Officers also liaise with operational crews for site visits and training

by allowing use of our premises where appropriate. Site visits have unfortunately reduced due to availability of fire crews and as a legacy of Covid.

Fire Safety Work Plan 2023-24

	Item	**Lead**	**Timescale**
	Fire Risk Assessments		
1.	Ongoing assessment on risks within the Trust	A E Fire	On-going
1.1	Work towards completion of actions from FRA's	Fire Committee	On-going
	Training		
2.	Annual Fire Training Monitor progress to ensure suitable levels of understanding and compliance	Fire Officer	On-going
2.1	Fire Warden Provide both new and refresher training	Fire officer	On-going
2.2	Fire Extinguisher Training (practical)	Fire Officer	On-going
2.3	Evacuation Training	Fire Officer	On-going
2.4	Develop training package for 2023/24	Fire Officer	On-going
	Capital Works		
3.	Ensure any works carried out complies with Fire regulations	Fire Officer	On-going
3.1	Give fire safety advice on reconfiguration projects	Fire Officer	On-going
3.2	Fire Door Replacement & Maintenance Ensure work carried out is to modern day standards	Fire Officer/ CHS/ EQUANS	On-going
3.3	Continue to oversee the fire alarm up grades at both CRH and HRI	Fire Officer/ CHS/ EQUANS	On-going
4.	Fire Fighting Equipment Ensure Fire extinguisher are appropriate for the fire risks they cover	Fire Officer/ CHS/ EQUANS	On-going
5	Fire Alarm Activations Continue to reduce the number of fire alarm activations across CHFT	Fire Officer/ CHS/ EQUANS	On-going

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	NHS Core Standards for EPRR - Statement of Compliance for Calderdale and Huddersfield NHS Foundation Trust
Author:	Sarah Rothery – General Manager for Resilience, Acute Flow and Transformation
Sponsoring Director:	Jonathan Hammond – Chief Operating Officer and Accountable Emergency Officer
Previous Forums:	Weekly Executive Board – November 2023
Purpose of the Report	The purpose of this report is to present to the Board of Directors the revised process for the annual assessment of compliance against the NHS Core Standards for EPRR. The new 'Check and Challenge' assurance process implemented across the North East and Yorkshire region in 2023 brought a more rigorous process to assessment and is designed to set a baseline for preparedness in the NHS. The paper also sets out the findings of the revised assurance process and the Statement of Compliance submitted to NHSE England by Calderdale and Huddersfield NHS Foundation Trust.
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.

2023/24 EPRR Assurance Model

The Core Standards self-assessment is undertaken annually. In previous years, all providers of NHS funded care self-assessed against each of the applicable Core Standards for their organisation, providing a commentary on the evidence held to support compliance against the standard. In June 2023 a significantly revised assessment process was launched across the North East and Yorkshire (NEY) region. This more rigorous assessment process had been piloted in the Midlands region in 2022 and involved a new, detailed analysis of compliance evidence against each Core Standard, alongside the organisation's self-assessment by an independent panel. The pilot demonstrated that there were substantial differences between the initial self-assessment results and the compliance level following evidential review of the organisation's documentation. Further details of the results shown across the Midlands region in 2022 can be found in Appendix 4 – NHS England EPRR Core Standards Overview for Boards November 2023. This new process was adopted by 3 of the 7 regions in England in 2023 (the Midlands, North East and Yorkshire and the North West). The remaining 4 regions of England will continue with the assessment process as prior and so it is highly likely that there will be a differential in the compliance levels between those regions undertaking the new process and those under the old.

The revised process has required an initial self-assessment with the upload of supporting evidence into a national online portal by 29 September 2023. The self-assessment and primary evidence underwent a review by the NEY EPRR team against the EPRR Assessment Guidelines and rated as to whether they were 'accepted' or 'challenged'. Where a standard was challenged, the Trust had 5 working days to respond with a narrative and upload supplementary evidence for consideration during a secondary evidence review. Upon review of the supplementary evidence, the Trust was provided with a final outcome of the overall check and challenge assurance process.

The new assurance model was launched across NEY in June 2023 without prior consultation with organisations and therefore created substantial workload challenges. A NEY regional guidance document setting out an extensive set of compliance requirements against each Core Standard was issued in addition to the NHS Core Standards

documentation. A letter was received from the Locality Director at West Yorkshire September 2023 setting out the assessment changes and potential impacts to organisation's ratings and can be found at Appendix 3.

NHS Core Standards for EPRR Assessment 2023

Following the significant changes to the assurance process and requirements, CHFT returned an initial self-assessment of 53 fully compliant standards, 9 partially compliant and 0 non-compliant standards, giving an overall compliance level of 'partial compliance' with a score of 85%. Following independent assessment of the evidence by the North East and Yorkshire EPRR team, the final outcome of the check and challenge process assessed CHFT as fully compliant against 19 standards and partially compliant against 43 standards. No individual standard was assessed to be non-compliant. An overall assessment of 'non-compliant', with a score of 31%. The Statement of Compliance stating a rating of 'non-compliant' was presented to the Weekly Executive Board on 16 November 2023 and can be found at Appendix 1.

Next Steps

The Trust must now commence improvement against the 43 standards assessed as partially compliant, notwithstanding ensuring to maintain the 19 standards assessed to be fully compliant.

There are some standards that the Trust cannot directly influence. It is anticipated that there will be an ICB priority rag-rated workplan developed with timescales which will incorporated into the Trust's action plan. Areas such as mass casualty dispersal and mass fatality plans are led by the ICB and require reference within local plans.

The confirm and challenge process has highlighted gaps within the Trust's level of preparedness. The partially complaint standards have been compiled into an Action Plan (with timescales and owners) which will be used to manage a programme of resilience improvement over the next 12 months. The action plan (Appendix 2) has been prioritised into priority 1, 2 and 3 actions. As a non-compliant rating organisation, the Trust is required to attend monthly supportive progress meetings with the ICB and provide updates against progress at the quarterly Local Health Resilience Partnership (LHRP) meetings over the next 12 months. A quarterly progress update will also be provided to the Weekly Executive Board.

Working to improve the Trust's overall level of compliance for EPRR is however resource intensive. The EPRR function is managed and delivered by a very small team and achievement of progress requires commitment from wider Trust Divisions and services, where necessary, to deliver actions. Training, exercises and testing of plans brings additional pressures to the Trust not only in the design and delivery of sessions, but also through the ability to release time to enable participants to attend.

	APPENDICIES Appendix 1 – Statement of Compliance Appendix 2 – BoD Core Standards and Action Plan 2023 Appendix 3 – Letter from Locality Director, West Yorkshire September 2023 Appendix 4 - NHS England EPRR Core Standards Overview for Boards November 2023
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	The Board is asked to: 1) **Receive and note** the outcome of the annual NHS Core Standards for EPRR assessment for Calderdale and Huddersfield NHS Foundation Trust; 2) **Be assured** that a comprehensive action plan is being implemented.

Calderdale and Huddersfield NHS Foundation Trust

NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

NHS Core Standards for EPRR

Public Board of Directors

11 January 2024

One Culture of care

compassionate care

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

NEY Core Standards – Revised Process

Calderdale and Huddersfield NHS Foundation Trust

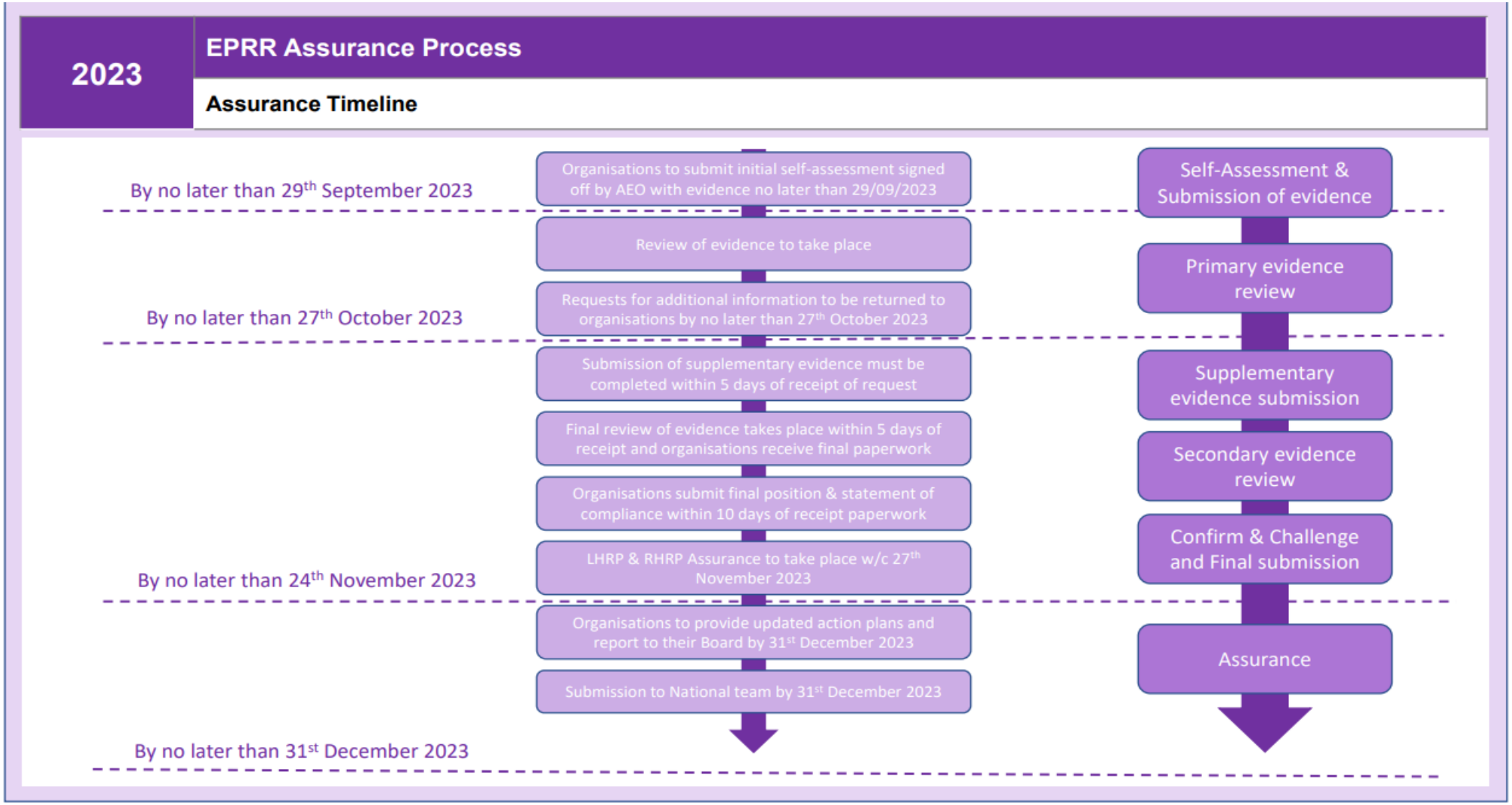
- In 2023 there have been significant changes to the Core Standards for EPRR assurance process in the North East and Yorkshire (NEY) region, with new timelines (see next slide)
- The revised process was piloted in the Midlands in 2022 and demonstrated significant differences in the compliance ratings in self-assessment compared to the final confirm and challenge rating
- The new process is designed to introduce a more rigorous assessment through an independent panel considering organisational evidence alongside the usual self-assessment
- The revised process aims to establish a new baseline assessment across the NEY region
- Alongside the national NHS England EPRR Core Standards documentation, an additional NEY Assessment Guidelines were issued, setting out an extensive set of compliance requirements
- The revised assessment process has been far more rigorous and time consuming to complete
- 3 of the 7 regions in England have adopted the new process in 2023 (Midlands / NEY / NW)
- The remaining 4 regions continue with the process as prior this year
- Expectation that there will be a differential in compliance across regions
- All West Yorkshire organisations have been rated as 'non-compliant' in 2023 by the new process
- It is awaited to understand how many regions will be subject to the new process next year
- Timescales for the 2024 submission are also still awaited *(anticipated to be Aug / Sept 2024)*

One Culture of care

compassionate care

Core Standards Assessment Process (NEY)

Calderdale and Huddersfield NHS Foundation Trust



One Culture of care

compassionate care

Core Standards – Self Assessment

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	5	1	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	9	2	0	0
Command and control	2	2	0	0	0
Training and exercising	4	4	0	0	0
Response	7	7	0	0	0
Warning and informing	4	3	1	0	0
Cooperation	4	4	0	0	3
Business continuity	10	9	1	0	1
Hazmat/CBRN	12	8	4	0	7
Total	**62**	**53**	**9**	**0**	**11**

Percentage Compliance	**85%**
Overall Assessment	Partially Compliant

compassionate care

Check and Challenge - Overview

NHS
Calderdale and Huddersfield
NHS Foundation Trust

- Initial self-assessment returned a compliance level of ‘partial compliance’ with an overall score of 85%.
- Following the primary evidence review, NHSE Regional EPRR team returned the check and challenge findings in which 43 of the 62 standards were ‘challenged’ and 19 standards were ‘accepted’.
- Of the 43 standards challenged, 41 were challenged from fully complaint (green) to partial compliance (amber); and 2 standards were challenged from a status of fully compliant (green) to non-compliant (red).
- Within 5 working days, we submitted supplementary evidence for 24 of the 43 challenged standards, including the two standards challenged to non-compliant (red).
- We accepted 19 of the 43 challenges due to time constraints to submit supplementary evidence (these were discussed with and agreed by AEO)
- Upon secondary review, NHSE Regional EPRR team accepted 8 of our 24 supplementary evidence submissions. The 2 red standards were also accepted and upgraded – 1 to amber, 1 to green
- Final confirm and challenge score was 31% (non-compliance)
- The significant downgraded score compared to self-assessment is consistent with the scoring across West Yorkshire
- An action plan has been produced (slide 5 refers)

One Culture of care

compassionate care

Core Standards – Confirm and Challenge Findings

NHS
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

compassionate care

Action Plan

- An Action Plan has been developed
- Core Standards have been given timescales for completion as follows:
  - Timescale 1 Actions – complete by end April 2024
  - Timescale 2 Actions – complete by end August 2024
  - Timescale 3 Actions – complete by end August 2024 but have interdependencies with other agencies (such as ICB. NEY Region)

- 23 Core Standards have been allocated timescale 1
- 12 Core Standards have been allocated timescale 2
- 6 Core Standards have been allocated timescale 3
- 2 Core Standards are now complete for the action required* (as at end November 2023)

- To be noted that the majority of individual Core Standards have more than one action required to ensure compliance
- Progress against the Action Plan will be presented at the quarterly Local Health Resilience Partnership (LHRP) meetings
- Progress will also be reported to Board of Directors in April and July 2024

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

11 JANUARY 2024

NHS CORE STANDARDS FOR EPRR - STATEMENT OF COMPLIANCE

1 INTRODUCTION

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

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

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

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

The additional 10 standards in the deep dive section do not contribute to the overall level of compliance but are mandatory for Acute Trusts to complete. The deep dive questions in 2023 are on 'EPRR Training'.

2 CHANGES TO THE ASSURANCE PROCESS

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

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

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

Alongside the national NHS England EPRR Core Standards documentation, an additional NEY Assessment Guidelines document was issued setting out an extensive set of compliance requirements against each Core Standard that had to be met to achieve full compliance. Key dates for the new process are shown in Table 1 below:

Table 1 - NEY Region Core Standards for EPRR Key Dates 2023

By no later than 29 September 2023	Organisations submit initial self-assessment and evidence in document repository
By no later than 27 October 2023	Primary review of evidence to take place by Regional panel. Requests for supplementary evidence to be returned by Trust no later than 27 October 2023
By no later than 24 November 2023	Submission of supplementary evidence must be completed within 5 days of receipt of request. Secondary evidence reviews within 5 days of receipt Organisation receives final position paperwork. Trust to submit final position and statement of compliance within 10 days of receipt of paperwork.
By no later than 31 December 2023*	Organisations provide updated action plans and report to Board by 31 December 2023* Submission to national team

*Where Public Board dates are in January 2024 this is accepted

Over 500 individual files were uploaded into the national portal by CHFT for the primary evidence review.

The revised assessment process has been far more rigorous and time consuming to complete. However, it has provided the Trust with a new baseline from which to develop a comprehensive programme of resilience improvement.

3 ASSESSMENTS

3.1 Compliance Rating Thresholds

Compliance levels for the NHS Core Standards for EPRR follow national assurance rating thresholds. The thresholds for compliance ratings did not change in the new assessment process. They are shown below in Table 2:

Table 2 – Assurance Rating Thresholds

Assurance Rating Thresholds
• Fully Compliant = 100%
• Substantially Compliant =99-89%
• Partially Compliant = 88-77%
• Non-Compliant = 76% or less
Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

3.2 Initial Self-Assessment

The initial self-assessment completed for 2023 returned a score of 85% equating to 'partial compliance'. Within the first self-assessment, 53 indicators were 'fully compliant', 9 indicators 'partially compliant' and 0 'non-compliant'. In the deep-dive, 9 indicators self-assessed as 'fully compliant' with 1 indicator 'partially compliant'. Table 3 shows the 2023 initial self-assessment position.

Table 3 – 2023 Self-Assessment Position

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

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

Percentage Compliance	**85%**
Overall Assessment	**Partially Compliant**

3.3 Check and Challenge – Primary Evidence Review

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

3.4 Check and Challenge - Supplementary Evidence Review

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

3.5 Confirm and Challenge – Outcome Findings

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

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

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

The confirm and challenge final assessment position is shown below in Table 4:

Table 4 – 2023 Confirm and Challenge Final Assessment

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	3	3	0	0

Duty to risk assess	2	1	1	0	0
Duty to maintain plans	11	2	9	0	0
Command and control	2	0	2	0	0
Training and exercising	4	0	4	0	0
Response	7	4	3	0	0
Warning and informing	4	0	4	0	0
Cooperation	4	1	3	0	3
Business continuity	10	4	6	0	1
Hazmat/CBRN	12	4	8	0	7
Total	**62**	**19**	**43**	**0**	**11**

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

4 NEXT STEPS

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

- **Priority 1** actions are locally controlled actions and should be completed by March 2024
- **Priority 2** actions are locally controlled actions which are expected to take at least 8 months to achieve and therefore should be completed by August 2024
- **Priority 3** actions have an interdependency with other agencies and therefore are to some degree reliant upon other organisation's action plans (i.e. the ICB). These should be completed by August 2024

The EPRR function and delivery of actions will be strategically led by the General Manager for Resilience, Acute Flow and Transformation managing the overall cycle of improvement works. Progress and accountability against action plan will be monitored locally by the Accountable Emergency Officer, reported to Weekly Executive Board on a quarterly basis and reviewed at the quarterly LHRP meetings. Supportive monthly meetings will also be put into place by the Integrated Care Board.

The overall strategic aim of the EPRR function is to achieve (at least) the threshold for partial compliance (77%) in the 2024 assessment. Action plan and timescales will be aligned to achieving this. It is recognised however that whilst striving to improve the overall level of compliance for the 2024 assessment, maintenance of the standards currently assessed as fully compliant increases the challenges on the EPRR function.

EPRR is a Trust priority and therefore the function will be supported in its work to achieve action and progress against plan. Working to improve the Trust's overall level of compliance for EPRR is however resource intensive. The EPRR function is managed and delivered by a very small team and achievement of progress requires commitment from wider Trust Divisions and services, where necessary, to deliver actions. Training, exercises and testing of plans brings additional pressures to the Trust not only in the design and delivery of sessions, but also through the ability to release time to enable participants to attend.

APPENDICIES

APPENDIX 1 – Statement of Compliance

APPENDIX 2 – BoD Core Standards and Action Plan 2023

APPENDIX 3 - Letter from Anthony Kealy, Locality Director for West Yorkshire

APPENDIX 4 – NHS England EPRR Core Standards Overview for Boards

APPENDIX 1 – STATEMENT OF COMPLIANCE

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2023-2024

STATEMENT OF COMPLIANCE

Calderdale and Huddersfield NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Calderdale and Huddersfield NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

(Copy submitted to NHS England – signed by Jonathan Hammond, Accountable Emergency Officer)

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Now provided a copy of the Workplan in full rather than screenshots – note this is a live working document. Please refer to Workplan, tab 'RSG' which sows the planner for review – workplan monthly review. Also provided are examples of the EPRR and Business Continuity Assurance Reports that are forwarded to RSG. Please refer to Assurance Reports.	Fully Compliant			
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.		Fully Compliant			
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	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.		Partially Compliant	See Action Plan		
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan		Fully Compliant			
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.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	The EPRR Policy sets out the EPRR function resource and the supporting roles and has been ratified at Board – please refer to EPRR Policy Page 9, section 8 inc. 8.1 & 8.2. There are no current vacancies within the Resilience team within the Resilience, Acute Flow and Transformation (RAFT) Directorate. The RAFT Directorate was established formally in April 2023 following a service redesign within the Corporate Division of the Trust. RAFT holds the EPRR function and the roles delivering this were proposed and agreed in the approval of the new Directorate - see paper for new RAFT Directorate	Partially Compliant	See Action Plan		
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.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	The EPRR Workplan is provided, note this is a live working document. Please refer to the 'tested plans' tab within the workplan for evidence of logging actions. The governance process is identified within the EPRR Policy, refer to page 25, section 13.2 specifically. Learning application and debrief is also covered in the Policy.	Partially Compliant	See Action Plan		

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.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	The evidence uploaded in the primary submission showed how the EPRR risks are held within the RAFT Directorate and are managed. The Trust process is that we upload all risks onto the Trust Risk Register. There is one Trust risk register – this is the way all risks are logged across the Trust. The risk assessment form is contained within the risk register which includes likelihood and impact scores, plus mitigation and next steps. In RAFT we hold the log numbers and details of RAFT specific risks and these are managed by appropriate team members according to the risk. Please see again the RAFT risks Sept 2023 for a full record which include EPRR risks. The RAFT risks are reviewed at every RAFT Governance Group which takes place monthly. Risks for proposal are discussed here plus changes of scores. Please refer again to the email from Gemma Berriman titled 'Risk Register Email to Review' for evidence of asking for monthly review of risks. Please also refer to ToR RAFT Governance Group 2023/24 which sets out the requirement to review risks at the monthly meeting. EPRR risks are also logged on the EPRR Workplan – refer to EPRR Risks tab The EPRR Policy sets out the management of risks at local level, Divisional level and Trust level according to score. Please refer to the EPRR Policy, page 21, section 10.8 specifically however risk is mentioned throughout the policy also. The Trust Risk Management Policy sets out the Trust method for managing risks. The EPRR Policy for managing risk is aligned to the Trust policy in terms of the scoring and management of risks – again refer to Page 21. For risks that require Divisional management, these will be forwarded to the Corporate Performance Review Meeting (PRM) held on a quarterly basis – see examples of PRM slides uploaded Responsibility sits with the individual risk owner, with overall accountability for RAFT risks sitting with the Director of Operations for RAFT (Chair of the RAFT Governance Group) and attendee of the Corporate PRM on behalf of RAFT	Partially Compliant	See Action Plan
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Please refer to standard 7 above for detail on risk assessment and risk management.	Fully Compliant	
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Evidence was provided of collaboration with external partners, these include Yorkshire Ambulance Service and Yorkshire Fire and Rescue Service. Please see example emails attached again – CHFT MIP and HAZMAT Plan Comments Please. The EPRR Policy sets out the governance for the need to collaborate with external partners as in line with the CCA – please refer to EPRR Policy page 19, section 10.3 specifically. Governance around this is also covered in sections 10.4, 10.5, 10.6 and 10.7 Previously also provided was evidence of collaborative planning by the Trust across West Yorkshire footprint to support the Industrial Action response at both Trust and WY level. This evidence should be referred to to see collaborative planning.	Fully Compliant	
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.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust does have first and second on call structures 24/7. See On Call Structure PowerPoint Also explained here: 09:00 – 17:00 Monday to Friday ONSITE Clinical Site Matron – First On Call. A Clinical Site Matron is available 24/7, one based at each site (HRI and CRH). Takes the role of Operational (Bronze) Commander during this timeframe. 09:00 – 17:00 Monday to Friday ONSITE Director of Operations – Second On Call Takes the role of the Tactical (Silver) Commander during this timeframe. Chief Operating Officer (or nominated Deputy) Strategic (Gold) Commander. 17:00 – 09:00 Monday to Sunday ONSITE Clinical Site Matron – First On Call Takes the role of Operational (Bronze) Commander and Tactical (Silver) Commander – split between the two CSMs as one at each site 17:00 – 09:00 Monday to Thursday OFFSITE Strategic On Call (Director level – including Exec Directors and Senior Team) – Second On Call Takes the role of Strategic (Gold) Commander and is required to attend to site if required 09:00 – 09:00 Friday / Saturday / Sunday (24 hour shifts) OFFSITE Strategic On Call (Director level – including Exec Directors and Senior Team) – Second On Call taking a 24 hour shift	Partially Compliant	See Action Plan
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.		Fully Compliant	
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.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Establishing an outbreak management team – please refer to Outbreak of Infection Policy, Page 9-12, section 6 and also action card on Appendix 6 Antivirals, contact tracing – please refer to Outbreak of Infection Policy, Page 18, Appendix 3 PPE and FFP3 considerations – please refer to the Standard Precautions Policy, page 9, section 6.b Further detail of Infection Control is also available in the following policies: •Multi-resistant organisms •Aseptic Technique Policy •Isolation Policy Please also refer to the wealth of information previously provided.	Partially Compliant	See Action Plan
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	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	No supplementary evidence	Partially Compliant	See Action Plan

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	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Please see email attached	Partially Compliant	See Action Plan
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.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	No supplementary evidence	Partially Compliant	See Action Plan
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.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	No supplementary evidence	Partially Compliant	See Action Plan
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.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required		Partially Compliant	See Action Plan
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.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	No supplementary evidence	Partially Compliant	See Action Plan
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.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements	No supplementary evidence	Partially Compliant	See Action Plan
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.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	On Call rotas provided for: Strategic On call Silver Tactical Chair Duty Matron Weekend Visible Leadership Community On call Clinical Site Matron and Site Commander Rota Also see the comments provided in Core Standard 10 regarding On Call structures. Please also refer to the documents provided as evidence in Core Standard 10. EPRR Policy sets out On Call expectations. Please refer to Page 15, section 8.2. Page 22, 23 sections 11, 11.1, 11.2, 11.3 and Page 42	Partially Compliant	See Action Plan
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	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	A TNA is being worked up with West Yorkshire ICB and CHFT are part of the MOS training portfolios working group – first meeting scheduled for 26/10/23. See email from Laura Siddal – Email Draft Training Needs Analysis and also see calendar invitation – FW MOS WY Training Portfolios Working Group The draft TNA is provided on the related attachment – Consolidated EPRR TNA A draft TNA mapped to the MOS has been provided by Laura Siddal from WY ICB Emergency Planning and the group will be working to establish a final version of this for use within organisations (including CHFT). The TNA will map out the courses required, their availability and the type i.e. online / face to face. At CHFT, the EPRR Policy provides Appendix A showing the MOS for EPRR 2022, and Appendix B shows the roles with incident response responsibilities and the training required. This will be replaced with the WY TNA once a final version is available. All CHFT Strategic Commanders and Tactical Commanders have been directed to attend the Principles of Health Command training – all have either already attended or are booked before the end of 2023. See Uploaded Workplan – Strategic Training and Tactical Training tabs. Training Records West Yorkshire have not agreed the training portfolios but this will be picked up in the working group commencing on 26/10/23 – see calendar invite. In the meantime, a query was raised at the LHRP questioning how records are kept in the interim. Advice was to keep a list of training attended with dates until portfolios are available. See therefore Training tabs on workplan	Partially Compliant	See Action Plan

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.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Training Records West Yorkshire have not agreed the training portfolios but this will be picked up in the working group commencing on 26/10/23 – see calendar invite. In the meantime, a query was raised at the LHRP questioning how records are kept in the interim. Advice was to keep a list of training attended with dates until portfolios are available. See therefore Training tabs on workplan Training is being undertaken on incident response For strategic commanders and tactical commanders – Principles of Health Command – please see workplan – strategic and tactical training tabs RAFT Development Days with Clinical Site Matrons and Clinical Commanders – please see RAFT Development day slides. Included training on incident response and an exercise. JESIP online training also being worked through by Clinical Site Matrons – see workplan – tactical training tab Some strategic commanders have undertaken media training – see workplan – strategic training tab AEO has attended legal awareness training – see workplan – strategic training tab Training will also be informed by the WY TNA once agreed – see calendar invite	Partially Compliant	See Action Plan
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)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Intent of the organisation to train and exercise is clear within the EPRR Policy. Exercise is referenced 59 times and training is referenced 68 times in the EPRR Policy. Tested Plans can be found on the workplan – see workplan EPRR Policy, page 44-45, Appendix 3 shows a 3 year testing and exercising plan.	Partially Compliant	See Action Plan
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	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Please refer to Workplan – Strategic Training tab and Tactical Training tab Training Records West Yorkshire have not agreed the training portfolios but this will be picked up in the working group commencing on 26/10/23 – see calendar invite. In the meantime, a query was raised at the LHRP questioning how records are kept in the interim. Advice was to keep a list of training attended with dates until portfolios are available. See therefore Training tabs on workplan	Partially Compliant	See Action Plan
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.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Strategic commanders and tactical commanders are indeed undergoing training – see workplan – strategic commander training and tactical commander training Clinical Site Matrons and Commanders are undergoing training – see RAFT development Days Loggists are undergoing training – 11 trained loggists currently with a further 3 planned in November. – see Loggists CHFT Mandatory training – this is not currently on our mandatory training for all staff, however the Principles of Health Command training was mandatory for all strategic and tactical commanders to attend.	Partially Compliant	See Action Plan
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.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	We have 4 ICC locations identified – 2 for Tactical Command and 2 for strategic command. ICC Set up document provided again. Workplan shows those trained in commander posts – PHC training The rooms identified for ICC are all in use daily. This is due to space constraints however if required, they would be able to be used as an ICC. We would also look to use MS Teams as a resource for tactical and strategic command meetings for effectiveness and time management.	Partially Compliant	See Action Plan
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	Governance for intranet uploads and hard copies – please refer to workplan, Policy Status tab Assurance that hard copies are available in the ICC is shown in a selection of photos showing the HAZMAT plan and MIP in the ICC Plans and Policies folder.	Fully Compliant	
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes		Fully Compliant	
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	Y	• Documented processes for accessing and utilising loggists • Training records	Provided again the trained loggist list – see loggists CHFT We have an informal arrangement with the trained loggists for out of hour cover (24/7). They are asked to provide their personal contact details if they are happy to be contacted out of hours. All contact numbers for loggists named on this sheet are personal contact numbers. This was provided last time – and was the case then too.	Partially Compliant	See Action Plan

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.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Governance documents provided showing minutes, papers, logs etc. Please see all uploaded evidence files for assurance and governance Email from Assistant Director of THIS confirms: "All mandatory returns are captured on an overarching list that is updated continually and tabled at Data Quality Board (DQB) at least annually but over the last two years 6 monthly. List attached – to note this contains detail of sign off, sign off back up, produced and producer back up. Sample DQB Minutes attached (specifically section 3.1) and paper that tabled at DQB. In addition DQB has a series of KPIs that are assessed each year via deep dive audit the list being agreed annually in advance – the programme for 23/24 as attached."	Partially Compliant	See Action Plan
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	See photos provided	Fully Compliant	
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	See photos provided	Fully Compliant	
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	No supplementary evidence provided	Partially Compliant	See Action Plan
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	We do have pre-prepared statements in the on call strategic handbook – see Media Statements Strategic Handbook 1 and 2. These were previously provided (in core standard 33) We have advice on the intranet – see 'If a Journalist calls you' Some strategic directors have had media training – see Media training strategic command	Partially Compliant	See Action Plan
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.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	No supplementary evidence provided.	Partially Compliant	See Action Plan
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.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	No supplementary evidence however a challenge back on this as the ICB hold the information sharing protocol document in question and are currently reviewing it. We were advised that organisation's would not be marked down on a core standard if we are reliant on another organisation completing their action to support it. We supplied a raft of information documenting our Trust information governance processes in the primary submission including the WY info sharing protocol	Partially Compliant	See Action Plan
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning		Fully Compliant	
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.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	No supplementary evidence provided Action: Already commenced review of BCMS Policy and work to align to the NHS BCM Toolkit 2023. Work to align to risks, escalation, testing and exercising also underway	Partially Compliant	See Action Plan

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).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	No supplementary evidence provided	Partially Compliant	See Action Plan
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices		Fully Compliant	
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.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Workplan shows evidence of business continuity tests in the last 12 months – please see workplan, Tested Plans tab (first column) Tested plans have a post-exercise report written. Please see further examples of this – Exercise report Catering and Exercise Report Medical Engineering Governance is through the RSG – see workplan, RSG tab and RSG ToR	Partially Compliant	See Action Plan
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved		Fully Compliant	
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.	Y	• Business continuity policy • BCMS • performance reporting • Board papers		Partially Compliant	See Action Plan
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	External audit was conducted 2023 – by Audit Yorkshire. Documents provided again. Previously we provided documents showing the Audit report and also the action tracker. Also now attached confirmation email that a Board paper was presented at Exec Board on 29/06/23 by Audit Yorkshire (Leanne), and the action tracker was presented there. The AY actions are uploaded to a portal, the actions for upload are provided via the action tracker.	Fully Compliant	
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.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	No supplementary evidence provided	Partially Compliant	See Action Plan
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.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	No supplementary evidence provided	Partially Compliant	See Action Plan
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning			

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	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	No supplementary evidence provided	Partially Compliant	See Action Plan
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services		Partially Compliant	See Action Plan
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient		Fully Compliant	
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	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste	Challenge accepted however supplementary evidence provided on the following: Tests have been conducted – please see CRH Decon Tent Test 06.07.23, Exercise Photos 01.11.22, Report Exercise HAZMAT 01.11.22, and this was accepted as evidence of testing the processes in the comments provided on CS 66. The contaminated bodies process was due to be tested and exercised on 06.07.23 in addition to the tent test but had to be shortened due to ED operational pressures and industrial action planning taking priority. Action: We provided detail on planning (HAZMAT) which included procedures for contaminated waste, contaminated bodies, however further exercising of this is required	Partially Compliant	See Action Plan
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improwsed decontamination where necessary.	Y	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Please note – the comments provided state that "rosters have been provided but these do not demonstrate which staff have been trained within the last 12 months." However, rosters were not provided in the primary submission so we are unclear as to what this comment is referring to. Trained staff in ED – for training stats please refer to MAJAX Compliance excel document. (HRI stats on one tab, CRH stats on a second tab.) For capability arrangements, please see a selection of ED Rotas for a weekday day, weekday night and a weekend day and weekend night – ED Rota Thurs day and night ED Rota Sat day and night In a major incident requiring HAZMAT response, the Trust would initiate a call out for support on site which would increase the number of trained people on site. The response would be subject to the scale and size of the incident at hand. We have tents and HAZMAT equipment available 24/7 at both sites (HRI and CRH) which support a 24/7 capability response at both sites and tested in exercise Nov 2022.	Fully Compliant	
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Please note – the comments provided state that "whilst a copy of the audit checklist for 2023 has been provided this is blank". However, the audits that were provided – equipment and PRPS suits – were both complete, not blank. We have provided copies of these audits again. Please see – PRPS Sizing audit template – refer to both tabs (please scroll across left on both tabs) Also see MAJAX equipment Checklists for CRH and HRI	Fully Compliant	
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	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	PRPS suit audit showing checks prior to Sept 2023 provided – please see PRPS Sizing audit – refer to both tabs (please scroll across left on both tabs) For governance processes please also refer to EPRR Policy page 14 section 8.1 and page 15, table 8.2	Partially Compliant	See Action Plan

62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Y	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultaion with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit		Fully Compliant	
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	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment		Partially Compliant	See Action Plan
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	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records		Partially Compliant	See Action Plan
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	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS		Partially Compliant	See Action Plan
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	Y	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	An example of lessons learned being embedded is the YAS Audit 2022 identifying that there was no process for contaminated bodies within our arrangements. Since then, the contaminated bodies process has been established in collaboration with mortuary teams and written in to the HAZMAT IRP. Action from YAS Audit 2022 was: Liaise with hospital mortuary to ensure there is a process in place for dealing with contaminated bodies COMPLETE The workplan also documents the HAZMAT actions and track progress against completion	Partially Compliant	See Action Plan
67	CBRN Support to acute Trusts	Capability	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist		Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).			
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.			
69	CBRN Support to acute Trusts	Capability Review Frequency	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. Evidence of progress/close-out of actions.			
70	CBRN Support to acute Trusts	Capability Review report	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.		Evidence of those reports and that the designated hospital and NHSE EPRR Lead are in receipt of those. Dip sample of last 10 years of reports, e.g., please provide reports from 2015, 2018, and 2022 to show adherence to the retention of reports for 10 years.			

71	**CBRN Support to acute Trusts**	**Train the trainer**	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.	Written statement as to how this is achieved, which can then be further investigated during inspection. Evidence of training records and/or a documented training schedule. Provision of suitable training documentation – syllabus, lesson plans, etc., that shows the detail of training delivered.
72	**CBRN Support to acute Trusts**	**Aligned training**	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.	NARU can provide the latest version number of associated training packages. This can then be cross-referenced against lesson plans and training packages in acute Trusts to ensure up-to-date national training is being delivered.
73	**CBRN Support to acute Trusts**	**Training sessions**	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.	Clear evidence of documentation (e.g., a contract, MoU, or equivalent, that details how training is delivered to acute Trusts, how often, etc.).

APPENDIX 3 - LETTER FROM ANTHONY KEALY, LOCALITY DIRECTOR FOR WEST YORKSHIRE

Dear all,

Please see the below communication from Anthony Kealy, WY Locality Director, and Beverley Geary, Director of Nursing and Accountable Emergency Officer for NHS WY Integrated Care Board.

To: Trust Chief Executives
Accountable Emergency Officers
CC: Emergency Planning Managers

Dear Colleagues

The annual assurance process for the EPRR core standards is currently under way. Each Trust will need to submit an initial self-assessment of its compliance levels by 29 September.

We wanted to make sure you are sighted on the significant changes that have been made to the assurance process this year, as they may have an impact on your Trust's reported level of compliance.

Previously Trusts were required to provide a RAG-rating for each applicable standard and comments on the evidence that supported this assessment.

This year the process has been revised, requiring the submission of actual evidence via a national portal. The evidence will then be reviewed by a regional panel and may be subject to challenges and requests for supplementary evidence.

This is a more rigorous process which should support a more consistent set of assessments. Clearly it is also a much more onerous exercise. We recognise, and are grateful for, the hard work of your EPRR leads and teams in completing this process at a time when their capacity is severely stretched as a result of other demands, not least the ongoing industrial action.

The experience of organisations in the Midlands region, which piloted this new process in 2022, was that it typically resulted in a reduction in the reported level of compliance. (66% of organisations reported a reduction and only 2% an improvement on their previous assessments).

We should regard this year's assurance process as, in effect, a re-basing of organisations' self-assessments. We will not be surprised to see some deterioration in the reported levels of compliance. We expect the outcomes will provide a clear indication of the priorities for further joint work to address gaps and areas for improvement.

As you complete your internal governance processes for the self-assessment you may wish to ensure that your Board understands the material changes to the requirements.

We will continue to support AEOs and EPRR leads through this process over the coming months. However, if you have any specific concerns or issues that you would like to discuss please do get in touch.

Thank you

Anthony Kealy
Locality Director, West Yorkshire
NHS England – North East and Yorkshire
anthony.kealy@nhs.net

Beverley Geary
Director of Nursing
b.geary@nhs.net
NHS West Yorkshire Integrated Care Board

Classification: Official-Sensitive

NHS England EPRR Core Standards Overview for Boards

Applicable to – NHS organisations in the North East & Yorkshire and North West regions

Content – Overview of changes to the NHS England EPRR Core Standards assurance process in the North East & Yorkshire and North West for the 2023/24 assurance cycle

Version – 1.0 FINAL November 2023

Contact – england.eprrney@nhs.net or england.eprrnw@nhs.net

Publication reference: NEY&NWEPRRAssurance2023

The rationale for change

Over recent years the Emergency Preparedness Resilience & Response (EPRR) world has seen both significant disruption and major change – from our exit from the European Union to the COVID-19 pandemic, Manchester Arena attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professionals and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public inquiries (Manchester Arena, Grenfell & the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirlwall Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried & tested plans is one which requires a dedicated assurance framework which can ensure our collective system resilience

The 2023/24 EPRR Assurance model

In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process. This pilot, involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment.

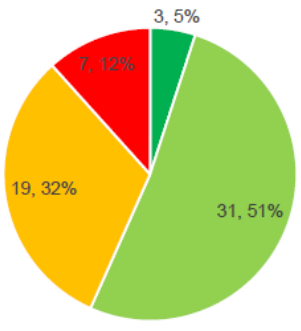
This model required commissioners and providers of NHS commissioned care to submit evidence, which went through a formal review and subsequent check and challenge, whereby they were given the opportunity to submit supplementary evidence against any challenges before finalising their assurance position.

The Midlands results, as detailed in the diagrams below, clearly demonstrated that despite the efforts of organisations in delivering their EPRR responsibilities, there were substantial differences between the self-assessment results and the evidential review of the organisations documentation.

NHS England Midlands

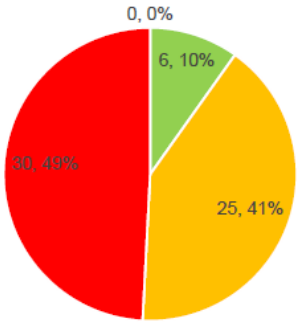
Levels pre and post confirm and challenge

Pre confirm and challenge



- Organisations declaring full compliance
- Organisations substantially compliant
- Organisations Partial Compliance
- Organisations Not Compliant

Post confirm and challenge



- Organisations declaring full compliance
- Organisations substantially compliant
- Organisations partial compliance
- Organisations non compliant

The position before and after the confirm and challenge shows the value in this step of the process in assuring the wider NHS of the positions being self reported.

NHS England recognises several organisations were already very open with the positions they had with 5 organisations not moving in position.

The highlighting of issues assists the whole of the system manage and improve.

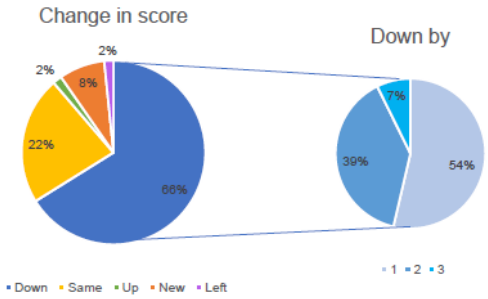
The maximum of accepted challenges to an organisational assessment was 30 standards.

OFFICIAL – SENSITIVE

Change from 2021/22

Breaking down the change into positive or reduced positions.

- 8% of organisations had a first assessment
- 2% increased in position
- 22% remained in the same assessment position
- 66% decreased on the previous assessment, of these:
  - 7% dropped three compliance levels (full to non compliance)
  - 39% dropped two compliance levels (full to partial or Sub to non)
  - 54% dropped one compliance level (Full to Sub, Sub to partial or Partial to Non)



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

Implementation of the same model within the North East & Yorkshire and North West regions was agreed with the intention to undertake an open, honest and transparent, review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving our collective resilience for patients and communities.

NHS England worked with ICB colleagues through the summer to provide guidance and clarity on the assessment requirements and highlighted that it was likely we may see the same compliance shift that Midlands colleagues had seen in 2022.

Introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The way forward

Following completion of the evidence reviews, provider organisations will undertake a check & challenge via their Local Health Resilience Partnership (LHRP), this will give an opportunity for peer discussion and for ICBs to seek assurance ahead of their own system level check & challenge via the Regional Health Resilience Partnership (RHRP).

Organisations will be required to participate in ongoing assurance against their action plans, this will follow pre-existing arrangements that are well established across both regions –

- **Fully compliant** – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- **Substantially compliant** – formal updates against action plans every 6 months.
- **Partially compliant** – formal updates against action plan every 3 months.
- **Non-compliant** - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

The intention of the revised process is absolutely intended to be constructive, and to allow organisations to reflect on the robustness of the plans they have in place, what more they could or should be doing to improve their resilience, and to demonstrate that position to their Boards.

The collective focus over the coming months, will be to identify common themes and the NHS England EPRR teams will continue to proactively support opportunities to collaboratively address areas for improvement in order to enhance system preparedness, patient outcomes, and opportunities to share best and notable practice. This will deliver greater resilience at provider level, for place based systems and across the regions, with greater interoperability and opportunities to undertake collective planning.

It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

Following completion of this years process, it is important to take time to come together and reflect on the lessons identified through this process. This will enable opportunities to collectively provide greater guidance to colleagues where questions have been raised (e.g. annual review of plans and policies), ensure that areas which have worked well in this process are embedded in future years, and to identify improvements in the assurance process ahead of next year's assurance cycle.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	Freedom to Speak Up Mid-Year Review
Author:	Andrea Gillespie, Freedom to Speak Up Guardian
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Workforce Committee 18 December 2023
Purpose of the Report	This paper provides information regarding Freedom to Speak Up (FTSU) activity in the Trust from 1 April 2023 to 30 September 2023.
Key Points to Note	• Freedom to Speak Up is an important part of an organisation's safety culture. • This is reflected in the increasing importance being placed on FTSU by the Care Quality Commission in its Well-led assessments. • There has been an increase in FTSU concerns being raised, this follows increased communications and promotion of FTSU in the organisation. • Additional capacity is being recruited into the FTSU service and the service has transferred from Workforce and Organisational Development to Corporate Services • An update to this report will be given at the Board meeting.
EQIA – Equality Impact Assessment	The equality impact for specific actions arising following consideration of the report will be assessed, considered, and mitigated as appropriate.
Recommendation	The Board of Directors 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.

Calderdale and Huddersfield NHS Foundation Trust

FREEDOM TO SPEAK UP MID-YEAR REVIEW

1. PURPOSE

This paper provides information regarding Freedom to Speak Up (FTSU) activity in the Trust from the 1st of April 2023 to the 30th of September 2023. The annual report was presented to the Board meeting in September by the Deputy Director of Workforce and Organisational Development. Several questions were asked at that meeting and a short presentation providing a response and key themes will be provided at the Board meeting in addition to this report.

2. BACKGROUND

Freedom to Speak Up is vital in healthcare if we are to continually improve patient safety, patient experience and the working conditions for our colleagues. The National Guardian's Office (NGO) believes a positive speaking up culture makes for a safer workplace, for workers, patients, and service users. At Calderdale and Huddersfield NHS Foundation Trust (CHFT) our aim is to make speaking up business as usual and normal behaviour in both being able to speak up and in how we respond to those that do.

Effective speaking up arrangements help to protect patients and improve the experience of NHS colleagues. Having a healthy speaking up culture is an indicator of a well-led Trust. As part of the new inspection framework currently being rolled out by the Care Quality Commission (CQC), a Trust's FTSU arrangements will be assessed as part of the Well-Led review. The new quality statement headed FTSU includes four sub-topics of Speaking up culture, Freedom to speak up guardian, Whistleblowing and Closed Culture, highlighting the increasing importance placed on this within organisations.

3. PROGRESS UPDATE

3.1 The FTSU Network at CHFT

The Trust's FTSU Guardian is Andrea Gillespie who currently works 18.75 hours per week. Interviews for an additional Guardian who will also work 18.75 hours will take place on 9 January 2024.

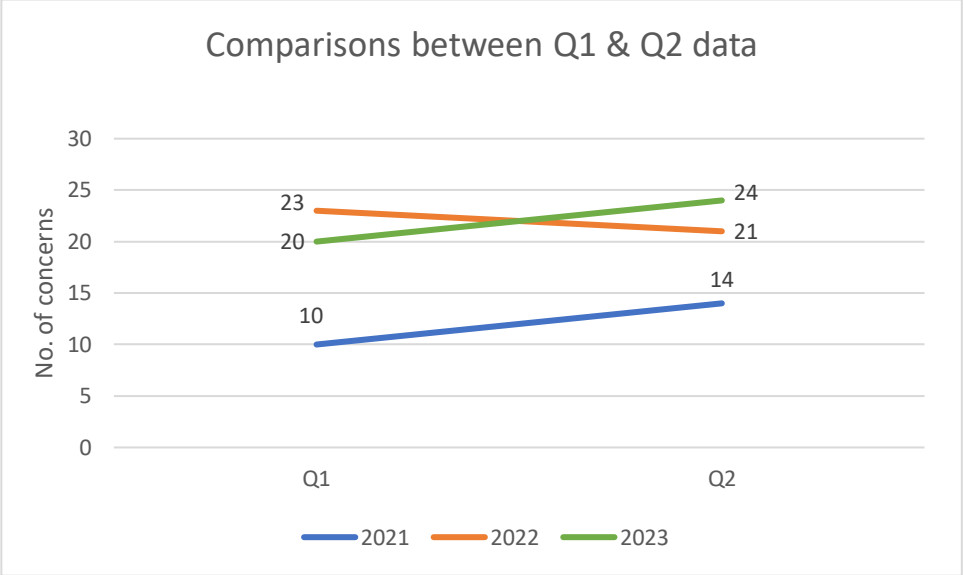
On December 1st, 2023, the FTSU service transferred from the Division of Workforce and Organisational Development to the Corporate Division. Andrea is now supported by the Executive Lead for FTSU, Victoria Pickles and twenty-three active FTSU Ambassadors that come together as an FTSU network group. The FTSU Ambassadors promote the FTSU agenda in their areas of work and are a point of contact and source of support for any colleague who wants to raise and escalate a concern. The Ambassadors have no protected time to dedicate to FTSU within their substantive roles. In November 2023, the NGO published new guidance for Freedom to Speak Up Champions and Ambassadors. The FTSUG is in the process of reviewing the guidance to ensure CHFT's compliance and is using the opportunity to review the current CHFT Ambassador network.

3.2 FTSU concerns raised in Q.1 and Q.2 at CHFT (1 April to 30 September 2023)

The table below shows the number and types of concerns raised in Qu.1 and Qu.2:

Quarter	No. of concerns	No. raised anonymously	No. with element of patient safety/ experience	No. with element of bullying/ harassment	No. with element of worker safety or wellbeing	No. with element of inappropriate behaviours
April to June 2023	20	12	5	1	5	10
July to September 2023	24	8	13	5	9	15

The table below illustrates the number of concerns raised in Q.1 and Q.2 2023 compared with 2021 and 2022:



Q.2 data indicates a small rise in the number of concerns raised. Following the conviction of Lucy Letby in August 2023 CHFT increased communications promoting FTSU which triggered an increase in the number of concerns in September, with eleven concerns raised. The increase in the number of concerns raised in relation to patient safety also correlates with this.

Q.1 data indicates a significant rise in the numbers of concerns raised anonymously, with 60% of concerns being raised anonymously through the FTSU portal. There appears to be no identifiable reason for this anomaly however Q.2 saw a significant decrease with 35% of concerns being raised anonymously.

In Q.1 and Q.2 25 of the forty-four concerns raised refer to inappropriate behaviours. Inappropriate behaviours are referenced in relation to all levels of staff and examples include verbal abuse, bias, favouritism, lack of kindness and compassion.

At the time of writing this report there are thirty-six open FTSU concerns. This number has increased due to concerns taking longer to process due to their complexities. Colleagues raising their concerns are also requiring additional support from the FTSUG as they often present to the FTSUG in extremely stressed and anxious states. Discussions at FTSU Regional meetings indicate that what we are experiencing at CHFT reflects the current Regional and National pictures.

3.3 Feedback

Feedback from colleagues raising their concerns remains positive, recognising that the number of feedback responses received through the actual FTSU portal is low. When the FTSUG closes a concern on the portal, the colleagues are asked the NGO feedback question: 'Given your experience, would you speak up again' and given an opportunity to add some narrative if they wish. This is the only touchpoint with colleagues once their concern has been closed. The FTSUG is exploring how we can improve the current process to include a wellbeing check and create an opportunity to identify whether the colleague has been mistreated in any way because they have spoken up. The FTSUG is reviewing processes used in organisations in the region to identify how regularly they check-in with colleagues and over what periods.

Feedback received August 2023:

'I was hesitant to approach FTSU initially, as within the department it had caused some animosity when a colleague brought an issue to light anonymously. I am, however, very pleased that I did. I was listened to, perhaps for the first time regarding an incident and subsequent bullying. I was treated with respect and taken seriously. I did find that I had not experienced these things from my manager or from colleagues within my own department, so to have a 'safe' place to discuss the issues, concerns and have actions was not only a relief, but it really did help to turn my mental health around. FTSU works – the person I spoke with (the FTSUG) was professional, collated information- not only from my side, raised concerns when appropriate and really is the reason I am still here at work at all.'

3.4 Current FTSU priorities

FTSU Guidance published by NHS England, in collaboration with the NGO, included requests for organisations. The requests include a revision of the local FTSU policy, the completion of a self-assessment tool, a communication strategy, and an improvement strategy with a delivery plan. Each of these will help CHFT deliver the People Promise for workers, by ensuring they have a voice that counts, and by developing a speaking up culture in which leaders and managers value the voice of their staff as a vital driver of learning and improvement. There is also a self-assessment exercise to be completed by the end of January. The FTSUG is in the process of revising existing documents and creating new documents as required, with help from appropriate teams and senior leaders. Completion will ensure that CHFT is in line with National guidance.

There will always be barriers to speaking up and FTSUGs play a vital role in helping leaders identify people facing barriers and in helping deliver actions to bring about change. To begin conversations around this important subject the FTSUG intends to engage with the CHFT staff networks in the first instance. It is crucial that Guardians build strong connections with all staff networks as part of their work to understand the barriers some people face to speaking up.

4. CONCLUSION

The Board is asked to note the contents of the report, the number of concerns raised in Q1 and Q.2 2023 and the work of the FTSU Guardian and Ambassadors.

Andrea Gillespie

Freedom to Speak Up Guardian

December 2023

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 11 January 2024
Meeting:	Public Board of Directors
Title:	Update on reinforced autoclaved aerated concrete (RAAC) in leased premises
Author:	Tom Donaghey, Calderdale and Huddersfield Solutions (CHS) Head of Estates
Sponsoring Director:	Stuart Sugarman, CHS Managing Director
Previous Forums:	Private Board of Directors - 2 November 2023
Purpose of the Report	The purpose of this paper is to provide assurances that properties leased to the Trust have been checked for the presence of RAAC.
Key Points to Note	The Trust lease a number of properties from private landlords, partner organisations and NHS Property Services. Calderdale Huddersfield Solutions, CHS, retain a property database which documents these properties in accordance with Health Building Note (HBN) 00-08 The efficient management of healthcare estates and facilities. CHS have contacted our landlords to identify whether RAAC is present in their buildings.
EQIA – Equality Impact Assessment	N/A
Recommendation	It is recommended that the Board **NOTE t**he 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.

Reinforced Autoclaved Aerated Concrete (RAAC) in Trust leased premises

1.0 Background

In 2019 SCOSS (Standing Committee on Structural Safety) published the safety alert "Failure of Reinforced Autoclaved Aerated Concrete (RAAC) Planks" following the sudden collapse of a school flat roof in 2018. The collapse occurred at the weekend and fortunately there were no casualties.

RAAC is a form of lightweight concrete material used in some buildings to form roof planks, wall panels and sometimes floor planks, predominantly between the mid-1950's and mid 1960's. Although called concrete, it is very different from traditional concrete and, because of the way in which it was made, much weaker. The useful life of RAAC planks has been estimated to be around 30 years.

If properly designed, manufactured, in good condition and with good bearing, RAAC installations are considered safe. However, panels can defect over time, exasperated by water ingress, and if they have insufficient bearing and their structural integrity is compromised they can fracture and collapse.

2.0 Purpose

The purpose of this paper is to provide assurances that properties where Calderdale and Huddersfield NHS Foundation Trust have a formal lease and/or have formalised occupational agreements have been identified for the presence of RAAC, and where required suitable monitoring and remediation are managed.

Following the safety alert in 2019 NHS England has put in place a now well established programme to identify RAAC, support providers to put mitigations in place and plan for eradication. In May 2023 NHS England sent out additional guidance to organisations including all provider Trusts (including mental health, community and ambulance) following updated guidance from the Institute for Structural Engineers (IStructE) on RAAC identification, management and remediation. They asked Trusts to assess their estate again based on the updated guidance. NHS England wrote to ICBs to inform the requirement for Primary Care estate and they continue to work closely with local primary care practices. NHS Property Services have conducted their own surveys.

NHS England issued further correspondence in September 2023 to outline actions we should be taking to assure ourselves as far as possible that RAAC is identified and appropriately mitigated, to keep patients, staff and visitors safe. All guidelines on RAAC are based and driven by expert advice from the IStructE. The government has confirmed this guidance continues to be the basis of action to manage the situation in the NHS and wider public sector.

CHFT have undertaken structural surveys for properties they own which were constructed within the time period of RAACS commercial use. BWB Structural Engineers were appointed to undertake this work and found no evidence of RAAC at Huddersfield Royal Infirmary. Equans undertook similar survey work at Calderdale Royal Hospital which found that there was no evidence of RAAC.

For each leased property, the CHS property manager has contacted the respective landlords and the results are tabled in section 3.

3.0 Leased In Properties

The table below outlines the properties CHFT lease, the name of the landlord and a summary of the responses received.

Property	Landlord	Landlords Response
Acre Mill Z Block	Pennine Property Partnership	Fully refurbished building after RAAC was commercially used
Beechwood Health Centre	British Overseas Bank Nominees Limited and WGTC Nominees Limited	The building survey from acquisition in 2019 states the property is not of a construction which would be at risk of concrete additives (HAC, RAAC, etc). It was constructed in circa 1998 and RAAC was used between the 50's and mid 80's only.
Broad Street Plaza	Palace Capital	Built after RAAC was commercially used
Park Valley Mills	Park Valley Huddersfield Ltd	We had our architects and structural engineers out to visit and inspect. They didn't think there was any but just waiting for them to confirm in writing.
Todmorden Health Centre First Floor	NHS Property Services	Built after RAAC was commercially used
Todmorden Health Centre Second Floor	Assura Todmorden Ltd	Built after RAAC was commercially used
Grange Dean	GP	Grange Dean is 18 years old, traditional construction. No RAAC
Hebden Bridge Health Centre	SWYPFT	I can confirm that we have not identified RAAC in any of our estate including Hebden Bridge Health Centre.
Hebden Bridge Group Practice	GP	Valley Road is a converted former textile factory built mid 20th century, photo records indicate plasterboard ceilings above the suspended ceilings with fixings consistent with timber floors. Further intrusive inspections will take place but the building was not constructed within the timeframe for RAAC.
Princess Royal	Locala	The area of the building used by your service was built 50 years before RAAC had been invented, so we are reasonably confident it was not used in its construction.
Allan House Clinic first floor 31005335	NHS Property Services	Surveys have been completed and nothing has been identified in the properties CHFT occupies.
Allan House Ground floor(Old Annex) 31005559	NHS Property Services	Surveys have been completed and nothing has been identified in the properties CHFT occupies
Brighouse Health Centre	NHS Property Services	Surveys have been completed and nothing has been identified in the properties CHFT occupies.
Holme Valley	NHS Property Services	Surveys have been completed and nothing has been identified in the properties CHFT occupies.
Clock House	BW Sipp Trustees Limited	Given the age and type of construction we do not think that RAAC is present. The building was stripped out during the Trust fit out and no evidence of RAAC was found.
Westgate	Calderdale council	Further to our building surveyor visual inspection no RAAC has been identified at the property. However, it has been recommended that the Landlord carry out an intrusive survey (where opening up is

		required to confirm forms of structure) and we are awaiting further instructions
THIS/Loan store	BW Sipp Trustees Limited	Fully refurbished building back to shell after RAAC was commercially used. CHS witnessed full refurbishment including a new roof and internal fit out. No evidence of RAAC.

CHFT provide some services from educational facilities within Calderdale and Kirklees, managed within the division. The Department for Education (DfE) has issued its own guidance for Responsible Bodies and education settings with confirmed RAAC in their buildings, which has been distributed to local authorities, governing bodies, academy trusts and school and college leaders. The DfE instructed a survey programme to identify RAAC in education buildings, and under this guidance where RAAC has been identified buildings should be vacated and restricted access to ensure they are out of use. A report of educational facilities containing RAAC as of 27/11/23 has been issued and we can confirm CHFT do not provide any services from the schools identified within Kirklees and Calderdale.

5.0 Conclusion

The table above confirms to the best of our knowledge no properties leased by CHFT contain RAAC.

CHS issue a duty of care- statutory Compliance letter on an annual basis to leased properties where CHS do not have maintenance liabilities. We have adapted the letter to include RAAC going forward. We will continue to monitor national guidance and will ensure suitable inspections are undertaken on newly leased properties.

6.0 Recommendation

It is recommended that the Board note 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.

Date of Meeting:	Thursday 11 January 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) Updated governance structure b) Senior Independent Non-Executive Director and Deputy Chair arrangements c) Board Development Plan 2024 d) Board workplan for 2024
Key Points to Note	**a) Governance Structure** The Trust governance structure depicts the Board Committees that report into the Board of Directors and their subgroups. There have been changes to some of the subgroups and the structure has been updated to reflect these changes. The current governance structure is presented for information. The key changes are: • update of reporting for partnerships • removal of operational reporting structure for digital (THIS) • Resilience and Safety Group added which streamlines a number of groups that previously met separately (Health & Safety Committee, Fire Committee, Security and Resilience Group) • Amendments to reporting groups to the Quality Committee: - removal of the Trust Patient Safety Quality Board (PSQB) which disbanded in December 2023, with those groups that previously reported into the Trust PSQB now reporting directly into the Quality Committee, including the divisional PSQBs - To note the Clinical Effectiveness and Audit Group is currently being reviewed and discussions are taking place regarding the Medical Gases group. **RECOMMENDATION:** The Board is asked to **NOTE** the updated governance structure as at January 2024.

b) Senior Independent Non-Executive Director and Deputy Chair arrangements

Karen Heaton, Non-Executive Director, current Senior Independent Non-Executive Director (SINED) and Deputy Chair, ends her tenure with the Trust on 27 February 2024. Karen Heaton is thanked for her contribution to the Trust as both NED, SINED and Deputy Chair.

The Trust has therefore considered the future arrangements that will take effect from 28 February 2024. The Trust Constitution (section 15.1) details the process for appointing the Deputy Chair, who is appointed by the Board of Directors with ratification of this decision at a Council of Governors meeting.

15.1. 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.

The Code of governance for NHS provider Trusts advises that the Chair of the Audit and Risk Committee, currently Nigel Broadbent, should not ideally be the Deputy Chair or SINED.

As noted above the Senior Independent Non-Executive Director may be, but does not have to be, the Deputy Chair. The roles have the following remit over and above that of a NED:

Deputy Chair – Chairs meetings in the absence of the Chair and takes on Chair duties, including when the Chair has a conflict of interest.

SINED – maintains regular contact with the Council of Governors and is available to governors if they have concerns which contact through the usual channels of Trust Chair, Chief Executive, Director of Corporate Affairs and Company Secretary has failed to resolve or where such contact is considered inappropriate. The SINED carries out the Chair's appraisal. The SINED also provides a sounding board for the Chair and is an intermediary for other Directors where necessary.

NED commitments are considerable and the Trust Chair, following discussion with NEDs, has agreed to have a Deputy Chair and a separate SINED. The benefit of this is that whilst the Deputy Chair is eligible to be the SINED, the Deputy Chair cannot carry out this role when acting as Chair of the Trust, due to the need to be independent of the Chair role.

It is proposed that the following NEDs are appointed to these roles, subject to ratification by the Council of Governors at its meeting on 25 January 2024, with effect from 28 February 2024.

Deputy Chair – Peter Wilkinson

SINED – Denise Sterling

	Given the additional responsibilities, each role attracts additional remuneration of £1,000 per annum, in line with NHS England remuneration guidance. **RECOMMENDATION:** The Board is asked to **APPROVE** the proposed appointments for the Deputy Chair to Peter Wilkinson and Senior Independent Non-Executive Director to Denise Sterling with effect from 28 February 2024 and seek ratification of this decision from the Council of Governors on 25 January 2024. **c) Board Development Plan 2024** The Board met in December to agree the focus of sessions for 2024 and the plan is included for information. The focus will be on system partnership working and transformation and innovation. **RECOMMENDATION:** The Board is asked to **NOTE** the 2024 Board Development Plan. **d) Board Workplan** 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. **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: **a)** **NOTE** the updated governance structure **b)** **APPROVE** the appointments to the Deputy Chair and Senior Independent Non-Executive Director with effect from 28 February 2024 **c)** **NOTE** the Board Development plan for 2024 **d)** **APPROVE** the Board Workplan for 2024/25.

GOVERNANCE STRUCTURE

January 2024

WYAAT Committee in Common
WY Community Collaborative
Kirklees Health & Care Partnership
Calderdale Cares Partnership
Reconfiguration Round Table

BOARD OF DIRECTORS

Charitable Trustees

Charitable Funds Committee
Chair: Helen Hirst / Frequency: Quarterly

Organ Donation Committee
Chair: Helen Hirst / Frequency: Bi-annual

Council of Governors
Chair: Helen Hirst / Frequency: Quarterly

Nominations & Remuneration Committee (Sub Committee to the Council of Governors)
Chair: Helen Hirst / Frequency: Ad hoc

Audit and Risk Committee
Chair: Nigel Broadbent
Frequency: Quarterly

Risk Group
Chair: Director of Corporate Affairs
Frequency: Monthly

Information Governance & Records Management Steering Group
Chair: CDIO

Data Quality Board
Chair: COO
Frequency: Monthly

Data Quality Group

Compliance Group
Chair: Director of Corporate Affairs
Reporting: Monthly

Resilience & Safety Group (includes H&S Committee) COO
Frequency: Monthly

Transformation Programme Board
Chair: Peter Wilkinson
Frequency: Monthly

Green Planning Committee
Chair: Managing Director, CHS
Frequency: Monthly

Finance & Performance Committee
Chair: Andy Nelson
Frequency: Monthly

Turnaround Executive

Capital Management Group

Business Case Approvals Group

The Health Informatics Service Board

Huddersfield Pharmacy Specials Board

CHS & CHFT Joint Liaison Committee

CHFT/PFI Quarterly Contract Meeting

CHFT/Pennine Property Partnership Board

Urgent & Emergency Care Delivery Group

Access & Delivery Group

Cash Committee

Divisional Performance Reviews Executive Lead &
Chair: **COO**
Frequency: Determined by position e.g. monthly, bi-monthly or quarterly

Nominations & Remuneration Committee (Board of Directors)
Chair: Helen Hirst
Frequency: Ad hoc at least once annually

Workforce Committee
Chair: Karen Heaton
Frequency: Bi-Monthly

Education Committee
Chair: Deputy Director Workforce & OD
Frequency: Bi-monthly

Inclusion Group
Chair: Deputy Director Workforce & OD
Frequency: Bi-monthly

Infection Prevention and Control Committee

Antimicrobial Strategy Group
(formulary / policy updates)

Quality Committee
Chair: Denise Sterling
Frequency: Monthly

Research and Innovation Group
Chair: Deputy Medical Director
Reporting: Annually

Safeguarding Committee
Chair: Associate Director of Nursing (AD)
Reporting: 6-monthly

Infection Prevention and Control Board
Chair: Medical Director
Reporting: Quarterly

Divisional Patient and Safety Quality Boards
Chair: Divisional Director
Reporting: Quarterly

Patient Experience and Involvement Group
Chair: Chief Nurse
Frequency: Quarterly

CQC Group
Chair: Director of Corporate Affairs
Reporting: Monthly

Clinical Outcomes Group*
Chair: Medical Director/ Chief Nurse
Reporting: Monthly

Medicines Management Committee
Chair: Consultant Oncologist
Reporting: 6 monthly

Controlled Drugs (CD) Sub-Group

Medication Safety and Compliance Group
Chair: Clinical Director of Pharmacy

Point of Care Testing

Medical Devices & Procurement Group

Medical Gases Group
Chair: Acute Consultant
Reporting: 6 monthly

Clinical Effectiveness and Audit Group
Chair: Associate Medical Director
Reporting: Quarterly

Transfusion Committee

Resuscitation Committee

Thrombosis Committee

Cancer Board

Radiation Protection Board

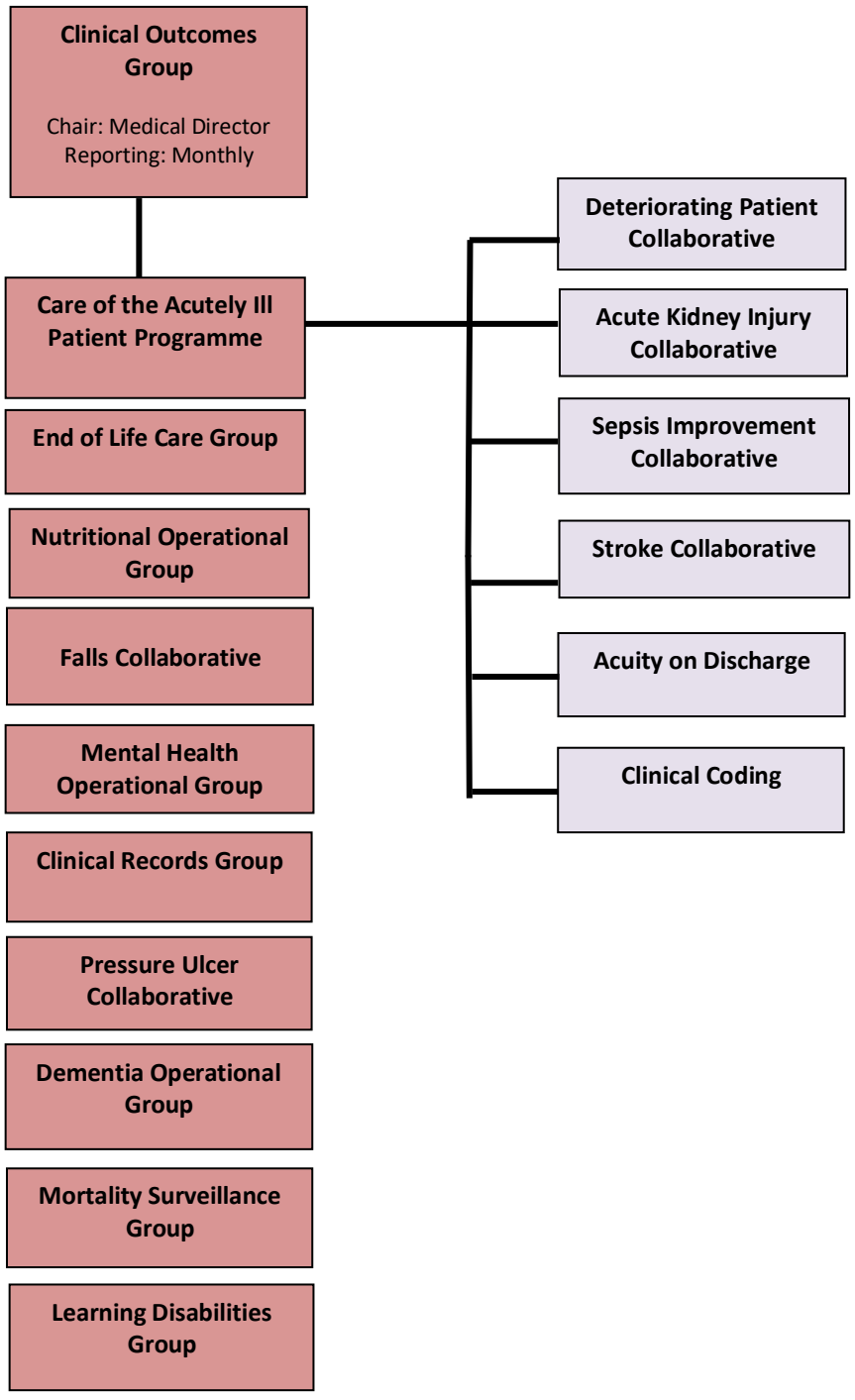
Trust Executive Board
Frequency: Weekly
Chair: CEO
Frequency: Weekly

CDIO: Chief Digital Information Officer

COO: Chief Operating Officer

CHS – Calderdale Huddersfield Solutions

*Subgroup reporting arrangements



Board Development Programme 2024 Draft

Venue: Forum 1A/1B, Learning Centre, Huddersfield Royal Infirmary

Session Date	Strategic Objective	Topic	Lead (s)	External Involvement
1 February 2024	All	System Partnerships	Chief Executive and Chair	West Yorkshire Integrated System WYAAT (West Yorkshire Association of Acute Trusts)
4 April 2024	All	System Partnerships – Trust response	Director of Finance (Kirklees partnership working) Director of Transformation and Partnerships (Calderdale partnership working) Chief Operating Officer	N/A
6 June 2024	Transform Services and Population Outcomes	Transformation and Innovation	Director of Transformation and Partnerships	TBC
3 October 2024	Transform Services and Population Outcomes	Transformation and Innovation	Director of Transformation and Partnerships	TBC
5 December 2024	All	Reflections on 2024, including discussion of Trust strategy based on transformation and innovation sessions Planning for 2024/25 Board development	Chair	TBC

Other sessions may be organised throughout the year as required.

Draft BOARD PLAN 2024/2025 – as at 04.01.24 V3

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	30 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
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		✓					
Diversity	✓				✓ Board Diversity Action Plan		✓

DATE OF MEETING	7 March 2024	2 May 2024	4 July 2024	5 September 2024	7 November 2024	9 January 2025	6 March 2025
Medical Revalidation and Appraisal Annual Report				✓ Annual Report			
Public Sector Equality Duty (PSED) Annual Report	✓						✓

GOVERNANCE & ASSURANCE AGENDA ITEMS							
Emergency Planning Annual Report / EPRR Core Standards Submission	✓ Annual Report					✓ Compliance statement	✓ Annual Report
Freedom to Speak Up Annual Report				✓ Annual Report		✓ 6 month report FTSU themes and qualitative presentation	
Health and Safety Update (if required – routinely reports to ARC)		✓				✓	
Health and Safety Policy (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	✓		✓		✓		✓

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	✓QC ✓F&P ✓ NRC BOD	✓ NRC ✓ Workforce		✓ARC	✓ TPB review Sept		✓QC ✓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	✓	✓ (B/f from March 2023 BOD)					✓
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)		✓	✓	✓	✓	✓	✓
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)

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Wednesday 25th October 2023, 09.30am – 12noon Via Microsoft Teams

PRESENT

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Kirsty Archer (KA)	Director of Finance
Vicky Pickles (VP)	Director of Corporate Affairs
Karen Heaton (KH)	Non-Executive Director
Anna Basford (AB)	Director of Transformation and Partnerships
Rob Aitchison (RA)	Deputy Chief Executive
Gary Boothby (GB)	Director of Finance
Stuart Baron (SB)	Associate Director of Finance
Adam Matthews (AM)	HR Business Partner

IN ATTENDANCE

Rochelle Scargill (RLS)	PA to Director of Finance (Minutes)
Peter Keogh (PK)	Assistant Director of Performance
Andrea McCourt (AM)	Company Secretary
Gemma Berriman (GBE)	Director of Operations, RAFT
Ansah Jamil	Member of the Shadow Board.
Michael Folan	Director of Operations Community.

OBSERVERS

Robert Markless (RM)	Public Elected Governor
Isaac Dziya (ID)	Public Elected Governor
Pam Robinson (PR)	Public Elected Governor

APOLOGIES

Jonathan Hammond (JH)	Chief Operating Officer
Philippa Russell (PR)	Deputy Director of Finance
Robert Birkett (RB)	Managing Director of THIS

ITEM

170/23 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting. Welcome to Pam Robinson and members of the shadow board.

171/23 DECLARATIONS OF INTEREST

172/23 MINUTES OF THE MEETING HELD 26th September 2023

The previous minutes were approved as an accurate record.

173/23 MATTERS ARISING

174/23 ACTION LOG

The Action Log was reviewed as follows:

141/23 – Deep Dives. This action can be closed. See workplan.

134/23 - 2022/23 National Cost Collection Pre-Submission Report. The national cost collection has been delayed nationally. There have been some technical problems in the national team. This is the latest of several delays so the Finance team will advise when it is appropriate to come back.

146/23 – IPR – Workforce have proposed reducing the turnover target of 11.5% to 10% and this was agreed by the committee. This detail will go into October's IPR. Close action.

162/23 – IPR – Overall performance number request from Governors. This was discussed at the most recent governors meeting. There is a stakeholder briefing which is shared on a regular basis with a select number of colleagues. The governors will be added to this mailing list. The IPR is to be reviewed this month and this will be shared with the Governors, along with a new summary sheet to be included at the front of the IPR. Action to be closed.

164/23 – BAF risk – ICS has been referenced where appropriate in the risk. Remove from action log and pick up at next BAF review.

175/23 LENGTH OF STAY DEEP DIVE

Gemma Berriman and Michael Folan were in attendance to present the update as circulated as Appendix C.

Our business plan for this year set targets to reduce Length of Stay, bed occupancy levels and numbers of patients on our Transfer of Care list. To help meet these targets a new Urgent and Emergency Care Delivery Group was set up which is chaired by the Chief Operating Officer. This identified a number of areas the group wanted to work on. These were narrowed down to projects that could be done well and completed in year. This work created two improvement groups Same Day Emergency Care (SDEC) and Length of Stay (LOS), into which a number of task and finish groups report. The full list of projects is included in the papers. As work has progressed several of the task and finish groups were found to have overlapping actions so they have been merged.

There are 4 patient pathways. Pathway zero are patients who can be discharged without any extra support and these are within the gift of CHFT to reduce the length of stay of. Pathways 1-3 will require extra support ranging from pathway 1 where their package of care needs restarting to pathway 3 who require 24-hour care in a care or nursing home. These are known as transfer of care patients (TOC) and CHFT requires support from the system to discharge these patients.
NHSE have set a bed occupancy target of 92%. CHFT set a target to reach 96% by the 1st July 2023 from 98% in April, then would plan to remove some beds. This

has not been successful. Today's bed occupancy stands at 99.3%. The acuity of patients is higher than pre-Covid often presenting with more than one condition. The industrial action has also had an impact.

We have an average of 95-100 patients on our TOC list which reached 154 at its highest point this year.
Acuity has seen an increase of 30% which has led to a 10% increase in length of stay. Activity however is 88% of pre-Covid levels. Data included in the pack breaks this down by area and by speciality.
Length of stay is monitored at 7 / 21 / 51 and 100-day patients. When this work started there were 8 patients who had been in hospital for 100 days, the longest of which was 372 days; there is now 1. This has been achieved by looking at this cohort of patients weekly and adopting a multidisciplinary approach.

The committee asked what proportion of patients are on pathway zero. This is the majority of patients.
The acuity difference between CRH and HRI is most likely due to the types of specialities at each site. For example, respiratory is at CRH. The exact reasons for the increases in acuity are unknown but Covid is expected to be a factor both from people suffering from long covid and those who delayed seeking treatment during the pandemic.

Community options are being explored to reduce the bed capacity and improve the patient experience. It has been proven that patients recover quicker in their own homes. This involves working with Kirklees and Calderdale partners to deliver services like the discharge to assess home first model. Funding for such services has now been agreed with these partners so recruitment is underway for posts to support this. The correct care would need to be in place before putting any patients on this pathway and clear escalation processes will be in place should it be required.

The Well Organised Wards project (WOW) is underway and better structure is being introduced to all the wards but adapted slightly for each ward to allow for their ways of working.
The surgical SDEC works well and is being rolled out to medical. There is national work going on around standardising SDEC's. There are currently really strict criteria around who can be accepted at SDEC's but this is being reviewed to allow expansion of the service e.g. The ambulance service admitting direct to SDEC when appropriate. This needs to be closely monitored to make sure the ED problems are not transferred to SDEC,

When the new ED opens the plan is to use the old ED to trial an integrated flow hub prior to reconfiguration. This will be a centralisation of services specified in the papers. Collectively all the improvement projects are expected to improve the service and reduce LOS and TOC but it will take time and we should not expect performance to improve until later in the year.

The committee will do a follow-up review of performance in March.

FINANCE & PERFORMANCE

176/23 MONTH 6 FINANCE REPORT

The Deputy Director of Finance presented the financial position as reported at Month 6, September 2023.

It was noted that the Trust has reported a year to date (YTD) £0.9m adverse variance from plan. The Trust will continue to forecast being on plan. The YTD position is better than has been seen in previous months in terms of how far away we are from plan. This improvement is primarily as a result of receiving a bonus of £0.54m for delivering the 22/23 Maternity Incentive Scheme and £0.35m additional Elective Recovery Funding (ERF) reflecting our above plan levels of activity.

Challenges and pressures remain the same as discussed in previous months with strike costs now at £2.1m YTD.

Cost Improvement Programme (CIP) is showing slightly favourable to plan with the Maternity bonus reflected in this. There are challenges in the full year against CIP.

The overall forecast continues to be delivery of the planned £20.8m deficit with the likely case scenario reported to the ICB of an adverse variance to plan of 6.7m.

We continue to be slightly behind our profile capital spend, but this is expected to improve in the coming months..

The cash position is currently stronger than planned partially as a result of the capital position as well as some sizeable bills that that have not yet been received e.g. utilities.

Pressures are being experienced across the whole West Yorkshire Integrated Care System. Work is being done around the consistency of the data reported and assumptions that have been included within the numbers. There is further information required from the centre but the whole system is expected to be unable to deliver the plan this year. It has been agreed across West Yorkshire that we will use the forecast at Month 8 as our final and firm forecast for the year. The forecast position cannot be changed in months 11 and 12. The timing of the Board meeting will not align with the protocol approvals deadline so GB will make a request to Board to delegate approval of the final forecast to this committee.

KH asked if the likely case scenario includes the strike costs. It only includes the costs of the strikes that have happened to date. This will be amended for any future announcements. The maternity incentive scheme bonus was for last year. This year the maternity incentive scheme is to be added to the risk register as we are risk of not delivering some aspects of the scheme.

Additional scrutiny has already taken introduced and over the Summer the team have been asked to demonstrate the controls that have been put in place e.g. vacancy control. The ICS created a checklist of controls needed and CHFT shows green across all of them.

The Use of Resource metric remains at level 3.

The committee asked whether there would be extra scrutiny if the metric changed from a level 3 to a level 4.

ACTION: To find out for the next meeting.

The committee **RECEIVED** the Month 6 Finance Report.

177/23 OVERVIEW OF CAPITAL PLANNING / DRAGONS DEN DAY

The Associate Director of Finance talked to the paper. A capital planning day took place on 13th October. Due to the delay in the development of the multi-storey car park (MSCP) divisions were asked to bring forward any capital requirements to this year to allow for the capital resource needed for the MSCP in 2024/25 The paper lists schemes which were agreed to a value of £8.5m which must be completed before the end of this financial year

The majority of the schemes relate to items which are on the risk register. A contingency pot has been set aside in case of emergencies..

The approved schemes are being man marked to make sure they are completed within the timeframe.

The Committee **RECEIVED** the Capital Planning update

178/23 TURNAROUND EXECUTIVE 2023/24 CIP PROGRESS

The Deputy Chief Executive gave an update. The turnaround executive continues to meet every week. £25.8m of the schemes are now at gateway 2. . The risks of delivery of some of the high-risk schemes means there is £6m of unidentified savings. A workshop identified some more potential savings which would reduce the gap from £6m to around £3.2m. The conversations that have taken place have been good.
Work has started on identifying schemes for next year including looking at building on some of the successes that have been had with the robotic processes.

The committee expressed appreciation to everyone involved for the work they have been doing to close the gap. It was agreed a fuller and more detailed review of the CIP programme and the latest forecast for it would be brought to the next committee meeting.

ACTION: Detailed review of CIP at next meeting showing progress against all the schemes and actions to reduce the level of unidentified savings

The Committee **RECEIVED** the Turnaround Executive update

179/23 IPR

The Assistant Director of Performance covered the highlights of the September IPR, including changes in performance for 8 of the performance matrix metrics.

We continue to perform well on Elective Recovery despite the impact of then strikes and Cancer performance continues to be strong with the faster diagnosis target being achieved for the first time since April.
ED performance reduced in month to 68% with continuing pressures around numbers of patients and acuity. There has also been an increase in the number of patients wating over 12 hours in ED plus an increase in bed occupancy.
Ambulance waits have increased by 3% and is expected to increase again from October when the performance measurement changes to using the arrival time of the ambulance as the trigger for when the clock starts. This is expected to add 5 minutes to each wait.

For Community we have now included % of patients dying within their preferred place of death – palliative care. Performance is consistently above the 80% target with 96% of patients dying at home.

September saw another never event.

The percentage of patients receiving a MUST target within 24 hours has been a difficult challenge but there has been further improvement in month to 86%.

Sickness Absence in September was at its lowest level since April 2021 at 4.3%.

The Committee **RECEIVED** the IPR for September

180/23 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.
The number of patients currently waiting:

- 104 weeks - 1
- 78 weeks - 1
- 65 weeks -1
- 52 weeks – 11
- 40 weeks – 997

The patients at 65 weeks and above is as a result of the issue described at the last meeting where patients dropped off the national referral list. The ones without treatment plans are being man-marked.

Activity was down on plan in month but overall year to date we are still 9% above plan.

We are behind plan regarding our patients waiting more than 40weeks.As mentioned in previous meetings, this is impacted by the challenges in ENT and the strike action. Data has been included in the report to demonstrate the effect of

the ENT challenges and the strike action on the trajectory. This shows that without the delays in ENT and the impact of strike action we would be ahead of our trajectory for 40-week waiters. The committee will do a deep dive into ENT at the next meeting.

There is a plan to carry out deep dives in specialities with a large number of outpatient follow-ups to reduce the overall number of follow-ups for CHFT to 20000 by the end of March 2024.

Diagnostics performance is still impacted by performance in Echocardiography and Neurophysiology and the forecast position for the year has worsened in the last month. The target of reducing the backlog in Neurophysiology to zero by the end of November has now moved back to March and Echocardiogram are still expecting to have 300 patients waiting at the end of March.

It is worth noting that the strikes are also affecting the ability to expand some of the outpatient transformation work. For example, clinics cancelled due to the strikes reduced the opportunity to introduce patients to the patient-initiated follow-up scheme.

The Committee **RECEIVED** the Recovery Update

181/23 4th CT SCANNER FOR CALDERDALE ROYAL

At the last Business Case Approval Group (BCAG) Case on 17th October a case was presented to purchase a second CT scanner for Calderdale Royal. Approval is required from both this committee and Trust board due to the scale of the investment. CHFT have been awarded £2.3m from NHSE against the cost of £2.6m for the second scanner. The paper describes the amount requested from Capital to purchase the scanner in this financial year.

The ask from this committee and the Board is to approve the variation to be signed off with our partner to then allow the external funding to be drawn down. There are patient benefits to purchasing the new scanner including that Bariatric patients who currently have to be transferred to Bradford Trust for CT scans would be able to have them at CHFT.

There are additional revenue costs which will be an ongoing commitment which has been flagged as a cost pressure for next year.

The second scanner would future proof capacity based on the growth of CT requirement.

The committee commented that since the Trust is currently leasing a mobile CT scanner at Calderdale Royal at £15k per week to purchase a new scanner makes financial sense.

The temporary scanner was due to be removed but it was agreed to extend the lease until March 2024 while knowing that the extension is not in budget for this year.

The removal of the leased CT scanner was considered around mitigation to reduce the run-rate costs, but it was decided that that would be detrimental to the patient service.

The committee **APPROVED** the CT Scanner business case to be passed to the Board.

182/23 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.

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

183/23 WORKPLAN – 2023/24

Addition of deep dives for the remainder of the year to March 2024. Follow-up deep dives to be shorter and scheduled around the planning season which requires more of the committees focus.

THIS Commercial Strategy and Future Planning pushed back to November.

Committee **APPROVED** the work plan for 2023/24.

184/23 ANY OTHER BUSINESS

-

185/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Positive operational performance continues in many areas with the improvement in the MUST score being notable
- Risk to financial plan remains with unidentified savings in the CIP programme and the impact of the strikes
-
- Delegated approval to be requested from Board for finalising the year end forecast at month 8
- Helpful deep dive into LOS shows lots of good work being done but unlikely to meet targets for LOS and TOC until later in the year

DATE AND TIME OF NEXT MEETING:

Tuesday 28th November 09:30 – 12:00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Tuesday 28th November 2023, 09.30am – 12noon Via Microsoft Teams

PRESENT

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Kirsty Archer (KA)	Deputy Director of Finance
Karen Heaton (KH)	Non-Executive Director
Anna Basford (AB)	Director of Transformation and Partnerships
Rob Aitchison (RA)	Deputy Chief Executive
Gary Boothby (GB)	Director of Finance
Jonathan Hammond (JH)	Chief Operating Officer
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
Andrea McCourt (AM)	Company Secretary
Philippa Russell (PR)	Assistant Director of Finance
Adam Matthews (AM)	HR Business Partner
James Houston (JHO)	Shadow Board
Mohammad Maqsood (MM)	Shadow Board

OBSERVERS

Robert Markless (RM)	Public Elected Governor
Isaac Dziya (ID)	Public Elected Governor
Pam Robinson (PR)	Public Elected Governor

APOLOGIES

Stuart Baron	Deputy Director of Finance

ITEM

186/23 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting including members of the shadow board.

187/23 DECLARATIONS OF INTEREST

188/23 MINUTES OF THE MEETING HELD 25th October 2023

The previous minutes were approved as an accurate record.

189/23 MATTERS ARISING

190/23 ACTION LOG

The Action Log was reviewed as follows:

134/23 - 2022/23 National Cost Collection Pre-Submission Report. There are still delays so a verbal update is expected to the January meeting with a formal report expected in February based on current timescales.

Actions from previous minutes –

Would there be extra scrutiny if the Use of Resources metric changed from 3 to 4. Currently this is not being closely monitored externally. We would expect extra scrutiny if there was overall movement rather than an individual metric. CHFT have met with NHSE and ICB reps in the last month and the questions are more around the overall plans and the scrutiny is more on the system than individual organisations.

Detailed review of CIP at next meeting showing progress against all the schemes and actions to reduce the level of unidentified savings. Covered in the agenda.

191/23 ENT and CANCER DEEP DIVE

Assistant Director of Performance gave a presentation covering both deep dives.

ENT – As mentioned in previous months, ENT has been particularly struggling which has impacted on the Trusts otherwise excellent recovery position. This is not unique to this Trust; the same picture can be seen both regionally and nationally. There are recruitment issues both nationally and within this Trust and we currently have several vacancies advertised. It is acknowledged nationally that ENT is a fragile service.

We currently have 5612 active refer to treatment (RTT) pathways of which 4851 are appointment slot issues (ASI's) with 2401 being over 18 weeks.
Of the 608 patients waiting for surgery, 8 are now over 52 weeks. The trajectory for the Trust was to reach zero patients waiting over 52 weeks by the end of September 2023.

There is an increase in the two week wait demands for cancer and currently we only have one head and neck consultant. Therefore, ENT are picking up the work which in turn reduces the available ENT capacity for elective recovery work.

A task and finish group was created who produced an action plan,
ACTION: To share after the meeting.

Most of the actions are dependent on recruitment. The biggest gain is to be seen from reducing the intensity of night on-call for middle grades.

Other actions include a change in the booking of emergency clinics from ED and ward attenders, recruitment of 2 new CT1/2 in ENT and recruitment to the 2 vacant posts in middle grade rota.

Discussions are taking place across WYAAT about mutual aid and collaborative working but since the situation is not specific to CHFT, it is unlikely these will be productive at this time.

Daily tracking of 40-week waits is taking place and we are using Pioneer Healthcare for insourcing. CHFT consultants are working with theatres and we are participating in the "Getting is Right First Time" programme.

It is difficult to put a trajectory in place for recovery until some of the recruitment is in place. All avenues of recruitment including agency have been tried without success. There may come a point where joint recruitment between trusts is considered but we are not at that point.

As well as using Pioneer for insourcing but are also trialling Consultant Connect for ENT which has been used successfully within Neurology.

There are some challenges within primary care. Initial work from Consultant Connect found that 20% of referrals do not need a new patient appointment. There is a broader piece of work ongoing to get patients onto the correct pathway.

CHFT do meet regularly with both local medical committee chairs and officers to discuss demand management around referral thresholds. These are not straightforward discussions, and each surgery works differently. We are trying to reach a point with the local medical committees where there are general principles around expectations.

CANCER – CHFT is one of only 2-3 Trusts who have regularly achieved the cancer targets since they were put into place. We are currently second in the country for achieving all the key indicators at the same time.

Changes to the indicators took place in October this year, with some of the indicators being rationalised and the two-week standard being removed completely. CHFT has chosen to continue to monitor the two-week standard internally. The national focus will be on the 28day faster diagnosis standards.
The new targets are:

- The 28-day Faster Diagnosis Standard (75%)
- One headline 31-day decision to treat to treatment standard (96%)
- One headline 62-day referral to treatment standardised (85%)

There are issues with some cancer sites including lower GI, upper GI and Urology which have actions in place to address the issues.

JH highlighted that patients waiting over 62days is being driven by challenges within dermatology in Leeds, who are struggling with their pathways. There are ongoing discussions around mutual aid for cancer as well as broader elective recovery that we are still waiting to see how it plays out. It is expected that there will be a focus on ICB performance rather than individual organisations.

There have been several approaches from trusts who would like to come and see how we do what we do. We have an excellent tracking team who work very closely with clinical teams. Workforce models have been reviewed and adjusted to release consultant and specialist nurse capacity. The cancer delivery group has a good buy in from all the attendees. The group focuses on deep dives and the challenges within specialities and tries to stay ahead of any problems.
The scanning capacity is also good and the new MRI and CDC's help with the cancer pathways. It is a lot of hard work but good work.
Excellent reporting has also been put in place which allows the managers to know the exact position of their specific cancer sites.

The mutual aid expectation is that the patient will transfer in their entirety which would affect CHFT performance figures as the patients waiting time will also transfer for example 72 week waits. Work is to be done to see how this will work through and to discuss with the ICB how these patients will be reported.

FINANCE & PERFORMANCE

192/23 IPR

The Assistant Director of Performance covered the highlights of the October IPR, including changes in performance for 8 of the performance metrics.

The language on the summary page has been adjusted clearly explain what is happening. As per a suggestion colour coding has been added with items in dark green denoting improvement and items in purple denoting deterioration.

- **Total Patients waiting >65 weeks** – change due to ASI drop-off issue that resulted in one patient waiting > 65 weeks. (pathway now closed)
- **Total Patients waiting >40 weeks (LD)** – ENT impacting on small increase in numbers.
- **Total RTT Wating List** – industrial action has impacted on numbers.
- **Staff Movement (Turnover)** – target has reduced from 11.5% to 10%.
- **% of patients that receive a diagnostic test within 6 weeks (IMD 1 and 2)** – impact of Echocardiography and Neurophysiology.
- **Diagnostic activity undertaken against activity plan** - CDC activity for CT began in October - this is additional activity and has increased activity.
- **Proportion of patients spending more than 12 hours in ED** – pressures in ED have increased numbers.
- **ED 4-hour (LD)** – slight improvement in month but still well below overall Trust performance.
- **ED 4-hour (IMD1/2)** – pressures in ED have increased numbers.

In general, CHFT are performing very well against elective recovery. ENT and industrial action are impacting services.

The expectation of a new booking process is to reduce our follow-up backlog numbers down to below 20,000 by end of March 2024.
Cancer performance achieved the first faster diagnosis target for the second month running.
ED performance continues to be challenging and was down to 66% in October. There have been a high number of attendances at both sites which has impacted the 12 hour waits. Bed occupancy reached 99% in October.
There has been a change to the way that ambulance handovers are measured with timings now from the point an ambulance arrives instead of the notification period. This has added an additional 8.5 minutes to ambulance handovers which in turn increased the number of 30-minute waits. The Yorkshire Ambulance Service (YAS) are reporting an increase in demand of 9% compared to last year and a 16% increase for category one calls.

The MUST score has continued to improve over the last few months due to the actions in place and the readily available data. For complaints the 95% target has been achieved.

JH added that the particular challenge is the ED 4-hour target and the number of patients waiting over 12 hours. Late Summer and early September it was possible to reduce the bed base but additional beds have now had to be re-opened to allow flow through ED. Information in relation to the patient cohorts has been reviewed and there has been an increase in the acuity of patients arriving at ED which correlates with the information shared by YAS.

The transfer of care list has also increased over the last few months and into this month has been extremely high. It is thought this is linked to the higher acuity meaning patients are requiring more support when discharged. This is repeated both regionally and nationally.

So far CHFT has managed to keep discharge breaches to a minimum.

KH asked if there is a plan in place to reduce the waiting list post-industrial action?

JH responded that up until the consultant strikes CHFT was able to maintain the position on key targets for waiting times and still be on track to reach zero patients waiting over 40weeks by the end of this year. The impact from strikes over summer and ENT caused CHFT to move away from the 40-week trajectory. Since the strikes have ended, we are not back where we want to be but are moving in the right direction. It is hoped that the trajectory will now be met by the end of March 2024 instead of January 2024 as originally planned but the performance of ENT could prevent that. The mutual aid may affect this. So far 120 patients have been identified for CHFT to take from other organisations.
If there are no more strikes CHFT will be in a good position except for ENT which is expected to still have patients waiting over 52 weeks.

The number of patients attending is expected to increase as usual over Winter and seems to have started earlier this year. A new resilience and a surge and escalation plan is in place to manage this. Within ED changes have been made to the workforce model to make sure that the correct colleagues are present at the times they are needed. This is having a positive impact already. The biggest

challenge is the admitted pathway which impacts not only the admitted but the non-admitted pathways.

The criteria to reside and the delayed transfer of care does overlap. However, not all patients are on both. It has recently been rebased to make sure CHFT is in line with how other organisations measure it.

ACTION: JH to raise the paediatric virtual ward capacity with Stephen Shepley to make sure it is included in the CHFT offering.

What would the ambulance times look like without the newly added 8.5minutes?
ACTION: PK to work through.

Virtual ward is currently reporting 99% against a target of 80%. This number is slightly misleading at the moment as the reporting of the service is worked through. It is expected that demand for virtual ward with grow and more capacity will be needed in future years. Virtual ward has just been opened for acute patients and CHFT is the first Trust in the country to do this. There is a daily focus to maximise capacity of the virtual ward where we can.

The target for Did Not Attend (DNA) is set at 3%. The Chair asked what confidence there is that the DNA's would reach this level. Work has been done with the inequalities team to simplify the patient letters and looking at the reasons that people do not attend.

JH has requested an audit from internal audit to look at the booking pathways. They are currently at the planning stage. There is a split booking process currently where some appointments are booked through the booking team and some through the secretaries. The intent is for the audit to give a baseline position and highlight areas for improvement. This will not be a small piece of work and will take a couple of years to improve the system and ensure it is fit for purpose.

Work is also being done through the getting it right first time (GIRFT) which is allowing benchmarking against other organisations. A lot of work can be done around communication and to better understand why patients do not attend. The new patient portal scheduled to go live in 2024 will assist with patients accessing the information they need.

Sickness absence has increased slightly but this is seasonal. If you track sickness over time hotspots can be identified when sickness levels increase. There is a usually a spike in winter.

The new format IPR has been in place for seven months and as agreed a review has taken place. Assistant Director of Performance covered the key points from the review. The full details can be found in the paper.

Executive directors have been made responsible for sign off of each of the metrics. The timeline has been amended over the last couple of months to allow papers for the committee to be distributed earlier than the day before. It should be noted that December will be tricky for reports due to Christmas.

The making data count team have been used to help decide what information goes into the IPR. The team prefer SPC graphs but currently some of the profile targets do not work with SPC graphs.

Any changes requested during the last seven months have been taken on board. Cancer changes have gone in along with the amended ambulance handover timings. The performance matrix has also been updated. More benchmarking will be going in overtime. The actions have been reviewed to make sure they are still relevant and made leaner when they have been found to include too much detail.

The committee acknowledged that the IPR is a sizeable document but that all the information within it is essential and provides a clear and helpful analysis of performance.

When providing the summary, it is important not to react to one bad month and the summary includes the good news as well as the areas needing improvement.

The Committee **RECEIVED** the IPR for October

193/23 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.

Currently there zero patients at 65 weeks. Previously there had been one as a result of the previously discussed ASI issue but this patient has now been treated. The Patient Initiated Digital Mutual Aid System (PIDMAS) may impact on this performance going forward.

The full performance details are within the paper which highlights the areas overperforming and not performing well. As previously mentioned in this meeting ENT is a problem in relation to the overall position. Graphs within the report show the impact of the industrial action and what level of performance would have been achieved without them. The also show the impact of the ENT backlog.

Within diagnostics there are still problems with ECHO and Neurophysiology where recruitment has been a problem.

The outpatient follow ups have been affected by the industrial action but there and medium- and long-term actions in place to reduce the backlog.

The Committee **RECEIVED** the Recovery Update

194/23 MONTH 7 FINANCE REPORT

The Deputy Director of Finance presented the financial position as reported at Month 7, October 2023.

Year to date (YTD) the Trust is reporting a £1.5m adverse variance to plan as a result of similar drivers to previous months including £2.1m strike costs YTD. Bed pressures are impacting both CIP delivery and presenting additional financial pressures. These pressures were offset to some extent by early delivery of other efficiencies and higher than planned commercial income plus an additional £350,000 for elective recovery.

Capital spend is at £7.79m year to date which is below planned levels driven by timing delays on projects such as the CT scanner, pharmacy robot and reconfiguration. Capital spend has a bearing on the cash position and there is currently £14.6m more in the bank than planned. Utility bills form part of this as one of the suppliers has only invoiced for £0.6m so far instead of the expected £4m. This has led to a requirement to re-assess the cash support for quarter 3 which was discussed at a previous meeting. This will now be required in quarter 4.

CHFT has received permission to spend £13m on reconfiguration in year but this is not cash backed so it is expected the cash support will need to be increased to accommodate this. This will require further approval from board.

PDC charges for the borrowing will outweigh any benefit gained by having cash in the bank.

JHO asked how it works if the deficit is £14m and the cash in the bank is £14m how does it affect the reporting?
It is a timing issue. The money in the bank is spent but due to things like the utility bills the actual bills have not arrived for payment.

FORECAST - The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £5.87m. Key drivers of this forecast are £2.1m of Strike costs, £3.65m unidentified CIP, non-pay inflationary pressures and additional bed capacity. The forecast improved by c.£1m in month compared with the position reported in M6. The likely gap on efficiency plans reduced by £2.5m as additional schemes have been progressed. This improvement has been offset to some extent by the emergence of some additional technical pressures: a likely downward revaluation of the Trust's Joint Venture assets and an expected increase in PDC Dividend due to the proposed funding arrangements for this year's Reconfiguration Capital plan.

Current likely case assumes receipt of £15.02m of ERF as 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 may be an opportunity for the Trust to secure additional funding as a result of the current strong performance on Recovery.

It has been announced that £800m nationally has been given to the NHS in relation to the strike action. This is not additional funding but money that has

been repurposed from existing funds. £32m has been allocated to West Yorkshire which has been distributed based on strike costs, so CHFT has received £2.1m. West Yorkshire have allocated around half of the £32m across the ICB.

This plus the other items highlighted within the papers means that CHFT is closer to plan and is now forecasting an adverse variance to plan of £1.7m.

GB highlighted that there is an existing risk in relation to delivering this year's plan which is scored at 20. It was suggested that this be reduced to 12.

Bed capacity has been a risk throughout the year and continues to be so delivery of the length of stay CIP schemes are not expected.

The committee **RECEIVED** the Month 7 Finance Report.

195/23 FUTURE PLANNING

The Assistant Director of Finance updated the committee on the future planning. Over the summer NHSE requested that the ICS's came up with a medium-term plan that would cover the next two to three years.

CHFT worked out what the underlying position would be carried forward into 2024/25 which would be the starting point for next years planning.

Across the ICS there is a lot of non-recurrent benefit in this financial year.

The paper gives an early view of the 2024/25 challenge based on Month 4 which is the point the ICS was asked to produce the plan. The risks included have not changed much from the forecast in month 4. The potential deficit for CHFT is £48.3m which is slightly more aligned with system partners than CHFT was this year where we were an outlier. Overall, as an ICS the initial deficit is forecast to be around £300m. The details of other trusts are included in the paper.

Some assumptions have been made as a system which are now playing into the planning as the planning guidance is not expected until Christmas. It has been assumed the ERF will remain recurrent.
An action plan in included in the paper along with the planning timetable for information.

Finance and the Transformation Team have met to discuss opportunities for the new year to build into the plans. The target operating models will also be built in where possible.

In the underlying position £3.1m has been accounted for inflationary pressures. The position does not include any inflationary pressures for next year, and in year is now nearer £4m.

The planning exercise for the next two three years was done at the ICS level and not at Trust level so is not included within the paper. There was a 25-year financial

plan produced as part of the initial reconfiguration work which is updated each year.

The Committee **RECEIVED** the Planning update

196/23 TURNAROUND EXECUTIVE 2023/24 CIP PROGRESS

The Deputy Chief Executive gave a brief update due to most of the items covered under previous agenda items. The TE position and the financial forecast are closely aligned, and the forecast is unlikely to change now. The focus now is to get the existing schemes over the line for this year and start CIP planning for next year.

ACTION: RA to share the month 7 TE dashboard with the committee after the meeting which details the scheme

Since the CIP for next year is not yet known, all opportunities and ideas are on the table at this stage. There is time before pressures and developments are put forward, where the message can go out; the higher the number of pressures and developments the higher CIP will be for next year.

The Committee **RECEIVED** the Turnaround Executive update

197/23 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.
- Cash Committee
- Capital Management Group
- CHS/ CHFT Joint Liaison Group
- CHFT / THIS SLA Review
- Pennine Property Partnership

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

198/23 WORKPLAN – 2023/24

THIS Commercial Strategy pushed back to January

Committee **APPROVED** the work plan for 2023/24.

199/23 ANY OTHER BUSINESS

-

200/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Overall performance strong with the same challenges.
- ENT a real concern.

DATE AND TIME OF NEXT MEETING:
Tuesday 2nd January 2024 09:30 – 12:00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 23 October 2023

STANDING ITEMS

163/23 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Nikhil Bhuskute **(NBhu)**	Deputy Medical Director
David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Penny Daynes **(PD)**	Pharmacist **(item 166/23)**
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	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

Katherine Cullen **(KC)**	Deputy Clinical Director - Pharmacy **(Observing from Shadow Board)**
Laura Douglas **(LDo)**	Deputy Head of Midwifery **(Observing from Shadow Board)**

Apologies

Neeraj Bhasin **(NBha)**	Deputy Medical Director
Sharon Cundy **(SC)**	Head of Quality and Safety
Jonathan Hammond **(JH)**	Chief Operating Officer
Andy Nelson **(AN)**	Non-Executive Director

Lorraine Wolfenden, Governor, was welcomed to her first meeting.

164/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

165/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 25 September 2023, circulated at appendix B, were approved as a correct record. The action log can be found at the end of these minutes.

SAFE

166/23 MEDICINES MANAGEMENT COMMITTEE REPORT AND TERMS OF REFERENCE

Penny Daynes was in attendance to present the report and terms of reference as circulated at appendix C1 and C4.

PD reported that the Medicines Management Committee (MMC) has a huge agenda, which looks at new project requests; updates the Trust guidelines and the Trust Medicines Code; work on drug shortages and drug recalls; updates on the Trust's antibiotic usage; updates from the Electronic Patient Record team; and compliance with NICE guidance.

There was a previous concern from the MMC regarding the migraine service not providing some of the treatments which were recommended by NICE, however, this was reviewed,

escalated to the Clinical Effectiveness and Audit Group, and has now been resolved, due to having a Neurology Consultant in place who is now providing the new treatment.

The MMC have also reviewed their clinical guidelines on the intranet relating to medicines, and identified that some have gone past their review date. Prompts have been made to the authors, and any outstanding guidelines have now been followed up, and will be updated at the next MMC in November.

The MMC meets six times a year, and is chaired by Dr Nick Brown, Medical Oncology Consultant. There is good representation from Medical, Nursing and Pharmacy staff, and representation from the Medicines Management Leads from the Integrated Care Boards. It is a really well-attended meeting, which gets through a lot of business on the agenda.

There were no items to escalate, except assurance that the Committee is meeting, and an update on the meeting's activities.

ES conveyed thanks to **PD** who will be leaving the Trust next week, for her work with the MMC and supporting Dr Brown.

LR queried whether the report should be a combined report going forward, including the medicines safety agenda. It was agreed that this will be discussed outside of the Quality Committee, with an update provided at a future meeting.

KH commented on the number of approvals of new products that are undertaken at the MMC meeting, and asked how quickly these are fed back to colleagues in order for them to follow. **PD** stated that the requester of the new products attends the MMC and receives immediate feedback on whether their product has been accepted or rejected. Each directorate has their own Pharmacist who also liaises with the directorate. Once approved, products are put in place straight away and can be rolled out fairly quickly, due to **PD** also being in charge of the pharmacy stock control system.

ES stated that there is some cross-over work with the NICE Technology Appraisals, whereby drugs have to be made available within a three month period. This is also reported into the Clinical Effectiveness and Audit Group if there are any concerns.

In relation to medication shortages, **DS** asked whether the position has now changed regarding diabetic medication. **PD** stated that this is now being managed by a regional group. There are a number of treatments that are currently unavailable, and any patients who are on those treatments are being reviewed by the Diabetes Team to determine whether they could be moved to an alternative product. One of the products will be a long-term supply issue, which is being managed with input from the Diabetes Team and Primary Care.

Copies of the Medicines Management Committee minutes from May and July 2023 were also available at appendices C2 and C3.

The terms of reference were ratified.

OUTCOME: **PD** was thanked for the update and the Committee noted the report and ratified the terms of reference.

167/23 Q2 INFECTION PREVENTION AND CONTROL (IPC) REPORT

David Birkenhead presented the report as circulated at appendix D, highlighting that Clostridium difficile will be in a challenging position at year-end, with 28 cases so far this year, against a ceiling of 37. CHFT is not unique in this, and there will be some revision of how the targets are set across the network, as the objective is not an easy one to achieve at this point in time.

There have been four cases of Pseudomonas Aeruginosa, which is a waterborne organism. These are small numbers and very difficult to manage, however, work is taking place to test, flush and decontaminate certain parts of the water systems throughout CHFT and taking guidance around any abnormal results from our authorised engineer.

Aseptic Non-Touch Technique (ANTT) Competency assessments by medical staff has been taken through the Performance Board, and improvement is expected over the coming weeks.

The recording of Infection Prevention and Control (IPC) Level 2 training is being followed up to ensure that all training has been uploaded onto the Electronic Staff Record (ESR) following the induction of new medical colleagues.

An increase in COVID through the last quarter has been noted, with about 45 cases in total in the last month, which have now started to decrease, with around 16 patients at the moment. Many of those are hospital onset COVID cases, following transmission on the wards. It is also difficult at this point in time as there is no guidance to colleagues to remain off work if they have COVID, or no guidance for them to test, therefore if they are fit to work, they can attend. Colleagues are being reminded of the importance of vaccination and to use masks and socially distance if they have respiratory symptoms. The good news is that most patients have not been desperately unwell, and many have been asymptomatic.

ES mentioned the investigations following a Clostridium difficile case, and asked whether the learning is shared across divisions. **DB** stated that learning is taken largely through the Antimicrobial Group, with a lot of targeted work at the moment on antimicrobial usage and intravenous (IV) oral switches and avoidance of raw spectrum antibiotics. The learning sits within the divisions to cascade from those individual root cause analyses, however, the move to the Patient Safety Incident Response Framework in relation to Clostridium difficile investigations will hopefully provide a more systematic review of the issues faced, therefore there will be better learning across the number of Clostridium difficile cases seen, rather than individual learning for teams, which is currently happening through the Serious Incident framework process. Learning is feeding through, and also through the Performance Board.

OUTCOME: **DB** was thanked for the update and the Committee noted the report.

168/23 MATERNITY AND NEONATAL OVERSIGHT REPORT

Gemma Puckett presented the above report, circulated at appendix E.

LR informed the Committee of the risk in relation to the Maternity Incentive Scheme, which is on the CHFT risk register and being monitored closely. There has also been an escalation into the Local Maternity and Neonatal System (LMNS), which is also being monitored nationally, as this is part of the PROMPT training which requires a Multi-disciplinary Team approach. The disruption through the industrial action has created a risk which has disrupted the sessions.

KH commented on the workshops which looked at the outcomes and the recommendations from the Healthcare Safety Investigation Branch (HSIB) reports, and queried whether the work is continuing from those workshops. **GP** stated that the work is continuing and the team are looking at how all the work can be brought together and embed learning into the health inequalities workstream into personalised care. **LR** stated that the work will be set out into the themes from the three-year plan, to ensure it is business as usual.

VP mentioned the Maternity Incentive Scheme visit on Tuesday, 28 November 2023, which the team are well prepared for. **LR** stated that the inspectors will be the Regional NHSE Midwife, her deputy, and the Lead Chief Nurse on the Local Maternity and Neonatal System (LMNS).

DS thanked **GP** for including the presentation on the 15 steps to success, and the feedback received, and commented on the good progress made on the Perinatal Mortality Review Tool (PMRT) action plan.

DS also commented on the 4.52 whole time equivalent (WTE) fixed term Band 5 posts within the midwifery staffing section of the report, and queried why Band 5 colleagues were on fixed term contracts. **LR** stated that these are staff nurses who are working in women's services, who are trialling a different working model.

DS mentioned the statement around safety action 6 and the significant amount of manual audit which needs to be undertaken, and asked how this will be addressed. **GP** stated that work with the business intelligence team will be undertaken to build a dashboard for saving babies lives, as well as carrying out snapshot audits.

Copies of the Avoiding Term Admissions in Neonatal Unit (ATAIN) report (July to September 2023); the Perinatal Mortality Review Tool (PMRT) action plan and the CHFT 15 steps presentation were also available at Appendices E2, E3 and E4 respectively.

OUTCOME: **GP** was thanked for the update and the Committee noted the report.

169/23 QUALITY AND SAFETY STRATEGY

Lindsay Rudge provided a verbal update on the above, stating that a Quality Summit took place on Wednesday, 11 October 2023, which was well-attended, with over 60 colleagues across each division, as well as the senior leadership teams, including Clinical Directors and Matrons.

The feedback and recommendations from the Summit are now being collated to be utilised to shape the Quality and Safety Strategy going forward. An outline of the proposed strategy was presented at a recent Board Development Day, reframing the approach to quality assurance and quality improvement, with a real focus on building quality improvement (QI) capacity and ensuring focus on the right quality agenda.

There was some good feedback on the day of the Summit around some of the processes; there were updates on the fantastic work from the Collaboratives, which now need their work connecting across divisions.

Engagement has now taken place via the Summit with clear feedback, and a draft Quality and Safety Strategy will be brought into the next Quality Committee meeting.

OUTCOME: **LR** was thanked for the update.

170/23 NASOGASTRIC TUBE ASSURANCE REPORT

Lindsay Rudge presented the above report, circulated at appendix G.

Am internal audit was commissioned following two Never Events in relation to placement of nasogastric tubes. The first incident was in January 2023 and the second in April 2023. A number of immediate actions were undertaken as a result, and are detailed within in the report.

A number of ongoing actions have been undertaken, and the plan is to carry out a re-audit in quarter 4 of 2023-2024, given that processes, policies, guidance and education have been strengthened to ensure that actions taken have made an improvement.

OUTCOME: **LR** was thanked for the update and the Committee noted the report.

WELL LED

171/23 BOARD ASSURANCE FRAMEWORK (BAF) RISKS

The report was circulated at appendix H:

6/19: Compliance with quality & safety standards

LR reported that the risk has been updated, and the Strategy is expected to be drafted by the end of November 2023. Work has been undertaken around risk management and risk registers; a response to the Lucy Letby case which came through the Board of Directors has taken place, along with some deep dives into different neonatal cases. There are still some inconsistencies in quality improvement methodology, therefore, some of the recommendations from the Quality Summit will be how colleagues are supported around quality improvement, and a restructure of the Quality Structure, as part of the Quality and Safety Strategy.

KH asked about progress with the Quality and Safety Team structure and accountability action and whether this was near completion. **VP** stated that the new structure has been drafted, and an agreed structure is expected to be in place by the end of the 2023 calendar year, if not before.

4/20: CQC Rating

VP provided an update on the BAF risk, which is currently scoring 12, mainly due to working through what the new CQC inspection framework means for the Trust. There was an engagement visit around Discharge, Patient flow and Medicines Management on Friday, which had extremely positive feedback.

A presentation was provided to the Board of Directors on the new inspection framework, and a similar presentation was provided at the Quality Summit.

4/19: Public and Patient Involvement

VP provided an update on the BAF risk, which is currently scoring 12. The strategy was approved earlier this year which is now starting to be rolled out. There is currently a gap in the Patient Experience manager role, however, in the interim, Amanda McKie (Nurse Consultant for Learning Disabilities), will be supporting the Patient Experience and Caring Group, as well as an experienced patient experience and public involvement senior nurse colleague from NHS England who will be doing some hours through the Bank. The Strategy is being reviewed to ensure that it is on plan and that we are meeting our statutory obligations for patient experience and involvement.

3/19: Seven day services

This risk was removed from the Board Assurance Framework in July 2023. The standards remain, but are not a key risk to the Trust's strategy. National reporting is no longer required. Audits of progress against the standards will continue to be reported to and scrutinised by the Quality Committee.

OUTCOME: **LR** and **VP** were thanked and the Committee noted the report.

EFFECTIVE

172/23 Q1 LEARNING FROM DEATHS REPORT

Nikhil Bhuskute presented the report circulated at appendix I.

Compliance during quarter one for the initial screening reviews has shown a steady downward trend, and actions are engaged with each member of the review team. Discussions now take place on the clarity of what is needed for the initial screening reviews, as they were previously done simultaneously with the quarterly mortality reviews, which is why the data showed a peak every three to four months, as colleagues were not aware of the policy. Communications have now improved, and confident that compliance will improve going forward.

OUTCOME: **NB** was thanked and the Committee noted the report.

RESPONSIVE

173/23 QUALITY REPORT

Lindsay Rudge presented the report circulated at appendix J, highlighting:

- Two open Never Event incidents which remain open – one was the wrong eye injected (declared in July 2023) and the other was medication administrated via wrong route (declared in September 2023). **LR** and **DB** met with the Surgical senior leadership team around the never events that had occurred, and asked the division to carry out a deep dive, and awaiting their report on actions undertaken.
- 14 incidents were over 60 days (not including Healthcare Safety Investigation Branch). A revised escalation process has been in place from July 2023 to manage investigations that have breached the 60-day timescale. It remains a challenge to allocate investigators due to clinical commitments. The transition to Patient Safety Incident Response Framework (PSIRF) principles regarding learning responses is expected to support this.
- Four open patient safety alerts:
  - *Potential risk of underdosing calcium gluconate in severe hyperkalaemia*
  - *Shortage of GLP-1 receptor agonists*
  - *Shortage Of Verteporfin 15mg Powder For Solution For Injection*
  - *Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls- action on going*.
- Good performance against complaints continues, with themes being patient care, clinical treatment and communication
- Breakdown of the areas where compliments have been received
- Legal services continue to have inquests at coroners courts; and an update on Martha's Rule was included, which is around all patients in NHS hospitals in England (and those acting on their behalf) to have the legal right to request a second opinion from a senior clinician in the same hospital, if a patient is deteriorating rapidly but it appears concerns are not being taken sufficiently seriously by medical staff. From Quarter 4 2023-2024, as part of the Deteriorating Patient collaborative, the HOOP (Hospital out of hours Programme) Team and the Critical Care Outreach Team will be combined to give a 24/7 cover for acutely unwell adults and deteriorating patient. As part of that, some of the recommendations from Martha's Rule will be included around people being able to speak up and access a different review.
- Action plan submitted to the CQC to meet the must do and should do actions.
- There are a number of external regulatory visits planned which are detailed in the report
- The Council of Governors were updated on the progress of the Quality Priorities
- Work is underway on the backlog of responses from the Medical division on NICE guidance
- Focussed work is being undertaken on the clinical repository is being maintained and up to date.

- Highlights from the Clinical Outcomes Group included:
  - Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio are both within the normal range, with the Hospital Standardised Mortality Ratio better than national average. Both pertain to the work of the Care of the Acutely Ill Patient Programme.
  - A statistically significant decrease in the number of harm falls
  - A significant increase in the Malnutrition Universal Screening Tool scores
  - Some progress being made with dementia screening
  - Ongoing work with antimicrobial best practice and the related audit

DS asked about progress with ward assurance. **LR** stated that there is improvement in where information is recorded, and still working through the well organised ward, ensuring that information is recorded in the right place.

OUTCOME: The Quality Committee noted the report.

174/23 INTEGRATED PERFORMANCE REPORT

David Birkenhead presented the report circulated at appendix K.

The organisation remains challenged in relation to performance, with a number of patients attending, particularly over the last week. Extra capacity wards are now open and there are also challenges around the delivery of the acute service, which has not been helped by the number of strikes from medical staff over the last seven months, and upcoming joint strikes between consultants and junior doctors. There are also challenges in relation to elective activity, albeit, still performing well compared to peer organisations.

LR reported that a message from the Quality Summit was around moving indicators from the 'hit and miss' column to the 'pass' column on the performance matrix summary.

OUTCOME: The Quality Committee noted the report.

ITEMS TO RECEIVE AND NOTE

175/23 INFECTION PREVENTION AND CONTROL COMMITTEE MINUTES

A copy of the minutes from 13 July 2023 were circulated at appendix L. There were no comments.

176/23 CLINICAL OUTCOMES GROUP TERMS OF REFERENCE

The 2023 Clinical Outcomes Group terms of reference were circulated at appendix M for ratification.

OUTCOME: The Quality Committee ratified the terms of reference.

177/23 SAFEGUARDING COMMITTEE TERMS OF REFERENCE

The 2023 Safeguarding Committee terms of reference were circulated at appendix N for ratification.

OUTCOME: The Quality Committee ratified the terms of reference.

178/23 NHS ADULT INPATIENT SURVEY 2022 BENCHMARK REPORT

Lindsay Rudge presented the report circulated at appendix O, which was an overall positive report, with CHFT being in the top five for a number of indicators.

The plan is to now integrate the key area results into an action plan, and take through the Patient Experience and Caring Group. The results also need to be shared more widely with colleagues as the report is a positive read.

In terms of one culture of care, **LR** stated that the investment placed in colleagues, their health, their wellbeing and support cannot be taken out of context from the results, therefore, it was asked that **KH** referenced this at the Workforce Committee.

179/23 ANY OTHER BUSINESS

There was no other business.

180/23 BOARD TO WARD FEEDBACK

The Chair noted the NHS Adult Inpatient Survey 2022 benchmark report will be monitored through the Patient Experience and Caring Group.

181/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

- Assurance from the Medicines Management Committee report and the ratification of their terms of reference (item 166/23)
- Updates on the Quality and Safety Strategy and feedback from the Quality Summit (item 169/23)
- Assurance report on nasogastric tubes (item 170/23)
- Update from Quality Report, including the Serious Incident reduction of backlog (item 173/23)
- Updates on the Board Assurance Framework (BAF) risks (item 171/23)
- Ratification of the Clinical Outcomes Group and Safeguarding Committee terms of reference (items 176/23 and 177/23)
- Update on NHS Adult Inpatient Survey 2022 Report (item 178/23)

182/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix P for information.

POST MEETING REVIEW

183/23 REVIEW OF MEETING

The meeting ended early.

NEXT MEETING

Monday, 20 November 2023
2:30 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE
Monday, 20 November 2023

PRESENT

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Gina Choy **(GC)**	Public Elected Governor
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jonathan Hammond **(JH)**	Chief Operating Officer
Karen Heaton **(KH)**	Non-Executive Director
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

Jo Banks **(JB)**	Advanced Practitioner – Frailty Team **(item 188/23)**
Gemma Berriman **(GB)**	Director of Operations **(item 187/23)**
Robert Birkett **(RB)**	Managing Director for Digital Health **(item 189/23)**
Renee Comerford **(RC)**	Associate Director of Nursing For Resilience, Acute Flow and Transformation (RAFT) **(Item 187/23)**
Andrea Dauris **(AD)**	Associate Director of Nursing – Corporate **(item 194/23)**
Richard Hill **(RH)**	Head of Health and Safety **(item 190/23)**
Dr Karin Schwarz **(KS)**	Consultant Paediatrician **(Item 196/23)**

STANDING ITEMS

184/23 - WELCOME AND APOLOGIES

Neeraj Bhasin **(NBha)**	Deputy Medical Director
Nikhil Bhuskute **(NBhu)**	Deputy Medical Director
David Birkenhead **(DB)**	Medical Director
Jennifer Clark **(JC)**	Head of Therapies
Sharon Cundy **(SC)**	Head of Quality and Safety
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Lorraine Wolfenden **(LW)**	Governor

185/23 - DECLARATIONS OF INTEREST

There were no declarations of interest.

186/23 – MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 23 October 2023, circulated at appendix B, were approved as a correct record. The action log can be found at the end of these minutes.

187/23 – MATTERS ARISING: UPDATE ON LENGTH OF STAY AND WELL ORGANISED WARD (WOW)

Gemma Berriman and Renee Comerford were in attendance to present an update on length of stay and the well organised ward, as circulated at appendix C.

In relation to the Delays in ED slide (slide 5) which outlined the serious incidents in the Emergency Department since 2021, **LR** asked how long the delays were and whether they were from the ambulance or delays in the ED. **GB** stated that the delays were in-department delays, from the time the patient arrived and the time leaving the department. Some of those were delays of 6 hours and the longest was 23 hours.

The Committee were advised to watch the 5-minute video on the Well Organised Ward which was embedded in the presentation.

In relation to the risks relating to extra capacity, and the 22 patients who had six or more moves, **LR** requested a thematic review takes place, and will liaise with the clinical audit team regarding this.

In relation to excess deaths, **AN** asked whether local performance shows any trends or correlation with our rising pressures in the Summary Hospital-level Mortality Indicator. **GB** stated that this is difficult to tell, however, it is known that there is an increase in the length of waits in the ED above 12 hours. **LR** stated that outcomes need to be looked at, and proposes a recommendation that a different set of safety metrics are required in Urgent and Emergency Care that monitors ongoing quality aspects, and to describe the population risk and what delays mean for people.

In relation to the bed moves, **AN** asked if the bed moves were a symptom of the extreme pressures, and if there is a correlation between pressures and moves. **RC** stated that getting to a proactive point is needed in order to plan discharges better, as the pressures in the ED are creating the late moves and the number of moves. Audits are taking place on the bed moves which take place after 10:00 pm, as part of the Discharge Quality Group.

In summary, the well organised ward approach should make an impact on identifying patients who do not need a hospital bed. **LR** also noted that this work will be monitored through the Clinical Outcomes Group for a safety and quality oversight, as it is not only about urgent and emergency care, but also about pathways for patients.

OUTCOME: **GB** and **RC** were thanked for the update.

SPECIFIC REPORTS

188/23 – DISCHARGE PATIENT STORY

As part of the presentation at item 187/23, Jo Banks was in attendance to present a snapshot of a good patient story and patient journey through the hospital until discharge.

OUTCOME: **JB** was thanked for the update.

189/23 - PROGRESS OF TRAINING AND DIGITAL SOLUTIONS FROM FOLLOW-UP APPOINTMENT CONCERNS

Robert Birkett was in attendance to provide an update on the approach to education and training in relation to best practice use of digital clinical systems including the Electronic Patient Record (EPR), as circulated at appendix D.

ES asked whether the provision of the change team were available wider. **RB** stated that the team are a CHFT resource and are available for specific areas.

AN asked how the impact of training is measured in order to continue developing. **RB** stated that this is being measured in terms of outcomes, reduced incidents, less serious incidents, and it is hoped that some of the training will feature in those outcomes.

AN also asked whether the local digital champions are still a possibility, and if any progress has been made. **RB** stated that there is now a position to make progress, as it is hoped that colleagues within the change team will be inspired to eventually become digital champions, as well as the students from the University of Huddersfield undertaking Digital Nursing Placements.

LR gave a mention to Louise Croxall (Chief Nursing Information Officer) for driving this forward and having a pragmatic approach to supporting this work.

KH and **DS** commented on the useful update and the innovative work being done.

OUTCOME: **RB** was thanked for the update and the Committee were in support of the multi-method approach to digital clinical systems education, training and development.

190/23 - HEALTH AND SAFETY OVERVIEW

Richard Hill was in attendance to provide an update, circulated at appendix E, on the personal safety of colleagues around violence and aggression and security, and the NHS health and safety workplace standards, which are a range of subjects to comply with in line with the Health and Safety Executive (HSE).

AN stated that a previous issue was the reporting of incidents, and the ability to reach security when needed, and asked whether this has improved. **RH** stated that a newsletter was produced in the last six months in terms of Datix reporting and the availability of security and how to access them, however, this newsletter may be repeated in a different format early next year to ensure colleagues are aware that these facilities are available. **RH** also stated that it is difficult to measure what good DATIX reporting looks like, although, this could possibly be benchmarked with other Trusts, if this information is released. **VP** commented on spending some time with Reception colleagues within the Emergency Department at CRH and was surprised at the level of abuse they receive, to the point of not wanting to leave the reception desk area to use the toilet facilities, which were in the public area. **VP** asked the colleagues about reporting this, however, they felt jaded with the process, and it was felt that some visibility from senior leaders in that space may help during the evening hours. **RH** stated that closer work is required between ISS and Equans to bring both security services together.

In relation to lone working and on-call Pharmacists who are sometimes on their own and unsupervised, **ES** asked whether they would be notified if there was any change to what should be done differently. **RH** stated that a health and safety audit of Pharmacy is due to take place and work is underway on Stage 2 work with CHS and key members of staff who often work alone.

KH commented on the Violence and Aggression Policy and would like to see this pushed throughout the organisation; and that Lone Working is also important and needs to be monitored that the processes and procedures are being followed, in order that colleagues do not feel vulnerable in any circumstance.

JH supported the joint working with ISS and Equans, and stated that the work on the Policy was triggered by feedback from security colleagues who felt vulnerable. The key in improving

the Policy and the training offer is continuing to work collectively with security colleagues to ensure momentum is kept. It was also suggested that targeted training is required for the Emergency Department reception colleagues.

LR noted that as part of the launch of the Violence and Aggression Policy, a video is being recorded for support of the policy, and keen to capture some of the key messages from a patient perspective around a comprehensive nursing assessment, and also providing some resources to help when things do escalate. This will form part of a document which will supplement the Policy on the intranet. Key messages will also include support for colleagues.

DS asked whether there are any sanctions for individuals who display inappropriate behaviour to colleagues and who may be persistent offenders. **RH** stated that this will form part of the promotion and awareness of the Policy, which has been tested.

OUTCOME: **RH** was thanked for the update and the progress being made on safety issues for patients and colleagues.

191/23 - UPDATE ON NASOGASTRIC (NG) TUBE ACTION PLAN

Lindsay Rudge presented the update circulated at appendix F, and highlighted the immediate learning and actions taken, and the ongoing improvement actions. Further reviews and implementation of actions are being done following two previous never events, and assurance that compliance is being monitored through ongoing audit activity, training and daily reviews of every patient that receive a nasogastric (NG) feed. It is hoped that the Well Organised Ward, in relation to Multi-disciplinary Teams reviewing and discussing the nasogastric (NG) feeds and tubes, will provide part of ongoing clinical reviews.

DS asked what measures are in place to ensure the ongoing competency of medical colleagues. **LR** reported that there is no difference between medical and nursing colleagues, as they both require up-to-date competencies to be able to access, place and review those nasogastric (NG) tubes. **DS** also asked if there was a timeline for the external review. **LR** stated that this will be carried out soon.

OUTCOME: The Committee noted the update.

SAFE

192/23 - TRUST PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT

Lindsay Rudge presented the report as circulated at appendix G, highlighting the items for escalation to the Quality Committee, including:

- Divisions noting increase in moderate harm medication incidents, pharmacy undertaking a deep dive to understand if any further Qi work is required on any themes. **ES** stated that these incidents are being reviewed at the Medication Safety and Compliance Group to see if there are any themes and trends and working with Community colleagues on how to improve.

- Work within surgical division on Appointment Slot Issues (ASIs) and harm reviews. It was noted that a robust process is in place, and **JH** stated that a full investigation was carried out, which was positive and now cleared all patients who were highlighted and no longer have any patients awaiting treatment who were on the list. Additional fail safes have also been put in place, which are being monitored and audited in six months' time through the Data Quality Board.

- Ongoing work within medical division on focussing to close incidents and testing of High Impact Level Assessments and Patient Safety Incident Response Framework learning responses.

- Quality and Safety team working through a proposal regarding ownership of the green and yellow incidents, with wards closing the incidents, not the risk management team. **DS** asked about the benefit of the approach of the wards closing the incidents. **LR** stated that the wards will be able to update and be clear about the reviews and actions taken, rather than creating another step in the process and causing a delay, and the risk team can concentrate on the learning. The consistency of this across all wards will be raised with the new Risk Manager who is due to start in post next week.

- Children's Therapies – Special Schools are increasing their demand which will have an impact on the Childrens Therapy Services. A visit from Calderdale is expected, and notification received from Kirklees.

OUTCOME: The Committee noted the update.

193/23 - PROPOSAL FOR TRUST PATIENT SAFETY AND QUALITY BOARD (PSQB)

Lindsay Rudge reported that a review has taken place and it is felt that the PSQB, as it currently functions, is repetitious for divisional colleagues. The proposal is to take the PSQB out of the governance structure and place the quarterly reports which divisions previously submitted, back into the Quality Committee on a quarterly basis, with one division dedicated to reporting to the Quality Committee at a time. **JM** and **NBhu** will work with divisions to outline what the Quality Committee needs, and create a reporting cycle and programme for the three divisional meetings during the quarter, before they are reported to the Quality Committee.

DS stated that this is a good response to the recurring theme of duplication, which was put forward during the Quality Summit in October, and asked at what point it would be envisaged that the change will take place with the divisions reporting into the Quality Committee. **LR** responded that it is hoped that this is done during quarter 4, and the first reporting cycle starts in the new financial year.

LR stated that this will be included in a paper which formally describes the governance arrangements.

194/23 - SAFE SUSTAINABLE AND PRODUCTIVE STAFFING

Andrea Dauris was in attendance to present the new report into Quality Committee, circulated at appendix H, summarising the activity undertaken within the Safe, Sustainable and Productive Staffing Meeting (SSPSM) during May to September 2023.

The SSPSM was set up in response to the National Quality Board (NQB) standards of 2016. Activity is split between the SSPSM and the Nursing, Midwifery and AHP Workforce Steering Group. The SSPSM is focused on the qualitative, outcomes and impacts on patient experience. It was assured that the requirements of the NQB are being met to undertake and deliver safe, effective, caring, responsive and well led staffing levels. It was also noted that the Chief Nursing Officer for Safer Staffing is also briefing the CQC in terms of the framework on how safe staffing levels are achieved.

The report provides a response to a previous gap and provides assurance on how the NQB and the developing workforce safeguards expect the Trust to work. A dashboard has been developed which integrates a number of key pieces of information, and further work is required regarding the red flags, which is the escalation which takes place when there is a staffing

issue. The report details a number of closed red flags. The Committee was asked to note the retraction plan, and the volume of activity associated with agency workers, however, there is confidence that with the on-boarding of new graduates by the end of November, there should be a difference in the volume of activity.

In terms of the model hospital and benchmarking, **AN** asked whether this prompts any follow-up. **AD** reported that there is a wealth of information available from model hospital, and a recent piece of work has been done which identified that under 25s were a significant outlier in the number of leavers. The majority of the Band 5 vacancy positions are made up of internationally educated nurses and the graduate workforce, and if this group of people are identified as leavers, this is a line of enquiry which needs to be explored.

LR assured that triangulation is carried out with the quality and safety metrics and a trigger to carry out deep dives.

ES asked how links are made to Physician Associates who are consistently on the wards, and Pharmacists, who would not fit into the AHP bracket. **LR** stated that there are rules on how they are counted, and what is in or out of the scope for care hours per patient day (CHPPD). AHPs are a paraphyletic workforce which cover a number of areas, and is difficult to determine how many hours they contribute to. Pharmacy Technicians are included and from a CHPPD perspective, where others can be included, they will be, however, the correct decision is required in order to not create any unintended consequences.

AD asked about the frequency of the report coming into the Quality Committee going forward. **DS** stated that the report also goes to the Workforce Committee, and as long as this report focuses on patient experience, and safe and quality of care, there will not be a duplication of information which already goes into Workforce. It was agreed that the frequency will be a twice yearly report.

OUTCOME: **AD** was thanked for the update and the Committee noted the report.

195/23 - MATERNITY AND NEONATAL OVERSIGHT REPORT

Gemma Puckett presented the above report, circulated at appendix I.

GP noted that health inequalities will be included in the report moving forward, and the work being done to make outcomes better for those who are impacted most.

AN commented on the encouraging staffing position, and asked if there was anything further which could be done in relation to areas on the maternity dashboard which are scoring red. **GP** stated that regarding breastfeeding, some targeted work and actions are being done rather than a general approach.

DS commented on the positive initiative of Dads Matter, which will signpost dads to support services; as well as the change in the Maternity Incentive Scheme reduction in the percentage for compliance, and whether this will impact the risk register. **GP** stated that the change is only for the submission in this period, and is likely to be 90% compliance moving forward. Once the workforce improves and the risk improves, the CNST risk will be different.

DS mentioned the next CQC visit and the key lines of enquiry now received, and asked whether the service is comfortable that there is sufficient information and evidence to respond. **GP** stated that the service submitted a significant amount of evidence in advance, which formed the questions from the Local Maternity and Neonatal System (LMNS) and it has been emphasised that this is a positive visit to look at the good work of the service, rather than an assessment.

LR also noted that colleagues from the service will be attending the Health Overview and Scrutiny Committee meeting this week to update on the Birth Centre.

Copies of the Avoiding Term Admissions in Neonatal Unit (ATAIN) report (July to September 2023) and Transitional Care Report (July to September 2023) were also available at appendices I2 and I3 respectively.

OUTCOME: **GP** was thanked for the update and the Committee noted the report.

196/23 - REVIEW OF NEONATAL DEATHS

Dr Karin Schwarz was in attendance to present an update, circulated at appendix J, on the results of a cluster of neonatal deaths on the Neonatal Unit in November 2022.

In terms of escalation, transparency, and openness, **LR** noted that **KS** rapidly escalated these cases in order to commission and review. In order to close the loop, **LR** suggested that an external audit now takes place to review the review.

OUTCOME: **KS** was thanked for the update.

CARING

197/23 - PATIENT EXPERIENCE AND CARING GROUP REPORT

Lindsay Rudge presented the update on patient experience, as circulated at appendix K, including a report which went to the Calderdale Place Quality Committee on patient experience, and a presentation describing progress, a refresh of the approach to patient experience and the key areas of focus.

AN commented on the positive wording of the shared definition, and the central point of what matters most to the person and how that is implemented.

VP stated that it is important to also have patient engagement within patient experience, and that work will be underway soon for formal engagement with patient groups, including changes planned for Community Podiatry; the moving of some therapy services out of the CRH site, and public engagement regarding the Medical Examiner service.

DS commented on the capacity for this, as is mindful of the upcoming work in relation to Patient Safety Incident Response Framework (PSIRF). **LR** reported on this being the reason for strengthening the resource available within the Quality Directorate to support this agenda.

OUTCOME: **LR** was thanked for the update.

WELL LED

198/23 - CQC GROUP REPORT

This report was deferred to the next meeting.

RESPONSIVE

199/23 - INTEGRATED PERFORMANCE REPORT

A copy of the report, circulated at appendix M, was available for information.

ITEMS TO RECEIVE AND NOTE

200/23 - COMMITTEE ACTION PLAN UPDATE

An update of the Quality Committee action plan, circulated at appendix N, was available.

201/23 - CLINICAL OUTCOMES GROUP MINUTES

A copy of the above minutes from September 2023 were circulated at appendix O for information

202/23 - INTEGRATED CARE BOARD MINUTES

A copy of the minutes from the Kirklees ICB Committee from July 2023 were circulated at appendix P for information.

203/23 - ANY OTHER BUSINESS

There was no other business.

204/23 - BOARD TO WARD FEEDBACK

It was acknowledged that information was received on the length of stay and well organised ward.

205/23 - MATTERS FOR ESCALATION TO THE TRUST BOARD

- Assurance on length of stay and well organised ward **(item 187/23)**
- Updates on the progress of training for digital solutions **(item 189/23)**
- Update on Health and Safety **(item 190/23)**
- Update on nasogastric tube action plan **(item 191/23)**
- Proposal for Trust Patient Safety and Quality Board meeting **(item 193/23)**
- Update from Safe, Sustainable and Productive Staffing Meeting (SSPSM) **(item 194/23)**
- Review of Neonatal Deaths **(item 196/23)**
- Update on refresh of Patient Experience and Caring Group **(item 197/23)**

206/23 - QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix Q for information.

POST MEETING REVIEW

207/23 - REVIEW OF MEETING

The meeting over-ran.

NEXT MEETING

Wednesday, 20 December 2023
2:30 – 5:00 pm
Microsoft Teams

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE: ENGAGEMENT CHAPTER

Held on Tuesday 17 October 2023, 2.00pm – 4.30pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Nigel Broadbent	(NB)	Non-Executive Director
Suzanne Dunkley	(SD)	Director of Workforce and OD
Karen Heaton	(KH)	Non-Executive Director (Chair)
Vicky Pickles	(VP)	Director of Corporate Affairs
Lindsay Rudge	(LR)	Chief Nurse

IN ATTENDANCE:

Jason Busby	(JB)	General Manager, Emergency Medicine (for item 116/23)
Mark Bushby	(MB)	Workforce Business Intelligence Manager (for item 121/23)
Arley Byrne	(AB)	Senior Clinical Educator for AHPs/Shadow Board
Jenny Clark	(JC)	Head of Therapies
Laura Douglas	(LD)	Deputy Head of Midwifery/Shadow Board
Natalka Drapan	(ND)	General Manager, Eye Care Services (for item 117/23)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Terry Gamble	(TG)	Staff Side Chair
Nikki Hosty	(NH)	Assistant Director of HR (for items 118/23 and 119/23)
Ansah Jamil	(AJ)	District Nurse, Beechwood/Shadow Board
Kam Khera	(KK)	Surgical Operations Manager/Shadow Board
Mohammad Maqsoob	(MM)	Finance Manager/Shadow Board
Adam Matthews	(AM)	Workforce and OD Business Manager (for item 115/23)
Lis Street	(LS)	Clinical Director, Pharmacy

110/23 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting. Arley Byrne, Laura Douglas, Ansah Jamil, Kam Khera and Mohammad Maqsoob were in attendance from the Shadow Board to observe.

111/23 **APOLOGIES FOR ABSENCE**

Jonny Hammond, Chief Operating Officer
Denise Sterling, Non-Executive Director

112/23 **DECLARATION OF INTERESTS**

There were no declarations of interest.

113/23 **MINUTES OF MEETING HELD ON 23 AUGUST 2023**

The minutes of the Workforce Committee held on 23 August 2023 were approved as a correct record.

114/23 **ACTION LOG – OCTOBER 2023**

The action log was received.

115/23 **PEOPLE STRATEGY/WORKFORCE DESIGN**

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

OUTCOME: The Committee **NOTED** the Workforce Design model.

116/23 **EMERGENCY DEPARTMENT (ED) RECONFIGURATION**

JB began with providing the historical picture of ED. The Committee noted that many elements of the department had not changed for 17 years. The service was failing to meet Royal College of Emergency Medicine standards and was reliant of up to 75% locum cover at premium rates. He explained the steps adopted to create change which included the development of a one culture of care charter and a mission statement. The department underwent transformation resulting in career progression, senior medical rotas, consultant rostered into weekends.

The Committee noted the massive change that consultants are now rostered at weekend and SD asked how this was achieved. JB stated the rich data available in conjunction with feedback and patient stories were the key drivers. The weekend rosters went live on 9 September 2023 without challenge. KH said this is a great example of people working together and congratulated colleagues.

More generally, NB commented on how we could inspire other areas across the Trust to have the same positive mindset to change. JB explained listening to individuals, identifying issues and recognising the need for teamwork influenced buy-in from everyone in the ED team. JB acknowledged LS comment that pharmacy prescriber roles within ED would add value.

OUTCOME: The Committee **NOTED** the ED reconfiguration results.

117/23 **OPHTHALMOLOGY COLLABORATIVE WORKING**

ND presented a detailed overview of the extensive activity that redesigned services across Ophthalmology. She described how results were achieved by listening to both staff and patients, reviewing national guidance and performance against KPIs. Different ways of working and funding to support training were explored, scoping of trials to increase capacity together with collaboration across WYAAT and ICB transformed the service. The Committee noted:-

- Increased capacity
- Improved staff morale
- Improved staff retention and career progression
- Staff feel empowered, valued and celebrated
- Improved care for patients

SD recognised the hard work in both Ophthalmology and ED noting particularly that the stories link to the patient and embed one culture of care and suggested this would make a great case study. LR added this is a great retention story in terms of expanding roles, different career opportunities and a blended workforce. KH commented on the hard focus required in getting change through and congratulated colleagues on their success.

OUTCOME: The Committee **NOTED** the Ophthalmology service transformation.

118/23 **NHS EQUALITY, DIVERSITY AND INCLUSION IMPROVEMENT PLAN**

NH shared the national EDI Improvement Plan and progress made against the six high impact action plans to date. NHS England will provide guidance to assist provider trusts and ICBs in adopting an improvement approach to the implementation of the plan and will establish a good practice repository. The EDI improvement plan supports the progression of CHFT's Inclusion Agenda, People Strategy and our EDI Strategy launched in 2019. NH gave an overview of our local actions developed to deliver against the six high impact actions.

VP commented that the NHS England plan plus the EDS22 and the PSED report will need a collaborative approach so each describes the same story. NH gave assurance of a linked response by providing examples of the planned activity. NH will connect with VP over the next few months to discuss further. JE stated the majority of objectives have a delivery date of 31 March 2024 confirming the Inclusion Group is focussed to make progress in delivery of actions. He acknowledged a lot of excellent work is already happening particularly in relation to workforce. KH does not feel the timescales are realistic and highlighted the challenges of a single national plan. KH referred back to the extensive ED&I data that was discussed at the May 2023 Committee meeting. JE agreed we need to continually test the data in order to demonstrate progress. KH noted the plan describes appraisal objectives for Boards and highlighted that all leaders and managers have accountability.

OUTCOME: The Committee **NOTED** the report.

119/23 **WORKFORCE RACE EQUALITY STANDARD AND WORKFORCE DISABILITY EQUALITY STANDARD ACTION PLANS 2023-2024**

NH reminded colleagues the action plans had been shared at the August 2023 Workforce Committee meeting. The action plans have been further developed following consultation with the equality network groups. The standards support the progression of CHFT's Inclusion Agenda. Both reports were shared and discussed with the BAME steering group and Colleague Disability Action Group. The data was discussed and initiatives to address the areas of focus were suggested and documented on the action plan. Both groups agreed the content on the action plans will improve the colleague experience for these under-represented groups.

OUTCOME: The Committee **APPROVED** the action plans for publication on the Trust's website on 31 October 2023.

120/23 **BAF DEEP DIVE 10B/19**
NURSE STAFFING

LR presented the BAF Nurse Staffing deep dive and provided the Committee with a level of assurance in terms of risk and mitigation. The following key points were noted:-

- The current reality of staffing shortages and availability.
- Despite relevant controls and assurances, the reality remains that nurse staffing continues to present a challenge.
- A high proportion of new graduate nurses, combined with an ambitious recruitment programme aimed at internationally educated nurses, requires a focus upon responding to the learning needs of this junior workforce.

The risk rating has been reviewed and remains the same.

JE commented on the excellent work in recruiting nurses. He asked what the intention is regarding domestic and international colleagues. LR confirmed there has been further work around growing and being a good global partner. Stay and thrive is at the core and the new nursing strategy will include a whole section on how we develop, retain and talent manage colleagues through their journey. LR added we have good evidence of colleagues from

previous international recruitment progressing into senior posts and examples of grow your own from apprentice level into healthcare support workers roles transitioning into higher bands and further onward progression. She recognised the importance of managing all our colleagues in a cohort of a really diverse workforce.

KH acknowledged the assurance and noted the score remains following the deep dive. NB echoed the positive work to address gaps in control. He noted the score had reduced prior to the deep dive.

OUTCOME: The Committee **NOTED** the report.

121/23 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) AUGUST 2023 DATA**

MB presented the highlights:-

- Staff in post figures for headcount and FTE have increased by 31 and 18.99 FTE respectively
- Overall budgeted establishment dropped slightly by 10.79 FTE
- Substantive recruitment has not progressed at the rate predicted during the planning rounds earlier in the year
- Turnover remains stable at 7.66%
- Appraisal compliance figure at September is 52% which is significantly better than the same point in 2022
- Core EST shows strong performance with an overall rating of 93.86%
- In month sickness decreased in both long and short-term absence.
- Top 3 reasons for absence are anxiety/stress and depression, musculoskeletal problems and gastro
- Bank spend decreased by £0.16m
- Agency spend dropped by £0.08m
- 294 apprentices in the Trust

KH commented the tables are really good and asked if other targets can be populated in future reports. KH expressed concern regarding HPS low scores in appraisal and staff survey. VP agreed in relation to appraisal data which is being addressed via HPS Board. However she feels HPS is a very different environment to NHS and suggests in terms of NHS staff survey that HPS is benchmarked against HPS historic survey results. SD concurred HPS is a long-standing area of concern that has had various levels of support over the years. SD referred to the need for change as described in the earlier ED and Ophthalmology presentations and suggested intense actions are implemented.

NB noted the low MUST training compliance and LR responded the cleansing and revalidation of role specific training is impacting on the number of colleagues being added and/or deleted to training requirements. There has been an increase in colleagues added to the MUST training which is reflecting lower compliance.

NB noted Harrogate is an outlier on turnover but have the lowest sickness absence. SD responded that she has been liaising directly with Harrogate to understand their position. It seems this is a historical picture however SD will continue to seek out trusts who have both good performance and lower absence.

MM commented on the variation in sickness absence across the Divisions. MB responded clinical divisions notably have higher level of sickness absence. SD agreed adding that sickness levels do fluctuate and suggested the absence by staff group data offers a different perspective. LR advised a number of divisions have health and wellbeing groups giving FSS as a good example of innovative work to support the workforce. FSS has an established Wellbeing Board.

OUTCOME: The Committee **NOTED** the report.

122/23 **INCLUSION GROUP NOTES**

The notes of the Inclusion Group had been circulated with papers for information.

123/23 **WORKFORCE COMMITTEE WORKPLAN**

OUTCOME: The Committee **REVIEWED** the Workplan.

124/23 **ONE CULTURE OF CARE – MEETING REVIEW**

SD had definitely seen one culture of care embedded in all the transformation improvement work and the work of the nursing recruitment team.

125/23 **ANY OTHER BUSINESS**

No other business was discussed.

126/23 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

KH will present the highlight report to the Board.

127/23 **DATE AND TIME OF NEXT MEETING:**

Workforce Committee Hot House:
24 November 2023, 10.30am – 12.30pm
Theme: Workforce Design

Workforce Committee:
18 December 2023, 2.00pm – 4.30pm
Chapter: Health and Wellbeing