Public Board of Directors

Schedule	Thursday 2 November 2023, 10:00 — 13:00 GMT
Venue	Forum Rooms 1a and 1b, Learning Centre, Huddersfield Royal Infirmary
Organiser	Amber Fox

Agenda

			126
		App M3 - Quarterly Director of Infection Prevention and Control (DIPC) report Q2 – 1st July 2022 to 30th September 2022 (October 2023) (A).docx	130
11:37	18.	Integrated Performance Report To Note - Presented by Jonathan Hammond	134
		APP N1 - QWF_Performance narrative BoD_2nd November 2023 (A).docx	135
		APP N2 - IPR September 2023.pdf	137
11:47	19.	Audit and Risk Committee Chair Highlight Report To Note - Presented by Nigel Broadbent	215
		APP O - ARC Chairs Highlight Report November 2023 (A).docx	216
		KEEPING THE BASE SAFE	219
11:52	20.	Resilience Plan 2023/24 To Approve - Presented by Jonathan Hammond	220
		APP P1 - Resilience Plan 2023 24 Cover Sheet (A).docx	221
		APP P2 - Resilience Plan 2023-24 Including Winter Plan V2 FINAL.docx	223
12:02	21.	Guardian of Safe Working Hours Reports Covering the Period March – August 2023 Presented by Dr Liaquat Ali, Guardian of Safe Working Hours To Note	314
		APP Q1 - GOSWH Board Report - March 2023 to May 2023 (A).docx	315
		APP Q2 - GOSWH Report - June 2023 to August 2023 (A).docx	322
12:12	22.	Board Assurance Framework To Approve - Presented by Andrea McCourt	328
		APP R1 - BAF coversheet (A).docx	329

		APP R2 - BAF Update 2 for Board and ARC 2023 24.pdf	333
12:17	23.	High Level Risk Register For Review - Presented by Victoria Pickles	361
		APP S1 - High Level Risk Register Front Sheet Board (A).docx	362
		APP S2 - High Level Risk Report October 23.pdf	371
12:22	24.	Governance Report a) Annual Review of Non-Executive Director Roles b) Revisions to Standing Financial Instructions and Scheme of Delegation c) Use of Trust Seal d) Board Workplan e) Board Committee Annual Reports: • Huddersfield Pharmacy Specials (HPS) Annual Report To Approve - Presented by Andrea McCourt	382
		APP T1 - Governance Report (A).docx	383
		APP T2 - 2023 Seal register July to October 2023 (A).docx	389
		APP T3 - Draft Public BOD Annual Workplan 2024 version 1 - 26.10.23 (A).docx	393
		APP T4 - HPS_annual_report_2022-23_061223.pdf	397
12:27	25.	Transformation Programme Board Terms of Reference To Approve - Presented by Peter Wilkinson	402
		APP U1 - TPB ToR - for Trust Board 2 November (A).docx	403
		APP U2 - TPB ToR October 2023 - FINAL (A).docx	404
12:32	26.	Items to receive and note 1. Minutes of Board Committees - Finance and Performance Committee 30.8.23, 26.9.23 - Quality Committee 21.8.23, 25.9.23 - Workforce Committee 23.8.23 2. Partnership papers: - Kirklees Health and Care Partnership Kirklees ICB Committee meetings - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk)	409

- Calderdale Cares Partnership Meeting papers - Calderdale Cares Partnership (https://www.calderdalecares.co.uk/about-us/meeting-papers/)

To Receive

APP V1 - 30 AUGUST 2023 Finance and Performance Minutes.docx	410
APP V2 - 26 SEPTEMBER 2023 Finance and Performance Minutes.docx	421
APP V3 - FINAL Quality Committee minutes & action log - 21 August 2023 (Approved 25.09.23).docx	430
APP V4 - FINAL Quality Committee minutes & action log - Mon 25 Sept 2023 (Approved Mon 23 Oct 2023).docx	440
APP V5 - 23 August 2023 approved Minutes Workforce Committee.pdf	446

12:34 27. DATE AND TIME OF NEXT MEETING 455

Date: Thursday 11 January 2024
Time: 10.00 – 2.00 pm
Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

To Note - Presented by Helen Hirst

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1. Welcome and Introductions:

Krish Pilicudale, Director of Digital Information, University of Huddersfield

Dr Liaquat Ali, Guardian of Safe Working Hours

Invited Public Governors:

Robert Markless

Brian Moore

Tony Wilkinson

To Note

Presented by Helen Hirst

2. Apologies for absence:

Rob Aitchison

To Note

Presented by Helen Hirst

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 7 September 2023

To Approve

Presented by Helen Hirst

Draft Minutes of the Public Board Meeting held on Thursday 7 September 2023 at 9.00 am, Forum Room 1A / 1B, Sub-Basement, Huddersfield Royal Infirmary

PRESENT

Helen Hirst	Chair
Brendan Brown	Chief Executive
Robert Aitchison	Deputy Chief Executive
Lindsay Rudge	Chief Nurse
Kirsty Archer	Director of Finance
Nigel Broadbent **(NB)**	Non-Executive Director
Tim Busby **(TB)**	Non-Executive Director
Denise Sterling **(DS)**	Non-Executive Director
Karen Heaton **(KH)**	Non-Executive Director

IN ATTENDANCE

Anna Basford	Deputy Chief Executive/Director of Transformation and Partnerships
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Andrea McCourt	Company Secretary *(minutes)*
Neeraj Bhasin	Deputy Medical Director
Jason Eddleston	Deputy Director of Workforce and OD
Nicola Greaves	Quality Improvement Manager (for item112/23)
Kim Scholes	Head of Planned Access (for item 119/23)
Sue Burton	Revalidation and Appraisal Officer (for item 127/23)

OBSERVERS

Christine Mills	Public Elected Governor

107/23 Welcome and Introductions

The Chair welcomed everyone to the Board of Directors meeting held in public, including invited governor Christine Mills as observer to the meeting.

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

108/23 Apologies for absence

Apologies were received from Andy Nelson, Non-Executive Director, Peter Wilkinson, Non-Executive Director, David Birkenhead, Medical Director, Suzanne Dunkley, Director of Workforce and Organisational Development (OD), Victoria Pickles, Director of Corporate Affairs, Rob Birkett, Chief Digital and Information Officer and Jonathon Hammond, Chief Operating Officer and Andrea Gillespie, Freedom to Speak Up Guardian.

109/23 Declaration of Interests

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

110/23 Minutes of the previous meeting held on 6 July 2023

The minutes of the previous meeting held on 6 July 2023 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 6 July 2023 as a correct record.

111/23 Matters Arising and Action Log

There were no matters arising listed on the agenda and none were raised during the meeting.

The action log was reviewed.

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

112/23 Patient Story – Surgical Robot

The Chair welcomed Nicola Greaves, Quality Improvement Manager to the meeting.

Nicola began with an overview of the Quality team's work giving patients and carers a voice in the Trust and shared some brief examples of patient stories. She then shared, Ken's story, which detailed his journey from bowel cancer screening, colonoscopy, scans and surgery with the Versius surgical robot, (the first surgery done using the robot in the Trust), to when he received the news that no further treatment was required. She described how Ken was involved throughout the process and was at ease throughout the whole procedure. She also shared what mattered to Ken, which was a seamless pathway, six week process, responding to his questions, feeling safe, support for his wife and a smile from Miss Grey, the Consultant he saw straight after the procedure. Ken described his care as "top notch". Nicola thanked the surgery team for their work in securing the surgical robot for the Trust.

In the context of the NHS long term workforce plan, which has a focus on using digital to ensure the workforce is prepared to deliver care, the Deputy Director of Workforce and OD commented this was a great way we are making a difference to patients. Nicola noted feedback from staff had been positive and advised that the first wave of robotic surgery has been for colorectal operations with plans to extend its use to gynaecology.

A request was made to share the presentation with the Finance team, who were key to managing the money to secure the surgical robot and the Medical team, to share at the medical workforce briefing.

TB asked how we were building on activity. The Deputy Medical Director shared ongoing work within the colorectal service to integrate this within the patient pathway and plans to expand use to gynaecology, urology and other specialties following training, as this was key to ensuring the right case selection.

The Chief Nurse thanked Nicola Greaves for sharing Ken's story and for her hard work in her role ensuring the voice of the patient was heard and highlighted the importance of how patients feel about their healthcare experience.

NB queried how patients less comfortable with technology would experience use of the robot for their healthcare. Nicola acknowledged there were different patient experiences and levels of comfort and the quality of conversations between the patient and staff was key. She noted the team were good at communicating with patients and addressing fears. The Deputy Medical Director added that there was an initial assessment about the

clinical suitability of a case, communication with the patient regarding informed consent and shared decision-making with a focus on what works best for the patient. KH reiterated the importance of patient choice, explaining and communicating with patients and treating them with respect and understanding.

Nicola Greaves left the meeting.

OUTCOME: The Board **NOTED** the patient story and the surgical robot developments and thanked Nicola Greaves for the presentation.

113/23 Chair's Report

The Trust Chair noted the detail within her report and shared details about Organ Donation, the annual report of which was in the papers. She highlighted that 18 September 2023 was the start of Organ Donation week and encouraged Board members to raise awareness of this.

DS commented it was helpful to see the report on Organ Donation and noted that we were successful in what we do though numbers were low. Given the need for more donors from a BAME background she asked how we are engaging with families from BAME communities to see if we can increase donations. The Chair responded that much activity takes place at a regional level led by the Blood and Transplant Authority. She referenced work to address perceived religious barriers to organ donation, for example work by Ambassadors and an information event planned in Calderdale.

TB asked if there was anything further the Trust should do and the Chair responded that general awareness raising in non-traditional areas (ie not Intensive Care Unit or Emergency Department) would be helpful, She also fed back that a rose wall at HRI was planned which would have more prominence than the small display currently.. She noted the Organ Donation Committee focused on staff training and support for general awareness raising as advocates and informed the Board that the Trust had delivered high numbers of training and compliance through using organ donation funding to backfill colleagues to release them for training.

The Chair also presented her report detailing activities since the last meeting within the Trust, and local systems, regionally and nationally. She noted that the report was current as at 31 August 2023 and added that together with the Chief Executive she had attended an NHS England (NHSE) event on 6 September 2023 regarding current issues, including Boards' response to the Countess of Chester / Lucy Letby issues, patient safety, industrial action, building safety (reinforced autoclaved aerated concrete) and financial challenges noting these all link to an organisations' culture, including patient safety, management and leadership. The Chair advised the Chief Executive would share key messages from the NHSE meeting.

OUTCOME: The Board **NOTED** the update from the Chair and the highlight report from the Calderdale and Huddersfield Charitable Funds Committee and Organ Donation annual report.

114/23 Chief Executive's Report

The Chief Executive presented the report which provided strategic and delivery context for the meeting. Progress against each of the Trust's strategic priorities of Transforming services and population outcomes, Keeping the base safe – quality and safety of care, Inclusive workforce and local employment and financial, economic, and environmental sustainability was detailed in the report. The Chief Executive noted industrial action by doctors had taken place over the summer.

The sad events relating to neo-natal deaths and incidents at the Countess of Chester Hospital were noted. The Chief Executive asked for initial reflections from Board members and KH questioned how this impacted on the Trust and what our response would be. The Chief Executive referenced the "True for Us" report included in the papers which detailed actions taken to date by CHFT's Executive team and the senior leadership team in the Family and Specialist Services division and changes in the NHS that had taken place since the time of events in 2016.

The Chief Executive noted that it had been reported that staff at the Countess of Chester spoke up but were not heard and, whilst the Freedom to Speak Up route is for concerns that have not been heard, it should be a back stop. The Trust needs to focus its attention on signals and be more curious, for example positive performance metrics are not an indicator of either staff experience of providing care or patient experience receiving care. He emphasised the importance of managers at every level listening and engaging with colleagues day to day to discuss and debate issues, with Freedom to Speak Up being a route for when other avenues to raise issues have failed.

The events have also led to a focus on greater regulation of managers nationally and DS commented that organisation reputation at Countess of Chester appeared to be a greater priority than clinical risk. The Chief Executive shared his view that the regulation of managers was probably not the answer as many of those involved at the Countess of Chester were already regulated. He referenced doing the right thing for patients in line with the Trust's risk appetite. The Chair advised that all Board members need to reflect on what's within the Board papers and how we respond.

TB queried how the Board gets assurance that concerns are fully responded to. The Chief Executive responded that it is important that Board members are curious at Board meetings, the Board has the right conversations to get true insight where things do not go right and that there is the right culture across the organisation aligned with our goals, for staff to act appropriately. The Deputy Chief Executive commented on the importance of leadership and organisational development and how difficulties are resolved when things go wrong. The Deputy Director of Workforce and OD gave assurance that the Trust has a robust People Strategy and through the Workforce Committee tests out the colleague voice and experience and has set clear expectations of leaders. Christine Mills described the Board as being open and noted that, when she raised questions, these were always answered with explanations where appropriate, which was important for the public.

The Chair reminded Board members that the 5 October 2023 Board development session would focus on One Culture of Care and Patient Safety. This would be a useful forum to reflect on how the Board learns in a relevant way considering this context.

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

115/23 Strategic Objectives Progress Report Q1, 2023/2024

The Deputy Chief Executive and Director of Transformation and Partnerships presented progress against the 2023/24 strategic objectives. Of the 15 objectives, 14 were rated green (on-track) and one was rated amber, which relates to the sustainability goal and delivery of the financial plan. She noted that work was in progress to develop quantifiable metrics for objectives where possible.

TB noted the report was re-assuring and showed positive progress. He asked about capacity of the virtual ward and the Chief Nurse responded that the capacity available is

not yet fully maximised, with ongoing work to revise some of the pathways and make improvements to increase availability and capacity in the service.

KH noted good progress was being made and asked how we communicate this progress against strategic objectives with staff. The Deputy Chief Executive and Director of Transformation and Partnerships outlined how aspects of progress are shared with staff via the newsletter and the weekly CHFT live meeting and agreed to work with Communications colleagues to develop a way of sharing aggregate performance against strategic objectives.

NB also commented that good progress was being made and questioned at what point the sustainability objective relating to finance would move from an amber to a red rating given the likely £7.1m adverse variance forecast. The Director of Finance advised work was in hand reviewing the current position and this work needs to be completed before the rating can be re-considered, with a workshop being held at the end of September. She confirmed that the amber rating was appropriate given the stage in the financial year, the potential for opportunities as funding is clarified nationally and mitigating actions internally within existing governance frameworks, such as escalation processes.

NB suggested that it would be helpful to revise the rating terminology which currently shows red being off track with no plan in place as, if the rating moves to red, there will be plans in place to manage the position. The Chief Executive advised of the need to be cognisant of the Board Assurance Framework and that the national context presents further risk.

ACTION: Deputy Chief Executive and Director of Transformation and Partnerships to liaise with Communication leads on sharing aggregate performance against the strategic objectives with staff.

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

116/23 Finance and Performance Chair Highlight Report

NB presented this highlight report to the Board from the Finance and Performance Committee meetings held on 1 and 30 August 2023. The report detailed items for the Board to acknowledge, be assured about and items for awareness.

In terms of finance NB highlighted that at month 4 2023/24 there was an £8.95M deficit, a £1.27M adverse variance to plan due to higher than planned bed capacity, the impact of cost improvements, cost of industrial action and higher utility costs. He referenced work to remedy and mitigate these pressures, such as escalation to the Turnaround Executive and other meetings being held to mitigate the impact from current challenges with the financial position.

In terms of performance NB advised the Committee noted the positive performance position on cancer performance, recovery of activity and outpatient transformation and referenced deep dives and improvement actions in neurophysiology, echo cardiology and stroke.

In relation to the assure section of the report, TB asked what the key points were from the NHSE deep dive into finances received by the Committee. NB advised that the Committee had received a presentation from the Director of Finance with actions for the Trust to consider and an action plan had been developed. None of the actions had been a surprise. The Chief Executive noted that the Trust has had two deep dives into finance

in one year and has a tight grip on finance, with external factors impacting on the underlying deficit position which remained a concern.

TB asked about the next steps in relation to delayed transfers of patient care noted in the aware section of the report. The Deputy Chief Executive advised the number is currently around 100 and needs to reduce to 70 in the short / medium term. He advised that this was escalated through meetings with partners and noted potential for improvement by using the discharge to assess/ home first service in Calderdale for transitional care which is coming onstream.

DS commented that the West Yorkshire benchmarking on referral to treatment in the report shows a positive position despite the challenges and noted that some operational pressures may impact on pressured roles, for example through sickness.

The content of the report was reviewed and noted by the Board.

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

117/23 Month 4 Financial Summary

The Director of Finance presented the financial position as reported at Month 4, July 2023, which shows a £1.27M adverse variance from plan, reporting a £8.95m deficit. The paper detailed the drivers of the adverse variance. She noted that capital expenditure was behind the planned profile but anticipated this would be in line with revised plan to spend higher capital amount due to further approvals by the year end. She advised that close monitoring of the cash position will take place as we become challenged as the year progress and require cash support.

OUTCOME: The Board **NOTED** the Month 4 Financial Summary as at July 2023.

118/23 Approval of Cash Support

The Director of Finance advised Board members that the Trust will be required to request cash support in the form of national Revenue Public Dividend Capital, with a planned value of £9.5m support for the 2023/24 financial year, expected to be needed by quarter 3. This required an application for Revenue Support from NHS England via Public Dividend Capital in September 2023. The paper detailed the cash forecast and forecast revenue support by month and noted the need for a minimum required cash balance of £2 million. She advised that a request for any further cash support would be brought back to the Board and gave assurances about strong management of the cash position.

NB confirmed this request had been discussed and agreed at the Finance and Performance Committee which supported this request.

KH queried when the 3.5% PDC charge was payable and the Director of Finance advised this would be in the 2023/24 finial year and was built into the financial plan.

TB queried whether sufficient cash support was being requested, given the potential for further industrial action. The Director of Finance responded that cash is managed within tolerances, with flexibility in cash management and forecasting would highlight any further requirements in a timely way. The Chief Executive commented that funding relating to industrial action impacted all Trusts.

OUTCOME: The Board **APPROVED** the Trust's Public Dividend Capital revenue support request.

119/23 Protecting and expanding elective capacity – Board assurance

On behalf of the Chief Operating Officer, the Deputy Chief Executive and Director of Transformation and Partnerships presented this paper requesting approval of the process for the Trust to submit to NHS England (NHSE) by 30 September 2023, a Board self-certification, signed off by the Trust Chair and Chief Executive, which will provide NHSE with assurance of the activities that are being implemented to drive outpatient recovery. She noted the Trust was in a good place to drive elective recovery and outpatient work and detailed assurance to NHSE was required. Kim Scholes attended the meeting to support this item.

It was noted that a requirement for the NHSE self-certification was a specific assurance for the Board to receive a report on referral to treatment (RTT) data quality and LUNA scores, a national measure of data quality based on 19 metrics which identify any data quality errors and cohorts of patients requiring further validation. Kim Scholes provided a detailed explanation to the Board of the LUNA score measures of data quality which is the foundation of managing waiting lists and helps focus validation work within the Trust. She provided positive assurance to the Board that the Trust confidence score relating to accuracy was high and above target at 99.56% accuracy. She referenced positive working with the Business Intelligence team which supports this work.

The Chair highlighted that the report was not included in the Board papers as planned and the Company Secretary advised this would be circulated to Board members after the meeting.

As the self-certification requires Board sign off by 30 September 2023, delegation for sign-off to the Chair and Chief Executive was requested, with a prior review of the completed self-certification template by the Finance and Performance Committee planned for 26 September 2023.

ACTION: Company Secretary to circulate the RTT Data Quality and LUNA presentation to Board members.

OUTCOME: The Board:

i. **NOTED** the organisations position in relation to LUNA data quality score and ongoing actions;

ii. **APPROVED** the delegation of responsibility to the Finance and Performance Committee to review and confirm the content of the self-certification template providing assurance on recovery plans;

iii. **APPROVED** the delegation of authority to the Trust Chair and Chief Executive to sign-off the self-certification on behalf of the Trust Board.

120/23 Workforce Committee Chair Highlight Report

KH presented the Chair's highlight report from the Workforce Committee of 23 August 2023. She highlighted the Committee had received presentations on progress with the Recruitment Strategy and the Apprenticeship Strategy and an expanded learning offer for staff. She assured the Board that an analysis of the Trust People Strategy against the new NHS Long Term Workforce Plan had taken place, noting as yet there were no national milestones for review. Gender pay gap data, reports on workforce equality (WRES) and disability equality (WDES) had been received with action areas identified

which would be followed up on behalf of the Workforce Committee by the Inclusion Group.

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

121/23 Quality Committee Chair's Highlight Report

DS presented the Chair's highlight report from the Quality Committee meeting of 21 June and 24 July 2023. She directed Board members to read the July minute item regarding the Patient Safety Incident Response Framework (PSIRF) and confirmed the Trust's top ten incident themes had been identified. She noted the Trust's response to PSIRF will come back to a future meeting of the Quality Committee before submission to the Integrated Care Board. The Chair commented that it would be helpful for Board members to review relevant PSIRF documents in advance of the October Board development session, which will focus on patient safety and One Culture of Care.

DS summarised the key items discussed at these two meetings and noted that a new quality dashboard which had been developed supports the Committee in identifying areas for focus.

The content of the report was reviewed and noted by the Board.

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

122/23 Learning from Deaths, quarter 4 report, 2022/23

In respect of the Learning from Deaths quarter 4, 2022/23 report TB queried the reduction in compliance with initial screening reviews. The Deputy Medical Director responded that additional capacity to undertake the reviews has been identified. NB questioned what action is taken when reviews identify poor care. The Deputy Medical Director advised that the poor care rating did not always relate to direct patient care and could be issues of documentation or communication. Learning from reviews was fed into Trust and divisional governance processes.

OUTCOME: The Board **NOTED** the Learning from Deaths quarter 4, 2022/23 report.

Director of Infection Prevention Control (DIPC) Q1 Report 2023/34

OUTCOME: The Board **NOTED** the Infection Prevention Control Q1 2023/24 report.

123/23 Integrated Performance Report

On behalf of the Chief Operating Officer, the Deputy Chief Executive presented the Integrated Performance Report for July 2023 noting that key issues had been raised in the previous committee reports. The report identified one movement in the performance matrix; diagnostic activity undertaken against plan has moved from common cause variance hit/miss to special cause improving variation and hit and miss.

The following was highlighted:

- Positive performance with elective recovery for 65/52/40 weeks although we did see a small increase in 40-week waits due to cancelled lists following strike action
- Emergency Department (ED) performance for July was 61% with a drop in daily attendances but still high numbers of transfer of care patients and high bed occupancy. The Trust was still within the top 13 Acute Trusts nationally for type 1 ED performance.

- In terms of SHMI (summary hospital – level mortality indicator) the latest reporting month of April 2023 shows a performance of 108.85 following the national annual rebasing exercise, often with the first reporting month after that rebasing performance can deteriorate, this is updated as we move through the year and we would expect this performance to improve, as has been seen with the HSMR (hospital standardised mortality ratio) performance being over 100 for April 2023 which improved to the 94 range for May 2023.
- Complaints closed within timescale was at 87%, lower than aspired to due to Family and Specialist Service Division's performance of 75%.
- Health Inequalities metrics have been further expanded with the introduction of key indicators for deprivation (IMD 1 and 2 patients). Further work continues for these patients alongside patients with Learning Disabilities to try and reduce the disparity in waits and patients not attending appointments.

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

124/23 Audit and Risk Committee Chair's Highlight Report

NB presented the Audit and Risk Committee Chair highlight report from the meeting held on 25 July 2023, with items for the Board to acknowledge, be assured about and for awareness. He highlighted deep dives that had taken place on data quality and cyber security and a request for a risk on cyber security to be added to the Board Assurance Framework. In terms of internal audit, he advised good progress and noted one report with limited assurance regarding national and local standards on invasive procedures would be discussed at the October meeting. He confirmed the terms of reference of the Committee had been reviewed and the Risk Management Strategy appended for approval.

TB queried whether further external assessment on cyber security was needed and NB advised that the Chief Digital and Information Officer had a regular cycle of assessment and additionally at each Audit and Risk Committee current issues are highlighted by the Counter Fraud Specialist which alerts the Trust to areas where controls may need changing.

OUTCOME: The Board **NOTED** the Audit and Risk Committee Chair highlight report

125/23 Approval of Risk Management Strategy

NB advised the Risk Management Strategy had been review by the Audit and Risk Committee and recommended it to the Board for approval. He noted that the risk appetite would be updated following approval of the risk appetite later in the Board meeting**.**

OUTCOME: The Board **APPROVED** the Risk Management Strategy

126/23 Medical Revalidation and Appraisal Annual Report

The Deputy Medical Director, together with Sue Burton, Revalidation and Appraisal Officer, presented the General Medical Council (GMC) revalidation and appraisal compliance for non-training grade medical staff for 2022/23. The Board is required to oversee compliance in this area which is led by the Medical Director.

In terms of revalidation there were 75 positive recommendations and two deferred recommendations for more data to be gathered to make a positive revalidation.

A total of 99% of medical colleagues were appraised during 2022/23, with 4 missed appraisals due to lack of engagement by the doctor. It was noted that referrals are made to the General Medical Council if there is recurrent non-engagement with appraisals.

Positive external assurance from an audit of revalidation and appraisal processes by Audit Yorkshire had been received.

The paper included a recommendation to the GMC and the Board approved the submission.

OUTCOME: The Board **NOTED** the Medical Revalidation and Appraisal Annual Report for 2022/23.

127/23 Maternity and Neonatal Oversight Report including CQC Maternity report

The Chief Nurse presented this paper which provided the Board with information for oversight of key quality issues within maternity services, including an update on the monthly Maternity and Neonatal Transformation Board, chaired by the Chief Nurse, which has oversight of delivery against the 3 Year Delivery Plan for Maternity and Neonates. It was noted that year 5 of the Maternity Incentive Scheme has been launched with a submission date of the 1 February 2024 at 12 noon.

Included in the paper was the CQC maternity report published on 25 August 2023 following an inspection on 7 and 8 June 2023. Maternity Services maintained the overall CQC rating of Good. It was noted that the safe domain was rated as Required Improvement, down from Good in 2018 due to the staffing position. The Chief Nurse noted the report was good and a great achievement by the team. She highlighted the importance of leadership and the ability of colleagues to speak up, the culture and outcomes for safety which were shown in the report.

KH, Board Maternity Safety Champion, asked the Board to record its thanks to team for work and dedication and the Chair also expressed her thanks to the team.

The Chief Nurse advised that there were four Healthcare Service Investigation Branch open cases, there had been no neo-natal deaths or stillbirths in June 2023 and the perinatal mortality review tool had been submitted.

The Chair asked about a spike in neo-natal deaths she had seen in the IPR and where we had sought assurance in relation to this. The Chief Nurse advised that Quality Committee reviewed this through receipt and review of a supplementary audit requested by the Trust, which identified a need to better understand the health inequalities impact on some of the women where there had been a neo-natal death.

Further updates were given on Baby friendly status, visibility of the Chief Nurse and Maternity Safety Champion, the workforce position and continuation of work on health inequalities. July saw successful implementation of the Badgernet electronic patient record on the neonatal unit which was helpful for patients and families, with Phase 2 implementation underway, which is the interfacing of the equipment to Badgernet.

The Chief Nurse highlighted a strategic partnership with Mid Yorkshire Hospitals Trust's Director of Midwifery to lead strategy across both Trusts to complement existing structures and build capacity, leadership and capability. It was noted that Ockenden peer review data was to be submitted in October for an Ockenden review in November.

OUTCOME: The Board **RECEIVED** the CQC Maternity Report and **NOTED** the assurances within the report.

128/23 Freedom to Speak Up Annual Report 2022/23

The Deputy Director of Workforce and OD presented this 2022/23 Freedom to Speak Up (FTSU) annual report on behalf of Andrea Gillespie, Freedom to Speak Up Guardian.

The key points highlighted were:

- 88 concerns raised in 2022/2023 and the number of concerns raised as per the National Guardian's Office submission categories and by staff groups, highest in four years with nurses and midwives the highest reporting group and medical and dental staff the lowest reporters
- Number of concern by the following category were shared: patient safety/quality, bullying or harassment, inappropriate attitude/behaviours, colleague safety/wellbeing.
- The ethnicity of the colleagues that have raised their concerns via FTSU
- Staff survey comparative data showing the Trust as an average reporter
- The work being undertaken to create a culture where staff feel safe to speak up and make FTSU business as usual at CHFT.

In response to a question from TB the Deputy Director of Workforce confirmed that all FTSU concerns have a proper inquiry and commented that improvements can be made in reporting action taken in response to a concern and evaluating the experience of the colleague who raised the concern.

The Chair asked how we compared with other Trusts in terms of reporting by doctors and dentists and the Deputy Director of Workforce and OD advised the FTSU Guardian would be able to access that information. The Deputy Medical Director advised FTSU is the last stop for raising concerns and there are a number other forums used by medical staff to raise issues.

DS advised she would be interested in learning from the FTSU Guardian how we develop the FTSU network and whether there are any capacity issues and the Deputy Chief Executive noted he would welcome the Guardian's comment on inclusion and underrepresented groups. The Deputy Director of Workforce and OD emphasised that issues should ideally be raised with immediate managers for resolution and colleagues should be confident in receiving a positive response and resolution.

OUTCOME: Andrea Gillespie, Freedom to Speak Up Guardian to be invited to the November 2023 Board meeting to provide a qualitative update.

OUTCOME: The Board **NOTED** the Freedom to Speak Up Annual Report for 2022/23 and the work of the Freedom to Speak Up Guardian and Ambassadors.

129/23 Board Assurance Framework – Performance Risk

The Company Secretary presented a new performance risk, risk 4/23 scored at 16, regarding not achieving local and national targets, noting this was an addition to the Board Assurance Framework presented to the Board in July 2023.

The risk had been reviewed at the Finance and Performance Committee on 30 August 2023 which recommended the risk to the Board for approval.

The Chair queried whether the risk score should be increased further and the Company Secretary responded that a second update of all Board Assurance Framework risks was to take place imminently, with an opportunity for further review of the score for this risk by the Board at its November 2023 meeting once it had been updated.

OUTCOME: The Board **APPROVED** the Board Assurance Framework – Performance Risk, 4/23 at a risk score of 16.

130/23 Risk Appetite Statement

The Company Secretary presented the annual review of the risk appetite statement for approval by the Board. A review by Directors had confirmed that the current risk categories were appropriate and current and reflected the Trust culture. The Chair confirmed that she felt the risk appetite aligned with the Trust's culture. The Company Secretary noted the minor wording changes to the risk appetite proposed reflected system working arrangements.

The Company Secretary advised that, following discussion with the Audit and Risk Committee Chair about the risk appetite, it had been agreed to review the alignment of target risk scores with the risk appetite when updating all Board Assurance Framework risks in September / October.

NB highlighted there was not a consistent approach to risk appetite or risk categories across Trusts from the risk appetites he had reviewed to date. He informed the Board that he had liaised with Audit Yorkshire regarding this and they were planning to undertake work in this area. The Company Secretary confirmed the Trust's risk appetite followed the Good Governance Institute risk appetite matrix.

OUTCOME: The Board **APPROVED** the Risk Appetite Statement

131/23 High Level Risk Register

The Chief Nurse presented this report which gave an overview of risks scoring 15 or above and themes by each strategic goal were noted, with 50 risks of which 39 were rated as high and 11 very high (16), with 11 risks having had their risk score reduced and one had the risk score increased.

Ongoing work with divisions to review the risks on the risk register was noted and delivery of training to support staff recording of risks and use of the risk register, with the high level risk register to be presented to the Board at its November meeting. The Chief Nurse highlighted the risk areas in the register align with those discussed at the Board, notably the financial position, backlogs and workforce.

The Chair, following a conversation with Andy Nelson (prior to the meeting) and NB, raised the issue of mitigation for risks given the Board needs assurance that there is appropriate action being taken. NB proposed the high level risk register be brought to the meeting of the Audit and Risk Committee on 24 October 2023 for scrutiny in advance of the November Board meeting. The Chief Executive recommended that the high level risk register should be shared with all Board members in advance and NB welcomed any Board members to join the Audit and Risk Committee to discuss this on 24 October.

TB queried the difference between risks on the Board Assurance Framework (BAF) and the high level risk register and was advised risks to strategic objectives are on the BAF

and operational risks are on the high level risk register. The Chief Executive noted a Board conversation about the risk register was needed. DS advised it would be useful to view the risk register by division and directorate.

Action: Director of Corporate Affairs to share high level risk register report with all Board members in advance of 2 November 2023 Board meeting.

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

132/23 Governance Report

The Company Secretary presented the Governance report which contained:

a. Board Workplan
b. Annual reports for 2022/23 for the Quality Committee and Finance and Performance Committee, which confirmed that the Committees were working in line with the terms of reference and the principal activities of Committee work over the last 12 months.

The Board agreed to defer the Digital strategy item on the November 2023 workplan to allow for the Freedom to Speak Up Guardian to provide a qualitative narrative to the Board as she had been unable to attend this Board meeting.

Action: Corporate Governance Manager to revise Board workplan to defer Digital Strategy item for November, with Freedom to Speak Up item / discussion with the Guardian added for November 2023 Board meeting.

133/23 Review of Board Sub-Committee Terms of Reference

It was noted the terms of reference had been reviewed by the Audit and Risk Committee and Charitable Fund Committee.

OUTCOME: The Board **APPROVED** the Audit and Risk Committee and Charitable Funds Committee Terms of Reference.

134/23 Items to receive and note

The following were provided for assurance:

- Minutes of Committee meetings:
  - Finance and Performance Committee: 28 February 2023, 28 June 2023.
  - Quality Committee: 21 June 2023, 24 July 2023
  - Workforce Committee: 20 June 2023, 3 May 2023
  - Audit and Risk Committee: 27 June 2023, 25 July 2023
  - Charitable Funds Committee: 9 August 2023

- Partnership papers: Kirklees Health and Care Partnership and Calderdale Cares Partnership

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

135/23 Any Other Business

Gary Cleaver, Regional Officer from Unison and Kim Mellor and Anna Macowski, healthcare assistants, joined the meeting between agenda items 115/23 and 116/23**.** They presented a petition to the Board on behalf of healthcare assistants regarding job evaluation and banding for the healthcare assistant role. Gary Cleaver stated colleagues

have taken on more clinical responsibilities without the pay to match and urged the Board to address this matter quickly. They referenced that the recent listening and engagement events with healthcare assistants and the Trust on this matter had been positively received. They then exited the meeting.

The Chair asked colleagues for their feedback on this matter. The Chief Nurse updated the Board on recent conversations with affected colleagues via three listening events, with one of the four listening events yet to be held at the HRI site. She reported the conversations had been very professional focusing on how colleagues felt the role had expanded and why they considered the healthcare assistant role should be regraded from Band 2 to 3. She advised that once the final listening event was concluded a review of what's been heard will take place and an evaluation of the response.

The Chief Executive advised that in response, he, and the Chair, on behalf of the Board, would formally acknowledge receipt of the petition, provide the facts of where the Trust was currently and outline the next steps.

The Deputy Director of Workforce and OD provided the broader context of the healthcare assistant banding issue across the whole NHS, noted that Unison locally is seeking a quick resolution to this and there was a need to move this forward at pace.

Action: Chief Executive and Chair to respond to the petitioners on behalf of the Board.

OUTCOME: The Board **RECEIVED** the petition from Unison regarding the banding of healthcare assistants.

136/23 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 2 November 2023
Time: 10.00 am
Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

5. Matters Arising and Action Log

To Note

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 25.10.23

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
7.09.23 115/23	**Strategic Objectives Progress Report Q1, 2023/2024**	Deputy Chief Executive and Director of Transformation and Partnerships	Liaise with Communication leads on sharing aggregate performance against the strategic objectives with staff – Update on progress against objectives included in various internal comms routes and as part of stakeholder briefing	2 November 2023		25.10.23.
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		
7.09.23 131/23	**High Level Risk Register**	Director of Corporate Affairs	Share high level risk report with Board members in advance of 2 November 2023 Board meeting.	26 October 2023		17.10.23.
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	November 2023		
4.05.23 57/23	**Annual Strategic Plan Final Year Progress Report**	Deputy Chief Executive and Director of Transformation and Partnerships	Identify quantifiable measures for objectives in the year-end report. Included within progress report on strategic objectives on 2 November 2023 agenda and future reports.	2 November 2023 (revised date)		2.11.23.

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 25.10.23

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
7.09.23 132/23	**Governance Report**	Company Secretary	Corporate Governance Manager to revise Board workplan to defer Digital Strategy item to January for the Freedom to Speak Up item / discussion to be added to the November 2023 Board meeting.	11 October 2023		11.10.23
7.09.23 119/23	**Protecting and expanding elective capacity – Board assurance**	Company Secretary	Circulate the RTT Data Quality and LUNA presentation to Board members.	8 September 2023		08.09.23
7.09.23 135/23	**Any Other Business**	Chief Executive and Chair	To respond to the Healthcare Assistant petitioners on behalf of the Board	29 September 2023		14.09.23
4.05.23 70/23	**Risk Management Policy**	Director of Corporate Affairs	Review of high level risk register and internal audit plan on risk management. *Update 19.9.23. following 7 September 2023 Board meeting:* Board workplan confirms high level risk register presentation to Board in November 2023 and January and March 2024. Internal audit plan risk management audit scheduled for Q3 2023/24, which will include review of high level risk register.	7 March 2024		19.09.23

6. Board Diversity (Non-Executive development and Shadow Board)

To Note

Presented by Victoria Pickles

7. Board Diversity Action Plan

To Approve

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title:	Board Diversity Action Plan
Authors:	Nikki Hosty, Assistant Director of Human Resources Jason Eddleston, Deputy Director of Workforce and Organisational Development
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	None
Purpose of the Report	The paper proposes an action plan that will enable the Board of Directors to be representative of the Trust workforce.
Key Points to Note	• Our People Strategy has equality, diversity and inclusion at its core. • 2023 Workforce Race Equality Scheme (WRES) submitted data shows the Black Asian Minority Ethnic group is underrepresented on the Board of Directors by two colleagues. • The Trust performed better than 27% of Trusts and worse than 73%. • 2023 Workforce Disability Equality Scheme WDES data shows Board membership in respect of declared disabilities is better than 85% and worse than 15% of Trusts. • Non-Executive Director opportunities on the Board in early 2024 and the retirement of an Executive Director in late 2024 will allow action to address the situation. • The NHS equality, diversity and inclusion improvement plan published in June 2023 sets out six high-impact actions, one of which is focused on the activity of the Board. • The proposed plan comprises seven actions owned by the Board collectively and by individual Board colleagues. • Progress in delivering the actions will be reviewed quarterly.
EQIA – Equality Impact Assessment	The action plan will enable the Board of Directors to be representative of the Trust workforce.
Recommendation	The Board is asked to consider and **APPROVE** the Board Diversity action plan.

BOARD OF DIRECTORS

2 NOVEMBER 2023

BOARD DIVERSITY ACTION PLAN

1. PURPOSE

Our People Strategy has equality, diversity and inclusion at its core – we celebrate difference and are inclusive. We believe having a diverse group of people working at the Trust helps develop a whole range of ideas and solutions that ultimately delivers truly inclusive and compassionate care.

This paper proposes an action plan that will enable the Board of Directors to be representative of the Trust workforce.

2. CONTEXT

The NHS published an equality, diversity and inclusion (ED&I) plan in June 2023, co-produced through engagement with staff networks and senior leaders. The plan sets out why ED&I is a key foundation for creating a caring, efficient, productive and safe NHS. It identifies 6 high-impact actions including one for NHS Boards of Directors.

To be effective and make the best possible decisions the Board of Directors needs to have diverse, inclusive and compassionate leadership. This is key to creating a culture that values and sustains a diverse workforce. The Trust recognises that a Board made up of colleagues with a mix of experience and skills gained from a range of backgrounds and lived experience bring fresh ideas, greater challenge and enable robust decision making.

Our Workforce Race Equality Scheme (WRES) 2023 data shows the Trust performed better than 27% of Trusts and worse than 73% in respect of Black Minority Ethnic (BME) Board representation. WRES analysis shows the BME group is underrepresented on the Board by 2.5 colleagues if counting only voting members of the Board or 3.5 colleagues if non voting members are also included in the Board's make up.

Our Workforce Disability Equality Scheme (WDES) 2023 data shows the Trust performed better than 85% and worse than 15% of Trusts in respect of declared disabilities by Board colleagues.

Non-Executive Director opportunities on the Board in early 2024 and the retirement of an Executive Director in late 2024 will allow action to address the situation.

3. ACTION PLAN

The proposed Board plan comprises 7 actions owned by the Board collectively and by individual Board colleagues. The action plan is at Appendix 1.

1. Develop a clear approach to Board recruitment and selection, using competency assessment referenced in the Kark review.
2. Ensure Nominations and Remuneration Committees (CoG/BoD) 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 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.

Progress in delivering the actions will be considered quarterly.

The actions are supported by enabling activity including Board colleagues completing equality, diversity and inclusion training every 2 years, review of the Trust workforce demographic annually to ensure it represents our local communities at all leadership levels and the Board diversity profile, diversity action plan and progress published on the Trust website.

4. RECOMMENDATION

The Board is asked to **CONSIDER/APPROVE** the proposed action plan.

Nikki Hosty, Assistant Director of Human Resources
Jason Eddleston, Deputy Director of Workforce and Organisational Development

November 2023

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Board Diversity Action Plan

Board of Directors
2 November 2023

One Culture of care

Our People Strategy

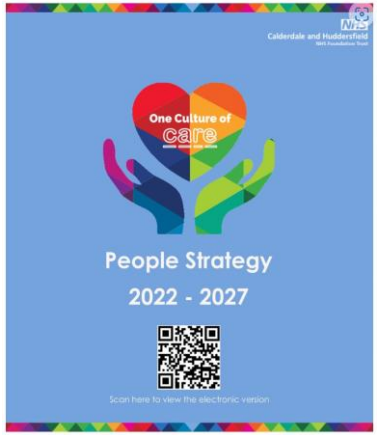
We are committed to delivering One Culture of Care for **all** our colleagues.

Our people strategy ensures we recruit and retain colleagues who are kind, compassionate and want to learn.

We will talk and listen to colleagues in a meaningful way, support wellbeing, support growth and development an collaborate when we design how we deliver services.

The People Strategy aligns closely to the six high impact action plans in the NHS ED&I Improvement Plan and our commitments reflect the importance of ED&I:-

- We celebrate difference and are inclusive.
- We prioritise colleague wellbeing.
- We seek out views and act upon them.
- We will continuously improve services for patients.
- We grow our own.
- We design services informed by the patient and colleague experience.



NHS ED&I Improvement Plan High Impact Actions

Calderdale and Huddersfield NHS Foundation Trust

High-impact actions

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

Our response to high-impact action 1

High-impact action	Activity	Lead	Timescale	Success Metric	
<u>Action 1</u> Chief Executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable .	Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process.	Rob Aitchison/Lindsay Rudge	31 March 2024	Annual chair and chief executive appraisals on EDI objectives	Board Assurance Framework
	Board members should demonstrate how organisational data and lived experience have been used to improve culture.	Rob Aitchison/Lindsay Rudge	31 March 2025		
	NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework.	Jason Eddleston	31 March 2024		

Our Inclusion Strategy

Calderdale and Huddersfield NHS Foundation Trust

We've focused attention on the ED&I agenda at the Trust since 2019. We have an established approach, working closely with colleagues to shape its focus.

Our 2023/2024 activity includes:-

- establishing an Inclusion Group reporting directly to the Workforce Committee.
- publishing ED&I education resources.
- launching our Inclusion Ally pledge.
- participating in the NHS Employers Diversity in Health and Care Partners Programme.
- supporting the West Yorkshire BAME Fellowship programme.
- partnering with local authorities/local colleges/universities to establish a Health Academy.
- establishing our Youth Network and refreshing the Women's Voices colleague network.
- introducing ILM Level 5 and Level 7 apprenticeships.
- progressing our formal Menopause accreditation work.

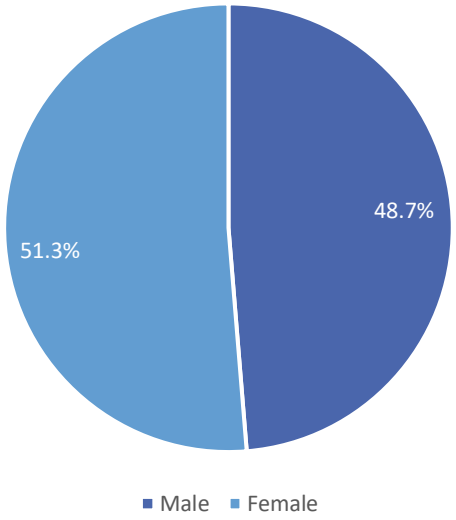
One Culture of care

Our local community demographic

Calderdale and Huddersfield NHS Foundation Trust

Calderdale

Gender



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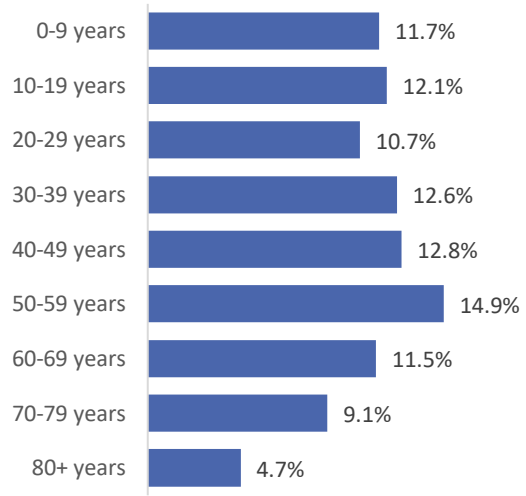

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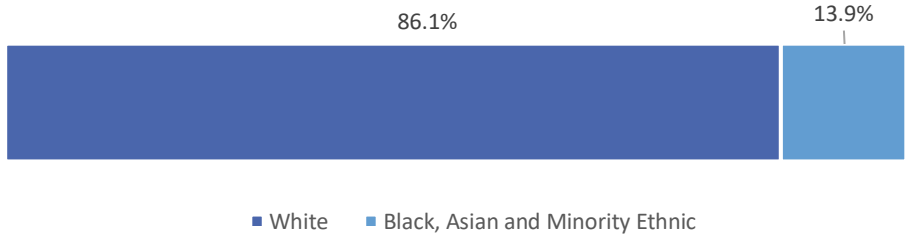
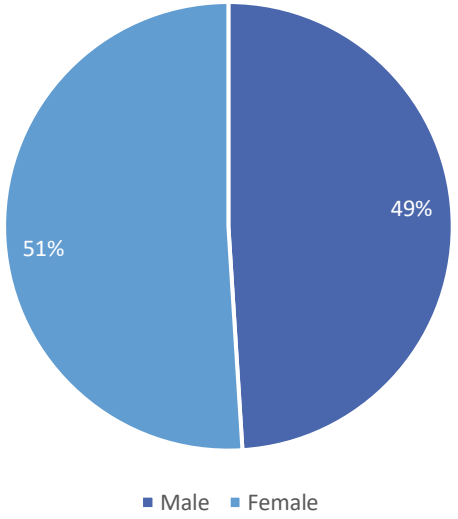


Kirklees

Gender



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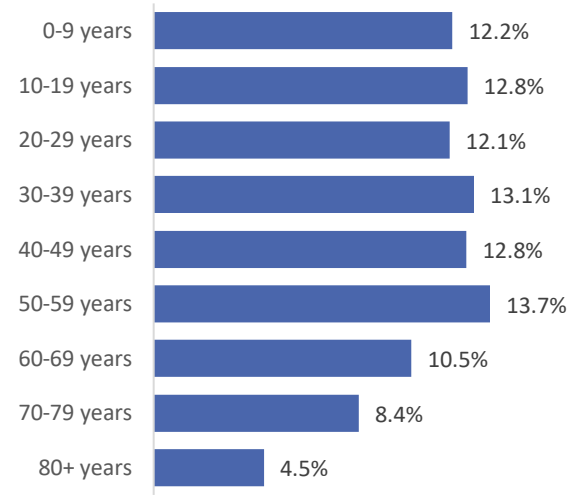

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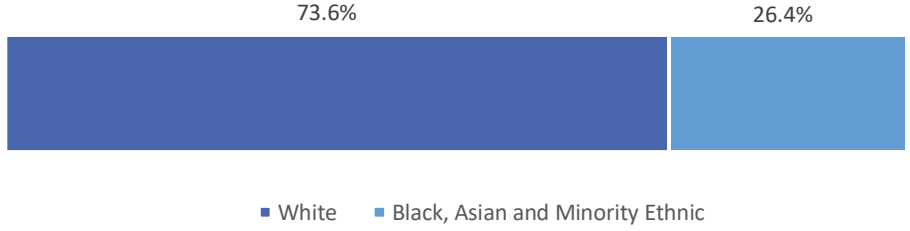
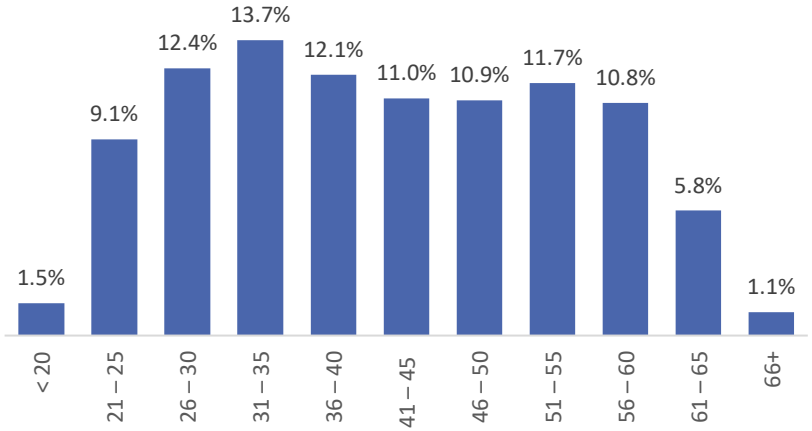
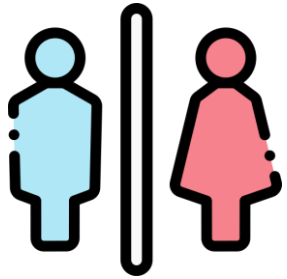


Our Trust workforce demographic

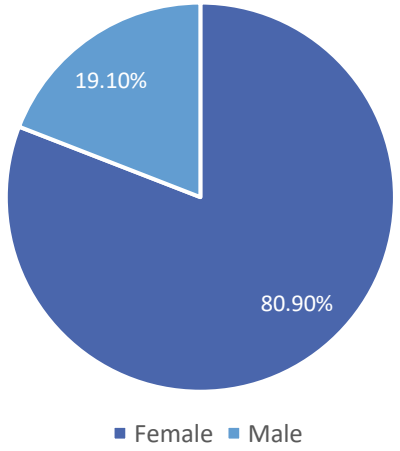
Calderdale and Huddersfield NHS Foundation Trust

Age





Gender



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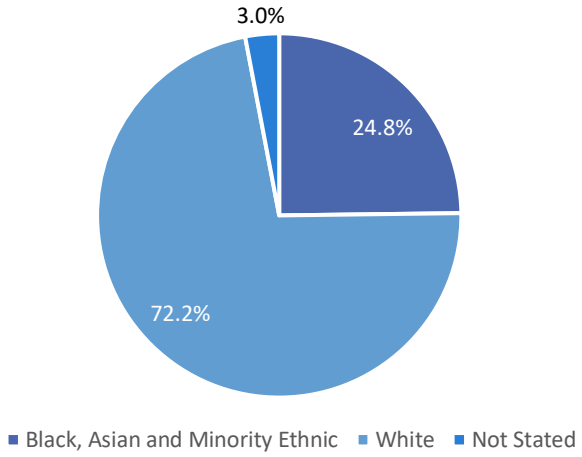
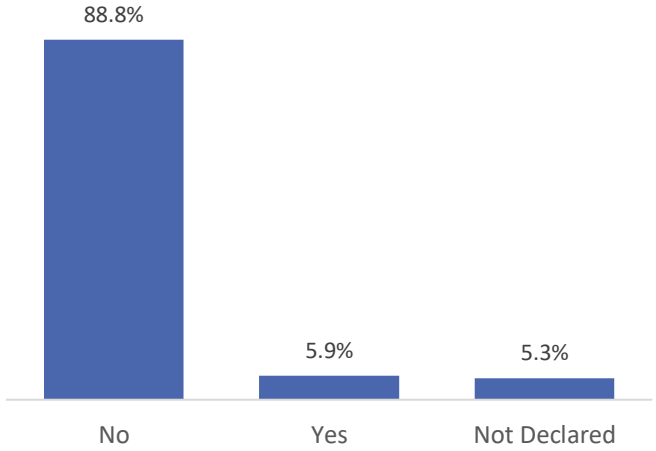


Disability Status



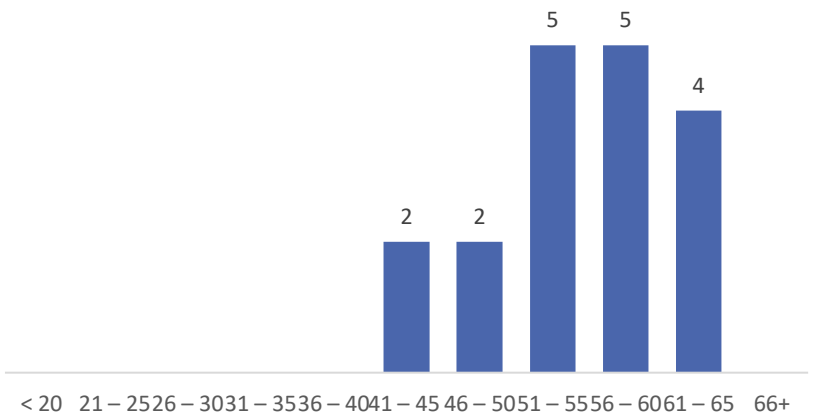
One Culture of care

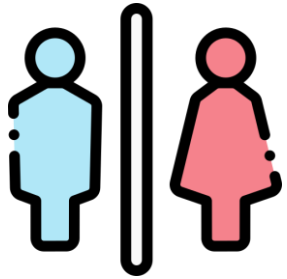
Our Board demographic

Includes: -
BB, RA, SD, GB, DB, LR, RB, AB, VP, JH, SS
HH, TB, NB, AN, DS, KH, PW

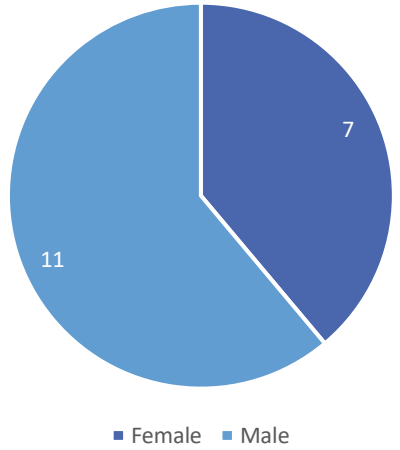
NHS
Calderdale and Huddersfield
NHS Foundation Trust

Age

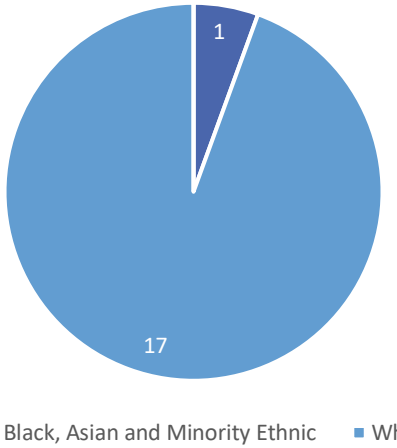




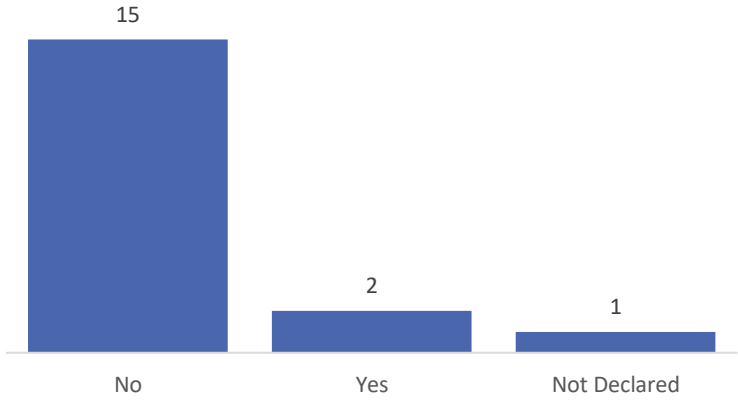
Gender



Ethnicity



Disability Status



One Culture of care

WRES submitted data shows BAME is underrepresented on the Board by 2 members. The Trust performed better than 27% of Trusts and worse than 73% of Trusts

WDES data shows Board membership in respect of declared disabilities is better than 85% and worse than 15% of Trusts

Our proposed Board diversity action plan

Calderdale and Huddersfield NHS Foundation Trust

Result: A Board that is representative of our workforce demographic.

Response	Lead
1. Develop a clear approach to Board recruitment and selection, using competency assessment referenced in the Kark review.	Director of Workforce and OD
2. Ensure Nominations and Remuneration Committees (CoG/BoD) 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.	Director of Workforce and OD/Company Secretary
3. Complete an annual evaluation of Board colleague skills/experience/knowledge in relation to ED&I.	Company Secretary
4. The Board succession plan to be updated annually at the start of each service year.	Director of Workforce and OD
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.	Board of Directors
6. Continue to grow the Shadow Board with a clear focus on ED&I and the diversity of senior leadership.	Deputy Chief Executive(s)
7. Support applications for/participation in national/regional Aspirant Director/Board development programmes.	All Board colleagues

One Culture of care

8. Chair’s Report

To Note

Presented by Helen Hirst

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	2 November 2023
Meeting:	Board of Directors
Title:	Chair's Update
Author:	Helen Hirst, Chair
Sponsoring Director:	N/A
Previous Forums:	None
Purpose of the Report	To update the Board on the actions and activity of the Chair.
Key Points to Note	The enclosed report details information on key issues and activities the Trust Chair has been involved in over the past two months within the Trust, with local system partners and regional and national work.
EQIA – Equality Impact Assessment	The attached paper is for information only and does not disadvantage individuals or groups negatively.
Recommendation	The Board is asked to **NOTE** the report of the Chair.

Chair's Report to the Board

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

1. **Trust activities**

This month, with a changeover in the Council of Governors I have enjoyed spending time with our new stakeholder and staff governors - Jo Lawson, Jules Williams, Josh Fenton-Glynn and Emma Karim, running a development session for the Council of Governors (CoG) and our first CoG with the new team.

I have continued to meet up with new people in the Trust, from attending the clinical apprentices programme to two evenings arranged by Neeraj Bhasin, to bring Consultants, specialist and specialty doctors together in a more informal, social setting.

I gave a brief talk to the Trust's Menopause Peer Support Group, during the week of World Menopause Day, and shared my own experiences of the menopause.

Following the last Board meeting, Brendan and I met with Andrea Gillespie, Freedom to Speak up Guardian and had a good conversation which included capacity to support colleagues, an open culture and learning from others within her network.

I attended the Yorkshire regional Organ Donation Committee (ODC) chairs meeting. This is a useful network for ODC chairs to discuss the challenges that face Trusts and learn from each other.

Our Board development session this month covered One Culture of Care – reflecting whether we need to change anything in our approach and being confident that this approach remains relevant. We spent the much of the session on patient safety, quality improvement and NHS Impact and the new CQC assessment framework. We also heard from Rob and Anna about our Shadow Board. The Shadow Board is one of a number of developments in the Trust to support our Board and leadership diversity. We will hear more about this at this Board meeting as well as hearing from Krish Pilicudale, an Insight Programme participant assigned to the Trust and sponsored and supported by me.

Finally, it was great to go on the tour of the new A&E at Huddersfield. I went on the 'public' day and was pleased I had gone early before the rush!

2. **Health and Care System**

West Yorkshire ICS Partnership Board was held on the first Tuesday of September. It was in two halves – a formal meeting available to watch online and a development session where we discussed the model of mutual accountability and our partnership's ambition. At the formal meeting we were joined by West Yorkshire's Mayor, Tracey Brabin as we discussed the partnership agreement between the ICB and the West Yorkshire Combined Authority.

A meeting of West Yorkshire NHS Chairs preceded the Board where we discussed collective efforts to improve the diversity of non- executive directors something we are

pursuing with partners across West Yorkshire. One of these is the Insight Programme referenced above and the other is an open evening for prospective NEDs on 26 October 2023 where I am talking about my own experience of becoming a Chair, Board development and trailing our upcoming vacancies. Cathy Elliot, Chair of the Integrated Care Board is hosting the session and Keith Ramsey Chair at Mid Yorkshire Hospitals and Colin Lynch, Chair designate of Locala are also speaking.

WYAAT CIC was held at the end of July and as well as our usual updates and assurances on WYAAT strategy and programmes of work we were joined by the chair and chief executive from Yorkshire Ambulance Service and colleagues from the West Yorkshire community collaborative to discuss, separately, our shared agenda and opportunities for partnership,

I attended the opening of the Centre for Laboratory Medicine, along with David Birkenhead and Brendan Brown. As well as the official ceremony, we had a tour of the facility and met colleagues, some from CHFT, who will be working in this fabulous, state of the art partnership facility.

Other system/ partner meetings and events included Brendan and I met with Jo Bibby, Chair of the Calderdale Cares Partnership Board, meetings with Cathy Elliot, ICB Chair and various one to ones with other Trust chairs.

National/other

September was a month of reflection for NHS Boards across the country since the trial of Lucy Letby. I attended two events with other Chairs and Chief Executives. The first of these Brendan and I reported back on verbally at the last Board. The second focused on the effectiveness of Boards and the quality improvement agenda and the role of NHS Impact, something we explored further at our internal Board development session referenced above.

I am a member of the strategic advisory board for the Yorkshire and Humber Health Innovation Network (previously known as the Academic Health Science Network) and attended our quarterly meeting at Calderdale College where our focus was workforce innovation. There were a range of presentations from across Yorkshire and Humber and some clear opportunities to learn and share across the wider health and care system. Being held in Calderdale, it also provided a good opportunity to hear about developments that we are involved in such as simulation training. One of our colleagues, Caren Reid gave a fantastic presentation about the work she has led on training for simulation technicians and the creation of the first apprenticeship programme.

Helen Hirst
Chair
25 October 2023

9. Chief Executive’s Report

To Note

Presented by Brendan Brown

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
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	• It is important that we consider the impact of international events on our people in the Trust. • We continue to see high levels of patients attending our accident and emergency departments and we have a high bed occupancy as a result. • There are a number of our services experiencing programmes of external assessment and scrutiny. • We are completing the inspection and review of our new A&E at Huddersfield to ensure it is fully ready prior to opening. • Our annual colleagues' awards take place on the same day as this Board meeting, and we have had a record number of nominations and shortlisted entries. • The Trust is forecasting to deliver the planned £20.80m financial deficit but this will be challenging given the recent strikes and the ongoing level of activity.
EQIA – Equality Impact Assessment	There are no differential equality impacts resulting from the areas of work highlighted in this report at the point of writing.
Recommendation	The Board of Directors are requested to receive this paper as assurance and progress against both the local and national agenda, and as an update against leadership responsibilities within the CEO portfolio.

Calderdale and Huddersfield NHS Foundation Trust
Chief Executive's Report
2 November 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. As I write this report we continue to see the tragic events continue in the Middle East. I know that while these events are happening more than 2,000 miles away, colleagues across the Trust, and the people in our care, will be affected by these events, just as there are those equally affected by the ongoing war in Ukraine. We work with and care for people of all races and religions equally. We also stand with our communities who are suffering racist attacks and abuse physically and across social media platforms.

1.3. We have reminded all colleagues of the support available to them if they are struggling or impacted by these events and the need to ensure we remain true to our values of one culture of care.

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

2.1. Against a backdrop of political, socio-economic unrest, and ongoing industrial action we continue to have strong operational performance. Board colleagues will see from the Integrated Performance Report on the agenda for this meeting that we continue to perform well in terms of elective recovery and remain the best performing Trust in West Yorkshire as well as one of the best nationally.

2.2. Cancer performance continues to be strong, with the two-week, 28 day, and 62-day referral to diagnosis and treatment standards being met.

2.3. We are still seeing extremely high attendances at both of our Accident and Emergency (A&E) departments. As a result, we have opened all our additional beds and have 100% bed occupancy against a national target of 92%. We are not yet meeting the national target of 76% of patients being seen within four hours, which all trusts are required to achieve by March 2024. We have had particularly long waits for those not assessed as being urgent. Our transfer of care list is increasing, with patients who are medically fit for discharge. We continue to work with those patients who have had a long length of stay, reducing those who have been with us over 100 days down to one. There is an increasing level of acuity of our patients including paediatrics and patients being cared for in the community.

2.4. Making full use of our same day emergency care service, our virtual wards, our community services, and our emergency community response is a key part of helping to manage the capacity within the hospital. We are also collaborating closely with partners to ensure that patients who are medically fit for discharge are safely discharged as quickly as possible. Nevertheless, the consistent high attendances at A&E are a concern ahead of what we know will be a challenging winter period. Our two local places (Calderdale Cares Health and Care Partnership and Kirklees Health and Care Partnership) have recently approved a Winter

Plan. Our Resilience Plan, recognising that pressures occur all year round, describing the structure within which operational pressures will be anticipated and managed is included on the agenda for approval at this meeting. It sets out the arrangements during the winter period and provides the framework for managers and clinicians in the Trust to work together and with other organisations.

2.5. The quality and safety of the services we provide remains our key priority, including at times of pressure. Last month the Care Quality Commission (CQC) visited the Trust to look at our medical discharge and medicines management arrangements. The feedback from the team on the day was positive and they commented that patient care is at the centre of everything we do at the Trust, there are obvious positive working relationships between the teams, and that teams are enthusiastic, positive, open, and passionate about what they do. CQC colleagues were also impressed with the work of the BLOSM team (our service supporting vulnerable young people in A&E) and with our initiatives in place to support carers who were not carers before admission.

2.6. The CQC recently published their Annual Inpatient Survey in which we performed well. The survey looks at the experiences of people who stayed at least one night in hospital as an inpatient during November 2022. Questions included in the survey follow people's journeys from admission to hospital, treatment, and discharge. Patients had confidence in the doctors and nurses treating and looking after them, and felt they were treated with dignity and respect.

2.7. The CQC has also recently published its annual report on the state of health care and adult social care in England. While this report looks at the trends nationally, it also shares examples of good and outstanding care, and highlights where care needs to improve, providing an opportunity for us to review and consider where we can make improvements to the care we provide.

2.8. Over the next couple of months we will receive a number of assessments and reviews including the Joint Advisory Group Accreditation of endoscopy services; Calderdale CQC / OFSTED Special Educational Needs and Disability Inspection which includes our nursing service in Special Schools and our paediatric ward at Calderdale Royal Hospital; the West Yorkshire and Humber Local Maternity and Neonatal System Assurance Visit; Yorkshire and Humber Paediatric Surgery and Anaesthesia Standards Review; and the Radiology United Kingdom Accreditation Service Inspection. These regulatory assurance visits are important to evaluate the quality of the services we offer and to ensure we are keeping up to date with best practice. We do also need to remember that they place additional pressures on our colleagues at a time of heightened patient activity.

2.9. I am pleased to report that four years on from being part of the first shared UNICEF UK Baby Friendly Initiative (BFI) Gold assessment in the country, our teams have achieved the standard again. Led by the Infant Feeding Team we were jointly assessed with Calderdale Health Visiting Services, Locala and Public Health Early Years. The assessors described the Trust as "an organisation in the forefront of BFI."

2.10. The Achieving Sustainability Gold Award is intended to be an organisational roadmap for how to implement Baby Friendly care in a way that is both effective in the short-term and sustainable over time. It involves a significant amount of work undertaken over several years to secure Gold Award status.

2.11. Colleagues on Ward 12 at HRI and the Stroke Floor at CRH have been recognised by Healthwatch Kirklees for going above and beyond regarding the end-of-life care they provide to their patients. The feedback had been received from patients' relatives and both teams were invited to the launch of the Kirklees Dying Well Campaign.

2.12. As part of World Patient Safety Day, Our Community Health Care Division launched their first Patients' Charter. The aim of a Patients' Charter is to set out the commitment our community services make to patients, their families, and carers. It encourages patients to ask questions about their care and treatment, to tell staff if they do not understand and need support in engaging with their care or if they have any concerns. The Charter supports the principle of mutual respect and is about staff and patients working together as a partnership.

3. Transforming services and population outcomes

3.1. During September and October, we opened the doors of the new A&E at Huddersfield to enable colleagues, partners, residents, and the communities to experience the new facility. Feedback on the way finding, facilities, and environment has been extremely positive.

3.2. As with any new construction, and particularly one of this size and complexity, it is important that a thorough final inspection and review is undertaken to ensure that the building is fully ready and meets required quality and safety standards before opening for service delivery. We are working hard with our construction partner to complete this review and any outstanding works. Based on the progress of this work, we will decide in November as to whether to open the new A&E department prior to or after Christmas, given the increase in activity that all hospitals see in the emergency departments in December and early January. We will keep all stakeholders and members of the public informed of our opening plans.

3.3. Work is progressing on the new community diagnostic centres for Halifax and Huddersfield. The centre in Halifax will be based in Broad Street and is due to open in Spring 2024. It will offer cardio-respiratory testing, phlebotomy, CT scanning, Xray and ultrasound.

3.4. Calderdale and Huddersfield NHS Charity has been shortlisted for the Charity of the Year in the Calderdale Community Spirit Awards being held on 23 November. The shortlisted nomination focused on the Charity's contribution to kit out the newly opened Rainbow Community Hub in Elland, and how donations have made a difference to families within the Calderdale area.

3.5. Following a visit from clinical and executive teams from a health system in Sweden earlier in the year, a small team from CHFT paid a return visit to look at how they use electronic and digital systems for the provision of health care and gathering data intelligence. Rob Birkett, Chief Digital and Information Officer will provide an update from the visit at the meeting.

3.6. The Director of Public Health in Kirklees has published her Annual Report focusing on poverty. This report focuses on the lived experiences of Kirklees residents, living across the borough in a range of circumstances. We are discussing health inequalities at today's meeting, and it is important that in addition to our provision of health care, we consider our contribution to addressing poverty locally through our role as an anchor partner. One of the

key elements of the build of the new A&E at Huddersfield was ensuring that the local economy and wider community benefitted from the investment being made in our hospital. Our Foundations for the Future website describes the 'social value' we achieved as part of the new build including taking on apprentices in building trades who then went on to secure permanent employment, and using exclusively local suppliers. Our intention is that we will apply the same principles in the Calderdale build. We are keen to strengthen this approach and have been working with Kirklees Council and the University of Huddersfield on expanding the social value we can secure together from our large-scale building projects and developments.

4. Inclusive workforce and local employment

4.1. During October we held appreciation week, encouraging our people to recognise the good work and positive impact of their colleagues in line with our value of One Culture of Care. Executives visited areas across the Trust to take small treats and to talk to colleagues about their experience of working for the Trust and we promoted excellent examples of colleagues doing things large and small for their patients and the people they work alongside. Just one example of excellence in the midst all the pressures, was how colleagues on the acute floor managed to organise an incredibly special wedding in around six hours for a couple going through the most heart breaking of times. Ben and Jess got married and despite the circumstances it really was a special day. Congratulations and best wishes to Ben and Jess and a massive well done to the whole acute floor team (and the chaplain) for making this happen.

Photo used with permission of Ben and Jess

4.2. We will be celebrating the outstanding compassionate care provided by teams and individuals across the Trust as part of annual CHuFT awards following this Board meeting. We received a record breaking 339 nominations and have thirty-five finalists for the seven awards (One Culture of Care; Putting People First; We do the must dos; Work together to get results; Go see; Rising Apprentice; and Driving digital innovation and change). It is a cliché to say it but although we pick one winner per category, all of them are deserving of an award and I look forward to seeing all the shortlisted entries.

4.3. The national Staff Survey is currently running, and we are encouraging all colleagues to share their views to inform and influence future improvements and help to improve their working experience.

4.4. The Board will be aware that throughout the year, across the NHS, we have experienced significant industrial action. Following strikes in October, the British Medical Association are now in talks with the Government and there is no further strike action planned at this point. The BMA have also confirmed specialist, associate specialist and specialty (SAS) doctors in England would meet the government for talks. The BMA's SAS committee said a formal ballot for industrial action would be held if no progress was made by 6 November. We continue to monitor the situation closely and support our colleagues.

4.5. At this Board meeting we will receive feedback and comment on the papers for the first time from our Shadow Board. The Shadow Board programme demonstrates an organisation's commitment to being well-led through the development and investment of senior leadership outside of the Board of Directors. These leaders can critically appraise the governance process and structures to assure the delivery of high-quality, person-centred care. This supports learning and innovation whilst promoting an open, fair, and inclusive culture through diversity of thought at the most senior levels.

4.6. We also contribute to the development of senior leaders across West Yorkshire and in October celebrated the completion of the first West Yorkshire Association of Acute Trusts senior leadership programme.

4.7. October has been Black History Month and we celebrated with a launch and flag raising and a month of celebrations and learning. This year the theme was 'Saluting our sisters' - to recognise and applaud the invaluable contributions of Black women. Our Non-Executive Director, Denise Sterling, said at the launch "If you look in every corner of British society you will see imprints of their accomplishments in the arts, sciences, politics, academia, healthcare to name a few. By highlighting the trailblazers who have overcome immense challenges and adversity to achieve greatness we help promote inclusivity and representation."

4.8. On 13 October we celebrated Allied Health Professionals (AHP) Day. There are 14 AHP professions, with ten of them represented in the Trust including dietitians, podiatrists, radiographers, sonographers and speech and language therapists. There are almost 900 AHPs working at CHFT, making them our second largest workforce. This year has been a big one for AHPs, with the roll-out of AHP Preceptorship, exciting new roles within Research and Occupational Health, degree apprentices, and international recruitment - including our first intake of international Occupational Therapists and Radiographers. Thank you to all our AHPs, and support workers for their hard work, dedication, and motivation, and for always looking after each other and showing incredible care to your patients.

4.9. Our second cohort of digital nursing associates start with us this month. This is an innovative and successful programme for the Trust working with the local university and colleges.

4.10. It was a pleasure to see our A&E Consultant Andy Lockey receive his MBE for his work leading the Resuscitation Council UK's 'Restart a Heart' initiative since it began in 2016. The prestigious ceremony, hosted by Anne, The Princess Royal, took place at Windsor Castle. Andy took his 93-year-old mum, along with his brother and sister-in-law to the ceremony. Congratulations Andy.

5. Financial, economic, and environmental sustainability

5.1. The finance report at this meeting shows a £12.57m deficit, a £0.91m adverse variance from plan. The in-month position is a deficit of £1.49m, a £0.70m 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 and the continued high numbers of patients attending our A&Es plus strike costs of £2.12m; and non-pay inflationary pressures.

5.3. The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £6.69m. We have a strong history of delivering cost efficiencies and have well developed plans to deliver £25.8m of savings this year. We will need to consider our final forecast for the year at the next Board meeting.

5.4. The report back from Finance and Performance Committee demonstrates that we have an ambitious capital programme in place and continue to make investment across all areas of the Trust including the new Community Diagnostic Centre in Halifax and a new CT scanner.

5.5. We continue to focus on improving our environmental sustainability and have recently installed new electric car charging points on the Huddersfield Royal Infirmary site.

6. Recommendations

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

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

10. Strategic Objectives Progress Report

To Note

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title of report:	2023-24 Annual Strategic Plan – Progress Report
Author:	Anna Basford, Deputy Chief Executive / Director of Transformation and Partnerships (with input from all Executive Directors)
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None
Purpose of the Report	Provide an update on progress against the 2023-24 annual strategic plan.
Key Points to Note	In March 2023 the Trust Board approved a refreshed five year strategic plan and the one year strategic objectives for 2023-24. The strategic plans describe the Trust's ambitions across the four goals: • To transform patient care and population health outcomes • To provide the best quality and safety of care • To be the best place to work, supporting a workforce for the future • To be sustainable in our use of financial and environmental resources This report provides an update on progress to implement the 2023-24 annual strategic objectives.
EQIA – Equality Impact Assessment	For each objective described in the annual strategic plan the Lead Director is responsible for ensuring that Quality and Equality Impact Assessment is undertaken and where possible that this follows best practice to involve patients, public and colleagues in the process of assessment and the agreement of any required actions to mitigate risks or negative impacts.
Recommendation	The Board is requested to **NOTE** the assessment of progress against the 2023-24 strategic plan.

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

Purpose of Report

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

Structure of Report

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

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

For each objective the following information is provided:

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

Summary

This report highlights that of the 15 objectives:

0	are rated red
1	is rated amber
14	are rated green
0	has been completed

Recommendation

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

2023-24 strategic plan on a page

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

Our vision:

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

Our values and behaviours:

- We put patients and people first
- We go see
- We work together to get results
- We do the 'must dos'
- We care for ourselves and each other in the same way we care for our patients through 'one culture of care'

Our goals and results:

Transforming services and population outcomes

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

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

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

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

Keeping the base safe – best quality and safety of care

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

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

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

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

Inclusive workforce and local employment

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

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

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

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

Financial, economic and environmental sustainability

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

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

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

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
Transforming and improving patient care	We will have opened the new A&E at HRI and commenced construction of the new Learning and Development (L&D) Centre and Multi-storey Car Park (MSCP) at CRH.	**GREEN** on track	Construction of the new A&E at HRI has been completed. The Trust is working with the Construction Partner IHP to address estates 'snagging' issues and to commission the building prior to confirming the opening date for service delivery. The Trust is progressing dialogue with DHSC and Treasury regarding approval of the Reconfiguration Outline Business Case. Plans have been developed to commence enabling works for the MSCP and construction of the new Learning and Development Centre at CRH.	**We will have built new 'state of the art' hospital buildings that will enable delivery of the best safety, outcomes and experience of care for people.** **Lead: AB** Transformation Programme Board, Trust Board ICS, NHSE, DHSC	20 BAF Risk 1/19 Reconfiguration	• Opening date of new A&E • Confirmed dates for construction of new L&D Centre and MSCP at CRH
Transforming and improving patient care	We will deliver our 12-month digital programme to improve integration within the Trust and across the system, this will provide digital developments and products (e.g. Patient	**GREEN** on track	Good progress has been made in line with the digital strategy and prioritised against operational demand and clinical requirements (Chief Operating Officer, Chief Nurse, Medical Director). Over the last 12 months key developments within the programme include: - Relaunch of Nursing Documentation - Electronic Controlled Drug Register	**Patients and colleagues will be digitally enabled to provide and receive care wherever this is needed.** **Lead: RB** Divisional digital boards	12 BAF risk 02/20 Digital Strategy	• HIMSS level (either maintain level 5 or achieve level 6 in 23/24) • Progress against CHFT Digital Strategy (e.g. continual delivery of our digital roadmap/plan) • NHSE Digital Maturity Assessment (DMA)

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	Portal, Same Day Emergency Care (SDEC) module, and ensure the infrastructure and end user devices are secure, current and designed for the role.		- Neo-natal ICU EPR roll out - Pharmacy Catalogue upgrade (Multum) - Development of SDEC EPR Module - Point of Care Testing (POCT) - Plan for every patient MPage - 2nd Cohort of Digital Nursing Placements. Our approach to Data Science has been defined through further work on waiting list validation and frailty, alongside initiating a place-based response to a High Risk Adult cohort of patients. Our infrastructure continues to be fit for purpose through the edge device replacement programme and security is assured through a compliant Data Security Protection Toolkit submission alongside Cyber Essentials accreditation, External testing and ISO 27001.	Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.		• Maintain 3 ISO Standards (27000/9001/20000)
Transforming and improving patient care	We will make progress against the Year 1 milestones in the Trust's Health Inequalities	**GREEN** on track	Delivery of the 1-year milestones in the Health Inequalities strategy continues. This includes: • Health inequalities indicators now included	**Working with partners we will use population health data to prevent ill health and reduce**	12 BAF risk 07/20 Health Inequalities	• Delivery of actions within the Trust's approved Health Inequalities strategy 2022-2025

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	Strategy within the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion and provide updates on these to the Board.		within the Trust Integrated Performance Report. • Continue to develop a "Health inequalities vulnerability index" to identify patients at increased risk of experiencing inequalities. • Continue to maintain equity of access for people with a learning disability. • The BLOSM service continues and has been recognised nationally for work done to support vulnerable service users. • Presented and shared progress at a number of national forums/learning events. • The NHS England Director of Health Inequalities made a successful visit to the Trust in September 2023. This has led to CHFT being featured in a number of forums/case studies. • The CQC commended the maternity team for the work they have done in relation to health inequalities on their most recent 'Good' inspection visit.	**health inequalities.** **Lead: RA** Health Inequalities Group Executive Board Board of Directors Health Inequalities Oversight Group (England)		• Inclusion of Health inequalities indicators within the Trust Integrated Performance Report. • Maintain equality of elective care access for different protected groups.

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
Transforming and improving patient care	We will: continue with the established successful clinical research portfolio, engaging with Partners; participate in the Integrated Care Board (ICB) Place Based Research Collaborative; work to address Health Inequalities; broaden the research portfolio to a wider group of patients, and further encourage participation in Research and Development (R&D).	**GREEN** on track	The Trust received a small increase in the National Institute for Health and Care Research (NIHR) core allocation & secured extra funding to support further improvements in research delivery this financial year. We are due to receive £25K as a result of commercial research activity increase and performance in November and in line for 3 separate financial incentives for recruiting the 1st UK patient to 3 commercial trials. Once payment is received, this will be transferred to the relevant divisions. Opportunities to increase Commercial research continue to be explored; our dedicated study set-up co-ordinator has received 165 commercial studies to review since April. This has led to in-depth feasibility assessments for 22 studies, from which we have 3 currently in set up. Our most recently opened commercial studies are within haematology and gastroenterology. Our refreshed Research Strategy launched in	**We will participate in research and innovation to improve patient care, prevent ill-health, and achieve better outcomes and faster recovery for patients.** **Lead: DB** Research Group Executive Board Quality Committee	12 BAF risk 01/20 Clinical Strategy	• Number of colleagues participating in research • Number of patients recruited to participate in research

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
			September. Engagement with partners as started, to work together to secure the ICB Place Based Research Collaborative for Calderdale & Kirklees. This month we open the CRASH 4 study, as a shared care site, which demonstrates partnership & collaboration with Yorkshire Ambulance Service, to deliver their important study. We have increased opportunities in new areas like orthopaedics and physiotherapy and embed research in neonatology and surgery. We continue to increase clinicians participating in research and are very successful, supporting colleagues through the NIHR Associate Principal Investigator (PI) scheme. One of our trainee Associate PIs, a physician associate within the surgical division is now being supported to lead a new surgical study as PI.			
Keeping the base safe	We will deliver the quality, safety and experience	**GREEN** on track	We have developed a new patient experience, involvement and inclusion strategy. The Quality and Safety strategy is	**We will be delivering and enabling outstanding**	12 BAF risk 04/20 CQC rating	• Strategies developed and approved. – progress reports

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	strategies; implement PSIRF; meet the KPIs of the Trust Quality priorities; undertake a programme of work to maintain HSMR/SHMI within expected range; support and respond to a CQC inspection of Maternity Services		under review to ensure it is reflective of the Patient Safety Incident Response Framework (PSIRF) and NHSE recommendations from the NHS delivery and continuous improvement review. The Trust is progressing with the implementation of the PSIRF framework. The Trust quality priorities are reported in the integrated performance report. Trust wide MUST (nutritional risk) scores and the KPIs for Urgent Care Response and Virtual ward within community services are under performing and actions are in place to improve performance. Mortality measures (HSMR/SHMI) are within expected ranges. The CQC inspection of Maternity services has continued to rate the service as GOOD, and an action plan is in place to respond to the 2 Must Do actions and 5 Should do actions. A quality review summit is planned for October 2023 to review progress against quality and safety indicators and	**quality, safety and experience of care for people needing hospital and community services.** **Lead: LR** Quality Committee Executive Board		against 1year objectives 23/24 • Progress update against PSIRF national implementation plan • HSMR/SHMI within expected range IPR report metric • Quality Priority targets achievement metrics within IPR • Compliance with the Maternity CQC MUST Do action plan

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
			quality improvement priorities with senior leadership team. The Trust MUST score compliance has improved significantly The trust submitted its action plan to the CQC following the Maternity inspection The quality summit has been held and outputs will form part of the revision of the Quality and Safety strategy. HSMR remains within expected range. The Trusts PSIRP has been submitted to the ICB as planned.			
Keeping the base safe	Working within the resources available we will meet national standards in relation to elective recovery. We will meet priority KPIs for cancer services. We will maintain our position within the top quartile of diagnostic performance. We will maintain our position	**GREEN** on track	The Trust achieved the national targets in relation to no over 104 week and no over 78 week waits by the end of the financial year. In addition, the volume of over 52 week waits reduced significantly and compares favourable regionally and nationally and remains on track to meet the target of no over 52 weeks by end of financial year 2023/24. The Trust continues to achieve cancer access standards ensuring that people who have an urgent referral from their GP for suspected	**We will be consistently achieving key performance targets that matter most to patients.** **Lead: JH** Integrated Board Report Executive Board Audit and Risk Committee Finance and Performance Committee	16 BAF risk 05/20 Recovery	• The monthly Integrated Performance Report details performance against key targets.

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	within the top quartile nationally of ED performance, with a focus on ambulance waits over 30 minutes and over 12 hour ED waits.		cancer receive the timely treatment they need. The Trust's performance on the Accident and Emergency 4 hour waiting time standard continues to perform better than most Trusts despite increasing demand on services. Emergency Department (ED) performance for August was 70.32% against the target of 76%. CHFT placed in the top 10 Acute Trusts nationally for type 1 ED performance. The Trust also continues to perform well in relation to timely ambulance handover.	Access Delivery Group		
Keeping the base safe	We will complete the governance review; deliver the key elements of the System Oversight Framework (SOF); ensure compliance with the new CQC framework.	**GREEN** on track	Governance review due to be finalised by end of September. Update of IPR stage one complete and will be further reviewed in three months, which demonstrates compliance with key elements of the SOF. CQC new Assessment Framework will be published and rolled out in the South Network in November 23 with staged implementation for all providers using the new framework by March 24. Once published will undertake self-	**We will be 'well-led' and governed and compliant with our statutory duties.** **Lead: VP** Executive Board Trust Board	16 BAF risk 3/23 Partnerships 6 BAF risk 16/19 Health & Safety 12 BAF risk 4/20 CQC rating	CQC Good SOF segment 2 •

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

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
			Maternity services has an established workstream. The RESPECT project continues to be rolled out across the organisation. Ongoing work within the health inequalities group to deliver the plans working with partners. The birth centre remains suspended at HRI due to the Maternity staffing position. A strategy Director of Midwifery is in place across the Calderdale, Kirklees, Wakefield place to oversee partnership working across both midwifery services.			
A workforce fit for the future	We will increase emphasis on appreciation and continue to focus on providing a healthy workplace, providing access to physical, mental and financial wellbeing advice.	**GREEN** on track	• In-person welcome and induction events for new employees reintroduced with a focus on One Culture of Care and showcasing the Trust wellbeing offer. • Delivery of a 12-month engagement and wellbeing calendar that focuses on celebrating success, appreciation, recognition, support, reward and increased staff survey uptake paying particular attention to divisional hotspot areas is underway. • Annual CHuFT award event on 2 November 2023	**We will be widely known as one of the best places to work through an embedded one culture of care - supporting the health and wellbeing of all colleagues.** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention	• Reduction in sickness absence rates.

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
			• Staff survey hotspots identified, and high impact action plans created. • 'How to guide to appraisals' video now available as part of our management fundamentals offer, to make it a more people centred conversation. • Implementation of a tiered approach to intervention low (CareFirst, Friendly Ear service, peer support), medium (virtual mental health kit, psycho ed groups, critical incident debrief) and high (1:1 assessment and therapy) • Deep dives into sickness absence hotspots with divisional teams to develop plan on a page for each area. • Youth Forum launched in August 2023. Monthly line manager bulletin			
A workforce fit for the future	We will ensure personal and professional development is accessible and open to all through health academies,	**GREEN** on track	• Increased focus on greater apprenticeship take-up and deployment of levy funds with workshops delivered from August 2023 and monthly workstream reports in place.	**We will foster an open learning culture that demonstrates lessons learnt, and actively seeks and**	12 BAF risk 11/19 Recruitment and Retention	• Increase in internal apprenticeships

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	apprenticeships, equality, diversity and inclusion education and awareness.		• 'Go see' approach adopted to assess how other organisation measure/ record internal mobility. • All Trust colleagues able to access free of charge Maths and English qualifications. • 'Development for all' offer is in place. • Management Fundamentals now available. • 'New to Manager' programme launch by 31 August 2023. • 'Empower' personal development programme is continuing. • A programme of 'Connect and Learn' sessions available to all colleagues. • New Shadow Board launched in September 2023.	**celebrates best practice.** **Lead: SD** Workforce Committee		
A workforce fit for the future	We will deploy workforce planning tools to design roles and approaches to deliver our reconfigured hospital and community services and implement an	**GREEN** on track	• Implementing inclusive recruitment during 2023/2024 to improve representations at all levels in the Trust. • Continued work at Trust and Place to embed annual workforce planning activity and refine Trust	**We will have a diverse and inclusive workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.** **Lead: SD**	12 BAF risk 11/19 Recruitment and Retention	• Delivery of the Reconfiguration Target Operating Models

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	inclusive recruitment approach aligned to our values and behaviours.		reconfiguration workforce requirements. • Explorative work being undertaken to research recruitment of refugee communities into volunteering at PLACE / Healthwatch. • Reconfiguration Workforce Lead working collaboratively with service leads to design future workforce models. • Action plan developed in response to NHS Long Term Workforce Plan. • Tools to support Nursing and AHP future planning have been created and updated on a regular basis. • Access to Work and Reasonable Adjustments guidance documents have been published. • Work continues on a Disability Passport.	Workforce Committee		
A workforce fit for the future	We will increase routes into employment, working with Calderdale and Kirklees Councils and further education partners to	**GREEN** on track	• Delivery of regular Trust wide careers events working with a range of internal and external stakeholders – 4 events planned for 2023/2024. • Active engagement with local community groups targeting under	**We will work with partners to create local employment, career and development opportunities for people.**	12 BAF risk 11/19 Recruitment and Retention	• Increase in apprenticeships, T-levels, Project Search interns

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	develop a Health Academy for Calderdale and Kirklees.		representation in our workforce. • Improved utilisation of apprenticeship levy with a new dashboard launched to show take up. • Comprehensive employability support including applications and interview techniques is available. • Continued focus on partnership development including LA's, Princes Trust, DWP, Education providers, Third sector so to enable us to reach out further and support additional underrepresented groups. • Ongoing explorative work with clinical leads with the focus to target T Level cadets.	**Lead: SD** Workforce Committee		
Sustainability	Deliver the ICB and NHSE approved financial plan. Demonstrate improved performance against Use of Resources key metrics and	**AMBER** Off track – with plan	**Delivery of plan** The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario includes £7.1m of unidentified mitigation required to offset forecast pressures and emerging risks. A number of actions are underway to contain expenditure run rate and	**We will be consistently delivering our annual financial plans and demonstrating value for money.** **Lead: GB / KA**	16 BAF risk 07/19 Compliance	• Year to date financial performance presented monthly at both Board and Finance and performance committee

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	NHSE productivity metrics.		identify cost improvement programme mitigation. **Productivity metrics** • The latest issue of NHSE Acute Provider Productivity metrics shows an improving productivity trajectory for the Trust. Productivity opportunity remains based on the baseline year of 2019/20 (pre-pandemic), this is in line with peer organisations.). Month 4 data shows the opportunity for CHFT to be lower than national average and lowest amongst WYAAT peers which suggests we have improved our productivity more so than others.	Reported to Finance & Performance Committee Monthly regulator discussions		• Quarterly receipt of NHS productivity / opportunity tool
Sustainability	We will: develop a calendar of sustainability engagement events for 2023/24; achieve a minimum recycling target of 40% for non-clinical waste streams; work to reduce single	**GREEN** on track	The Green Plan was first approved by Transformation Programme Board in March 2021. Delivery is managed by the CHS and progress against the Sustainable Action Plan (SAP) is monitored through the bi-monthly Green Planning sub-group Chaired by the MD of CHS. The Green Plan is a Board approved document which is submitted at ICS level. Some	**We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.** **Lead: SS**	8 BAF risk 06/20 Climate Action	• a 100% reduction in direct (scope 1) carbon dioxide equivalent emissions by 2040. An 80% reduction will be achieved by 2032 • convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028 • a minimum recycling target of 40% for non-clinical waste streams

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
	occupancy vehicle journeys by 5% by 2026; make progress towards our targets of a 100% reduction in emissions by 2040 and to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028		of the key progress this year include: • We received around 1000 responses to our new travel survey which went out for consultation in February 2023 and will update the travel plan accordingly. • The Trusts Green Plan and Sustainability Action Plan outlines individual actions across 11 key themes. In total there are 206 interventions proposed. 159 of these actions are designated as complete. We are also developing a calendar of sustainability engagement events for 2023/24. • Audit Yorkshire – Sustainability audit gave significant assurance and confirmed that CHFT is demonstrating a commitment to minimising its adverse impact on the environment • A heat decarbonisation plan with actions has been developed for both hospital sites • 94% of CHS fleet currently ultra-low emissions vehicles	Transformation Programme Board Trust Board		• a 5% reduction in single occupancy journeys by 2026 •

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
			• 100% of our energy is bought from green sources • a Travel Plan has been adopted by the Trust to support more active travel. The Travel Plan outlines 47 individual actions across 4 key themes and 39 out of the 47 actions are designated as complete. • HRI reconfiguration scheme is on track to meet BREEAM Excellent requirements for sustainable design in new construction • 10 new secure cycle lockers and 2 Sheffield Stands with capacity for up to 8 bikes each, installed in key locations across the site at HRI along with new shower and locker facilities • a Biodiversity Management Plan has been developed covering our estate. Since November 2022, over 600 trees have been planted at HRI • CHS is an active member of Kirklees climate commission and Calderdale Councils climate action plan group. • We have started our sustainability events. In			

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
			September we had a 'Car Free Day 2023' on both sites to encourage more active travel and offered vouchers at our restaurants for staff who choose to cycle to work on this day. We have further events planned throughout 2023/24. We have also developed, and the Green Planning committee has approved the new green plan branding which can be used on all email footers, teams background and the cover art for use to promote our green plan.			
Sustainability	We will demonstrate the additional social value generated by investment in the new A&E at HRI to create local jobs, training opportunities and to support local businesses.	**GREEN** on track	The Trust's construction partner for the new A&E has met all targets set across the different aspects of Social Value. An overview is provided below. Overall the project has achieved 75% local labour supply and 100% of supply chain spend locally. **Jobs** A partnership with Kirklees College enabled apprentices from the college to spend time on work placements on the A&E development site, alongside experienced construction workers in areas such as	**Our investments and use of resources will be generating Social Value to support economic recovery in Calderdale and Kirklees Places.** **Lead: AB** Transformation Programme Board Trust Board	9 BAF risk 2/23 Social Value	• % Local Labour • % Local Supply Chain •

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
			plumbing, electrical and bricklaying. Other activities include: • Employer visits with Calderdale and Kirklees Careers Advisors who work directly with adults as well as young people in schools and colleges. • Presentations to Kirklees College students who are looking to find employment within construction. • Attendance and presentation at a “Women in Construction” event at Kirklees College **Growth** The partners engaged with the development of the A&E are almost exclusively local firms, and a local workforce using local suppliers. 16 local suppliers have been used. **Social** Construction partner colleagues have facilitated learning through play at a local nursery and have supported community litter picking activities. **Environment** The HRI A&E development remains on target for BREAMM Excellent accreditation.			

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score	Indicative Measure of Delivery
			Initiatives included in the development are: • Vacuum excavation around existing trees and vegetation • Utilisation of Sustainable Urban Drainage Systems (SUDS) • Ensuring the total number of trees and shrubbery is increased following completion. • Installation of Air Source Heat Pumps			

11. Health Inequalities Update

To Note

Presented by Anna Basford

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title:	Health Inequalities Strategy Update
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	We are currently completing the first annual review and refresh 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) which will maintain oversight of and responsibility for the action plan. We will continue to present regular updates on progress and key developments to Board throughout the year. The accompanying presentation outlines what is planned next across the four priority areas (connecting with our communities and partners, equitable access and prioritisation, lived experience and outcomes, diverse and inclusive workforce). Key elements to highlight within this update include: • A recent visit from Dr Bola Owolabi (Director of Health inequalities at NHSE) to learn about CHFT's approach to health inequalities. • Targeted work is underway to try to reduce inequalities in patients who do not attend (DNAs). • The initiation of a new project to improve patient communication and letters in order to reduce DNAs both overall and particularly inequalities.

	• We are looking at developing our role as a Trust in addressing poverty as a health issues, including promoting poverty aware practice and poverty proofing pathways within 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 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** this update on the Health Inequalities Strategy.

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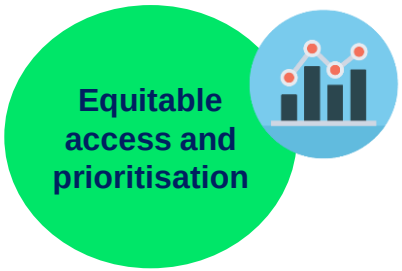
Progress update against the Trust's Population Health & Inequalities Strategy

2nd November 2023



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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

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Visit from Dr Bola Owolabi

NHS England Director of Healthcare Inequalities, Dr Bola Owolabi, visited CHFT in August, following our success in areas that have gained national recognition, such as reducing inequalities in waiting times.

Bola visited heard from several teams to learn about the work they're doing, including:

- Work undertaken to improve experience and outcomes for patients with learning disabilities and within maternity services
- The apprenticeships and Widening Participation programmes and the work of our Employee Inclusion networks
- A visit to the BLOSM team in ED to hear about the work they're doing to support vulnerable young people.

Bola was amazed at the work happening here and committed to 'pinching with pride' the ideas and work we're doing.

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Headline updates

- **The BLOSM service**, engaging with vulnerable service users attending ED, goes from strength to strength. This year has seen the care navigators come into post and an analyst join the service to enable evaluation of the service and demonstration of impact. The service was shortlisted for a prestigious Nursing Times award and was recently visited by New Zealand's Chief Scientific Advisor and praised as "inspirational and unique.

- Community Matron, Sarah Wilson, continues to run a pop-up clinic in North Halifax to **support vulnerable service users,** and has started working with others in the Trust to look at expanding approaches to improving communication and access for vulnerable patient.

- We have joined the Kirklees **Tackling Poverty Partnership** and are setting out our role as a Trust in addressing poverty as a health issue.

- **Targeted work is underway to reduce DNAs** and particularly to try to narrow the gap in DNAs seen between patients from the most and least deprived communities. This includes a pilot where patients identified at high risk of DNAing by our Health Inequalities Matrix and pre-emptively contacted to remind them of their appointment.

- We have initiated a new project to **improve patient communication and letters.**

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Headline updates

- Over the past 12 months there has been lots of activity in the **three focus areas for lived experience and outcomes: learning disability, maternity, and mental health.** Work continues across all these areas. This has included a deep dive into learning disability pathways, further rollout of ESOL maternity classes, and 8 CHFT colleagues becoming registered trainers for a Mental Health Making Every Contact Count approach.

- We are looking at **promoting poverty aware practice and poverty proofing pathways** within our services.

- Work over the past 12 months has included: developing a ED&I Awareness and Education Programme, embedding EDI and wellbeing conversations into appraisals, a 12-month inclusion event programme, ongoing work to grow the apprenticeship programme and utilise widening participation channels as a tool to support inclusive improvement and talent development.

- In September, the new **Shadow Board** met for the first time. 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’.

12. Charity Strategy

To Approve

Presented by Victoria Pickles

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title:	Calderdale and Huddersfield NHS Charity Strategy
Author:	Victoria Pickles, Director of Corporate Affairs
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Charitable Funds Committee
Purpose of the Report	To present the Charity Strategy for 2024-2026.
Key Points to Note	The Trust has a Charity – Calderdale and Huddersfield NHS Charity – that fundraises for and manages the range of funds held. Over recent years, and certainly since the pandemic, there has been increasing focus and increased expectations on what NHS charities are intended to do, how they are governed, the relationship with its parent trust and the turnover of funds. The Board is the Corporate Trustee of the Charity and delegates management and decision making (within a scheme of delegation) to the Charitable Funds Committee. At its meeting in August, the Committee reviewed and approved (subject to some amends) the Charity's strategy for 2024-26. This is attached for ratification by the Board as the Corporate Trustee. 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 Alongside this, a review of the governance processes, the grant and funds requesting procedures and scheme of delegation has been undertaken. There will also be training on NHS Charity governance and development for Board and committee members, and fund advisors across the Trust.

EQIA – Equality Impact Assessment	The work of the Charity is assessed to ensure that both fundraisers and beneficiaries are supported equally and equitably and are able to engage with Charity.
Recommendation	The Board is asked to **RATIFY** the Charity Strategy as Corporate Trustee.

Calderdale and Huddersfield NHS Charity

proud to make amazing things happen in our communities

OUR STRATEGY

2024 -2026

INTRODUCTION

This plan sets out our aspirations for patients, their families and the staff who treat them in the 2 hospitals and community health care services we support as part of Calderdale and Huddersfield NHS Foundation Trust (CHFT).

OUR VISION

To improve the health and happiness of every patient cared for in our hospitals and community. Ensuring that everyone who needs access to CHFT's services or who is employed by CHFT receives the best possible care, support, and experience.

OUR MISSION

To make a lasting and meaningful difference to patients and families in our region by funding projects that enhance the experience of all those who step through our doors or come into contact with us.

OUR PURPOSE

We're here to bring moments of joy, comfort and hope to those who need it most. We help our Trust and our colleagues to do even more to treat and care for patients. We push the limits of what is possible where the NHS is unable to.

WE DO THIS BY

- By increasing awareness, fundraising and engaging with our communities, we aim to make everything from a home visit to stay in hospital memorable for all the right reasons.

- Working with CHFT colleagues, to identify ways to make a positive difference to patient experience and fund the things which matter most to patients and staff.

OUR IDENTITY

AMAZING! Simple yet powerful expression of our aspirations, beliefs, and the focus of everything we do.

Our logo and symbols are a visual metaphor for the work the charity does. It radiates positivity synonymous with the charity. It is a reflection on how the charity spreads positivity, radiating a vibrant, warm, and positive effect within our hospitals, communities and across all the work the charity is involved in. Positivity is at the heart of everything we do.

WHY WE'RE HERE

We are committed to helping our hospitals and community healthcare services go that extra mile for our colleagues, patients and communities, beyond the limits, services and provision NHS funding alone can provide.

We help our local NHS services at CHFT go further, providing amazing support for patients, staff and communities. This could be providing:

- New equipment – meaning better treatment for patients.
- Creating wellbeing spaces for staff and patients and visitors.
- Investing in new technology and piloting projects that will make lasting changes to our healthcare for years to come.

The money raised by our charity makes a huge difference to peoples live, providing help where it is needed most - in short, charity funding doesn't keep the NHS going – it simply makes it better.

TOGETHER WE MAKE
AMAZING
THINGS HAPPEN

OUR GOALS

GOAL 1

Direct funding where it will have the greatest impact, aligned with our five key priorities.

Whilst we'd love to fund every project identified as an opportunity to enhance the services and patient experiences at CHFT, we know there are some areas where we can have a greater impact and make a bigger difference to the people of Calderdale and Huddersfield. These are areas that might be short of traditional funding through the NHS or where there are opportunities for significant enhancement of the 'core' offer the NHS can provide.

We're prioritising:

Enhancing Patient Care through delivery of enhanced medical equipment.

We'll fund the most innovative and emerging technologies and treatments that can change or save a patient's life that wouldn't otherwise be available.

Improved Patient Experience from relief of symptoms to improving patient comfort.

We'll fund the transformation of tired, underused spaces into welcoming healing spaces. From wards to gardens, across our two hospitals and community sites.

Support the experience of colleagues through improvements to staff areas, fund projects that improve wellbeing, and provision of training opportunities, that ultimately translate into better care and treatment for patients.

Develop Major Capital Projects to improve our estate for our patients, visitors and staff. We'll support innovative and emerging technologies that can change or save a patient's life that wouldn't otherwise be available.

Work collaboratively to ensure our most vulnerable, disadvantaged or under-represented community members have the best possible experience for their individual needs – understanding health inequalities and alleviating barriers to support.

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GOAL 2

Work in partnership with CHFT and in collaboration with other organisations

As our primary beneficiary, supporting CHFT and ensuring charitable funds enhance their ability to deliver exceptional care is central to our work.

We will strive to ensure charitable funds are applied equitably across all areas (not just those currently with the greatest fund balances). We will do this by updating and refreshing the grant funding processes and financial operations of the charity.

We will work closely with key colleagues to ensure donations are spent in a timely manner, and charitable funds have a plan in place to remain active.

We will also support the Trust to provide integrated care services, collaborating with primary and community care settings and supporting projects which improve the health and wellbeing of local people.

GOAL 3

Ensure we are sustainable for the future

Financial health

Our aim will always be to maximise the amount of charitable funding we're able to provide to our Trust, while ensuring the charity remains financially stable for the future.

We will develop a long-term fundraising strategy that will enable the charity to grow and diversify income steams.

We will stay up to date with market trends and ensure all opportunities to grow the charity income are explored.

Our people

In order to deliver the very best for our Trust, we need the very best people working with us and who in turn feel valued and appreciated for their hard work and achievements. Our people will be energised by our shared amazing values and positive, inclusive culture.

Our digital capability, systems and processes

To operate at our best, we need to ensure we invest in having the tools, systems and processes in place to enable the charity to deliver the best possible experience for its beneficiaries and supporters, whilst operating as efficiently as possible to ensure every donation goes further.

Our governance

Good governance is fundamental to the charity's success, not only to ensure we fulfil our charitable purpose, but also to support the charity's mandatory compliance with the law and relevant regulations – protecting the beneficiaries we serve, the investments from our donors and the staff and volunteers who work for us. Our Board of Trustees will continue to steer us to deliver our charitable aims, objectives and plans for the future. Ensuring several key issues remain high on our agenda, such as safeguarding, cyber security, GDPR, social responsibility and equality, diversity and inclusion.

Our profile

A strong charity profile is a crucial enabler to support and our ability to engage with patients, hospital staff and the wider local community. With the refreshed brand we recognise that we won't become known, understood and trusted overnight and will continue to invest time and resources in building on the energy and momentum our new amazing brand creates. This will help us continue to go above and beyond for our Trust, not just over the next 12 months but on into the future.

HOW WE'LL DELIVER OUR GOALS

Our plan sets overall direction and our intent for what we want to achieve.

We'll continue to find new ways to diversify and source new funding, for example through launching a legacy campaign, corporate partner package and trust and foundation fundraising.

We will proactively engage with colleagues across CHFT and partner organisations, to maximise our impact and ensure donations are well spent.

We will identify opportunities to proactively fundraise by conducting a scoping exercise to determine the role the charity will play in the future transformation and reconfiguration of our hospitals and healthcare services at CHFT.

We will work hard to ensure we are effective at engaging our communities, and ensuring we establish long term relationships, for the future.

As we progress through our plan we will evaluate, monitor and assess ongoing in order to take an adaptive and flexible view to how we apply our valuable investments.

Together we can

By pulling together and supporting each other, no matter our role, we can achieve great things. When faced with adversity, we will ask for help, pitch in and look for solutions. When a friend or colleague achieves success, we will celebrate it.

Above and beyond

We can bring experiences for patients that go above and beyond what the NHS may provide. But 'above and beyond' is also a mindset – our charity team are not restricted by job titles, and will put our hands up to help wherever we can.

Full-hearted goodness

We never forget why we are here – to always seek to do good for our patients. But this extends to everything – our colleagues, our environment, our community. Before we embark on something new, we always ask ourselves **'will this make an amazing and positive difference'**

IN SUMMARY

Calderdale and Huddersfield NHS Charity: Improving the health and happiness of every patient cared for in our hospitals and communities.

GOAL 1

Direct funding where it will have the greatest impact, aligned with our four key priorities

Enhance Patient Care	**Improved Patient Experience**	**Support the experience of colleagues**	**Develop Major Capital Projects**	**Work collaboratively**

GOAL 2

Working in partnership with CHFT and others, we will

Improve our ways of working with CHFT	**Develop and deliver a professional, impact-led grant making service delivery**	**Work collaboratively with community-based organisations, mobilising partnerships to help people in our communities to live well**

GOAL 3

Ensure we are sustainable for the future

Financial health Maximising charitable funding available while ensuring financial sustainability for the future	**Operating at our best** Developing our People and culture, our digital capability and ensuring good governance	**Known, trusted and understood** Developing our profile and reputation, building on the energy and momentum our new brand platform creates

INTEGRATED PERFORMANCE

13. Finance and Performance Chair Highlight Report

To Note

Presented by Andy Nelson

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	26th September and 25th October 2023
Date of Board meeting this report is to be presented:	2nd November 2023
ACKNOWLEDGE	• Continued strong performance in Cancer with the faster diagnosis target being met for the first time since April • Recovery performance also remains strong and the best in the West Yorkshire ICS (see table below). Other than due to the fallout of patients who dropped off the national e-Referral system we now have no patients waiting over 65 weeks and just 11 52-week waiters. We have delivered 109.2% of our elective recovery plan in the year to date although we are now behind our trajectory for 40-week waiters due to issues in ENT and the impact of the strikes • Very positive improvement in the MUST score which is now at 86% and SHMI has continued to improve and is in the expected range nationally
ASSURE	• At our September meeting we were given assurance on a number of specific items: - We have produced a strong and comprehensive response to an NHSE request on how we are protecting and expanding elective capacity - We 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 - We reviewed the Surge and Escalation Plan and the Resilience Plan; the latter replaces what used to be called the Winter Plan • The capital spend is behind plan whereas the cash position is ahead of plan – the committee were assured that both are expected to meet the plan set for 2023/4. It should be noted additional capital funding has been awarded to support the development of the Community Diagnostic Centre taking our total capital plan to £40.92m. We have also brought forward £8.5m of spend into this year to allow for the capital spend needed on the multi-storey car park in 2024/25 • We approved the business case for the new CT scanner • We reviewed the target for staff turnover and agreed for it to be changed from 11.5% to 10%
AWARE	• The number of Appointment Slot Issues (ASIs) continues to be a concern with numbers rising in the last month. ENT is the main area for concern, but a task and finish group has agreed some actions. A similar picture is now also being seen in Outpatient Follow-Ups, despite the work done on admin validation, although the problem specialties are different with Neurology,

	Gastroenterology and Ophthalmology having the biggest backlogs • At our October meeting we had a 'deep dive' on Length of Stay (LOS) and Transfer of Care (TOC). Numbers on the TOC list are still typically between 100-110 (target is 50) – the Urgent and Emergency Care Recovery Plan is key to cracking this problem. There are plans in place for enhancing community care and 'home first', increased capacity in Same Day Emergency Care (SDEC), improving patient management and discharge through the 'Well Organised Ward' programme and the creation of an Integrated Flow Hub in the existing HRI ED once the new ED is open. However, the beneficial impact of these plans is unlikely to be felt for some time so we will remain above target for LOS and TOC. • This position along with continuing high levels of bed occupancy is feeding through into our adverse financial position • At month 6 we are reporting a £12.57m deficit which is a £0.91m adverse variance to plan but an improvement thanks to bonuses for achievement of the 22/23 Maternity Incentive Scheme and progress on our recovery plan. Other factors playing into this are the impact of the recent strikes and higher non-pay costs in areas such as utilities, maintenance costs and elective recovery • As required by regulators we have developed some forecast scenarios for this financial year which show a best case of meeting our planned deficit of £20.8m, a worst case of an adverse variance to plan of £14.06m and a likely case of a £6.7m adverse variance. This likely case is driven primarily by slippages in the ED and Length of Stay efficiency schemes, strike costs and some non-pay inflationary pressures. Current expectation is that a gap will remain in the CIP programme despite further schemes being identified. We will need to finalise our forecast for the year at month 8 The adverse variance to plan across the ICS was £40.8m YTD at month 6; and a forecast likely case of an £90m adverse variance to 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	2,057	928	219	5	0
Bradford	1,797	494	85	1	0
Calderdale and Huddersfield	997	11	1	1	1
Leeds	9,165	4,137	1,187	145	2
Mid Yorks	5,560	2,467	401	28	0

14. Month 6 Financial Summary

To Note

Presented by Gary Boothby

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title of report:	Month 6 Finance Report
Author:	Philippa Russell – Assistant Director of Finance
Sponsor:	Gary Boothby – Director of Finance
Previous Forums:	Finance & Performance Committee
Purpose of the Report	To provide a summary of the financial position as reported at the end of Month 6 (September 2023) for receipt by the Board. To seek Board approval for delegation of authority to the Finance and Performance Committee of any revision to the financial forecast outturn.
Key Points to Note	**<u>Year To Date Summary</u>** The Trust is reporting a £12.57m deficit, (excluding the impact of Donated Assets), a £0.91m adverse variance from plan. The in-month position is a deficit of £1.49m, a £0.70m 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), £2.26m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.12m; and non-pay inflationary pressures. These pressures were offset to some extent by early delivery of other efficiencies, including a bonus of £0.54m for the Maternity Incentive Scheme; 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 £7.86m. • West Yorkshire mechanism for allocating Elective Recovery Funding (ERF) focuses on targeting achievement of waiting list performance rather than activity volumes. Financial penalties will be imposed for any patients not treated within the 52 week target. Year to date the Trust has not incurred any penalties. • Overall Weighted Elective Recovery Position as a percentage of plan was 109.2%. • The Trust has delivered efficiency savings of £11.41m, £0.25m above the planned level.

- Agency expenditure year to date was £5.61m, £0.72m lower than the Agency Ceiling, (3.7% of total pay expenditure) but £1.32m higher than planned.

Key Variances

- Income is £3.39m above the plan. Clinical contract income is in line with plan with the exception of the confirmed allocation of Covid-19 testing funding (offset to some extent by costs) 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 £1.87m higher than the planned level. Pay pressures are linked: to higher than planned bed capacity (£2.26m) - £0.55m surge capacity, plus £1.71m 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 the further strike action (£2.12m impact YTD); supernumerary overseas nurses (£0.60m). 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 £4.94m higher than planned year to date due to: higher than planned rates and maintenance costs; the impact of actions required to eradicate Legionella; Health Informatics commercial contracts (£1.30m offset by additional income); pass-through Estates costs (£0.9m also offset by income); higher than planned expenditure on clinical supplies including devices, ward consumables, patient appliances and theatre costs; and higher than planned insourcing / outsourcing costs associated with Elective Recovery.

Forecast

The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £6.69m. The Trust needs to identify mitigation of this scale to offset unidentified CIP / expected slippage on high-risk efficiency programmes (£6.19m) and industrial action (£2.40m). Some potential mitigation has already been identified to offset these and other forecast pressures including non-pay inflationary pressures and additional bed capacity.

Whilst some loss of Elective Recovery funding is possible due to penalties for any patient waiting in excess of 52 weeks, the current likely case is receipt of £15.02m of ERF as planned. Discussions are still ongoing to agree what slippage in the agreed waiting list targets might be allowable as a result of the impact of Industrial action and best case the Trust may be able to access additional funding if current levels of performance are maintained. However, the forecast assumes that any required activity catch up as a result of Industrial

	action will not incur additional costs, but will be contained within the planned cost envelope agreed for Elective Recovery. Any revision to the financial forecast outturn requires Trust Board support and approval. However, across West Yorkshire it has been agreed to revise the forecast, if necessary, between month 7 and 8 which does not neatly meet the Board meeting timetable. The Board is 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. *Attachment: Month 6 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 Equali ty Impact Assessment will first be completed to assess the effects th at it is likely to have on people from different protected groups, as def ined in the Equality Act 2010.
Recommendation	The Board of Directors are requested to: **i.** **RECEIVE** the Finance Report and **NOTE** the financial position for the Trust as at 30 September 2023 **ii.** **APPROVE** delegation of authority to revise the forecast outturn to the Finance and Performance Committee.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Sep 2023 - Month 6

KEY METRICS

	M6				YTD (SEP 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)	(£2.19)	(£1.49)	£0.70		(£11.65)	(£12.57)	(£0.91)		(£20.80)	(£20.80)	£0.00	
Agency Expenditure (vs Ceiling)	(£1.06)	(£0.88)	£0.18		(£6.34)	(£5.61)	£0.72		(£12.67)	(£9.95)	£2.72	
Capital	£1.98	£0.78	£1.20		£10.54	£3.53	£7.01		£34.00	£50.20	(£16.20)	
Cash	£23.38	£27.86	£4.48		£23.38	£27.86	£4.48		£2.19	£1.90	(£0.29)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	94.0%	-1%		95.0%	94.7%	0%					
CIP	£2.25	£1.86	(£0.39)		£11.16	£11.41	£0.25		£31.50	£31.50	£0.00	
Use of Resource Metric	3	3			3	3			3	3		

Year To Date Summary

The Trust is reporting a £12.57m deficit, (excluding the impact of Donated Assets), a £0.91m adverse variance from plan. The in month position is a deficit of £1.49m, a £0.70m 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), £2.26m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.12m; and non-pay inflationary pressures. These pressures were offset to some extent by early delivery of other efficiencies, including a bonus of £0.54m for the Maternity Incentive Scheme; 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 £7.86m.
- West Yorkshire mechanism for allocating Elective Recovery Funding (ERF) focuses on targeting achievement of waiting list performance rather than activity volumes. Financial penalties will be imposed for any patients not treated within the 52 week target. Year to date the Trust has not incurred any penalties.
- Overall Weighted Elective Recovery Position as a percentage of plan was 109.2%.
- The Trust has delivered efficiency savings of £11.41m, £0.25m above the planned level.
- Agency expenditure year to date was £5.61m, £0.72m lower than the Agency Ceiling, (3.7% of total pay expenditure) but £1.32m higher than planned.

Key Variances

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Total Group Financial Overview as at 30th Sep 2023 - Month 6

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M6

CLINICAL ACTIVITY

	M6 Plan	M6 Actual	Var
Elective	2,269	2,319	50
Non-Elective	26,700	25,965	(735)
Daycase	24,621	25,879	1,258
Outpatient	214,347	225,709	11,362
A&E	87,385	88,159	774
Other NHS Non-Tariff	972,601	1,078,092	105,491
Total	**1,327,923**	**1,446,122**	**118,199**

TOTAL GROUP: INCOME AND EXPENDITURE

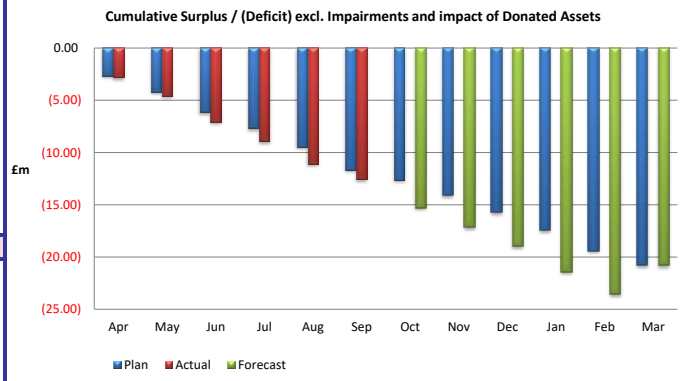
	M6 Plan	M6 Actual	Var
	£m	£m	£m
Elective	£8.68	£9.32	£0.64
Non Elective	£62.94	£64.05	£1.11
Daycase	£17.76	£18.88	£1.12
Outpatients	£21.78	£23.96	£2.18
A & E	£15.75	£16.47	£0.72
Other-NHS Clinical	£110.52	£104.23	(£6.29)
CQUIN	£0.00	£0.00	£0.00
Other Income	£27.38	£31.29	£3.92
Total Income	**£264.80**	**£268.19**	**£3.39**
Pay	(£175.41)	(£177.28)	(£1.87)
Drug Costs	(£23.78)	(£23.33)	£0.45
Clinical Support	(£17.01)	(£16.55)	£0.46
Other Costs	(£32.90)	(£38.56)	(£5.65)
PFI Costs	(£8.09)	(£8.29)	(£0.19)
Total Expenditure	**(£257.20)**	**(£264.00)**	**(£6.81)**
EBITDA	**£7.61**	**£4.19**	**(£3.42)**
Non Operating Expenditure	(£19.26)	(£16.76)	£2.50
Surplus / (Deficit) Adjusted*	**(£11.65)**	**(£12.57)**	**(£0.91)**

* 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

	M6 Plan	M6 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£52.37)	(£51.79)	£0.58
Medical	(£66.40)	(£71.46)	(£5.06)
Families & Specialist Services	(£47.56)	(£46.97)	£0.59
Community	(£16.15)	(£15.81)	£0.34
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£28.60)	(£28.25)	£0.35
THIS	£0.67	£0.65	(£0.02)
PMU	£0.56	£1.13	£0.57
CHS LTD	£0.31	£0.16	(£0.14)
Central Inc/Technical Accounts	£199.08	£200.28	£1.20
Reserves	(£1.19)	(£0.51)	£0.68
Surplus / (Deficit)	**(£11.65)**	**(£12.57)**	**(£0.91)**

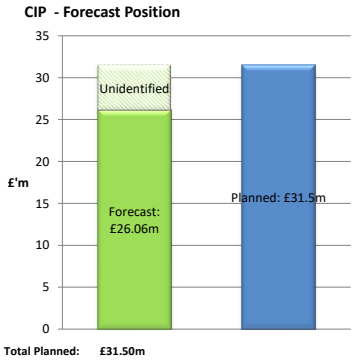
TOTAL GROUP SURPLUS / (DEFICIT)

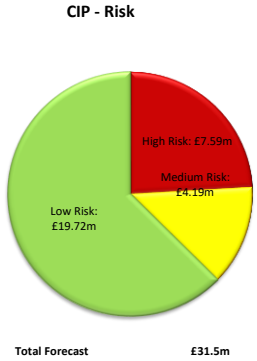


KEY METRICS

	Year To Date			Year End: Forecast		
	M6 Plan	M6 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£11.65)	(£12.57)	(£0.91)	(£20.80)	(£20.80)	£0.00
Capital	£10.54	£3.53	£7.01	£34.00	£50.20	(£16.20)
Cash	£23.38	£27.86	£4.48	£2.19	£1.90	(£0.29)
Invoices Paid within 30 days (BPPC)	95%	95%	0%			
CIP	£11.16	£11.41	£0.25	£31.50	£31.50	£0.00
	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	4,636	0
Non-Elective	53,866	53,866	0
Daycase	49,935	49,935	0
Outpatient	434,259	434,259	0
A&E	174,293	174,293	0
Other NHS Non- Tariff	1,975,197	2,189,543	214,347
Total	**2,692,185**	**2,906,532**	**214,347**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£17.69	£17.69	£0.00
Non Elective	£125.90	£125.90	£0.00
Daycase	£36.01	£36.01	£0.00
Outpatients	£44.01	£44.01	£0.00
A & E	£31.42	£31.42	£0.00
Other-NHS Clinical	£219.67	£218.33	(£1.34)
CQUIN	£0.00	£0.00	£0.00
Other Income	£55.28	£61.46	£6.18
Total Income	**£529.98**	**£534.82**	**£4.84**
Pay	(£350.38)	(£350.49)	(£0.12)
Drug Costs	(£47.98)	(£47.21)	£0.75
Clinical Support	(£33.68)	(£32.70)	£0.98
Other Costs	(£63.83)	(£73.62)	(£9.79)
PFI Costs	(£16.19)	(£16.57)	(£0.38)
Total Expenditure	**(£512.06)**	**(£520.60)**	**(£8.54)**
EBITDA	**£17.92**	**£14.22**	**(£3.71)**
Non Operating Expenditure	(£38.72)	(£35.02)	£3.71
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

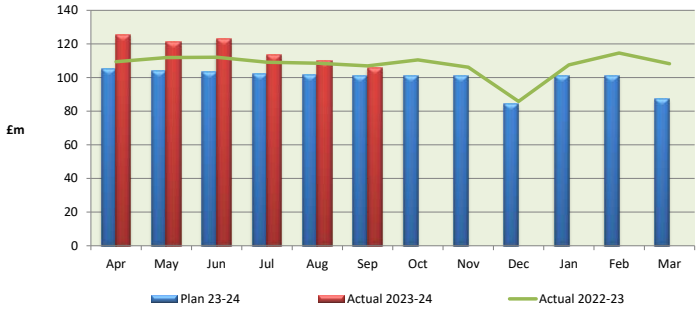
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£104.03)	(£104.83)	(£0.80)
Medical	(£135.57)	(£143.96)	(£8.39)
Families & Specialist Services	(£95.68)	(£95.67)	£0.01
Community	(£33.23)	(£32.72)	£0.51
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£56.68)	(£56.34)	£0.34
THIS	£1.33	£1.33	(£0.00)
PMU	£1.10	£1.80	£0.70
CHS LTD	£0.66	£0.42	(£0.24)
Central Inc/Technical Accounts	£402.38	£400.90	(£1.49)
Reserves	(£1.07)	£8.28	£9.35
Surplus / (Deficit)	**(£20.80)**	**(£20.80)**	**£0.00**

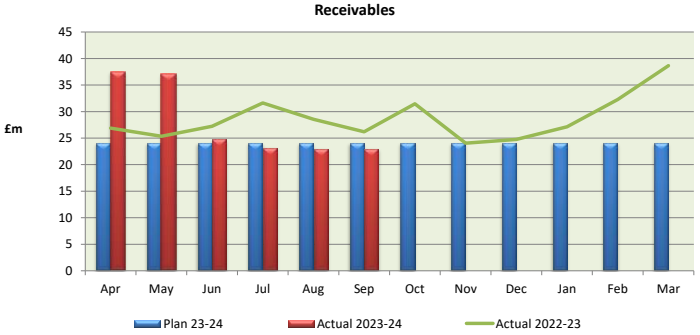
Total Group Financial Overview as at 30th Sep 2023 - Month 6

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

WORKING CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Payables (excl. Current Loans)	(£100.99)	(£105.88)	£4.89	
Receivables	£24.04	£23.04	£1.00	





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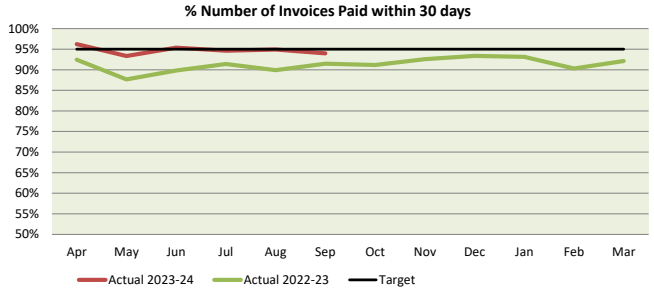
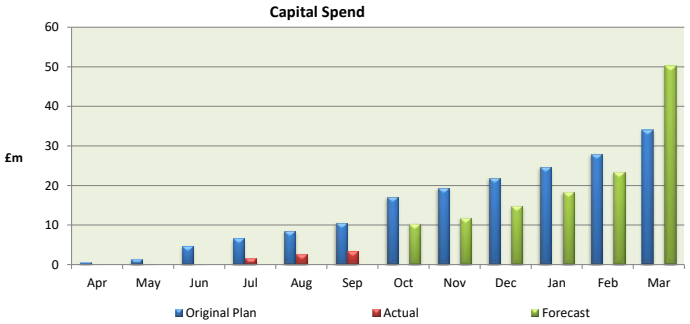


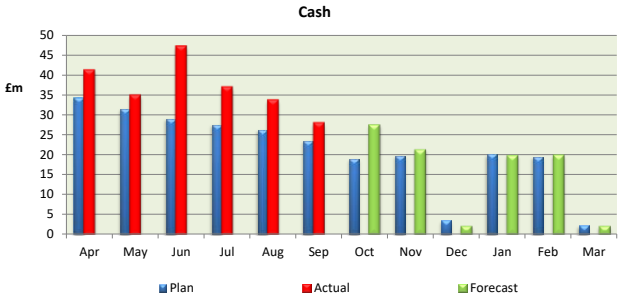
CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Capital	£10.54	£3.53	£7.01	

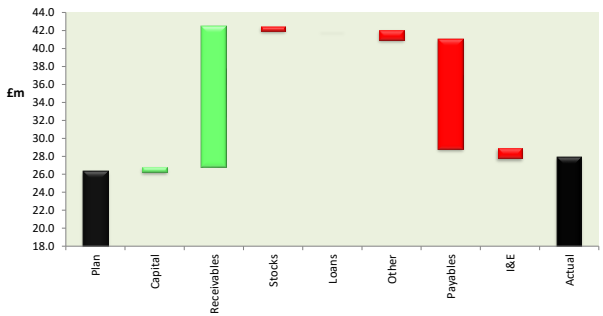


CASH

	M6 Plan £m	M6 Actual £m	Var £m	M6
Cash	£23.38	£27.86	£4.48	
Loans (Cumulative)	£14.36	£14.36	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust is reporting a £12.57m deficit, (excluding the impact of Donated Assets), a £0.91m adverse variance from plan.
- Year to date the Trust has incurred higher than planned costs due to: higher than planned additional bed capacity of £2.26m; Strike costs of £2.12m; and non-pay inflationary pressures. These pressures were offset to some extent by the early delivery of other efficiencies, including a bonus of £0.54m for the Maternity Incentive Scheme and higher than planned commercial income (HPS).
- Position includes additional Elective Recovery Funding (ERF) of £0.35m to reflect above plan activity performance. Total year to date is £7.86m.
- Overall Weighted Elective Recovery Position as a percentage of plan was 109%.
- The Trust has delivered efficiency savings of £11.41m, £0.25m above the planned level.

- The Trust has a cash balance of £27.86m, £4.48m more than planned.
- Capital expenditure is lower than planned at £3.53m against a planned £10.54m.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3, as planned, with 1 metric (I&E Margin Variance) away from plan.

NOTES

- The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £6.69m. The Trust needs to identify mitigation of this scale to offset unidentified CIP / expected slippage on high-risk efficiency schemes and forecast pressures including industrial action.
- Forecast assumes full receipt of £15.02m of Elective Recovery Funding (ERF)
- The Capital forecast is to spend £50.20m, £16.20m more than planned. Additional PDC funding has been awarded to support the Community Diagnostic Centre. Internally funded capital is forecast at £29.21m, £12.19m more than planned, including £13m for Reconfiguration where the Capital allocation has been agreed in advance of the Public Dividend Capital Funding.
- The total loan balance is £14.36m as planned. The increased capital expenditure agreed for Reconfiguration is likely to 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 is likely to mean that the Trust will now be required to drawdown £20.80m of Revenue Support PDC to support the deficit.
- 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

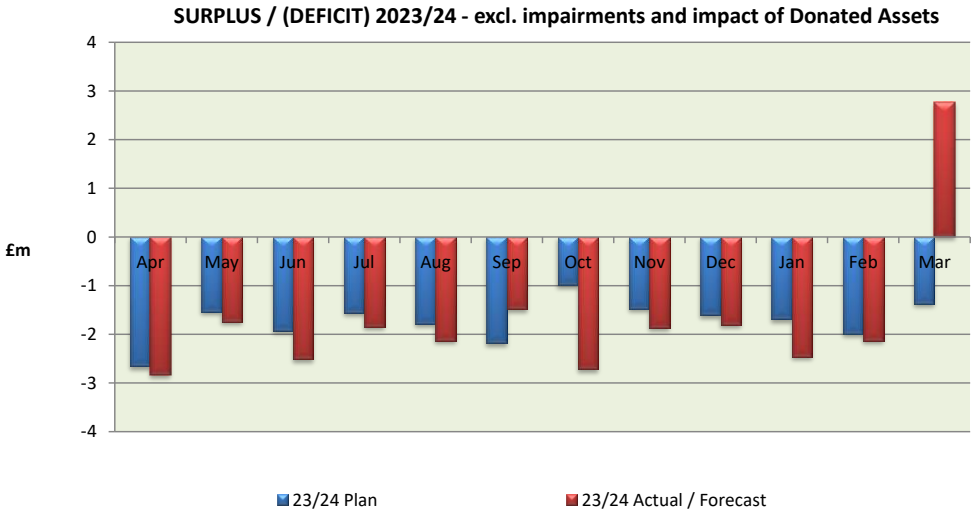
FORECAST 2023/24

23/24 Forecast Position (31 Mar 24)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m	
Income	£530.07	£534.83	£4.76	
Pay expenditure	(£350.38)	(£350.49)	(£0.12)	
Non Pay Expenditure	(£161.68)	(£170.11)	(£8.43)	
Non Operating Costs	(£39.15)	(£35.59)	£3.56	
Total Trust Surplus / (Deficit)	**(£21.15)**	**(£21.37)**	**(£0.23)**	
Deduct impact of:				
Impairments & Revaluations (AME)[1]	£0.00	£0.00	£0.00	
Donated Asset depreciation	£0.43	£0.58	£0.15	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.01)	£0.08	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Gain on Disposal	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**(£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 £27.5m, £6.7m worse than planned. £6.2m is linked to unidentified and extremely high risk efficiency programmes including: a reduction in LOS and DTOC and associated bed closures; staffing efficiencies in A&E; and benefits associated with WYAAT system wide business cases. Some mitigation has already been identified and is likely to be sufficient to offset the slippage on efficiency, but there are also other pressures which it will be much more difficult to mitigate including: the cost of Strike action up to the end of October of £2.4m (any further future strikes will increase these costs); higher than planned non pay inflationary pressures (£4.0m); additional 'Surge' bed capacity (£0.80m); and the impact of the Medical Staffing Award (£0.33m). A number of further opportunities and potential mitigations are currently being worked up for review through Turnaround Executive which may further improve the current likely case forecast.

The worst case scenario is a £14.06m adverse variance from plan and in addition to the above includes: other high risk efficiency schemes; a further risk on additional 'Surge' bed capacity during the winter months; ongoing pressures due to supernumerary overseas nurses, mobile CT requirements; Radiology outsourcing and additional PDC Dividend payments.

Whilst some loss of Elective Recovery Funding (ERF) is possible due to penalties for any patient waiting in excess of 52 weeks; there is also a potential upside if the Trust is able to maintain it's current performance and exceed planned levels of Elective recovery. Current Best case is an increase in ERF of £0.90m. Discussions are still ongoing to agree what slippage in the agreed waiting list targets might be allowable as a result of the impact of Industrial action, which may provide a mitigation opportunity for the Trust.

Microsoft Licence income top slice described in previous reports has now been resolved and the income reduction previously recognised has been reversed.

Other Assumptions and Potential Risks / Opportunities

- 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.

15. CT Scanner Business Case Approval

To Approve

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Meeting of the Trust Board
Title of report:	CT Scanner – Business Case Approval
Author:	Gary Boothby, Director of Finance
Sponsor:	Gary Boothby, Director of Finance
Previous Forums:	Business Case Approvals Group / Capital Management Group / Finance and Performance Committee
Purpose of the Report	The aim of the report is to ask Trust Board to approve the business case for a fourth CT scanner for the Trust, to be located at Calderdale Royal Hospital (CRH). The majority of the capital is externally provided but release of capital resource is subject to Trust Board approval. Subject to approval of the business case, the Board is asked to approve authority to Executive Directors for signing the associated transaction documents with the Trust's Private Finance Initiative (PFI) partner which runs the CRH site, in line with Standing Orders of the Trust.
Key Points to Note	• 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 are being asked to pay the difference which is planned for the financial year 2023/24. The total capital cost includes the purchase of the CT Scanner and the associated construction and infrastructure costs. The latter will be transacted as a Variation with the PFI partner. • CHFT are currently leasing a mobile unit onsite at CRH at a cost of £15,392 excluding vat per week. This unit can only perform limited examinations but would remain in place until the new CT scanner is operational. • The number of CT scans carried out is increasing year on year. • Staff would be required to run the scanner 11.5 hours per day 7 days per week. This approval commits additional revenue and would need prioritisation in any funding allocations for future years. • The scanner would improve the service Radiology is able to provide to patients, including removing the need to send bariatric patients to Bradford. • This case was presented at the Business Case Approvals Group on 17 October 2023 where three options were considered (do nothing, continue with one scanner at CRH and the modular unit, purchase of a fourth scanner). Option 3, the purchase of a fourth scanner for CRH was supported, being the best option for patient experience and in line with

	the Trust strategic plan of CRH becoming the main acute site. The additional capital cost was approved, and a commitment made to support future additional revenue costs. The paper was also approved at Finance and Performance Committee on 25 October 2023. The business case submitted is enclosed as an appendix to this paper. • The approval of the business case at the Board of Directors will provide the Executive Directors with the authority to sign and, if necessary, seal the relevant contracts with PFI parties engaged in the delivery of the project. • This approach is in line with Standing Financial Instructions which require Board approval for variation to a PFI contract which is above £2 million. The Trust Standing Orders (section 6.4) allows for the signature of documents necessary in legal proceedings by Executive Directors or when authority is given from the Board. This approach also meets the external governance requirements of NHS England in documenting the Trust's governance process for approval of the business case.
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: i. **APPROVE** the business case for £2.643m for the purchase of a CT scanner for CRH and the associated construction and infrastructure costs. ii. **APPROVE** 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.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Project Name:4th CT scanner

Sponsoring Division: FSS

Author: Lucy Thomson

Version [1.2]

October 2023

Amendment History

Issue	Date	Author	Reason
1	01/03/23	Lucy Thomson	Draft Business Case
1.1	30/08/23	Lucy Thomson	Revised version
1.2	Oct 2023	Leanne Royle/Nic Ventress	Updated finance

Distribution List

Name	Department / Organisation

Contents

1. Executive Summary

The purpose of this business case is to seek Trust approval of the addition of a 4th CT scanner at CRH.

We currently have 3 CT scanners at the Trust and also the use of a modular unit which is positioned in the A&E car park at CRH. The provision of a 4th scanner will also support the Trusts plans for reconfiguration of the hospital services.

We would like to place a further permanent 4th CT scanning suite at the CRH site. This would be the 2nd scanner at CRH although we do currently rent a staffed modular unit 7days per week 8am-8pm at high cost. This would be placed in the room made vacant by the old MRI scanner and be back to back with the existing scanner. This would replace the modular unit usage once installed. We would also require funding for the estate costs for the room refurbishment, maintenance costs and a contrast injector pump to be able to perform contrast enhanced scans.

CT Demand has increased to 140% over the last three years of what it was pre covid. In order to meet this demand we need to increase scanning capacity. Demand is expected to increase by 10% each year going forward.

The case for change is supported as follows-

1. The CT service currently operates with 3 static scanners (2 at HRI and 1 at CRH) and use of the modular CT unit. All 3 static scanners are running to maximum capacity with the current staffing levels. This will not support demand going forward.

2. The current in-house scanner at CRH is now 11 years old and is now beyond its expected lifespan. This scanner supports the stroke service at CRH as well as all the on-site acute services.
It is prone to breakdown and will soon be no longer supported for part replacement. During any down time the acute patients have to currently be transferred to the modular unit or to HRI. The provision of a second in house scanner would provide stability in case of breakdowns and servicing of the existing scanner.

3. Without the use of the modular unit, which provides extra capacity, we would have an immediate breach for our fast-track patients and 6WW.

4. If we continued with the modular unit we would need to pay £15k exc VAT per week for the service.

5. The improved technology of a new scanner would also increase capacity due to faster scanning times.

6. We have two risks associated with the CRH CT scanner on the risk register regarding the age of the equipment and the risks of breakdown causing risks to providing a service at CRH.

7. The expected capital cost of the project is £2.643m, of which we have secured £2.266 million funding from NHSE for the installation of the fourth scanner as we are one of 10 acute hospitals in England with only one CT scanner. The Trust has to contribute the remainder of the capital costs and this has already been approved as part of the capital planning process. The funds need to be spent in 2023/24.

	Year 1* £000	Year 2 £000	Year 3 £000	Year 4 £000	Year 5 £000	Year 6 £000	Year 7 £000	Year 8 £000	Year 9 £000	Year 10 £000	Total Cost
Investment Value (£) – Capital	2,643										2,643
Investment Value (£) – Revenue (pay assumed 5 months in year 1 and 3% inflation each year), maintenance from year 2	132	402	411	421	432	442	454	465	477	489	4,124
External funding	- 2,266										-2,266
TOTAL INVESTMENT VALUE (£)	509	402	411	421	432	442	454	465	477	489	4,502
WTE's impact (5.15 x B6, 2.58 x B3)	7.73	7.73	7.73	7.73	7.73	7.73	7.73	7.73	7.73	7.73	7.73

* Financial Year 1 to be the part year effect where the business case income/cost/benefit does not commence on 1 April.

Cash Implication

	April £000	May £000	June £000	July £000	Aug £000	Sept £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000	Total £000
Income (capital funding from NHSE)												2,266	2,266
Expenditure								26	26	26	26	26	132
Capital												2,643	2,643

2. Business case sign-off

	Approval Confirmed	Name:
Division of Surgery & Anaesthesia		
Division of Medicine		
Division of Families and Specialist Services		
Estates		
The Health Information Services		
Medical Illustration		
Workforce & Organisational Development		
Finance & Procurement		
Division of Community		

3. Introduction and Overview

The Trust currently provides a CT service from both HRI and CRH sites and a rented modular unit positioned in the AE carpark at CRH.

Referrals are received into the service via the following routes:

Secondary care referrals (from within CHFT) – this activity consists of inpatient, outpatient and A&E activity.

Direct access referrals – referrals from GPs for patients managed within primary care.

CHFT currently has three static CT scanners-2 at HRI and 1 at CRH. We also have the use of a modular unit until October 2023.The current cost of the modular unit is £15,392 exc VAT per week (including two radiographers)working 8am-8pm each day. This includes maintenance fees.
This is obviously very expensive and the money would be better spent investing in an in-house static unit for use over the longer term. Due to it's size the static unit is not as efficient as a permanent on-site scanner where we can have a cannulation room and larger waiting room to accommodate waiting patients and also create a better experience for the patients.
This would enable us to meet our fast-track and 6WW targets. The modular unit can also only perform limited examinations not including cardiac examinations and CT colonography examinations.

The current activity of the four scanners equates to approx. 55,000 scans per year compared with 38,000 pre Covid. We are currently running at 145% in comparison to pre covid figures. However the modular unit only produces approximately 9100 of these-17% so it isn't very efficient. The demand for CT is expected to continue to grow at a similar rate to what it is now-approximately 10% each year or 110 scans per week.

By the moving of the CRH MRI scanner into a new suite this has freed up a scanning room which could run back to back with the current CT scanner. This will allow it to be integrated into the existing CT area within the radiology department making it more efficient.

We have already secured funding of £2.266 million from NHSE to fund the new scanner and the majority of the buildworks. The expected capital cost is £2.643m with the Trust contributing the balance, which has already been accounted for in the capital planning process. The expenditure is planned for the 23/24 financial year.

4. Strategic Context

Corporate Strategy	
Keeping the base safe	Ensures the delivery of an efficient and safe CT service. Would avoid the lack of CT services due to breakdown In line with Trust reconfiguration
Transforming and improving patient care	Better patient experience as no need to transfer to HRI due to scanner breakdown. Improved efficiency. Increased scanning capacity so faster throughput of stroke/acute/ward patients
A workforce for the future	Will allow for staff development due to new technology Attract new staff Improved staff morale and retention of staff
Financial Sustainability	Reduced level of downtime due to having a second scanner on site Increased capacity Better value for money.

5. Option appraisal – Assessed options:

This business case is to assess and compare the options available to us.

Option 1.

Do nothing
Continue with 3 static scanners-2 at HRI and 1 at CRH. If we were to continue with this option every time the CRH scanner broke down the patients requiring a scan would need to be diverted to HRI. This would cause delays to patient diagnosis and treatment. The existing scanner at CRH is now 11 years old and

beyond it's expected life span. We have already been told that it will not be able to support some parts after January 2024. The addition of a new scanner would again add stability to the CT service at CRH especially for reconfiguration of the acute services.

Option 2.

Continue with 3 static scanners plus the use of the modular unit. The modular unit does offer some back up in case of breakdown to the in-house scanner but this is at high cost and inefficient. We also cannot rely on there being a modular unit being available for our use and the cost would increase as the years go by. The modular unit is not accessible to all types of patients due to its size and equipment available. They are usually designed for relatively able patients and also don't currently offer any specialized scanning eg CT colonography patients or cardiac imaging.

Option 3.

Purchase a fourth scanner to be sited at CRH. Although there would be some initial cost and building works/expertise required for the initial room creation and installation this would be a more cost effective option in the long run versus the hire of a fourth scanner. We would also need to purchase a new injector pump to enable contrast enhanced scans to be performed. We will also need to arrange maintenance cover for this.

The capital cost is:

	£000
Scanner	998
Injector Pump	28
Installation works	1,617
TOTAL	**2,643**

The addition of a new scanner would again add stability to the CT service at CRH especially after reconfiguration when the acute services have moved onto this site.

Revenue costs:

We would also need to provide staff to run the scanner 11.5 hrs per day 7 days per week as this is additional capacity (the CT van in use is staffed by the van provider).

Staffing:	**£000**
2x B6 radiographers (5.15wte)	240
1x B3 assistant (2.58wte)	77
Total staff cost	**317**
Maintenance costs (year 2 onwards)	75
TOTAL Revenue costs	**392**

	Advantages	Disadvantages		Outcome
Option 1 **Do nothing**	No investment required	• No contingency in place for provision of CT service on CRH site in the event of major/fatal failure of the existing equipment. Resulting in requirement for patients to be transferred cross-site or out to other hospitals for care.		**Reject**
		• Existing scanner-Outdated technology means reduced image quality – likely clinical risk is however low		
		• Scan times are longer than on newer systems due to outdated technology.		
		• This is not a guaranteed viable option due to the age of the equipment, increasing levels of downtime and an increasingly unreliable service. Replacement parts may become unavailable, company will be able to offer limited replacement parts.		
Option 2 **Continue with just one scanner at CRH plus the use of the modular unit**	Support from modular unit currently situated in the AE carpark at CRH.	• As above if the current scanner is not replaced we have no reliable contingency, outdated technology and possible total failure of the existing scanner.		**Reject**
		• Have to rely on the availability of the modular unit and staff to run it		
		• Modular unit is not able to perform all types of patients and examinations		
		• Poor patient experience for acute patients on the modular unit.		
Option 3 **Purchase or lease of a 4th scanner for CRH**	Continuity of service at the CRH site should the existing scanner breakdown	• Cost of initial building works and investment in the scanner		Preferred option
	Newest technology available for operating system platform			
	Better patient experience			

	due to faster scans and improved surroundings.			

Our preferred option would be Option three-Purchase or lease a fourth scanner to be sited at CRH. Although there would be some initial cost and building works/expertise required for the initial room creation and installation this would offer a significant saving in the long run versus the hire of a fourth scanner. We would be able to use this scanner 7 days per week and have full access to it for all types of patients and examinations.

This offers stability to the service, reduced downtime, increased through-put and an improved patient experience.

6. Market analysis:

As per the Richards report demand for almost all diagnostic procedures had been increasing markedly in the 5 years before the pandemic, with increases of 7% or higher for computed tomography (CT). These increases were higher than those for other aspects of activity within the NHS, such as emergency department (ED) and outpatient attendances or emergency admissions. However, diagnostic capacity had not kept pace with demand. We have seen an increase of 10% each year on demand for CT scans at the Trust and now depsite the use of the modular unit we struggle to fulfill our 6 week and fast track targets. There has also been an increase in specialized examinations such as CT cardiacs of 50% over the last four years.

There are multiple manufacturers who could provide a CT scanner. They include Canon, G.E, Siemens, Philips and Fuji.
We currently have Canon and G.E equipment installed at the Trust so felt that for ease of future training we should undertake site visits to assess their current options.
Both systems offer similar options-dose reduction, wide area detector, image quality, low contrast resolution, organ perfusion, metal artefact reduction, interventional package, flouroscopy option, cardiac package option, bariatric table
We felt that this should be the opportunity to acquire a scanner that could enhance our services by providing dynamic imaging with the scanning of entire organs in a single rotation. This can be used for cardiac and head perfusion scans so will benefit both the stroke service and the increasing cardiac service. The single rotation can also be used for scanning paediatric patients. The advanced scanner would also fit in with reconfiguration plans by ensuring a fast efficient system for emergency/acute patients.
Our preferred scanner is the Canon Aquilion One Prism. Staff are familiar with the platforms on the current scanner and their knowledge and skills can be easily transferred to the new scanner. Training on the new system will therefore be an efficient process.
We have found that Canon have a good response time to breakdown and servicing requests.

7. Assessment of benefits:

The benefit of purchasing a second scanner for CRH include-

- A more robust contingency for breakdown or repair of the existing scanner. Continuity of the service can be maintained on an in-house scanner ensuring better patient experience.

- All patients would be able to access the new scanner. The current mobile scanner is not able to accept transport or bariatric patients due to it's dimensions.
- Capacity would increase with faster scanning times. This would lead to faster throughput of the acute patients including stroke and emergency dept patients.
- The current mobile unit is high cost - £464k per year (rental cost without staffing) and more expensive over the equivalent time period compared to the capital cost of the scanner. We are also relying on availability of the mobile unit and also the price of it staying as it currently is.
- If we could install the new scanner now it would again provide continuity of service for when the existing scanner at CRH gets replaced.

8. Cost / Benefits /Key Assumptions Assessment

- We are assuming that growth in CT will continue at a rate of 10% per annum for the foreseeable future.
- We are assuming the cost of the hire the van and staff remain the same each year.
- The future capacity depends on staff recruitment and training.

9. Commissioning and capacity implications

Commissioning & Capacity Implications			
Commissioner support required		Commissioner support obtained	
Theatre capacity required	No	Theatre capacity secured	No
Outpatient capacity required	No	Outpatient capacity secured	No
Support division sign off required		Support division sign off secured	

10. Risk and Sensitivity analysis:

- Financial. This scheme will require buildings works and remodelling of the space. Quotations for the building works have been obtained but there is a risk of unanticipated costs.
- We will have to continue with the modular unit until the new scanner is installed.

11. Resource requirements and costs:

Resource requirements and costs:	WTE's	Capital £'000	Income	Pay £'000	Non-Pay	Net Cost
External (bought in equipment)		**1,026**				**1,026**
External services (installation)		**1,617**				**1,617**
Internal costs	**7.73**			**317**	**75**	**392**
Total		**2,643**		**317**	**75**	**3,035**

* Note: Please separately identify costs associated with agency staffing, explicitly stating where the case includes expenditure on agency that will breach current rules on agency staff.

12. Timescales/Implementation Plan:

Objective	Description of Action	Lead	Date to complete
Business case to be prepared	Write business case and send to finance	LAT	Sept 2023
Business case to be approved	BC to be presented at BCAG		17/10/23
Equipment ordered	Procurement	IM/LAT	
Estate work completed	Equans to compete project		01/02/24
Equipment installed and training given	Training arranged when scanner up and running	LAT	01/03/24

13. Comments / Issues:

The funding we have been awarded has to be used by the end of this financial year.

14. Conclusions and Recommendations

It is recommended that option 3 is taken to purchase a 4th scanner rather than continue with the mobile rental on a long term basis.

With this option the scanner and injector pump could be bought outright or leased. We have secured NHSE funding of £2.266 million towards the project.

This option would provide contingency during downtime and aligns with the strategic plan of CRH becoming the main acute site.

A static scanner allows the best patient experience as all types of scans are possible, there are appropriate waiting areas and easy access for patients. This would also allow the service to build capacity in line with demand.

14. Appendices

BENEFITS REALISATION TABLE

Benefit to Measured	Owner	Baseline Value	Target Value	Method of Measurement	Measurement Dates	Risks & Mitigation
Improved throughput	LAT	Current throughput figures on CRH site	Increased figures	Activity reports	Monthly	Existing CRH scanner may fail before planned installation date leading to lower than expected throughput. Delays to project may impede implementation date
Improved patient experience	LAT	Current Datix incident reports/patient experience survey	Improved figures	Datix reports and ongoing patient survey results for radiology	Monthly	Patients who have had a scan on both new and old scanners may express preference to not be scanned on 'older scanner'.
Reduction in dose levels received	LAT	Current dose levels compared with NDRLs	Reduction in dose levels for all examinations	Audit	3/12	Dose level reduction dependent on image quality that the reporters will accept. Often new scanner parameters take some time to get used to.
Improved staff morale	LAT	Survey before project	Survey post completion	Review of staff survey and agree actions with staff	01/06/24	Failure to properly plan unit/layout and train staff on new scanner

Addendum to CT Scanner Business case

The table below shows the revenue impact of the additional 4th CT scanner over the 10-year lifespan, across each of the appraised options:

		Option 1 Existing 3 scanners, no mobile		Option 2 Existing 3 scanners plus mobile		Option 3 4 scanners (purchase of 4th)
Cost over 10 years		**£000**		**£000**		**£000**
	mobile hire	-		9,605		-
	staffing	-		-		3,920
	maintenance	-		-		675
	depreciation	-		-		2,643
	PDC charges	-		-		509
	Total cost - 10 years	**-**		**9,605**		**7,747**
Impact on capacity - 10 years		-		120,360		182,000
Qualititative		Reliance on existing CT scanner at CRH (beyond useful life)		Not all patients can use modular unit plus cant offer full range of scans		Full range of scans and open to all patients

Note that the above excludes the impact of inflation.

16. Workforce Committee Chair Highlight Report

To Note

Presented by Karen Heaton

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:	17 October 2023
Date of Board meeting this report is to be presented:	2 November 2023
ACKNOWLEDGE	The following points are to be noted by the Board following the meeting of the Committee on 17 October 2023 where the strategic theme was Workforce Design. • The Committee received two presentations on Workforce Design in practice from the leaders of the Emergency Department covering the reconfiguration and from Ophthalmology on Collaborative working. The Committee was impressed with how both departments had led and engaged with the process and taken colleagues with them on the change journey which resulted in a positive team effort. It was recognised that a great deal of effort had been invested in communicating the change to colleagues, engaging their support and commitment to a different and better way of working which had not been easy to achieve. • The NHS Diversity and Inclusion Improvement Plan was discussed. The NHS EDI improvement plan is co-produced through engagement with colleague networks and senior leaders. The plan:- a) sets out why equality, diversity and inclusion is a key foundation for creating a caring, efficient, productive, and safe NHS; b) explains the actions required to make the changes that NHS colleagues and patients expect and deserve, and who is accountable for them; c) describes NHS England implementation support. d) provides a framework for integrated care boards to produce local plans. • The Workforce Race Equality Standard and Workforce Disability Equality Standard action

	plans 2023-2024 have the full support of our colleague networks. • IPR- a revised format was presented to the Committee. Concerns remain over the level of sickness absence although the absence rate was reducing. It was recognised that the new format requires some additional work to ensure all areas, where appropriate, have agreed and stated targets. The turnover and staff survey results in HPS were highlighted as an area of concern and requiring support from WOD.
ASSURE	• The EDI improvement plan supports the progression of CHFT's Inclusion Agenda and People Strategy. All activity in CHFT will be aligned to this plan and we will continue to engage and gain support from the equality networks. The Inclusion Group will oversee progress. • The Committee undertook a deep dive into Nurse Staffing which remains a challenging area not just for CHFT but nationally. The Committee was assured that all was being done to mitigate the risks and whilst the BAF had been updated the risk score remained unchanged. • Minutes were received from the Inclusion Group.
AWARE	• The Committee will receive a report on the Trust's Retention Strategy at its December meeting. • The Trust's People Strategy has been adjusted to take on board the focus of the NHS Long Term Workforce Plan which will continue to require Partnership working.
ONE CULTURE OF CARE	One Culture of Care is considered as part of the workforce reports and in discussions.

17. Quality Committee Chair Highlight Report

- Learning from Deaths Quarterly Report Q1
- Director of Infection Prevention Control (DIPC) Q2 Report

To Note

Presented by Denise Sterling

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	21st August 2023, 25th September 2023
Date of Board meeting this report is to be presented:	2 November 2023
ACKNOWLEDGE	• Learning from patient story - End of Life Experiences, the key areas identified from the strands of feedback were improving communication, involvement of loved ones and carers in decision making and identifying end of life sooner. The improvement work of the end of life team over the past year was outlined, with the team's approach now is to highlight that end of life care is the responsibility of everyone within the Trust, not just those working within Palliative Care. • An overview was provided of the formation of the National Improvement Board and the NHS improvement approach that will build on the best approaches to organisational quality assurance, planning and improvement and to support increased productivity and enable improved health outcomes. A new Operating Framework is to be introduced and will align with the publication of the new single assessment framework for CQCs. Quarterly progress reports will be provided to the Quality Committee. • Committee noted the proposal for mandating Essentials of Patient Safety (e learning) in response to the Patient Safety Incident Response Framework (PSIRF) preparation.
ASSURE	• Follow up appointment concerns – significant progress has been made on the eight recommendations to reduce the risk of harm to patients that are waiting for follow up outpatient appointments. The task and finish group has been stepped down and further work and oversight will be undertaken through various governance structures. • Patient Experience Annual Report provides a comprehensive overview of the wide range of work undertaken over the year with excellent examples of patient, family and carer engagement. A number of patient surveys have been referenced and the response to these have helped to inform the development of the 3 year patient experience strategy alongside the staff involvement from across all divisions. Key ambitions have been identified to further develop services and enhance the patient experience. • IPC Report – the Trust's Clostridium difficile position has improved from previous years, there has been a limited number of outbreaks associated with norovirus and COVID -19 numbers have been quite low during Q1. The IPC Board Assurance Framework continues to be revised, the quality improvement audits and front line ownership audits are positive. Committee noted that action plans are in place for the Healthcare Associated Infections to improve on last year's performance, this is challenging and not unique to CHFT.

	• 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. There were 2 must do findings related to training and workforce. An action plan has been drafted and returned. The maternity service has also completed a reaccreditation assessment for Baby Friendly Initiative (BFI), this has been successful., and the unit has been reaccredited as a BFI Gold service. Quality Committee was also provided with information on the embedded learning event, a report on Avoiding Term Admissions in Neonatal Unit (ATAIN) – April to June 2023, the ATAIN action plan, a Transitional Care report – April to June 2023 and a Perinatal Mortality Review Tool (PMRT) action plan. • Medical Examiner Report - good progress continues to be made with the development of the service and the consistency of high level of performance from the team. A number of GPs have been employed which will enable the service to scrutinise community deaths. A gradual roll out to 13 GP practices has commenced with a plan to cover all 56 practices, local hospices and the Mental Health Trust by April 2024 when statutory legislation comes into effect. • Quality Report received and highlights from the Clinical Outcomes Group discussed, it was reported that there are challenges with attendance at the meetings. Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio are within the expected ranges; In-hospital crude mortality remains the same; there is good progress and work ongoing within sepsis and learning from deaths. • IPR – Impact of strikes on waiting lists increase in 40 weeks wait, concerns regarding ENT and the current position is being actively managed. Cancer performance remains good and support ongoing for Mid Yorkshire. The Safe and High Quality Care metrics is showing an improving position falls, pressure ulcers and infection. • Getting it Right First Time (GIRFT) achievements highlighted, CHFT is one of 25 Trusts chosen to participate in the GIRFT Further Faster Programme for clinical transformation across 15 specialties. The Elective Surgical Unit at HRI is one of eight surgical hubs nationally to be awarded GIRFT accreditation to recognise the unit meeting top clinical and operational standards. Committee noted that the national level approach from GIRFT appears to have changed from specialty deep dives locally and regionally to national programmes. Consideration is being given to CHFTs response to the changes. • Clinical Outcomes Group 6 month report - A number of the workstreams have slipped from significant assurance to limited assurance since the last report into QC. Actions have been outlined to address the workstreams with limited assurance. The newly appointed Deputy Medical Director will be focusing on this group to look at monitoring arrangements, frequency of meetings and agreed priorities and actions. It was noted that the Quality Summit scheduled for October will reset some of this work moving forward. • Under any other business at the August meeting an update was provided on the actions agreed with Directors, regarding the CHFT response to the Lucy Letby case. A ‘true for us’ report will be completed to test how the Trust fits against the learning from the case. It is important to recognise that a significant amount of time has passed since the crimes were committed and processes in place now were not at that time. The report was submitted to the September Board meeting.

AWARE	• 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. • A recurrent theme reported by presenters at Quality Committee is the impact the industrial action is having in many areas.

Learning from Deaths Report

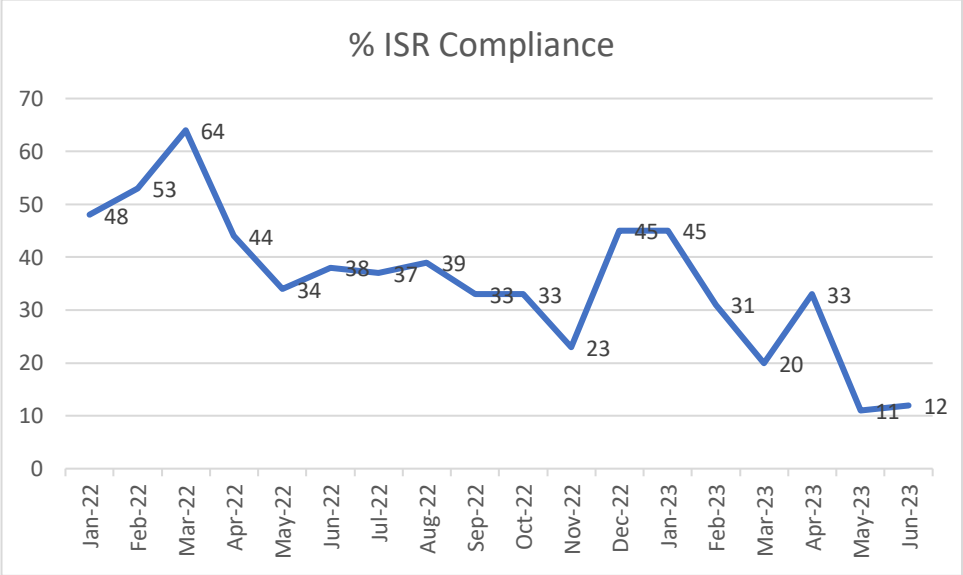
In Quarter 1 (April – June 2023), there were **419** adult inpatient deaths at CHFT recorded on Knowledge Portal.

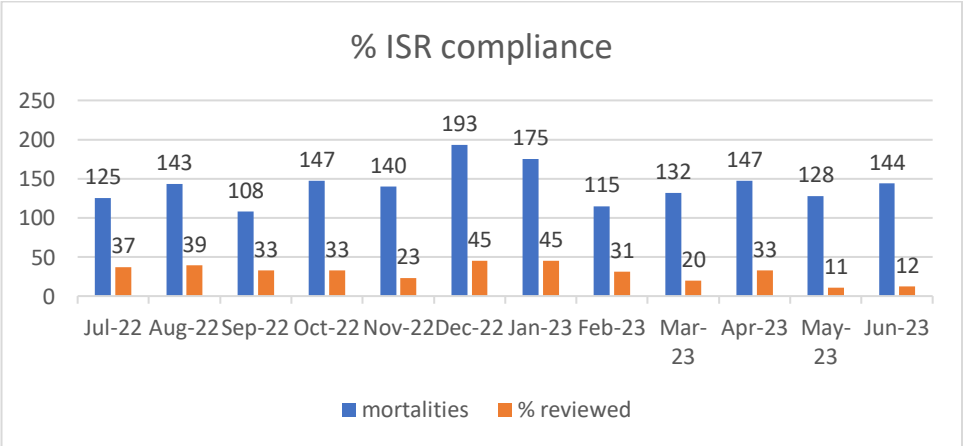
Initial Screening Reviews (ISR)

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

Of the **419** adult inpatient deaths recorded in Quarter 1 of 2023/2024, **100** (**24%**) have been reviewed using the initial screening tool. The committee is reminded of the slight lag between issuing cases for review and completion of this report (MSG have allocated mortalities up to June 2023). However, we are still falling short of the 50% target. Extra capacity for completion of ISRs has been offered by our Trust CT trainees. Trainees will be provided with confirmation of completion for their portfolios once they have undertaken 10 completed ISRs. And Mortality Leads have been contacted to remind all staff that the timeframe from allocation to review is 4 weeks.

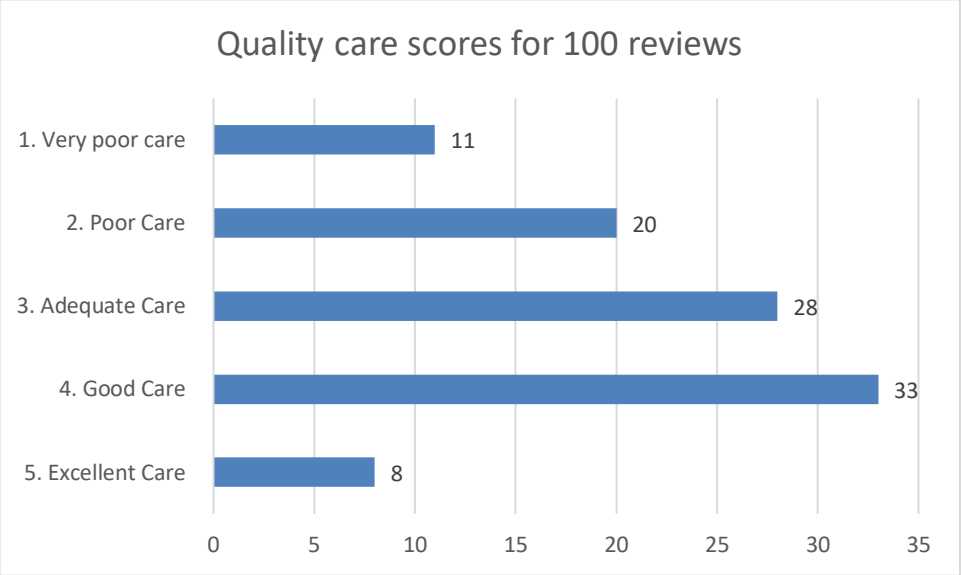
The table below shows the number of adult inpatient deaths reviewed by ISR by month over the last 12 months





Quality of care reviewed

% Quality Care Scores for ISRs completed in Q1 (April to June 2023/24) n=100



31% (31 cases) = poor care. Of these 31 initial screening reviews, 10 were deemed poor care by two separate structured judgement reviewers.
All have been reported on datix and are going through the respective divisional orange panels for validation

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

Structured Judgement Reviews Overview

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

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

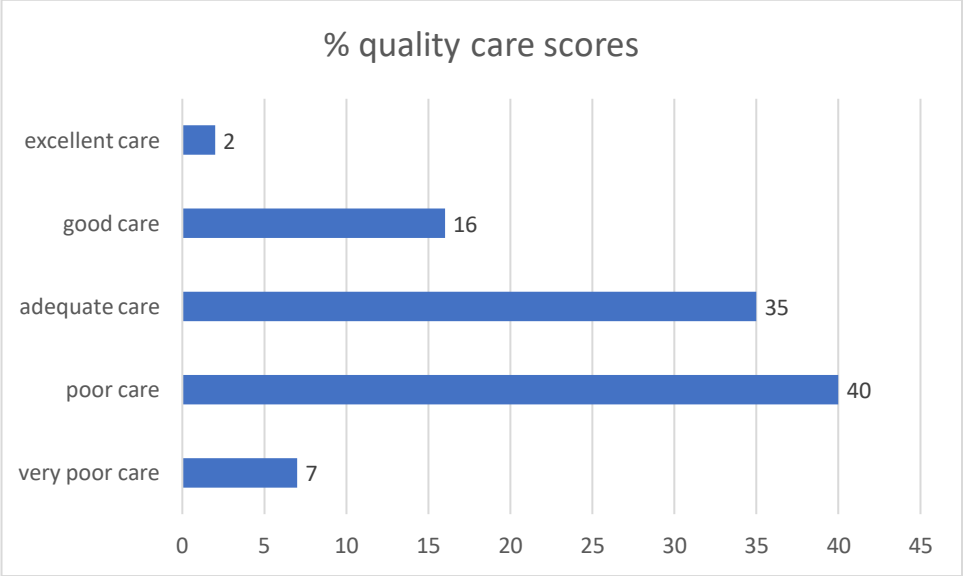
There have been 43 SJRs requested in Q1 of 2023/24

	Escalated by ISR	Escalated by ME	2nd opinion	SI Panel	Elective	Learning Disability	Total
April 23	**10**	**2**	**2**	**0**	**0**	**1**	**15**
May 23	**2**	**8**	**6**	**0**	**0**	**0**	**16**
June 23	**2**	**6**	**4**	**0**	**0**	**0**	**12**
total	**14**	**16**	**12**	**0**	**0**	**1**	**43**

A total of 43 SJRs were requested in Quarter 1 (April to June) of 2023/24 of which **40** have been completed.

There is currently a backlog of approx. 24 incidents reported via the SJR process that are awaiting discussion & validation at Medicine orange panel. The Learning from Deaths Lead is working with the Division of Medicine and the Interim Risk Manager to clear this backlog. Extra panel, dedicated to incidents identified by SJR, are planned in the coming weeks.

Quality of Care score distribution for 40 completed SJRs



10 SJRs were reported on Datix and escalated to the divisions for validation in Q1.
The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

Of the SJRs completed in Quarter 1 2023/2024 the following learning themes and concerns were identified:

The following good practice was identified:

- Diagnosis, management plan and decision making were good.
- Good practice to bring in family and discuss situation and alternative causes such as Stroke were considered.
- Good communication with the family, patient's family was involved in decision making process.
- Excellent documentation
- Capacity assessments done and documented.
- Prompt reaction to changing patient's condition.
- Multiple consultant reviews.
- Recognised deterioration and last days of life care was done appropriately.

The following poor practice was identified:

- Unsafe transfer from CRH to HRI

- Lack of senior review in view of repeated high NEWS scores in initial hours after admission
- Not seen by a consultant within 14 hours of admission
- Treatment prescribed but not given according to the chart like furosemide.
- Poor discharge planning from elderly/surgical team.

Recommendation to Quality Committee

Quality Committee is asked to note the Learning from Deaths Quarter 1 report.

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title of Report:	Quarterly Director of Infection Prevention and Control (DIPC) report Q2 – 1st July 2023 to 30th September 2023
Author:	Belinda Russell, Matron Lead IPC
Sponsoring Director:	Dr David Birkenhead, Executive Medical Director
Previous Forums:	Infection Control Committee
Purpose of the Report	The report provides an update on Infection, Prevention and Cont rol (IPC) performance and activity for the second quarter of 23/2 4.
Key Points to Note	Summary of the urinary Catheter Fixation device Audit The planned move to Patient Safety Incidence Response Frame work **PSIRF** for review of HCAI's in line with national guidance.
EQIA – Equality Impact Assessment	This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections.
Recommendation	The Board is asked to **NOTE** the performance against key IPC targets and **APPROVE** the report.

Calderdale and Huddersfield NHS Foundation Trust

IPC Report Q2 – 1st July 2023 to 30th September 2023

1. Introduction

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

2. Performance targets

Indicator	Objective 2023/24	CHFT Year to date performance	Actions/Comments
MRSA bacteraemia	0	0	Not mentioned on this year's targets 0 -HOHA 1-COHA
C.difficile (HOHA & COHA)	37	28	18 -HOHA 10 -COHA (10 -COCA) (Q1 HOHA 4 April, 3 May, 2June =9) (Q2 HOHA 1 July, 6 Aug, 2 Sept = 9)
E. coli bacteraemia	67	38	16 - HOHA 22- COHA (130- COCA)
Pseudomonas aeruginosa	2	4	2 -HOHA 2 -COCA (8-COCA)
Klebsiella spp.	28	22	9 -HOHA 13 -COHA (36-COCA)
MSSA	0	15	Not mentioned on this year's targets continue to be monitored. 8 - HOHA 7 - COHA (38 – COCA)
ANTT Competency assessments (medical staff)	90%	65.17%	
ANTT Competency assessments (nursing and AHP)	90%	89.85%	
Hand hygiene	95%	100%	
Level 2 IPC training (Medical staff)	90%	80.79	
Level 2 IPC training (nursing and AHP)	90%	93.00%	

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

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	92.16%	
Isolation breaches	Non set	Not recorded this quarter	COVID-19 patients remain priority for side room isolation

4. MRSA bacteraemia:

No objective for MRSA cases in year. 1 COHA case deemed unpreventable to report during the current reporting period/year to date.

5. MSSA bacteraemia:

There is no objective set for MSSA. The IPC team continue to review these cases. 8 HOHA cases Q1 zero HOHA case in Q2.

6. Clostridium difficile:

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

There has been a total of 18 HOHA cases and 10 COHA cases year to date. Each case up to the end of September is being investigated following the PIR guidance within the IPC team. All Cases going forwards will have a Patient Safety Incidence Response Framework (PSIRF) review using a Multi-Disciplinary Team (MDT) approach and steps away from blame being apportioned, instead the emphasis is on what learning can be found across the system using contributory factors which are then appraised into themes; these will help to formulate the IPC team annual plan.

7. E. coli bacteraemia:

There have been 16 post-admission HOHA plus 22 COHA *E. coli* bacteraemia cases. This is 56% of the years target figure and will continue to be monitored.

8. Outbreaks & Incidents:

Increased incidence Covid-19: There has been a gradual increase in Covid19 cases recorded during Q2 where increased case mitigations have been in place within wards affected across all divisions.

Water hygiene: An ongoing series of water tests have been carried out across the site where positive results for known water organisms have been found. Remedial actions have been carried out under advisement from the Trust water specialist including purging of the system. Further sampling has been undertaken and a broader water hygiene sampling programme has been implemented across HRI and CRH.

9. Audits

Urinary Catheter Fixation Device: An audit has taken place during August 23 following the urinary catheter audit earlier in the year; showing 50% compliance in the use of catheter fixation devices**,** the main theme arose from lack of knowledge around the devices. This has been fed back to ward managers and to the Continence and Clinical Education teams, a piece of education is to be planned collaboratively around this and will be a focus area within the Urinary catheter training going forwards.

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

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

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

Performance Summary | Performance by Division | Performance by Ward | Graphs | Date audit last completed

FLO Inpatient Performance

Table will show overall Trust performance, please add division or ward/dept filter to show performance for a specific area

Section / Question	Month: Jul-2023	Aug-2023	Sep-2023
Total	93.76%	92.75%	92.96%
1. Hand Hygiene	96.48%	95.29%	97.06%
2. General Environment	89.35%	85.48%	89.74%
3. Patient's immediate area/bed space	97.69%	95.15%	96.08%
4. Isolation of Infected Patients	95.74%	96.00%	95.08%
5. Dirty Utility/linen and waste disposal	94.16%	95.53%	94.54%
6. Kitchens	88.38%	88.30%	86.86%
7. Sharps Safety	88.57%	85.95%	85.95%
8. Storage Areas & Clean Utility	94.69%	94.32%	93.93%
9. Patient Equipment	96.90%	97.76%	95.13%
10. Clinical Practice	96.48%	95.41%	95.34%

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

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

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

11. Recommendations

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

18. Integrated Performance Report

To Note

Presented by Jonathan Hammond

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
Meeting:	Board of Directors
Title:	Quality & Performance Report
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Jonathan Hammond, Chief Operating Officer
Previous Forums:	Executive Board, Finance & 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 September 2023.
Key Points to Note	**Performance Matrix Metrics Changes** • **40 and 52-week waits** special cause improvement pass to special cause improvement hit/miss. • **Total RTT Wating List** special cause concern and hit/miss to common cause and hit/miss. • **Diagnostic activity** special cause improvement and hit/miss to common cause hit/miss. • **Staff Movement** special cause concern pass to special cause improvement and pass. • **Hospital Discharge Pathway Activity** special cause concern and hit/miss to common cause and hit/miss. • **ED 4-hour (LD)** common cause and fail to special cause concern and fail. • **ED 4-hour (IMD1/2)** special cause concern and hit/miss to common cause and hit/miss. **Performance Summary** For September 2023 we continue to perform well in terms of **elective recovery** 65/52/40 weeks although there has been further impact on the > 40-week position due to the continuing Industrial Action and the ENT ASI position. For **diagnostics** we still have challenges in Echo and Neurophysiology with trajectories now stretching out until March 2024. There is significant work happening to reduce our **follow-up** backlog. As of 23rd October we now have over 25,000 follow-up patients past see by date with plans to reduce this to below 20,000 by the end of March 2024. **Cancer** performance continues to be strong with faster diagnosis target being achieved for the first time since April.

	ED performance for September reduced to 68% with continuing pressures around numbers of patients and acuity. We have also seen an increase in the number of patients waiting over 12 hours in ED plus an increase in bed occupancy due to the decrease in open beds in month. Proportion of ambulance arrivals delayed over 30 minutes rose to 3% in September and is expected to increase again from October onwards due to the use of arrival destination as the trigger for when the clock starts - this will remove any notify times previously used. 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. There was 1 **Never Event** in September. The data collated from all of the Never Events has demonstrated common themes around training, documentation and record keeping. 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 have seen a further improvement in-month to 86%. **Sickness Absence** in September was at its lowest level since April 2021 at 4.3%.
EQIA – Equality Impact Assessment	The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.
Recommendation	The Board of Directors is asked to **NOTE** the narrative and contents of the report for September 2023.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report
September 2023

Report produced by this

Contents:

Performance Matrix Summary:

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

VARIANCE	ASSURANCE: PASS	ASSURANCE: HIT or MISS	ASSURANCE: FAIL
SPECIAL CAUSE IMPROVEMENT	• Total Patients waiting >65 weeks • Total Patients waiting >40 weeks (LD/IMD 1 and 2) • Staff Movement (Turnover) • Core EST Compliance	• Total Patients waiting >40 weeks • Total Patients waiting >52 weeks	• Proportion of ambulance arrivals delayed over 30 minutes • % of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward.
COMMON CAUSE/NATURAL VARIATION	• Patients dying within their preferred place of death	• Total RTT Waiting List • Diagnostic activity undertaken against activity plan • Total Patients waiting > 62 days for cancer treatment compared with February 2020 • Proportion of patients meeting the faster diagnosis standard • Non-site-specific cancer referrals • ED Proportion of patients seen within 4 hours • Proportion of patients spending more than 12 hours in ED • Hospital Discharge Pathway Activity • Stillbirths per 1,000 total births • 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 Never Events • Number of Serious Incidents • % of incidents where the level of harm is severe or catastrophic • % of complaints within agreed timescale • % of episodes scoring NEWS of 5+ going on to score higher • Proportion of patients meeting the faster diagnosis standard (LD) • % Outpatient DNAs (LD) • % of patients that receive a diagnostic test within 6 weeks (LD) • ED Proportion of patients seen within 4 hours (IMD 1 and 2) • 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 • Bed Occupancy • % of beds occupied by patients who no longer meet the criteria to reside • % Outpatient DNAs (IMD 1 and 2)
SPECIAL CAUSE CONCERN	• No KPI's	• Transfers of Care	• ED Proportion of patients seen within 4 hours (LD)

Not included in table – Finance, Virtual Ward, elective activity, follow-up activity, Community Waiting List, Admission avoidance (frailty), neonatal deaths and Care Hours per Patient Day (CHPPD)

Elective Care:

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Patients waiting >40 weeks to start treatment	Sept 2023	1,081	0			-	-	-
Total Patients waiting >52 weeks to start treatment	Sept 2023	10	0			-	-	-
Total Patients waiting >65 weeks to start treatment	Sept 2023	0	0			-	-	-
Total RTT Waiting List	Sept 2023	34,478	31,586			32,223	29,698	34,478
Total elective activity undertaken compared with 2023/24 activity plan	Sept 2023	101.8%	100%	-	-	-	-	-
Percentage of patients waiting less than 6 weeks for a diagnostic test	Sept 2023	82.9%	95%			87%	80%	94%
Diagnostic Activity undertaken against activity plan	Sept 2023	14,321	14,547			13,175	11,328	15,021
Total Follow-Up activity undertaken compared with 2023/24 activity plan	Sept 2023	94.6%	100%	-	-	-	-	-

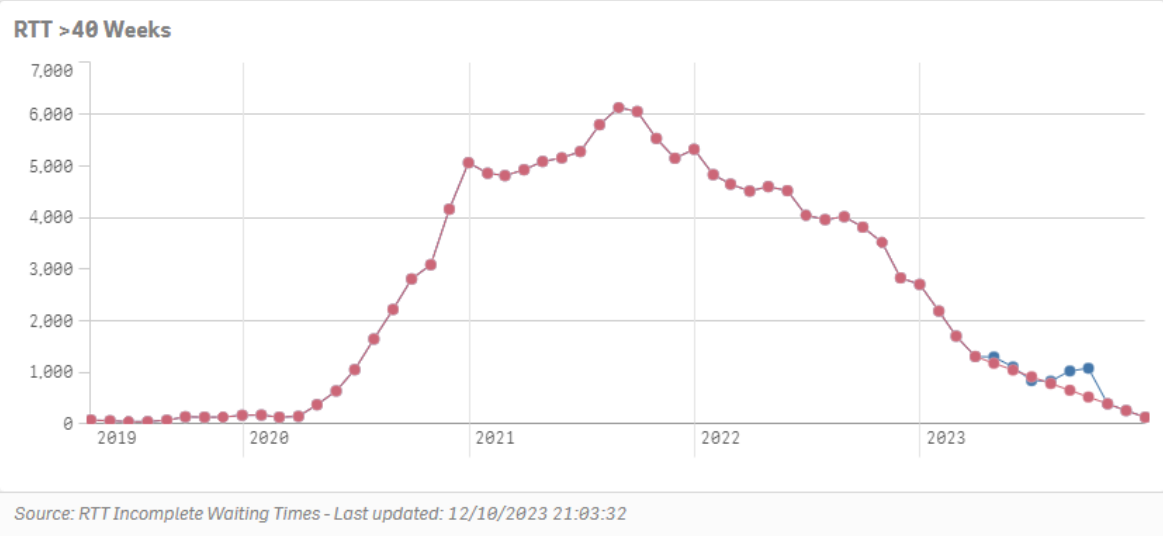
Total Patients waiting more than 40 weeks to start consultant-led treatment

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 had been reducing monthly from a peak of 6,000 but has now increased again to the current position of 1,081 at the end of September 2023. The target trajectory was 524, so we are behind trajectory.
- Most of our remaining patients who are waiting over 40 weeks are in ENT (318), Max Fax (85), T&O (85), General Surgery (262), Urology (79) and Gastroenterology (51).

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. Of our specialties with patients over 40 weeks, ENT is currently the most challenging and has ASIs that are now 35 weeks since referral and are continuing to increase. This is now starting to impact on the over 40 weeks position. The over 40 weeks position has also been impacted in other specialties by the continuing industrial action.

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.

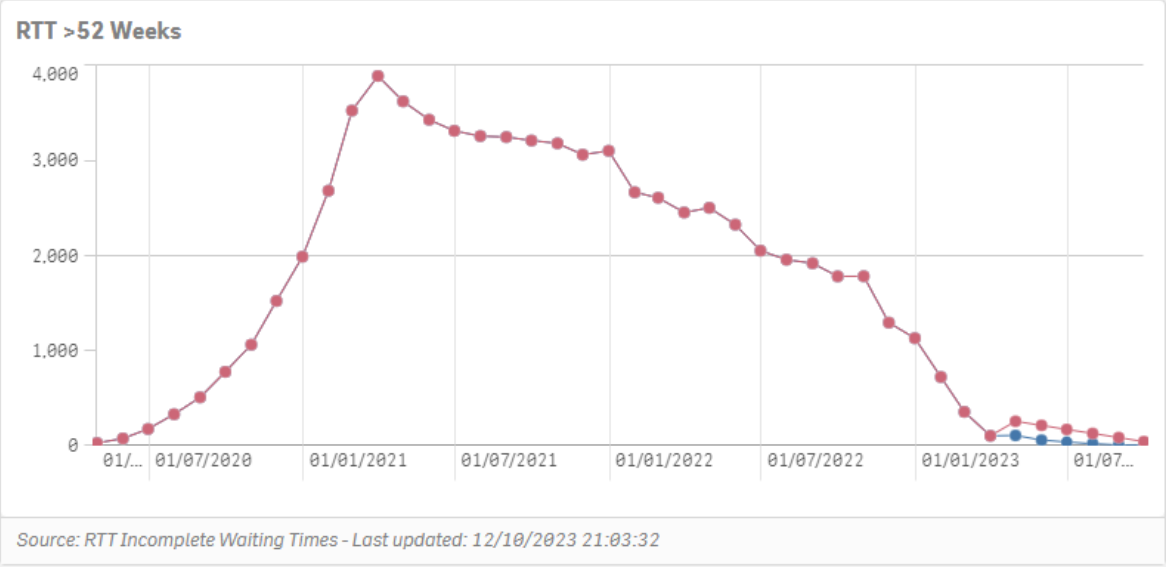
Total Patients waiting more than 52 weeks to start consultant-led treatment

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 has been reducing monthly from a peak of 4,000 to the current position of 10, but we have missed the internal target.
- The remaining patients who are waiting over 52 weeks are in General Surgery (3), Urology (2), ENT (4) and Gastroenterology (1).
- There are 248 waiting between 46 and 52 weeks, of which General Surgery (75), Urology(22), T&O (23), ENT (50), Max Fax (23), Plastic Surgery (15) and Gynaecology (10).
- All other specialties have fewer than 10 patients waiting between 46 and 52 weeks.

Underlying issues:
- Of the remaining patients who are over 52 weeks, most have a treatment plan in place before the end of September, therefore in the short term we would expect the position to continue to fall to zero.
- The longer-term risk to the 52-week position is specifically from ENT ASIs.

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

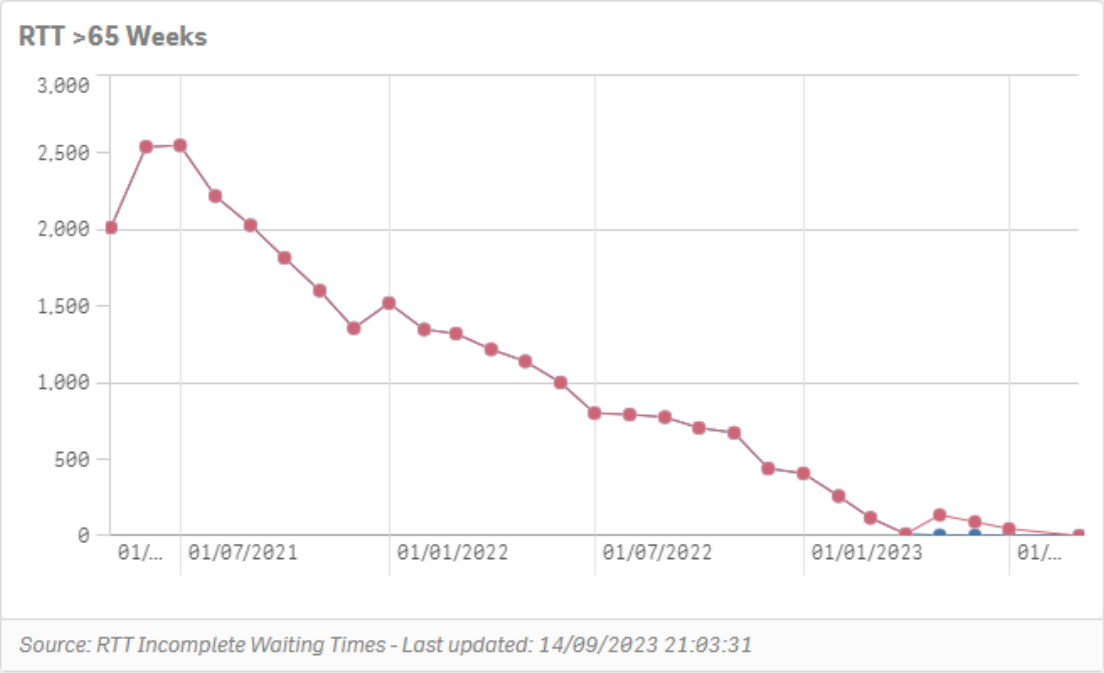
Total Patients waiting more than 65 weeks to start consultant-led treatment

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:
- Our 65-week position had reduced monthly from a peak of 2,500 to 0 from July. At the end of September there are 0 patients waiting over 65 weeks.

Underlying issues:
- No underlying issues

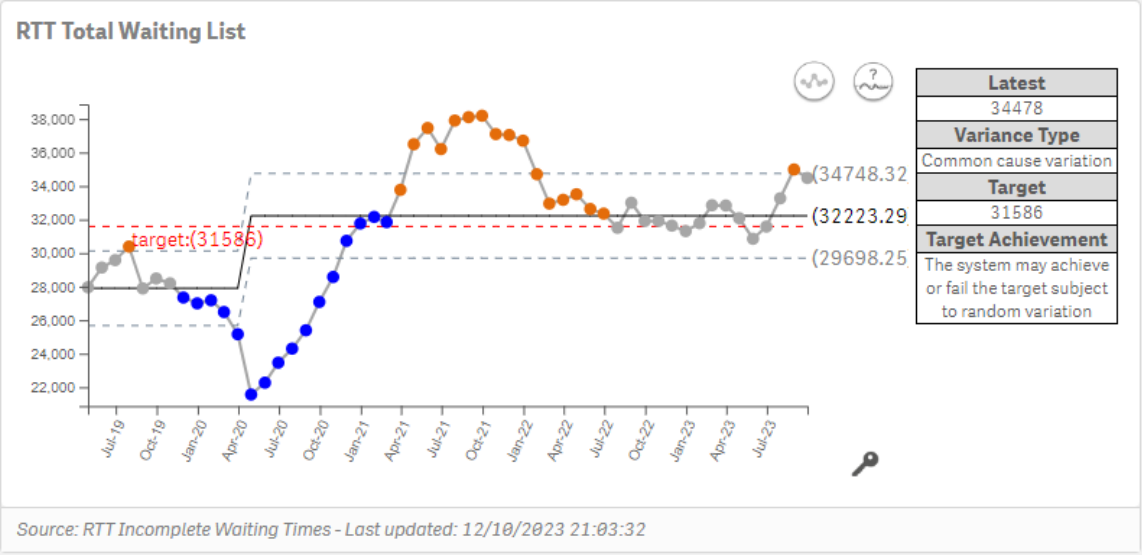
Actions:
- No actions required

Total RTT Waiting List

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

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

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



What does the chart show/context:
- Our waiting list size had been consistently between 31,000 and 33,500 since February 2022 after increased variation at the start of 2020 (a reduction caused by several patients being returned to GPs at the start of Covid/not accepting new referrals and then an increase due to referrals being accepted but capacity being reduced in both admitted/non-admitted areas between July 2020 and July 2021).
- After a significant rise in August, the list has now fallen slightly and stands at 34,478 at the end of September.

Underlying issues:
- We currently have a relatively stable RTT Waiting list position.
- 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.

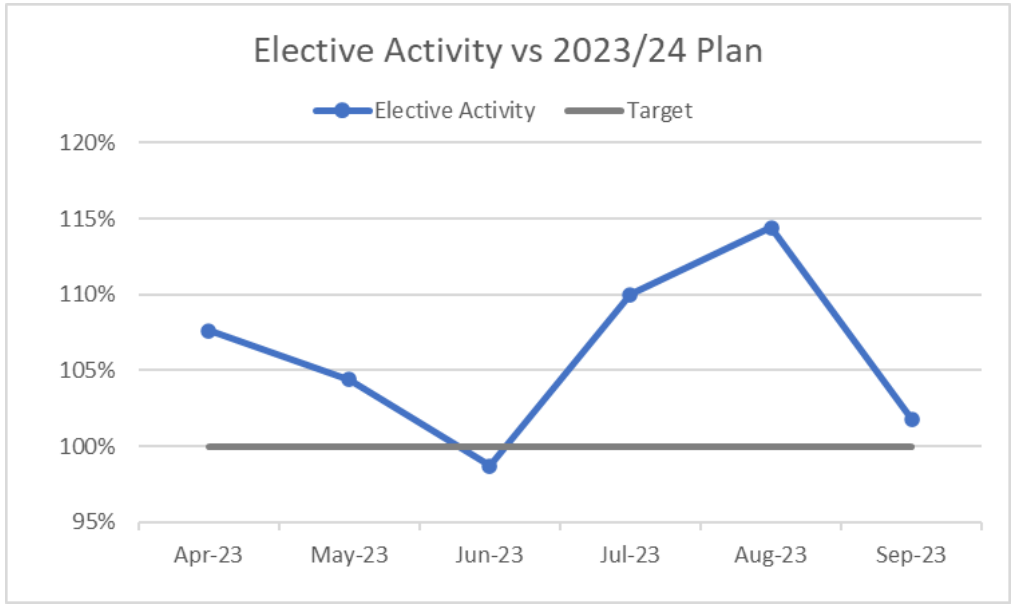
Actions:
- Validation team to monitor LUNA (National DQ RTT Benchmarking tool – currently in top 30 Trusts in the country for RTT DQ Assurance).
- Meet the trajectory for no ASIs over 18 weeks by the end of March 2024.
- Meet the trajectory for 40/52/65 weeks.
- Operational teams to be tracking patients 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 5 of the 6 months compared with the 2023/24 activity plan.
- Performance in September 2023 has decreased to 101.8% in month.
- Day cases were above the planned position for September, standing at 102.8%, this is a drop from August.
- The YTD performance for the elective activity overall remains above the planned position and currently stands at 105.8%, which is a total of 1,299 spells more than the plan at this stage.
- Both day case and elective activity have performance above the 100% planned position.

Underlying issues:
- We continue to deliver over 100% of our activity plan and therefore continue to see a reduction in 52 week waits.
- 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.

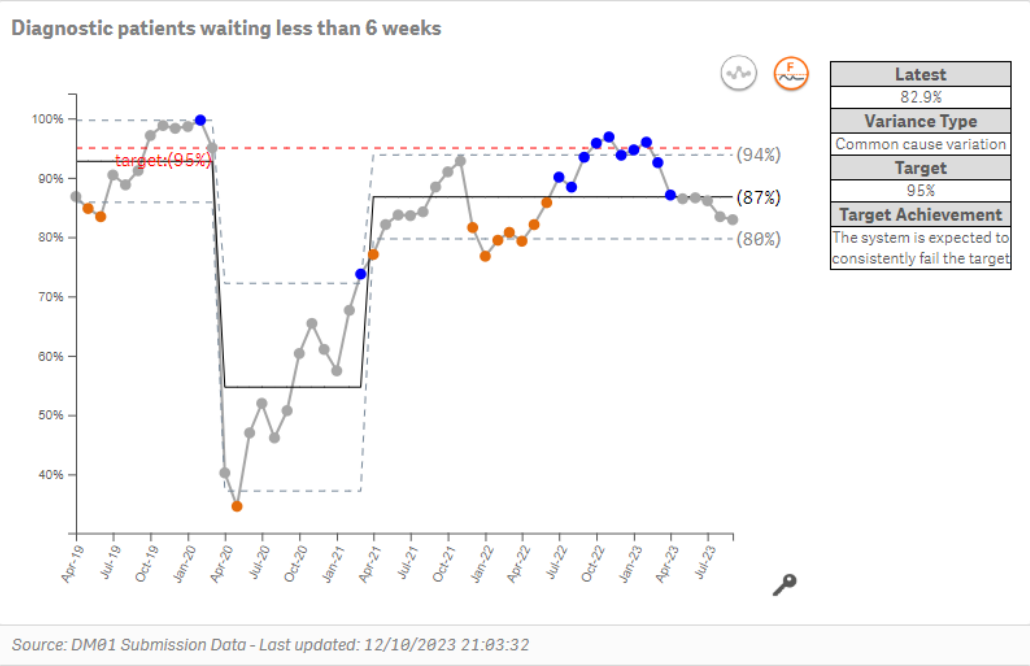
Percentage of patients waiting less than 6 weeks for a diagnostic test

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 (44.7%) and Neurophysiology (51.4%).

Actions:

Echocardiography
- Enhanced rates of pay agreed for reporting and scanning backlog reduction:
- Reporting backlog at 610 down from 819 and should be cleared by mid-December.
- TTE additional clinics live from October.
- Able to recover half of the backlog with current substantive workforce.
- Awaiting further recruitment to bank posts.
    - 1.4 WTE due to begin in December.
    - Advert out currently.
- One of the trainees is now accredited and can run clinics independently.

Neurophysiology
- It is acknowledged that the service has fallen behind planned trajectory due to staffing.
- A second consultant has been appointed which will increase EMG capacity, however as EMGs are performed by one doctor and one physiologist together, we will need to be mindful of CTS/EEGs and other physiology test waiting times increasing.

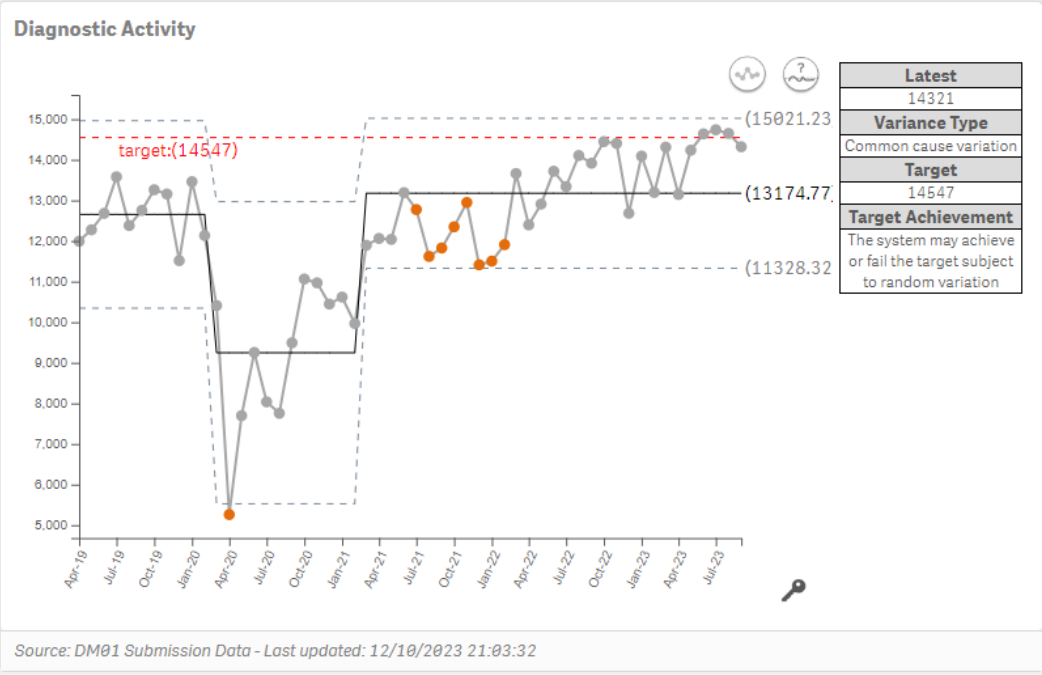
Total Diagnostic Activity undertaken against the activity plan

Executive Owner: Jonathan Hammond
Business Intelligence Lead: Fiona Phelan

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

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

Target:
Recovery of diagnostic testing is key to wider elective recovery, including RTT performance. Target 14,547 (activity plan 2023/24)



What does the chart show/context:

- The Trust is unable to consistently meet the target of 14,547 and may achieve or fail the target subject to random variation.
- Performance can be expected to vary between 11,328 and 15,021. Activity is similar to pre-Covid levels.

Underlying issues:

- Overall we are performing below the target level, but in most modalities this is due to being at 6 weeks or less from a diagnostic waiting time perspective, and therefore 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

- Enhanced rates of pay agreed for reporting and scanning backlog reduction:
- Reporting backlog at 610 down from 819 and should be cleared by mid-December.
- TTE additional clinics live from October.
- Able to recover half of the backlog with current substantive workforce.
- Awaiting further recruitment to bank posts.
    - 1.4 WTE due to begin in December.
    - Advert out currently.
- One of the trainees is now accredited and can run clinics independently.

Neurophysiology

- It is acknowledged that the service has fallen behind planned trajectory due to staffing.
- A second consultant has been appointed which will increase EMG capacity, however as EMGs are performed by one doctor and one physiologist together, we will need to be mindful of CTS/EEGs and other physiology test waiting times increasing.

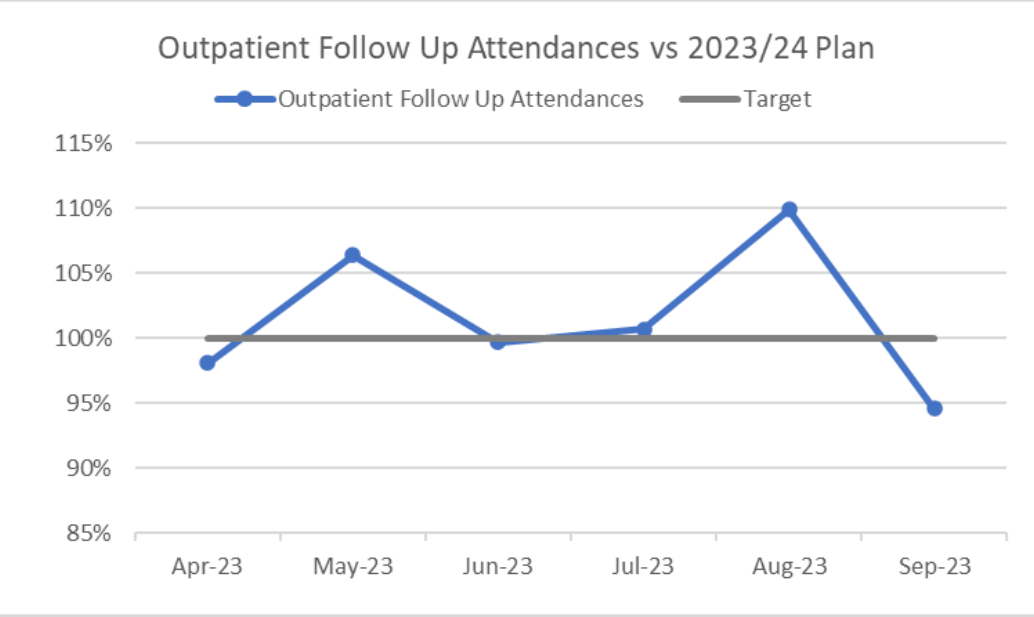
Total Follow-Up attendances undertaken compared with 2023/24 activity plan

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 declined for month 6 and CHFT achieved 94.6% of the planned position in month for follow-up attendances.
- The YTD position remains above the planned levels standing at 101.6%, this is 1,945 attendances over the planned position.

Underlying issues:
- Although the national target for follow-up activity is 75% of 2019/20 activity, due to a significant follow-up backlog (25,204) CHFT have not taken this up.
- The majority of the backlog has been waiting less than 12 weeks.
- Industrial Action has had an impact on follow-up attendances in the month of September.

Actions:
- There are currently 8,916 (of the 25,204 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 is 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, we now have over 25,204 follow-up patients past see by date (gradually increasing weekly after the 3,000 admin validation reduction).
- Deep dives are being undertaken at specialty level, to create a bespoke plan for each specialty to continue to reduce the follow-up backlog and long waiters.

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	9th Oct 2023	43	35			35.13	20.83	49.43
Proportion of patients meeting the faster diagnosis standard	Sept 2023	79.03%	75%			76.63%	66.56%	86.7%
Non-Site-Specific Cancer Referrals	Sept 2023	22	25			17.93	4.07	31.80
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	Sept 2023	43.8%	75%			48.72%	34.01%	63.42%

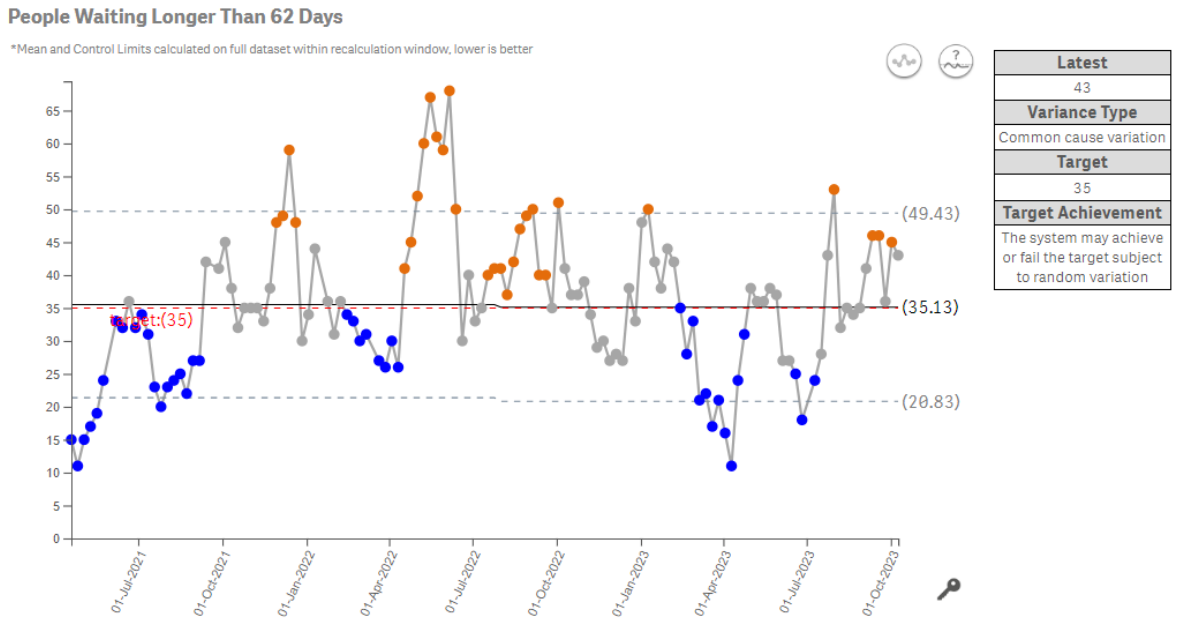
Total Patients waiting over 62 days to begin cancer treatment compared with February 2020 baseline

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Bethany Todd

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:
- The snapshot reflects the Sunday position of that week.
- The Trust is unable to consistently meet the target of 35 or less and may achieve or fail the target subject to random variation. Performance can be expected to vary between 21 and 50.
- 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. Effort went in to reduce our PTL to pre-pandemic levels by March 2023.

Underlying issues:
- At least 50% of the long waiters are Colorectal.
- We also do not work at weekends, therefore this report does not consider Friday's activity, which is captured on Monday's tracking.
- As of Monday 9th October there were 43 patients on the long waiters' report.

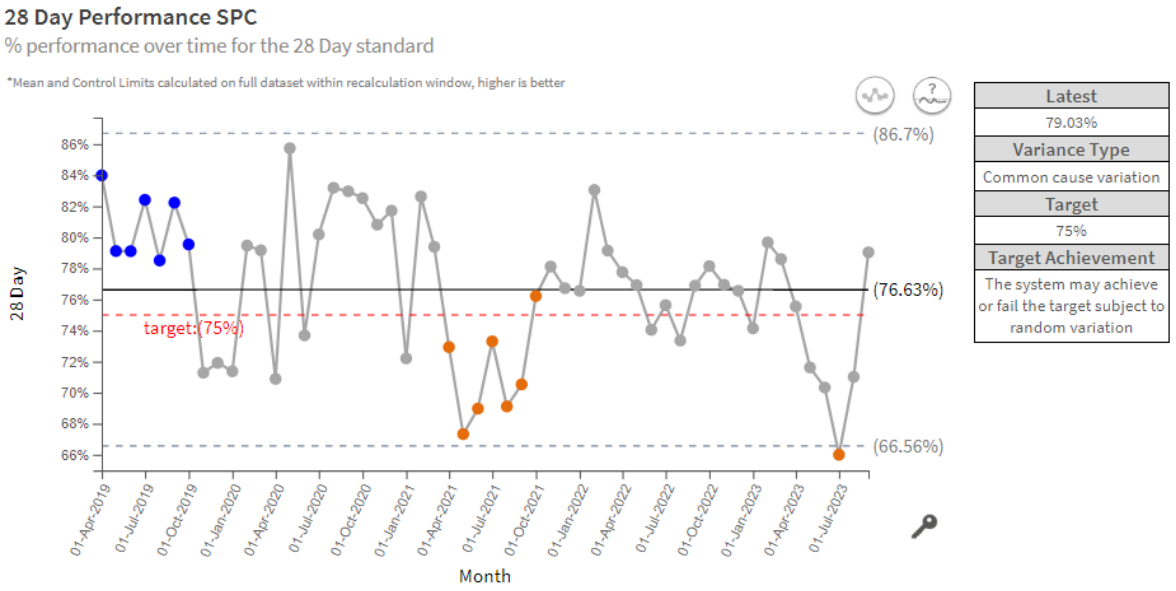
Actions:
- Over 62-day waiters continuing to be monitored on a case-by-case basis by PPC team.

Proportion of patients meeting the faster diagnosis standard

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Bethany Todd

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 79.03% which is above the NHSE target.
- 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.

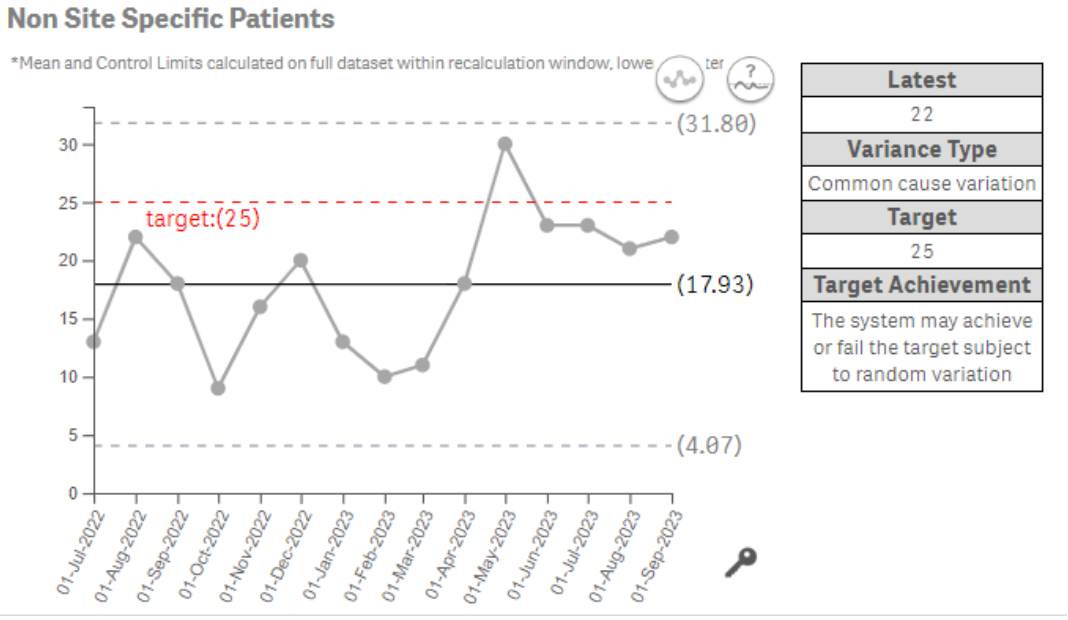
Actions:
- Skin have reverted back to their face to face clinics, Skin and the overall 28 day target have improved as a result.
- Pathway navigator in place for Lower GI and Upper GI to support patients to engage with the pathway.

Non-Site-specific Cancer Referrals

Executive Owner: Jonathan Hammond Operational Lead: Maureen Overton Business Intelligence Lead: Bethany Todd

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 4 and 32

Underlying issues:
- Referrals have remained steady this month at 22 with a minor decrease on the projected number (25).
- 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.

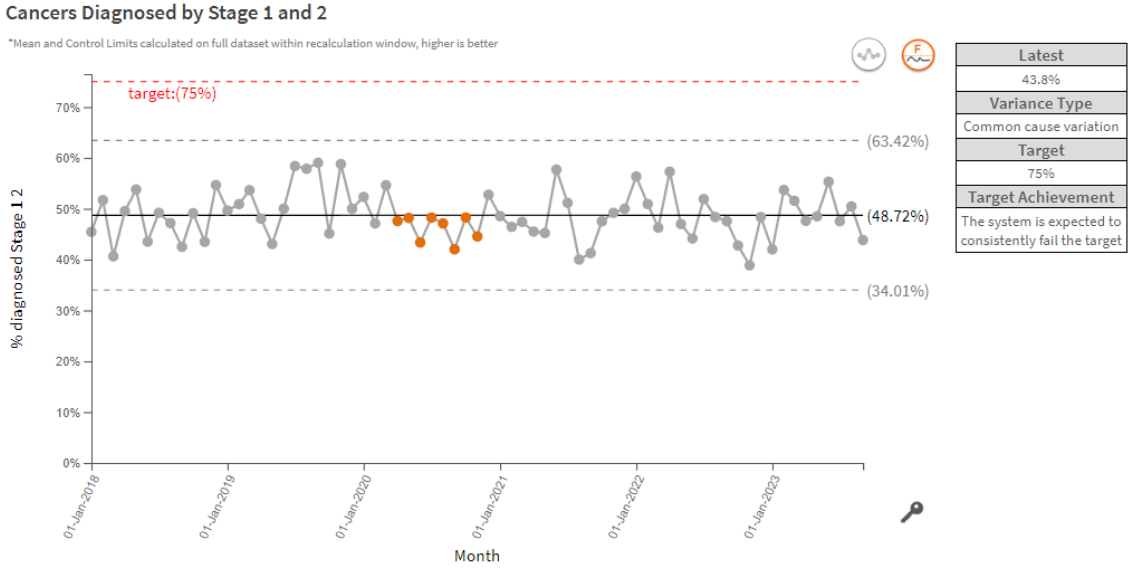
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Maureen Overton Business Intelligence Lead: Bethany Todd

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 34.01% and 63.42%.
- Nationally this metric stands at 52%, and CHFT are below this

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.

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	Sept 2023	68.31%	76%			69%	60%	77%
Proportion of ambulance arrivals delayed over 30 minutes	Sept 2023	3.0%	0%			4%	1%	7%
Proportion of patients spending more than 12 hours in an emergency department	Sept 2023	4.09%	2%			3%	0%	5%
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	Sept 2023	98.3%	96%			98%	96%	100%
% of beds occupied by patients who no longer meet the criteria to reside	Sept 2023	23%	14.21%			22%	18%	26%
Hospital Discharge Pathway Activity – AvLOS pathway 0	Sept 2023	4.3	4.1			4.00	3.60	4.41
Transfers of Care	Sept 2023	111	50			89	47	131

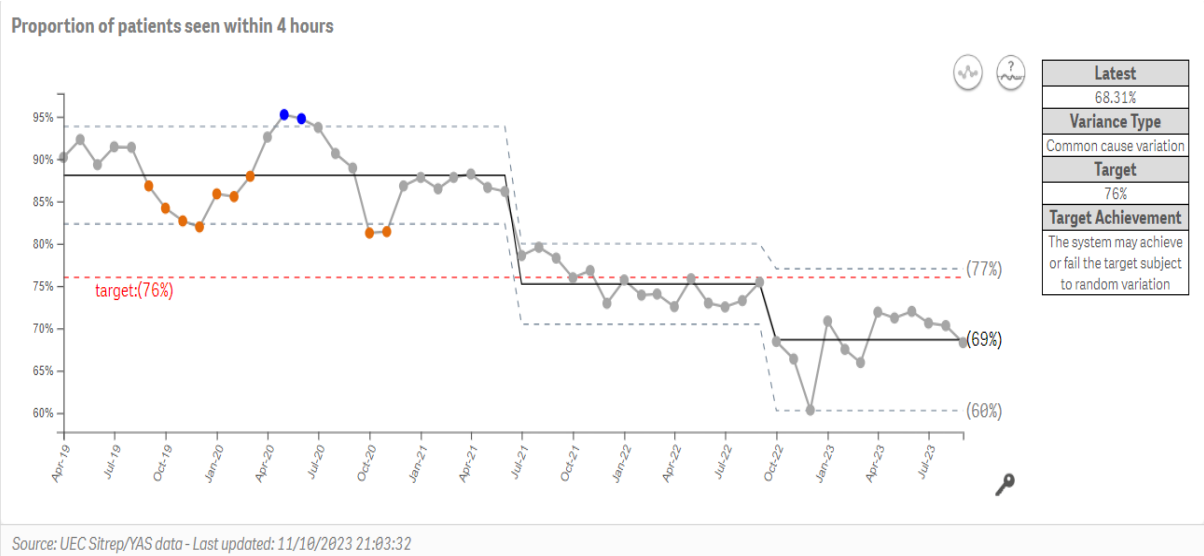
Proportion of patients seen within 4 hours

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 60% and 77%.
- The performance for September was 68.3% which is a decrease from previous months' performance.

Underlying issues:

- Increase in attendances
- Increase in occupied beds - long wait for beds
- Increase in acuity

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.

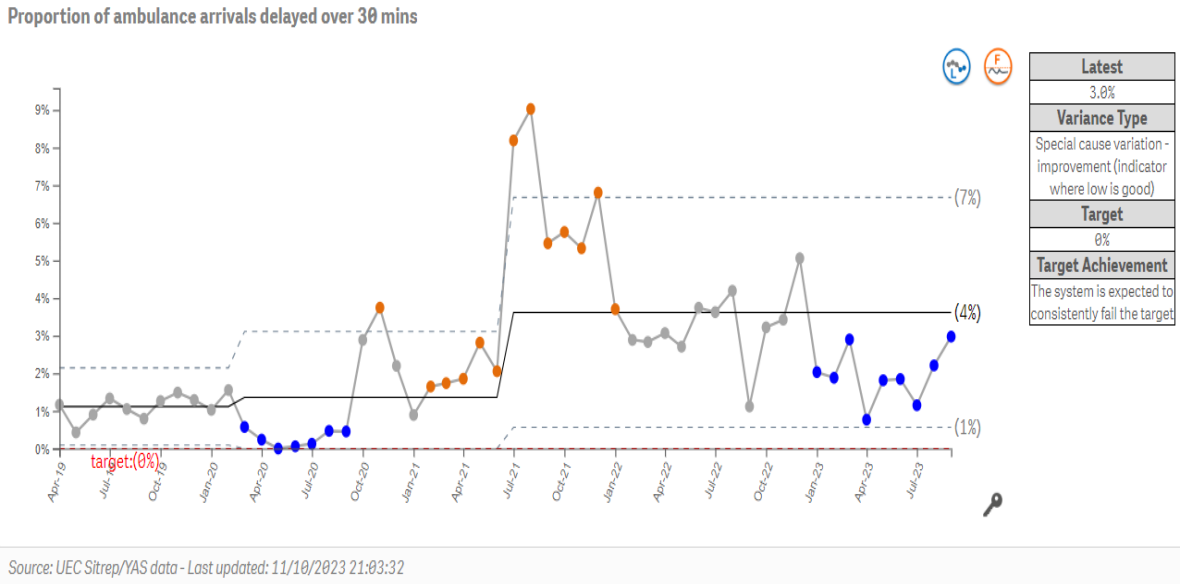
Proportion of ambulance arrivals delayed over 30 minutes

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 September was 3.0%.
- The Trust is expected to consistently fail the target of 0%. Performance can be expected to vary between 1% and 7%.

Underlying issues:
- We will see an increase in this indicator from October onwards 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 will remove any notify times previously used and 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)

Actions:
- Improvement for all metrics for ambulance handovers - SOP in action that ensures consistent approach to validation.

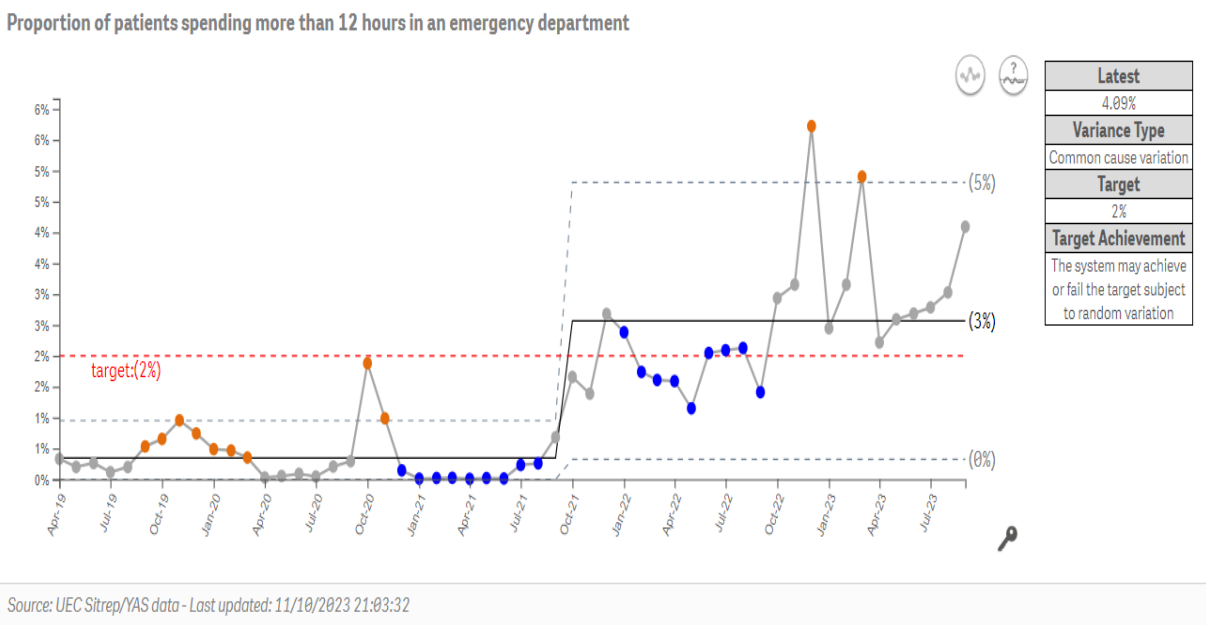
Proportion of patients spending more than 12 hours in an emergency department

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 September the performance was 4.09% with 620 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% and 5%.

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.

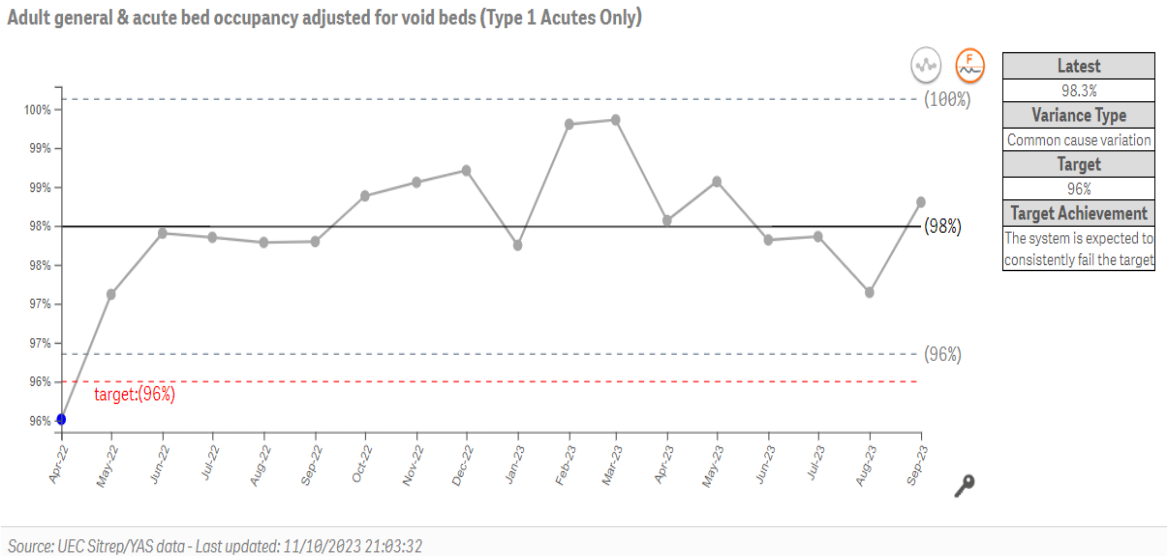
Adult general & acute bed occupancy adjusted for void beds (Type 1 Acutes Only)

Calderdale and Huddersfield NHS Foundation Trust

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

Rationale:
Understand the proportion of adult general and acute beds that are occupied.

Target:
Target 96% or less.



Source: UEC Sitrep/YAS data - Last updated: 11/10/2023 21:03:32

What does the chart show/context:
- Adult bed occupancy remains high with September at 98.3%. The increase was due to the decrease in open beds in month.
- 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.

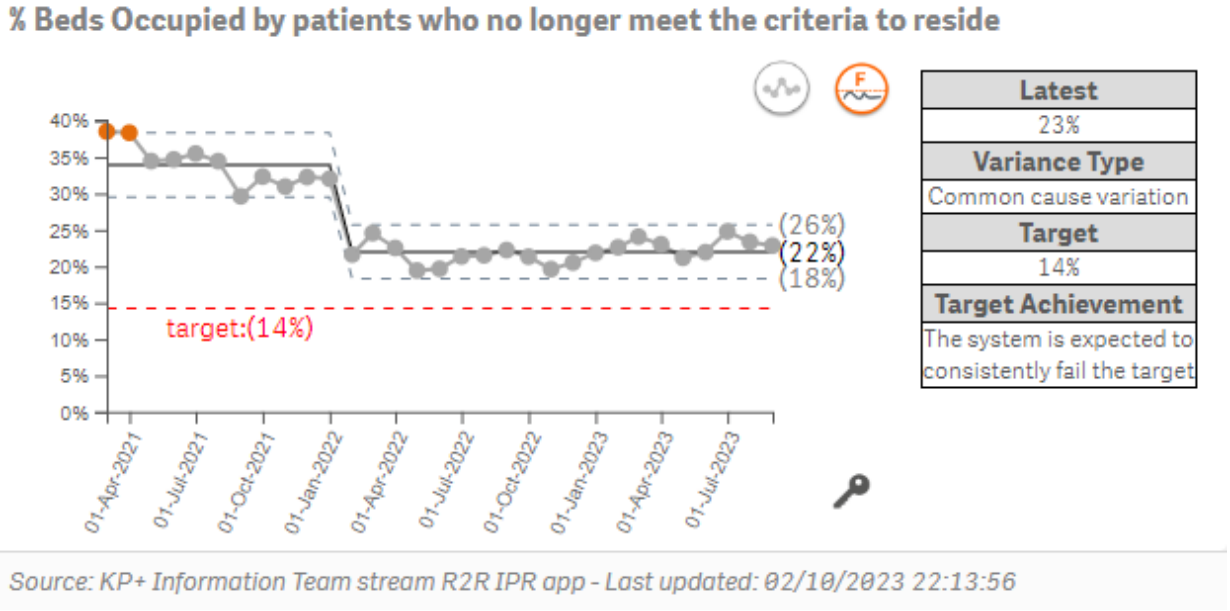
Percentage of beds occupied by patients who no longer meet the criteria to reside

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Sarah Rothery Business Intelligence Lead: Alex King

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

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



What does the chart show/context:
- In September 23% of patients had no reason to reside.
- Slightly more beds were occupied in September, but this was still in line with the number of patients with no reason to reside, hence the percentage remaining similar to previous months.
- September's data is above 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.

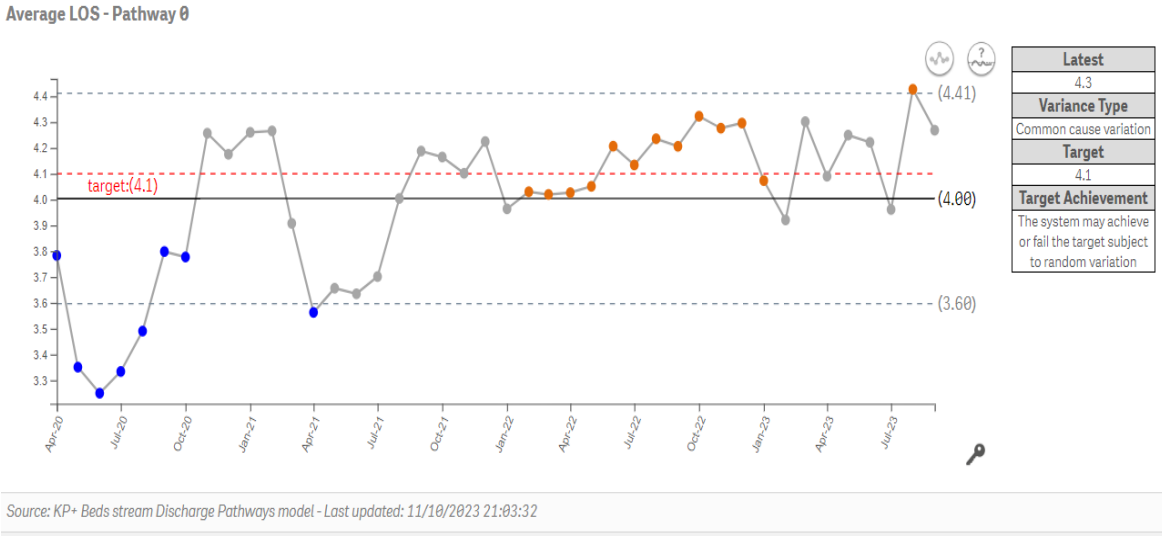
Hospital Discharge Pathway Activity

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 September the performance was 4.3
- Performance can be expected to vary between 3.60 and 4.41 days.
- The LOS for pathway 0 patients was 4.3. We have seen an increase in LOS through the home first project which has reduced overall LOS.

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

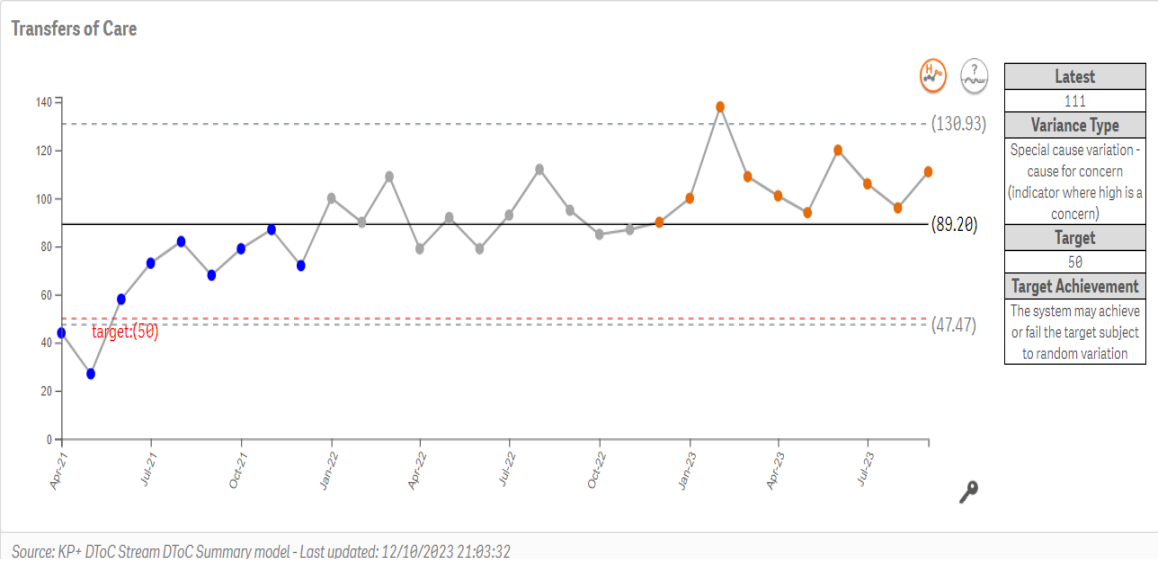
Actions:
- Improvement groups continue with PMO support to develop and improve groups.
- Launch of the Well Organised Ward Programme.
- Approval of funding to reablement and trusted assessors.
- New LOS pack to be launched in October 2023.
- Governance structures defined within the divisions and through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

Transfers of Care

Executive Owner: Jonathan Hammond Clinical Lead: Gemma Berriman 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 September 111 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.

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	Sept 2023	0	1.53	-	-	-	-	-
Stillbirths per 1,000 total births	Sept 2023	2.82	3.33			3.78	0	13.18

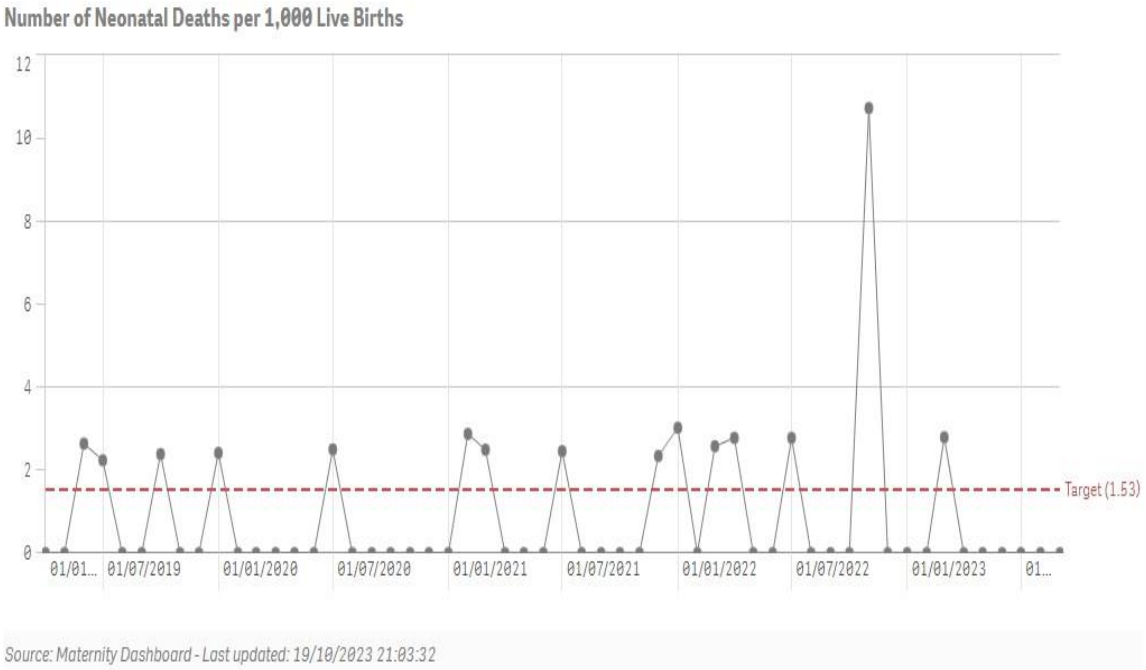
Neonatal deaths per 1,000 total live births

Calderdale and Huddersfield NHS Foundation Trust

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

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

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



What does the chart show/context:
There were 0 neonatal deaths in September

Underlying issues:
- Currently there are no underlying issues.
- 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 completed
- All early neonatal deaths referred to HSIB
- Regular quarterly stillbirth/neonatal audit undertaken
- Responsive review of neonatal deaths undertaken due to increase in 2022
- Audit discussed at Maternity Health Equalities Workstream
- Monthly Saving Babies Lives Group
- MDT with tertiary fetal medicine centre for known fetal anomalies

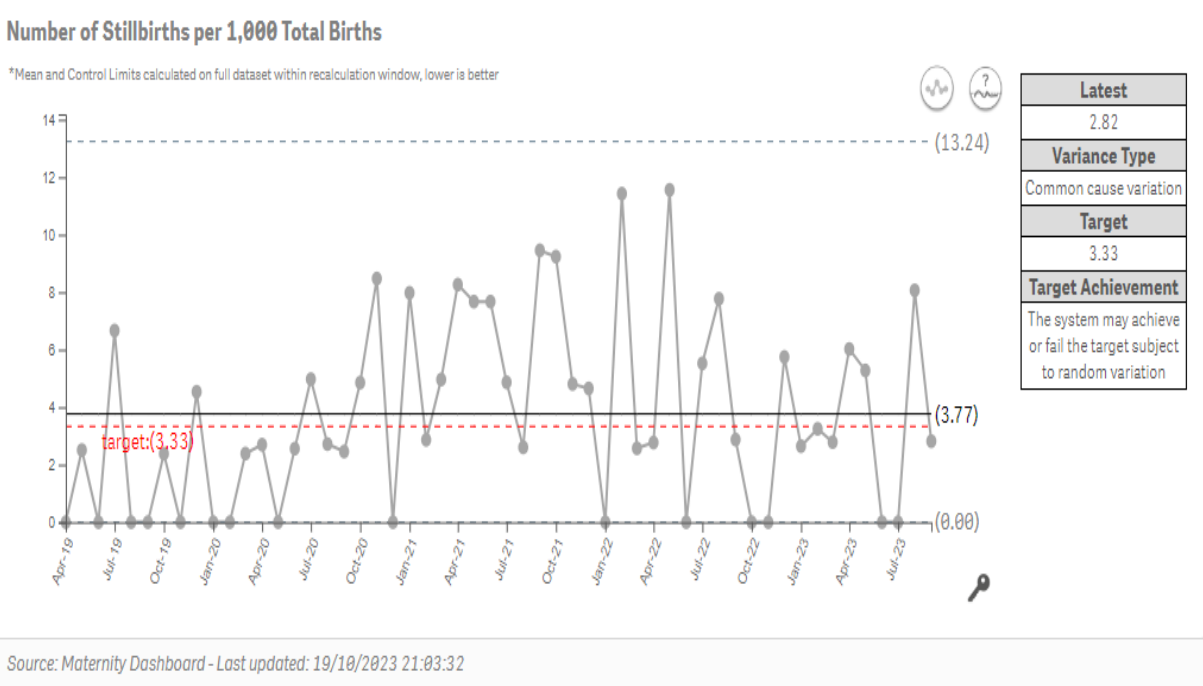
Stillbirths per 1,000 total births

Calderdale and Huddersfield NHS Foundation Trust

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

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

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



What does the chart show/context:
There were 2.82 stillbirths per 1,000 total births in September which is below the expected rate.

Underlying issues:
- A theme identified in August 2023 is contact with the maternity assessment centre (MAC). Workforce challenges show reduced capacity to man the MAC telephone line with a dedicated midwife leading to some calls taking longer to answer or women phoning more than once to get a response.
- The workforce challenges are captured on the risk register and there is daily senior oversight and risk assessment of staffing in place.
- There is a total of 19.28 WTE due to commence in post between September and December 2023 and a rolling recruitment programme is in place including return to practice and internationally educated midwives.
- Deaths will continue to be monitored and investigated as required.
- Actions below will ensure performance is maintained.

Actions:
- All stillbirths reviewed at Orange Panel and weekly governance meeting
- All stillbirths MDT PMRT completed (MDT PMRT is Multi-disciplinary Team Perinatal Mortality Review Tool - a structured national tool that is used to review all deaths)
- All intrapartum stillbirths referred to HSIB
- Regular quarterly stillbirth/neonatal audit undertaken
- Audit discussed at Maternity Health Equalities Workstream
- Monthly Saving Babies Lives Group
- MDT with tertiary fetal medicine centre for known fetal anomalies

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	Sept 2023	59.5%	70%			69%	51%	87%
Community Waiting List	Sept 2023	6,629	4,387 (end 23/24)		-	5880	5553	6206
Virtual Ward	Sept 2023	98%	80%	-	-	-	-	-
Patients dying within their preferred place of death	Sept 2023	91.5%	N/A			92%	80%	103%

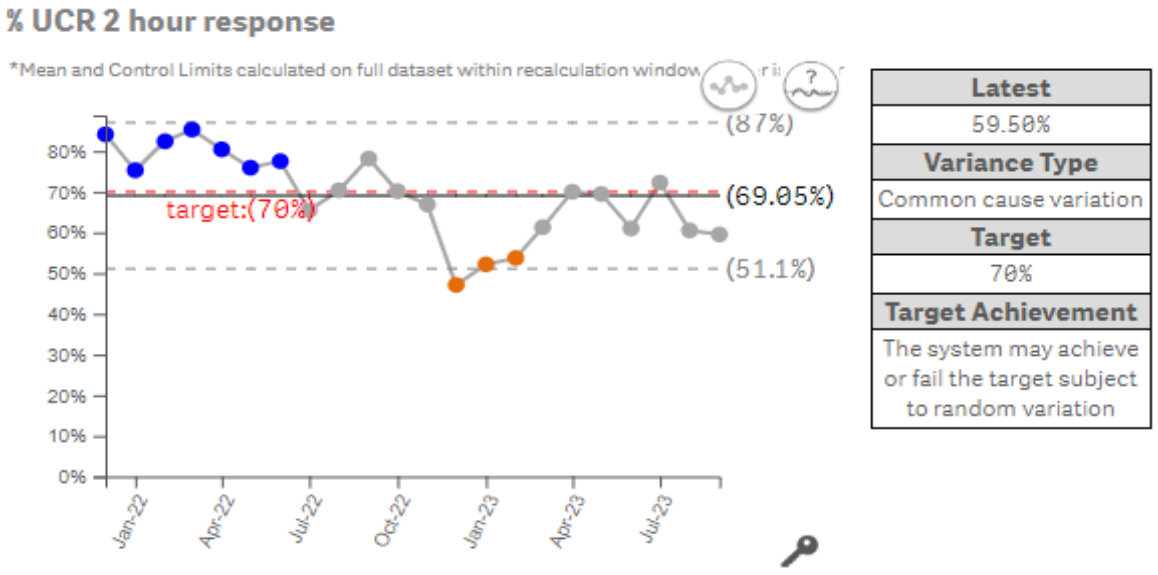
Proportion of Urgent Community Response referrals reached within two hours

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%.



Latest
59.50%
Variance Type
Common cause variation
Target
70%
Target Achievement
The system may achieve or fail the target subject to random variation

Source: SR Data. Last updated 20/10/2023 09:32:44

What does the chart show/context:
- December 2021 – June 2022 showing as over 70% target. Followed by 5-month period (July – November 2022) of random variation. From December 2022 onwards significant drop in performance due to service adopting new functionality – however improvement trend over 4 months leading onto 6 months natural variation.
- Current position for September 2023 at 59.5%
- 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 87%.

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

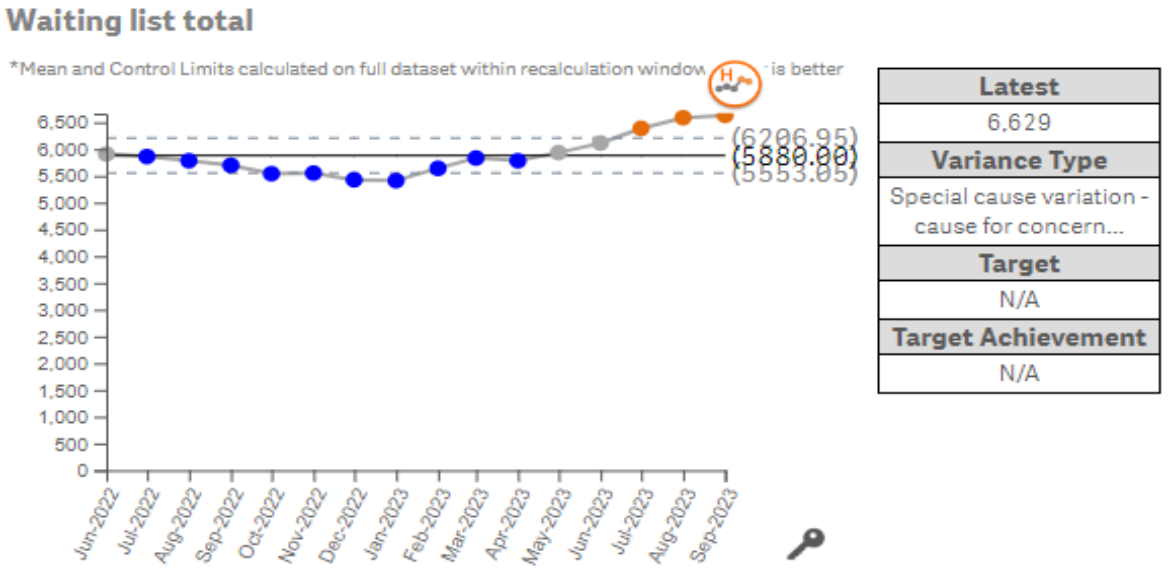
Actions:
- Communications to service leads around accurate data recording.
- We are meeting with Local Care Direct at the end of the month and have some case studies we have shared with them to discuss.
- Manual audit being completed to examine the different elements of the 2-hour response.

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.



Latest
6,629
Variance Type
Special cause variation - cause for concern...
Target
N/A
Target Achievement
N/A

Source: SR Data. Last updated 20/10/2023 09:32:45

What does the chart show/context:
- The overall waiting list numbers trend shows a slight reduction from when data collection began in June 2022 to January 2023. Since then the trend shows an overall increase in numbers. 6,629 total in September 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 2WTE maternity leaves.
- Podiatry is prioritising high risk patients, therefore the routine waiting list has remained fairly static, and longer than we would like for the last year.

Actions:
- We have now been successful in recruiting 3.8 WTE SALT who are soon to be in post between December and March and we have also identified a locum to support whilst the other posts are being filled.
- Short-term waiting list initiatives being planned for Children's SALT alongside agreed dates for implementation for new service structure which will improve efficiency.
- The podiatry service is undergoing a review, including workforce modelling and a review of the service specification.

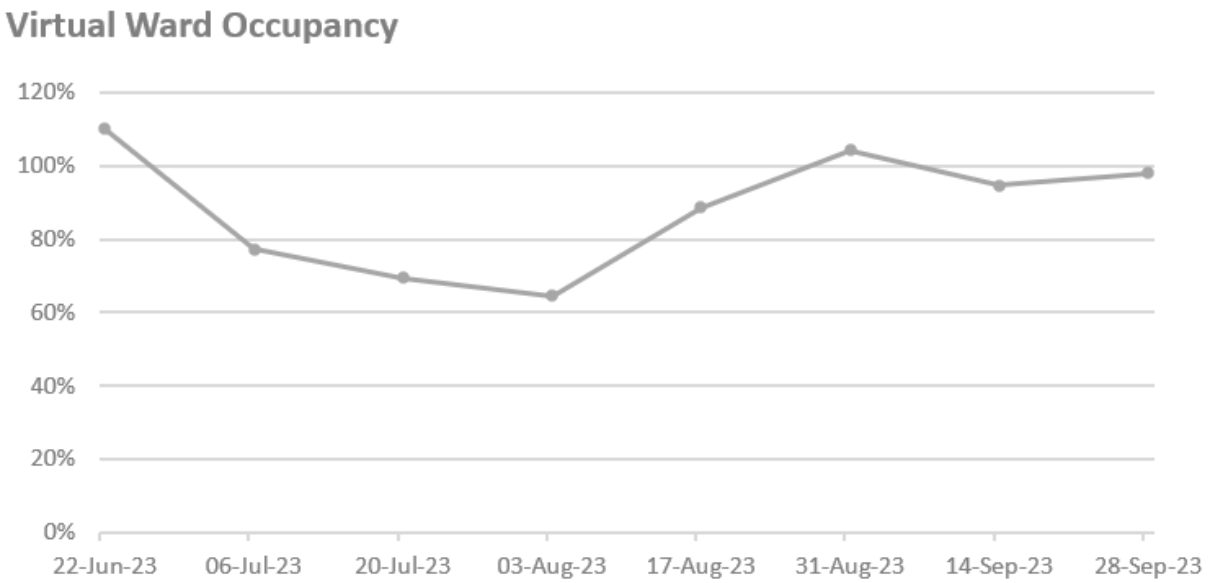
Virtual Ward

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Renee Comerford 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 24 and will rise progressively to 42 total by the end of March 2024

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 September 2023 is 98%.

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.

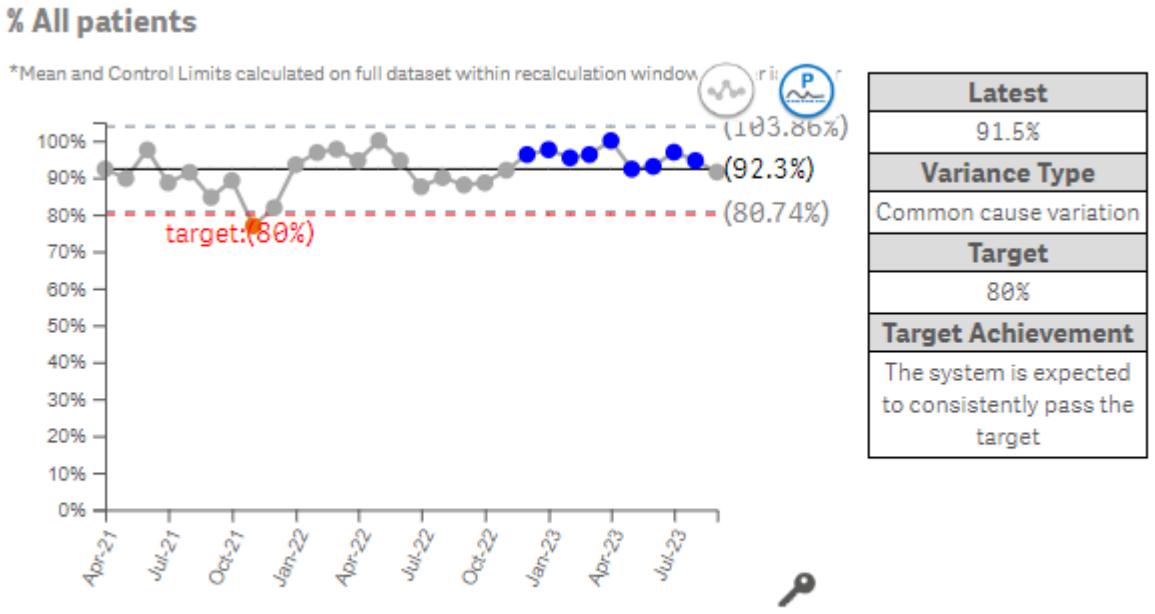
Actions:
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care 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 – Palliative Care.

Target:
80%



Latest
91.5%
Variance Type
Common cause variation
Target
80%
Target Achievement
The system is expected to consistently pass the target

Source: SR Data. Last updated 22/10/2023 08:00:43

What does the chart show/context:
- SPC chart shows Common Cause Variation.
- Consistently above 80% target (exception November 2021).
- Current month combined 91.5% (EOL 95.2% and Palliative 88.5%).
- Palliative patients - 96.4% patients die at home.

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:

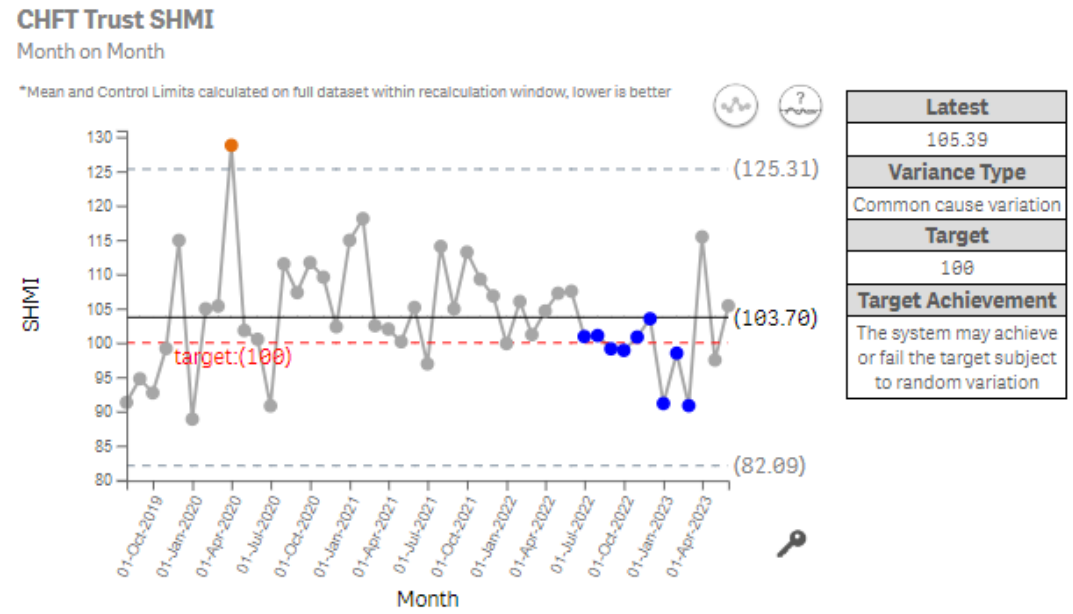
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator	June 2023	100.09	100			103.70	82.09	125.31
Care Hours Per Patient Day (CHPPD)	Sept 2023	9.2/8.4	-	-	-	-	-	-
Falls per 1000 Bed Days	Sept 2023	7.6	7.02			8.56	5.95	11.18
CHFT Acquired Pressure Ulcers per 1000 Bed Days	August 2023	1.8	1.76			2.01	0.81	3.21
MRSA Bacteraemia Infection	Sept 2023	0	0			-	-	-
C.Difficile Infection	Sept 2023	2	3.1			3.11	0	9.37
E.Coli Infection	Sept 2023	1	5.6			3.56	0	9.19
Number of Never Events	Sept 2023	1	0	-	-	-	-	-
Number of Serious Incidents	Sept 2023	2	0			3.47	0	9.52
% of incidents where the level of harm is severe or catastrophic	Sept 2023	0%	2%			1%	0%	2%
% of complaints within agreed timescale	Sept 2023	88%	95%			89%	75%	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 shown a continuous improving position with a 12-month rolling figure standing at 100.09.
- Month on Month performance has declined slightly in June with performance standing at 105.39
- Performance remains within the expected range in the latest release.
- The latest national SHMI position stands at 99.98 and CHFT now sits very slightly above this 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.

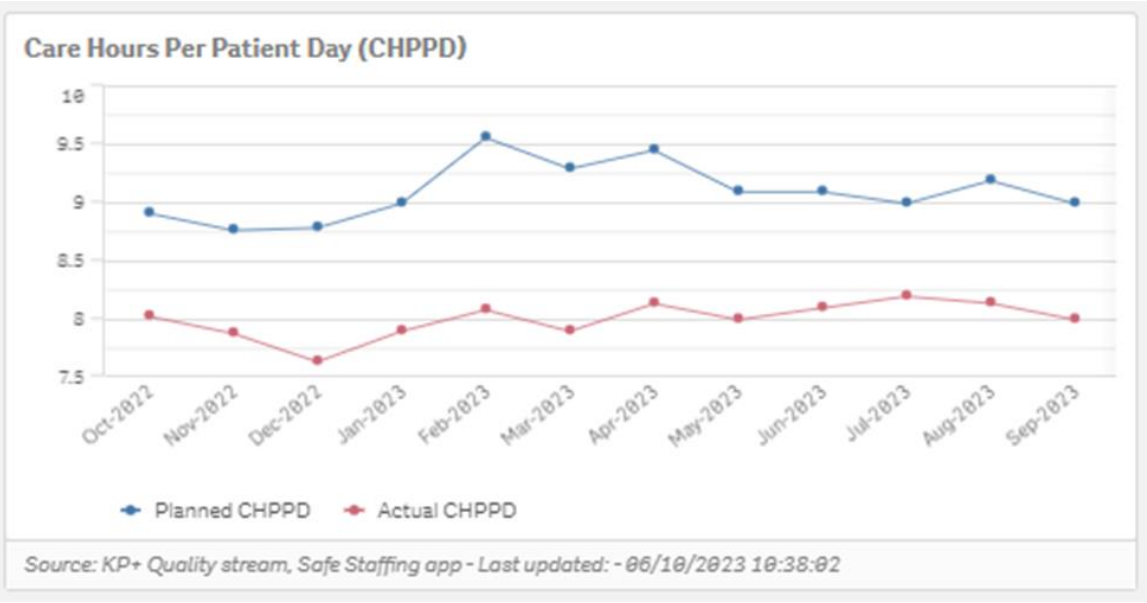
Actions:
- Clinical Lead has contacted all mortality leads in all specialties to communicate the need to increase the level of mortality reviews being carried out on a monthly basis and the timeliness of these reviews being improved.
- The Trust target is for 50% of deaths to be reviewed using the initial 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:
- For September the actual CHPPD is less than the planned by a deficit of 1 care hour per patient day.
- The latest data in Model Hospital is from July when CHFT reported providing 8.2 CHPPD against a peer median 8.7 and national median 8.5

Underlying issues:
- The CHPPD deficit reflects unfilled shifts of both the registered and unregistered workforce. Reducing the CHPPD deficit is dependent on having the right workforce aligned to appropriate workforce models.

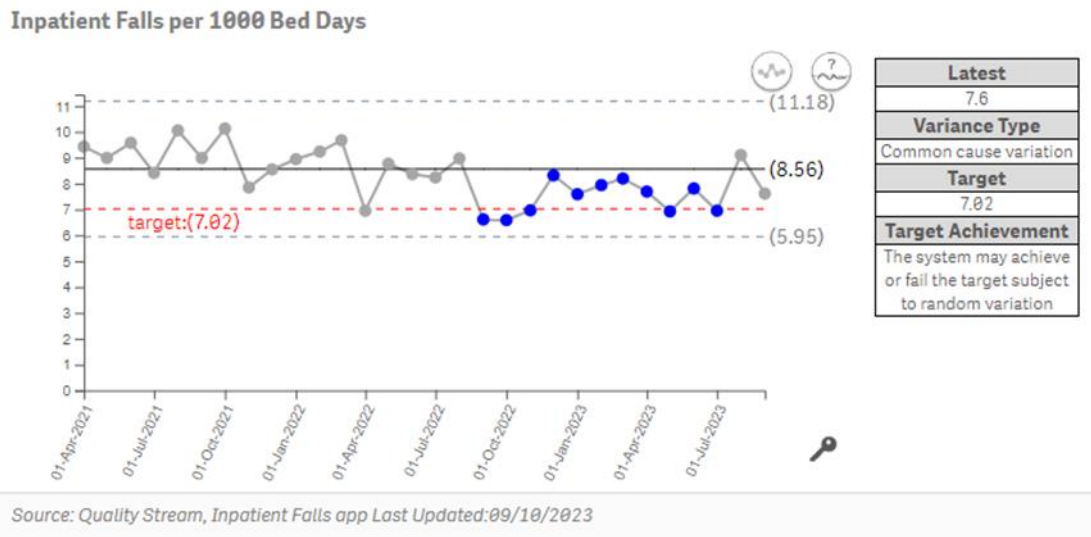
Actions:
- Undertake biannual Safer Staffing (Hard Truths) review. This process provides assurance of the correct workforce models based on an evidence-based methodology. The bi-annual review is currently underway Led by the Chief Nurse.
- Ongoing monthly reviews of recruitment strategies ,including employment of new graduates; internationally educated nurses, midwives, and Allied Healthcare Professionals (AHPs) and supporting apprenticeships by the Nursing, Midwifery and AHP Workforce Steering Group (NMAHPWSG)
- Review and refresh of the retention strategy- October NMAHPWSG
- Strong roster management maximises efficiency of the available workforce. Continue monthly roster scrutiny.
- Ongoing twice-daily staffing meetings chair 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



What does the chart show/context:
- The rate of inpatient falls for September was 7.6.
- Currently performance can be expected to vary from 5.95 to 11.18.
- There was an increase in falls in August, this has now returned to below average in September

Underlying issues:
- Falls collaborative needs reformatting and attendance from falls link nurses from each directorate mandated due to historic poor attendance.
- Enhanced care team issues with 1-1 cover for areas inconsistent.
- Inconsistencies in wards using falls prevention measures e.g. bay tagging, co-horting.

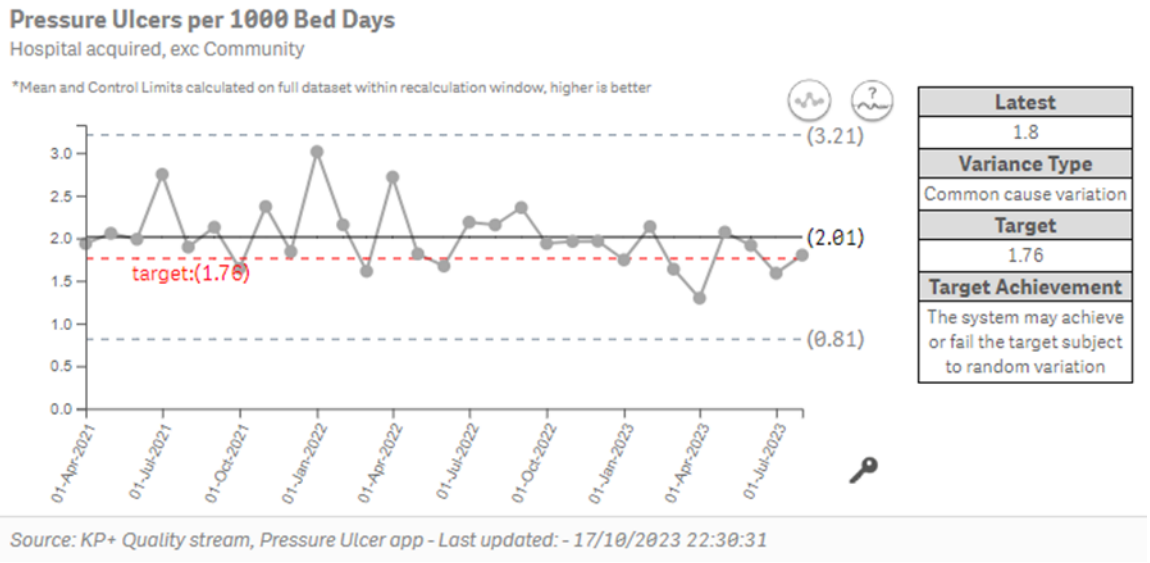
Actions:
- Relook at the TOR of the falls collaborative.
- Falls link nurses to be allocated and invited.
- Continuing with reconfiguration plan around the enhanced care team.
- Education as part of the revamped Enhanced Care team processes and assessments
- We are now joined a WYAAT falls collaborative 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

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 for August 2023 was 1.8.
- 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 0.81 to 3.21.

Underlying issues:
- According to Ward Assurance data for August 2023 only 46% of patients are being PU risk assessed within 6 hours (slight improvement from 31% in July 2023 – likely to be related to new risk assessment tool training). CQUIN data has also identified variable compliance with timely risk assessment
- A proportion of PU develop in patients who are end of life and skin changes may be attributed to skin failure (14% of PUs occurred in patients at end of life between January and August 2023)
- A proportion of CHFT acquired PUs are existing PUs which have deteriorated (22% reported January-August 2023)

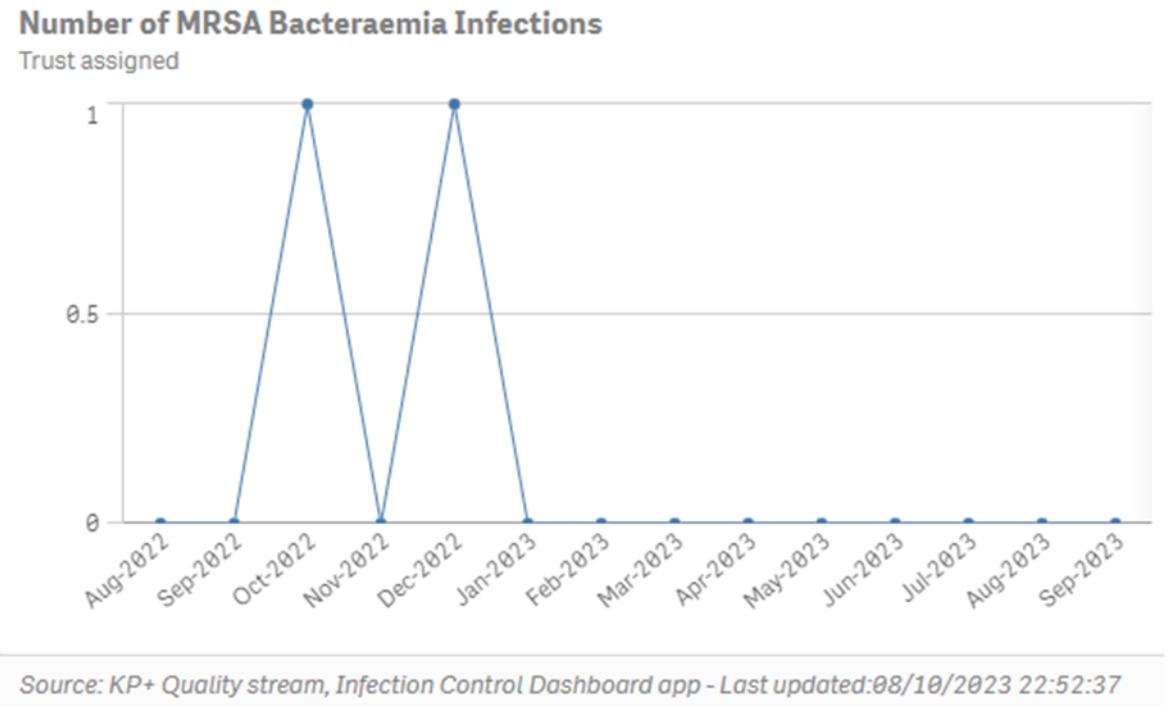
Actions:
- New PU risk assessment tool and associated care plans launched across hospital and Community in July 2023. Audit of risk assessments planned for December 2023.
- Request to review skin bundle on Cerner with BTHFT logged and awaiting response from Digital Change Board
- Processes for PU investigations and learning being reviewed in line with PSIRF. Ongoing project. New pressure ulcer checklist devised for Medicine.
- Heel PU audit being undertaken on Orthopaedic wards as part of national PRESSURE 3 Research. Due 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 September.
- The Trust is unable to consistently meet the target of 0 infections and may achieve or fail subject to random variation.
- 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.

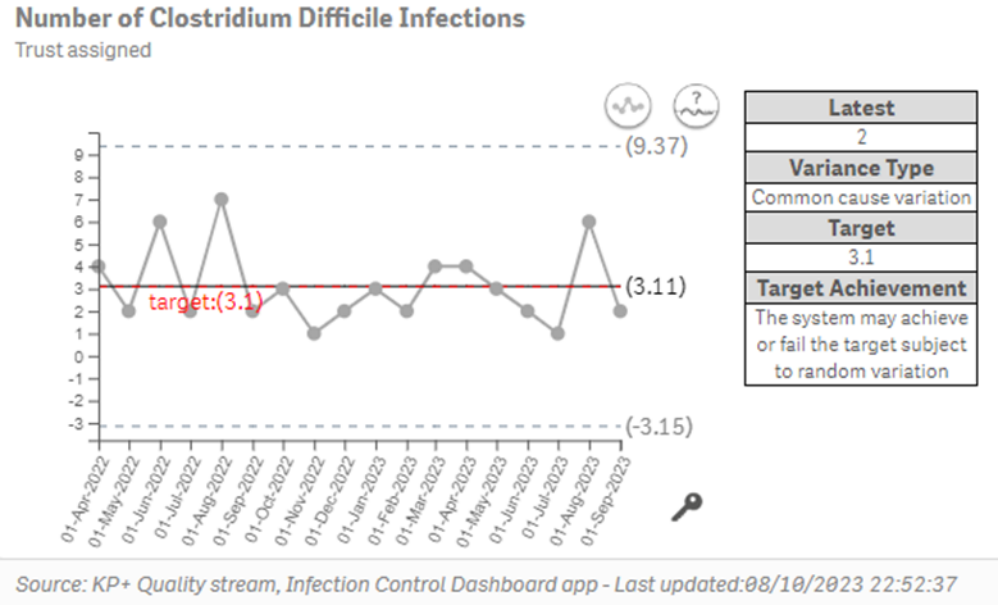
Actions:
- MRSA screening data cleanse has been completed and improvements seen. A further piece of work is underway with FSS to be completed by end of November.
- Colonisation suppression visual user guides have been provided to patients to ensure correct application.
- Mandatory training to be monitored 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 2 C.Difficile infections in September.
- 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 9.37.
- YTD 2023/24 - 18

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.

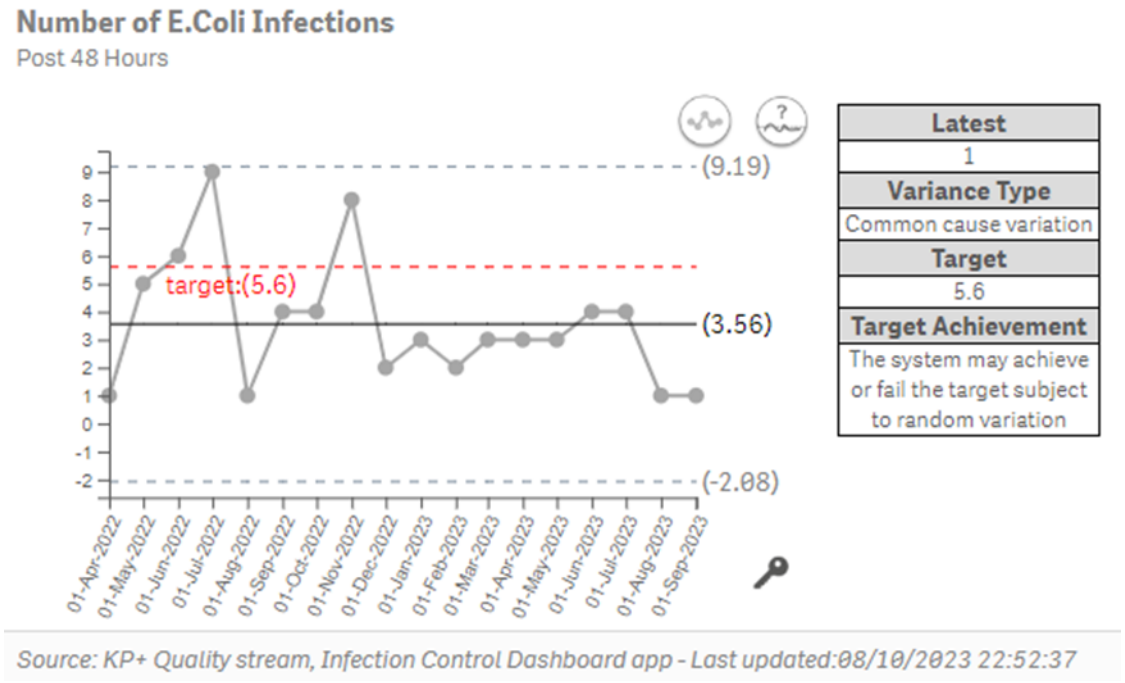
Actions:
- The Trust has implemented an improvement plan including a programme of HPV deep cleaning (to be agreed),
- C.Diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases.
- NHSEI has carried out a support visit in March, with positive feedback. Their recommendations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

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 1 E.Coli infection in September.
- 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 9.19.
- YTD 2023/24 - 14

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.

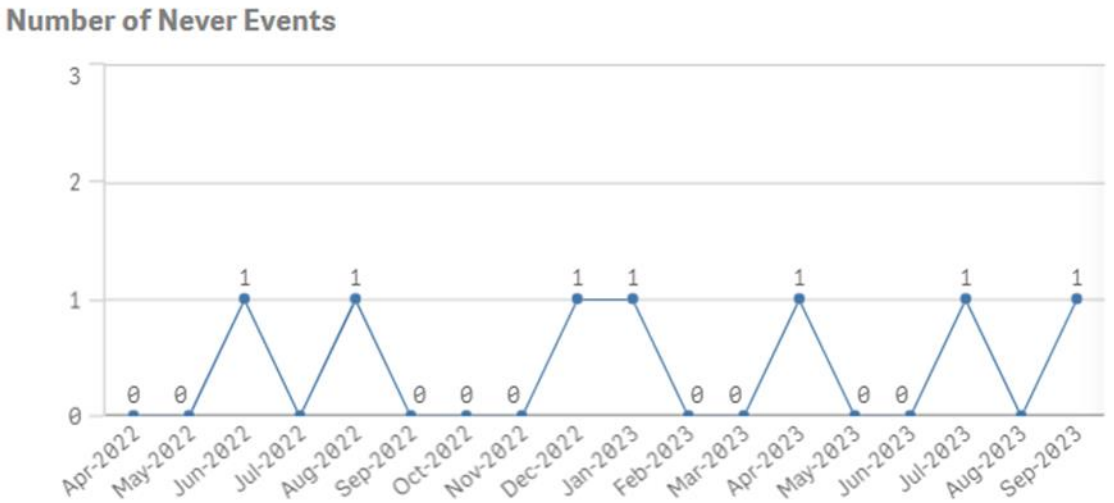
Actions:
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working 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



Source: KP+ Quality stream, Incidents app - Last updated:06/10/2023 13:25:42

What does the chart show/context:
- There was 1 never event reported in September 2023.
- There has been 5 never events in the last 12 months, compared to 3 in the previous 12 months The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month.

Underlying issues:
- This Never Event reported in September is currently under investigation.
- The data collated from all of the Never Events has demonstrated common themes around training, documentation and record keeping.

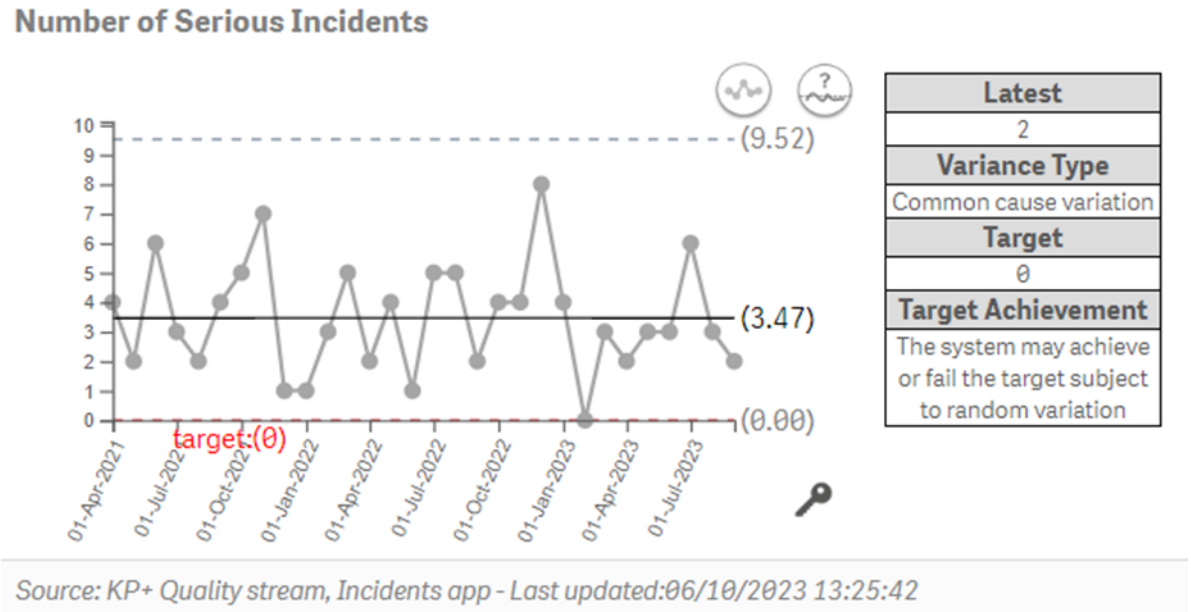
Actions:
- The Trust will continue to hold SWARM huddles as required to ensure learning is identified to keep our patients and staff safe.
- Three investigations (including the Never Event in September) are currently ongoing.
- Immediate learning and actions were carried out for all Never Events and ongoing improvement actions are in place.
- Ongoing updates to senior nursing teams in relation to the two NG tube incidents continue.

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 September 2023.
- 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 to 9.52.
- The 2 incidents resulted in no harm to patients (following guidance with the SI framework).
- The 2 incidents were reported within the Surgical & Anaesthetics division.
- Both incidents were categorised as medicine incidents.

Underlying issues:
- The 2 incidents are currently under investigation.

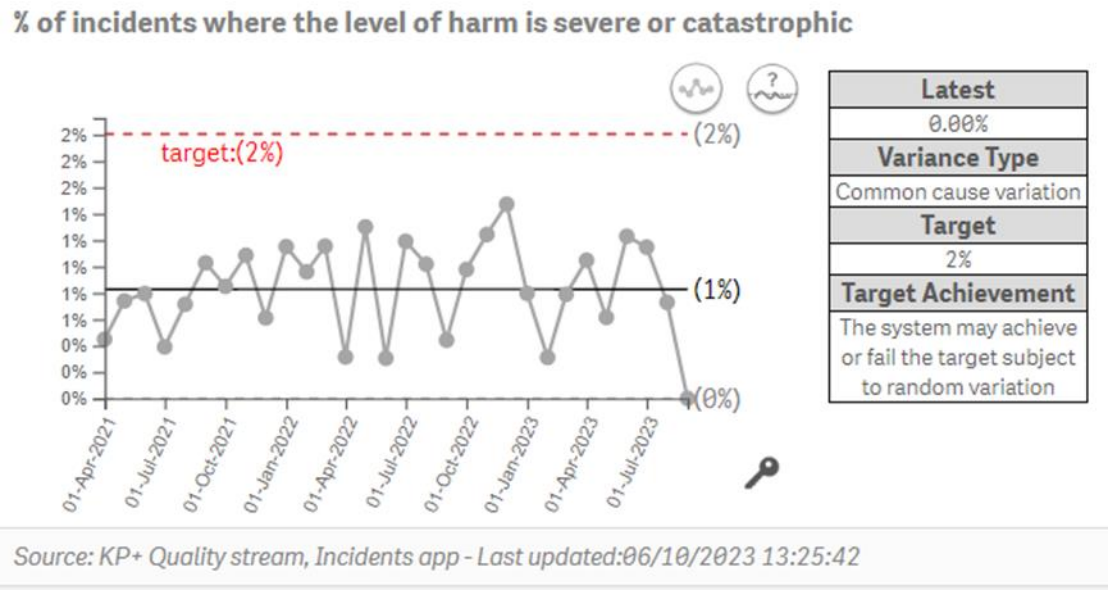
Actions:
- The Risk management Team and the Quality Governance Leads continue to support the divisions to triangulate and review data for learning.

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

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

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

Target:
2% or less



What does the chart show/context:
- The 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 2%.

Underlying issues:
- None.

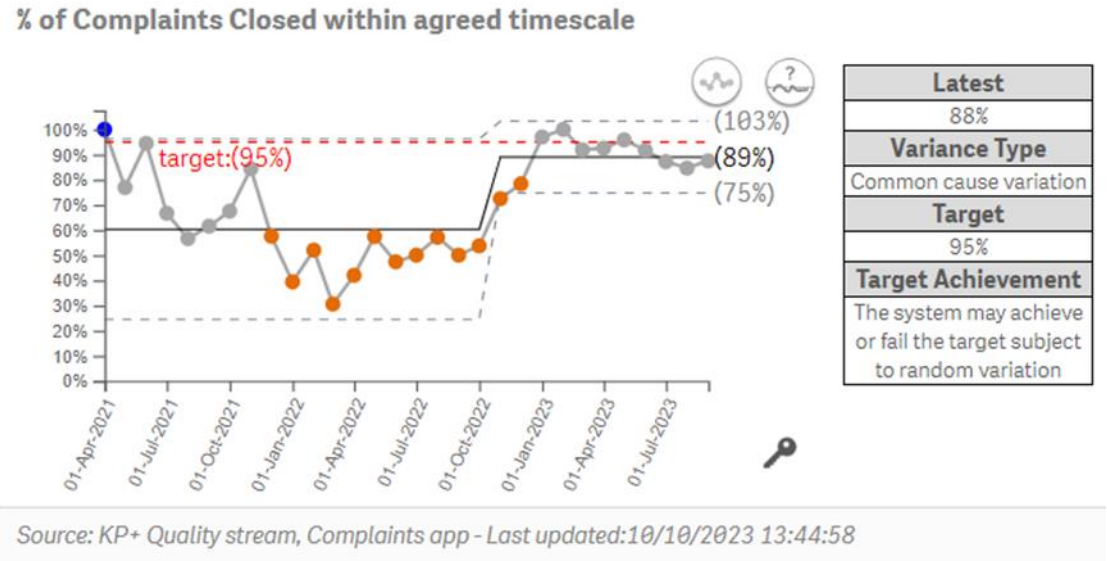
Actions:
- The Risk Management Team and the Quality governance Leads continue to work with clinical teams/departments to identify and triangulate themes and trends for implementation of quality improvement initiatives and shared learning Trust wide.
- To monitor the trend within the upper controls limits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

% 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:
- Performance in September was 88% and therefore did not meet the 95% target.
- The Trust is unable to consistently meet the 95% target however improved performance has been maintained.
- Currently performance can be expected to vary from 75% to 100%.

Underlying issues:
- 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.
- Continue to monitor Trust performance daily and meet with divisions on a weekly basis to maintain oversight of performance.

Quality Priorities:

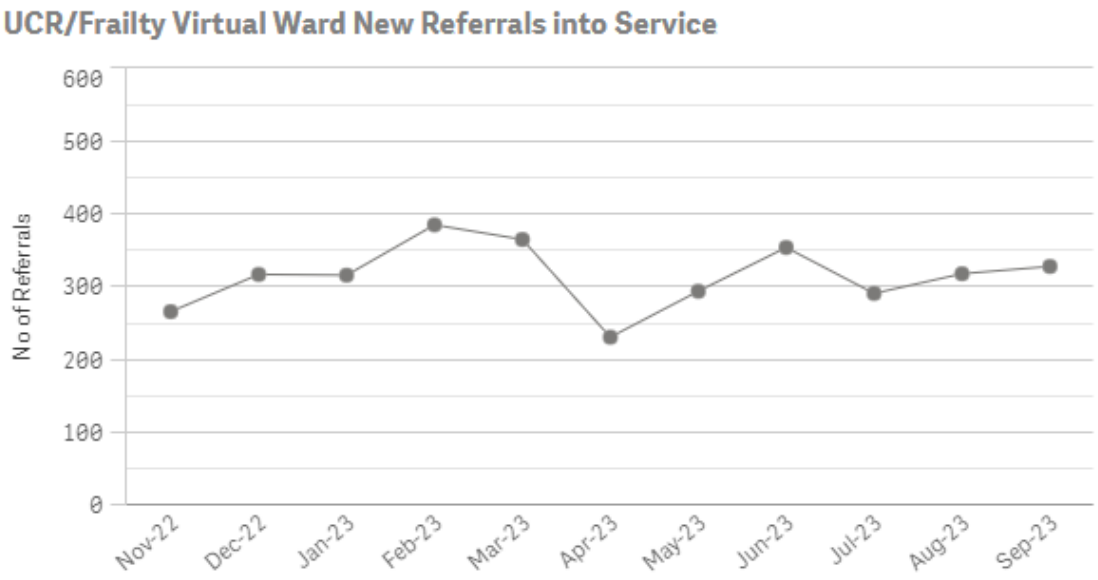
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Alternatives to Hospital Admission – Number of referrals into the Frailty service	Sept 2023	328	TBC	-	-	-	-	-
% of episodes scoring NEWS of 5 or more going on to score higher	Sept 2023	35.0%	30%			32%	28%	37%
% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward.	Sept 2023	85.56%	95%			37%	20%	54%

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:
To have TBC referrals per month by the end of March 2024.



Source: SR Data. Last updated 20/10/2023 09:32:45

What does the chart show/context:
- New referrals into service for the whole Urgent Community Response / Frailty Virtual Ward service.
- Average of 315 per month for all. 328 for September 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.

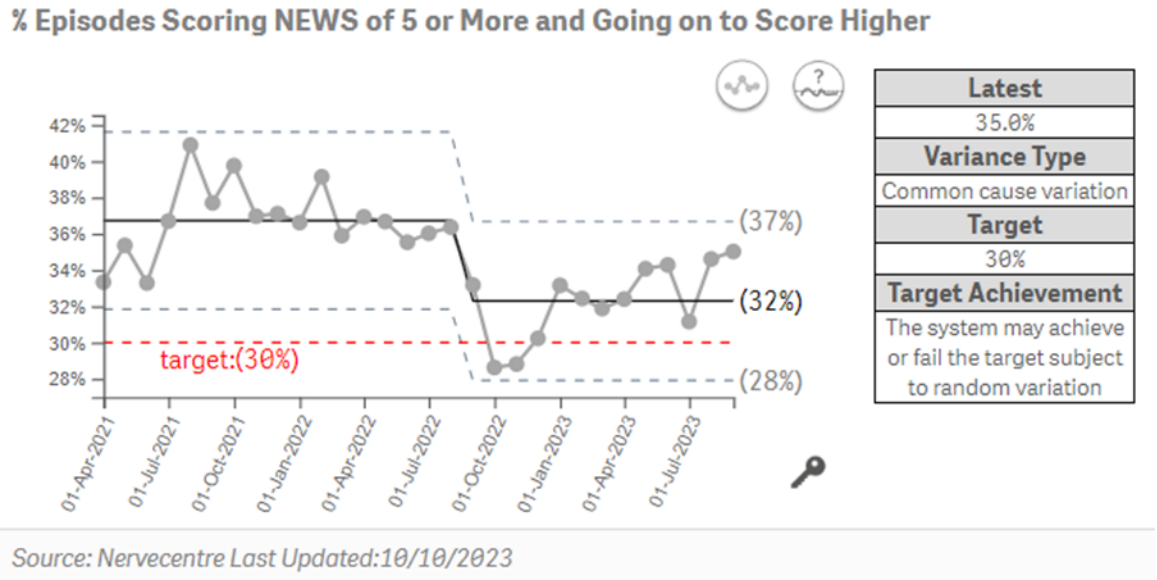
Actions:
- Medical division reviewing medical cover to support a 7-day Multi Discipline Team meeting for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
- Advanced Clinical Practitioner working on Frailty Same Day Emergency Care on a weekend is supporting Kirklees virtual Frailty service with advice and guidance.
- 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 35.0% in September.
- 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% to 37%.

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.

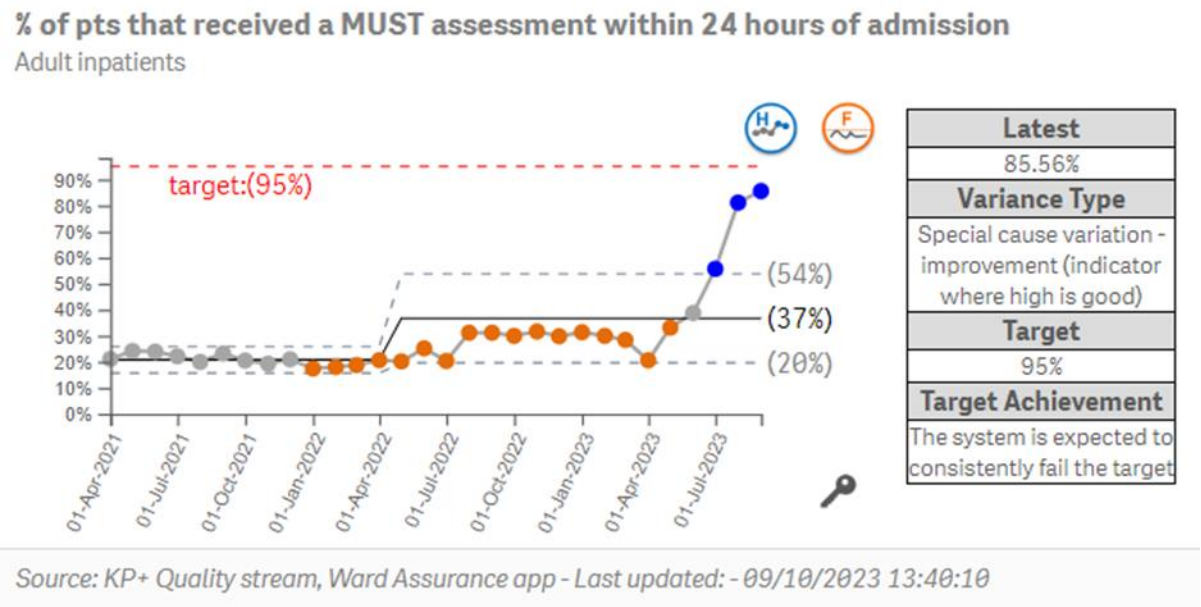
Actions:
- A new dashboard is being developed to ensure data is available easily – due to be completed by December 2023
- A snapshot review of patients' records is being undertaken - any further actions to be fed through Deteriorating Patient & Sepsis collaborative at December 2023 meeting.
- Deteriorating 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 September performance was 85.96%.
- Performance is in special cause variation indicating improvement.
- Currently performance can be expected to be between 20% and 54% and therefore will consistently fail the 95% target.

Underlying issues:
- Not all staff requiring MUST assessment training have been identified correctly on the ESR system, this is affecting the results.
- Protected mealtimes are not yet embedded in all ward areas, unfortunately a need for further education has been identified.
- The release of the Food and Drink Strategy had been delayed waiting a response for the Johns Campaign. This has now been completed and is in the process of review with the N&H group. Planned release now October.
- An audit has been completed by Audit Yorkshire regarding MUST assessments which resulted in limited assurance.

Actions:
- All Divisions have looked at the MUST training requirement for their teams and updated lists sent to the ESR team. Debra Rees is in the process of updating the system to reflect this
- There will be a presentation at one of the Friday senior nurse leaders' meetings to discuss protected mealtimes, what this means and the benefits to our patients. This will be followed by a walk round in each ward area, results to feed back into the N&H group.
- Some policies relating to N&H have been updated and are in use. A task and finish group has been set up by JW to review and update all outstanding ones.
- 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.

Health Inequalities: Learning Disabilities

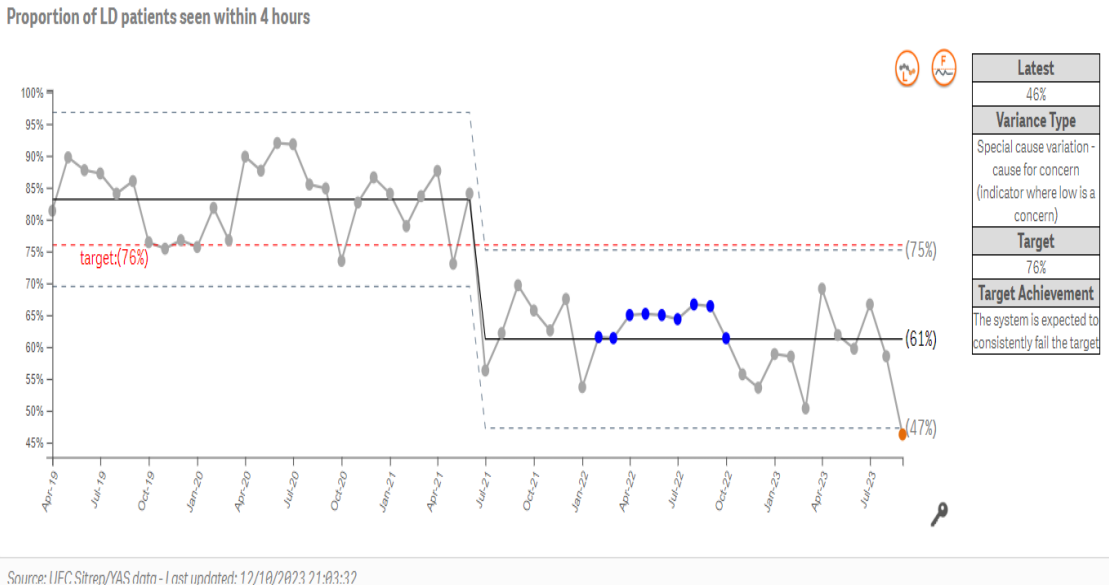
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Emergency Care Standard	Sept 2023	46%	76%			61%	47%	75%
Outpatients DNAs	Sept 2023	6.5%	3%			8.91%	2.71%	15.12%
Cancer Faster Diagnosis Standard	Sept 2023	83.3%	75%			63%	0%	100%
% of patients waiting less than 6 weeks for a diagnostic test	Sept 2023	95.1%	95%			87.79%	75.01%	100%
Patients waiting more than 40 weeks to start treatment	Sept 2023	2	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 75%.
- We saw a big reduction in performance in September to 46% 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.
- 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.

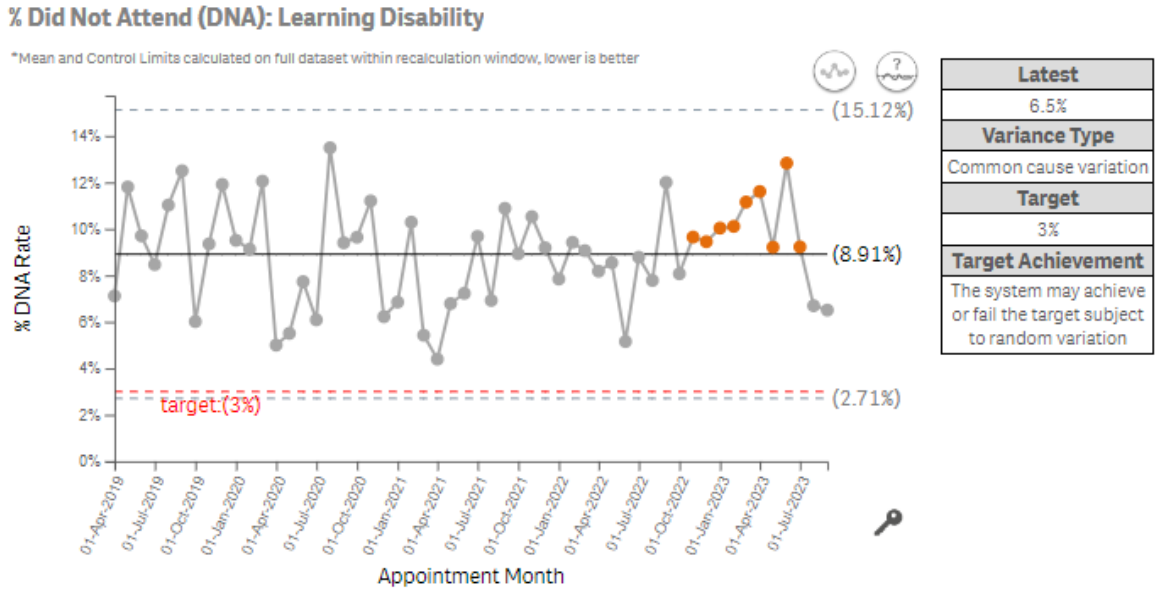
Actions:
- The Senior team in ED to undertake a deep dive audit of a random sample of Learning Disability patients to understand why they are not meeting the 4-hour target.
- Once we understand more about the care and treatment of patients with a Learning Disability in ED and the issues, we can review any improvement work/reasonable adjustments that are required and monitor.

% Did Not Attend (DNA): Learning Disability

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

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

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



What does the chart show/context:
- The current DNA rate for appointments for patients with learning disabilities improved in September 2023 and stands at 6.5%.
- This performance has remained within the expected range from April 2019 to date and shows consistent common cause variation throughout that time.
- This sits slightly below the DNA % for the wider population at CHFT for outpatient appointments which currently stands at 6.6% for September 2023.
- This performance is an improving position from August 2023 which stood at 6.6%.

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.

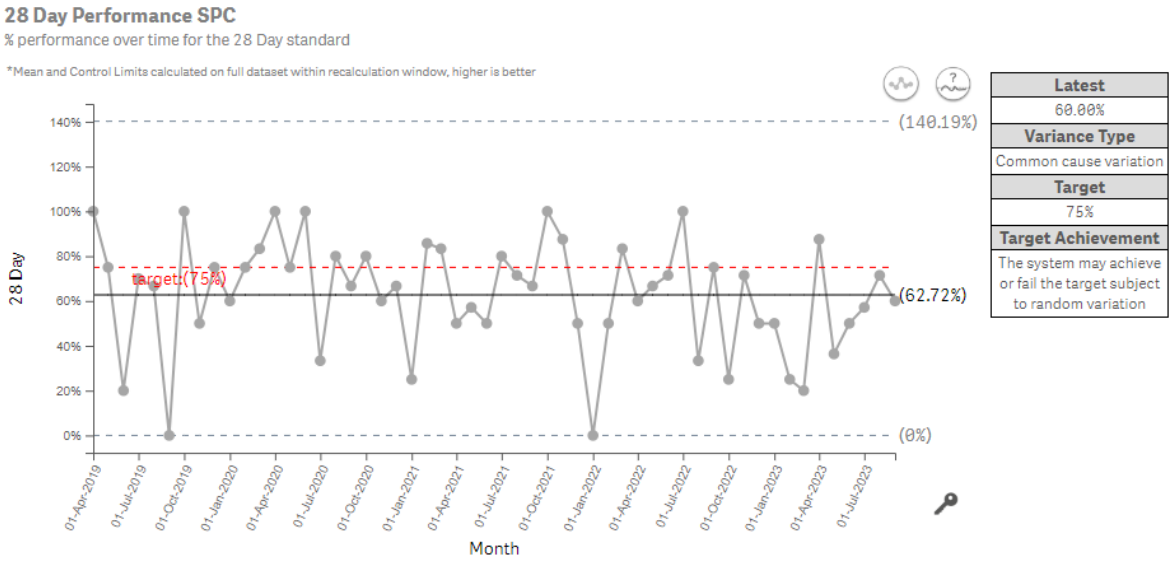
Proportion of patients meeting the faster diagnosis standard: Learning Disability

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Maureen Overton/Amanda McKie Business Intelligence Lead: Bethany Todd

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 60% which is below 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.

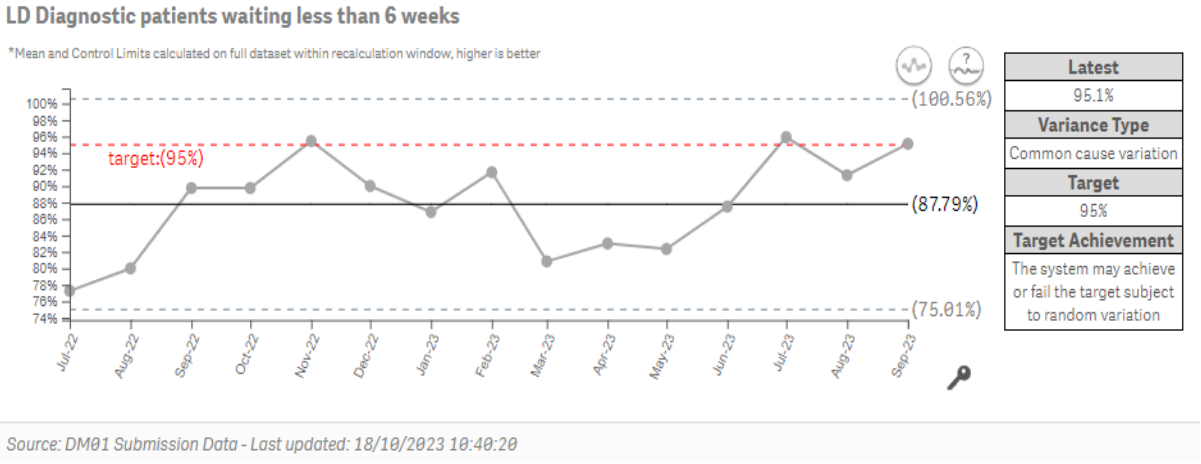
Percentage of patients waiting less than 6 weeks for a diagnostic test: Learning Disability

Calderdale and Huddersfield NHS Foundation Trust

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

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: 18/10/2023 10:40:20

What does the chart show/context:
- Latest monthly performance stands at 95.1% which now meets the NHSE target of 95% In-month performance is better than in-month CHFT overall performance which is 87% Mean performance however is similar.
- 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.

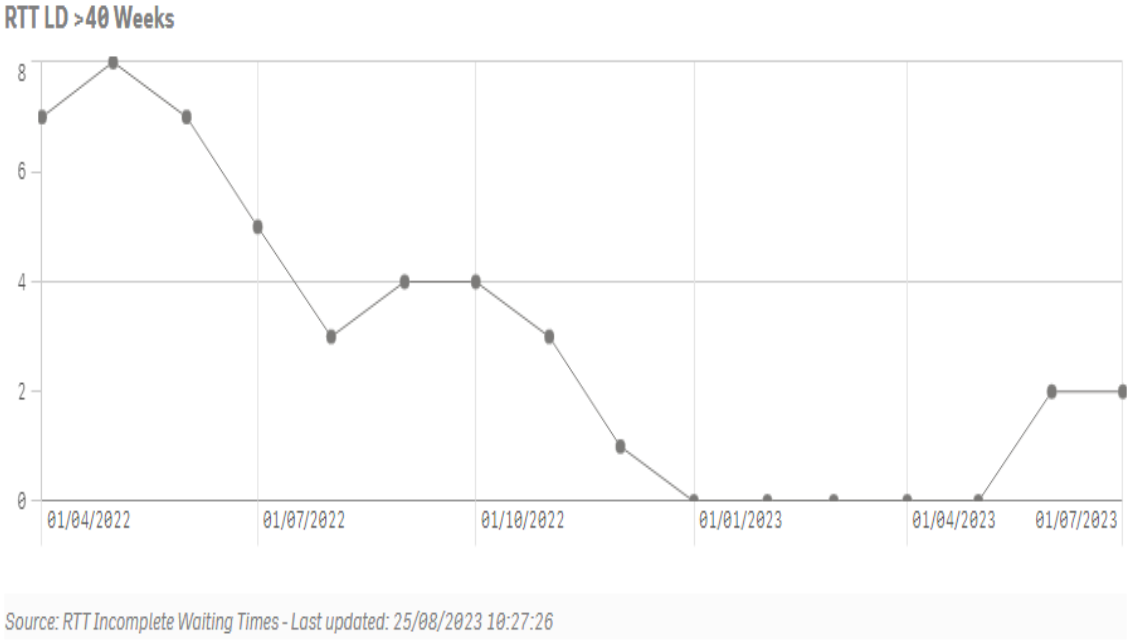
Actions:
- Audit Learning Disability breaches to check no other reasons for breaches other than capacity.

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: 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:
- 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 and we have had no more than 2 patients over 40 weeks for the last 8 months.

Underlying issues:
- Both patients have actions in place to enable treatment to take place.

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	Sept 2023	68.7%	76%			72%	65%	78%
Outpatients DNAs	Sept 2023	9.7%	3%			9.42%	7.92%	10.91%
Cancer Faster Diagnosis Standard	Sept 2023	77.7%	75%			75.76%	62.47%	89.05%
% of patients waiting less than 6 weeks for a diagnostic test	Sept 2023	85.9%	95%			87.38%	73.65%	100%
Patients waiting more than 40 weeks to start treatment	Sept 2023	301	0			-	-	-

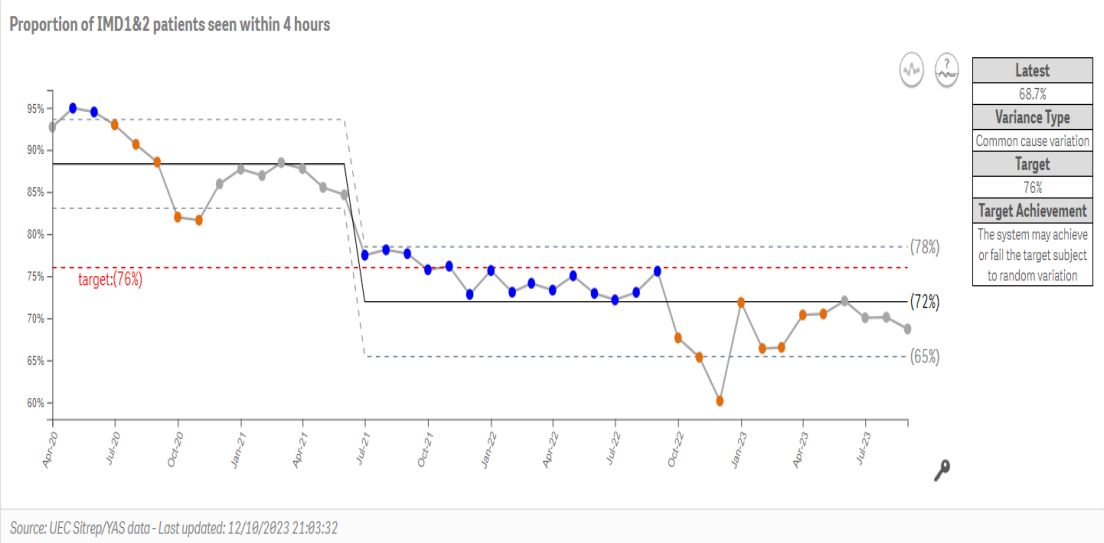
Emergency Care Standard: Deprivation (IMD 1 and 2)

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 September was 68.7% which is similar to the overall Trust performance of 68.31% 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.

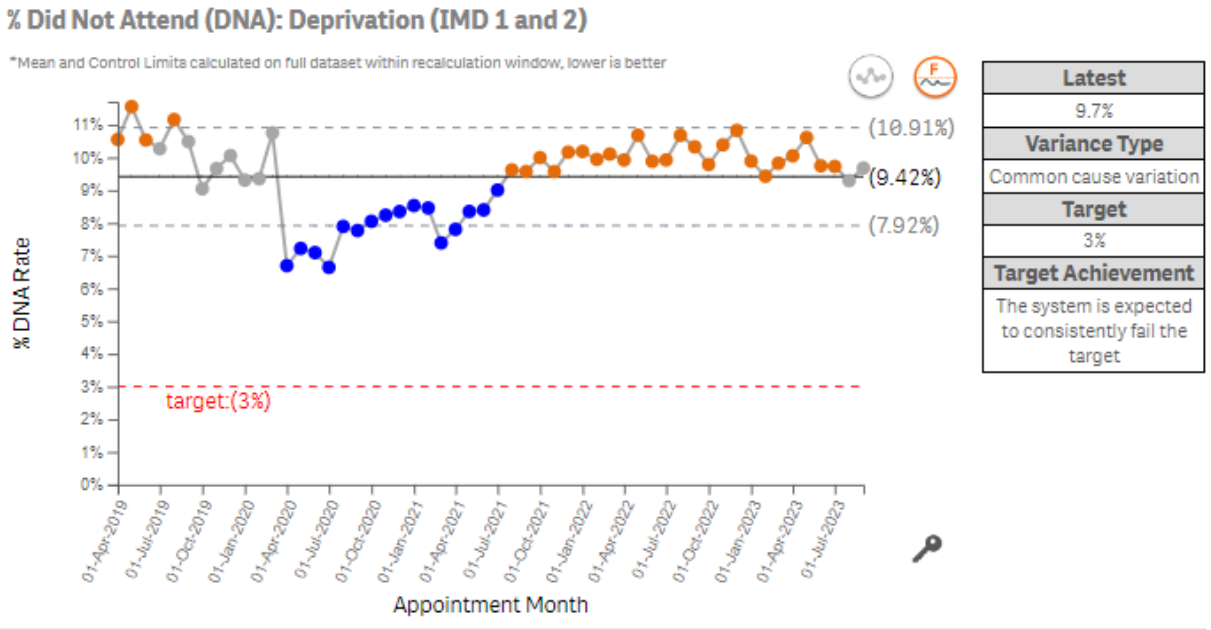
Actions:
- Recruitment into Medical WFM at interview stage, 3 locum consultants appointed.
- Evenings into nights is problematic and breach review identifies poor skill/seniority mix in employed medical workforce. Now addressed with 2 ST4+ on nights and evening consultant staying on until department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

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

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

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

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



What does the chart show/context:
- The current DNA rate for appointments for patients from the IMD 1 and 2 groups stands at 9.7% for September 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 6.6% for September 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.
- Audit of patients to understand reasons for DNA.

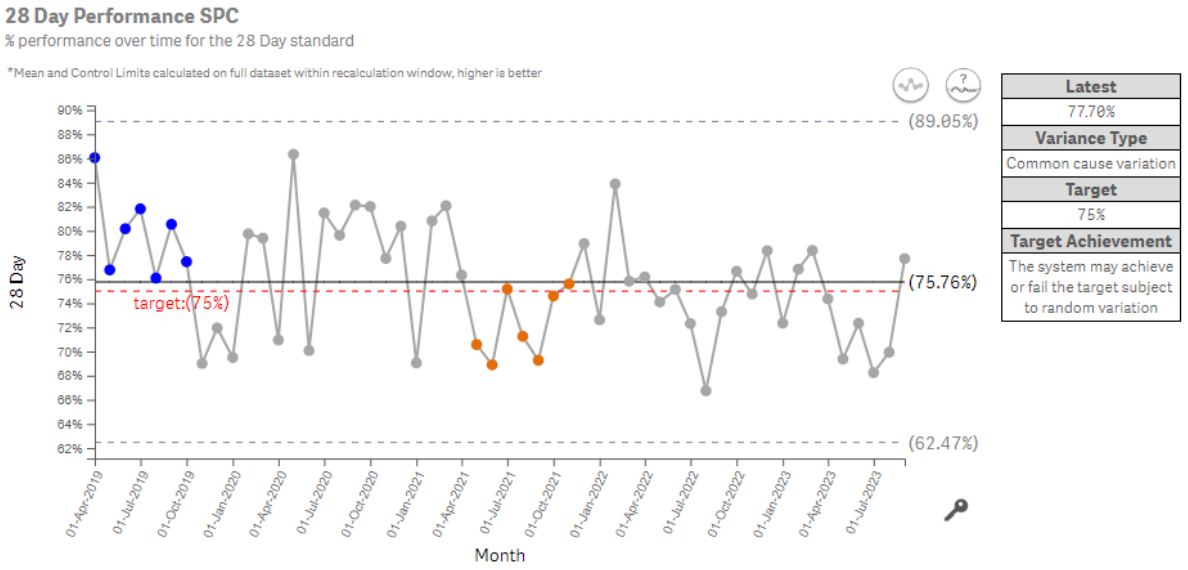
Proportion of patients meeting the faster diagnosis standard: Deprivation (IMD 1 and 2)

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison Operational Lead: Maureen Overton Business Intelligence Lead: Bethany Todd

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 77.7% 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 62.47% and 89.05%.

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 have improved as a result.

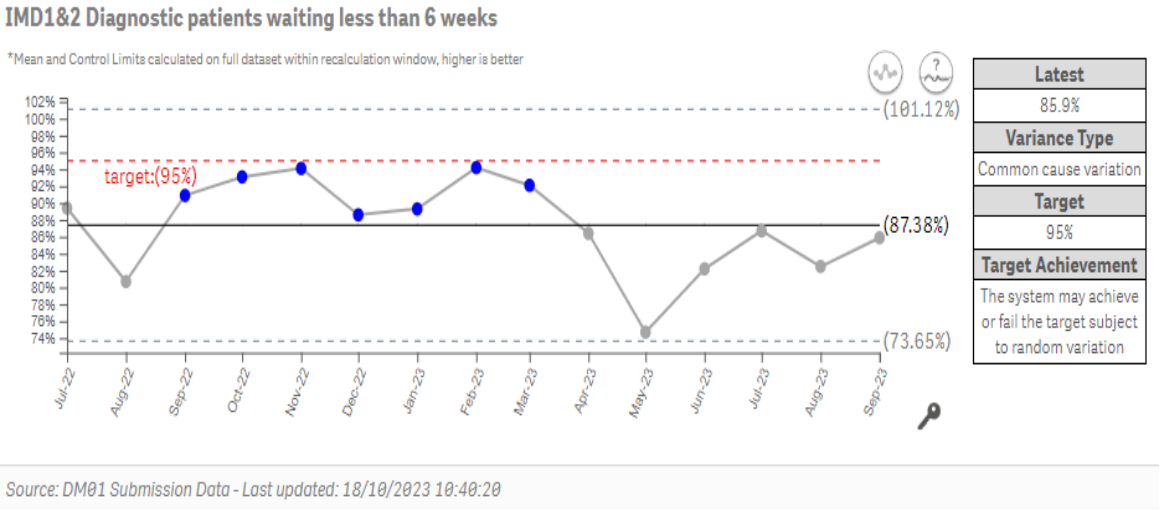
Percentage of patients waiting less than 6 weeks for a diagnostic test: Deprivation (IMD 1 and 2)

Calderdale and Huddersfield NHS Foundation Trust

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

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 85.9% which is below the NHSE target but reflective of 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 73.65% 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 99%.

Actions:
Echocardiography
- Enhanced rates of pay agreed for reporting and scanning backlog reduction:
- Reporting backlog at 610 down from 819 and should be cleared by mid-December.
- TTE additional clinics live from October.
- Able to recover half of the backlog with current substantive workforce.
- Awaiting further recruitment to bank posts.
    - 1.4 WTE due to begin in December.
    - Advert out currently.
- One of the trainees is now accredited and can run clinics independently.

Neurophysiology
- It is acknowledged that the service has fallen behind planned trajectory due to staffing.
- A second consultant has been appointed which will increase EMG capacity, however as EMGs are performed by one doctor and one physiologist together, we will need to be mindful of CTS/EEGs and other physiology test waiting times increasing.

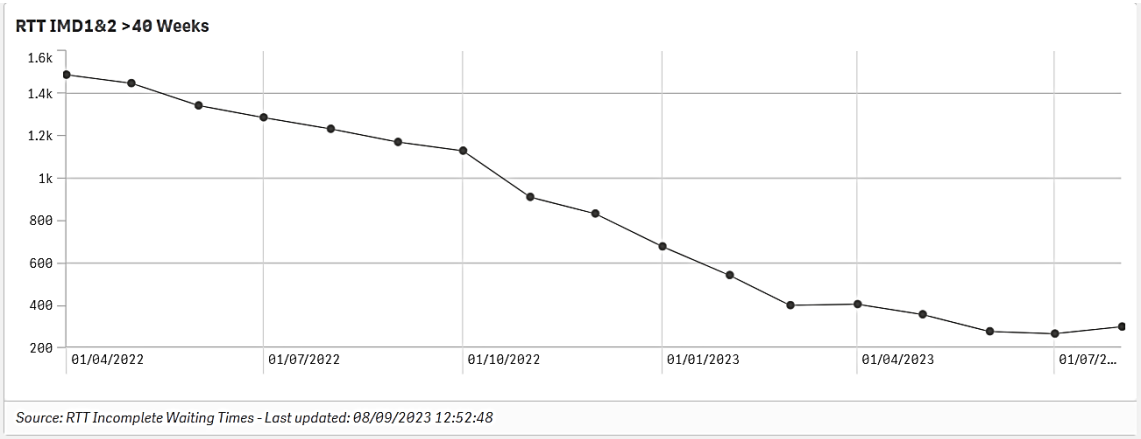
Total Patients waiting more than 40 weeks to start consultant-led treatment: Deprivation (IMD 1 and 2)

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 301 patients over 40 weeks with 88 in ENT.

Underlying issues:
- A growing ASI list (especially in ENT) represents a risk to the continuing reduction in list size.
- Cancelled lists/appointments due to strike action may have resulted in a delay in reducing the 40-week position.
- Of our specialties with patients over 40 weeks, ENT is currently the most challenging and has ASIs that are now 35 weeks since referral and are continuing to increase.

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 now in place.
- Actions have been identified in 3 cohort areas:
  - Demand management
  - Increasing internal capacity
  - Increasing external capacity

Workforce:

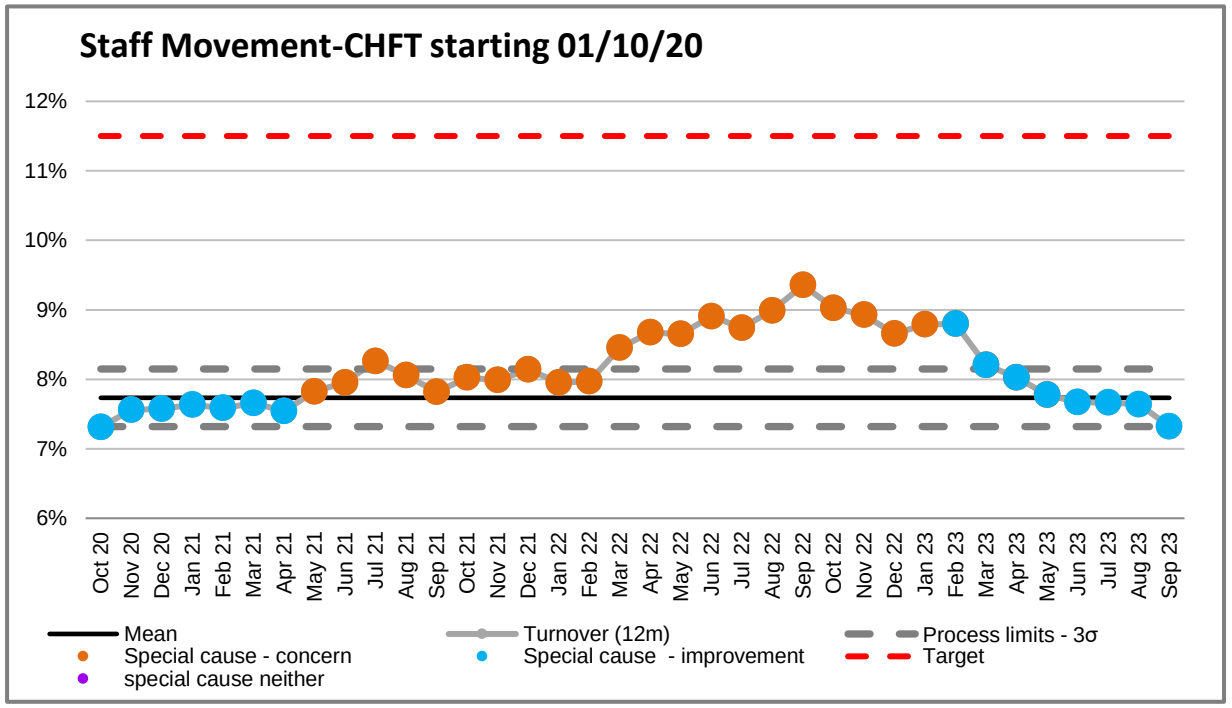
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	Sept 23	7.32%	11.5%			7.73%	7.32%	8.15%
Sickness Absence (Non-Covid)	Sept 23	4.26%	4.75%			4.82%	4.17%	5.47%
Appraisal Compliance (YTD)	Sept 23	57.36%	95.0%	-	-	-	-	-
Core EST Compliance	Sept 23	93.56%	90.0%			92.84%	91.79%	93.89%
Bank Spend	Sept 23	£3.20M	£1.60M			£3.21M	£1.63M	£4.79M
Agency Spend	Sept 23	£0.88M	£0.53M			£0.94M	£0.70M	£1.17M

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.

Target: 11.5% **Current: 7.32%**



What does the chart show/context:
- Total FTE lost due to colleagues leaving all employment with the Trust against the average headcount of the reporting period.
- Turnover is consistently below the Trust target of 11.5%.
- Current turnover rate is slightly below the mean average at 7.32%.
- September 2023 rolling turnover rate has decreased to 7.32% from 7.64% in August. This has been a continuing downward trend for 8 months.
- The Trust benchmarks well against other WYAAT organisations.

Underlying issues:
- Directorates with turnover above the 11.5% target include FSS Management (18.9%), Outpatients and Records (12.7%), and Pharmacy (13.0%).

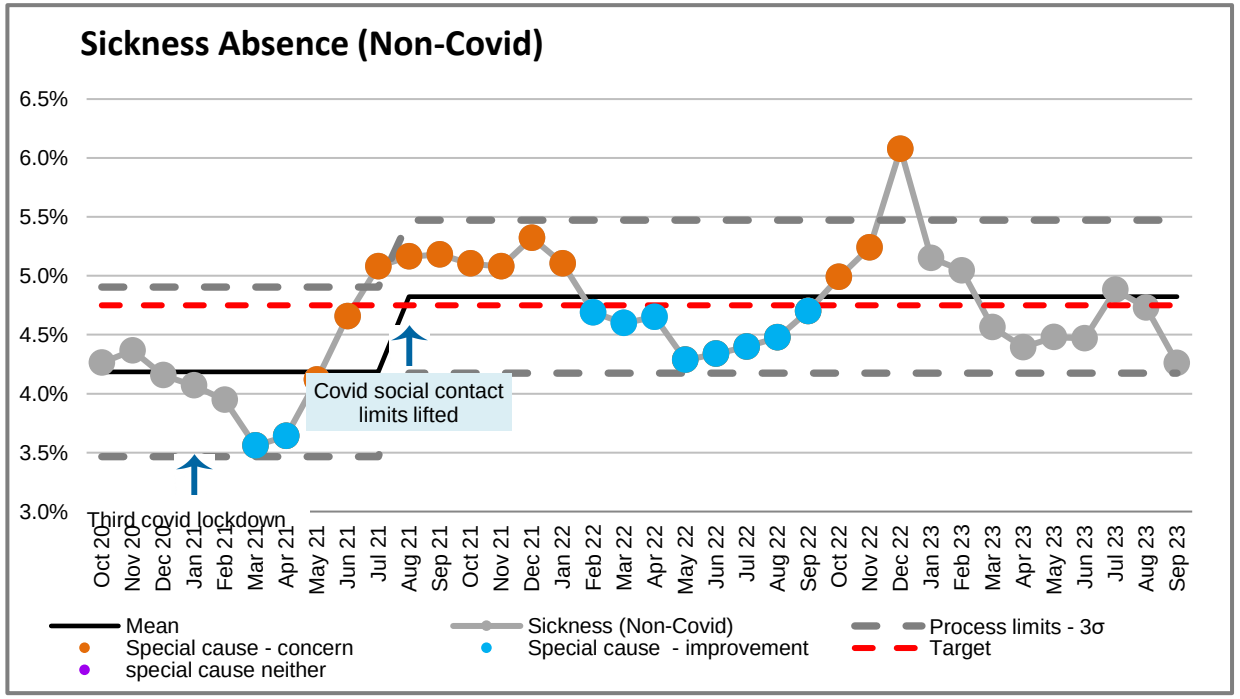
Actions:
- HCSW retention review is continuing with a Task and Finish group meeting every 3 weeks. Matrons are completing exit interviews with all HCSW that leave the Trust.
- Leavers surveys' information to be analysed to highlight any trends and hotspots.
- Turnover data is reviewed in the Workforce 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**	**4.26% (in month)**	**4.85% (12m)**
		Long	**2.57% (in month)**	**3.12% (12m)**
		Short	**1.69% (in month)**	**1.73% (12m)**



What does the chart show/context:
- Absence rate calculated as a percentage of FTE Days Lost within the reporting month.
- The mean and target for absence are very similar, and the upper limits are above target causing compliance to be hit and miss on a monthly basis.

Underlying issues:
- Top 3 reasons for sickness in September 2023 – Anxiety/Stress/Depression, Chest and Respiratory Problems and Other musculoskeletal problems.

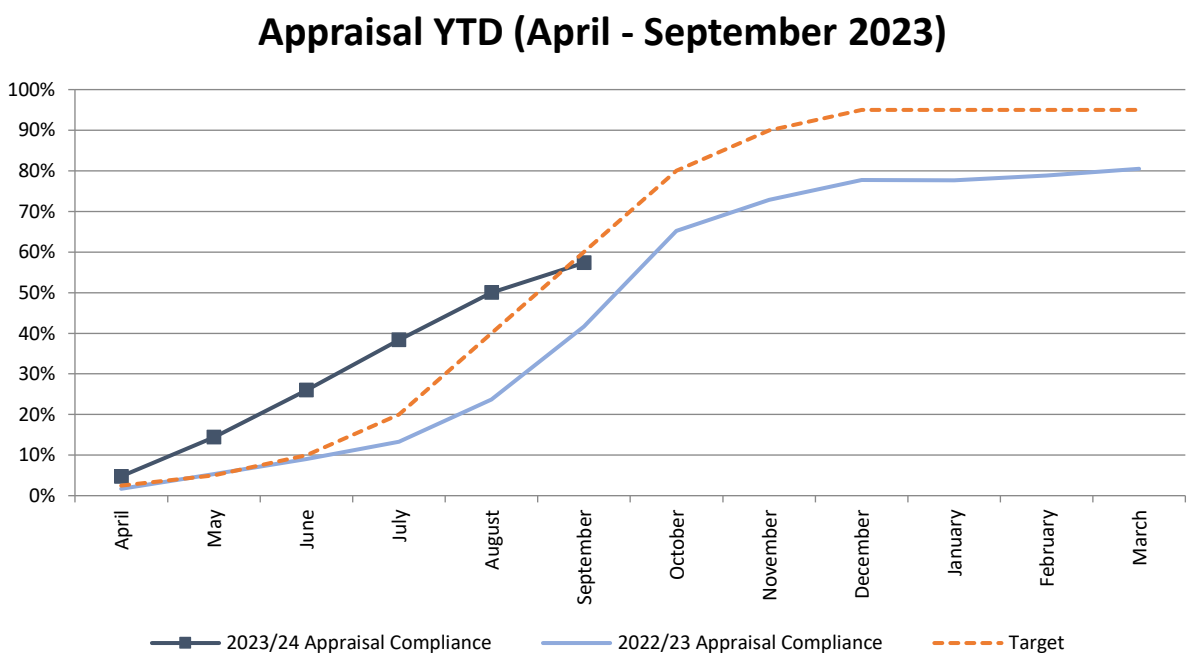
Actions:
- Promotion of the winter vaccination programme, which commenced 25th September 2023, within divisions with the aim of reducing the number of colleagues becoming seriously ill with chest and respiratory issues over the winter months.
- Promotion of physio provision for all MSK absences. We will also report on the number of absences prevented because of the MSK intervention and where colleagues have returned to work sooner.
- Rollout of the 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 for short-term sickness. HR Team holding monthly meetings to discuss every long-term absence case and ensure an appropriate management plan is in place.
- Absence data presented at Executive Board meeting on a regular basis to ensure focus on reducing the level of absence.
- Management guidance developed to support managers 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), 60.0% (in month) **Current: 57.36% (in month)**



What does the chart show/context:
- Total compliance where Appraisals have been completed in the current appraisal season
- Appraisal compliance was consistently above the in-month planned position however the current compliance is below the in-month planned target with 57.36%
- Appraisal compliance is performing above the rate of the previous year at the same point in time.

Underlying issues:
- Time and availability of colleagues to undertake appraisals.
- 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 holidays and strike activities.

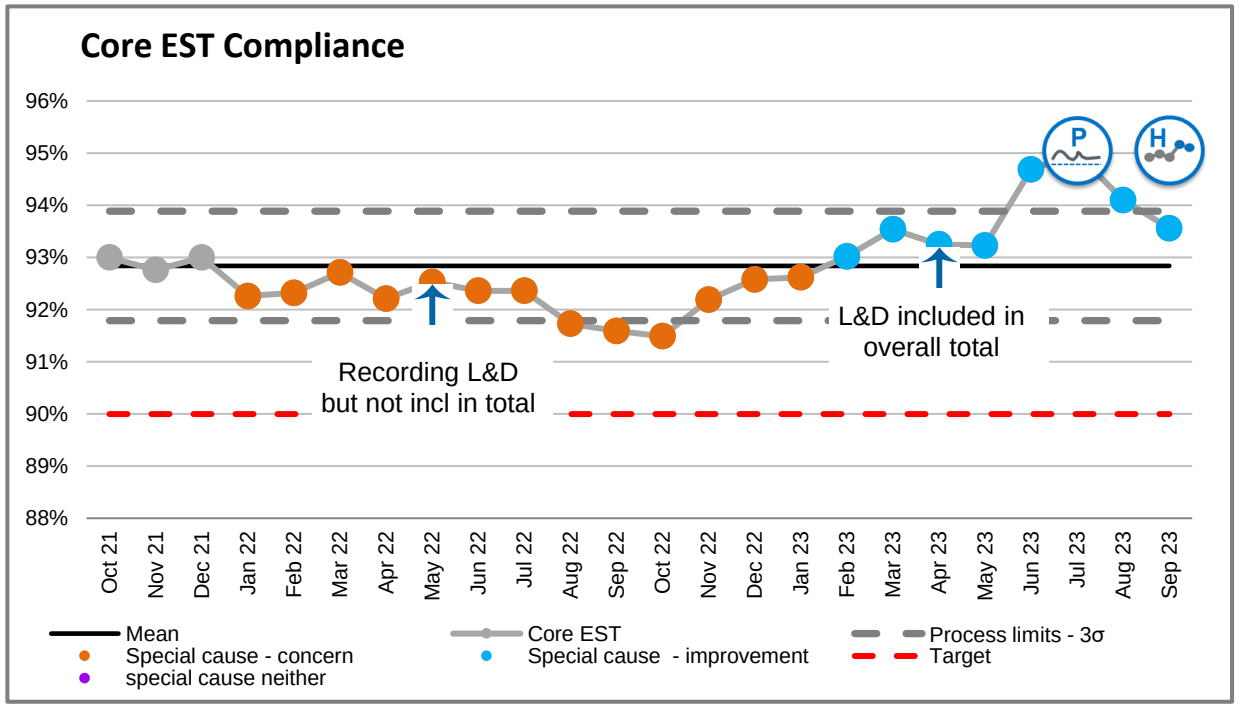
Actions:
- Recent qualitative audit undertaken with NHS England showcasing our process, compliance and engagement approach.
- ‘How to’ guide to appraisals video now available as part of our management fundamentals offer, to make it a more people centred conversation.
- ESR recording guidance produced to support managers to ensure all activity is captured.
- Targeted approach to support hotspot areas.
- Connect & Learn sessions ongoing to improve the quality of conversation, with two additional sessions added on top of original schedule.

Core EST Compliance

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

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

Target: 90.0% **Current: 93.56%**



What does the chart show/context:
Underlying issues:
- The Trust is currently achieving the 90% target, however the EST compliance is slightly under the 95% stretch target at 93.56%.
- Compliance in September 2023 remains above the mean but has since returned to a rate within the process limits.
- From April 2023 Learning Disability Awareness is now included in the overall EST compliance rate

Underlying issues:
- No current issues.

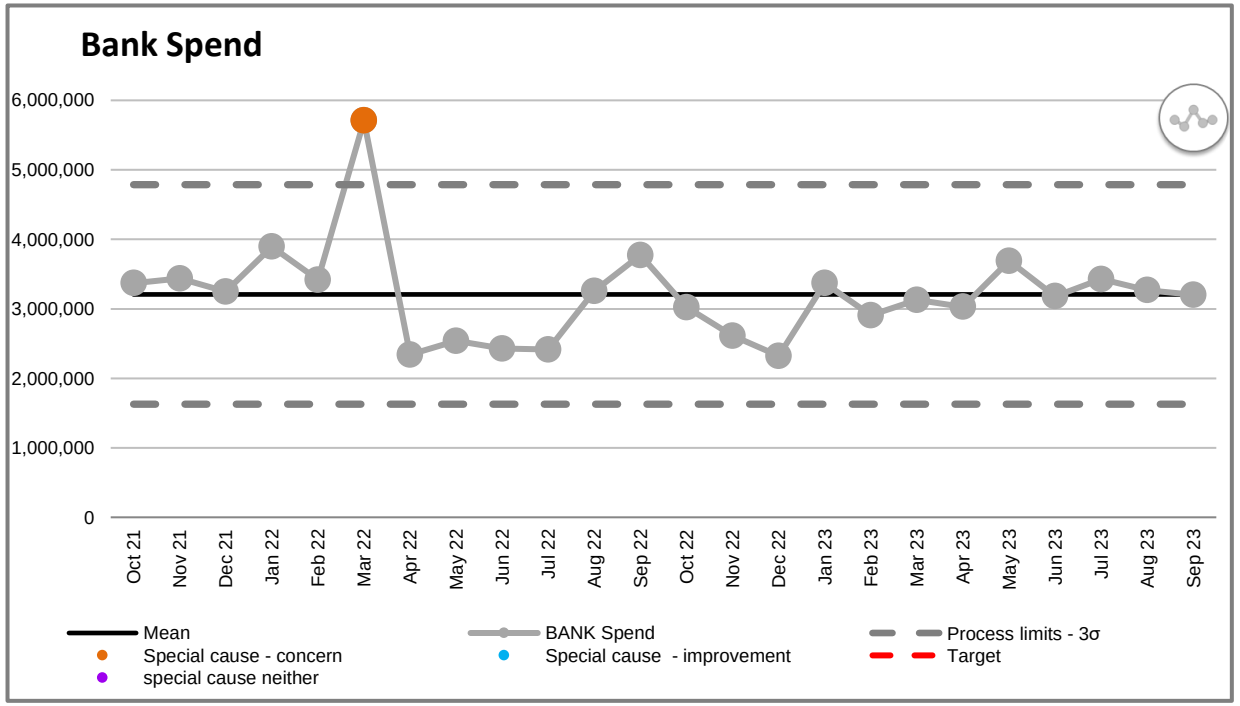
Actions:
- Compliance rates are shared with Directorates on a weekly basis.
- Enhanced Divisional accountability
- Local campaigns to focus on mandatory learning in divisions.
- Task and Finish Group has been developed to retain focus on EST compliance activity.

Bank Spend

Executive Owner: Suzanne Dunkley | Lead: Samuel Hall | Business Intelligence Lead: Mark Bushby

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

Target: £1.15M **Current: £3.20M**



What does the chart show/context:
- From April 2022 bank spend has followed 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 £3.20M in September compared to £3.27M in August 2023

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.

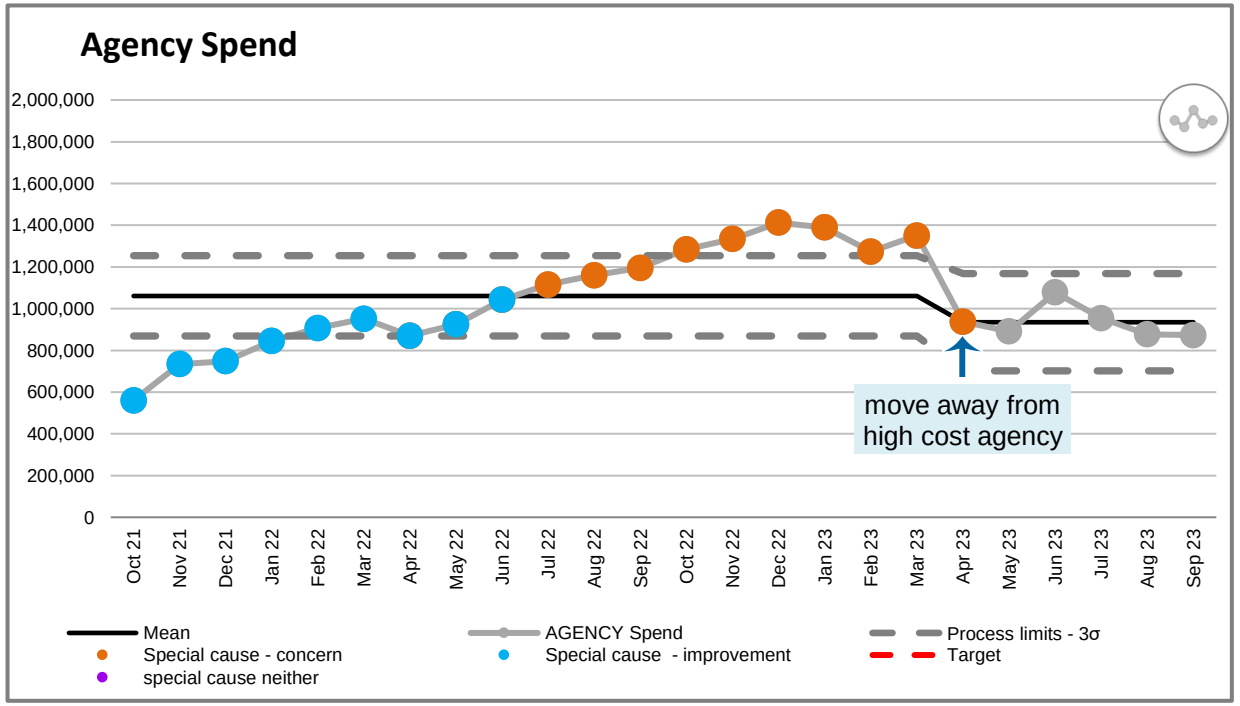
Actions:
- Nursing teams to monitor newly qualified nurses' supernumerary periods and ensure that they contribute to shift fill as soon as possible, reducing the need for Bank to support care hours.
- Apply further scrutiny on shifts required to be sent out to Bank to cover.

Agency Spend

Executive Owner: Suzanne Dunkley Lead: Samuel Hall Business Intelligence Lead: Mark Bushby

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

Target: £0.6M **Current: £0.88M**



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 April 2023.

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 reduced from March 2023 to present due to a structured agency retraction plan.
- Agency spend appears to have plateaued in the months of August and September 2023.

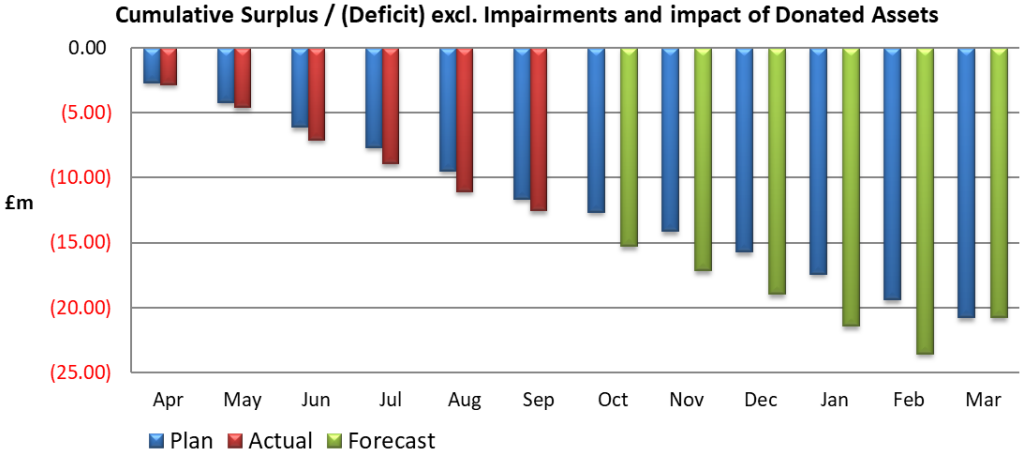
Actions:
- High-cost Nursing agencies have migrated to Tier 1 (lowest cost), lowering the average hourly rate significantly.
- Medical Agency usage to be reviewed and divisional colleagues to discuss migration to Bank with existing agency colleagues.
- Recirculation of NHS I Agency rules- i.e. not to use agency to cover admin/IT roles and estates roles.

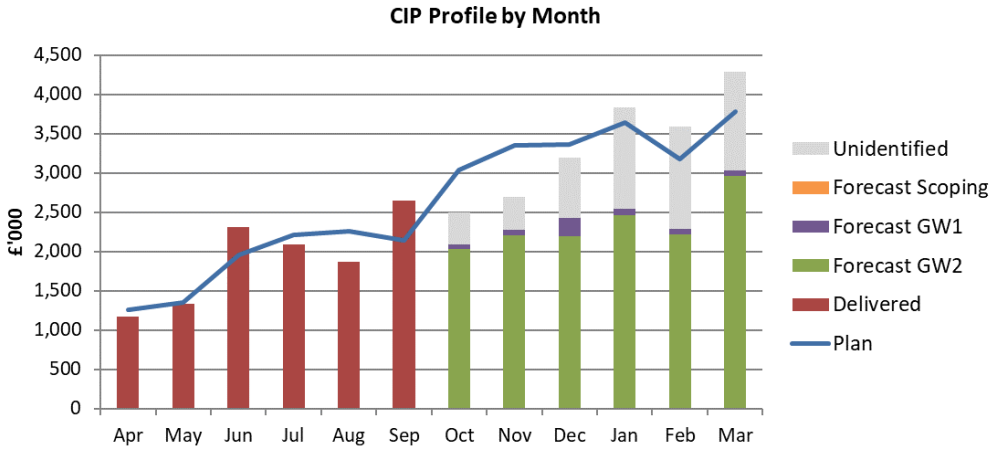
Finance:

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

Financial Performance

Executive Owner: Gary Boothby Finance Lead: Philippa Russell





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

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

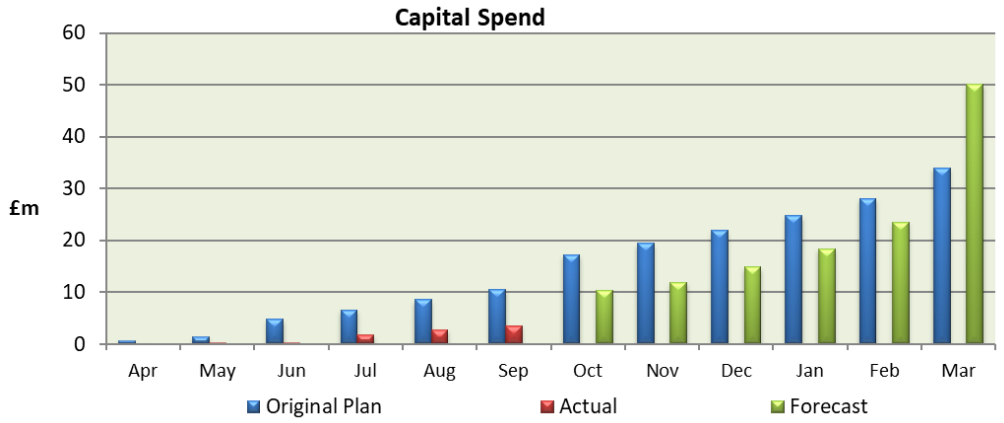
What do the charts show/context:
The Trust is reporting a YTD deficit of £12.57m, a £0.91m adverse variance from plan. The forecast is to deliver the £20.80m deficit as planned. The Trust has delivered efficiency savings of £11.41m year to date, £0.25m above the planned level.

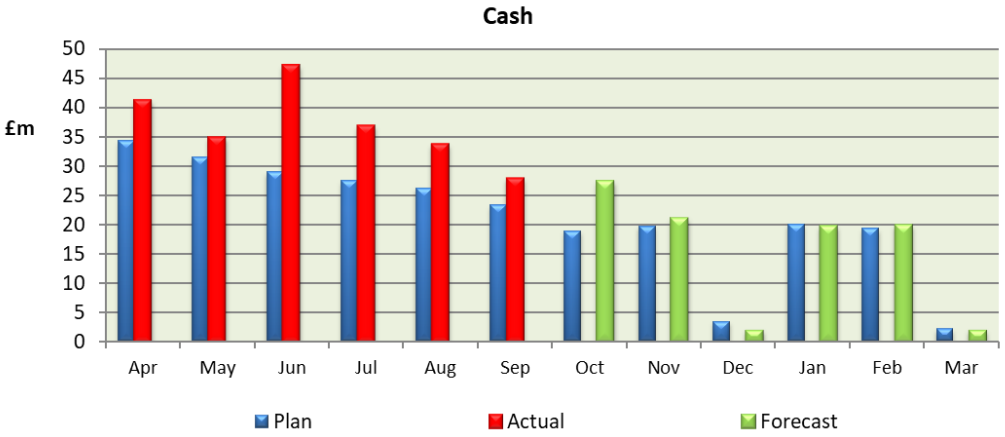
Underlying issues:
- Key drivers of the adverse variance included: higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £2.26m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £2.12m; and non-pay inflationary pressures. These pressures were offset to some extent by early delivery of other efficiencies, including a bonus of £0.54m for the Maternity Incentive Scheme; and higher than planned commercial income (HPS).
- The Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance of £6.69m. The Trust needs to identify mitigation of this scale to offset unidentified CIP / expected slippage on high-risk efficiency programmes (£6.19m) and industrial action (£2.40m). Some potential mitigation has already been identified to offset these and other forecast pressures including non-pay inflationary pressures and additional bed capacity.

Actions:
A number of further opportunities and potential mitigations are currently being worked up for review through Turnaround Executive.

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 £3.53m on Capital programmes year to date, £7.01m lower than planned. Capital Forecast is to spend £50.20m, £16.20m more than planned: including additional Public Dividend Capital (PDC) funding awarded to support the Community Diagnostic Centre and Reconfiguration.. At the end of September, the Trust had a cash balance of £27.86m, £4.48m higher than planned. Use of Resources (UOR) stands at 3, as planned, but with 1 metric (I&E Margin Variance) away from plan.

Underlying issues:
The Capital underspend is due to delays in the Pharmacy Robot project, HRI Reconfiguration and the Community Diagnostic Centre. Leases are also underspent.
The increase in the capital expenditure plan is likely to mean that the Trust will be required to drawdown £20.80m of Revenue Support PDC.

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)

19. Audit and Risk Committee Chair Highlight Report

To Note

Presented by Nigel Broadbent

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Council of Governors

Committee Name:	Audit and Risk Committee (ARC)
Committee Chair:	Nigel Broadbent, Non-Executive Director
Date(s) of meeting:	24 October 2023
Date of Board meeting this report is to be presented:	2 November 2023
ACKNOWLEDGE	• The Committee noted the good progress which has been made in terms of the implementation of recommendations from internal audit reports. 79% of all recommendations (122 in total) over the last 12 months have been completed, 24 recommendations are not yet due, a further 7 recommendations have revised target dates and only one recommendation was overdue. • The fire safety annual report for 2022/23 provided information that the mandatory fire safety training target had been achieved with 90.4% undertaken during the year and that the fire warden training had increased by over 500.
ASSURE	• The Committee undertook a deep dive into the processes involved in producing the Clinical Audit programme. The Committee was appraised of the overall process, how audits are prioritised, the improved staffing position and how the process was being reviewed. Improvements are planned to the clinical audit processes with an emphasis on agreeing clear timescales for each audit. • The Committee also undertook a deep dive into the processes on LocSSIPS and NatSSIPS (safety standards for invasive procedures) which had recently been subject to a report from Internal Audit with limited assurance. ARC took assurance from the fact that most of the recommendations from the report had now been implemented and there were agreed timescales for the outstanding actions. The clinical audits on invasive procedures would be restarted in Q4 this year and a follow up has been arranged by Internal Audit. • The Committee approved the fire safety report for 2022/23 with some changes to reflect the fact that additional capital funding had been approved for

	the current year which would address some of the issues raised in the report. • The High Level Risk Report (HLRR) was considered by ARC prior to it being presented to the Trust board. It was agreed that some presentational changes would be made to the HLRR to combine some of the risks with common issues and highlight the mitigation which is in place for each risk. The current risk management system makes this difficult and it has been agreed that a new system will be procured which will make the triangulation of data with other systems and the presentation of information easier. It was also agreed that greater emphasis would be placed on risk at the performance review meetings to ensure that key performance issues are reflected in the High Level Risk Report. • ARC also considered the latest version of the Board Assurance Framework and approved the updates including the addition of a new risk on cyber security which has a risk score of 15. • The Committee approved an update to the Trust Scheme of Delegation. ARC had recently approved changes to the authorisation limits of new expenditure by the board or relevant sub group, transactions with delegated authority, and authorisation limits for disposals, losses, write offs and other compensation items. The Scheme of Delegation has been updated to reflect these changes to the Standing Financial Instructions and changes to the delegations under the Mental Health Act. • Internal Audit have completed a further five reports in the 2023/24 audit plan including Huddersfield Pharmacy Specials follow up and Compliance with ISO standards which have high assurance, and Financial Planning and budget setting and payroll which have significant assurance. One audit on compliance and training on Nasogastric tubes has been finalised with limited assurance. It was agreed that the relevant Executive lead would be invited to the next ARC meeting to discuss the audit and for the Committee to receive assurance that the recommendations from the audit have been implemented.

	• The Committee received a progress report on counter fraud which outlined the position on current investigations, on fraud prevention awareness and latest fraud alerts issued.
AWARE	• Some minor changes were agreed to the timing of audits as part of the Internal Audit work plan and that the planned audits of length of stay and elective care would be replaced with an audit on outpatient appointment processes. • The Committee approved the losses and special payments and waivers of standing orders for quarter two of the financial year. An update was provided on new processes for reducing the number of losses of patients' personal effects. Audit Yorkshire expressed interest in the new initiatives as it is a common issue among their clients. It was agreed that the opportunity to undertake further deep dives would be included with the Committee work plan. Potential options include the potential impact on the decision making and capacity of Trust colleagues due to the evolving nature of partnership governance, environmental sustainability, procurement/social value or health inequalities.
ONE CULTURE OF CARE	The Committee noted that the reports produced for the meeting were concise but informative providing more time for discussion and thanked the authors and presenters for that.

KEEPING THE BASE SAFE

20. Resilience Plan 2023/24

To Approve

Presented by Jonathan Hammond

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Meeting of the Trust Board
Title of report:	Resilience Plan (Including Winter Plan)
Author:	Gemma Berriman
Sponsor:	Jonathan Hammond
Previous Forums:	Urgent and Emergency Care Delivery Group Finance and Performance Committee Weekly Executive Board
Purpose of the Report	A policy to support operational pressures, including winter plans for Board approval.
Key Points to Note	This policy has replaced what was previously described as the Winter Plan. It has changed this year to the 'Resilience Plan (including winter plan)' recognising that operational pressures may exist throughout the entire year not just during winter. The policy was developed with the following input; • Working with Divisional colleagues • Working with specific areas such as the Emergency Department • Working with system partners across the Local Authority, Integrated Care System (ICS) and Integrated Care Board (ICB) • Sharing the information in different forums across CHFT (Such as Weekly Executive Board) and amending the document based on feedback. The plan consists of the following information; • Purpose of the Plan • CHFT's Resilience & Winter Strategy • Operational Pressures and Scoring Frameworks • Communication • Workforce • Divisional Level Plans • Severe Winter Weather • Escalation and Business Continuity Plans • Infection Control • Holiday Periods National OPEL (Operational Pressure Escalation Levels) scoring has been introduced; this is incorporated into the Resilience Plan. The national OPEL scoring aims to do the following. • Provide a unified, systematic and structured approach to detect Acute Hospital pressures. • Provide a consistent framework to represent each Acute Trust linking into ICS and NHS regions and nationally. • Provide guidance to Acute Trusts, ICS and NHS England so a co-ordinated response to pressures can be sourced.

	• Provide guidance on the alignment and interaction between the OPEL framework and the National Emergency Preparedness, Resilience and Response (EPRR) framework. The nine parameters for the National OPEL scoring are shown below; **OPEL – National Scoring Parameters** 1. Mean ambulance handover time. 2. ED all-type 4-hour performance. 3. ED all-type attendances. 4. Majors and resuscitation occupancy. 5. Time to treatment (TTT). 6. Percentage of patients spending >12 hours in ED. 7. General and Acute (G&A) bed occupancy as a percentage. 8. Percentage of open beds that are escalation beds. 9. Percentage of beds occupied by patients no longer meeting the criteria to reside (NCTR) The new OPEL scoring system will go live on 1 November 2023 and at CHFT this information will be available live on the Trust's business intelligence system, Knowledge Portal Plus (KP+). CHFT will no longer use a local OPEL scoring system but will continue to use a set of local RAG (red, amber, green) rated triggers to invoke a set of actions. These actions link to the Surge and Escalation Plan and the Full Capacity protocol which describes the specific set of actions to undertake during periods of surge in acute demand, in order to support clinical and operational teams. The Resilience Plan includes 14 appendices which support the plan. The following appendices have embedded documents which are not accessible within these papers: • Appendix 1, System Resilience Plan • Appendix 8, Ambulance Handover Procedure • Appendix 9 Red Border template • Appendix 11, ICU escalation plan Copies of these documents are available on request from the Corporate Governance Manager.
EQIA – Equality Impact Assessment	Not required
Recommendation	The Board of Directors are requested to review and **APPROVE** the Resilience Plan.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Resilience Plan 2023/24
(Including Winter Arrangements)

Final

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Document Summary Table	
Unique Identification No.	G-136-2023
Status	Draft
Version	1
Implementation Date	October 2023
Current/Last Review Dates	New
Next Formal Review	August 2024
Sponsor	Chief Operating Officer
Author	Director of Operations – Resilience, Acute Flow & Transformation
Where available	Trust Intranet
Target audience	All Staff

Ratifying Committees	
Executive Board	12/10/2023
Finance & Performance Committee	29/09/2023
Resilience, Acute Flow and Transformation Governance Group	19/10/2023

Consultation Committees	
Finance & Performance Committee	
Urgent and Emergency Care Delivery Group	
Resilience and Safety Group	

Other Stakeholders Consulted
Medical Division
Surgical Division
Families and Specialist Services Division
Corporate Teams
NHS England
System Partners

Does this document map to other Regulatory requirements?	
1	New National OPEL Framework
2	Urgent and Emergency Care Recovery Programme
3	EPRR

Document Version Control	
1	First Version

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Contents

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

1. Introduction

The Resilience Plan describes the structure within which operational pressures will be anticipated and managed. It includes arrangements for during the winter period and it provides the framework for managers and clinicians in the Trust to work together and with other organisations. The Resilience Plan should be used in conjunction with the Surge and Escalation Plan (SEP) including the Full Capacity Protocol (FCP).

The Calderdale and Huddersfield NHS Foundation Trust (CHFT) Resilience Plan also forms part of the larger system Resilience Plan pulled together by the Integrated Care System (ICS) (Appendix One)

2023 has brought many challenges to the NHS due to the worldwide pandemic and starting to live with COVID-19 as it moves from pandemic to endemic. Preparedness for operational pressures and winter in particular is imperative to ensure we keep our patients and staff safe. We remain resilient as an organisation, as well as continue with our elective recovery programme to reduce backlogs.

Whilst the winter period is normally defined as the period from October through to the end of March the pressures in the NHS remain throughout most of the year, so the Resilience Plan and the Surge and Escalation Plan need to be prepared and tested with daily monitoring of data in place to trigger OPEL/LOPEL and escalation.

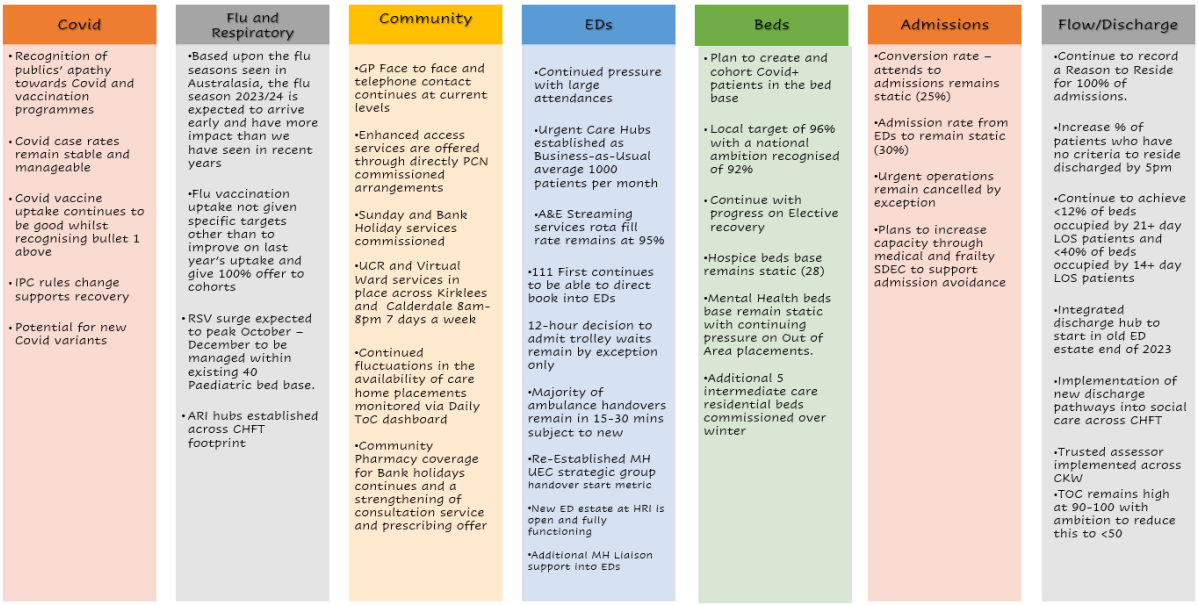
2. Purpose of the Resilience Plan

The objectives of the plan are in line with the West Yorkshire Integrated Care System (ICS) Operational Pressures and Winter Planning Principles as listed below:

- System resilience is 365 days of the year – winter challenges October to March
- Staff Support and Wellbeing arrangements should be in place to enable a resilient workforce.
- Health Inequalities integral to all plans.
- System wide clinical engagement and leadership in the ongoing development of plans and oversight.
- Data trends to inform planning assumptions – including public health.
- Focus on prevention – Vaccination, Infection Prevention Control (IPC).
- Consideration of impact of wider transformational schemes on system plans.
- Early identification of winter schemes through winter learning.
- Robust command and control arrangements to support system escalation.
- Mechanisms in place to ensure systems escalate early in anticipation of demand surges, not in response to them.
- Development of communication plans with system partners and the public to influence behaviour.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Broad Assumptions



Alongside the above principles and assumptions there is also a regional Urgent Emergency Care Recovery Plan, this is a programme designed to cover a 2-year period but there are a set of rapid roll out priorities identified to ensure pressures are manageable for the 2023/24 period.
There are 3 high level focus areas:

- Increasing flow and capacity
- Improving Discharge
- Expanding out of hospital care

These are committed to deliver the following:

- 80% A&E performance by 31st March 2024.
- Average 30min response time for Category 2 ambulances.

This will be achieved by prioritising the following:

- **Same Day Emergency Care (SDEC):** Improving SDEC provision and operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
- **Frailty:** Improving expanding frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
- **Inpatient flow and length of stay (Acute):** Reducing variation in inpatient care and length of stay for are key for Urgent and Emergency Care pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
- **Community bed productivity and flow:** Implementing in-hospital efficiencies and bringing forward discharge processes to reduce variation in inpatient care and length of stay (LOS).

- **Transfer of care hubs:** Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
- **Intermediate care demand and capacity:** Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
- **Urgent Community Response (UCR):** Increasing volume and consistency of referrals to ease pressure on ambulance services and avoid admission.
- **Single point of access (SPA):** Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
- **Acute Respiratory Infection Hubs (ARI):** Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.
- **Virtual wards (VW):** Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital.

The CHFT resilience plan will aim to achieve the following:

- To support existing plans by increasing the operational focus on pressures and winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the operational pressures including winter.
- To provide the basis for agreement and working with other partners and organisations.
- To provide reference material for use in the Trust.
- To set out the information systems to be used to manage the response.

3. Duties (roles and responsibilities)

Chief Operating Officer (COO)

- Responsible officer at Executive level for Resilience and Winter Planning.
- Will represent Trust on the Urgent Care Delivery Board.

Director of Operations for Resilience, Acute Flow and Transformation (DoP RAFT)

- Represent the Trust on the Calderdale and Huddersfield Urgent and Emergency Care Board planning meetings.
- Represent the Trust on the West Yorkshire and Humber (WY&H) ICS System Resilience Workshops.
- Update the divisional leads regarding resilience across the local healthcare system.
- Respond to requests for assurance from the Integrated Care Board (ICB) and NHS England.
- Benchmark and share good practice from partner organisations.

- Ensure that resilience plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans.
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period.
- Ensure that contingency plans that are in place for surge in non-elective demand for inpatient capacity, resurgence of COVID-19, outbreaks of winter infectious diseases and severe winter weather are appropriate and will deliver safe patient care and experience and organisational resilience.
- Ensure that the Trust Resilience Plan aligns with those across the local health and social care system.
- Lead in Partnership with the Chief Nurse specific plans to support the organisation to manage resurgence of COVID-19 through the creation of Isolation capacity and new operating model for managing patients with infections that require isolation.

Divisional Directors (DDs)

- Ensure each Division takes responsibility for securing sufficient capacity to meet out of hours demands on a daily basis.
- Ensure collaboration across Divisions.
- Ensure each Division has robust arrangements for escalation and any associated operational and site management meetings.

Chief Nurse

- Ensure each Division has robust arrangements for escalation through the site management meetings.
- Lead in partnership with the Director of Operations for Resilience, Acute Flow and Transformation specific plans to support the organisation to manage resurgence.
- Support the divisional teams to implementation of any new IPC guidance.
- Lead in Partnership with the Director of Operations for Resilience, Acute Flow and Transformation specific plans to support the organisation to manage resurgence of COVID-19 through the creation of Isolation capacity and new operating model for managing patients with infections that require isolation.

Divisional Directors of Operations (DoPs)

- Ensure that appropriate plans are in place to manage an increase in non-elective activity within the division.
- Ensure that divisional plans are joined up across the organisation.
- Ensure that contingency plans are in place for surge in severe winter weather and outbreaks of winter infectious diseases.
- Ensure that key staff groups are aware of the risks and response arrangements for winter.
- Ensure robust communication of the resilience plan is in place across the divisions.
- Ensure all Business continuity plans are updated following learning from the COVID-19 pandemic.

Calderdale and Huddersfield Solutions (CHS), Clinical Site Matrons (CSM), Commanders Site Commanders (CSC)

- Initiate and respond to surge following Surge and Escalation procedures and the Local Operational Escalation Pressures Levels (LOPEL) and Operational Escalation Pressures Levels (OPEL) framework.
- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements.
- Contact alternative transport providers if required.
- Work with IPC to optimise inpatient isolation capacity.
- Liaise with those contracted to arrange access to 4X4 vehicles for transport services if required.

CHS/ EQUANS

- Ensure that there are sufficient supplies of salt/grit for clearing car parks, pathways and roads on site and in community buildings where CHFT staff and patients are working/attending.
- Ensure that additional staff accommodation is available if required.
- Cascade weather updates throughout the year including winter.
- Be prepared for additional outbreak cleaning and curtain changes as and when required.
- Ensure staffing levels are maintained by calling upon generic pool of bank workers.
- Ensure cleaning requirements are in place to manage infection outbreaks and possible resurgence of COVID-19.

4. The Trust's Resilience and Winter Strategy

The resilience plan is based on the following strategic aims.

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs.
- To work collaboratively with other health and social care providers to effectively manage capacity.
- To assess risks to continued service provision and put plans in place to mitigate those risks.
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels during pressures and over the winter period to minimise the risk of harm.
- To ensure patients do not wait in any part of the system unless clinically appropriate.
- To ensure learning from Winter 2022/23, the COVID-19 pandemic and WY&H ICS Resilience Workshops is incorporated into 2023/24 Resilience Plan (Including Winter).

5. Resilience and Winter Planning Arrangements

The Trust Operational Lead for resilience planning is the Director of Operations for Resilience, Acute Flow & Transformation in collaboration with the Divisional Senior Management Teams.

The local Calderdale and Huddersfield Urgent Care Delivery Board has overall responsibility for ensuring that the health and social care service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity and acuity during times of pressure and during the winter period. The Urgent and Emergency Care Delivery Group is responsible for assurance regarding resilience planning including winter arrangements. It is responsible for ensuring that the Trust has plans in place for severe winter weather, COVID-19 resurgence, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

In 2023 the Trust's internal Urgent and Emergency Care Delivery Group with membership of all Clinical Director's, contributed to resilience planning by developing new innovative schemes providing increased resilience and clinical effectiveness. All innovations are being monitored against clear aims and Key Performance Indicators (KPIs):

Work Stream	Description	KPIs
Well Organised Ward (WOW)	Well Organised Ward (WOW). Plan for Every Patient (PFEP). Sessions including standardisation of board rounds and SOPs – linking with improvement projects to reduce ward LOS.	• Releasing time to care. • Adding value to patient journey with clear actions. • Reduction in use of paper-based notes. • Improved dementia screening and VTE screening. • Reduction in LOS. • Increased discharges before lunchtime.
Long Length of Stay Review	Review of all patients with a length of stay over 40+.	• Reduction in super-stranded and stranded patients.
Criteria to Reside	A daily review of all patients who do not have a criteria to reside. Information available and live on KP+ with parameters set out by NHS England. Daily meeting to discuss plans and challenge decisions on remaining in hospital.	• Reduction in LOS. • Clear plans of care. • Utilisation of community services such as virtual ward, UCR and OPAT.

	Optimising the use of Virtual Ward OPAT and Urgent Community Response.	
UCR	The Service Aim for the Calderdale UCR is to provide a 0–2-hour response **for all age adults** to accelerate the treatment of urgent care needs closer to home and prevent avoidable hospital admissions. These 0-2hour and 2-day urgent response standards are part of a range of commitments which aim to help keep people well at home and reduce pressure on hospital services. In Calderdale the UCR service will supplement other aspects of the Ageing Well programme such as. • Discharge to assess pathways • Enhanced Health in Care Homes • Anticipatory Care • Frailty Strategy	• Reduction in hospital admissions.
Virtual Ward	Early supportive discharge and admission avoidance, providing remote monitoring linking with Urgent Community Response, and Discharge to Assess. Prescribing and offering diagnostics.	• Reduction in LOS. • Reduction in admissions.
Criteria Led Discharge	Criteria to allow a patient to be discharged should they meet a required set of parameters set by the clinician, without the requirement for a further review.	• Early discharge. • Freeing up of clinician time to see other acutely unwell patients. • Improved discharges at the weekend.
SDEC Improvement	Improving access to SDECs by • Increased opening hours. • Inclusion criteria based rather than pathway based. • YAS direct referral. • Increasing capacity by moving to integrated flow hub.	• Reduced patients in ED. • Reduced admission and LOS. • Admission avoidance.

6. Operation Pressures and Scoring Frameworks

All acute Trusts have seen a requirement to respond to an ever-increasing demand for their services. Calderdale and Huddersfield Foundation NHS Trust (CHFT) is committed to providing the highest level of patient care to the public including times when it is experiencing capacity pressures and periods of high demand.

In 2016 NHS England introduced the National Operational Pressures Escalation Framework (OPEL), this was to bring consistency to local and system escalation. The framework was further reviewed in 2018 and released in 2019, however there has been considerable variation to its application and utilisation, in addition there has been changes in services and care since Covid-19. Therefore a New National OPEL framework has been released in late 2023 in preparation for 2024.

The New OPEL Framework will be used to support the wider NHS Health and Social Care economy surge and will determine what actions are necessary to protect core services and supply the best possible level of services with the resources available, they also link with the NHS England Emergency and Preparedness and Resilience framework (Appendix Two)

OPEL is designed to “be informed” by any disruptive challenges and “to inform” internally and to the wider NHS of the pressures facing the organisation. The considerations and actions contained with the OPEL should be viewed as guidance in challenging situations. The OPEL will assist the Trust in operating at a steady state and in proactively managing visible pressures to enable a return to that status as soon as possible.

The new framework aims to achieve the following:

- Provide a unified, systematic and structured approach to detect Acute Hospital pressures.
- Provide a consistent framework to represent each Acute Trust linking into ICS and NHS regions and nationally.
- Provide guidance to Acute Trusts, ICS and NHSE so a coordinated response to pressures can be sourced.
- Provide guidance on the alignment and interaction between the OPEL framework and the National Emergency Preparedness, Resilience and Response (EPRR) framework.

The following benefits should be felt.

- Improved patient safety
- Increased efficiency
- Improved communication
- Enhanced decision making

6.1. National Operational Pressures Escalation Levels (OPEL)

The OPEL Framework 2023/24 focuses on assessment of an acute hospitals' operational pressures and how this assessment contributes to the OPEL score of their corresponding NHS trust, ICS and NHSE region, and NHSE nationally. Each acute hospital at CHFT in this case Calderdale Royal Hospital and Huddersfield Royal Infirmary with a Type 1 emergency department (ED) is required to complete an OPEL assessment, this generates an OPEL score. The score from each acute hospital contributes to the acute trust's OPEL score.

A Type 1 ED is a consultant-led, 24-hour, 7-day service, with full resuscitation facilities, and designated accommodation for the reception of patients receiving 'emergency care' – Emergency care department type (datadictionary.nhs.uk)

The OPEL score must be calculated at a hospital level. Acute trusts with multiple hospitals must use the current proportionate contribution calculations published in the technical guidance issued by NHSE. Subsequently, the acute trust OPEL scores are proportionately aggregated to give the ICS OPEL score. The ICS OPEL scores are aggregated to provide the NHSE region's OPEL score. In turn, the regional scores are aggregated to produce the national OPEL score and trend analysis.

6.2. OPEL Parameters

The following core parameters make up the OPEL assessment for each submission.

1. Mean ambulance handover time.
2. ED all-type 4-hour performance.
3. ED all-type attendances.
4. Majors and resuscitation occupancy.
5. Time to treatment (TTT).
6. Percentage of patients spending >12 hours in ED.
7. General and Acute (G&A) bed occupancy as a percentage.
8. Percentage of open beds that are escalation beds.
9. Percentage of beds occupied by patients no longer meeting the criteria to reside

Only the core parameters listed above should contribute toward the OPEL score and level for an acute hospital reported through to NHSE. The reported OPEL score for each acute trust, ICS, NHSE region and NHSE nationally is to be based solely on the scores produced for each acute hospital within it.

6.3. How the OPEL Score Works

Table 1 outlines the core OPEL parameters, their thresholds and the scores attributed to each threshold, there descriptors can be found in (Appendix Three). Scores range from 0 to 44 – with the lowest pressure assessment being 0 and the highest-pressure assessment being 44.

Table 1.

OPEL parameter	Score						
	0	1	2	3	4	5	6
Mean ambulance handover time	<15 min		15–30 min		>30–60 min		>60 min
ED all-type 4-hour performance	>95%	76–95%	60–76%		≤60%		
ED all-type attendances	≤2%	>2–10%	>10–20%		>20%		
Majors and resuscitation occupancy (adult)	≤80%		>80-100%		>100–120%		>120%
Median time to treatment	≤60 min	>60–90 min	90–120 min		>120 min		
% of patients spending >12 hours in ED	≤2%	>2–5%	>5-10%		>10%		
% G&A bed occupancy	≤92%		>92–95%		>95–98%		>98%
% of open beds that are escalation beds	<2%	2–4%	4–6%		>6%		
% of beds occupied by patients no longer meeting criteria to reside	≤10%		>10–13%		>13–15%		>15%

OPEL parameters outlined above have been assigned scores within the ranges 0-4 and 0-6, with the score reflecting how far that parameter deviates from the expected standard. The ranges indicate the weighting of those parameters that contribute to the overall OPEL for CHFT. The sum of the score assigned to the 9 parameters gives the OPEL score. Table 2 indicates the OPEL that is attributed to each range of OPEL score; the indicated risk is also denoted.

Table 2.

Aggregated OPEL Score	OPEL	Clinical Risk	Response
0–11	OPEL 1	Low	**See OPEL action card** (and local policy/ protocols)
12–22	OPEL 2	Medium	
23–33	OPEL 3	High	
34–44	OPEL 4	Very High	

Assessments should be time-cycled as per the OPEL action cards; (Appendix Four) this calculation is digitally automated and managed through Knowledge Portal Plus (KP+) under Command Centre (Appendix Five). The Clinical Site Matrons will share this information with the System Coordination Centre (SCC). An OPEL assessment must be completed as a minimum once per 24-hour period or in response to any changes in OPEL status. The first assessment must be completed no later the 10:00hrs, 7 days per week.

6.4. CHFT Action Triggers

Prior to the introduction of the new National OPEL scoring system CHFT had developed its own OPEL score with a wide-ranging number of parameters and descriptors. These triggers will remain and will produce a score but will no longer produce a local OPEL level meaning only the national OPEL score and level will be quoted. However the local parameters will be RAG rated so that we can make sure that they trigger required actions . This internal score is currently managed digitally through KP+ and will continue to do so and run alongside the National OPEL scoring system.

6.5. The Triggers

Table 3 outlines the core triggers at CHFT that have attributed actions within the action cards. These triggers will be RAG rated (Appendix Six) and actions will be discussed in each site management meeting depending on their levels of concern.

Table 3.

Triggers
1. Previous days ambulance turnaround (30-60 mins & 60 mins +).
2. Patients waiting for a bed in ED.
3. Previous day non-elective admissions.
4. Previous days discharges.
5. Previous day SDEC utilisation.
6. Previous day ED attendances.
7. Previous day ECS standard.
8. Current number of patients with a LOS over 12hrs in ED.
9. Current number of patients with a LOS between 6 & 12 hours.
10. Current number of extra beds open.
11. Infection Control Position.
12. Current Number of Patients in ED.

13. Current number of outliers.
14. Critical Care Bed Availability.
15. Bed occupancy levels.
16. Nurse staffing OPEL Score
17. Medical Staffing OPEL Score

6.6. OPEL and Triggers Response

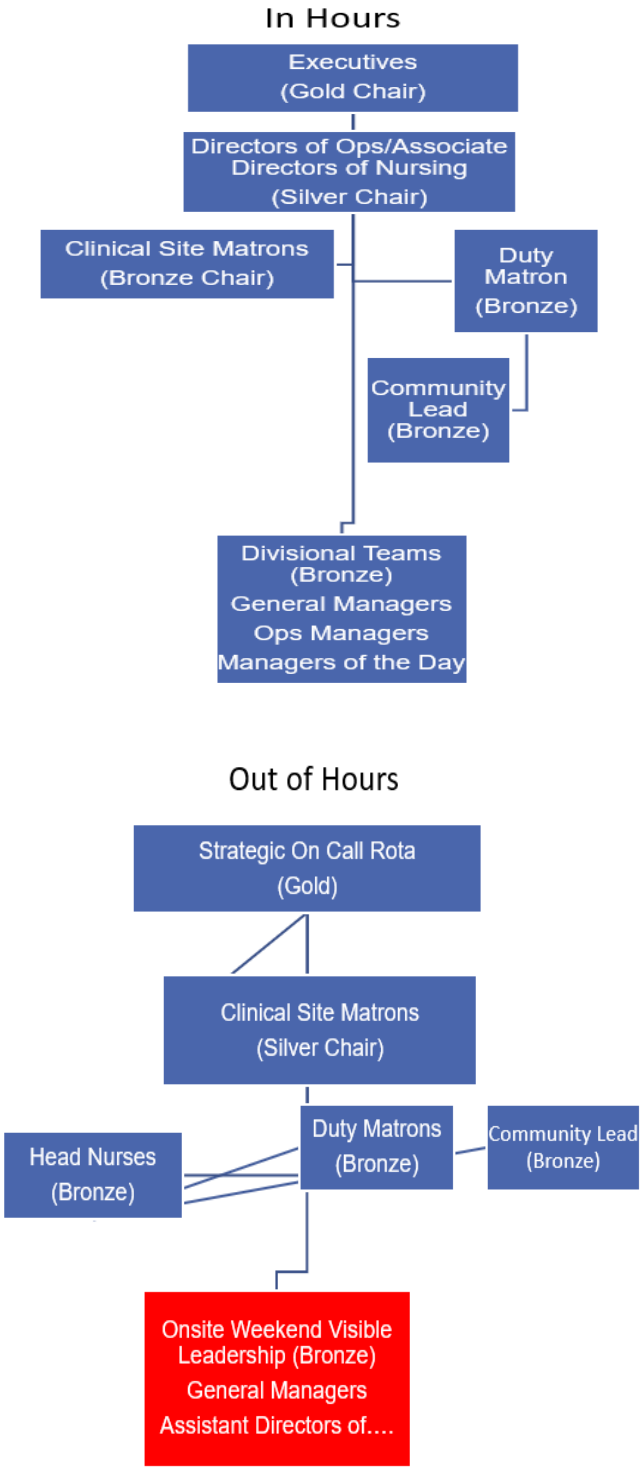
The OPEL framework will recognise operational pressures and the standardised approach with parameters will allow the system to provide a systematic response to aid stabilisation.

The response to both OPEL and CHFT triggers will be conducted using the integrated action cards, these can be seen at Appendix Four. These core actions and any additional actions taken will follow the below guiding principles.

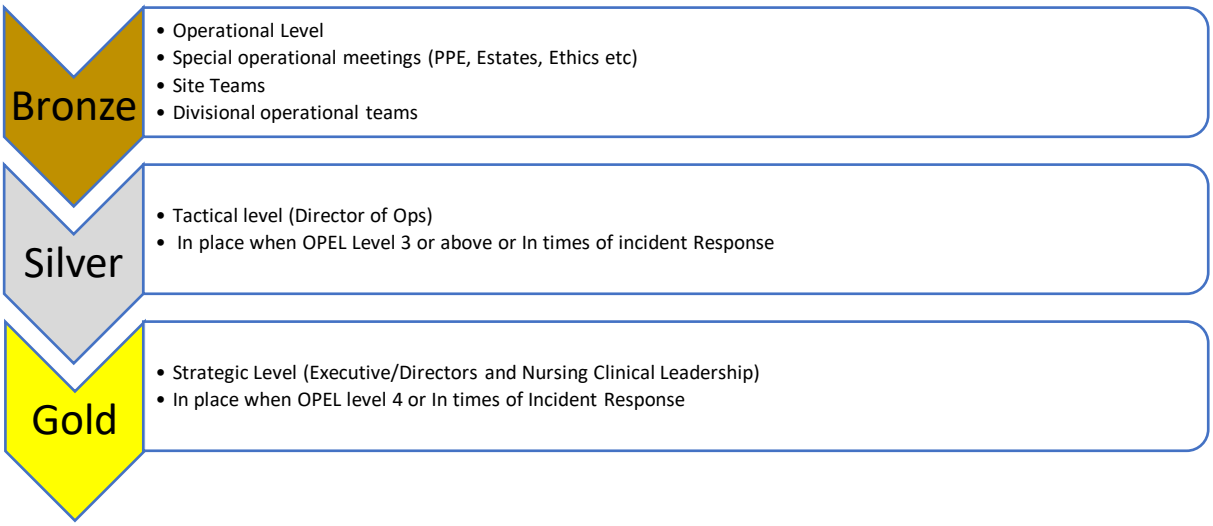
- OPEL actions are grounded by the assessment undertaken, this means the acute trust, ICS and NHS regionally are expected to take OPEL 3 or 4 actions, this is regardless of the aggregated score.
- Making decisions in extremis for crowding and delays will involve risk: it is recognised that actions within this framework would not routinely be taken. Choosing to enact them should reduce a more significant risk in another part of the pathway.
- Risk is dynamic and everyone sees it in different ways: for this reason a more considered safety decision will result from involving those who can articulate and share insights about the risks and courses of action.
- Decisions about the actions taken should always be recorded: Along with documentation of any anticipated risks, a consideration of how these might be identified and measured and determine the scale of potential harm must be recorded. This also provides an opportunity for learning and evaluation going forward.

6.7. Decision Making within OPEL

Decision making within OPEL should follow the bronze, silver and gold command structures already in place see below and are stipulated using the action cards. OPEL 1 and 2 bronze command. OPEL 3 bronze and silver command and OPEL 4 and critical incident bronze silver and gold command.



Each level of command includes various team members across the trust and can be seen below.



The bronze silver and gold structures are laid out below and their terms of reference can be seen at Appendix Seven.

Bronze Command	Silver Command	Gold Command
Runs 7 days a week 365 days a year. Site management meeting 07:00hrs/09:00hrs/13:00hrs/ 16:00hrs/19:00hrs/23:30hrs Chaired by Clinical Site Matron Set agenda and recording template.	Triggered at OPEL 3 stepped up in diaries by the Clinical Site Matrons. Held daily through 09:00hrs site management meeting. Chaired by a DOP through a rota available on Teams. Meeting recorded and minutes taken. Set agenda and recording template.	Triggered at OPEL 4 or when a critical/major incident occurs. Held at 14:00hrs. Chaired by COO or Executive lead. Meeting recorded and minutes taken. Set agenda and recording template.

6.8. Recording and Monitoring of OPEL

OPEL scores will be digitally available on KP+ under the Command centre tab (Appendix Five)

All the parameters for OPEL scoring will be retrieved digitally and will be sent directly to the SCC via the digital team, this will be determined based on the OPEL Score

OPEL 1 – Once a day on or before 10:00hrs.
OPEL 2 – Every 6 hours
OPEL 3 – Every 4 Hours
OPEL 4 – Every 2 Hours

The CHFT triggers score will also be available through KP+ under the command centre tab, most of these parameters are retrieved digitally, with a small set of parameters that require writeback.

All site management (bronze) meetings are recorded, with silver and gold meetings also recorded but with published minutes.

7. Performance Metrics

As an organisation we will be measured both regionally and nationally against a set of performance metrics related both to unplanned and elective care, recognising that unplanned activity and performance has a knock-on effect against elective care and elective recovery.

IPR Section	Metric	Target
Elective	Total Patients waiting >40 weeks to start treatment	0
	Total Patients waiting >52 weeks to start treatment	0
	Total Patients waiting >65 weeks to start treatment	0
	Total RTT Waiting List	31,586
	Total elective activity undertaken compared with 2023/24 activity plan	100%
	Percentage of patients waiting less than 6 weeks for a diagnostic test	95%
	Diagnostic Activity undertaken against activity plan	14,547
	Total Follow-Up activity undertaken compared with 2023/24 activity plan	100%
Cancer	Total Patients waiting >62 days to begin cancer treatment compared with February 2020 baseline	35
	Proportion of patients meeting the faster diagnosis standard	75%
	Non-Site-Specific Cancer Referrals	25
	Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	75%
Urgent and Emergency Care and Flow	Proportion of patients seen within 4 hours	76%
	Proportion of ambulance arrivals delayed over 30 minutes	0%
	Proportion of patients spending more than 12 hours in an emergency department	2%
	Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	96%
	% of beds occupied by patients who no longer meet the criteria to reside	14.21%
	Hospital Discharge Pathway Activity – AvLOS pathway 0	4.1
	Transfers of Care	50
Maternity	Neonatal deaths per 1,000 total live births	1.53
	Stillbirths per 1,000 total births	3.33
Community	Proportion of Urgent Community Response referrals reached within 2 hours	70%
	Community Waiting List	4,387
	Virtual Ward	80%

	OPAT - Outpatient Parenteral Antimicrobial Therapy	N/A
Safe, High-Quality Care	Summary Hospital-level Mortality Indicator	100
	Care Hours Per Patient Day (CHPPD)	-
	Falls per 1000 Bed Days	7.02
	CHFT Acquired Pressure Ulcers per 1000 Bed Days	1.76
	MRSA Bacteraemia Infection	0
	C.Difficile Infection	3.1
	E.Coli Infection	5.6
	Number of Never Events	0
	Number of Serious Incidents	0
	% of incidents where the level of harm is severe or catastrophic	2%
	% of complaints within agreed timescale	95%
Quality Priorities	Alternatives to Hospital Admission – Number of referrals into the Frailty service	TBC
	% of episodes scoring NEWS of 5 or more going on to score higher	30%
	% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward	95%
Health Inequalities - LD	Emergency Care Standard	76%
	Outpatients DNAs	3%
	Cancer Faster Diagnosis Standard	75%
	% of patients waiting less than 6 weeks for a diagnostic test	95%
	Patients waiting more than 40 weeks to start treatment	0
Health Inequalities - IMD	Emergency Care Standard	76%
	Outpatients DNAs	3%
	Cancer Faster Diagnosis Standard	75%
	% of patients waiting less than 6 weeks for a diagnostic test	95%
	Patients waiting more than 40 weeks to start treatment	0
Workforce	Staff Movement (Turnover)	11.50%
	Sickness Absence (Non-Covid)	4.75%
	Appraisal Compliance (YTD)	95.00%
	Core EST Compliance	90.00%
	Bank Spend	£1.60M
	Agency Spend	£0.53M
Finance	Cumulative Surplus	
	CIP Profile	
	Capital Spend	
	Cash Balance	

There will particular scrutiny this year on

- Ambulance delays and the organisations ability to turn ambulances around to get back on the road and respond to emergency call, a Standard Operating Procedure has been developed to manage this (Appendix Eight).
- Emergency Care 4 Hour Standard
- Elective Recovery

Regionally we are also measured against the following metrics:

- Numbers of patients without a Criteria to Reside (CTR).
- Bed occupancy levels.
- Numbers of patients on Transfer of Care List (TOC).
- Length of Stay LOS at 7 days, 14 days and 21 days.
- Numbers of patients on Virtual Ward (VW).

8. Communication

Operationally, communication routes will be via the Site Management Meetings, however there will be a need to be able to communicate with staff in a variety of ways, particularly in times of pressure.

We will continue to effectively use the following internal communication routes to inform and keep staff up to date, as well as provide a way for staff to ask questions.

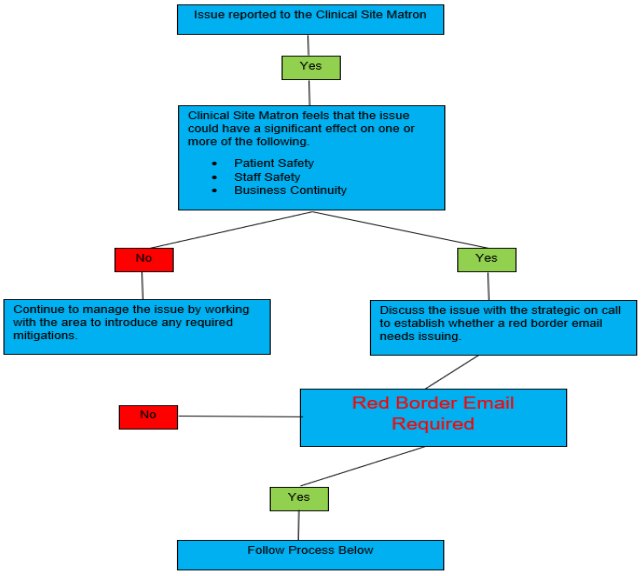
Communication Forum	Style	When
CHFT Live	• Microsoft Teams Live Event. • Information giving. • Questions from staff.	Wednesdays 13:00hrs (plus additional ad hoc sessions when required)
CHFT News	• Web-based newsletter shared by email. • Information giving.	Mondays
Brendan's Update	• Email. • Information giving.	Fridays
Leadership Conversation	• Microsoft Teams Meeting. • Multiway conversation and information giving.	Every other Wednesday
Screensavers	• Screensavers on desktop and laptop computers logged onto the CHFT network. • Information giving.	Continually updates
Intranet latest news	• News article.	Daily

Staff App	• Push notifications and links to content channels above.	As required
All user emails	• Email content with important, but not urgent, information.	As required
Weekend Plan	• Information giving. • Email	Every Friday

8.1. Red Border Emails

As well as the communication routes listed above, we also have the ability to issue 'red border' emails. If a serious issue has occurred or is occurring across the organisation and we need to urgently inform as many people as possible, then a red border email can be issued.

During normal working hours (Monday to Friday 09:00-17:00hrs) this will be discussed and issued by the executive team and the Director of Ops for Resilience Acute Flow and Transformation. It will be issued by the Communications Team on behalf of a director. If a red border email needs issuing out of hours, then the following flow chart should be followed.



Use red border email template and follow instructions in (Appendix Nine).

The Communications Team will issue media statements during times of pressure to reinforce key health messages.

When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

Prior to the Christmas and New Year period a press release will be issued reminding the public them when it is appropriate to use primary care services rather than accident and emergency departments and to stock of home medicines cabinets prior to the holiday.

In the event of a significant infection outbreak the Trust communications team will work with Calderdale and Greater Huddersfield CCG to implement a media and communications strategy utilising key messages which will include advice for visitors.

9. Workforce

9.1. Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover arrangements especially over holiday periods and to ensure annual leave is managed appropriately over these periods. Staffing gaps should be identified and mitigated by Divisional teams in hours, only last-minute absences will be actioned by on-call, out of hours teams. Staffing for the weekends will be managed through the week and conveyed onto the weekend plan.

CHFT will run twice daily site staffing meetings 7 days a week and have a clear term of reference Daily_Staffing_meeting_ToR_-_Hospital_-_V11_as_at_15.06.23.pdf (cht.nhs.uk) these will be chaired by the Divisional Matrons Monday to Friday and the Clinical Site Matrons on a Saturday and Sunday. The use of an OPEL scoring system for staffing (Appendix Four) will be undertaken and the relevant actions undertaken depending on OPEL scoring level.

For Christmas & New Year a further review will be completed weekly from the beginning of December with a final sign off and escalation of any risks with mitigation plans by week commencing 27th November 2023.

9.2. Vaccination

The target for Trust staff to have had the ‘flu vaccine for this year for Calderdale and Huddersfield the ambition is to achieve 100%of frontline staff. The emphasis will be on staff in clinical frontline roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, ‘myth busting’ and league tables of performance have been advertised on the intranet. Additional groups of staff are being trained to administer the vaccine so that it can be more accessible to staff. District nursing services provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine.

Vaccinations booster for COVID-19 will be issued alongside flu should frontline staff wish to be vaccinated.

Vaccinations will be available on both hospital sites:

CRH – Old Rainbow centre
HRI – Ward 11A

9.3. Personal Winter Plan/Engagement Plans

All members of staff have a personal responsibility to ensure that they are available for work and that they have alternative arrangements for carer responsibilities and journeys to work. All staff will be reminded of preparations they should make for winter – seasonal flu vaccination, checking public transport alternative routes, vehicle preparation as well as contingency plans. This will continue to be reinforced through the business continuity management system and staff communications strategy. In severe weather conditions staff in District nursing, community midwifery and other community services will report to their nearest team to their home not necessarily where they usually work. The Trust's attendance management, carer leave and adverse weather policies will be used to support staff and to maintain service levels.

9.4. Wellbeing Support

Colleague wellbeing has become a people priority over the past 2 years, having to work in a health care setting during the pandemic and having to deal with personal issues relating to the pandemic. The organsiation has supported 1000's of colleagues through a range of interventions and it was pleasing that colleagues fed back through the staff survey that 'the organisation definitely takes positive action on health and wellbeing'. The NHS Staff Survey 2021 core increased by 28.1% from 32% to 60.1% (national score 57%).

Colleagues perform better when they are healthy, energised, fit and well. It is more important than ever that NHS workplaces become environments that encourage and enable staff to lead healthy lives and make choices that support positive wellbeing. Everyone should feel able to thrive at work.

9.5. Well-being Hour

Here at CHFT we encourage all colleagues to look after each other and themselves in the same way we look after our patients. This helps to build One Culture of Care and make CHFT a great place to work. To support this, and as part of our refreshed People Strategy, colleagues can focus on wellbeing and development activities through a one hour a week initiative, when the needs of the service allows.

The wellbeing hour is one of the great initiatives to come out of the pandemic as we strive to improve colleague wellbeing. This time allows colleagues the chance to get involved in initiatives they may have not had chance to get involved in before, such as attending a Schwartz Round or supporting an Equality Network.

When the colleague feels they need to take the hour, they can speak with their line manager and ask them if this is possible. This gives an opportunity for the manager and the team member to have a wellbeing conversation to explore the support options available.

Following a review by the Executive Board in September 2022, a decision was taken to simplify how wellbeing time is taken to ensure it is fair, equitable and inclusive for all. The changes are:

- The wellbeing hour is available for 1 hour per week (pro-rata) – there can be no 'banking' of time or carry over.
- The wellbeing hour is not rostered, job planned or contractual and flexes with the needs of the service and doesn't form part of the terms and conditions of employment.
- The wellbeing hour will not cost and will not be costed – the main benefits of the hour come from the flexible flexibility!

We will continue to review the wellbeing time annually as part of our Health and Wellbeing strategy.

9.6. Colleague support

Here is a round-up of support for colleagues. You'll also find lots of other information and support on these pages.

- **Care First**. Support when you need it the most – 24hrs a day, 365 days a year. Whatever you need support with, whenever you need it, Care First can provide confidential advice, guidance, help and support. Call free on 0800 174 319 or use their online lifestyle portal here. Username: cht and Password: cht4321
- **Samaritans** – 24/7 listening support for the stressed, distressed, or suicidal plus signposting to specialist services. Call free on 116 123.
- **24-hour mental health support line**. For residents of Calderdale, Kirklees, Wakefield, Barnsley & Leeds. Call free on 0800 183 0558.
- **FRONTLINE** – national NHS service offering staff health and wellbeing support advice and signposting to other services. 24/7 support by text. Text FRONTLINE to 85258 or call 0300 131 7000 between 7am and 11pm any day of the week.
- **Friendly Ear** – Listening service for all CHFT colleagues. Offering support and signposting to self-help resources and specialist support services. To book a call contact Wellbeing@cht.nhs.uk (Available Mon-Fri 9:00-5:00, if outside of these times please call Care first on 0800 174 319 who are available 24/7/365)
- **Frontline 19** – free confidential psychological support service for NHS staff and other health emergency and social care workers in the UK. To arrange support from an experienced therapist, visit www.frontline19.com
- **Nurse Lifeline** - the listening service, here for you. Free, confidential, UK-wide and peer-led, space to offload and decompress and chat with another nurse or midwife who gets it. Available Monday- Friday 7pm- 11pm. Tel: 0808 801 0455 or see their website

All colleagues should be encouraged to complete the health and well-bring questionnaire available on the intranet.

Health and Wellbeing Risk Assessment - CHFT Intranet (cht.nhs.uk)

Further support information is available through the trusts intranet pages, links below.

Colleague support - CHFT Intranet (cht.nhs.uk)

Coronavirus - CHFT Intranet (cht.nhs.uk)

9.7. Managing absence

The Trust's Adverse Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

In the event that essential staff have difficulty getting to work and there are no alternate travel options, including car sharing or public transport, it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

10. Divisional Resilience Plans

CHFT's Divisional teams have prepared their resilience plans including winter through analysing their expected demand, using bed modelling tools tracking assumptions against their business plans and understanding the impact transformational work is having.

10.1. Medical Division

The medical division will endeavour to maintain its usual bed base during operational winter by:

- Focusing Same Day Emergency Care pathways – increasing and maximising existing capacity.
- Admission avoidance.
- Working with community services and partners to expedite discharges.
- Maximising the use of community pathways, for example Outpatient Parental Antimicrobial Therapy (OPAT), Virtual wards (VW), Urgent Community Response (UCR).

- Working closely with the site management team on the day-to-day management of the bed capacity.
- Piloting new SDEC criteria.

10.1.1. Medical SDEC – Inclusion & Exclusion Criteria V1

Pilot from 25th September 2023

Note: If the referrer feels the presentation of a patient is not within the inclusion/exclusion criteria they can still contact the SDEC co-ordinator and check for acceptance into SDEC.

- *ED referrals ONLY 08:00-18:00hrs*
- *Check Capacity prior to sending.*
- *Investigations: FBC/U&E/Clotting/ECG*

ALL existing Medical SDEC pathways will continue.
(For example DVT, PE, Cellulitis, low-risk CP)

Patients outside of this would need ST4+ review and discussion with the Medical SDEC consultant.

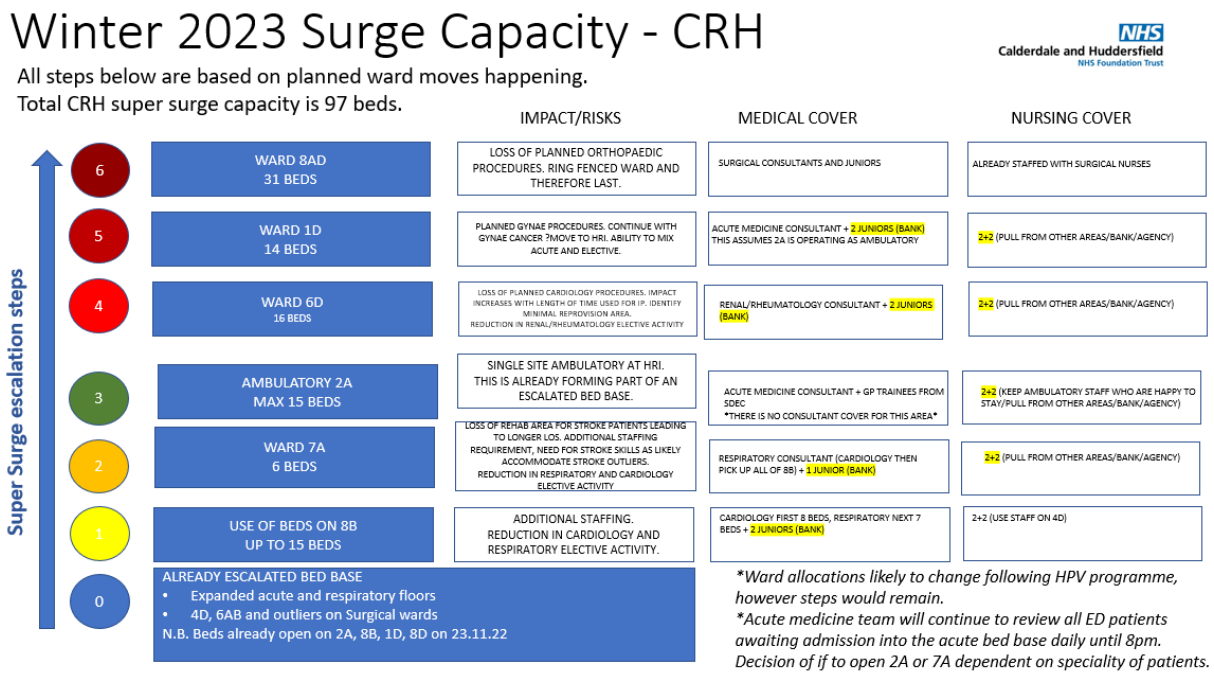
Medical SDEC exclusion criteria:

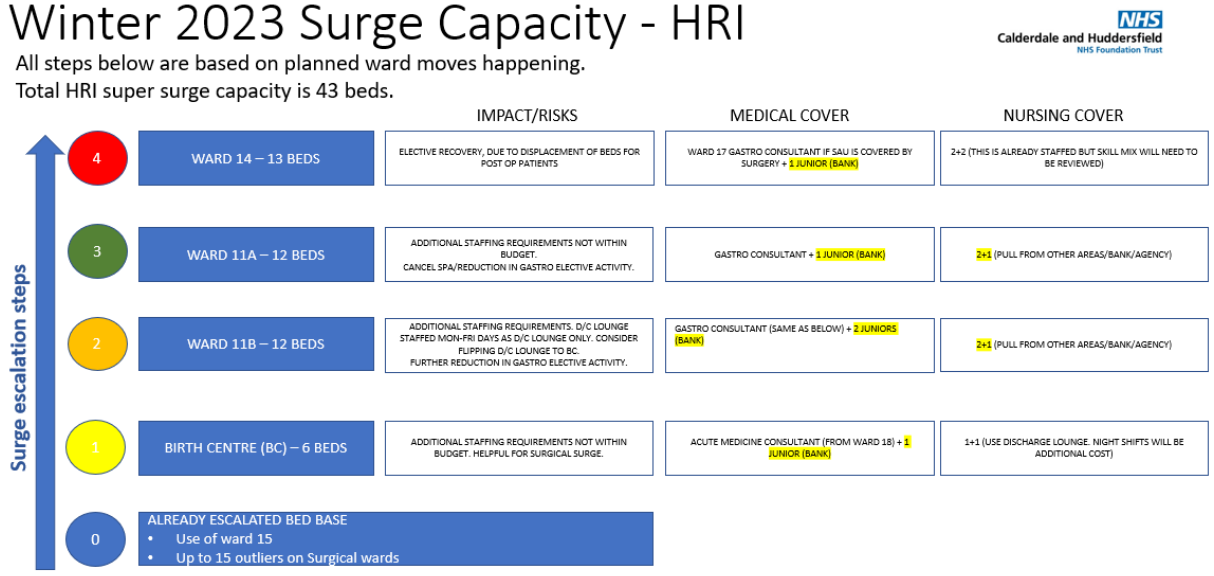
- **Age <16yrs old**
- **Not General Medical** (For example: Trauma, Surgical, Frailty, Haematology/Oncology, Renal, Mental Health)
- **Not mobile or at baseline** (Bed-bound patients are exclusions)
- **Oxygen Requirement**
- **NEWS2 ≥5** OR individual score of 3
- **Suitable for Urgent Care Hub/Local Care Direct**
- **Required Frailty input.**
- **Time-Critical diagnoses** (examples)
    - High-risk chest pain:
        - STEMI
        - New acute ECG changes such as LBBB
        - Ongoing cardiac chest pain
        - Troponin positive
    - Stroke including TIA.
    - Sepsis
    - Seizure
- **Require Admission/monitoring** (examples)
    - Overdose or intoxication with alcohol/drugs
    - Hypothermia
    - Severe pain (pain score >6/10 despite analgesia)
    - Haematemesis/melaena (with GBS>2)
    - Asthma with peak flow <75% of best/predicted.
    - Severe electrolyte abnormalities (Requiring IV therapy)
    - Acute Confusion (senior discussion only)

- **Requires Isolation** (examples)
  - Diarrhoea and vomiting
  - COVID-19/flu
  - Measles

10.1.2. Bed Surge

If all of the above responses are not giving us the flow we require and surge capacity is required it will be undertaken in the following order. The decision to open surge capacity will be undertaken via the site management meetings by the silver command lead and the opening checklist completed (Appendix Ten).





Step 3 may take place before step 1 and 2 if there is a Surgical surge
Acute medicine team will continue to review all ED patients awaiting admission into the acute bed base daily until 8pm

10.1.3. Inpatient Length of Stay

All medicine ward areas are engaging with well organised wards programme and are committed to reducing the length of stay of patients.

Where there is a surge in demand for beds then the division will support by:

- All General Managers (GMs), Operational Managers and matrons being deployed to support ward discharges.
- GM's will contact consultants to ensure senior reviews have taken place and patients have plans.
- Using the criteria to reside list, to ensure the 'medically fit' are reviewed and progressed to discharge.
- Standing down non-essential meetings.
- Ensuring senior representation at Site Management meetings.
- Escalating to standing down elective activity to support ward area reviews.

10.1.4. Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Attendance at Multi-Disciplinary Team (MDT) meetings and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of consultants that are off at any one time over this period.

10.2. Surgical Division

The Surgical Division has developed plans to be able to respond to increased non-elective demand.

10.2.1. Critical Care

- The escalation plan and standard operating procedure for the demand for critical care exceeding capacity ICU is at Appendix Eleven.

10.2.2. Trauma & Orthopaedics

- In addition to current planned trauma lists, additional increases in demand will be delivered by following the Trauma Surge Pathway (Appendix Twelve).
- 4 Additional Trauma 2 lists available which in turn can be flipped to a 2nd acute theatre supporting all specialities.
- Acute fracture clinic referrals direct from ED for Consultant led treatment for patients with confirmed fractures are in place maximising virtual fracture clinics.
- Improved access to theatre will reduce pre-op bed days and overall LOS for some Minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre.

- An additional plaster room and adjoining clinic room capacity for fracture patients will be advantageous to Trauma and Orthopeadics (T&O) and this is now being sought.
- Continue with the SDEC streaming from ED triage, maximise SDEC pathways, extended opening plan currently being written.
- The elective inpatient orthopaedic surgery at CRH will continue as per the Phase 3 planning.

10.2.3. General and Specialist Surgery

- Current medical workforce on Surgical Assessment Unit (SAU) will be increased with an additional middle grade to maximise reviews, ambulatory care and reduced length of stay.
- The elective inpatient surgical theatre capacity at HRI will continue as per the Phase 3 planning due to the ringfenced 'green' nature.
- During high OPEL/LOPEL 3 levels HRI Ward 10 (elective surgical ward) can be used flexibly to accommodate non-elective surgical patients. Strict criteria apply to those non-elective patients who can be admitted to the ward, strictly no medical patients to be admitted.

10.2.4. Inpatient Length of Stay

The Criteria to Reside work is integral in reducing length of stay within all specialties and maximise community pathways with a particular focus on T&O.

Where there is a surge in demand for surgical beds then the divisional plan would be enacted:

- All GM's, Ops managers and matrons are deployed to support ward discharges.
- GM's to contact consultants to ensure senior reviews have taken plan.
- Using the criteria to reside list, to ensure the 'medically fit' are reviewed and progressed to discharge.
- Non-essential meetings would be stood down.
- Ensure senior representation at Flow meetings and tactical command.

10.2.5. Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously (no patients were cancelled during winter 2022/23 due to no bed) – this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of consultants that are off at any one time over this period.

10.3. Family & Specialist Services Division

There will be daily attendance in the Site Management Meetings of Operational management from FSS to support patient flow, support prioritisation of diagnostics during increased demand.

10.3.1. Paediatrics

- During periods of operational pressure including winter the Matron for the service continues to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity on the Paediatric ward, to support and underpin this there is an Escalation Plan in place.
- Continued support to the paediatric stream in the Emergency Departments (ED) at peak times in both EDs and planned at Huddersfield Royal Infirmary.
- The Paediatric ward operates on a workforce model that accounts for surge during the winter period which strengthens nurse staffing and leadership during the winter period with the plan to have a senior Nurse Band 6 and 7 working clinically across all shifts.
- The service has introduced rapid access clinic which will support reviewing some patients who had previously been seen in ED or referred via there GP to paediatric assessment.
- From a medical perspective the following actions will be taken between Nov and Feb to support winter pressures: A new rota has been introduced that will ensure that there is a tier one and two doctors on Paediatric assessment to triage and manage flow.
- The Consultant scheduled for Ward 4 HRI will cover in the morning and will if appropriate to undertake a virtual round of ward 4 patients by phone utilising EPR this will ensure they are available to help on the ward round on the Ward 3 CRH – to improve flow and timely discharge at times of peak activity.
- Paediatric Escalation and Surge plan is attached in appendices of this document.
- Advanced Paediatric Nurse Practitioner escalation can also be found in appendices of this documents (Appendix Thirteen).

10.3.2. Neonates

Neonatal services work in partnership with Maternity services as part of a wider network that is managed by transport service Embrace.

During operational pressures and the winter period the Matron for the service continues to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity on the Neonatal unit to support and underpin this there is an Escalation Plan in place (Appendix Fourteen).

10.3.3. Gynaecology

During operational pressure including the winter period the activity theatre plan has been developed to ensure the surge in medical emergency activity is supported.
In addition, prior to transferring to ward 1D the patient must be assessed against essential criteria as outlined below.

CRITERIA FOR MEDICAL TRANSFERS TO: - THE GYNAECOLOGY AREAS

Prior to transferring to ward 1D or GAU the patient must be assessed against essential criteria as outlined below.
If the criteria to outlie are not met please escalate to the Matron for Gynaecology, On Call Duty Matron or Night Matron as appropriate.

- Side room not required.
- No acute delirium, confusion, disorientation.
- Patient is not on the End-of-Life Care Pathway
- Minimal risk of falling.
- Minimal assistance required with mobility.
- For patients requiring reablement, intermediate or 24-hour care section 2 physio and OT referrals must have been completed.
- NEWS within expected limits.
- Patient does not require specialist nursing skills i.e. NIV, Peg feeds, unstable cardiac symptoms, unstable diabetic, active seizures, suspected strokes.
- Patient with a known ongoing complaint/grievance must have Senior review to assure that a move is in the best interest of the patient.
- Patient has not been admitted with a diagnosis of long-term substance misuse.

10.3.4. Maternity

Maternity will need to continue to provide essential services in line with National Institute of Clinical Excellence (NICE) and Royal College of Obstetrics and Gynaecologists (RCOG) guidance.

- During times of operational pressure or during winter period the Clinical Managers/Matrons for the inpatient and Birth Centre services continue to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity throughout the Maternity Unit. This may happen more frequently dependant on the initial sit rep report.
- The Clinical Managers/Matron for community will also review staffing/acuity on a daily or more regular basis as the need requires.
- If weather does not permit home visiting (particularly for postnatal care), the midwife is to contact the woman by telephone/virtual appointment to conduct a review of maternal and baby wellbeing.
- If an essential visit is required, the midwife/manager must undertake a full risk assessment and utilise the 4x4 service if all other options have been explored (i.e. staff members with 4x4's undertaking visit or transporting another member of staff – to go in 2's).
- On call midwifery staff should ensure their vehicle is in a place where easier access is enabled.
- On call midwifery staff should follow the loan worker policy and alert the LDRP Coordinator of being called out and ascertain if safe to do so.
- There is an Escalation Plan in place –that provides information for steps to take dependant on staffing and acuity levels which winter may affect. Escalation Plan can be found on the intranet here:

https://documentation.cht.nhs.uk/uploads/715/April%202022%20NEYMaternity%20Escalation%20Policy%20%20Operational%20Pressures%20Escalation%20Levels%Framework.pdf

10.3.5. Radiology

There is a central contact point for in-hours escalation of specific issues – contact details are available to Site Management Teams.

Additional twilight cover is available for the Emergency Department x-ray to enable extra capacity out of hours, during periods of exceptional demand throughout operational pressure and the winter period (November to March; triggers will be agreed with the ED team.

10.3.6. Pathology

Urgent blood sciences results will be available within 60 minutes of receipt in the laboratory. For any escalation of urgent results please contact Haematology or Biochemistry on the relevant site.

In the circumstances of increased demand in the laboratory due to COVID or any other outbreak the service will be flexible to support demand.

10.3.7. Pharmacy

Pharmacy staff will work with medical and nursing staff to prioritise supply of medicines for discharge.

Wards should identify patients due for discharge on all ward areas as soon as possible, and e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Where possible, discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge.

Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines at home before a request is made for a supply for discharge, which will enable pharmacy to dispense items which are genuinely required more quickly.

At HRI the Safari discharge team can help write and prescribe TTOs and can be contacted by the following 07503981265. On the Acute floor there is an enhanced pharmacy service covering 08:00-18:00hrs 7 days per week who can also assist with prescribing Tablets to Take Out (TTOs) and medication supply.

If any medication is required urgently and pharmacy is closed, if this medication is not available in the Out of Hours emergency medicines cupboard, then the on-call pharmacist should be contacted.

10.4. Community Division

10.4.1. Discharge Team

- There is daily huddles Monday to Friday with both local authorities at 09:00hrs each morning to discuss all patients on the Transfer of Care List (TOC) and escalations as appropriate where there are delays or no progress. There is an internal CHFT meeting around discharges that the discharge team will attend at 12:00hrs each day Monday to Friday.
- Working hours will be reviewed daily as part of the huddle and extended as required. Staff will work flexibly to support the service.
- A representative from the discharge team will attend 13:00hrs tactical meeting Monday to Friday.

Contacts for the Discharge Team

Natalie Hinchliffe- Team lead	07769300408
Andrea Liquorish – Clinical lead	07469125526
Christine Bentley – Discharge Sister (part time)	07766905534

10.4.2. Priority 1 Clinical Services

The following services have been deemed as **Priority 1 Clinical Services:**

- District Nursing priority one patients(complex wound care, blocked catheters, administration of medications, OPAT and palliative care).
- Administration of medications including IV therapy and syringe drivers.
- Palliative Care.
- UCR.
- Intermediate Care bed base/ Discharge to Assess Beds.
- Reablement.
- Palliative care priority one patients.
- Gateway to Care.
- Quest Matron support to Care Homes.
- Community Respiratory Service.
- Community Heart Failure Service.
- Home Enteral Feeding.
- Community Matrons.
- Community Rehabilitation Team.

Community Services Available

10.4.3. Gateway to Care

Gateway to care is a hub for health and social care and can take referrals provide advice for professions, patients and public.

Hours of Operation	08.45-17.30hrs Monday to Thursday and 08.45-17.00hrs Friday
Contact Details	01422 393000

10.4.4. Intermediate Care

The intermediate care service is delivered by an integrated partnership of health and independent care home provider, ensuring a multi-disciplinary approach to care. Care is provided in one of our bed bases:

Brackenbed View (15 beds) and 5 additional beds for Winter (location to be confirmed but will be outside of Brackenbed View).

The Service Aims to:

- Promote a faster recovery from illness.
- Prevent unnecessary presentation and admission to an acute hospital bed.
- Prevent premature and unnecessary admission to long term care.
- Maintain independence as long as possible.

Service Criteria:

- Service user/patient must be over 18 years of age.
- Medically stable.
- Be able to consent to referral.
- A resident of Calderdale or Registered with a Calderdale GP.
- Consent to rehabilitation.
- Have an active rehab goal where it is expected that they will achieve this goal in a 6-week period.
- They must require a bed base at this time – if needs can be managed at home, an individual should be referred to a home-based service such as Reablement or package of care.

Hours of Operation	24 hours a day, 7 days a week
Referrals Accepted	Via Gateway to Care (in-hours) and via Crisis Intervention Team (weekends)
Lead Manager	Stef Walker
Contact Details	07471517082 (CHFT therapy team clinical lead)

Heatherstones provides temporary accommodation for adults for up to 6 weeks and facilitates early discharge, or prevents the need for admission to hospital, residential or respite care. The service is most appropriate for people who want to live independently but need short-term alternative accommodation or short-term help and support to achieve this.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

The service aims to reduce individuals' dependency and reliance on direct services and prevent their level of need from increasing with people returning to their own home with the confidence and level of care required to enable them to cope long- term. Residents are expected to cook their own meals and do their own shopping and laundry. Reablement assistants provide support where needed.

Hours of Operation	Monday to Sunday 08.00a– 21.45hrs 7-day service
Lead Manager	Nicola Gayle
Contact Details	01422 392229

10.4.5. Reablement

The Reablement service provides therapeutic care and support; with therapy care plans provided by CHFT community therapy team and then delivered by social care reablement staff. Access to reablement is via Gateway to Care following an assessment by a social worker.

Reablement is offered for up to 4 visits a day for a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	08.00-21.00hrs, 7-day service
Lead Manager	Tracey Proctor (Council) Emily Sutcliffe (CHFT therapy
Contact Details	07748 797896 (Tracey) 07826535497 (Emily)

Reablement Team	**Allocator**	**Contact number**
Lower Valley	Julia Green	01484 728943
Upper Valley	Karen Willows	01422 264640
Central	Jo-Anne Rice	01422 383584

10.4.6. Urgent Community Response Team

Urgent Community Response Team will provide support to someone in crisis in their own home for up to 72 hours. For example if someone is struggling in their own home after a fall, or discharge from hospital where packages of care cannot start immediately. They are a responsive service and will assess within 2 hours for urgent referrals and 24-72 hours for routine referrals.

The team consists of Advanced Clinical Practitioners (ACPs), Specialist Practitioners (nurses and therapists with blurred boundary training) – response times are between 2hr and 72hrs dependent on the referral that is made. Rehabilitation assistants in the team offer up to 4 visits a day for a period of 72 hours with the aim to increase function and reduce dependence. If further reablement is required after 72 hours, the locality reablement teams continue the care following an onward referral to them, or Independent Living Officers assess for and set up a long-term package of care for the individual on behalf of Calderdale Council.

The Urgent Community Response Service also incorporates the Frailty Virtual Ward and the Home First Pathway.

Referrals are made via Local Care Direct for ACP support and urgent 2hr calls. Referrals can also be made directly to service for example when support is needed for hospital discharge.

Hours of Operation Assessors	08.00–19.00hrs 7 days a week
Reablement Service Work	08.00-21.00hrs 7 days a week
Lead Nurse	Susan Johnson (Manager)
Contact Details	Coordinator on shift: 07785476418

10.4.7. Specialist Palliative Care and End of Life services Out-of-Hours Team

All the clinical services provide responsive action to address complex symptom management and psychospiritual needs, explore advance care planning and treatment escalation plans, and provide holistic patient and family/carer support including pre & post bereavement care, providing individualised care in last days of life.

- The Calderdale Community SPCT work across all community settings, aiming to maintain the patient in their home, transfer to hospice when required and avoid unnecessary hospital admissions.
- The Hospital SPCT works across both HRI and CRH to support ward teams with clinical management plans and facilitate hospital discharge to the patient's own home, or 24hour care setting or hospice if needed.
- The Hospital End of Life Care & Bereavement team support families of patients who have died in our hospital settings, but also provide End of Life Care (EOLC) education to all staff and pastoral care to ward teams (the team do not provide direct clinical care)
- The Calderdale Community End of Life Out-of-Hours team is a collaboration between Overgate Hospice, Marie Curie and CHFT. This small team of a Specialist Palliative Nurse working alongside a Marie Curie Healthcare Assistant provide crisis support to people out of hours who are near the end of their life, to enable the person to remain in their chosen place of care.
- All teams are supported by Consultants in Palliative Medicine during daytime hours, in addition to a rotational on-call consultant providing telephone advice overnight and at weekends.
- Direct admissions to Overgate Hospice in Calderdale and The Kirkwood in Kirklees are facilitated by all clinical SPC teams.

Days of Operation	7-day services
Lead Nurse	Abbie Thompson

Contact Details - **Calderdale Community SPCT (09:00-17:00hrs)** **Hospital SPCT (Mon to Fri 09:00-17:00hrs & weekend 08:00-16:00hrs)** **Out-of-Hours PCT (7pm to 8am)**	 01422 310874 01484 342965 07917 106263
Hospital End of Life & Bereavement service (5-day) Mon- Fri 09:00-17:00hrs	01484 342180

10.4.8. OPAT/ IV Therapy

This team provides antibiotic intravenous therapy to patients in their own homes and in the care home setting. Patients remain under the care of their Physician or Consultant. This prevents some admissions and certainly reduces the LOS for many more.

- Patients have to be medically stable. Need to be under consultant referrals.
- Commissioned for 12 administrations a day.
- Compatible drugs need to be administered within 30 minutes.

Hours of Operation	7-day/24-hour service
Lead Nurse	Jayne Woodhead
Contact Details	07795 825106

10.4.9. Community Nursing Services

District Nurses visit housebound patients that have complex health care needs. Patients that are able to be transported are expected to attend treatment rooms.

Hours of Operation	7-day/24-hour service
Contact Details Core Hours (08:00-18:00hrs)	01422 652291
Contact Details Evening/Night/Weekends (18:00-08:00hrs)	07917 106263

Only **priority 1/urgent patients** are seen at night i.e. palliative care requiring symptom management, blocked catheters and patients requiring prescribed medication at agreed intervals.

Quest for Quality Service

CHFT has a well-established multi-disciplinary team consisting of community matrons, pharmacist, therapist and consultant geriatrician who caseload residents in all residential and nursing homes in Calderdale. The team's main role is to reduce the number of calls made to general practitioners to prevent avoidable admissions. They use Telecare and Tunstall Telehealth to promote health and wellbeing to the residents

within the care homes. Throughout the COVID-19 pandemic an enhanced service was implemented. This enhanced service is being commissioned to be in place permanently.

The team have a responsive function to the care homes dealing with calls that would have been received by a General Practitioner (GP) and managing the residents. They also provide support to the care home staff to better manage their residents through training and education. Every Care Home will have a named GP.

The pharmacist role has greatly helped with reviewing patient medication, reduction in polypharmacy and education and training of care home staff.

Hours of Operation	09:00-18:00hrs, 7 days a week
Lead	Emma Vant
Contact Details	07795061342

Community Matron Service

Community Matrons provide a service to people with Long Term Conditions (LTC) who have complex health and social care needs which without effective case management are likely to result in the individual having repeated and avoidable hospital admissions and increased lengths of stay in hospital and frequent contact with primary care services.

They are based in localities with District Nursing Teams.

Hours of Operation	08.30-16.30hrs, Mon-Fri
Lead	Louise Byrom 07919057419

Locality	**Base**	**Matron**	**Contact Details**
Upper Valley	Todmorden Health Centre	Kim Scarlett	07833353162
Lower Valley	Church Lane Surgery	Louise Watson Kay Foley Sarah Jenkins	07717347547 07795603605 07464493519
South Halifax	Elland and Allan House	Rachel Bulmer Katie Berry	07795825215 07789944447
North Halifax	Beechwood	Louise Nattrass	07795825199
Halifax Central	Lister Lane	Sheryl McGinn Vicky Leah	07769365247 07768207674

Specialist Nursing

There are a range of specialist nursing services that support people in community settings.

Service Area	Hours of Operation	Lead Nurse	Contact Details
Bladder and Bowel	07.00-16:30hrs Mon-Fri	Joanne Hoyle	01422 252086
Respiratory	08.30-16.30hrs 7-days/Week	Gareth McMahon	01422 835195
Heart Failure **Cardiac Rehab**	09.30-17.30hrs Mon-Fri 07.30-16.30hrs Mon-Fri	Clair Jones	01422 224260
Parkinson's	09.00-17.00hrs Mon-Fri	Gloria Tizora	07831120229
Tuberculosis (TB)	09.00-17.00hrs Mon-Fri	Mary Hardcastle	07824 343770
Lymphoedema	09.00am17.00hrs Mon-Fri	Katherine Stubbs	01422 350755

Respiratory Team

During the winter period the Respiratory team will increase their working hours until 8pm and double capacity at the weekend to have two members of staff instead of one. This will enable the team to provide further focus upon key services offered to reduce pressures on the hospital:

- Early Supportive Discharge (ESD) – facilitating patients going home as soon as possible with support from the respiratory team 7 days a week.
- Admission avoidance from ED 7 days a week, 9am-8pm and will also support Kirklees residents to be discharged directly from ED into Locala services.
- Crisis management for community patients via the Single Point of Access (SPA). Direct telephone access for patients 7 days a week
- Admission avoidance from the community 7 days a week

Hours of Operation	08.30-16.30 7 days a week
Lead Nurse	Gareth McMahon
Contact Details	01422 835195

Cardiac Rehabilitation Services

There will be increased capacity which will support extended working hours Monday – Thursday supporting the Cath Lab. This will allow the team to facilitate earlier discharges. When the Cath Lab sessions are scheduled for Saturdays this will be mirrored by the team facilitating patient flow. In focusing upon facilitating earlier discharges this would also allow the team to offer Cardiac rehab at the weekend which could reduce readmissions.

Early Supported Discharge for Stroke

This team provides support to enable patients who have had a stroke to be supported at home to reduce length of stay and increase function by facilitating people to be as

active as possible. An enhanced service will be in place from November as part of the innovation scheme plans.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Georgina Bell
Contact Details	01422 358146

10.4.10. Therapy Services

Therapy services provide interventions across in-patient, intermediate care and Community Services and will work flexibly across all areas to provide support where pressures manifest during the winter period.

Lead Manager	Debbie Wolfe 07825902363

Community Rehabilitation Team – Calderdale

The Community Rehabilitation Team covers the whole of Calderdale and see any patients with a rehab need and goal over the age of 18 years. This service is not an urgent response service and operates over Monday to Friday. The team cover a vast range of presenting complaints, diagnoses and reasons for referral. Referrals into the service can come from professionals or self-referrals from patients. The service includes provision for Physio, Occupational Therapy (OT), Speech and Language Therapists (SALT), and dietetics. The team work closely together and have blurred boundary competency training where appropriate. This service sees the vast majority of patients in their own homes.

Hours of Operation	8.00am-5.00pm, 5-day service
Lead Therapist	Dave Nuttall
Contact Details	07785456582

10.4.11. Senior Managers in Community Healthcare Division

Senior Managers on-call rota, contact Calderdale Royal Switchboard on **01422 357171.**

Senior managers contact details are as follows:

Name	Role	Work mobile
Michael Folan	Director of Operations	07785416708
Vicky Hattersley	Assistant Director of Finance	07827 808868
Liz Morley	Associate Director of Nursing	07747 630989

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Jennifer Clark	Associate Director of Therapies	07500312136
Debbie Wolfe	Head of Therapies and Service Manager for OP Physio, MSK, Podiatry, Orthotics, Speech and Language Therapy, Dietetics Children's Therapies	07825 902363
Caroline Lane	Head of Nursing	07713739144
Susan Scriven	Matron for Specialist Nursing	07770542879
Hannah Wood	Therapy Services Manager - Community	07584538456
Sally Grose	Therapy Services Manager - Inpatients	07881 359250
Nicola Glasby	Therapy Services Manager – Outpatients and Children's services	07823 535293
Carly Hartshorn	Therapy Services Manager – Childrens Services	07385400476
Sarah Wilson	Matron District Nursing/Lymphedema & Wound Management	07557157096
Abbie Thompson	Matron EOL	07747472125
Louise Byrom	Matron District Nursing/Community Matrons	07919057419

11. Severe Winter Weather

Overview	
Business Impact	
• Absence of staff because they cannot get to work. • Difficulty for staff and patients to travel around and between sites. • Difficulty for community staff to access patients homes. • Increase in minor injuries from slips, trips and falls. • Reduced patient transport service. • Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities. • Difficulty for suppliers to get supplies to hospital.	**Impact** / **Likelihood** 1 2 3 4 5 1 2 X 3 4 5
Proactive strategy	
• Adverse winter weather plan in place and reviewed. • Weather forecasts and gritting information published on the local authority websites. • Stockpile of salt/grit for car parks and access ways to Hospital sites.	

• Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes. • Yorkshire Ambulance Service winter plan. • Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work. • Community staff advised to work to nearest location to their homes.
Reactive strategy
• Implement flexible working arrangements where possible (adult community nursing) • Implement the joint surge and escalation plan. • Contact Local Council Highways to request roads are gritted for essential appointments and discharges (this will not always be possible). • Provide accommodation for essential staff who cannot get home from work. • Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible).

Trigger	Received by	Immediate action
Met Office Cold Weather Alert	Incident Control Inbox	• Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments. • Clinical Site Commanders will assess the consequences for discharges. • The Calderdale & Huddersfield Solutions have a planned process for maintaining the Hospital grounds. • Review by the outpatients and surgical management teams of impact on performance.
YAS PTS notification that journeys are affected or have been stopped	Clinical Site Matron	
Significant number of out-patient DNA	Outpatient manager	
Staff absence reporting	Department managers	• All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty. • Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager • All service areas will maintain up-to-date contact lists for all their staff. • Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence. • Staff will be reallocated according to service need.

11.1. Cold Weather Alerts

Alert trigger	Trust Actions
OPEL 1 Winter Preparedness.	• Work with partner agencies to co-ordinate cold weather plans. • Work with partners and staff on risk reduction awareness. • Plan for a winter surge in demand for services. • Identify those at risk on your caseload.

OPEL 2 Alert and readiness (60% risk of severe weather).	• Communicate public media messages. • Communicate alerts to staff and make sure that they are aware of winter plans. • Implement business continuity plans. • Identify those most at risk. • Check client's room temperature when visiting .
OPEL 3 Severe Weather Action.	• Communicate public media messages. • Activate plans to deal with a surge in demand for services. • Communicate with those at risk regularly. • Ensure that staff can help and advise clients. • Signpost clients to appropriate benefits. • Maintain business continuity.
OPEL 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days.	• Activate emergency management arrangements. • Communicate public media messages. • Activate plans to deal with a surge in demand for services. • Communicate with those at risk regularly. • Ensure that the hospital sites are kept clear and accessible. • Maintain business continuity.

11.2. Road Clearance

Kirklees

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at:

Winter | Kirklees Council

Winter maintenance is an important role for our Streetscene and Housing Service. We carry out winter maintenance to allow all road users to move about as safely as possible and to help minimise delays caused by adverse weather conditions.

Our winter maintenance service operates 24 hours a day, 7 days a week and is in place whenever the weather demands.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council

Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the Site Management Teams who will be responsible for liaising with Kirklees Council Highways.

Calderdale

Calderdale Council will try to keep the most important roads safe and as free as possible from wintry hazards.

- To do this they have 22 precautionary gritting routes. These cover over 600kms (around 67%) of the Calderdale Road network.
- It is impossible for the gritters to spread salt on every road. Over 600 salt bins are provided at key points throughout the district for use by residents, motorists and pedestrians.

Information on priority gritting routes can be found at:

Be prepared for winter | Calderdale Council

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations the Local Councils may assist with road clearance where possible.

Both Kirklees and Calderdale Councils will communicate messages regarding road closures and travel issues as well as weather updates via their social media platforms as well as via their websites and local radio stations.

As part of business continuity plans within estates there are processes in place to top up oil and fuel supplies for the boilers and generators to be prepared for any disruption to fuel supplies. Energy suppliers are also contacted to ensure the hospital is a protected site where blackouts are being considered.

11.3. Transportation 4x4

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. In the event of disruption to public transport and difficulties in staff getting to work. Minimal availability to a 4x4 will be available.is on standby. All requests must come through the Clinical Site Matrons.

The 4x4 should only be used if there is no public transport running, all other options have been exhausted and the staff member lives more than 3 miles away.

The following voluntary organisations in Yorkshire and the Humber also have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather.

The adult community nursing teams also work closely with Calderdale Council Adult Social Care to make best use of resources.

12. Equipment Ordering and Provision

Patients in the community may require equipment to keep them safe, assist daily living skills and improve mobility/function in their own home.

Physiotherapists, Occupational Therapists, Nursing Teams and the Crisis Intervention Team are regular referrers to access equipment. Equipment is arranged via the Loan Stores for Calderdale patients and the service is based at Unit 13, Ainley Top Industrial Estate, Ainley Bottom, Elland, HX5 9PJ.

Kirklees Loan Store

Loan Stores Hours of Operation	8:30am to 5:00pm Monday - Friday Saturday & Sunday priority service
Lead Manager	Mark Rance
Contact Details	01484 221000

Calderdale Loan Store

Loan Stores Hours of Operation	8.30am 4.30pm Monday to Friday, Saturday beds delivery 8.00 - 12.00PM
Lead Manager	Andrew Mould
Contact Details	01422 261396/261399

13. Escalation Plans and Business Continuity Plans

Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services. All Business Continuity Plans will be updated following learning from COVID-19 pandemic outbreak.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Below is a list of available and updated Business Continuity Plans:

Outpatient Business Continuity Plans	Emergency Preparedness and Resilience
Childrens Therapies	Critical Care ICU
Community Nursing Clinics	Cardiology
Community Nursing Home Clinics	Estates
Nutrition and Dietetics	General Office
Elective Orthopaedic Rehab	Catering
Intermediate Care Beds & Crisis Intervention	Cleaning
Immunisation Team	Linen
Orthotics	Waste Management
Outpatient Physiotherapy and MSK	Security
Podiatry	Medical Engineering
Specialist Nursing Clinics	Switchboard
Speech and Language Therapy	Equipment
Support and Independence Living Team	Transport
Tuberculosis Team	Portering
	Procurement
Corporate Business Continuity Plan	Appointment Services
Human Resources	Record/Reception Services
Infection Control	Pharmacy
Occupational Health	Pharmacy COVID Vaccine
Payroll	Transfusion
Nerve Centre	Microbiology
	Blood Sciences
	Phlebotomy
	Cellular Pathology
	Mortuary
	Radiology
	SCBU/NICU
	Child Health
	Paediatric wards
	Maternity Services
	Gynaecology
	Outpatient Services
	Endoscopy
	Operating Services
	HRI & CRH ICU
	Emergency Department
	Medical Wards
	Surgical Wards
	Medical SDEC
	Dermatology
	Acute Floor HRI
	Surgical SDEC
	Surgical Pre-Assessment
	Finance

	Communications Team
	EQUANS
	ISS
	Patient Flow

The Trust has a number of policies and plans that would be used in dealing with problems caused by operational pressures and adverse weather. They are both clinical and non-clinical, some are season-specific and others are for general use. They can be found intranet link below:

Emergency Preparedness, Resilience & Response (EPRR) - CHFT Intranet (cht.nhs.uk)

a. Adverse weather policy
b. Pandemic influenza
c. Major Outbreak of Infection Policy
d. Emergency Management Arrangements
e. Escalation guidelines for the maternity units
f. Discharge Policy/Transfer of Care Policy

14. Infection Control

There is an expected surge of patients with 'flu' and Covid-19 in 2022/23. Guidance through public health and CHFT internal IPC team including the lead clinician will be managed through the Pandemic Influenza Planning Group with all key partners within CHFT.

Point of care testing will be available in both EDs for both COVID-19 testing and flu testing, these tests will be carried out by the teams in ED against a set of criteria, non-urgent samples will be sent to pathology for testing.

Patients who need isolating will have a respiratory isolation sign should be displayed on the side room door (further information on isolation of patients is available in the Isolation policy section K). All staff must wear personal protective clothing (PPE) when entering the side room. When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum, on transfer these patients should be encouraged to wear a surgical face mask wherever possible.

In the event that there are number of admissions with confirmed or suspected influenza it may become appropriate to cohort patients in a single bed bay or ward area. The IPC team will be instrumental in developing the operational plan when cohorting is required.

Some members of staff will be at greater risk from influenza because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols.

14.1. Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons and surgical masks.

FFP3 masks or the positive pressure hood are required for specific infectious diseases (MERS and by staff performing cough inducing procedures for patients with suspected or confirmed infectious condition spread via respiratory secretions. FFP3 masks must be worn when performing the following procedures:

- Intubation, extubation and related procedures (e.g., manual ventilation and open suctioning)
- CPR
- Bronchoscopy
- Surgery and post-mortem procedures involving high speed devices.
- Some dental procedures (e.g., drilling).
- Non-invasive ventilation (e.g., bi-level positive airway pressure and continuous positive airway pressure ventilation)
- High-frequency oscillating ventilation; Induction of sputum.

Staff performing these types of procedures will include staff in ED, theatre, respiratory ward, ICU, and the acute floors in addition to staff groups such as Anaesthetists, Intensivists, endoscopists and physiotherapists (chest). Many wards and departments stock these masks and the following wards are 'top up' areas:

HRI = SAU, acute floor, 18, ICU, Emergency Department

CRH = acute floor, 3, 5, ICU and Emergency Department

14.2. Fit Testing for FFP3 Masks

All staff are required to be fit tested to 2 masks. Prior to using an FFP3 mask the make/model and size of mask MUST be fit tested to the user to ensure a seal can be attained and the member of staff will be safe. Face masks come in various shape sizes so users can determine the most effective.

There are competent ‘fit testers’ in most clinical areas within the Trust who can carry out the assessment (register held on the intranet). Fit test kits are available from the IPC team for competent fit testers to use. It is the responsibility of the fit testers in each area to fit test their staff and to record the make model and size of mask that they require. Staff who have been fit tested are adding onto the equipment training database by the fit tester or the staff members manager.

Where a member or staff does not successfully fit test with the FFP3 mask used by the Trust, each management team must put in place appropriate risk mitigation measures to protect the member of staff from being exposed to a respiratory infection at work. This may involve:

- Training to use the positive pressure hood.
- Reassigning to an alternative task .

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Positive pressure hood systems have been purchased for use across the Trust and are overseen by the IPC Respiratory Support Worker. Training is required prior to use by a competent user.

14.3. Seasonal influenza & Covid-19 Surge

<table>
<tr><th colspan="4">Overview</th></tr>
<tr><td colspan="4">Business Impact</td></tr>
<tr><td colspan="4">• Absence of staff due to influenza illness and/or Covid-19
• Spread of the virus to frontline staff due to ineffective use of personal protective equipment.
• Lack of available supplies of personal protective equipment.
• Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas.
• Lack of available side rooms to isolate infectious patients.
• Lack of available capacity on intensive care units to treat flu patients with serious illness.
• Closure of ward areas and loss of bed days due to outbreaks of infection.
• Increased monitoring and reporting requirements for flu-related activity.

Impact 1 2 3 4 5
Likelihood
1
2
3
4 X
5</td></tr>
<tr><td colspan="4">Proactive strategy</td></tr>
<tr><td colspan="4">• Immunise frontline staff for seasonal flu and Covid-19.
• Community staff continue support people to stay at home.
• Restate the risks and infection control requirements for managing flu patients.
• Key messages reinforced by community staff.
• Purchase additional supplies of face masks, gowns and goggles.
• Create and manage a stockpile of FFP3 masks.
• Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in ED, ICU, Respiratory and MAU).
• Point of Care Testing (POCT) for ED for patients with suspected seasonal flu.</td></tr>
<tr><td colspan="4">Reactive strategy</td></tr>
<tr><td colspan="4">• Promote key flu and Covid-19 messages for patients (if you've got flu, stay at home)
• Follow standard infection control precautions for managing flu and Covid-19 patients.
• Reassign or redeploy staff in high-risk groups as appropriate.
• Implement the joint surge and escalation plan.
• Implement the escalation plan for critical care if required.</td></tr>
<tr><td>Trigger</td><td>Received by</td><td colspan="2">Immediate action</td></tr>
<tr><td>DH reporting - proactive</td><td>DIPC</td><td colspan="2" rowspan="3">• Alert forwarded by email rule to Director of Operations, Chief Nurse, Director of Infection Prevention and Control.
• Staff in the Emergency Departments and outpatient departments will remind relevant patients to have their flu and Covid-19 jabs if they have not already done so.
• Implement management of flu and Covid-19 arrangements.</td></tr>
<tr><td>Surge in flu related activity</td><td>ED matron/CD</td></tr>
<tr><td>Surge in flu admissions</td><td>Infection control team</td></tr>
</table>

15. Holiday Periods and Bank Holidays

15.1. Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays and during holiday periods, Christmas and New |Year holidays are when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period to manage this as well as during other holiday periods.

15.2. Reduced Services

The Christmas and Bank Holiday arrangements for different services will be shared in the weekend pack which will be available in each Command Centre as well as emailed out to all those senior staff working and to switchboards. Copies of the operational arrangements for theatres and clinical support services will be included within this pack.

15.3. Partner organisations

CHFT has worked with our system partners to develop the overall resilience plan and this aligns with the CHFT plan. On call structures and rotas are available prior to the start of each week and weekend rotas are made available should escalation be required.

Cover arrangements during holiday periods and bank holidays for primary care, social care and safeguarding will be shared with the weekend packs.

16. Training and Implementation of the Resilience/Winter Plan

The Divisional Director of Operations have overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by.

- Involvement of leads from each division.
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news.
- Publication of related documents on the Preparing for Emergencies section of the staff intranet.
- Publication of the plan on the Trust intranet.

17. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement service policies and 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.

18. Monitoring Compliance with this procedural document

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

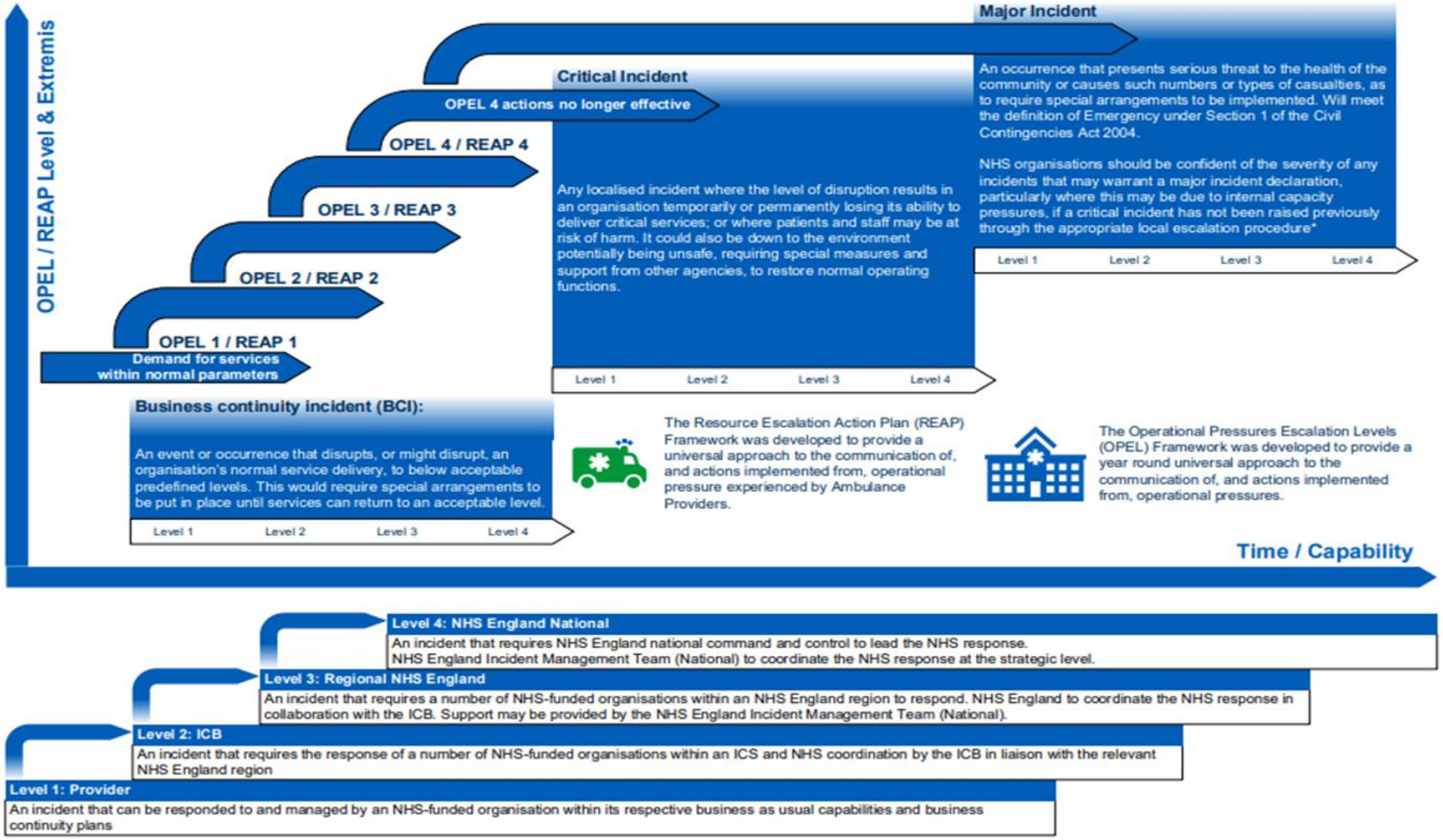
The Deputy Chief Operating Officer and Divisional Director of Operations in collaboration with key service winter leads are responsible for the successful implementation and monitoring of the winter plan. The plan and its effectiveness will be reviewed throughout the winter period and learning shared and acted upon. The Urgent Care Board membership will also play a key role in the review process.

Appendix One-System/ICS Resilience Plan

CH Resilience Plan 23-24 v4 FINAL.docx

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Two-National OPEL and EPRR Frameworks Diagram



With thanks to the NHS England East of England Regional Operations Centre (EPRR and UEC Operations) for this infographic.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Three-OPEL Score Parameters and Descriptors

					TACTICAL (SILVER) COMMAND		STRATEGIC (GOLD) COMMAND	
	Steady State		Moderate Pressure		Severe Pressure		Extreme Pressure	
	OPEL 1		OPEL 2		OPEL 3		OPEL 4	
Mean Ambulance Handover Time *Mean time from ambulance patient arrival to clinical handover within the last 60 minutes. Clinical handover is defined as handover of clinical information and transfer of patient to hospital trolley.*	<15 mins	0	15-30 mins	2	>30-60 mins	4	>60 mins	6
ED All-Type 4-Hour Performance *Percentage of all type attendances admitted, discharged or transferred within 4-hours since midnight. This is excluding booked appointments.*	>95%	0	>76-95%	1	>60-76%	2	≤60%	4
ED All-Type Attendances *The number of all-type attendances at the hospital within the past 60 minutes. This should be compared to the expected or anticipated number of attendances, which must be established and agreed locally based on historical demand. This can be a consistent hourly average or an average that considers varying attendances throughout a 24-hour period.*	<2%	0	>2-5%	1	>5-10%	2	>10%	4

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Major and Resuscitation Occupancy (Adult) *Percentage occupancy of adult majors and resus at time of assessment. Occupancy should be calculated as the sum of all patients in adult ED who require a majors space (regardless of whether they are receiving care in a traditional space or an escalation area), divided by the maximum number of patients who can be cared for in major and resus areas, as stated in the acute hospital OPEL statement*	≤80%	0	>80-100%	2	>100-120%	4	>120%	6
Time to Treatment (TTT) *Median longest total time between patient arrival at ED and the time that the patient is seen by a clinical decision-maker at time of review. Clinical decision-maker is a care professional who can define the management plan and discharge the patient or diagnose the problem and arrange or start definitive treatment as necessary*	≥60 mins	0	>60-90 mins	1	90-120 mins	2	<120	4
% of Patients Spending >12 Hours in ED *Total number of patients spending over 12 hours in ED from time of arrival to time of review as a percentage of total number of patients in ED at time of review.*	≤2%	0	>2-5%	1	>5-10%	2	>10%	4
% General and Acute Bed Occupancy *Percentage bed occupancy of hospital at time of OPEL assessment. Bed occupancy should be calculated as the sum of patients occupying all open general and acute beds (including assessment units). Below 92% occupancy should not be considered as a target, the correct level will vary locally. This should be considered*	≤92%	0	>92-95%	2	>95-98%	4	>98%	6

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

% Open Beds that are Escalation beds *Percentage of escalation beds as a proportion of the general and acute bed base open at the time of OPEL assessment. Escalation beds are those considered in line with A&E SitRep definitions. The denominator should be the G&A beds in the acute hospital SitRep.*	≤2%	0	>2-4%	1	>4-6%	2	>6%	4
% of Beds Occupied by Patients no Longer meeting the Criteria to Reside (NCTR) *Percentage of open beds occupied by patients NCTR at time of OPEL assessment. Denominator should be the number of beds on the acute hospital SitRep.*	≤10%	0	>10-13%	2	>13-15%	4	>15%	6
Score								

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Four-OPEL Action Cards

OPEL 1 – Bronze Command **Operational Action Card**	**STEADY STATE**

Site Management Meeting (Bronze) **Chair: Clinical Site Matron 07:00/09:00/13:00/16:00/19:00/23:30**	
Membership – Monday to Friday (MS Teams) • Clinical Site Matron(Chair) • Clinical Commanders • ED Representative • IPC Representative • Estates & Facilities Representative • Duty Matron • Head Nurses • Clinical Leads • Divisional representatives • Divisional Matrons	Membership – Saturday and Sunday (MS Teams) • Clinical Site Matron (Chair) • Clinical Commanders • Senior Nurse • Matrons

Actions
Clinical Site Matrons to review all OPEL actions that require oversight or intervention as per surge and escalation [policy, resilience plan and full capacity protocol. Clinical Site Matrons to set hospital objectives and ensure these are understood by all hospital teams are reviewed and agreed. Monitor and respond to activity changes across unplanned and planned care. - Repatriations from other organisations - Elective cases
Daily ward and board rounds using plan for every patient, identifying those that can be discharges via the discharge lounge before 09:00hrs.
Oversee staffing ensuring agreed staffing levels in place.
Monitor side room and isolation capacity.
Review inputs and escalations from core functions including Estates and facilities, IPC and AED ensuring mitigations appropriate .
Pre plan discharge for new patients - TTOs. - Referrals. - Discussions with families. - Monitor discharges from TOC list.
Utilise SDECs for appropriate patients in EDs.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

All discharges to go to the discharge lounge, ensure that discharge lounge is at its maximum utilisation.
Admission avoidance in place within ED.
LCD rotas filled or extra appropriate staffing sought.
Promote use of virtual ward/UCR and OPAT. Follow a rapid assessment tool to ensure high risk patients are prioritised for ambulance to hospital handover.
Ensure initial assessment is completed within 15 mins of patient arrival into ED and ensure diagnostic access is available to support clinical decision maker
Ensure regular re-assessments of patients in ED is undertaken.
Ensure teams are aware of escalation routes.
Update OPEL score before 10:00hrs each day.
Liaise with the SCC in the events of rising pressure.

OPEL 1 – Bronze Command
Nurse Staffing Action Card **STEADY STATE**

Escalation Level	Acute Trusts	Community Care	Action

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

OPEL 1	**No staffing issues identified.** **Use of specialist units/beds/wards have capacity.** • Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. • No technological difficulties impacting on patient care. • Good patient flow through ED and other access points. Pressure on maintaining 4-hour Emergency Care Standard • Infection control issues monitored and deemed within normal parameters	**No staffing issues identified.** Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	• Monitor current situation (daily staffing meetings) • Where surplus staff to patient care needs identified, feed into staffing meetings to support other areas. • Ensure changes to staffing are reported accurately with safe care. • Review actual staffing levels, understanding the gaps and the actions required to close them. • Ensure breaks and annual leave is taken as planned (working within Annual Leave Policy) • Ensure live recording of Safe Care describing service area acuity and professional judgement. • Divisional Confirm and Challenge meetings. • Regular staffing meetings should be adhered to. • Effective roster management - ensuring safer staffing planning reflects the principles of good health roster management and KPI's, including adherence to headroom. • Send shortfalls in WFM to Flexible Workforce Department in a timely manner. • Daily safety huddles • *Identify what activity can be brought forward

*Community Specific Actions

OPEL 2 – Bronze Command **Operational Action Card**	**MODERATE PRESSURE**

Site Management Meeting (Bronze) **Chair: Clinical Site Matron 07:00/09:00/13:00/16:00/19:00/23:30**	
Membership – Monday to Friday (MS Teams) • Clinical Site Matron(Chair) • Clinical Commanders • ED Representative • IPC Representative • Estates & Facilities Representative	Membership – Saturday and Sunday (MS Teams) • Clinical Site Matron (Chair) • Clinical Commanders • Senior Nurse • Matrons

• Duty Matron • Head Nurses • Clinical Leads • Divisional representatives • Divisional Matrons	

Actions
All actions followed from action card 1.
Consultants to ensure all patients plans are reviewed daily and any delays in their treatment plans are expediated and escalated where appropriate with completed EDDs. Matrons and ops managers to be visible in ward and department areas and support escalations.
MOD to link with wards to ensure support for escalations to expedite discharge/move patient journey forward as highlighted through board rounds. Matron support to board rounds/ward sisters to ensure clear plans for every patient.
Patients with no criteria to reside reviewed through board rounds to ensure clear plans. Write back used to provide continuity for the next day .
Review all patients inside rooms to step down where possible.
Discharge team to expediate discharge, escalation for any delays to appropriate service. Non-use of the discharge lounge by exception and for TTOs to be completed in the lounge not on the ward areas.
Review of any IPC issues, any capacity closed to ensure precautions in place and to understand impact of closed capacity and review options to increase capacity within existing footprint.
Lower admission treatment thresholds, consider outpatient or SDEC follow ups for patients.
Using the community sit rep info Expedite additional available capacity in primary care, OOHS, independent sector and community capacity. - UCR, HAT and START availability.
ICU escalation plan to be initiated and an update into patient flow meeting- timely transfer of patients to ensure any critical care patient has access within 4 hours.
Consider the need to open and staff extra capacity areas. Acute Floor CRH (Expand bed base) Respiratory Floor (Expand bed base) Stroke Floor CRH (Increase 7B to 10 beds from 8)
Undertake discharge intervention meetings for all extra capacity areas to be chaired by the system flow coordinator on a Monday and Thursday.
Consider onsite presence of ambulance commander through the SCC to work alongside the assessment team in ED. Patients who have a delay in ambulance handover will be jointly assessed by the ambulance commander and the ED team. Any patient unable to be off loaded from an ambulance within 30mins should be escalated to the SCC.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Update OPEL score every 6 hours and ensure Chief Operating Officer is aware.
Clinical Site Matrons to ensure all patients referred to speciality that cannot be moved to assessment areas due to no available bed are assessed by the speciality teams within 30mins of referral.

OPEL 2 – Bronze Command
Nurse Staffing Action Card **MODERATE PRESSURE**

Escalation Level	Acute Trusts	Community Care	Action
OPEL 2	**Lower levels of staff available but appropriate mitigation to maintain services.** **Opening of escalation beds likely (in addition to those already in use)** **Capacity pressures on PICU, NICU, and other intensive care and specialist beds** • Anticipated pressure in facilitating ambulance handovers within 60 minutes. • Insufficient discharges to create capacity for the expected elective and emergency activity. • Infection control issues emerging • Lack of beds across the Acute Trust • ED patients with DTAs and no action plan	**Lower levels of staff available but are sufficient to maintain services.** • Patients in community and / or acute settings waiting for community care capacity. • Lack of medical cover for community beds • Infection control issues emerging	• All appropriate actions at Level 1 completed. • Liaise with buddy wards to source any additional support (this may be a 2-3 hours etc) • Escalate concerns through safe care. • Ensure clear communication of expectations of what the escalation beds require from a workforce model. • Refer to local action cards that are established for clinical areas. • Ensure communication with health roster teams to initiate the builds to proposed escalations. • If required, offer additional hours at agreed enhanced payments & volunteers to rearrange annual leave to provide extra capacity. • Consider additional support from ward clerk role to support patient flow (admissions and discharges) • Chase reviews and diagnostics to expedite discharges. • Nurse in charge on ward areas to acknowledge and act on right to reside data. • Consider stopping accepting referrals for patients on the Practise Nursing caseloads – weekends and annual leave.

	*Community Specific Actions		• Inform CCG of any change to service provision and/or requests made to other providers for support/mutual aid

OPEL 3 – Bronze Command and Silver Command
Operational & Tactical Action Cards **SEVERE PRESSURE**

Site Management Meeting (Bronze)
Chair: Clinical Site Matron 07:00/09:00/13:00/16:00/19:00/23:00hrs

Membership – Monday to Friday (MS Teams) • Clinical Site Matron(Chair) • Clinical Commanders • ED Representative • IPC Representative • Estates & Facilities Representative • Duty Matron • Head Nurses • Clinical Leads • Divisional representatives • Divisional Matrons	Membership – Saturday and Sunday (MS Teams) • Clinical Site Matron (Chair) • Clinical Commanders • Senior Nurse • Matrons

Actions at Bronze

All actions followed at OPEL 1 & 2 actions cards.
Clinical Site Matrons will update OPEL score every 4 hours and send to the SCC, the COO is briefed and silver command in place with a nominated person to chair.
Consider cohorting ambulance patients in ED to release ambulance crews. Consider moving patients in ED to the corridor to prevent ambulance delays.
Escalate any MFFD mental health or CAMHs patient waiting beds to divisional leads to escalate.
Escalate patients waiting diagnostics to appropriate departments to facilitate prioritisation against discharge, MOD to support clinical commander to ensure actions are progressed.
Review of any IPC issues, any capacity closed to ensure precautions in place and to understand impact of closed capacity and review options to increase capacity within existing footprint.
Instigate further board and ward rounds within ward areas with support from Matrons/Ops teams to ensure clear plans with a focus on R2R alongside divisions, discharge coordinators and therapy teams.

Communicate decisions from site management meeting to silver tactical command meeting, direct communication through divisional teams.
Consider the need to open and staff extra capacity.

Tactical Command Meeting (Silver) **Chair: Director of Ops 09:00hrs**	
Membership – Monday to Friday (MS Teams) • Director of Ops (Chair) • ADNs • Operations Lead • Deputy Director of WOD • IPC Lead Nurse • Information Analyst • Head of Communications • CCG Representation • LA Representation	Senior team to determine requirement for silver during the weekend

Actions at Silver
Oversee outputs from site management meeting.
Identify position within the WYATT via the SCC - Alert of OPEL level 3.
Assess Emergency Care demand and consider changing the NHS 111 Directory of services to another provider would benefit flow. This will need discussing with SCC and if agreed the SCC will discuss with NHS 111.
Escalate through system silver. - TOC list and how to increase discharges. - MFFD mental health and CAMHs patients - Escalation information to be cascaded to all primary care and out of hours providers to recommend alternative care pathways including independent providers with the intention of avoiding admissions wherever possible. - Alert YAS Regional Operations Centre of handover delays, discuss options to support timely handover.
Escalate patients waiting repatriations to other organisation to facilitate transfer.
Ensure most senior clinical decisions maker is present in ED to support alternatives to admission such as SDEC, Hot Clinics, Urgent Community Response and virtual ward.
Consider cancellation of all non-urgent meetings to support recovery and prevent escalation, releasing staff to work alongside ward areas promoting discharge.

Commence buddy ward rota to support board and ward rounds promoting discharge and escalating and actioning blockages.
Identify next day discharges for awareness and ability to create early flow the following day.
Transfer all suitable patients to the discharge lounge and consider widening the criteria.
SDEC Coordinators to pull through all appropriate patients from ED to SDEC using FirstNet and SDEC services to remain SDEC areas rather than in-patient beds.
Divisional representatives to identify clinical staff undertaking non-clinical duties for targeted deployment at hotspots" of demand e.g., dedicated specialist consultant in reach to ED- ensure professional action cards being used.
Coordinate communication across CHFT OPEL Score using intranet, email, screensavers and leadership walk rounds.
Coordinate communication of escalation across local health and social care as well as public communications around alternatives to ED.
Consider communication to the wider public regarding use of services and support in taking relatives home.
Divisional representatives to determine requirement for additional shifts to be employed and to agree period of implementation.
Consider use of Care Club and volunteers to support ward areas in delivery care.
Consider cancelling working from home for operation working from home for operational staff.
Consider activating parts or all the Full Capacity protocol.

OPEL 3 – Bronze Command and Silver Command
Nurse Staffing Action Cards SEVERE PRESSURE

Escalation Level	Acute Trusts	Community Care	Action
4	**Actions at OPEL Two failed to deliver capacity.** **Significant unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas** **Serious capacity pressures escalation beds and on PICU, NICU, and other intensive care and specialist beds**	**Significant unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow.**	• All appropriate actions at Level 2 completed. • Daily sit-rep reporting of position by affected services. • Where appropriate, cancel/defer all meetings not immediately required for the provision of safe services.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

	• Significant deterioration in performance against the 4-hour Emergency Care Standard (e.g. a drop of 10% or more in the space of 24 hours) • Patients awaiting handover from ambulance service within 60 minutes significantly compromised. • Patient flow significantly compromised. • Unable to meet transfer from Acute Trusts within 48-hour timeframe. • Awaiting equipment causing delays for a number of other patients • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that cannot be rectified within 2 hours	Community capacity full	• Consider cancelling all non-essential training (risk assessed within divisional areas and oversight by ADN's for consistency of approach) • Implementation of daily Nursing and Midwifery Safer Staffing meeting (this will receive escalations from staffing meetings) • Band 7 visibility on the clinical area – leading from the front, supporting staff to take breaks. • Staff on days off or annual leave contacted to see if available to support. • Visible senior leadership walk rounds to clinical areas. • Maximising the opportunity for the right staff, with the right skills are in the right place and at the right time (Prompt: - consideration of multi-professional response) • Mobilise ward helper support (e.g. from care club or volunteers) to support clinical services. • Non-essential procedures postponed where clinically indicated. • Undertake reviews of specialist nursing roles and risk assessment of ability to release nursing capacity to clinical areas (mobilisation will be activated in OPEL 4) • Organise 'Buddy Matron' roster to ensure coverage on both sites 7 days per week. (Implement at OPEL 4) • Depending on where the pressures lie within the system, ensure attendance at the • *Suspend District Nursing clinics • *Consider declining new OPAT referrals • Offer additional hours at agreed enhanced payments. • *Community Matrons to cancel non urgent visits to support District nurses and Quest Team • Review all patients due for discharge to assess whether discharge can take place sooner

OPEL 4 – Bronze Command, Silver Command and Gold Command **Operational, Tactical and Strategic Action Card**	**EXTREME PRESSURE**

Site Management Meeting (Bronze) **Chair: Clinical Site Matron 07:00/09:00/13:00/16:00/19:00/23:30hrs**	
Membership – Monday to Friday (MS Teams) • Clinical Site Matron(Chair) • Clinical Commanders • ED Representative • IPC Representative • Estates & Facilities Representative • Duty Matron • Head Nurses • Clinical Leads • Divisional representatives • Divisional Matrons	Membership – Saturday and Sunday (MS Teams) • Clinical Site Matron (Chair) • Clinical Commanders • Senior Nurse • Matrons
Actions at Bronze	
All actions followed at OPEL 1, 2 & 3 actions cards.	
Tactical Command Meeting (Silver) **Chair: Director of Ops 09:00hrs**	
Membership – Monday to Friday (MS Teams) • Director of Ops (Chair) • Divisional Directors of Ops • Associate Directors of Nursing • Clinical Site Matrons • Clinical Directors • Deputy Director of Workforce and Organisational Development • IPC Lead Nurse • Information Analyst • Head of Communications	Senior team to determine requirement for silver during the weekend

• CCG Representation • LA Representation	

Actions at Silver
All actions completed at OPEL 1, 2 & 3
Oversee outputs from site management meeting
Clinical Site Matrons will update OPEL score every 2 hours and send to the SCC, the COO is briefed and silver command in place with a nominated person to chair.
Identify position within the WYATT via the SCC - Alert of OPEL level 3.
Cohort ambulance patients in ED to release ambulance crews. Consider moving patients in ED to the corridor to prevent ambulance delays.
Escalate through system silver into Gold.
Cancel all meetings for 24 Hours (with the exception of command and control) and released staff to be assigned to ward areas.
Implement full capacity protocol.
Every bed to be used within the organisation including paediatrics and maternity.
All specialities to release a consultant to work within the Emergency Department to avoid admissions.
Commence See and Treat Model in ED.
Commence Emergency Department front door streaming with the following outputs. -Needs to be seen in ED -See a treat at front door in ED -Referred directly to SDEC -Refer directly to clinic slots -Redirect to primary care/community services
Communicate via red border email OPEL 4 status and upload OPEL 4 screensaver.
Announce via bleep system OPEL 4 status.
Create a hub on each site for the Clinical Site Matron to direct extra support.

Cancel working from home for operational roles.
Corporate nursing teams to work clinically providing support to challenged and extra capacity areas, as directed by the clinical site matron.
Create a temporary discharge lounge at the CRH on ward 6D.
Consider patient boarding in wards and departments to designated areas as per the FCP.
Open any available extra capacity.

Strategic Command Meeting (Gold) (Instigated by COO) **Chair: Chief Operating Officer 14:00hrs**	
Membership – Monday to Friday (MS Teams) • Chief Operating Officer • Deputy Chief Executive • Medical Director • Deputy Medical Director • Chief Nurse • Deputy Chief Nurse • Executive Director of Finance • Director of Workforce and Organisational Development • Director of Transformation and Partnerships • Director of Digital Health • Managing Director of CHS • Director of Corporate Affairs • Divisional Directors • Non-executive Directors (by Invitation)	Senior team to determine requirement for silver during the weekend

Actions at Gold
Identify position within the WYATT via the SCC - Alert of OPEL level 3.
Oversee outputs from silver command meeting. Initiate critical incident plan.
Multiagency gold to invoke partners dynamic risk assessments on what business as usual functions can be suspended to release staff to focus on acute community demand - with focus on early supported discharge, admission avoidance and proactive planning for the next 72 hours.

Cancellation of elective work- use of resources to be defined depending on incident- for 24 hours then review.
Consider use of ward 10 for non-elective surgical patients as per Ward 10 SOP
Notification of NHS England via SCC that despite implementation of extra-ordinary resources the Trust is unable to provide safe patient care and is failing to meet its key performance targets and recovery is unlikely within the next 24-48 hours or indefinitely.
Coordinate communication of escalation across local health and social care as well as public communications around alternatives to ED
All agencies to declare to ICB any bed not currently in use and the risk assessment as to why and move to utilise.
Surgical representatives to consider whether any electives cases require cancellation.
Initiate calling in staff from days off to support the site.
Cancel Outpatient appointments and use medical and nursing staff to support front end wards and departments.
Cancel admin/SPA and study leave.
Request extra portering services within both EDs and Acute Floors (Cost implication to be signed off at Gold).
Authorise extra locum consultant support 24-48hrs (Cost implication to be signed off at Gold).
Increasing On Call ED Consultant to 1 each site for 24-48hrs (Cost implication to be signed off at Gold).
Gold to discuss the need to call a formal critical incident and inform NHS England.

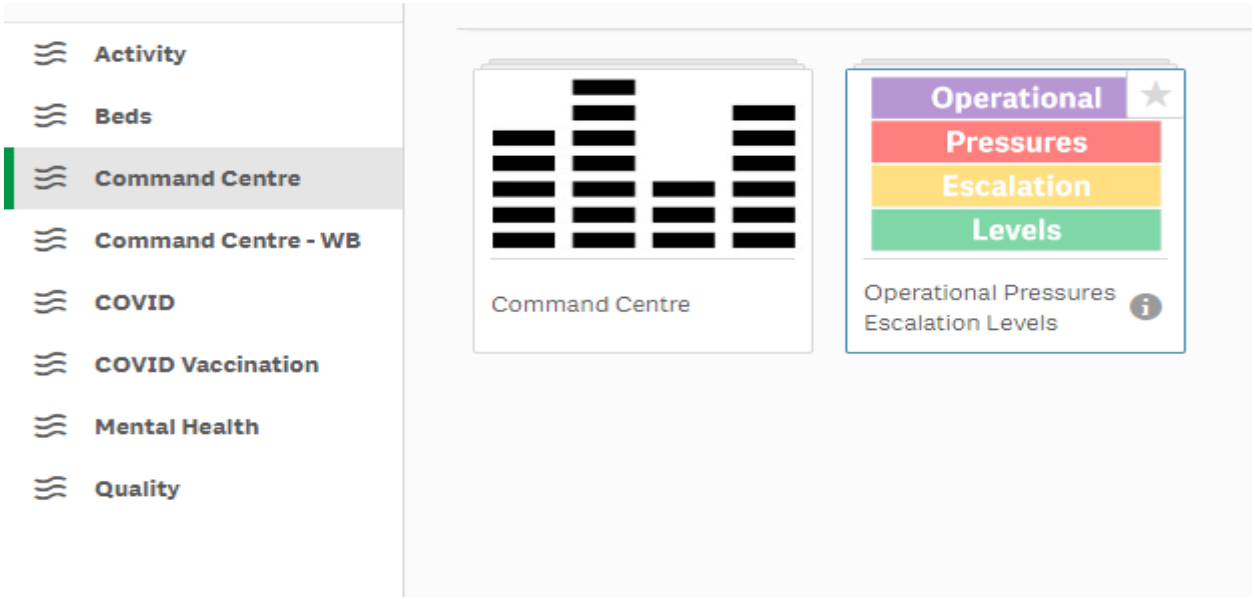
OPEL 4 – Bronze Command, Silver Command and Gold Command
Nurse Staffing Action Card **EXTREME PRESSURE**

Escalation Level	Acute Trusts	Community Care	Action

OPEL 4	**Actions at OPEL Three failed to deliver capacity. Unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety.** **Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds. Infectious illness, Norovirus, severe weather, and other pressures in Acute Trusts (including ED handover breaches)** • No capacity across the Acute Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised. • Unable to offload ambulances within 120 minutes. • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that cannot be rectified within 4 hours	**Unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety.** No capacity in community services	• All appropriate actions at Level 3 completed. • Staffing ratios will be reduced outside national guidance. The staffing position will be assessed at twice daily meetings chaired by the ADN. Professional Judgement will be used to mitigate risk on shift-by-shift basis, the risk of which will be escalated through Gold Command. • Matrons will be deployed to clinical shifts as determined by the ADN. • 'Buddy Matron' rota will be implemented to ensure presence on both sites 7 days per week. • Daily Huddles will be undertaken by the Outpatient departments to provide support where possible to other clinical areas. • Consider deferring essential safety training. • If required, defer appraisals and 1:1s unless high risk. • Mobilisation of deployment of specialist nurses as identified in OPEL 3 planning stage. • Admission avoidance – consider only accepting hospital discharges. • Use of other staff within CHFT (not including core services) with correct skill set to meet presenting need where appropriate. • All colleagues with a clinical registration to be available to support essential services and critical functions if required. • *Consider providing essential visits only • *Where possible, suspend non-core services to support core services • *Contact other healthcare providers to provide support for essential service delivery

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Five-Knowledge Portal + (KP+)



Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Six-CHFT Triggers and RAG Rating

Previous days Ambulance Turnaround between 30 & 60 minutes	0	1-5	6-10	11+
Previous days Ambulance Turnaround over 60 minutes	0	1-5	6-10	11+
Patients waiting for a bed in ED without a bed allocated	0	1-8	9-15	16+
Previous days non-elective admissions	90-100	101-129	130-159	160+
Previous days discharges from an in-patient bed	>115	<95	<70	<45
Previous days SDEC Utilisation (Medical, Frailty, Surgical)	>40	>30	>20	>10
Previous days Emergency Department attendances	Attendances <420	Attendances 421-480	Attendances 481-500	Attendances >501
Previous days ECS standard	>95%	<80%	<70%	<60%
Current number of patients with a LOS in ED over 12hrs	0	1-5	6-15	16+
Current number of patients with a LOS in ED between 6 & 12hrs	0	1-5	6-15	16+
Current number of extra capacity beds open	<10	11-25	26-45	46+
Infection Control Position	Isolated in bays or side rooms – empty beds available	Ward closure with no empty beds	Empty beds in closed ward, or more than 1 ward closed ward	Infection outbreak across more than 4 wards or infection closing both acute floors
Current number of patients in ED across site	60-70	71-100	101-140	141+
Current number of outliers (Patients in wrong speciality)	<5	6-10	11-25	25
Critical Care Bed Access	Available	Available in under 4 hours	Ward patients requiring Critical care with no bed availability and no network beds	Ward patients requiring Critical care with no bed availability, Cancellation of specific elective cases- No network beds and limited regional beds
Occupancy Levels	≤87.5%	87.6-92.5%	92.6%-97%	97%

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Maternity OPEL	OPEL 1	OPEL 2	OPEL 3	OPEL 4
Staffing Score	OPEL 1	OPEL 2	OPEL 3	OPEL 4

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Seven-Bronze, Silver and Gold Terms of Reference

To coordinate daily activity across the trust, maintain oversight of patient flow and operational delivery of plans

Responsibilities

- Monitor and respond to activity changes across unplanned care.
- Ensure sufficient capacity available to support safe, effective patients care
- Oversee staffing ensuring agreed staffing levels in place
- Monitor side room and isolation capacity
- Review COVID19 test results and action accordingly.
- Oversee day to day issues in relation to PPE.
- Review inputs and escalations from core functions including Estates and facilities, IPC and AED ensuring mitigations appropriate .
- Review inputs and escalations from Divisional hubs ensuring mitigations appropriate.

Structure

Membership

- Clinical Site Manager (Chair)
- Clinical Commander
- ED Representative
- IPC lead
- E&F representative
- Manager on-call
- Duty Matron
- Medical representative(s)*
- Divisional representatives

Other colleagues may be invited to attend for specific agenda items.

Quorum
A representative from all member teams is required at all meetings.

*Medical representatives will reflect on-call arrangements and position

Frequency
4 x Daily

Reporting

Decision-making
To support safe and effective patient flow by linking and using OPEL scoring and appropriate action cards

Authority
The meeting has authority to make decisions in line with agreed responsibilities

Reporting Strategy
Site Management will report into Silver and /or Gold depending on OPEL levels.

Escalation
The clinical site manager will escalate agreed items to silver.

Admin support
Not required for bronze whilst in BAU all meetings will be recorded on Teams and a daily sit rep to be sent until KP+ is set up as a dashboard.

Governance
The meeting provides a single forum for daily operational management of the hospital site and community services reporting into agreed structures.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

To oversee all activity and be the single point for all organisational decision making or escalation related to the incident

Responsibilities

- Oversee outputs from site management meeting and OPEL actions.
- Review data associated with the incident and advise planning and operational delivery accordingly.
- Understand and manage the risks associated with the OPEL level/incident and its impact on wider activity.
- Review Must Do dashboard.
- Review governance related outputs and ensure appropriate response or escalation.
- Coordination of communications
- Provide coordination of planning activities.
- Facilitate decision making or agree escalation for decision making on site management escalations.

Structure

Membership

- Director of Ops (Chair)
- ADNs
- Operations Lead
- Deputy Director of WOD
- IPC Lead Nurse
- Information Analyst
- Head of Communications
- CCG Representation
- LA Representation

Other colleagues may be invited to attend for specific agenda items.

Quorum
1 x Operational, 1 x clinical, 1 x corporate representative. It is expected that members attend 80% of meetings unless on A/L

Frequency
Daily or Twice Weekly

Reporting

Decision-making
This is a decision making forum

Authority
The meeting has authority to make decisions in line with agreed responsibilities.

Reporting Strategy
Reporting into Gold or Trust Board

Escalation
As required into the agreed appropriate forum

Admin support
All meetings will take place via teams and will be recorded. A loggist will be provided from the EPRR Team.

Governance
The meeting provides a forum for support into operational management of the hospital site and community services reporting into agreed structures.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

To apply strategic context to operational delivery of care during raised OPEL levels and times of incident and to ensure recovery is managed at pace across Interdependencies.

Responsibilities

- Observe Covid 19 activity & initiate surge plans as required.
- Review data associated with the recovery and advise planning and operational delivery accordingly.
- Understand and manage the risks associated with day to day operations at a raise OPEL level and/or incident.
- Receive, review, agree, action and disseminate guidance in relation to covid 19, recovery and planning.
- Ensure recovery activity & pace is in line with the framework .
- Ensure appropriate clinical and health inequality prioritisation.
- Coordination of communications.
- Provide coordination of planning activities.
- Facilitate decision making on silver escalations.

Structure

Membership
Chief Operating Officer
Deputy Chief Operating Officer
Medical Director
Deputy Medical Director
Chief Nurse
Deputy Chief Nurse
Executive Director of Finance
Deputy Director of Finance
Director of Human Resources
Deputy Director of Human Resources
Director of Transformation and Partnerships
Director of Digital Health
DOP from silver

Quorum

Frequency
Daily, twice weekly or weekly

Reporting

Decision-making
Strategic leadership.

Authority
The meeting has authority to make decisions in line with agreed responsibilities.

Reporting Strategy
Weekly update to WEB.

Escalation
As required into WEB.

Admin support
All meetings will take place via teams and will be recorded. Minutes , Action Log and agenda will be recorded by organisation PA.

Governance
The meeting provides a forum for support into operational management of the hospital site and community services reporting into agreed structures.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Eight-Ambulance Standard Operating Procedure

Ambulance handover SOP.pdf

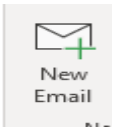
Appendix Nine-Red Border Email Process

1. Use red border email template below.

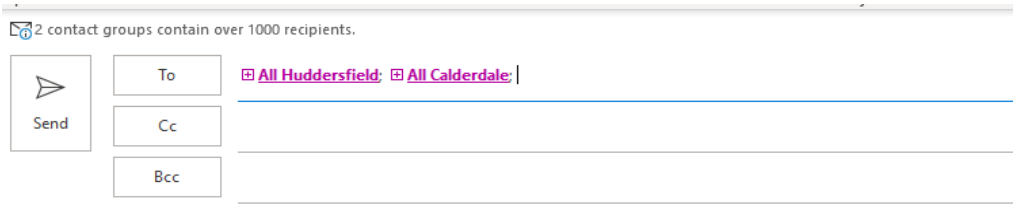

Red border template.docx

2. Clinical Site Matron to complete above template and send to the Strategic On Call approval and sending.
3. Strategic On Call to access emails through outlook by clicking on the link below.

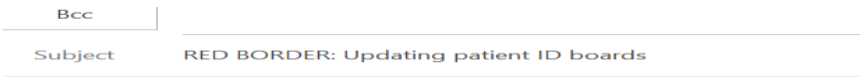
4. Click on new email.



5. Type in the To box All Huddersfield and All Calderdale



6. Type in RED BORDER in subject box, followed by brief description. RED BORDER: Updating patient ID boards.



7. Copy and paste the red border email into the main body of the email and send.

   DO NOT add as an attachment.
8. If the issues is with IT and emails cannot be sent copies should be printed and distributed to the ward areas.

Red Border Email Examples

Red border EPR issues.docx
Red border Blood.docx
Red border EPR Results Issue.docx
Red border PACs.docx
Red border Water Supply.docx

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Ten-Ward Opening and Closing Checklist

Checklist on opening additional beds at CRH/HRI.

Date……Staff member opening beds……..

	✓	Signature	Comments
Staff available at least 2 full days in advance. Administration support			
Ward keys			
Bed areas ; Beds/mattresses Chairs Tables Lockers Visitors chairs O2/air/suction Bed linen Curtains			
Thermometer/pulse oximeter			
Dynamap			
Nervecentre technology			
Check patients admitted are on a hire mattress or bed and inform Huntleigh			
Weighing scales ad slings			
BM machine			
Crash trolley(or access to one)			
Sanichairs/urinals			
Computer /printer working			
Telephone working			
Linen skips			
Stock pharmacy including CD			
Disposables(non stock)			
Stationary			
Admission book			
Ward notices (visiting etc)			
Drinks trolley			
Cups			
Jugs			
Glasses			
Check following department are aware of opening			
ISS			
Catering			
Laundry			
Porters			
Pharmacy			

Switchboard			
Supplies			
General office			
Coding			
Infection control- prior to opening			
Request full review from the following in the first 12 hours of opening or next working day			**Please indicate below the date and time review of the ward took place**
Infection control			
Resus officer			
Manual handling(Margaret Ward)			
Pharmacy Senior manager			

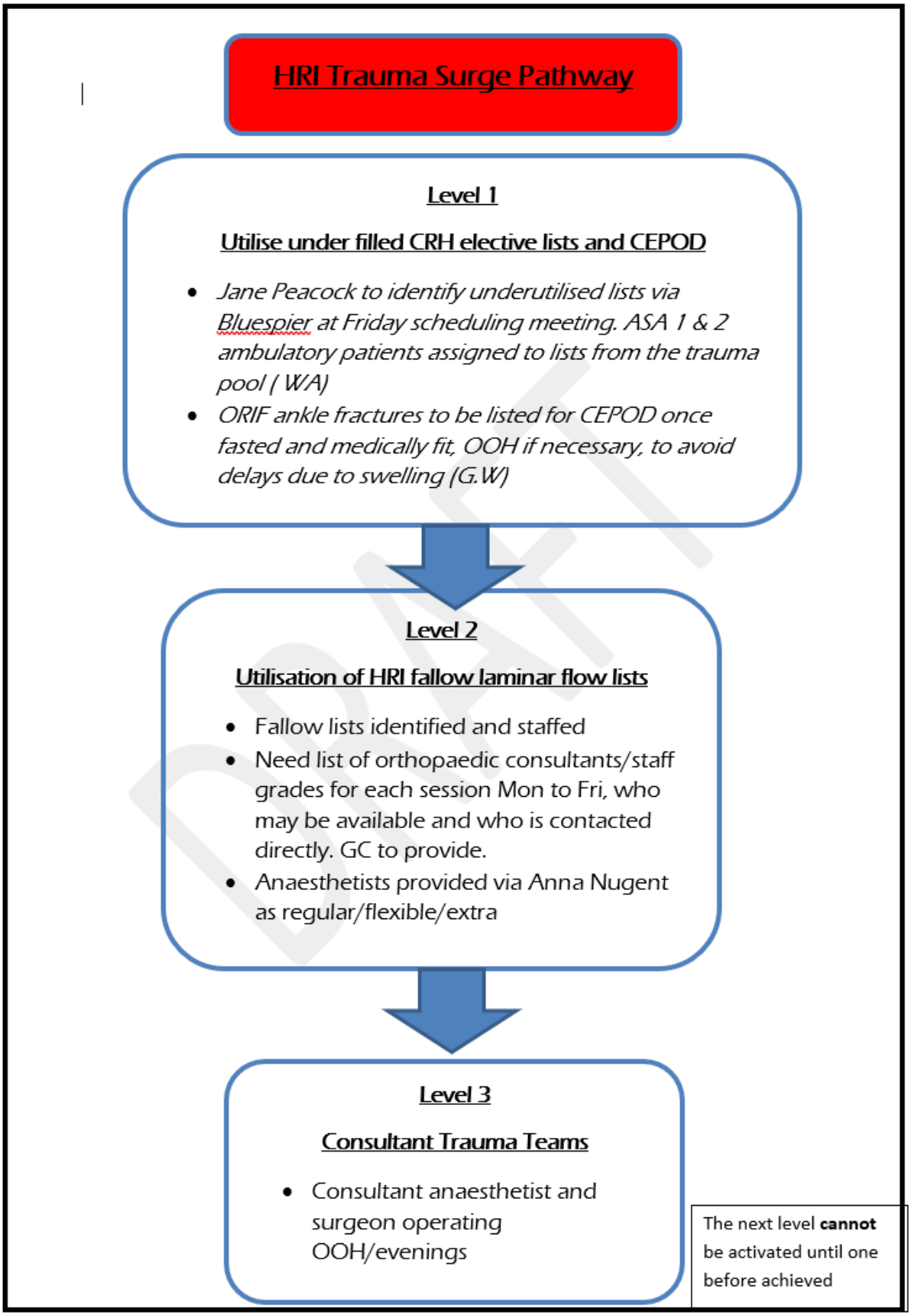
1. **For general opening/closing – Check and decontaminate all equipment, furniture and mattresses, if damaged, condemn as protocol.**
2. **Inform mattress coordinators of pending ward opening/closure.**
3. **In addition – if HPV cleaning is required (as determined by IPC) ensure the attached HPV guidance is followed (refer to page 8-10 of attached HPV work plan).**
4. **if you have any concerns please speak to the ICPN nurses on the respective hospital site**

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Eleven-ICU Escalation Process

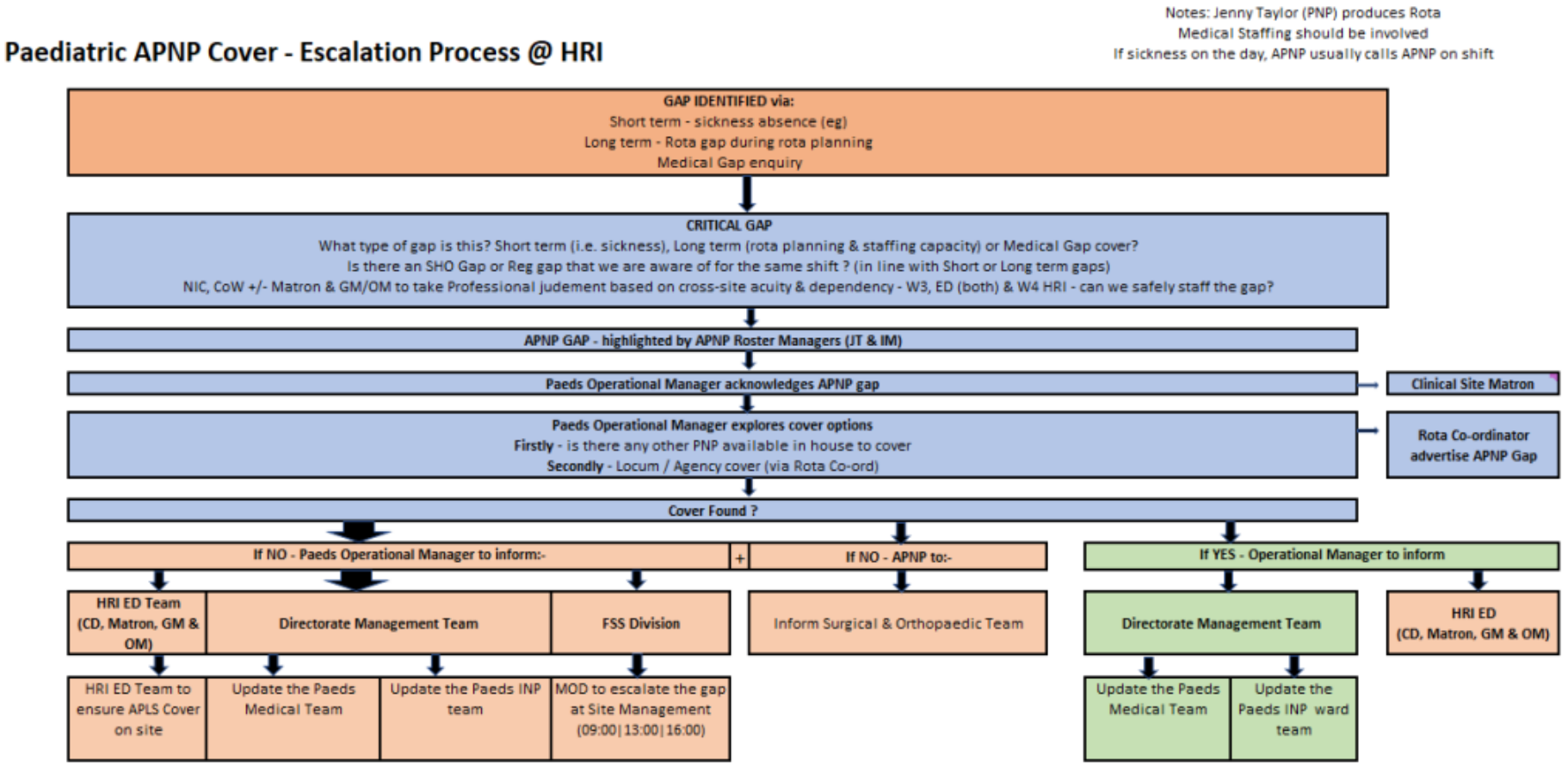
ICU escalation plan Sept 2023.pptx

Appendix Twelve-Trauma Surge Pathway



Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Thirteen-Paediatric Nurse Practitioner Escalation Plan



Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix Fourteen-Neonatal Unit Escalation Guidance

This document aims to provide clear operational guidance for bed management and escalation. It incorporates the escalation status, bed capacity, emergency trigger points and associated actions required in response to operational pressures. This will help provide a safe operating framework for staff and reduce the level of risk for patients. The guidance refers to the Neonatal Unit at Calderdale Royal Hospital.

To effectively manage fluctuations in workload, the Neonatal Unit maintain a fluid approach to accommodate demand by maximising cot availability. As a key principle the Neonatal Unit will always have a stabilisation place available for emergency admissions. The unit work with the Yorkshire and Humber Neonatal Network to manage capacity, recognising that families need to be kept as close to their home as possible.

Closure of the Neonatal Unit would only be under instruction by the Director on Call and would result in the declaration of a major incident.

The purpose of this guidance is to provide a structured and detailed plan of the actions to manage the flow of babies to the ward and to highlight actions needed during times of increased demand.

Important considerations:

1. Wellbeing of staff
2. Patients and family experience
3. Patient safety
4. Prompt escalation

This guidance also contains several guidelines to support the service at the time of a surge in activity:

Appendix 1: Process for dealing with incoming neonatal patient transfer requests.
Appendix 2: Checklist for suspension of services

The RAG rated action cards below identify the appropriate actions to be taken to enable the service to deal with fluctuations in demand and capacity so that it can manage associated clinical risk within acceptable limits.

Steady State OPEL 1 **Green – Normal service**

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Indicators	**Actions for Nurse in Charge**	**Actions for Clinical Manager**	**Actions for Deputy Head of Midwifery/General Manager**
Staffing 1. Actual staffing is greater or equal to planned according to capacity and acuity. 2. Actual staffing numbers and skill mix is less than planned, however assessment of the patient acuity using the acuity scoring tool against staffing number and skill mix does not pose a risk to patient care provision. **Capacity** 1. Cot capacity is limited but managed with usual planning arrangements. 2. Emergency activity accommodated. 3. Staffing levels: no patient safety compromised due to insufficient levels (assessment made of skill mix by senior staff and BPAM standards).	1. Complete Safe-care, including professional judgement 2. Match acuity to BAPM standards 3. Complete Badger nurse staffing and cot capacity database twice a day 4. Nurse in Charge to undertake MDT huddle twice daily on the unit. 5. Liaise with Midwifery colleagues regarding position. 6. Attend MDT handover	None, unless concerns expressed by coordinator in charge of shift.	None, unless contacted by Clinical Manager/Nurse In Charge/Consultant.

Moderate Pressure OPEL 2

Amber - Emerging capacity issues across the Neonatal service. Difficulty in managing volume or complexity of workload with the current skill mix (BRONZE)

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Indicators	**Actions for Nurse in Charge (NIC)**	**Actions for Clinical Manager in hours (Site- co or Clinical Commander out of hours)**	**Actions for Deputy Head of Midwifery/General Manager/Clinical Director (on call team out of hours)**
Staffing 1. Actual staffing is less than planned and there is prediction that nursing care may be impacted, or 2. Actual staffing is in line with planned levels but acuity is higher. 3. Gaps in the medical rota, with no ANNP available to support **Capacity** 1. No intensive or HDU cot or special care cots available in the organisation **2.** No beds available in the network 3. No anticipated discharges or drop down to transitional care. 4. Unable to transfer babies out to the network.	1. Review rota to support staffing. 2. Explore the possibility of support from other areas within the Directorate and Division 3. Contact agency to provide additional Q.I.S 4. Liaise with transitional care regarding a drop down in acuity. 5. Inform Consultant on Call and ask them to prioritise potential discharges. 6. Maintain MDT safety Huddle twice per day shift and once per night. 7. Escalate status to Clinical Manager in hours and OOH to the night matron	1. Clinical manager and Nurse in Charge to carry out a risk assessment of staff against acuity of patients and number of beds open. 2. Examine the possibility of support from other areas if not already carried out by Nurse in Charge 3. Ensure vacant shifts are out to Bank/Agency 4. Inform and escalate situation to the Deputy Head of Midwifery and General Manager as required. 5. Review non-clinical staff and allocate tasks to support with nursing. 6. Red flag any safe staffing issues on Allocate. 7. Ensure de-escalation is communicated when situation improves	1. Escalate unfilled shifts to staffing meeting/bed meeting. 2. Identify support to support from other areas of the Directorate and Division 3. Raise concern at Divisional and Tactical meetings as needed. 4. Alongside Clinical Manager, determine feasibility of opening surge cots.

Severe pressure - OPEL 3

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Capacity issues across NICU and the network or difficulty in managing either the volume or complexity of workload, resulting in an escalating level of concern about the safe provision of the service (SILVER)			
Indicators **Staffing – as per above, plus:** 1. Staffing is less than planned which will have a direct impact on patient safety. 2. At least one of the following red flags may apply. a. Unintentional omission of medication b. Observations and escalations not recorded in line with care plan. c. Gaps on medical rota remain unfilled and the Consultant is required to be resident. **Capacity,** a combination of: 1. Assessment cots occupied with inpatients. 2. All inpatient cots occupied and surge beds in use.	**Actions for Nurse In Charge** As per amber Opel 2 status, plus: 1. Request team to undertake an additional virtual ward round to prioritise potential transfers, risk assessing need. 2. Inform LDRP of bed capacity status. 3. Review status of mothers on LDRP 4. All potential admissions to be discussed with NIC and Consultant 5. Review elective admissions for the next 24 hours in conjunction with potential discharges – if unable to accommodate escalate to Deputy Head of Midwifery and General Manager for Maternity	**Actions for Clinical Manager/ consultant on call** As per amber Opel 2 status, plus: 1. Visible presence of ward manager on unit 2. Review rota for staff owing hours. 3. Ring ward staff put message out to staff on days off for extra hours. 4. Medical team to actively triage potential admission to the unit, informing the referrer of waiting times and the status. 5. Escalate to Deputy Head of Midwifery and General Manager or the Clinical Commander/Matron/On Call General Manager out of hours. 6. Ensure de-escalation is communicated when situation improves. 7. Contact Embrace for cot	**Actions for Deputy Head of Midwifery/General Manager/Clinical Director (on call team out of hours)** As per amber Opel 2 status, plus: 1. Determine feasibility of closing the unit for a predetermined time - to be agreed by DD/ADN/DOP and Network (out of hours discussion On Call General Manager and Director on Call) 2. Open surge cots 3. Consider cancellation of medical elective activity

	6. Escalate status to Clinical Manager in hours/OOH night matron. 7. On shift debrief if appropriate	availability	

Extreme Pressure - Opel 4 **Capacity issues across the NICU service, resulting in a significant level of concern about the safe provision of service. Directorate team recommend the Executive Director considers temporary suspension of services until the situation has de-escalated (GOLD)**			
Indicators As per Opel level 3, plus: 1. No de-escalating from a staffing perspective 2. Acutely unwell baby requiring an inpatient bed unable transfer out to network.	**Actions for Nurse in Charge** Actions as per silver Opel 3 status, plus: 1. Reassessment of the situation on an hourly basis with the responsible Consultant	**Actions for Clinical Manager/ Consultant on Call** Actions as per Opel 3 status, plus: 1. Liaise directly with senior management about the status.	**Actions for Deputy Head of Midwifery/General Manager/Clinical Director (on call team out of hours)** Actions as per Opel 3 status, plus: 1. Continue to update Divisional team on status. 2. Clinical Director to liaise with colleagues regarding additional cover. **<u>If services are suspended or transfer out agreed</u>**

			1. Debrief process for all staff

De-escalation

There is a recognised need for services to return to a normal function as soon as possible to enable everyday unit activity and business as usual. It is important that if the unit is in an escalated status that it is re-assessed regularly to ensure actions are taken.

Debriefs must take place after prolonged periods at OPEL 3 and 4.

Exception Reporting

As soon after de-escalation as is practical, any exception reports must be reviewed. Lessons learnt must be shared via Clinical Forum.

Staff Indemnity

As the escalation response continues, it is recognised that all groups of clinical staff are likely to be expected to work outside the scope of their usual working practices. Examples of this include:

- Caring for a greater number of patients than is recognised to be acceptable and safe by medical and nursing professional bodies.
- Non-critical care trained staff working alongside critical care trained staff caring for sick neonates.
- Staff providing a limited standard of care than is normally considered acceptable e.g.. observations every 2/3 hours instead of hourly.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

Appendix 1: Process for dealing with incoming Neonatal transfer requests.

In the event that you receive a direct patient referral from another hospital, it is important you follow the agreed transfer process to ensure any transfers are appropriate and requested following the correct process.

If you receive a transfer request directly from the clinical team in another Trust you should take the following steps:

- The referrer attempting to direct refer should be informed of the agreed process – i.e. they need to escalate this need in the first instance via their own Trust's hospital manager on-call.
- The referring Trust's on-call manager will liaise with the referring clinical team to ascertain the rationale for the transfer and determine if they support this request. If they support, they will then escalate this request to their own Director on-call (this request is only likely to be supported if the referring Trust is in an escalated position and the service is currently closed to inward referrals).
- If the referring Trust's Director on-call supports the request to transfer, they will then request support to transfer via the CHFT Director on call.
- The CHFT Director on-call will liaise with the CHFT on-call manager, clinical commander and ward teams to determine whether they are in a safe position to accept the requested transfer.

We want to support you to make the best decisions for your patients – we are therefore asking for your support in ensuring this process is followed and any direct requests are escalated as described. We know there will be instances where you need to make urgent decisions for patient safety reasons but please support this approach wherever possible to ensure any transfers you are asked to support are appropriate.
If you are involved in a situation where the correct process has not been followed please record this instance as an incident when it is safe to do so. We can then ensure the incident is fully investigated.

Review Lead: Director of Operations Resilience, Acute Flow & Transformation
Review Lead: August 2024
Unique Identification Number: G-136-2023

21. Guardian of Safe Working Hours Reports Covering the Period March – August 2023

Presented by Dr Liaquat Ali, Guardian of Safe Working Hours

To Note

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title:	Guardian of Safe Working Hours Report Covering the Period 1 March 2023 – 31 May 2023
Author:	Dr Shiva deep Sukumar
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None
Purpose of the Report	To provide an overview and assurance of the Trusts compliance with safe working hours for doctors/dentists in training across the Trust, and to highlight any areas of concern.
Key Points to Note	1. Exception reports 2. Information about cover arrangements for out of hours rota gaps 3. Junior doctors strike
EQIA – Equality Impact Assessment	The opportunity to exception report is available for all doctors in training and Trust doctors on the 2016 Contract irrespective of any protected characteristics.
Recommendation	The Board is asked to **NOTE** the contents of the report.

GOSWH Report
1 March 2023 – 31 May 2023

Introduction:

The purpose of this report is to give assurance to the board that the doctors in the training are safely rostered and that their working hours are compliant with the Junior doctor's contract 2016 and in accordance with the Junior Doctors terms and conditions of service (TCS).

The report includes the data from March 2023 to May 2023.

Executive summary:

The trust has used Allocate software since August 2017 to enable trainees to submit exception reports. All doctors in training and locally employed Trust doctors employed on the 2016 Terms and Conditions have an Allocate account. Educational supervisors and clinical supervisors also have access to this software.

There were 26 exception reports (ER) in total that were submitted during this period. Most of the exception reports were related to extra hours of working. Six were related to service support. There weren't any ER related to missed educational opportunities during this period. Most ER were submitted by FY1 doctors. All the ERs were analysed and closed on the Allocate system.

All our junior doctor rotas are fully compliant with the 2016 TCs. Rota gaps remain a challenge, when/where Health Education England don't provide a trainee, however a number of Trust doctors are recruited to cover wherever possible. Where there are out of hours gaps the flexible workforce team work to cover these shifts with bank/agency locums, with the junior doctor's cross-covering during the day.

Background Data:

Number of doctors / dentists in training (total): 260

Admin support is provided to the Guardian: The Medical HR team manage the payment for exception reports wherever this is agreed and create Allocate accounts for all those that need access. They also do initial prompts to clinical supervisors and educational supervisors regarding exception reports. There is a regular meeting scheduled with the GOSWH and the Medical HR manager for additional support if required.

The Medical Education team manage the invites, agenda, and minutes for the quarterly Junior Doctors Forum meeting.

Safety concern raised through Exception Report:

There were seven exception reports which were submitted and judged to be an immediate safety concern by the person submitting the report, for the period between March 2023 to May 2023. Six were about service support and were resolved by discussion made between the supervisor and the junior doctors. One was about work pattern which was investigated and resolved within the division.

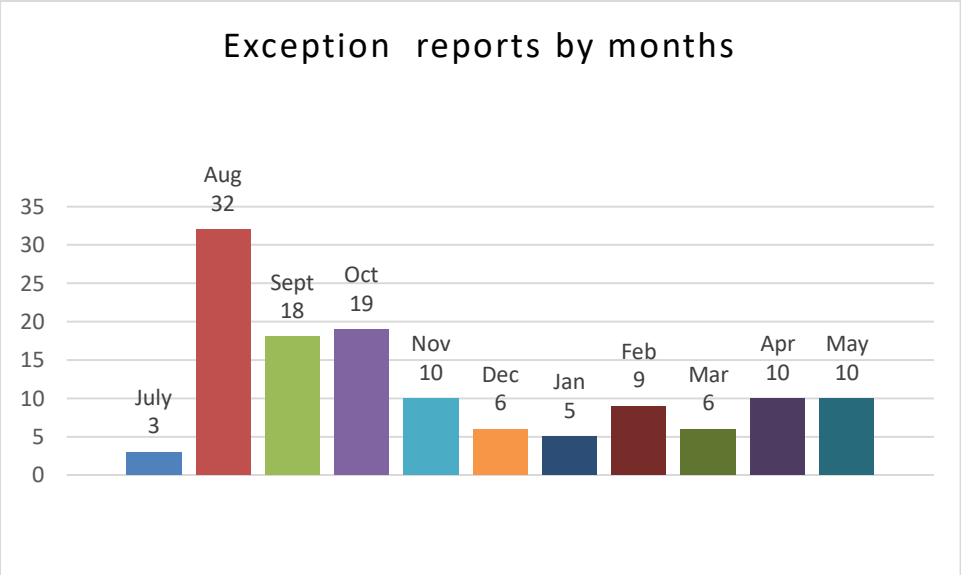
Work Schedule reviews:

There were no work schedule reviews during this period.

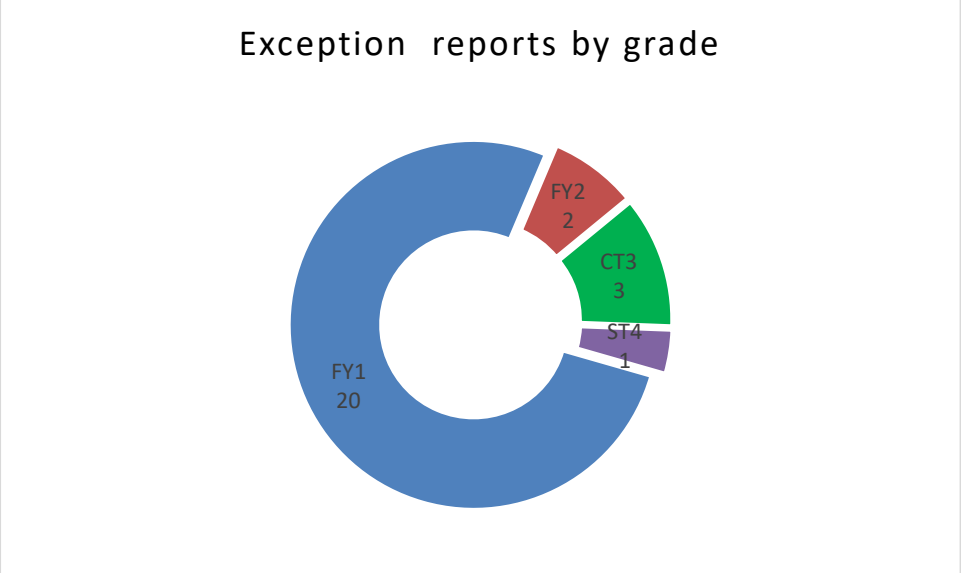
Exception reports details:

Total ER – 26

Exception Reports from March 23 to May 23

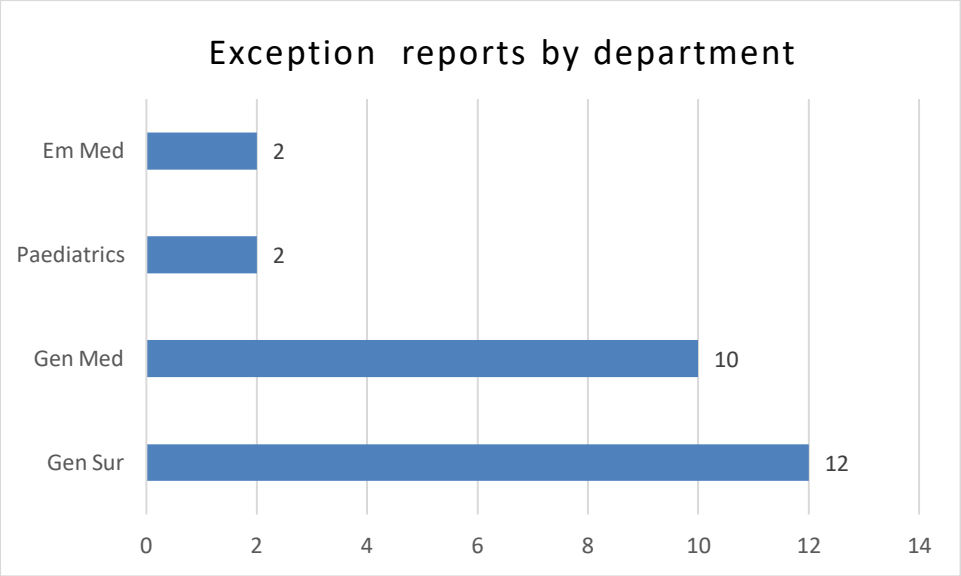


Exception report by Grades:



Most of the ER were from FY1 doctors. This is expected as the junior doctors are in the first year of working within the NHS and are still getting familiar with how the system works.

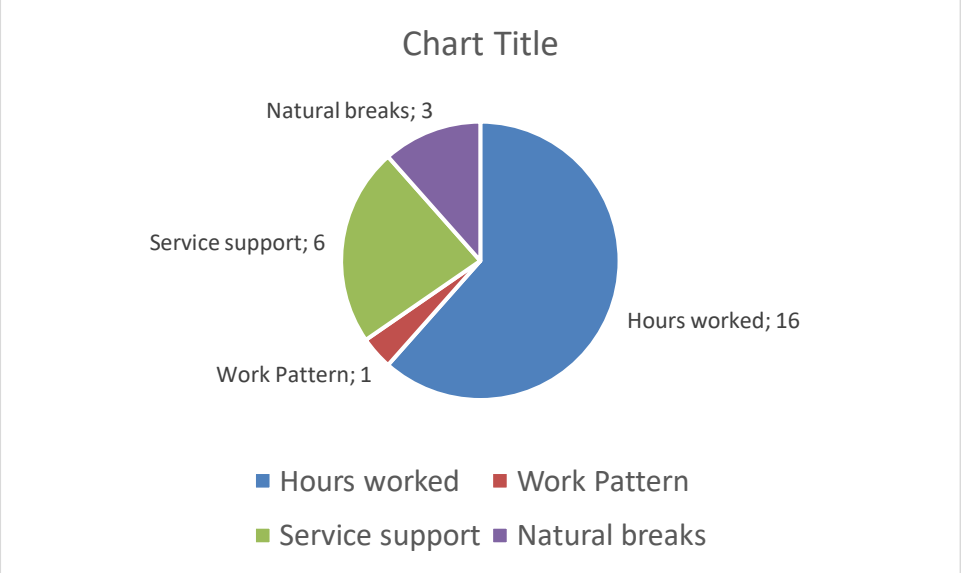
Exception reports by Departments:



We see that General medicine and General surgery are again the departments facing majority of ERs.

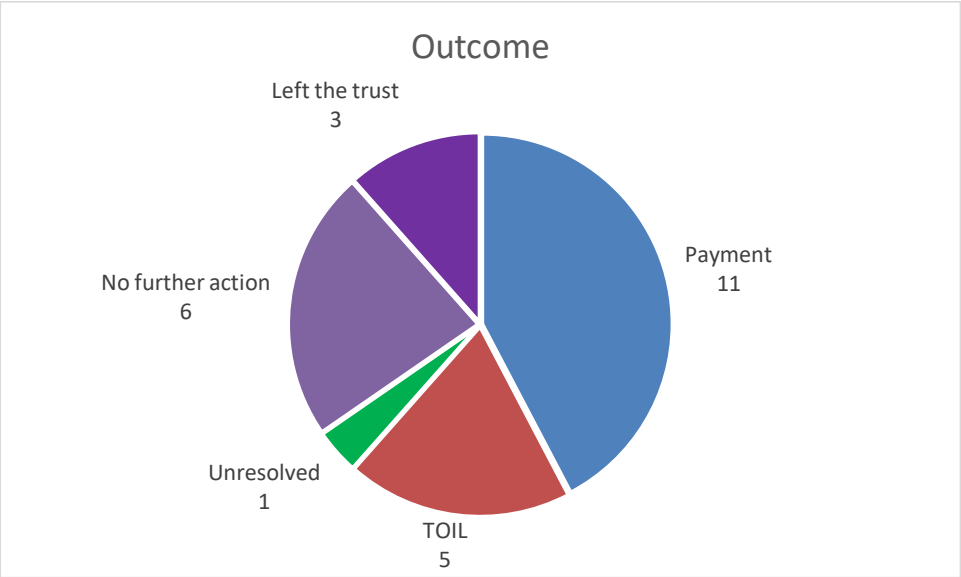
Distribution of exception reporting in relation to various reasons

Out of these 26 reports, 16 were related to extra hours of working and 7 were related to service support. 3 were about missed natural breaks and 1 was about work pattern.



Outcome of resolved exception reports:

Most of the ER were sorted by payment. Some were dealt with by time off in lieu (TOIL) For 6 reports, discussion with the doctors and suggestion with Rota changes solved the ERs. For three reports, TOIL / payment was offered but the junior doctor had moved to the next trust.



Fines:

There haven't been any fines issued in last three months.

Other Salient ER investigation:

There was one ER submitted by a ST4 registrar from medicine department in the month of March. The doctor had to work in a new hospital starting an out of hours on call without a formal induction and ID badge access. We investigated the concern raised and a remedial action plan has been put in place.

When the Trust has August, September and October changeover, the department will ensure that a local induction is given at both sites and that badges are sorted for both sites.

Prior to the pandemic, the Registrars used to work a whole rota cycle at one site and then switch sites to start the on-call rota cycle there. This is going to be re-introduced.

Trainee Vacancies:

Data on Rota gaps is challenging to obtain, as most rosters up to the Consultant level are covered by a combination of doctors in training, Trust doctors and specialty doctors. Where there are trainee vacancies, a Trust doctor may be recruited for a fixed term to cover that gap. Or alternative cover may be arranged for out of hours commitments.

As can be seen from the data held within ESR most of our training posts are filled currently.

	Mar-23			Apr-23			May-23		
Role	Budgeted FTE	Actual FTE	Vacancies by FTE	Budgeted FTE	Actual FTE	Vacancies by FTE	Budgeted FTE	Actual FTE	Vacancies by FTE
Consultant	292.36	270.46	21.90	300.46	267.77	32.69	299.46	268.24	31.22
Foundation Year 1	48.00	53.00	-5.00	48.00	52.60	-4.60	48.00	52.60	-4.60
Foundation Year 2	36.00	33.28	2.73	36.00	33.28	2.73	36.00	33.28	2.73
General Medical Practitioner	0.00	0.20	-0.20	0.00	0.20	-0.20	0.00	0.20	-0.20
Medical Director	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Specialty Doctor	115.22	87.13	28.09	135.42	88.90	46.52	133.42	88.93	44.49
Specialty Registrar	139.76	130.14	9.62	138.76	129.24	9.52	138.76	131.31	7.45
Staff Grade (Closed to new entrants)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Trust Doctor - Foundation Level	18.00	24.00	-6.00	34.00	24.00	10.00	34.00	24.00	10.00
Trust Doctor - Specialist Registrar Level	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trust Grade Doctor - Specialty Registrar	26.94	36.62	-9.68	30.02	34.62	-4.60	30.02	37.62	-7.60
GP Trainees - Trust Based (Specialty Registrar)	39	40.35	-1.35	39	40.35	-1.35	39.00	40.35	-1.35
Total	**716.28**	**676.18**	**40.10**	**762.66**	**671.95**	**90.71**	**759.66**	**677.53**	**82.13**

GP Trainees NOT based in the Trust have been excluded in this chart.

Shifts covered by Bank and Agency:

Out of hours shifts on trainee rotas can arise for a number of reasons. As you can see from the table below, most shifts are filled with alternative cover.

Bank and Agency fill rates by division- March 2023 – May 2023

	% Unfilled hours	% Filled Bank hours	% Filled Agency hours
Division of Family and Specialist Services	19.92%	75.79%	4.28%
Division of Medicine	11.62%	75.02%	13.34%
Division of Surgery and Anaesthetics	9.83%	82.86%	7.30%

Industrial Action:

On Friday 24 February the British Medical Association confirmed that doctors in training along with locally employed doctors engaged on mirror terms and conditions would be undertaking industrial action for 72 hours commencing at 6.59am Monday 13 March through to 7am Thursday 16 March 2023. Additionally, the Hospital Consultants and Specialists Association confirmed strike action on Wednesday 15 March 2023.

The industrial action was confirmed as a full stoppage of work, with no derogations agreed locally or nationally during the strike period. In the event of a major unpredictable incident the Trust could call for doctors to return as long as the nationally agreed process was followed. Whilst not obliged to inform the Trust about whether there was an intention to strike, many of our colleagues did let their operational management teams know so that plans could be put in place.

The Medical Director wrote to all medical and dental staff to confirm the details of the action, to remind colleagues to be respectful of others' views and to share a document with frequently asked questions. Well-being support was available to all and regularly referenced in Trust updates.

Additional strike action by the same eligible group happened for 4 days from Tuesday 11th April to Saturday 15th April 2023. The industrial action was again a full stoppage of work.

Strike in March 2023

	Monday 13 March	Monday 13 March	Tuesday 14 March	Tuesday 14 March	Wednesday 15 March	Wednesday 15 March
	Presented for Work	Industrial Action	Presented for Work	Industrial Action	Presented for Work	Industrial Action
Division of Family and Specialist Services	4	19	5	23	4	29
Division of Medicine	11	70	13	68	12	80
Division of Surgery & Anaesthetics	5	54	5	60	5	65
Total Number	20	143	23	151	21	174

CHFT as Lead Employer

Psychiatry	0	8	0	8	0	10
GP Practice Trainees	17	15	11	16	10	18

Strike in April 2023

	Tuesday 11 April	Tuesday 11 April	Wednesday 12 April	Wednesday 12 April	Thursday 13 April	Thursday 13 April	Friday 14 April	Friday 14 April
	Presented for Work	Industrial Action	Presented for Work	Industrial Action	Presented for Work	Industrial Action	Presented for Work	Industrial Action
Division of Family and Specialist Services	5	16	8	16	5	17	4	12
Division of Medicine	12	89	11	88	9	81	9	77
Division of Surgery & Anaesthetics	5	54	11	49	7	46	11	37
Total Number	**22**	**159**	**30**	**153**	**21**	**144**	**24**	**126**

CHFT as Lead Employer

Psychiatry	0	7	0	8	0	11	1	8
GP Practice Trainees	31	25	29	23	26	21	22	17

Regional GOSWH conferences and webinars:

I attended the two hours webinar on E-Rostering delivered as part of enhancing junior doctors working lives (EJDWL) event hosted by NHS England on 25th April.

I also attended one day Yorkshire and the Humber Annual GOSWH meeting by HEE Health Education, England on 3rd May. It gave an insight about the role of GOSWH.

Change of Guardian:

The present guardian is the Clinical Lead for the subspeciality of uroradiology. They intend to get more involved in academic and research work to develop the service further, and consequently have stepped down from the Guardian role. Dr Liaquat Ali, Consultant Respiratory Physician, has been appointed to undertake the Guardian role going forward.

Summary:

The trainees here at CHFT all have Allocate accounts to enable them to raise an exception report if they work outside of their agreed rota, or there are any issues that they wish to escalate, including gaps in educational support.

The rotas that are in place are all fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when changes may be needed.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title:	Guardian of Safe Working Hours Covering the Period 1st June - 31st August 2023
Author:	Dr Liaquat Ali, Guardian of Safe Working Hours
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None
Purpose of the Report	The purpose of this report is to provide an overview and assurance of the Trusts compliance with safe working hours for doctors/dentists in training across the Trust, and to highlight any areas of concern.
Key Points to Note	1. Exception reports 2. Information about cover arrangements for out of hours rota gaps 3. Junior doctors strike
EQIA – Equality Impact Assessment	The opportunity to exception report is available for all doctors in training and Trust doctors on the 2016 Contract irrespective of any protected characteristics.
Recommendation	The Board is asked to **NOTE** the contents of the report.

GOSWH Report June 2023 to August 2023

Introduction:

The purpose of this report is to give assurance to the Board that the doctors in the training are safely rostered and that their working hours are compliant with the Junior doctor's contract 2016 and in accordance with the Junior Doctors terms and conditions of service (TCS). The report includes the data from June 2023 to August 2023.

Executive summary:

The Trust has used Allocate software since August 2017 to enable trainees to submit exception reports. All doctors in training and locally employed Trust doctors employed on the 2016 Terms and Conditions have an Allocate account. Educational supervisors and clinical supervisors also have access to this software.

Most of the exception reports were initiated by FY1 doctors especially in the first month of their training /work in the NHS environment, as they take some time to get used to the system. Almost eighty percent were related to extra hours of working. Three of these were related to service support available to the doctors and one was published due to missed educational opportunities. Allocate software indicates 11 ER as unresolved, however, after scrutiny, it appears that these were resolved but have not been fully closed on the software by mistake.

All our junior doctor rotas are fully compliant with the 2016 TCs. Rota gaps remain a challenge, when/where Health Education England don't provide a trainee, however a number of Trust doctors are recruited to cover wherever possible. Where there are out of hours gaps the flexible workforce team work to cover these shifts with bank/agency locums, with the junior doctor's cross-covering during the day.

Background Data:

Number of doctors / dentists in training (total): 275.1, Non -Training Junior Doctors: 153.51

Admin support is provided to the Guardian: The Medical HR team manage the payment for exception reports wherever this is agreed and create Allocate accounts for all those that need access. They also do initial prompts to clinical supervisors and educational supervisors regarding exception reports. There is a regular meeting scheduled with the GOSWH and the Medical HR manager for additional support if required.

The Medical Education team manage the invites, agenda, and minutes for the quarterly Junior Doctors Forum meeting.

Safety concern raised through Exception Report:

There were no exception reports highlighting any safety concern for the period between June 2022 to Aug 2023.

Work Schedule reviews:

There were no work schedule reviews during this period.

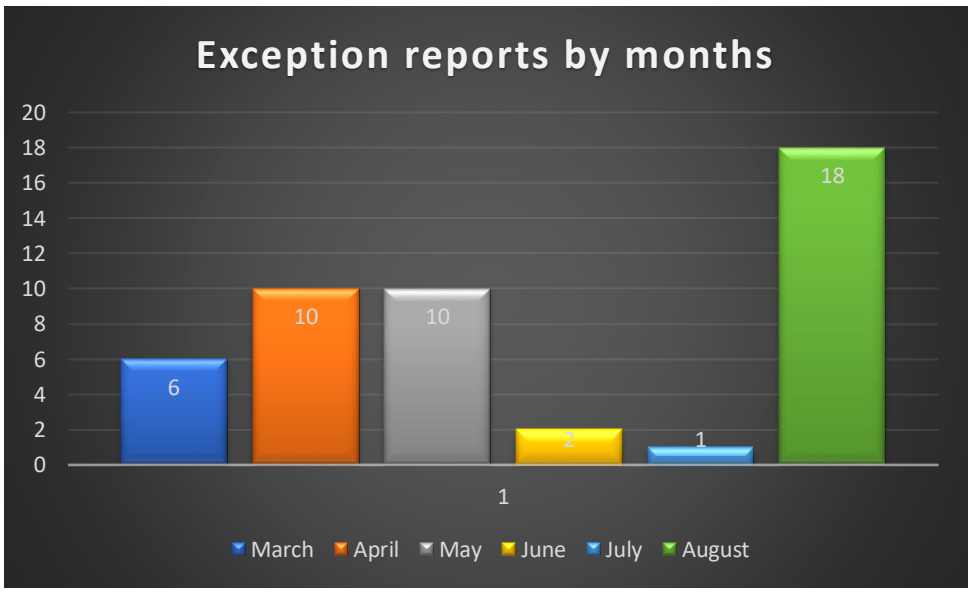
Exception Reports - details:

Total ER – 21

Distribution of exception reporting in relation to various reasons

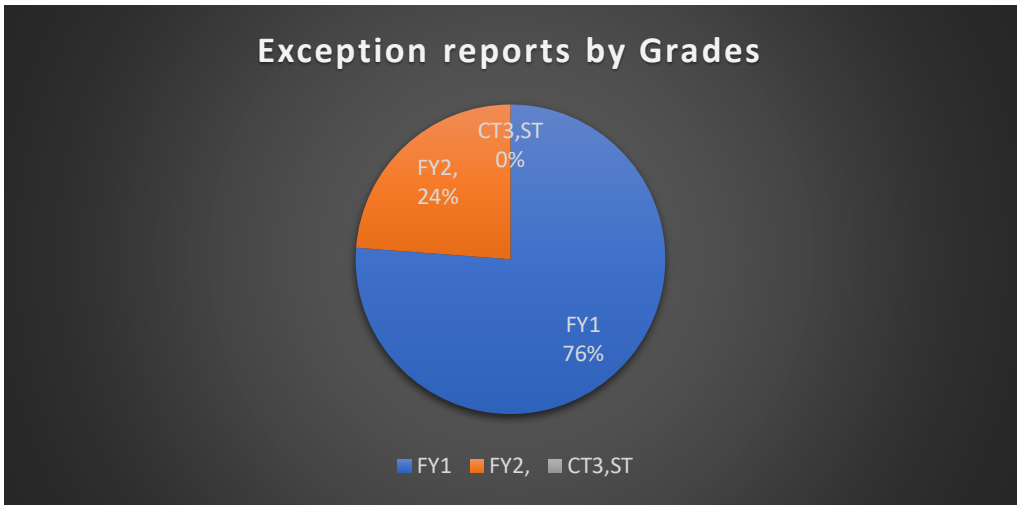
Out of these 21 reports, 16 were related to extra hours of working ,3 related to service support available to the doctor and 1 was related to pattern of work. One was related to missed educational opportunities (missed training day)

Exception Reports (ER) from June 2023 to August 2023:



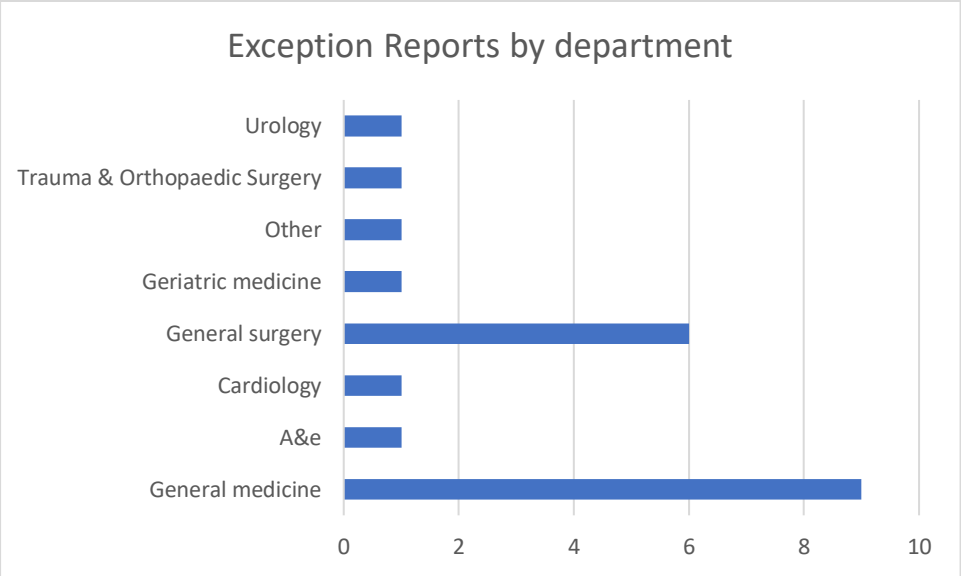
In total 21 reports were submitted. As we can see, the trend to submit ER is higher in August.

Exception report by Grade:



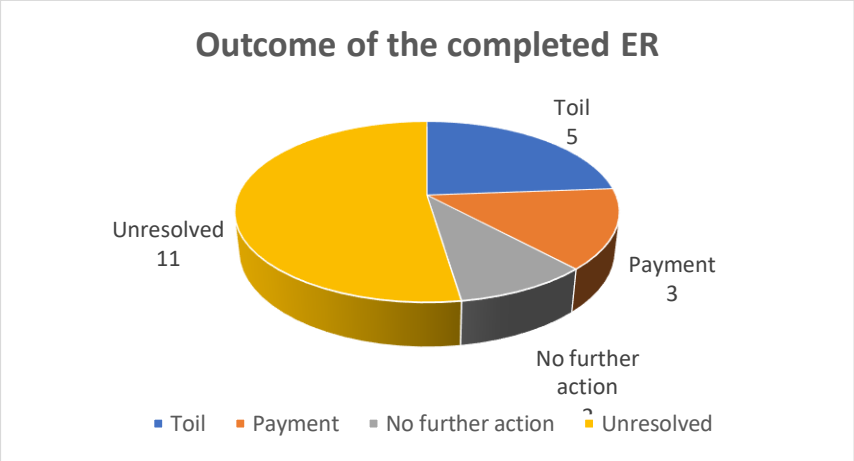
Most of the ER were from FY1 doctors. This is expected as the junior doctors are in the first year of working within the NHS and are still getting familiar with how the system works.

Exception reports by Departments:



We see that slightly more ER have been submitted in General Medicine as compared to General Surgery. This was other way round in the beginning of year.

Outcome of resolved exception reports:



Not all ER were resolved fully. Those shown as unresolved are the total number of exceptions where either no outcome has been recorded or where the outcome has been recorded but the doctor has not closed the record.

Steps from last Board meeting:

Fines:

There haven't been any fines issued in last three months.

Trainee Vacancies:

Data on Rota gaps is challenging to obtain, as most rosters up to the Consultant level are covered by a combination of doctors in training, Trust doctors and specialty doctors. Where there are trainee vacancies, a Trust doctor may be recruited for a fixed term to cover that gap. Or alternative cover may be arranged for out of hours commitments. As can be seen from the data held within ESR most of our training posts are filled currently.

	June-23			Jul-23			Aug-23		
Role	Budgeted FTE	Actual FTE	Vacancies by FTE	Budgeted FTE	Actual FTE	Vacancies by FTE	Budgeted FTE	Actual FTE	Vacancies by FTE
Consultant	300.96	267.81	33.15	300.96	273.01	27.95	307.06	274.23	32.83
Foundation Year 1	48.00	52.60	-4.60	45.00	52.60	-7.60	49.00	57.42	-8.42
Foundation Year 2	36.00	33.28	2.73	36.00	33.26	2.74	37.00	35.33	1.68
General Medical Practitioner	0.00	0.20	-0.20	0.00	0.20	-0.20	0.00	0.20	-0.20
Medical Director	0.00	0.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Specialty Doctor	133.51	88.73	44.78	133.51	91.06	42.45	133.56	89.02	44.54
Specialty Registrar	138.76	130.00	8.76	138.76	130.00	8.76	140.76	137.76	3.00
Staff Grade (Closed to new entrants)	1.00	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.00
Trust Grade Doctor - Foundation Level	34.00	24.00	10.00	34.00	24.00	10.00	34.00	23.00	11.00
Trust Grade Doctor – Specialist Registrar Level	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Trust Grade Doctor – Specialty Registrar	30.02	40.62	-10.60	30.02	39.62	-9.60	28.94	40.29	-11.35
GP Trainees - Trust Based (Specialty Registrar)	39.00	41.00	-2.00	39.00	41.00	-2.00	40.00	44.59	-4.59
Total	**761.25**	**679.24**	**82.01**	**759.25**	**686.75**	**72.50**	**772.32**	**703.82**	**68.50**

Shifts covered by Bank and Agency:

Out of hours shifts on trainee rotas can arise for several reasons. As you can see from the table below, most shifts are filled with alternative cover.

Bank and Agency fill rates by Division, June – August 2023

	% unfilled hours	% filled Bank hours	% filled Agency hours
FSS	4.90%	92.74%	2.36%
Medicine	10.87%	76.92%	12.36%
Surgery and Anaesthetics	12.1%	84.98%	2.91%

Industrial Action:

Significant planning was done within all divisions to pull together a comprehensive plan with a focus on patient and staff safety protecting critical services to deliver lifesaving care and

maintaining elective care for cancer patients during junior doctor's strike which took place between 14th June to 17th June, 13th to 18th of July and 11th to 15th of August 2023.

The Medical Director wrote to all medical and dental staff to confirm the details of the action, to remind colleagues to be respectful of others' views and to share a document with

frequently asked questions. Well-being support was available to all and regularly referenced in Trust updates.

The medical team was supported by physician associates, pharmacists, trust grade doctors and training doctors who did not participate in the strike action. Fortunately, no unpredictable events took place. ER were recorded during strike action. Adequate support services were available in terms of: The Safari team was available to prescribe for TTOs (take home prescriptions), and a "Floater" prescriber was available as well as Microsoft TEAM setup (CHFT – Digital Support) to act as a central resource to facilitate any issues colleagues may have with Cerner, Blood TRACK, ABG machine access and prescribing. There was a significant level of support for industrial action with approximately 90% of those eligible going on strike.

Other Updates:

Becky Colwill, Deputy Medical Education Manager has taken over as Medical Education Manager of learning centre of CHFT. Dr Shiva Deep Sukumar, consultant Radiologist has stepped down as Guardian of Safe Working Hours and Dr Liaquat Ali, Consultant Respiratory Physician has been appointed as the new Guardian. He commenced in role mid-October 2023.

Regional GOSWH conferences and webinars:

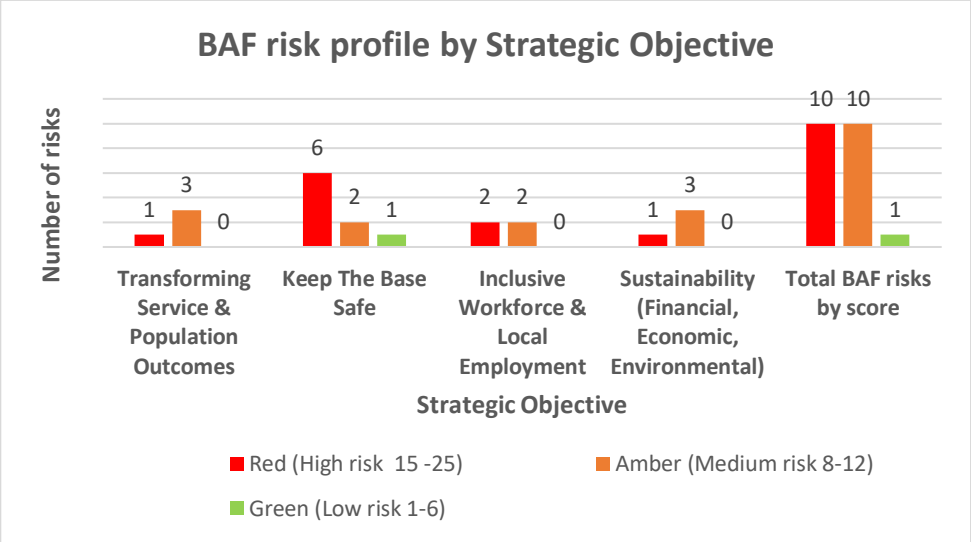
Dr Ali will be attending the Yorkshire and Humber GOSWH Regional Meeting on 25th October and the Guardian of Safe working virtual conference on 6th of Nov 2023 in his new role to liaise with other GOSWH.

Summary:
The trainees at CHFT have access to an allocate account to initiate exception reports and they have the provision if they want to raise any issue regarding safety concern, missed educational opportunities and extra work-outside their agreed rota. The rotas that are in the place are fully compliant with the rules of the 2016 contract and there is scope to review these where feedback highlights when changes may be needed.

22. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title:	Board Assurance Framework Update 2 2023/24
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Audit & Risk Committee 24 October 2023
Purpose of the Report	This paper presents the second update of the Board Assurance Framework (BAF) for 2023/24. A new risk relating to cyber security is also proposed for addition to the BAF.
Key Points to Note	**Risk Profile** The Trust has the following risk profile for risks to its strategic objectives as at 16 October with a total of 21 risks.  The Keeping the Base Safe goal has the greatest number of risks (9 of 21) and the highest number of red risk scores, at seven of the 21 risks on the Board Assurance Framework (BAF). Since the last report to this Committee the Board approved a revised performance risk, ref 4/23 at its September 2023 Board meeting.

	It was agreed that updates would include a focus on reviewing the risk appetite target score to check whether this was aligned with the risk appetite. Two risk appetite categories were changed, with the two risks relating to medical staffing and nurse staffing (10a/19, 10b/19) moving from the Innovation category (high risk appetite) to the workforce category (low risk appetite). All BAF risks have been reviewed and updated by the lead Director and / or teams with updates shown in red font for ease of reference in the enclosed worksheets within the BAF. **Top Risks** The BAF shows three top risks for the Board spread across three of the Trust goals: • Transforming Services and Population Outcomes - approval relating to hospital services reconfiguration, risk ref: 01/19, risk score of 20 • Keeping the Base Safe – demand and capacity (beds), risk ref: 1/23, risk score of 20 • Sustainability - risk 18/19 relates to the long term financial sustainability of the Trust and has a risk score of 16. **New Risks** Following discussion of cyber security at the Audit and Risk Committee in prompted by advice from the National Audit Office regarding cyber security risks, the Chief Digital and Information Officer has developed a cyber security risk which is proposed for addition, risk 5/23 with a risk score of 15 relating to the Keeping the Base Safe goal. The risk is described as: *Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resulting from a cyber attack impacting on patients via exposure of patient records, inability of workforce to access / record patient care affecting quality and safety, financial and reputational risk. (Including but not limited to Cyber vulnerability, Social engineering, malware, ransomware, phishing emails, loss of data and DOS attacks)* The Audit and Risk Committee will have oversight responsibility for this risk. **Risk Movement**: There are no changes to risk scores following reviews. **Risk Exposure** Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate) this has been identified as a breach of the risk appetite. In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of

<table>
<tr><td></td><td>information and assurance on the management of risks with risk exposure.

As at 23 October 2023 there are six areas of risk exposure summarised below based on the risk appetite:

<table>
<tr><th>Strategic Goal: Transforming and Improving Care</th><th>Risk Score</th><th>Risk Appetite category</th><th>Risk Appetite</th></tr>
<tr><td>7/20 Health Inequalities</td><td>12 =</td><td>Harm and safety</td><td>Low</td></tr>
<tr><th>Strategic Goal: Keeping the Base Safe</th><th>Risk Score</th><th>Risk Appetite category</th><th>Risk Appetite</th></tr>
<tr><td>1/23 Demand and capacity (beds)</td><td>20 =</td><td>Harm and safety</td><td>Low</td></tr>
<tr><td>4/23 Performance targets</td><td>16 =</td><td>Regulation</td><td>Moderate</td></tr>
<tr><td>5/23 Cyber Security</td><td>15 !</td><td>Regulation</td><td>Moderate</td></tr>
<tr><th>Strategic Goal: Workforce</th><th>Risk Score</th><th>Risk Appetite category</th><th>Risk Appetite</th></tr>
<tr><td>1/22 Workforce absence and retention</td><td>12 =</td><td>Workforce</td><td>Low</td></tr>
<tr><th>Strategic Goal: Sustainability</th><th>Risk Score</th><th>Risk Appetite category</th><th>Risk Appetite</th></tr>
<tr><td>18/19 Financial sustainability</td><td>16 =</td><td>Financial/Assets</td><td>Moderate</td></tr>
</table>
</td></tr>
<tr><td>EQIA – Equality Impact Assessment</td><td>The BAF has a specific risk, risk 07/20, which relates to the Trust not reducing health inequalities for our most vulnerable patients.

The Trust Board receives a report four times a year on progress with health inequalities actions at Board meetings.

In terms of other risks, should any of the Board Assurance Framework risks materialise and impact people from different protected characteristics the risk owner is accountable for assessing these and determining any proposed actions to mitigate any equality impact arising from the risk.</td></tr>
<tr><td>RECOMMENDATION:</td><td>The Board is asked to:

i. APPROVE the updates to the BAF</td></tr>
</table>

	ii. **APPROVE** the addition of risk 5/23 relating to cyber security at a risk score of 15

Update 2 - For 2 November 2023 Board
2023/24

Calderdale and Huddersfield
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2023/24 Update 2

Contents:

compassionate care

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming services and population outcomes								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	7413	Strategic/ Organisational	Significant
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	15	**12 =**	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	12	**12 =**	9	RB	None	Innovation/ Technology	High
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	**12 =**	8	RA	None	Harm and safety	Low
Keeping the base safe - best quality and safety of care								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**15 =**	10	LR / DB	See sheet	Regulation	Moderate
04/19	Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations	12	**12=**	4	VP	None	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**15 =**	8	GB	See sheet	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	9	**6 =**	3	JH	. 7413	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of service due to failure to comply with quality statements resulting in a reduction of qualiy of services to patients and an impact on reputation.	12	**12 =**	6	LR	None	Regulation	Moderate
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	16	**20**	12	JH	8606, 8528, 8468	Harm and safety	Low
3/23	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	16!	**16 =**	8	AB	None	Strategic/ Organisational	Significant
4/23	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**16**	12	JH	8528, 8324, 8398, 7874, 7689	Regulation	Moderate
5/23	**Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack**	15	**15**	10	**RB**	**None**	**Regulation**	**Moderate**

Inclusive workforce and local employment								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	DB	See sheet	Quality/Innovation & Improvement	Significant
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	LR	6345, 6911 , 7994	Workforce	Low
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.	16	**12 =**	9	SD	None	Quality/Innovation & Improvement	Significant
1/22	Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change	12	**12 =**	4	SD	None	Workforce	Low
Financial, Economic and Environmental Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**12 =**	12	GB	None	Financial/Assets	Moderate
18/19	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash support. developing a business case to support financial sustainability in the medium term, this plan is subject to approval and the release of capital funds. Impact financial sustainability not secured-increased regulatory scrutiny, reduced ability to meet cash requirements, inability to invest in patient care or estate.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate
06/20	Risk of climate action failure and not improving our environmental sustainability	16	**8 =**	8	SS	None	Strategic/ Organisational	Significant
2/23	Risk that the Trust cannot maximise its impact as an anchor institution in local communities to demonstrate social value	**9 !**	**9**	6	AB	None	Partnership	Significant

Area of risk exposure

REF	TOP RISKS	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**20=**	10	AB	8528, 7413	Strategic/ Organisational	Significant
TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE								
1/23	Risk re demand and capacity requiring additional beds above planned levels resulting in staffing and financial pressures.	20	**20**	12	JH	7689, 8283, 8324, 8034	Harm and safety	Low
TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY								
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16 =**	12	GB	8057	Financial/Assets	Moderate

Area of risk exposure

CHFT RISK APPETITE STATEMENT - Revised September 2023

Risk Category	This means	Risk Appetite
Strategic / Organistional	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	Where required we will make difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, local and system impact, aiming to deliver our services within our ICS approved financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commercial	We explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients and colleaguessafe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety, appropraite staffing levels and promoting the well-being of our staff.	**LOW**
Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery.	**SIGNIFICANT**

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
High Likely (5)			6/19 Compliance with quality standards =	1/23 Demand and bed capacity =	
Likely (4)			02/20 Digital Strategy =	18/19 Long term financial sustainability = 4/23 National and local performance targets = 10a /19 Medical Staffing levels = 10b/19 Nurse Staffing levels = 3/23 Partnership governance =	1/19 Approval of hospital reconfiguration outline business case and full business case =
Possible (3)			2/23 Anchor institution & social value =	1/22 Absence and retention = 4/19 Patient & Public Engagement = 04/20 CQC rating = 14/19 Capital = 11/19 Recruitment and retention = 01/20 Clinical Strategy = 07/20 Health Inequalities =	5/23 Cyber security ! 9/19 HRI Estate fit for purpose =
Unlikely (2)			16/19 Health & Safety =	6/20 Sustainability =	
Rare (1)					

= no change to risk score ! is a new risk ↓ reduced risk score

Assessment is Likelihood x Consequence

BOARD ASSSURANCE FRAMEWORK
OCTOBER 2023
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Strategic Risk appetite: Significant**		
1/19	Board of Directors / Transformation Programme Board	Deputy Chief Executive / Director of Transformation & Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration, Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE&I, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire Health & Care Partnership and Calderdale Cares Partnership and Kirklees Health and Care Partnership to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and Place based formal letters of support for the business cases. A Round Table Board is established that has members from NHSE, WY ICS, DHSC, Calderdale and Kirklees Places and meets quarterly to ensure system alignment and support for business case planning assumptions and development.	First line Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and the ICS, NHSE/ DHSC Second line Trust Board approval of business cases (SOC approved, March 2019). Reconfiguration OBC and FBC for new A&E at HRI approved by Trust Board in October 2021. Travel Plan approved by the TPB and the Green Plan by the Trust Board. Planning Permission for the new A&E at HRI was approved in September 2021. Planning Permission for the build of a Multi-storey car park and the new clincal buildings at CRH was approved by Calderdale Council in March 2022 Third line ICS and NHSE review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019. FBC for new A&E at HRI approved by NHSE Joint Investment Sub-Committee (JISC) in December 2021. Construction of the new A&E has completed and the date for opening is being planned. The Reconfiguration OBC was approved by NHSE Joint Investment Committee (JIC) on 25th February 2022. Reconfiguration OBC submitted for approval by Treasury.	• See below for further detail. 1. His Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 2. Agreement for development on the CRH site.	Work has been undertaken and presented to Transformation Programme Board (TPB) to define the skills and capacity needed for next stage of the programme to develop the Reconfiguration Full Business Case. Approval has been given to secure the necessary additional capacity / expertise. Project structures for the next phase of work have been implemented and progress is reported into the TPB each month.	**Initial**	**Current**	**Target**
								5x5 = 25	**5x4 = 20**	**5x2 = 10**

Gaps in Control	**Timescales**	**Lead**
1.Trust and ICBs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH.	1. Discussions have taken place with YAS and activity modelling and clinical protocols have been agreed. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been developed and is progressing to completion -this will require Treasury approval. 4. Build of a Multi-storey car park at CRH by 2024.	AB for all actions

Links to risk register from current service configuration:
8528 - ED operational performance
7413 - fire compartmentation risk HRI
Quarterly risk management report on the Reconfiguration Programme Risk Register to Transformation Programme Board

BOARD ASSSURANCE FRAMEWORK
OCTOBER 2023
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to lack of collaboration across the West Yorkshire system to enhance the quality and resilience of clinical services due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk	Refreshed Clinical Strategy - describes Trust position on service development across West Yorkshire (WY) Transformation Programme Board - ensures estate is aligned with the clinical strategy, which informs decisions made to reconfigure services and ensure redesigned hospital model is fit for purpose (see BAF risk 1/19 reconfiguration) ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Planned Care Alliance co-ordinates and plasn phased approach to reset, including redesign to planned care Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. Recruiting for additional Oncology staff to strengthen capacity Report into Oncology Services for WY by Mike Richards complete and supports CHFT as a hub. Independent reivew report (Dec 2021) recommends two site service model for NSO. CHFT Medical Director Chairs South sector implementation Board for NSO. Project Manager support. Target Operating Models in process of agreement. CHFT/ MYHT Partnership Board established which discusses fragile services and fosters closer working relationships CHFT partner at Calderdale and Kirklees PLACE level clinical and professional forums,Quality Forum and PLACE Boards (sub group of ICB) to agree local health priorities and strategy. CHFT Medical Director appointed as SRO for South Pathology Network	**First Line** Clinical strategy developed and shared with WEB (23.5.19.) **Second Line (Board / Committee)** Clinical strategy - Board 4 July 2019 (private), refreshed Clinical Strategy July 2021 Board approved New Pathology Partnership Update to January 2023 Board (CHFT Medical Director is SRO) LIMS implemetation progressing, CHFT planned for 2024. **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Diagnostics Board and Imaging Collaborative established across West Yorkshire	Non-Surgical Oncology (NSO) - acute system pressures across WY require additional support from CHFT. Working with MYHT to ensure short term service support in place, whilst sustainable WY solution in place. Action: Public engagment led by system partners on NSO service model commenced, ongoing autumn 2023. Industrial action impacting capacity to deliver clinical strategy WYAAT and ICS system-wide approaches to reset. Performance of CHFT in relation to Covid backlog position remains focus of work CHFT reconfiguration delays impacts timescale for service transformation - action: progressing supporting elements where possible. Trust financial deficit position may limit development of new services -see BAF risk 18/19 long term financial sustainability	Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone. Lead: David Birkenhead Timescale: 31.1.24. (dependent on completion by ICS)	3x5=15	3x4=12	3x3=9

Action	**Timescales**	**Lead**
Monitor impact of industrial action on clinical strategy progress	Ongoing	Medical Director
Progress supporting elements of reconfiguration where possible as part of clinical strategy	Ongoing	Medical Director / Deputy Chief Executive and Director of Transformation and Partnerships
Review alignment of Trust clinical strategy with ICS 5 year plan for Better Health and Well-Being for everyone	31 January 2024	Medical Director

Links to risk register: None

BOARD ASSSURANCE FRAMEWORK
OCTOBER 2023
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk Category; Innovation/Technology Risk Appetite: High**		
								Initial	**Current**	**Target**
02/20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund and deliver the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	Year 3 of 5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the next 5 year digital strategy Continued central funding available and committed capital funding from the Trust which will enable progression. Joint Director of Digital Operations and Delivery role co-ordinating digital programmes and providing leadership whilst maintaining alignment toTrusts operational needs. Year 3 of the Digital Strategy (23/24 digital/EPR plan) focuses on improving on the digital basics and optimised use of existing systmes where funding may not be available. Governance via Digital WEB and Digital Operations Board.Digital Operations Board chaired by Chief Digital and Information Officer (CDIO), with reviewed terms of reference Monthly meetings with Chief Digital and Information Officer (CDIO) and Director of Finance reviewing progress with digital investment strategy. Divisional Digital Boards ensure appropriate spend of investment and report into the Digital Operations Board which has oversight of investment in line with strategy. EPR team restructured to ensure sufficient capacity and capability, with funding to support third Trust via project. CNIO and CCIO play a key role in the Digital Prioritisation Process (part of the Digital Health Team). COO, Chief Nurse,and Medical Director supporting the direction of digital developments in line with CHFT operational requirements. Clinical Change resource in place to help aid digital adoption and deliver benefits.	**First Line:** Digital Operations Board meeting bi-monthly, programme of work and progress presented at each meeting. **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2023/24 secured. 10 November 2022 Digital Strategy Progress and Update to Board with plan to 2025. 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS. Review 10 November 2022 Board. BCAG provides assurance that digital benefits are realised and digital business cases are aligned to the Trust Digital Strategy. **Third Line:** WYAAT &WYICS Chief Information Officer meetings ensures alignment of stategy on regional digital deployment as well as availability and eligibility for central digital funding.		Availability of funding - continual monitoing of central funding available for digital investment. Lead: CDIO - ongoing	**4x3 = 12**	**4x3 = 12**	**3x3=9**
Action					**Timescales**			**Lead**		
Links to risk register see linked 1/19 reconfiguration risk										

BOARD ASSSURANCE FRAMEWORK
OCTOBER 2023
TRANSFORMING SERVICES AND POPULATION OUTCOMES

TRUST GOAL: 1. TRANSFORMING SERVICES AND POPULATION OUTCOMES										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Deputy Chief Executive	Risk of failing to respond to the health inequalities that exist within our populations due to lack of quality priorites to advance health equity, incomplete population health and patient ethnicity data, helthcare service delivery not matching patient needs in the most deprived areas or lack of resource allocation and programmes for health prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Deputy Chief Executive is the named Board Executive providing accountable leadership for tackling health inequalities. 2022-2024 Population Health and Inequalities Strategy approved at November 2022 Board with updates to Board throughout the year. Strategy focussed around four key areas of priority: Connecting with our communities and partners Access and prioritisation Lived experience and outcomes Diverse and inclusive workforce Health Inequalities Group, chaired by Deputy CEO, ensures oversight of all Trust workstreams in relation to health inequalities. Progress against delivery of Health and Inequalities Strategy reported regularly into the Trust Board. Equality impact assessment (EQIA) process for service and policy changes.	**First Line** - Trust-wide health inequalities group meets monthly and oversees the organisations action plan and response to health inequalities. Health inequalities consideration and understanding included as a core element of all services supported by the development of data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. **Second Line** - Progress against delivery of Health and Inequalities Strategy reported formally into the Trust Board on a quarterly basis (July, November 2023). Approved Board succession plan seeks to ensure clear talent pipelines for each Executive and non Executive roles in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line** The Trust is working in collaboration as part of the West Yorkshire (WY) Integrated Care Board, WY Association of Acute Trusts and WY Community Collaborative, as well as continuing to showcase work nationally.	Continue to explore approach to diversity with WYAAT and ICB colleagues to ensure a regional approach. The Trust has delivered a number of successful interventions in respective of equality and diversity including the apprenticeship programme and Project SEARCH. Work continues overseen by the Trust's Inclusion group. Lead: Director of Workforce and Development Timescale: March 2024 Update in relation to use of patient level demographic information to prioritise clinical care - methodology current being trialled within cancer pre-habilitation service. Further plans to use the tool to identify those at higher risk of non-attendance at outpatient appointments. Lead: Deputy Chief Executive Timescale: March 2024 Population Health - continue to develop place-based approach to population health information to inform service planning and decision making. Deputy CEO and Managing Director of HIS leading on this work on behalf of CHFT Lead: Deputy CEO and Managing Director of HIS Timescale: March 2024	Population Health and Inequalities Strategy (2022-24) now in place. Progress against action plan underway Update will be presented at Trust Board in November 2023	4x4=16	4x3=12=	2x4=8

Action	**Timescales**	**Lead**
Action Plan for more diverse Board and senior staffing consistent with local community and explore with WYAAT /ICBs	31/03/2024	Suzanne Dunkley
Development of tool to prioritise clinical care based on pateint demographic information to prioritise clinical care	31/03/2024	Rob Aitchison
Development of Place-based approach to population health information for service planning	31/03/2024	Rob Aitchison / Rob Birkett

Links to risk register: 2827

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
4/19	Quality Committee	Director of Corporate Affairs	**Risk** Risk that patients are not able to shape decisions about their care based on what matters to them due to lack of clear strategy and capacity for patient and service user engagement resulting in not designing services using patient recommendations **Impact** - poor patient experience - Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group (PEG) mandates the workplan and oversees progress and audit activity for public involvement and patient experience • Governor and Healthwatch are members of PEG •Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs •New Patient Experience and Engagement Strategy • Observe and Act patient observation tool as part of Journey to Outstanding reviews •Carer's Strategy approved March 2022, developed with service users and local voluntary sector organisations •Patient Story Process Map 2022 in place with a robust process for capturing, sharing, and learning through patient stories • Matron on Reconfiguration Team leads on patient experience • Complaints mapped to IMD (index of multiple deprivation) groupings • Director of Corporate Affairs Chairs Calderdale Place Communications, Involvement and Equality Group and have members on the Kirklees equivalent	**First line** Patient Experience Group Quarterly report on patient and public experience and equality to Quality Committee Examples of good practice on patient and public involvement including reconfiguration programme, children's services, carers etc **Second line** Patient Story to PEG, Quality Committee and Board Governor attends PEG Director of Corporate Affairs chairs Place Communications, Involvement and Equality Group reporting in to ICB Member of Place Based story tellers network PEG reporting to Quality Committee quarterly Keep carers caring presentation to Parliament **Third line** Quality Accounts, CQC rating of Good - report referenced positive examples of patient engagement. Healthwatch reports Recent external Government led review of accessibility of Trust website led to some actions which are now all complete	1. New Equality Delivery System 22 in place and not yet clear on the ask of providers versus that of Places. Clarity being sought with NHS England and Place lead 2. Work to do to improve compliance with Accessible Information Standard Director of Corporate Affairs to complete outstanding actions by March 2024. 3. Review of translation services contract required following patient feedback. Not clear if meeting KPIs.See action 3 below. 4. Need systematic way of capturing and reporting on patient and public engagement and its link to equality.Action:below. 5. Vacancy in Patient Experience post	Public Sector Equality Duty report was not robust for 2022/23 Action: Process agreed for key Committees to identify and populate report throughout the year to capture all relevant activity: Lead: Workforce Committee / Quality Committee Timescale: December 2023	**3x4 = 12**	**4x3 = 12 =**	**1x4 = 4**

Action	Timescales	Lead
1. Clarity on requirements of EDS2 to be sought and shared	January 2024	Chief Nurse
2. Complete actions to comply with Accessible Information Standard.	March 2024	Director of Corporate Affairs
3. Review contract with translation services provder	December 2023	Director of Corporate Affairs
4. Develop reporting databased and format for quarterly report to Quality Committee and annual report to Board (PSED report	December 2023	Director of Corporate Affairs
5. Work with story tellers network and community journalist to develop stories		Chief Nurse

Links to risk register:
No risks on the high level risk register

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE											
Ref	**OWNER** Board		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put*	**GAPS IN ASSURANCE** *(Where are we failing to gain*	**RATING OCTOBER 2023**		
								Initial	**Current**	**Target**
06/19	Quality Committee	Chief Nurse/ Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Quality governance arrangements monitor quality and safety bi monthly reports to Quality Committee for assurance , Monthly reports to Trust Patient Safety Quality Board for oversight and scrutiny • Quality and Safety strategy in place, currently under review, clinical division report into performance review meetings on delivery of the ambitions of the strategy and strengthened quality section in performance review meetings (analysis of quality and safety priorities) • Quality Committee scrutinises quality priorities with specific KPIs in place, and the Maternity Transformation Plan • Serious incident (SI) investigation process identifies recommendations to improve care with strong governance in place and process in place to address any immediate learning • Clinical Effectiveness and Audit Group (CEAG) reviews assurance on guidance and national audits • Clinical Outcomes Group monitors workstreams for patient safety and quality, reporting into Quality Committee • Risk management strategy revised and refreshed, trengthened risk management arrangements at divisional level. • Patient Safety Incident Response Framework (PSIRF) and draft investigation model that aligns with PSIRF framework implementation plan now in place, with aligned and approved Incident Reporting Policy • Board approved Infection Prevention Control (IPC) Board Assurance Framework (BAF) aligned with NHS England evidence-based framework •Compliance register refresh and scrutiny by Compliance Group • Focused Journey to Outstanding (J2O) programme • Ward assurance visits programme - clinical area quality dashboard reviewed at at Nursing and Midwifery Workforce meeting. Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry • Care of the Acutely Ill Patient programme in place to improve mortality outcomes • Nursing and Midwifery Strategy (October 2021) details minimim staffing requiremets and quality standards for patient care. • Children and Young Peoples Improvement Plan	First line Assessment of compliance with NICE guidance with increased oversight at CEAG. Performance against safety must dos reviewed at ward / matron level. HSMR & SHMI. Consistent mandatory and essential training compliance. Improved real time assurance on impact of safety staffing and quality - Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed with increased oversight at CEAG. Audit & Risk Committee deep dive 24 October 2023. Bi-monthly Quality Report to Quality Committee, QC highlight report to Board. Maternity report to Quality Committee and Board - response to Ockenden review KPIs in Integrated Performance Report, PSQB reports to Quality Committee. 6 July 2023, Board report on Infection Control and progress with IPC BAF recommendations. June 2023 signifcant assurance opinion on IPC BAF following internal audit review, Board approved Risk Management Strategy September 2023 Serious incident report to Quality Committee which includes lessons learnt section and "backlog" investigations addressed with positive feedback from CCG . Safer Staffing Hard Truths report to Board 10.11.22., 6.7.23. Refreshed Nursing and Midwifery Strategy (2021) approved by Quality Committee and Board. Maternity Services report to Board (March, May, July 2022) Complaints performance improved allowing time to focus on learning from complaints, with themes and trends identified and linked to Quality Priorities 2023/24. Ward to Board internal audit significant assurance opinion reviewed by Quality Committee (May 2023). 7.9.23. Board "True for Us" report in response to Lucy Letby case, Board development session quality and safety and PSIRF Third line CQC maternity inspection report August 2023 -retained overall good rating. CQC rating of Good, regional Ockenden Assurance Visit (28.6.22.)CQC In patient Children's and Young Peoples survey 2021 and visit 2022. Quality Account reviewed by stakeholder bodies for 2021/22 with positive feedback . Independent assurance on clinical audit strategy. Feedback through ongoing relationship with arms length regulatory bodies. CQC TMA visits have taken place in ED, Maternity, Surgical Services and End of Life Care.Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports and on site visits	Lack of clarity around quality and safety team structure and accountability, including divisional support Action: Review of quality and safety team structure Lead: Deputy Chief Nurse Timescale: Completion by November 2023 Quality priorities but gap re: Quality and Safety Strategy Action: Development of Quality and Safety Strategy Chief Nurse Timescale: November 2023 Variability in quality of divsional risk registers and understanding of their roles in risk management Action: Risk register training for divisional staff to support improved use of risk register to accurately identify risks to quality and safety of care Lead: Deputy Chief Nurse Timescale: December 2023 Ability to triangulate data to identify themes, trends and early warning signs of quality and safety issues Action: Business case for new risk management software which will triangulate data to be presented for approval October 2023 Deputy Chief Nurse	Internal audit further review of quality governance structure during 2023/24 Q3 Internal audit review of risk management processes Lead: Chief Nurse, Director of Corporate Affairs Timescale: December 2023 Gap in assurance re consistency in divisional management of quality and safety agenda Action: Quality Summit October 2023 - develop action plan for identified gaps in divisional processes - plan to confirm timescales Lead: Deputy Chief Nurse Inconsistent application of quality improvement (QI) methodology Action: Scope target audience and delivery method for QI training Lead: Deputy Chief Nurse January 2024 Integrated Provision in the community: relative immaturity of Place-based quality and safety governance and assurance and regulatory/ statutory prvider framework for integrated care. Continue to develop Place based governance infrastructure Lead: Director of Operations Community	3x5 = 15	3x5= 15 =	2x5 = 10

Action	**Timescales**	**Lead**
Review of quality and safety team structure	November 2023	Deputy Chief Nurse

Links to risk register:
Also see BAF risk re clinical strategy 1/20, 10a/19 and 10b/19 relating to staffing
8528 ED operational performance, 8429 PCI / angiogram wait, 7689 out patient, diagnostic waits, 8283 radiology demand and capacity, 7994 enhanced care nursing staff, 8429 Cardiology, 8537 complex demand special schools, 7479 children with mental health needs on paedatric wards, 6078 appointments slots, 6079 follow up out patient appointments, 7640 pharmacy (ICU), 8453 medication delays,7092 medication safety

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
04/20 July 2020	Quality Committee	Chief Nurse	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating as assessed by the new CQC single assessment framework and potential for ratings to be changed by CQC based on other intelligence or data from CQC portal outside of on site inspection of services, due to failure to comply with quality statements resulting in a reduction of quality of services to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC Group with refreshed terms of reference meets monthly, oversee compliance with regulatory standards/ -and reports to Quality Committee, monitoring progreess against 2018 must do and should do actions. Action plans in place re: must do and should do actions from 2018 CQC report, compliance with medical staffing in ED dependent on reconfigutaion and GPICS standards on critical care. Regular engagement meetings with CQC and on site focus visits taking place Process for internal assessment against CQC standards (Journey to Outstanding) Dedicated CQC lead Independent Well-led Governance development review completed. CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes (Journey to Outstanding) reviewed and updated, piloted and being rolled out. Journey to Outstanding (J20) implemented with increased breadth and depth of assurance - working towards business as usual model Focused Journey to Outstanding programme review of maternity services	**First Line:** Reports to CQC Group from divisions with increased scrutiny Journey to Outstanding results and action plan and findings shared with wards and presented to CQC & Compliance Group . Also have focused J20 process Divisional review of must do and should do actions from 2018 CQC report, September 2022 **Second Line:** CQC maternity inspection report presented to Board 7.9.23. Quality Committee reports from CQC Group and as part of Bi monthly quality report Quality Committee highlight report to each Board CQC well-led governance phase 2 report shared at Board workshop July 2021 Board Development Session 7 October 2021 on CQC effective domain. Maternity Services Update to Board 5.5.22. , review and assessment against East Kent Maternity report (10 November 2022) Caring Domain CQC Board Development Session 9.6.22. Update on CQC with Board at Board Development session, including review of quality statements February 2023 and new CQC single assessment framework 5 October 2023. **Third Line:** Formal engagement meetings with CQC and rolling programme of on site visits. Current CQC rating of "good" including well-led governance - maternity services rated as good overall in CQC maternity inspection report August 2023 Board well-led interviews undertaken by external reviewer as part of Board Development Programme CQC maternity review undertaken June 2023	Framework not yet developed at PLACE level for system / PLACE based CQC reviews under new regulatory framework. Action: progress through PLACE based Quality architecture. Lead: Medical Director / Chief Nurse Timescale: December 2023 New inspection frameworks for acute and community services published October 2023. Action: need to undertake assessment against new framework Lead: Director of Corporate Affairs	CQC maternity report August 2023 rating of requires improvement for safe Delivery of CQC action plan for 2 must do actions (training and qualified staffing levels) and 5 should do actions 2023 move to Single Assessment Framework for future CQC inspections and rating regime. Towards the end of 2023 CQC will gradually start to carry out assessments in the new way. This means a new approach to inspection and new assessment framework. In summer a new online provider portal will be lunched. This will be done in stages and provide support and guidance. In the first stage: Providers will be able to submit statutory notifications CHFT now have access to this portal and will submit notifications via this methodology for greater level of assurance Provider portal not yet published so unable to undertake review against information held	**4x3=12**	**4x3=12**	**3x2=6**

Action	**Timescales**	**Lead**
Development of CQC action plan following maternity inspection	December 2023	Chief Nurse
Journey to Outstanding implementation underway via rolling programme including focused visits	12 month rolling programme	Chief Nurse
Development of PLACE level framework for system reviews with partners	March 2024	Chief Nurse
Assessment of compliance against newly published inspection framwork for Acute Hospitals and for Community Services to be undertaken and report to Board	January 2024	Director of Corporate Affairs

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE									
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk appetite: Low (Ham and Safety)**	
								Initial	**Current**	**Target**
1/23 June 2023	Finance and Performance Committee	Chief Operating Officer	Risk that continued high acute demand, high patient acuity and shortfall in community provision leads to the requirement for additional beds over and above planned levels. This results in staffing and financial pressures.	Well Organised Ward programme and toolkit with four "must dos" to ensure consistency of fundamental actions at ward level by clincial teams. The Urgent and Emergency Care Delivery group (UECDG) is the overall assurance meeting for the delivery of Urgent and Emergency Care and reports to the Finance and Performance Committee and the Trust's Transformation Programme Board. It meets monthly to strategically review the performance of UEC delivery through the data dashboard and the improvement groups. The UECDG has two focused Improvement Groups: Same Day Emergency Care (SDEC) and Length of Stay (LOS), latter has phased reduction plan. The Improvement Groups are supported by project individual Task and Finish groups, which provide monthly data-led updates into the appropriate Improvement Group for appropriate discussion, challenge and steer. The Improvement Groups report assurance of the delivery of UEC into the UECDG. Working with partners in Calderdale and Kirklees to agree target operating models for integrated community urgent and intermediate health and care models of care (with interfaces to single points of access and neighbourhood teams). Target operating models to frame effective use of business as usual and transformation based monies aligned with Place and wider system objectives. Agreement in principle with Calderdale partners on target operating model, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap. Sept 23 - Agreement in place to use allocated funding for discharge to enhance reablement which will support improved discharge of cohorts of patients on the transfer of care (TOC) list. Recruitment and roll out underway.	**First Line** Length of stay improvement group in place meeting monthly. Separate working groups in place with clear leads that report in to the improvement group. Same Day Emergency Care (SDEC) improvement group in place , which through september and october are being supported by the external CLEAR project team. Seperate working groups with clear leads that report in to the improvement group. ED improvement workstream led by ED directorate Senior Management Team which also reports to UECDG. **Second Line** Urgent and Emergency Care delivery group chaired by COO, meeting monthly, improvement workstreams report in to U and E CDG, against identified KPI's. U and E CDG reports in to Finance and Performance committee which reports in to Trust Board. Focus through Turnaround Executive on the financial savings linked to reduction in LOS and reduced bed base. **Third Line** NHS England (NHS E) monitoring and production of reports linked to Emergency Department and bed occupancy. Monthly meetings with COO and NHSE. Calderdale and Huddersfield U and E Care Board meets monthly with community teams, ICB and Local authority representation. CHFT UECDG reports updates on workstreams in to this.	Kirklees community provision and commissioning models for that provision . Action:ongoing discsussion with Kirklees partners Lead: Director of Operations Community Michael Folan, Deputy Chief Executive, Chief Operating Officer	Absence of agreement in principle with Kirklees partners on target operating model to support increased discharge of patients on TOC list, gap analysis against and use of recurrent and non-recurrent funding to support delivery against that gap analysis. Lack of assurance re capacity and provision of social care System-wide discussions regarding programme of work focused on Home First and move away from discharge to assess beds. CHFT to continue to work with partners. Lead: Chief Operating Officer and Deputy Chief Executive Timescale: 30 November 2023	4 x 5 = 20	4 x 5= 20	4x3=12

Action:	**Timescales**	**Lead**
Use of allocated 'pot 2' funding to enhance reablement for Calderdale. Roll out of programme in alignment with recruitment System wide discussions re Home First for Kirklees.	September 23 - March 24 November 2023	Chief Operating Officer, Director of WOD and OD, Chief Nurse COO & Deputy Chief Executive
High level risks		

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
9/19	Transformation Programme Board	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Funding secured for ED HRI and MSCP CRH and in 2022/23 capital plan • Medical device and maintenance policies procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts •Premises Assurance Model (PAMs) illustrates to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, Plans in place to demolish DATs building to reduce backlog maintenance. Head of Estates and H&S lead from CHS now attend the Risk Group to align Trust and CHS risk registers • 6 monthly insepctions of cladding at HRI with report to CHS Board and Transformation Programme Board - programme of cladding works towards the end of the reconfiguration timetable supported by the Transformation Programme Board 19 December 2022 Capital has been secured for 20202/23 to meet the 2022/23 plan and requirements as agreed in the annual internal capital planning round.	<u>First line</u> • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS. Audits of routine checks, estates * Trust Health & Safety Manager with oversight of H&S across Trust & between partners. Audit of HTM Compliance to confirm appropriate control measures in place to manage the HRI and community estate completed Q1 2023. HRI A&E Build Assurance report delivered to reconfiguration core team with appendixed handover tracker and confirmation all life saftey systems commissioned & operational. <u>Second line</u> Estates strategy (revised) approved at Board 2.9.21. H&S Update to Board: January 2022. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports. Assurance provided by HTM Compliance reports via external Authorised Engineers inspections against HTM standards. WEB reports on medical devices July 2019 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI. Latest 6 Facet survey to be undertaken late 2023, covering both HRI & CRH <u>Third line</u> CQC Compliance report.PAMS. HSE review of water management. Familiarisation visits by local operational Fire and Rescue teams. External assurance from authorising engineers for high voltage/ low voltage systems.PLACE assessment (Patient-Led Assessments of the Care Environment) undertaken October 2022 by Quality Performance and Service Manager	• Multi Storey Car Park - the Trust awaits the outcome of the business case review process with HM Treasury before further progress can be made. - Implementation of ANPR at HRI & Acre Mill which will have a positive impact on patient experience with pay by app and phone, and DDA compliant payment machines. Tender approved and contractor appointed. **Go Live before Dec 23.**		**4x4 = 16**	**5x3= 15**	**2x4 = 8**
Action					**Timescales**			**Lead**		
Parking - ANPR to be introduced at HRI & Acre Mill					Complete by December 2023.			Head of Estates		
Links to risk register: Risk 7413 - Fire compartmentation risk, HRI ,8595 (flouorscopy equipment), 8161 CT scanning, 8562 Pathology, 7955 x ray, 8107 mammogram equipment, 8147 cath labs, 7970 childrens therapy (videoflouroscope)										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Regulation Risk appetite: Moderate**		
16/19 9/1/20	Audit and Risk Committee	Director Champion - Chief Operating Officer	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations resulting in harm to staff, patients, the public, visitors, potential regulatory failure, finanical risk and reputational damage	•Board approved 5 year H&S strategy NHS Workplace Safety Standards provides framework for H&S activity, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities (policy tracker written). The Strategy has been revised in early 2023 •General Health and Safety Policy (updated early 2023) clearly highlights the overarching roles and responsibilities and arrangements to achieve compliance. New lone working policy, revised COSHH policy (October 2023), with clearer process for completing COSHH assessments by key stakeholders - both ensure CHFT can demonstrate legal compliance. • Individual health and safety policies under continuous review across 2022/23 and shared with CHFT Resilience and Safety Group Meeting - each policy with individual subject matter expert ownerships • SLA in place for CHS to provide Health and Safety Induction Training of on-site contractors and visitors • Executive Director Health and Safety Champion identified • Proactive Resilience and Safety Group Meeting firmly established. • Head of Health and Safety involved in all new sub committees to H&S committee. 8 H&S subgroups formed - maintains traction upon stakeholder responsibilities • Annual report on Health and Safety to Board which is to be a combined fire, security and health and safety risk paper and presented for 2023 submission • Health and Safety with updates to Board, Audit and Risk Committee oversight and attendance to present at Quality Committee every 6 months . • Health and Safety mandatory ESR training for staff (3 years). • Auditing and monitoring of compliance via new health and safety dashboard which is presented at each Resilience and Safety Group Meeting. Desktop meetings take place between the subject matter lead and the Head of Health and Safety across the year to ensure/seek assurance of continuous compliance.	First line Minutes of the Resilience and Safety Group Meeting evidence good level of engagement by all partners. Review of Resilience and Safety Group Meeting by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information . Policy approval via Resilience and Safety Group Second line Board joint responsibility for risk understood with Weightmans Solicitor Legal update given in 2023 WEB reports on mandatory training, health and safety training compliance -Resilience and Safety Group Meeting to Audit and Risk Committee, with annual deep dive. Quality Committee engagement planned for 2022, 18 October 2022 and then every 6 months with last update in early 2023yr. Audit Yorkshire January 2021 9 January 2020 external Health and Safety review presented to Board • 2021/22 Annual Health and Safety report and action plan to Board - 12 January 2023, May 2023 • Health and Safety Strategy revised September 2022, review of 2023 - 2028 Strategy by Audit and Risk Committee 31.1.23. Updates to Board on H&S 3 September 2020, 14 January 2021, 1 July 2021, 13 January 2022, Third line External health and safety review (Quadriga) 2019.	Development and implementation of NHS Workplace Health and Safety Standards - 90% achieved (10% left = Security compliance), Lead: Head of H&S Timescale: November 2023 Embed COSHH sub group Lead: Richard Hill Timescale: December 2023.	Work continues upon the security compliance requirements, with a plan of action now written and working towards completion by early 2024yr. The action plan is cross referenced against NHS Violence Reduction Standards and the NHS Workplace Health and Safety Standards.	**Initial**	**Current**	**Target**
								3x3 = 9	**3x2 =6 =**	**3x1 = 3**

Action	**Timeframe**	**Lead**
Development and implementation of NHS Workplace Health and Safety Standards (10% remaining to do) Embed COSHH sub group Delivery of security improvement plan	November 2023 December 2023 Autumn 2023	Head of H&S all actions

Links to risk register:
7413 fire compartmentation

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
3/23	Anna Basford, Deputy Chief Executie and Director of Transformation and Partnerships	Board of Directors	Risk that decision making processes and capacity of Trust colleagues is impacted due to the evolving nature of partnership governance across the system and emergent governance arangements	Ensuring we have a voice and influence at all levels within the region and places: -Chief Executive is the Chair of the West Yorkshire Association of Acute Trusts and a member of the West Yorkshire Integrated Care Board - Chair and Chief Executive attend ICS - Chair and Chief Executive members of Calderdale Place ICB - Director of Finance has role as Finance Lead for Kirklees Place - Chief Executive and Deputy Chief Executive members of Kirklees Place ICB - Other Director and senior leadership part of governance structures and workstreams at West Yorkshire and Place levels Directors in Senior Responsible Officer roles across Places Board discussions on system governance arrangements and direction of travel Round table arrangements in place for reconfiguration decision making involving regional and local partners	**First Line** • Chief Executive and Chair reports to Board • WYAAT Reports to Board • Round table discussions reported through Transformation Board **Second Line** • Trust members in Place and Regional decision making arrangements • Shared involvement in Place based reviews including safeguarding, Ofsted etc **Third Line** • Place review	Operating Model published with consultation process leading to disruption with ICB partners and individuals	CQC system assessment framework not yet confirmed	4x4 =16	4x4=16	4x2=8

Actions	**Timescales**	**Lead**
Seek assurance on changes described in published operating model	December 2023	CEO

High Level Risk Register risks - none

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
4/23 Added September 2023	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets **Due to** Strike action; workforce gaps; partner responsiveness; activity pressures **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience -Elective recovery Funding - Reputational damage with stakeholders - clinician dissatisfaction	Clinical prioritisation of all patients on waiting lists to identify current priority status and a process for regular review of clinical need. Increased number of outcome metrics within performance reporting monitored through performance framework . WYAAT system approach to capacity management. Urgent Care System Board and ICS Discharge Forum with social care providers to plan / consider options Daily escalation of performance issues from divisional hubs into Bronze, Silver and Gold levels as appropriate. Access Delivery Group, Cancer Group, Urgent Care Delivery Group meet monthly to monitor recovery programmes, standards and waiting lists. Silver meeting has trajectory for reducing Transfer of Care list and is working through agreed actions Health Inequalities linked to elective recovery monitored at a divisional level. OPEL escalation arrangements reviewed and updated to provide clearer escalation process Performance is discussed at the Finance and Performance Committee and any areas of under performance are considered in detail or as part of deep dives Comprehensive and robust planning meetings in for the new ED, supported by a transition plan led by the Head NUrse of ED. Testing taken place regarding the configuration of the new ED prior to the move.	**First line** Daily Bronze meeting and silver when required with process to enact GOLD if needed. New OPEL levels in place Trust feeds into weekly silver meeting with partners. All areas have access to KP+ Risk registers reviewed at Divisional PSQBs & PRMs. Performance bulletin issued regularly to stakeholders Integrated Performance report focus of one WEB each month for detailed scrutiny of recovery performance and activity. Integrated Performance Report overhauled and in place using statistical process charts and NHS Digital good practice for performance reporting Elective care transformation programme relaunched **Second line** Integrated Performance Report discussed at each Board sub committee and Board of Directors Assurance on overall performance discussed in detail at Finance and Performance Committee **Third line** Routine reporting to NHS England Comparison data nationally shows Trust as one of the best performers on elective recovery and one of four Trusts achieveing all three key cancer standards Prof Tim Briggs visit demonstrated good practice in elective position and shared as an exemplar nationally Awarded elective recovery hub and community diagnostic hubs	Not meeting diagnostic wait times in some modalities - action plan in place to address re neurophysiology and ECG COO - January 2024 Strike action impacting on delivery of elective, diagnostics, outpatients and non-elective activity - Strike planning meetings in place internally and with partners COO. There is a need to model impact to date and project potential impct going forward - Ongoing Impact of the opening of the new A&E and the actions of individuals on the use of A&E unknown but could impact performance at the HRI site and overall in the short term. Modelling to be completed and impact to be monitored COO - November 2023	Still not meeting A&E wait time target of 76% by March 2024 Annual Plan doesn't achieve 92% bed occupancy Transfer of Care list significantly higher than planned 50 by end of July Inability to remove beds in line with annual plan resulting in additional financial pressures Reduction in outpatient follow-ups not yet being met	4x5 = 20	4x4 = 16	4 x 3 = 12

Actions	**Timescale**	**Lead**
Deliver action plan to address waiting times in neurophysiology and cardiology Strike action planning Undertake modelling of the impact of Industrial action on elective activity and model this going forward to enable projections Monitor impact of opening new A&E and model resulting performance	January 2024 Ongoing September 23 November 2023	Chief Operating Officer for all

Links to risk register: 8528 Emergency Department operational performance , 8324 non-compliance with elective access policy (RTT validation), 8398 colorectal surgery, 7874 colposcopy, 7689 waits (appointments, tests elective surgery)

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE

TRUST GOAL: 2 KEEPING THE BASE SAFE - BEST QUALITY AND SAFETY OF CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING October 2023 Risk category: Innovation/Technology Risk appetite: Moderate**		
								Initial	**Current**	**Target**
5/23 November 2023	Audit and Risk Committee	Chief Digital and Information Officer	Risk of an impact to the delivery of clinical or corporate services due to reduced or no digital provision resutling from a cyber attack impacting on patients via exposure of patient records, inability of workforce to access / record patient care affecting quality and safety, financial and reputational risk . (Including but not limited to Cyber vulnerability, Social engineering, malware, ransomeware, phishing emails, loss of data and DOS attacks)	Significant internal and external security technical controls including: Vulnerability Management, Threat Management, Real time threat monitoring. Dedicated Cyber team monitoring and addressing threat notifications. Incident response and recovery - Business continuity plans (BCP) for clinical and non-clinical areas in the event of no digital provision. Monitoring via national ATP (Advanced Threat Protection) service. Programme of maintenance / replacement of digital systems ensuring up to date operating systems and configurations as per NCSC guidelines. Dedicated resource through cyber security team for management of cyber security issues, inlcuding an NSCS accredited lead. Policies on the handling and storage of data, and Data Protection officer: Information Security Policy, Network Security Policy (identity and access management) & Incident reporting system Essential training for staff on information security and cyber risks via ESR & Controls on supplier systems /supplier chain security	First Line Formal certification re cyber securtiy via ISO 27001 - Information Security Standard, ITSEC manager - Cyber advisor certified by NCSC, Data Protection Security Toolkit (DSPT) compliant, Cyber Essentials compliance. Second Line Deep dive on cyber security to Audit and Risk Committee July 2023 Third Line Compliance with NHS Digital / NHS Engalnd Data Security Protection Toolkit 2022/23 External 3rd party security testing at least annually	Testing of resilience and recovery plans, BCPs etc. Action: Discussion with Emergency Preparedness and Resilience lead re testing continuity plans: Lead Rob Birkett / Sarah Rothery The ever changing landscape/threat around cyber security Lead: Keith Redmond Ongoing	Further assurance required from partner organisation with connectivity with CHFT (techincal mitigation in place) Action: Seek assurance from WYAAT / ICS / Chief Digital Information Officers partners Lead: Rob Birkett Timeframe: January 2024	**5 x 3 = 15**	**5 x 3= 15**	**5 x 2 = 10**

Action	**Timescale**	**Lead**
Testing of resilience plans	31/03/2024	Rob Birkett/ Sarah Rothery
Monitoirng of cyber threat	Ongoing	Keith Redmond
Seek assurance re: cyber security from system partners	January 2024	Rob Birkett

Links to risk register:

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk Category: Workforce Risk appetite: Low**		
								Initial	**Current**	**Target**
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to gaps in the clinical workforce (local and national challenges) **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver range of key performance indicators as defined by multiple organisations - Increased risk of litigation and negative publicity. - Poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	•Consultant Succession planning • "Grow our own" approach - through different methodologies. • CESR programme to increase Consultant workforce in appropriate specialties, Emergency Medicines scheme for overseas doctors with Royal College (Hybrid International Emergency Medicines) supports recruitment and retention. Global fellows in Radiology, •Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for Consultants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity (planning for April 2023/24 underway) • Recruitment and retention success, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals, use current staff effectvely - all new employees opted in to a bank contract (unless opt out). Elective and clinical attachment placements (attracts international colleagues) • Mitigate shortages in specialties nationally,eg Radiology by network working, explore advanced practitioner to support Consultant workforce, use external reporting for Radiology • WYAAT networking approach to pressured specialties, eg Non-Vascular Interventional Radiology, supporting MYHT with Non Surgical Oncology, Neurology • Ongoing medical staffing recruitment. Refreshed induction for trainees including EST completion, • Focus on alternative workforce models, allied health care professional roles – Physician Associates and Advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts • Medical Workforce Programme monthly meeting with wider group of stakeholders - provides an overview of the programme to ensure full visibility, shared view and tracking of all medical workforce based projects, with highlight reports from workstream leads. • Recruitment through external agencies for posts difficult to recruit to •New national contract launched for specialty doctors and specialist doctors enabling appointments at specialist level with more independence. Adopted SAS (Staff and Associate Specialists)doctor charter. •Refreshed engagement approach - eg Medical Director's Office created well-being talks, SAS Forum, Junior Doctor Forum , Consultant and SAS body informal catch up events October 2023 •SAS asdvocate appointed and new SAS tutor appointed - support more effective engagement with SAS cohort • Enhanced reporting data (eg sickness absence, staff in post by grade/specialty, turnover, vacacncy, retention) enabling a more robust view of medical workforce status. E-rostering provides understanding of rota gaps and workforce required, new e-roster lead in post, 2023/24 approach to Clinical Excellence Award discussed and agreed with Local Negotiating Committee to support retention of long standing Consultants	First line Staffing levels, training & education compliance reported and review through departmental and divisional governance structures. Escalation of any short term gaps to Bronze tactical meeting/ internal command arrangements. Weekly meeting between Divisional Directors and Medical Director's Office (with COO attending) to enable sharing of information. Roll out of new approach to sharing training data across Trusts for junior doctors IPR with key KPIs including sickness levels, and agency spend, with monitoring of spend. Weekly divisional medical staffing meetings to optimise fill rates. Medical workforce steering group meetings re-launched Significant Consultant recruitment across a number of specialities, especially within ED. Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – net recruitment gain of 39 wte medical and dental posts from September 2022 to September 2023. Turnover remains under 10% to August 2023 (7.73%) Medical Appraisal and revalidation report to Board, September 2023 Guardian of Safe Working Hours annual and quartely report to Board. Refresh of Recruitment Strategy Medical Workforce Programme Update to Workforce Committee Third Line GIRFT benchmarking tool RAG rates workforce establishment position Plans discussed with NHS England Assurance process with CQC colleagues - feeback from relationship with arms-length bodies GMC Report on Junior Doctor Experience GMC Employer Liaison Meeting with Responsible Officer / Medical Director Local Negotiating Committee (with BMA in attendance) regular engagement to raise any concerns regarding medical workforce.	Medical e-case rostering delivery team business case to Business Case Approvals Group November 2023.Deputy Medical Director by November 2023 Dependence on HEE allocation of trainees. Continued junior doctor and Consultant body industrial action (independent and combined). Monitor outcome of indicative ballott for SAS cohort of doctors. Action: Pre-strike planning including clinical activity risk assessment, responding to changing legal position (eg re use of agency staff), registers and contract notifications of deductions. Lead: Medical Director. Director of Workforce and OD/ Chief Operating Officer	Short term sickness absence may be under-reported by medical staff. Action: Divisional directors to monitor and manage. Working Together to Get Results sessions to build on success of embedded Physician Associate scheme by providing development opportunities and additional support to junior doctor rotas and aid retention. Lead: Deputy Director of Medical Education Timescale: Plan to be developed into 2024 Develop business case for lead Physician Associate - on hold due to industrial action and "go see" of other organisations: Deputy Director of Medical Education 2024.	**4 x 4= 16**	**4 x4=16 =**	**3 x 3 = 9**

Action	**Timescales**	**Lead**
Business Case for lead Physician Associate to Business Case Approval Group Industrial action planning, including clinical risk assessment and responding to changes in legal position	November 2023 Ongoing	Deputy Medical Director Director of Medical Education Becky Colwill, Medical Education

Links to risk register:
7078 medical staffing, paediatric medical staffing (7637, 8072, 6100), 8277 Neurology, 8508 + 8509 Opthalmology (Glaucoma), 8490 Neurology (delayed in patient review), 6035 (Neurology in patients), 7454 Radiology,
8006 Tier 2 Obstetric & Gynaecology rota, 8259 Obstetric medical cover, 7454 Radiology, 8315 Paediatric Opthalmology+A3

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2023 Risk Category: Workforce Risk appetite: Low		
								Initial	Current	Target
10b/19 2021/22	Workforce Committee	Chief Nurse	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing and midwifery staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Senior nurse staffing meetings twice a day, 7 days a week. •Senior nurse leadership rota provides ongoing visibility and dialogue across clinical areas, supporting staffing escalation • Adherence to best practice rostering processes. OPEL safer staffing actions cards. •Internal pay enhancements profroma developed to support response to workforce pressures • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, •Local Nursing and Midwifery retention strategy developed in line with national recommendations and high impact actions initiated, approved November 2022. • Flexible approach to maternity staffing includes RN working in maternity services •Maternity specific escalation plan to manage staffing issues and mitigate risk •Maternity Transformation Programme Board has oversight of 3 year maternity delivery plan and associated actions to manage risk, including staffing •Apprenticeship Strategy in place to support career pathways into nursing, midwifery,AHPS • Utilisation of bank and agency staff in place, managed and escalated through a Standard Operating Procedure. 20% bank enhancements continues for registered workforce to encourage uptake of shifts. • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Role of the Clinical Site Matron and responsiblity for tactical command • Journey to Outstanding (J2O) processs, reviewers provided with information on staffing levels, eg ward information on vacancies and fill rates re; falls, pressure ulcers and friends and family test which will include an assessment of staffing levels. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes, People Strategy in place to support colleague health and well-being in line with national People Plan priorities • Quality and Safety oversight meetings in place for clinical areas where concerns exist on nurse sensitive indicators. • Safe staffing information presented to the Workforce and Quality Committee, • Nursing and Midwifery, AHP Workforce Steering Group, meet monthly with an overview of recruitement and retention strategies supported by Business Intelligence dashboard identifying progress and hotspots for consideration. • Safe, Sustainable and Productive Staffing meeting meets alternative weeks which focuses upon the quality metrics associated with the staffing postion (Enhanced Dashbaord Metric)	First line Twice daily staffing meetings provide an on the day repsonse to staffing position, responding to areas of escalation (red flags) and agreeing actions to mitigate the curent position. This meetings also determines the agree OPEL safer staffing postion. Clear esclations to the Associate Directors of Nursing rota and approval sought for Tier 3 agency to mitigate unresolved staffing position. Alternative week review of the Enhanced Dashboard Metric that tracks CHPPD/FIll Rate and a number of staff metrics to track any potential harm as a result of staffing position Annual and bi-annual safer staffing reviews of Nursing and Midwifery staffing levels provides assurances of the current workforce models or provides a rationale/evidence base for change. This approch is reflective of best practice in adopting triangulation of safer staffing metrics. Business Intelligence dashbaord provides monthly review of vacancy position, identifying potential hotspots and identification of any futher actions required to respond to the staffing position. The activity undertaken within the Nursing, Midwifery and AHP Steering Group which has a workplan focused upon responding to the insufficient staffing position by determing programmes of work related to recrutitment and retention and compliance with a number of metrics Clinical Site Matron summary site reports which provide assurance of site staffing postion and action to respond to any concerns,. Second line Monthly performance meetings (PRM) review workforce reports as well as introduction of corporate PRM Workforce Commitee receives updates on recruitment and retention issues for both oversight and scrutiny Twice yearly report to Workforce Committee, Quality Committee and Board of Directors for both oversight and scrutiny and assurance (January and July) KPIs embedded in Integrated Performance Report. J20 reports presented to divsional PSQB providing an assessment of the staffing position Workforce Committee undertakes deep dive of this identified risk to confirm key controls are clearly identifeid and assurances are robust and comprehensive Third Line Performance reported into NHSE. Assurance process with CQC colleagues - feedback from relationship wth arms-length bodies Maternity CQC report from visit June 2023 confirms leaders had responsive approach for managing midwifery staffing shortages to mitigate risk.	Insufficent workforce availability to meet demand above core bed base and in community services. Action: Ongoing use of bank and agency staff and derogated staffing models in place as per OPEL action staffing cards. Unable to control use of extra capacity wards Action: Engagement in length of stay improvement work and nursing representative at tactical meetings to manage staffing position Lead: Associate Director of Nursing Resilience, Acute Flow and Transformation Directorate National shortage of registered midwives impacting on staffing recuritment pipeline: Action: Commissioning use of the birth rate plus tool, revised workforce models in line with current birthrate, international recruitment	CQC maternity report (August 2023)- requires improvement for safe domain. CQC action plan in response to safe "must do" re qualified staff for monitoring by Maternity Transformation Programme Board. Director of Midwifery Understanding data re:vacancies at Band 6 and above to drive recruitment and workforce development Action: Progress development of the local workforce dashboard Lead: ADN Coproate Nursing Discussion with Nursing, Midwifery & AHP Workforce Steering Group re: risk 6345 nurse and midwifery staffing and review impact on BAF score at update 3 January 2024 December 2024 Need for discussion on skill mix issues created by a combined effect of high proportion of new graduate nursing workforce and internationally educated nurses Action: Learning needs analysis and training and education delivery plan by March 2024 Lead: ADN Corporate	4x4 = 16	4x4 = 16	3x3 = 9

Action	Timescales	Lead
Implementation of CQC must do action for maternity re staffing	See action plan	Director of Midwifery
Use of bank and agency staff to meet demand	Ongoing	ADN Corporate Nursing
Length of stay improvement work and invovlement in tactical meetings re staffing	Ongoing	Deputy Chief Nurse
Review scoring of risk 6345 on nurse staffing and BAF risk score with Workforce Steering Group	December 2023	ADN Corporate Nursing
Learning needs analysis and training and education delivery plan	March 2024	ADN Corporate Nursing

Links to risk register:
Risk 6345 - nurse staffing risk, 6911 midwifery workforce, 7994 enhanced care nursing staff,

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant**		
11/19	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale.	• Recruitment strategy embedded and forms part of People Strategy • Recruitment events in place for 2023/4 – 4 large scale events to take place • Review of social media approach • Expanded International Recruitment pathways • Initial review of inclusive recruitment processes undertaken • Values based recruitment and selection training now face to face • Internal career planning guidance document to support 'grow our own' being developed • Progressed into implementation phase for values based recruitment • OD Plan developed • Deployed a screening tool for values and behaviours as part of the onboarding process. • Board to agree Succession Planning approach which links to co-ordinated talent management pipeline programme including Empower programme and Enhance talent approach • Inclusive Leadership is one of the modules within our core Leadership Development programme. Each module is a three hour education session with action to implement practical application of the learning. Check in sessions will then be held to collate evidence of the application which will enable the organisation to monitor the growth of inclusive leadership. • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • Focused recruitment and retention work through medical, nursing and AHP workstreams provides an opportunity to review traditional methods of recruitment which includes looking at alternative roles • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Refreshed our values and behaviours - to be incorporated in values based recruitment • Workforce design methodology developed to support with workforce remodelling and reconfiguration • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. • Further work undertaken to widen Trust welcome, induction and onboarding. This will be followed by further work to embed colleague journey after day one	<u>First line</u> • Clinicians leading of transformation programmes • Recruitment to key roles across the Trust - see BAF risk 10a • Workforce Committee reviews key workforce indicators at its meetings • CHuFT Awards - 300+nominations from a range of grades, Divisions and specialisms colleague to colleague nomination • REN happy with progress made on inclusive recruitment • Values Based Recruitment <u>Second line</u> Integrated Performance Report and Workforce Committee reports show Turnover of 7.62% Results of Medical turnover review discussed at Executive Board. Reduction in vacancies to 405.32 Revalidation report to Board. Monthly Workforce Monitoring data including recruitment KPI reviewed by WOD <u>Third line</u> GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT Trusts.	• Lack of comparative workforce data for medical and AHP staff groups compared to nursing, due to the delayed implementation of e-rostering. **ACTION**: Complete Medical roll-out by March 2024. • Review of inclusive recruitment approaches **ACTION**: further work to be undertaken to embed inclusive recruitment by March 2024.		**Initial**	**Current**	**Target**
								4x4 = 16	3x4 =12 =	3x3 = 9

Actions	**Action, Lead, Timescales**	**Lead**
Further work to be undertaken to embed inclusive recruitment	31/03/2024	Suzanne Dunkley
Complete roll-out of e-rostering for Medical and AHPs	31/03/2024	David Birkenhead/Lindsay Rudge

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT

TRUST GOAL: 3. INCLUSIVE WORKFORCE AND LOCAL EMPLOYMENT											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk Category: Workforce Risk appetite: Low**		
								Initial	**Current**	**Target**
1/22 June 2022 refreshed June 2023	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of colleague absence and retention rising due to: increasing demands and requirements for health and wellbeing offers that are not appropriate, not accessible, not embedded or not affordable; and/or inability or unwillingness to attract develop and retain compassionate and inclusive leaders who are able to succesfully lead their teams through sustained periods of change **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / Quarterly Pulse Survey	• Workforce and OD Wellbeing and Engagement teams in place • Clear responsibility for wellbeing and engagement in Assistant Director of HR portfolio. • Employee Assistance Programme through CareFirst • Friendly Ear Service • 50 Health and Wellbeing ambassadors to engage with colleagues across all services areas as investing in employee wellbeing • Health and Wellbeing Risk Assessment available to all colleagues. • Development of new Workforce Psychology offer • Appreciation week held w/c 22 May 2023 • Financial wellbeing resources currently in development • Refreshed guidelines on wellbeing hour • Weekly Wellbeing advisor walkarounds • Suicide prevention resource pack • Revised appraisal documentation with greater emphasis on health and well-being • Place-based funding for colleagues to access fast track MSK treatment. • Refreshed People Strategy and values and behaviours • 4 Hot Houses per year • Leadership conferences • 9 point plan for moving to a engagement score of 7 which is monitored by Workforce Committee. • External validation of our staff survey action plans and reflecting on results. • Colleague engagement focused on listening events, friendly ear and supportive events to engage colleague offering over difficult few years. • Leadership visibility / walkarounds carried out by senior colleagues • Weekly Communication to staff by Chief Executive with Q&A session: operational update(Mondays), CHFT LIVE meeting (Wednesdays), Chief Exeutive Update (Fridays) • Freedom to Speak Up (FTSU) Guardian and ambassador network • CHuFT awards and monthly Star Award • One Culture of Care checklist to aid visibility visit and provide consistency • Colleague engagement groups, now expanded to include following networks: Women's Voices, Armed Forces, Carers, International Colleagues in addition to REN network, Colleague Disability Action Group, Pride. Network chairs meet regularly to share best practice. • Equality, Diversity and Inclusion events • Executive buddies assigned to staff survey hotspot areas • Appraisal workshops held • Activity being aligned to the NHS EDI Long Term Plan • EDI objectives now in appraisals	First line Monthly workforce monitoring meeting reviews all workforce data sets Increase in completed appraisals in 2022/23 Monthly absence review meeting Second line Sickness absence metrics reported to every Board meeting via the Integrated Performance Report. Quarterly metrics provided by CareFirst. Workforce Committee reviews progress on engagement with health and wellbeing activities / programmes. PRMs monitoring roll out of staff survey actions Staff survey 2022 results and high impact actions presented to Board May 2023. Deep dive of risk to Workforce Committee People Heat Map Third line Quarterly People Pulse survey/ national staff survey Sickness absence benchmarking data through Model Health and Public View systems		Lack of assurance of the progress being made with hotspot areas from Staff Survey results. **ACTION**: Targeted plan for hotspot areas by June 2023. (update pending).	3x4 = 12	3x4 =12 =	1x4 = 4

Action to address gap in control	**Action and timescale**	**Lead**
Targeted plan for hotspot areas	Dec-23	HR Business Partners

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023** **Risk Category: Financial / Assets** **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
14/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability not secured - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Business Case Approval Group, including forecasting and cash payment profiling. Prioritised capital programme agreed as part of 2023/24 financial plan. Historic delivery of the capital plan. Contingency set within annual plan Transformation Programme Board has oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience. Senior Finance participation in West Yorkshire Integrated Care System Capital Group which meets regularly to review capital forecasts from all partners to manage regional capital envelope and reports to ICS Finance Forum. Horizon scanning for external funding opportunities and bids for funding regularly submitted where these align with strategic objectives and managing risk.	<u>First line</u> Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes <u>Second line</u> Strategic outline case for reconfiguration approved by NHS E . <u>Third Line</u> Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Lead: Director of Finance Action: Representation to key bodies re: securing appropriate funding.	5 year capital plans submitted to ICS but longer term funding allocation process is still to be agreed by ICS partners. Lead: Director of Finance – Backlog maintenance costs will remain in excess of planned capital spend. Action: Internal capital spend is prioritised on a risk basis. Price not yet agreed for CRH reconfiguration works and remains subject to change. Progressing elements where possible, Approval of Full Business Case Lead: Chief Executive, Director of Partnerships and Transformation and Director of Finance Treasury approval of reconfiguration business case Action: Close monitoring of Treasury plans via NHS E on behalf of Trust	**4x5 = 20**	**4x3 = 12**	**3x4=12**

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through Finance &Performance Committee and Board	Ongoing	Director of Finance

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY											
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023** **Risk Category: Financial / Assets** **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (achieving financial breakeven and providing value for money) due to the size of the underlying and current financial deficit and reliance on cash suppport. Whilst the Trust is developing a business case to support financial sustainability in the medium term, this plan is subject to approval and the release of capital funds **Impact** - financial sustainability not secured - increased regulatory scrutiny - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities - Joint Financial Recovery Group set up following review of PLACE based arrangements with partners Budgetary control process with increased profile and ownership Turanround Executive (meets weekly, with Deputy Chief Executive Chair) monitoring cost improvement plan delivery in year and development of 5 year cost improvement plans. Accurate activity, income and expenditure forecasting Development of 25 year financial plans in support of Business Case Standing Financial Instructions set authorisation limits, Audit and Risk Committee in place to monitor key areas of compliance. Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes.	<u>First line</u> Reporting on financial position, cash and capital through divisional Boards, Performance Review meetings and Exec Board monthly. Capital Management Group meeting receives capital plan update reports <u>Second line</u> Scrutiny at Finance and Performance Committee and Board. Reports on progress with strategic capital to Transformation Programme Board. Board Finance reporting.ICS submitted balanced financial plan for 2023/24 with risks clearly articulated to NHSE. Internal audit report on efficiencies - significant assurance April 2022. WYAAT Board to Board event September 2022 re: efficiency identified themes for new WYAAT strategy. <u>Third line</u> NHSE deep dive of financial position 7 June 2023. ICS Director of Finance assured re Trust financial management systems.–Report received and action plan developed pending final sign off and adoption by ICS. Monthly return to NHS E and	Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. Project Echo reliant upon external approval to progress. Action: Continued liaison with regulator and HM Treasury Lead: Chief Executive Limited additional revenue costs have been included for the development of the Reconfiguration Business Case.	Joint Financial Recovery Group requires further work to fully embed alongside wider PLACE based working. Action: Development of plans to drive efficiences across the Kirlees and Calderdale PLACE Lead: Partnership reps, CHFT Director of Finance, Director of Transformation and Partnerships, Chief Operating Officer Timescale: September 2023	5x5 = 25	4x4 = 16	3x4=12

Action	**Timescales**	**Lead**
System financial recovery plans to be developed led by external resource	Mar-24	Director of Finance

Links to high level risk register risks: Risk 8057 relating to financial position.
See BAF risks 10a and 10b re workforce shortages

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023 Risk Category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	Risk of climate action failure and not improving our environmental sustainability, including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS who is the Trust's lead for climate and sustainability. Connected into a range of West Yorkshire sustainability groups involving the WY Combined Authority, WYAAT and local Councils. System working - MD CHS Climate Commissioner for Kirklees Climate Commission to respond to the climate emergency across Kirklees and member of Calderdale Council Climate Action Group, developing a climate action plan for Calderdale. Green Plan approved and in place, aligned with ICS Green Plan, aims to reduce the impact of travel on the environment and reduce carbon emissions Green Planning Committee (meets monthly,attended by internal and external partners) chaired by MD CHS oversees delivery of sustainbility action plan, dashboard monitors the impact of the Green Plan, reports to Transformation Programme Board on quarterly basis. Travel Plan in place to support more active travel, less car use and more car sharing, Travel Co-ordinator monitors progress. Reconfiguration design and build principles led by a sustainability design brief and overseen by Transformation Programme Board. Green solutions - eg remote temperature monitoring at parts of HRI to reduce energy cost and carbon emission. Green solutions integral to HRI A& new build, eg air source heat pump for renewable energy, permeable paving, due to achieve excellent BREEAM sustainability rating Carbon Literacy Training of CHS senior management team. 100% energy bought from green sources and installation of LED lighting to reduce energy consumption. Light swtich off campaign. Signed up to NHS pledge to reduce plastic usage in hospital . Recycling awareness raising with staff to encourage correct waste disposal Asset tracking ensures live track of equipment and reduces wastage. Procurement Strategy ensures minimum 10% wighting for socal value wighting in all prucrement . Funding bids to support sustainable activities by CHS, eg Salix Low Carbon Skills Fund for the development of the Trust's Heat Decarbonisation Plan. Digital Strategy supports sustainability - eg out patient transformation such as remote out patient appointments reduces travel, patient initiated follow up.	<u>First line</u> <u>M</u>onthly monitoring of the Trusts energy consumption Quarterly Update on progress with Green Plan and Sustainability Plan, via newly developed Green dashboard of key indicators to Transformation Programme Board. 44 of 47 travel plan actions complete. Green Plan - 163 of 206 actions complete. 12 month Trust-wide environmental calendar with focus on sustainable activities. <u>Second line</u> 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at 6 May 2021 Board meeting, following reviewed by Transformation Programme Board 8 March 2021. Green Plan shared with ICS. 2. Annual Board paper on sustainability/climate change, July 2023, May 2022 2022/23 Trust Annual Report details progress with sustanability. <u>Third line:</u>Share energy data records with NHS E on new NHS energy data platform	QIA sustainability impact assessment procedure to be reviewed along with business case applications for capital projects over £50,000 to ensure that sustainability is considered in business cases. Lead: Stuart Sugarman via Environmental Co-ordinator Timescale: June 2024 Lead: Stuart Sugarman Timescale to December 2024 Increase number Electrical Vehicle (EV) chargers: Lead: Stuart Sugarman Timescale: Multi Storey Car Park at CRH once built	CHS to present Green Plan and Travel Plan to Joint Overview & Scrutiny Committee on behalf of Trust. Lead: Stuart Sugarman January 2024	**4x4 = 16**	**4x2 = 8**	**4x2=8**

Action	**Date**	**Lead**
12 month environmental calendar and activities	Jan - December 2024	Stuart Sugarman
Increased number of EV chargers	Once muli-storey car park at CRH built	Stuart Sugarman
Review QIA procedure and business case applications re sustainability	01/06/2024	Stuart Sugarman via Environmental Co-ordinator
Green Plan to Overview and Scrutinty Committee	January 2024	
No related risks on high level risk register		

BOARD ASSURANCE FRAMEWORK
OCTOBER 2023
FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL, ECONOMIC AND ENVIRONMENTAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2023** **Risk Category: Partnership** **Risk appetite: Significant**		
								Initial	**Current**	**Target**
2/23	Transformation programme Board	Deputy Chief Executive / Director of Transformation & Partnerships	**Risk** Risk that the Trust cannot maxiimise its impact as an anchor institution in local communities to demonstrate social value in employment, career and development opportunities from investments and use of resources due to competing priorities and lack of partnership working **Impact** unable to support broader economic and social development as required under new NHS Provider Licence	Transformation Programme Board has oversight of Trust work to support generation of social value and economic support in our local Places. The Trust has developed a social value action plan in relation to its major capital investments and is monitoring delivery against specific projects within the estate investment programme. Trust 1 and 5 year strategy aligned to ICS and 2 Place strategies, with specific strategic objectives re sustainability with progress reported to the Board quarterly . Trust Chief Executive and Chair are members of Calderdale and Kirklees Place based Integrated Care Boards. Director memebrship of Calderdale and Kirklees Health and Well Being Boards and therefore contribute to Place and WY ICS strategy. Strategic collaboration with Huddersfield University development of Health Academy for the local area - regulatr meetings and partnerhsip projects, e.g. Community Diagnostic Centre. Collaboration with Calderdale and Kirklees Further Education Colleges and voluntary sector to increase routes into employment in our local Places, e.g. T -Level Cadet Pathway. Widening Participation Team promote activities for disadvantaged young people, work experience placements, Project Search. Apprenticeship schemes. Work with the Purpose Coalition to tackle challenges facing patients, customers, colleagues and communiities and map Trust activities against the Purpose Goals.	**First line** Reconfiguration leadership team. HRI Project team manages social value for A&E delivery **Second Line** Transformation Programme Board highlight report to Board Progress report on strategic objectives to Board **Third Line** Updates to West Yorkshire ICS on social value generation via capital invetstment and use of local supply chain. Update to Calderdale Place-based Committee on social value quarterly. Levelling Up Impact Report from Purpose Coalition confirms Trust commitment to being a purpose-led organisation and plays a central role in its communities beyond healthcare service.	Communication and engagement of wider colleagues and partners of this work to inform and shape actions. Action: Share Levelling Up Impact Report and seek feedback on further opportunities to work with partners Lead: Deputy Chief Executive & Director of Transformation & Partnerships Timescale: March 2024 Stretch Trust performance as a local employer and anchor partner by implementing the recommendations of the Purpose Coalition. Lead: Oversight by Associate Director of Strategy Timeframe Update December 2023:	December 2023 update on progress with recommendations of the Purpose Coalition to WEB Lead: Associate Director of Strategy	3x3 = 9	3x3 = 9	3x2= 6

Action	**Timescale**	**Lead**
Share Levelling Up Impact Report and seek opportunities to work with partners. Implement recommendations of the Purpose Coalition as local employer (3) and anchor partner (2)	31 March 2024 March 2024	Deputy Chief Executive & Director of Transformation & Partnerships, Associate Director of Strategy

Links to high level risk register: None. See related BAF risk 3/23 re partnership duties, 6/20 sustainability, 7/20 health inequalities

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCIO	Chief Clinical Information Officer
CNIO	Chief Nursing Information Officer
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CHS	Calderdale Huddersfield Solutions LTD
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HPS	Huddersfield Pharamcy Specials
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ICB	Integrated Care Board
ICS	Integrated Care System
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators

Outline Business Care
Overview and Scrutiny Committee
Private Finance Initiative

TMA	Transitional Monitoring Approach
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
DHSC	Department of Health and Social Care
IPC	Infection Prevention Control

	New risk
	Breach of risk appetite/ risk exposure
1-6	Low risk
8-12	Medium risk
15-25	High risk

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
JH	Jonny Hammond, Chief Operating Officer
RB	Rob Birkett, Chief Digital and Information Officer
AM	Andrea McCourt, Company Secretary
VP	Victoria Pickles, Director of Corporate Affairs
SS	Stuart Sugarman, Managing Director CHS
BB	Brendan Brown, Chief Executive
RA	Rob Aitchison, Deputy Chief Executive
LR	Lindsay Rudge, Chief Nurse
KA	Kirsty Archer, Director of Finance
ALL	All Board members

23. High Level Risk Register

For Review

Presented by Victoria Pickles

Date of Meeting:	Thursday 2 November 2023
Meeting:	Board of Directors
Title:	High Level Risk Report
Author:	Saj Rahman, Risk Manager
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group; Audit and Risk Committee
Purpose of the Report	The purpose of this report is to provide an overview of the risks scoring fifteen or more.
Key Points to Note	**Introduction** High level risks have the potential to impact on the entire organisation. Risks are identified and added to the risk register by colleagues across the organisation. Each division has a governance group in place that looks at all risks scoring 12 or above plus any new risks. Those scoring more than 15 are reviewed at the Trust wide Risk Group and if accepted are included on the High-Level Risk Register (HLRR). Where a risk presents a risk to the delivery of the Trust Strategy, either individually or as a collective, this is included on the Board Assurance Framework. **Current risk process** The Trust continues to manage and document risks using a bespoke risk register. When a risk is identified, the risk and impact on patient care is documented and then reviewed by the relevant department and division. All the appropriate information, including all mitigating actions to ensure the safety of patients and staff is maintained, is included. The Trust uses the information to not only track potential risks, but it also helps to inform local planning, management decisions and priorities and most importantly, share learning Trust wide. The current risk register system is not fit for purpose and is problematic in terms of being able to report on, theme and track risks. A business case has recently been approved to procure a more holistic risk, incident, and performance system as part of the preparedness work for the new patient safety incident reporting framework. This new system will enable risk triangulation and provide easier, clearer more comprehensive reporting to Board and its committees. In the meantime, 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. Risk training has been delayed due to vacancies within the risk team, but a training programme has been developed and approved and is now being rolled out.

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 49 high scoring risks on the Trust risk register (see details at the end of the report:

- 10 are scored as very high.
- 39 are scored as high.
- All risks have been recently reviewed and the mitigations (progress) updated
- Of the 49 risks, four have had their risk scores reduced whilst two have had their risk score increased.

Each risk is aligned to one of the Trust's strategic objectives. Against each of these 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, and radiology. Risks describe the Trust's ability to meet the care hours per patient day and delays for induction of labour.
  - Several risks in relation to meeting targets and waiting times including; emergency care standard, Percutaneous Coronary Intervention, angiogram waiting times, and national radiology targets.
  - There is a risk due the capacity available to validate outpatient appointments.

There are some clear themes across the risks on the HLRR:

- 16 risks related to staffing, either in relation to fragile services or about recruitment challenges in certain staff groups.
- 11 risks are about demand and capacity, particularly in outpatient specialties or in diagnostic services
- Six 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

There are refinements to be made to the current reporting process which will be done in advance of the next report. 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.

EQIA – Equality Impact Assessment	Risks are assessed considering any impact on equality.
Attachments:	**Appendix 1**- All risks scoring 15 or more.
Recommendation	The Board is asked to **CONSIDER** and discuss risks scoring 15 or more report and note the ongoing work to strengthen the management of risks.

Appendix 1 – All Risk scoring 15 or more

Risk Level	Risk No	Division	Directorate	Department	Objective	Risk Summary	Current Risk Score
Very High	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.	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	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.	20 4 x 5
Very High	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.	20 4 x 5
Very High	8324	Corporate	Planned Access and Data Quality	RTT Validation	Keeping the base safe	There is a risk of high volume of outstanding clinical outpatient validation and prioritisation on Mpage system.	20 4 x 5
Very High	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.	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	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	16 4 x 4
High	8562	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of Enforced removal of Siemens Track within the Biochemistry Department.	16 4 x 4
High	8161	Family & Specialist Services	Radiology	CT	Keeping the base safe	There is a risk of being unable to provide a CT scanning service in the event of a fatal breakdown of the CT scanner at Calderdale Royal Hospital due to the age of the equipment.	16 4 x 4
High	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	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.	16 4 x 4
High	8384	Family & Specialist Services	Pathology	Blood sciences	Keeping the base safe	There is a risk of disruption to transfusion service due to staffing levels	16 4 x 4
High	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.	16 4 x 4
High	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.	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	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.	16 4 x 4
High	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.	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	6100	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Keeping the base safe	There is a risk of providing safe care due to not enough paediatric consultants in post	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 possible 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 videofluroscopies 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	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.	15 3 x 5
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	7874	Family & Specialist Services	Women’s services	Gayne	Keeping the base safe	The risk of delayed diagnosis of due to waiting times of 17 weeks for colposcopy and 10 weeks wait for hyst 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	8107	Family & Specialist Services	Radiology	Mammography	Keeping the base safe	There is a risk of delay in reporting mammograms due to Mammography scanning equipment at the end of its life span.	15 3 x 5
High	8417	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 at CRH/HRI) due to potential breakdown of the injectors (old age) resulting in the Inability to diagnose the source of a bleed in a critical situation.	15 3 x 5
High	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.	15 3 x 5
High	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.	15 3 x 5
High	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.	15 5 x 3
High	8398	Surgery & Anaesthetics	General and Specialist Surgical Services	Colorectal	Keeping the base safe	There is currently a risk of high volumes of patients awaiting a follow up appointment within Colorectal surgery due to increased referrals post covid and historical patients waiting for their appointments.	15 3 x 5
High	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.	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	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	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%.	15 3 x 5
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	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.	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

Extreme and Major Risks (15 or over)

10/10/2023 14:30:39

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	Risk No	Div	Dir	Dep	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
Very High	7454	Family & Specialist Services	Radiology	Main X-Ray	Apr-2019	Active	Keeping the base safe	Objective: Service Delivery Risk Risk: Risk to Radiology service provision Cause: A reduction in Consultant capacity • Difficulties in recruiting clinical staff Effect: A reduction of cover in some specialist areas and overall general capacity Impact: Potential of breaching national targets	- Agency Sonographer cover (This Is My...). - NHS Locum cover. - IR: Daytime support from neighbouring organisation (1 day per week); reconfiguration completed in November and now sharing OOH cover with WYVAS. - NHS locum and Bank locum in place providing block cover (x weeks on/ x weeks off). - Head & Neck - part time consultant in post, US scanning supported by locum sonographer - Additional reporting support from external providers. - Neuro: Additional reporting support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts. - Global Fellow in place (Paeds) - Leaving in November 2022. - Support from BHFT and Mid Yorks in exceptional circumstances (e.g. NAI's/reporting).	Vacancies in all areas, including: - Intervention: Gap when contracted NHS Locum is on annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave. - Paediatrics. - Head and Neck (i.e. biopsies).	15 3 x 5	20 4 x 5	1 1 x 1	- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all required areas. - Existing consultants working through competencies to enable coverage of gaps. - Outsourcing increased to free up capacity where possible. - Locum support employed when available e.g. breast radiologists - Appointed a NHS Locum Chest Radiologist. - Chest substantive started April 2022. - New starters join on-call rota. - Recruited an additional Global Fellow due to start in 2022 - date tbc. - Advertised for Paediatric Consultant Radiologist. Interviewed and post offered and accepted. Candidate gave backword.	Confirm & Challenge Meeting 17/5/2023 Present: SS, SRF, NV, LH, GE, TO, SD, NB, SC, LR Update required include overseas programme, keep at score of 20 June 2023 Update: Bids submitted to participate in CDC International Recruitment Program for Radiologists, awaiting confirmation of approval. Currently seeking approval of four Radiologist on Trac. July 2023 - Confirm & Challenge Meeting Attending: SS, JE, CG, GE, LR If recruitment to 4 other roles on TRAC, the score will likely come down	Oct-2023	Mar-2024		DB	Stephen Shepley	Sarah Clenton
Very High	7078	Corporate	Medical Director's Office	Operational	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	9 3 x 3	• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	Number of specilist posts recruited to. Specialty doctor posts have been offered in Neurology, Gastroenterology, Stroke Medicine and Emergency Medicine. These are all individuals that have expressed an interest in progressing through the CESR process to attain specialist registration which will enable them to become consultants in the future. Appropriate locums in place to provide cover.	Oct-23	Jun-2023		WF	David Birkenhead	Pauline North
Very High	7689	Trustwide	All Divisions	All Departments/Wards	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	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	September 23 - Clinic capacity increasing across all specialties . Increasing weekend clinics in Neuro and Rheum to reduce backlog of New and F/up. Clinics still being cancelled within 6 weeks. 3 week text reminder to start in order to reduce short notice cancellation rate. Deep dive of cancellation data	Oct-23	Mar-2023		NA	Helen Barker	Jonny Hammand
Very High	8057	Corporate	Finance and Procurement	Trustwide Finance	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	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	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.	Oct-2023	Mar-2024		FPC	Gary Boothby	Philippa Russell

Very High	8072	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Jun-2021	Active	Keeping the base safe	The paediatric and neonatal medical rota only allows for 1 registrar at night. The registrar is responsible for the medical running of both ward 3 (CRH), ward 4 (HRI), NICU (CRH), postnatal emergencies, labour suite emergencies, CRH ED, resus and taking calls from HRI ED. The requirement to attend emergencies or urgent cases at once could result in harm to patients. Often the registrar is called to a number of patients at the same time. This prevents them from being able to effectively cover across all areas and can cause time delays to care, adversely impacting safety, quality and patient experience. Most units of a similar size have 2 night registrars and this is within Neonatal standards. Whilst this is mitigated with consultants supporting the department with any emergencies, this does not support gaps in staffing within the current establishment. Having just 1 registrar at night poses risks to the health of trainees and the reputation of trainee placements at CHFT. The expectation for NICU is a dedicated registrar to improve safety and patient care. Tier 2 NICU staffing is not in line with BAPM national standards as a Tier 2 practitioner should be immediately and solely available to the neonatal service and labour ward. Current staffing is: • Monday – Sunday – designated SCBU Registrar from 08:30 – 21:00 • Monday – Friday – Twilight Registrar until 22:00 • Monday – Sunday – one Registrar split between the ward and SCBU	- An on-call consultant supports the registrar with any emergencies (however, the on-call consultant is infrequently a neonatal consultant) - A Twilight Consultant is resident 2-4 evenings per week (however, the twilight consultant is a paediatric consultant) - From September 2021, the tier 2 rota was amended so that most evenings we have a Twilight Registrar. - See action plan section for updates.	The registrar rota requires an increase in 2.6 registrars to enable 2 registrars overnight. - See action plan section for updates.	12	3 x 4	20	4 x 5	4 2 x 2	Update April 2023 EGH - 0.8 WTE ST4+ permanent role closing again on 3/5 - Directorate plan to go out for an NNP if this round of recruitment is unsuccessful - Development submitted relating to registrar staffing on pause (plus all developments trust wide) - escalated concerns regarding this to the division on 3/3/23 - asked to escalate this at the next PRM (5/4/23) for escalation at divisional PRM. Divisional PRM response - audit required - audit started 24/4/23 - 22/5/23. Update June 2023 EGH - 0.8 WTE ST4+ permanent role closed again on 3/5, however both suitable applicants confirmed jobs elsewhere. Advert out again until 11/6 - if no suitable applicants, Directorate will go out for an NNP with this funding. - Development remains on pause. Audit findings shared with Divisional team on 26/5 (and audit will continue). Divisional Director informed Clinical Director this was not raised at Divisional PRM on 31/5. Update July 2023 EGH - 13 slot rota available from September due to inc. in Trust Doctors and a greater rota from the deanery. Raised formally via July PRM and PSQB. Risk potentially to be reduced for 6 months from September. - College Tutor continuing with audit work - Clinical Director, College Tutor and future GM to focus on strategic medical staffing now Operational Manager in post.	Sept 23 GH review improved position as additional funding and improved allocation of trainee doctors to review in Oct in order to potentially reduce score Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 - LR. Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Raised at last PRM, currently auditing and assessing risk - Feed back into PRM process. April 2023 - see action plans. January 2023 - see action plans	Sep-2023	Sep-2023		PSQB	Nikhil Bhuskute/Stephen Shepley	Venkat Thiyagesh/Elena Gelsthorpe-Hill
Very High	8283	Family & Specialist Services	Radiology	All Radiology	Mar-2022	Active	Keeping the base safe	Objective: Service Delivery Risk Risk: Risk of demand outstripping capacity across all areas of radiology. Cause: • An increase in demand/recovery plans; • Intermittent reduction in staffing capacity; • Persistent equipment failures Effect: Longer waiting times, breach of 6 week wait standard and delayed diagnosis. Impact: An increase in the number of pressure ulcer/falls incidents	- Weekly monitoring of activity/capacity. - All requests are vetted, however, even with this capacity is at its maximum. - Radiology requesting that they be informed of Trust wide service changes impacting on radiology. - Rolling program of staff development. - Annual over recruitment of newly qualified Radiographers. - Appointment of overseas clinical staff.. - Submission of capital bids internally and externally for equipment. - Regular maintenance of equipment (not possible for all equipment).	- Limited control over referrals. - Short term sickness and high turn over of staff in some areas. - Ageing and obsolete equipment. - Radiology having limited input into recovery plans.	12	3 x 4	20	4 x 5	9 3 x 3	- Workforce plan, equipment plan and Radiology 5 Strategy to be presented/approved at WEB.	Confirm & Challenge Meeting 17/5/2023 Present: SS, SRF, NV, LH, GE, TO, SD, NB, SC, LR Update required, Stay at score 20, reporting capacity to consider and availability of in-sourcing/outsourcing. Separate risk out into 3 risks - demand - kit. Describe the impact of the risks and likely hood in the narrative. July 2023: Consideration/drafting of individual risks underway as per C&C meeting. Attending: SS, JE, CG, GE, LR Focus more on patient outcome impact. Look to review the score of 20.	Oct-2023	Mar-2024		DB	Prf. Bhuskute	Sarah Clenton
Very High	8324	Corporate	Planned Access and Data Quality	RTT Validation	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 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 clinical priorities and finite resource the Trust has recently taken the decision to stop repeat clinical validation of already P rated patients. The impact of this is as follows 1. Patients are booked in order of P rating therefore capacity issues impact P3 & P4 patients the most with P1 and P2 patients always being booked as a priority. 2. By not repeating the clinical validation there is no opportunity to upgrade the patients P score therefore for many specialities patients categorised as a P3/P4 it is likely they will never receive an appointment. 3. When we were repeat P rating patients they were allocated a new due date and therefore would have stopped being classed as overdue. Now that the Trust has stopped the repeat P rating these patients will now show as overdue therefore the holding list position is expected to worsen.	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	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.	May 23 There are currently a total of 14865 patients awaiting clinical review of this 8752 patients have been waiting more than 90 days. In addition to this we currently have 3,902 P rated patients on the holding list that are now overdue due to insufficient capacity. We are now reporting this through quality priorities and EB/ADG. We have completed the repeat admin validation of IO's. Continue to highlight outstanding validation and capacity issues and customer contact meeting with emphasis on IO patients. Further training sessions have been undertaken with managers and clinicians on request around using the system and reporting available to increase engagement and viability. We continue to offer this. Engaged with the Trust RPA programme to automated validation where possible thereby increasing the amount of validation the central team can complete. Working with reporting teams on low hanging fruit model to maximise resource and identify training opportunities.	Sep-2023	Oct-2023		PCB	Jo Fawcus	Kimberley Scholes

Very High	8490	Medical	Integrated Medical Specialties	Neurology	Jan-2023	Active	Keeping the base safe	There is a risk of IP reviews being delayed due to a considerably reduced medical workforce of two consultants instead of four and without junior doctor support, resulting in delayed IP reviews. This will have an impact on both neurology care and discharge from hospital will be delayed due to only having 2 consultants covering both HRI and CRH. This also has an impact on treatment deliver as plans cannot be put in place as quickly due to the delay in reviewing the patient and providing treatment plans.	Reduction in internal outpatient capacity to release resource for inpatient reviews. To offset this additional support is being provided by insourcing providers. Inpatient referrals are triaged and reviews are based on clinical need. A response is also being provided for the referrals that cannot be reviewed to manage expectations along with further advice.	I/P are not receiving daily reviews.	12 3 x 4	20 4 x 5	4 2 x 2	Continue to readvertise vacant posts, aswell as liaising with partner organisations across the region in order to receive support. Activity has been stood down to minimise the impact to ensure reviews as timely as possible. May 2023 ACTION LOG Neurology 2023 CURRENT ACTIONS AGENDA TOPIC ACTIONS LEAD DUE DATE STATUS Neurology Medical workforce gap • Meet with Dr Mowafi to understand clinical implications without medical input – arranged Thursday 18th May 1 Nursing Support • Understand nursing support required – reach out to partner organisations and understand whether MDT/supervision can be offered Ongoing Regional support • WYATT have been approached to understand what can be fast tracked • BHFT are identify a clinician to have a discussion with us. Remote reviews were discussed and that's likely the only short term solution, this is part of the longer term proposal, linked to a Hub and spoke model. • There are 3 potential trainees due CCT in Feb. Sal is speaking with Hamish (MD at Leeds) re: support to recruit. • MY have now identified a lead clinician to be part of discussions between MY and CHFT – sue is on with sorting a date Gutcare • Additional clinician available to support clinics in week (4 days) to bolster outpatient capacity support for inpatient reviews has also been supported as part of this Ongoing Leeds • Looking to advertise two consultant posts with a 70/30 split and 7 consultants willing to set up what they referenced as a consortium to support Ongoing Acute med • Movement disorder support Ongoing CHFT • Advertising campaign Ongoing CHFT • Neurology hot clinics Julie Hoole • Overeseas recruitment	20/09/23: Risk Increased from 12 in Aug 2023 to 20 in Sept 2023. Risk group accepted risk scoring at 20. 15/09/23 Discussed at Medicine PSQB. Action for Christopher Roberts to review and downgrade as appropriate Unfortunately we have now had further resignations and we are now down to one consultant neurologist. Posts have been re-advertised for agency and permanent posts. Risk to be reviewed monthly in consideration of whether we are able to recruit. This risk remains the same but is at risk of being exacerbated due to further resignation of a neurology consultants which has taken the service down to 1 consultant and will further reduce to no medical consultants from August 2023	Sep-2023	Sep-2023		NA		Chris Roberts/Sam Bryant
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	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.	1/9/2023 - approval from exec team to implement outsouring 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. 22/05/2023- discussed at PSQB to increase to 25 due to no consultant (locum candidate does not look appropriate to interview) and locum agency still no definitive date. It was decided that 25 was for risks with evidential harm currently happening, where as here we are raising a likely risk. It was explained what the services does not know the risk that it is sat on due to 4000 patients not having been reviewed and the number that could come through with harm and sight loss once reviewed. Risk team agreed to review other risks at 25 to compare. It was raised that glaucoma had been a risk of 25 previously but had reduced to 20 as there was impending consultants due to start however these have not come to fruition. Waiting for risk team to advice. COO has raised at region WYAAT and COO meetings. Sal Uka has agreed to support discussions for mutual aid and IPT patients (currently IPT poses a risk as there is a delay in acceptance of these patients regionally). Regional GM meeting with Louise Corp to agree rota for mutual aid 23/5/23. 11/05/23- Locum agency consultant delayed start date, service still without lead	Oct-2023			PSQB	Natalka Drapan	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	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)	1/9/2023 - approval from exec team to implement outsouring 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 31.05.2023 - 290 incomplete outcomes which are all virtual glaucoma clinic appointments awaiting review. Do to lack of reviewers due to no substantive consultant, offered out WLIs to clinical staff to support undertaking these virtual reviews of those low risk routine glaucoma patients to try and get on top of the backlog while we continue to actively scope recruitment options. 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.	Oct-2023			PSQB	Aletta Carbone	Emma Griffiths

High	8537	Family & Specialist Services	Children's Services	Children's Community Nursing Team	Mar-2023	Active	Keeping the base safe	There is a risk to patient safety in the special schools from the start of September 2023 due to the increased number of pupils requiring health interventions. The frequency and intensity of interventions required for children with complex needs is increasing. This is further exacerbated with 2 of the schools opening additional school sites which require nursing support. The impact of this will result in three of the school sites not having a nurse on site with a complex caseload e.g. a ventilated patient, a tracheostomy patient and an unstable epileptic. Children with complex needs have the potential for deterioration at short notice and this can result in the school nursing team has the potential to respond to more than one medical emergency occurring simultaneously, together with qualified nursing duties for safe patient care.	There is a nurse on site in all of the special schools, with one sixth form site staffed by a HCA only. The site currently staffed by a HCA has a level of dependency of pupil need which the HCA is able to support. Additional nursing support is provided on a daily basis from within the current special school nursing team prior to school starting to draw up and check medication. The CCNT cover sickness or leave within the special school nursing team which impacts on CCNT cover arrangements.	There is no contingency to manage an increased number of pupils with increased intensity and frequency of interventions. The current workforce model has been in place for several years and has not evolved with the increased workload. On one site the school nurse works alone for 1 hour per day with a caseload of 160 pupils to manage. It is not uncommon for there to be 2 calls for assistance simultaneously during these times (Seizures, pulling gastrostomy buttons out, unstable diabetic, etc. In addition this nurse supports 70 on a satellite site. (total pupils currently supported by 1 nurse each day is 244)	16	4 x 4	16	4 x 4	3	1 x 3	CCNT Community Nurse Manager is working with Vicky Brown (finance) to review pupil numbers and interventions in the special schools to consider a revision of the special school workforce model and a contract variation. Directorate Team to meet with finance and formulate a plan for further discussion with the Contracting Team and ICB	July 2023 - Confirmation that the additional school site for academic year 23/24 is Springhall (current school site covered by special school nursing team). The premises will be a double decker portacabin. Springhall is currently covered by a HCA only. Pupil numbers will increase from 62 pupils and double to 124 in September. The acuity in terms of nursing provision will be high and the site requires a registered nurse. Meeting with NV, EGH, JE and ICB to discuss increase in pupils and acuity planned for 24.07.23 Update following meeting - ICB to look for non-recurrent funding to support additional B5 and B6 on a fixed term basis. July 2023 Risk discussed in meeting with JE and JI. Awaiting further update and plan. Short term plan discussed for Sept for 2x afternoons support from qualified SSNT to visit Spring hall to offer support to HCA at spring hall. Other 3x days ?CCNT to cover to give aditional support to HCA at Springhall. Will discuss further with SFR.	Aug-2023	Aug-2023		NA		Jo Ireson/Julie Mellor
High	8384	Family & Specialist Services	Pathology	Blood sciences	Jul-2022	Active	Keeping the base safe	RISK OF: Serious disruption to transfusion service and therefore clinical services during out of hours shift 8pm-8am Mon- Sun and 8am-8pm Saturday & Sunday. CAUSED BY: inability to find cover for a staff member falling ill whilst on shift. Invocation of BCP resulting in loss of service for up to 2 hours and 15 minutes. RESULTING IN: Possible catastrophic patient harm due to lack of availability of service.	Plan for business continuity to be enacted. Which will follow the following course of action: 1) If CRH staff member affected by sickness: HRI staff member will fill up HRI issue fridge with 8 O RhD Positive & 8 O RhD negative units of blood plus 4 Group A FFP for use in bleed. Staff member will then travel to CRH and remain there. Complete loss of service for 2 hours 2) If HRI staff member affected by sickness: CRH staff member will travel to HRI and fill up HRI issue fridge with 8 O RhD Positive & 8 O RhD negative units of blood plus 4 Group	Final BCP for lab detailing the specific action to be taken with non-priority samples (Haematology/Transfusion and Biochemistry) Final escalation procedure to be agreed and shared with staff.	15	5 x 3	16	4 x 4	5	5 x 1	Finalise finer detail of Blood sciences BCP and test with staff Finalise escalation process and share with all staff Introduce back up on call rota	Sept 28/09 - Lack of appetite for implementation of back up rota due to limited number of staff available to cover rota, when already covering additional shifts, together with standby payment of £15. BCP being worked up with S Rothery and Trust users. Locum paper accepted and currently trying to identify suitable individual. Aug 16/08 - Met with JE to discuss implementation of back up rota. JE speaking to HR for some clarification. Unsure of staff keenness to participate in back up rota due to the amount of additional shifts currently being covered. Will require staff consultation once clarification has been sought from HR. During Aug there has been two occasions where BCP has been close to being activated. July 27/7 - Confirm & Challenge Risk Meeting Attending: SS, JE, LR, NB, SRF, CC, SR, EZ Review risk and bring back through PSQB next month	Oct-2023	Oct-2023		PSQB	STEPHEN SHEPLEY	HAYLEY BAKER
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	16	4 x 4	16	4 x 4	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,	Sept 28/09 - Track is remaining in situ until new eqpt is installed, V and V performed. Awaiting Health check to confirm if solution offered by Siemens is fit for purpose. Additional enabling works required. Aug 16/08 During Biochem Sub committee meeting, it was agreed to increase risk score to 20 due to increased risk implications, risk presented at PSQB and rejected - re-discussed at path Board decision to remains at 16 as Siemens have agreed to keep track in situ until new eqpt has been delivered, installed and fully functional. July 27/7 - Confirm & Challenge Risk Meeting Attending: SS, JE, LR, NB, SRF, CC, SR, EZ Review risk and bring back through PSQB next month 22/8, look internally at aligning Risk Register scores with QPulse.	Oct-2023			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 LoS 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	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	Discussed at Medicine PSQB 15/09/2023.. Risk accepted and actions progressing as descried across	Oct-2023	Mar-2024		PSQB	Helen Rees	David Britton
High	8416	Family & Specialist Services	Radiology	All Radiology	Sep-2022	Active	Keeping the base safe	Objective: Financial Risk Risk: Risk of increased expenditure relating to reporting of images Cause: • Increase in imaging requiring reporting (linked to increase in demand) • Increased cost in reporting costs Effect: Increased expenditure. Impact: Overspend of the Radiology Directorate budget.	- Regular monitoring of reporting backlogs - Daily allocation of images for reporting - Regular liaison with external reporting company re: capacity, allocation, turnaround times etc.	- Inability to control demand for imaging which in turn creates reporting - Inability to control reporting capacity for external reporting companies	16	4 x 4	16	4 x 4	9	3 x 3	- To continue to monitor reporting needs on a daily basis - To continue to liaise with external reporting companies to maximise reporting - Offer of additional reporting to in-house Radiologists at a premium rate for a short period of time to help reduce backlogs - Consider other options for increasing in-house reporting capacity	June 2023 Update: AI implemented in Plain Film and making savings in line with CIP schemes. Implementation of second CIP scheme is about to commence in July 2023. Full review of outsourcing invoices/charging structure identified some charging adjustments (with a positive impact). A finance piece of work is to be undertaken to ascertain what we have in reserve and the forecast spend to year end with weekly monitoring to ensure that our spend is within budget. 26/7 - Confirm & Challenge Meeting Attending: SRF, SS, JE, CG, GE, LR Risk currently accurate, maybe be reduced once alternative funding has been re-directed, to be confirmed	Aug-2023	Mar-2024		DB	Prof. Bhuskute	Sarah Clenton
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 - Current use of mobile CT scanner in the event of a breakdown (at an additional cost) - Ability to scan patients at HRI if needed	- No cover when the mobile scanner leaves site (planned to leave March 2022) - Our staff are not trained to use the mobile scanner (the scanner is provided by a private company and is manned by their staff).	9	3 x 3	16	4 x 4	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.	June 2023 Update: Increase in CT capacity from 1 October 2023 (Acre Mill) and replacement of CRH scanner in 2022-23. 26/7 - Confirm & Challenge Meeting Attending: SRF, JE, CG, GE, LR Review the frequency of how often the scanner has broken down, to hopefully change the likely hood - How often have patients been moved and not had a scan, as every month there is major disruption according the current risk score which doesn't feel accurate.	Aug-2023	Mar-2024		PSQB	Stephen Shepley	Lucy Thomson

High	8277	Medical	Integrated Medical Specialties	Neurology	Mar-2022	Active	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 the depletion of the medical workforce, and not being to recruit replacement Consultants, will result in an unsustainable service. Broad overview of service requirements: - 70 new outpatient referrals per week - 25 inpatient referrals per week - Current backlog ASI's 979 - Holding list over 12 weeks 847 - Validation - 2300 to complete "	Reducing inpatient cover to 3 days a week Clinics have been stepped down to provide time for validation to ensure we fully understand the service risk and patient impact. Additional bank shifts offered.	Explored joint working with Leeds not possible until August 2022 at the earliest due to their current gaps. Approached Mid Yorks/Bradford to understand ability to offer mutual aid however, they are also under resourced and cannot support. Outsourcing in place but limited capacity. Looking to maintain rotational reg placement however, with reduced medical workforce and supervisory capacity this is a risk of being removed, reducing capacity further. Locum Agency's approached but no interest/nobody available.	20	4 x 5	16	4 x 4	6	3 x 2	Ongoing recruitment - interview of one candidate on 8th April. Discussions with deanery to maintain rotational registrar. Implemented different ways of working to mitigate risk (see existing controls).	27/3/2023 - Leeds support is now in place for A&G and a third party from April will be involved in triaging all new referrals to reduce outpatient demand which is currently being managed via insourcing, However we still have reduced capacity to manage all follow up appointments and resource to see inpatient referrals in 24 hours is still not possible. July 2023 - Meeting with Leeds - initial proposal of 2 days per week for consultant time. Will give 50% inpatient referrals and 50 % outpatients. Also with this in specialist nurse and MDT input/support. Aug 3rd is last week for the last substantive neurologist. We have a locum consultant 4 days per week currently - 6 clinics and 1 day admin in job plan. Potential to make substantive. Gone out for national adverts - BMJ etc.	Aug-2023	Mar-2024		PSQB	Purav Desai	Chris Roberts /Andy Hardy
High	7092	Trustwide	All Divisions	All Departments/Wards	Oct-2017	Active	Keeping the base safe	Medication Safety - risk of incorrect prescription details This may be due to selection errors, untrained users in EPR users not responding to decision support alerts , or users not following SOPS. This may result in incorrect drug details -eg selection of drug , incorrect drug doses , frequencies and durations. Incorrect information could be sent to the GP regarding drugs stopped , amended or new drugs started during hospital admission.	Training and SOPs are available Medications Safety Group reviews incidents of incorrect prescribing. Order sentences are built - which filters drugs and dosage by age/weight and gives a suggested dose Pharmacy / senior doctor review and feedback to junior prescribers Guided prescribing through care plans Critical incident / complaints reviews Training and education before access is granted Role based, access control within ERP	Training could be improved and refresher sessions offered. EPR SOPS are available but staff often unaware and dont follow- leading to errors Reducing the number of paper drug charts and paper outpatient prescribing. Not all prescriptions are verified by a pharmacist before administration	9	3 x 3	16	4 x 4	6	3 x 2	Escalate to Division - training and supervision of prescribing staff is required	September 2023 - Agreed risk to be held by divisions as a Trust wide prescribing risk and to be discussed at Divisional PSQB	Dec-2020	Feb-2021		QC	David Birkenhead	Becky Colwil
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 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	4	2 x 2	- Plan for MES. - Equipment on the 5 year capital plan.	June 2023 Update: Position the same as per the May 2023 update. 26/7 - Confirm & Challenge Meeting Attending: SS, JE, CG, GE, LR Look to review if any escalations significantly long waits or patients that can't access the service. Review score if needed. August 2023 Update: Position the same as per June 2023 update.	Sep-2023	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 personel 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	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.	Sept 26th 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 January 2022: Meeting with Leeds on 14th Jan, Leeds have agreed to perform 12 VFs a year for children in Calderdale and South Kirklees. Contracts are being worked up.	Nov-2023	Nov-2023		PSQB	Debbie Wolfe	Carly Hartshorn
High	8006	Family & Specialist Services	Women's Services	All Departments	Feb-2021	Active	Keeping the base safe	There is a risk of patient harm and poor outcomes across obstetric and gynaecology, due to an inability to cover the required rota at tier 2 level as a result of rotation vacancy, restricted duties and parental leave. Resulting in delays in timely treatment and delivery of safe care to women in both Obstetrics and Gynaecology services .	utilising existing bank contracts Utilising agency reviewing the rota daily to appropriately manage acute services Clear comms and discussion with consultant of the week around staffing gaps and safety concerns Reviewing supervision and training of doctors active recruitment to vacant posts and bank prioritisation of essential activity Actively managing sickness	Achieving adequate staffing Unexpected unavailability Burnout of colleagues Industrial action	12	3 x 4	16	4 x 4	4	2 x 2	recruitment to bank - ongoing July 23 recruitment for 1-2nwte specialty doctor for Sept Deanery gap extended contracts of existing specialty doctors risk score reviewed and amended to reflect current position Daily review of rota	Aug 23 MW GH LD reviewed risk , no changes, but predicted to be an improved position in Sept /Oct 23 when the risk score and risk will be reviewed July 27/7 - Confirm & Challenge Risk Meeting Attending: SS, JE, GH,FA, DT, LD, AF, LR, NB Been to Risk committee, had sickness etc and had to review day on day - Re-written the risk and require advice on the current score, should it be higher than a 16? Are we unsafe or uncomfortable? Concerns around loss of key staff and the number of staff. Likelihood is 'Almost Certain' on a daily basis. Risk needs to reflect the outcome. Reword the narrative to reflect that gaps on the rota have an impact on patient care. July 23 2x gaps on rota due to senior regs moving into consultant posts, I x Reg going on adoption leave and a number of pregnant reg moving to more restricted duties this has had a significant impact on the rota - Score review and increased to reflect current situation which is having a significant impact on covering activity May 23 No gaps at Tier one, 2 gaps will occur at tier 2 due to two ST7/8 moving to consultant posts. Denary Rota change over Aug/Sept 23 plan to extend 3 fixed term speciality doctor contracts and tier one doctors contract extended. following a recruitment process for an additional speciality doctor. To review score in July Feb 23 all gaps currently filled risk reviewed and score decreased this may increase due to Maternity leave and doctors leaving	Aug-2023	Oct-2023		PSQB	Nikhil Bhuskute	Tahira Naeem/Gill Harries
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	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.	July 2023 Position is improving in terms of ASI/18 week targets. Issue remains as follow ups and will continue to be an issue for neurology - other areas are improving.	Aug-2023	Mar-2024		PSQB	Helen Rees	Chris Roberts

High	7479	Family & Specialist Services	Children's Services	Children's Ward CRH (3)	Jun-2019	Active	Keeping the base safe	There is risk that young people with acute mental health needs and /or behavioural/social care needs, such as self harm, suicidal ideation and eating disorders, will be managed on the paediatric ward for an extended period by staff that do not have the appropriate skillset. This is due to a national shortage of inpatient provision for young people with acute mental health issues they are waiting for a specialist bed or Children's Social care management. Resulting in potential harm to the patient (due to required care and treatment not being provided) and other patients on the ward (due to exposure to inappropriate situations or violence and aggression).	1. Agreed joint admissions guidance with CAMHS provider 2. Restrictive holding policy in place 3. Mental health awareness training undertaken for key staff 4. All incidents investigated 5. Paediatric representation at the mental health operational group 6. All requested for one to one shifts immediately escalated 7. Paediatric/CAMHS partnership meetings commenced 8. Clear escalation plans formulated 9. CAMHS hot and cold debriefs instigated 10. Clinically related challenging behaviour guidelines 11. Restraint and use of force guidance (clinical holding) 12. Clinical PEARLS 13. Barriers to discharge protocol in place between CAMHS, Social Care and CHFT	Skill set of staff to care for children with complex psychological needs Inability to provide a one to one support from staff with the correct skill set and experience Consistency of escalation during out of hours periods Clarity of escalation pathway to ensure awareness and timely transfer of patients to inpatient mental health settings external to the trust	20 4 x 5	16 4 x 4	4 2 x 2	February 2023 Mental Health Liaison Nurse in post Review of mental health guidelines in progress MH liaison nurse shared Training opportunities shared with children's ward team April 2023 Task and finish group set up with ward staff to address learning from incidents, debrief and address learning needs. November 2022 Induction plan for Band 6 liaison nurse jointly developed between Paediatrics and Camhs. Aiming for CAMHS team to allocated band 3 to the children's ward following their recruitment. Linking with CHFT Nurse Consultant for Mental health re training plan and oversight. Paediatric attendance at Mental Health Operational group October 2022 Band 6 Mental Health liaison nurse appointed. Debrief sessions for team following complex cases. Task and finish group in place to develop Multi agency protocol for escalation and removing barriers to discharge. July 2022 - Band 6 Mental Health Nurse post out to advert (funding via CCG) - CYP barriers to discharge workshop completed on 20/07 and next steps agreed - new escalation process (agreed across services) to be developed	Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Task and finish group created for ward staff to address learning needs from incidents, debrief and address learning needs. Also been contacted by the lead of the ICB to provide some feedback about the effectiveness of Angie Salmons coming into Mental Health post. Mitigations: Ongoing work with ICB, from local prospective to push with CAMHS. Support of Band 3, not in post yet due to recruitment difficulties. April 2023 - as above February 2023 as above Divisional Risk Register confirm and challenge update 26/04/2023 Present:	Oct-2023	Dec-2023		HSC	Simon Riley-Fuller	Lola Duncan
High	7637	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Jan-2020	Active	Keeping the base safe	There is a risk that, due to regular sickness and isolation across the Tier 1 and Tier 2 medical staffing rota, the delivery of safe care for the Paediatric and Neonatal unit may be compromised. There is currently reliance on existing staff and bank and agency staff to fill shifts at both tier levels. If gaps are not filled there is a risk to patient safety. There's also an impact on the Consultant workforce, who may need to cover Tier 2 gaps, which can impact on other workload. This risk is ongoing and will be reviewed as part of rotations.	1. Fixed-term tier 2 post filled (historic) 2. Tier 2 6 month fixed-term (winter funding) post filled (historic) 3. Calculating additional funding required as part of business planning (some pressure accepted, however development not accepted) - looking at 23/24 4. Regular weekly meetings with medical staffing commenced in May 2021 to ensure gaps are picked up with as much notice as possible, with all possible options for cover explored.	Adequate workforce to enable an adequate rota.	16 4 x 4	16 4 x 4	6 2 x 3	1. Rotas monitored on a weekly basis, with daily escalation plans in place. 2. Continue work with HR to ensure rotational doctor information/updates in received in good timeframes. 3. Continue to seek recruitment for 2 x qualified APNPs. 2 trainee APNPs in post since Autumn 2020 and a 3rd trainee to start in Autumn 2021. Out to advert x4 times. No applicants. 4. Utilise existing APNPs/ANNPs to support medical rotas when able to. Engage with ED regarding gaps to ensure appropriate mitigation.	Sept 23 - review by GH - an improved position regarding tier i and tier 2 gaps for this risk to be reviewed in Oct 23 in view of reducing score and reviewing wording Update June 2023 EGH - 1 x Trust Doctor started in May (12 months). 2 other Trust Doctors due to start - June (12 months) and August (12 months) - these were rota gaps on the current rotation, however due to TRAC authorisation delays, these doctors will overlap with the future rotation - depending on gaps, this may impact 24/25 finances. - Sickness rates relatively ok and being well managed - however, risk remains due to gaps and significant impact when there are gaps. Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 - LR Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Pressure approved, reduced rota slots, twilight registrar due to gaps in rotation, awaiting a few doctors starting. Risk continues despite getting approval of funding as its more around having gaps covered - Mainly due to sickness across tiers 1 and 2. Other issues: 1. Depleted rota 2. Covid changes 3) Number of people able to do the job is limited due to skill set. Mitigation: Recruit, but not easy due to finances. Have enough locums in the region. Financial risk - consultant rates of pay.	Aug-2023	Sep-2023		PSQB	Nikhil Bhuskute/Stephen Shepley	Venkat Thiyagesh/Elena Gelsthorpe-Hill
High	6078	Family & Specialist Services	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	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.	24/4/2023 Need to be sat Divisionally, need to be altered by speciality at service level - SRF will address with other PRM directorates in FSS. Risk needs to be centrally May 9 2023- OPD directorate risk review- as above awaiting this risk to be moved to be held centrally as Trust risk. Jun 23 - still awaiting movement to central trust risk Jul 23 - still awaiting movement to central trust risk Aug 23 - Risk agreed to be realigned to overall trust risk with agreement at trust risk group. SRF and SS advised NB to contact GB to discuss the handover, e-mail has been sent no reply as of yet.	Sep-2023	Dec-2023		PCB	Helen Barker	Nicholas Buckley
High	6079	Family & Specialist Services	Appointment and Records	Appointments Service	Aug-2014	Active	Transforming and improving	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	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.	26/4/2023 - Update description as risk 6078 May 9th 2023- Outpatient Directorate team review of risk- as above, agreement that this risk needs to be held centrally as agreed from risk confirm and challenge meeting on 26/4/23. Awaiting transfer to Trustwide risk register. SRF lead to discuss at Trust Quality meeting Jun 23 - Awaiting movement to central trust risk register Jul 23 - Awaiting movement to central trust risk register Aug 23 - Risk agreed to be realigned to overall trust risk with agreement at trust risk group. SRF and SS advised NB to contact GB to discuss the handover, e-mail has been sent no reply as of yet.	Sep-2023	Dec-2023		PCB	Helen Barker	Nicholas Buckley
High	6100	Family & Specialist Services	Children's Services	Paediatric Medical Staff	Sep-2014	Active	Keeping the base safe	There is a risk of patient safety/delays (inc. ECS) as... - The paediatric department is not fully complying with the Royal College of Paediatrics and Health (RCPCH) paediatric acute medical standards. One example is paediatric consultant (or equivalent) presence at peak times of activity (17:00 - 22:00), leading to delays in senior review (all examples can be shown on the Directorate RCPCH action plan). This could result in delays in care and diagnosis and poor patient outcomes. 2 additional consultants are needed to support this rota. - The neonatal department is not fully complying with BAPM standards. The neonatal unit should have 7 consultants. 1 additional consultant is needed to support this. - There is a lack of resource to ensure children and young people are seen in appropriate time-frames in outpatient clinics. The above results in a greater number of incidents and an impact on flow, both impacting the medical care of children and young people. It is also impacting staff wellbeing. The paediatric consultant workforce is flexible and proactive in putting the needs of patients first. There is acknowledgement that the safety of the service is enhanced by their flexibility and this can impact on service delivery the next day. This is not sustainable.	- 24/7 on call consultant cover - Twilight consultant cover around 2-4 evenings per week - 24/7 Tier 2 rota (resident) - however, there are often gaps - 24/7 Paediatric Nurse Practitioner support at HRI. 4 hourly acuity and capacity risk assessment using RCN standards with escalation policy if demand compromises safe nursing care. However, there are often gaps due to sickness and vacancies. - Minimum roster standard - 1 APLS trained nurse on each inpatient area 24/7. - High levels of workforce compliance with HDU training and sepsis awareness training. - Matron daily sit rep provides daily focus on staffing, workload and risks	Gap in budget.	12 3 x 4	16 4 x 4	3 3 x 1	1. Rapid access clinics established once per week. 2. Winter resilience plan established in summer 2021 (also considering COVID-19 related factors). OPEL plan in place. OPEL plan being reviewed December 2022. See progress update for further action plan updates.	Sept 23 - GH review for risk to be reviewed in Oct 23 in relation to wording and scoring Update June EGH - Developments remain on pause across the Trust. Raised as 1 of 3 safety concerns to the Division - not escalated at Divisional PRM. Divisional Risk Register confirm and challenge update meeting held on 26/04/2023 LR Present: SRF, SS, NV, LRa, TO, VT, EGH, JM, WK, JE, HF Should have twilight cover Monday to Friday, currently it's 2 to 4 shifts a week at maximum with the current funding. Been through business planning, currently on hold awaiting approval. Update April 2023 EGH - Development submitted and on pause (plus all developments trust wide) - escalated concerns regarding this to the division on 3/3/23 - asked to escalate this at the next PRM (5/4/23) for escalation at divisional PRM. Awaiting update. Update March 2023 EGH - PCC funding has enabled the service to have a twilight consultant every week night until 31/3/23 (this means we are meeting standards but it's also helped with winter pressures). This is not a sustainable model with continuing elective activity with the same number of consultants - Development raised to increase the consultant workforce to enable the service to meet standards, however all developments across the Trust have been paused. Escalation raised with the division on 3/3/23 - asked to take this to PRM on 31/3/23 so the divisional team can raise this at the divisional PRM Update January 2023 EGH - Challenging paediatric winter has been evident. Additional (internal) consultant twilight shifts in place every week day evening from the start of December 2022 until the end of January 2023. Already realised in the budget by the Senior Finance Manager and General Manager - 3 x additional consultants put forward as part of business planning - awaiting outcome	Oct-2023	Oct-2023		PSQB	Nikhil Bhuskute/Stephen Shepley	Venkat Thiyagesh/Elena Gelsthorpe-Hill

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 thier 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	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	June 23 Following formal review at the Nursing and Midwifery Workforce Steering Group it was deceided to reduce the 'likelihood' of this risk to 4. This is based on a consistent level of OPEL 2 at the twice daily staffing meetings, an ability to reduce agency bookings due to increased shift-fill by substantive staff, and a stable and sustained CHPPD report, benchmarked at high quartile 2 on Model Hospital. The existing controls continue to be in operation and effective.	Aug-2023	Sep-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	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	Sept 23 Actions updated with revised target date Dec 23 July 2023 KP+ dashboard established to monitor compliance. The dashboard is discussed at weekly exe board and quality committee. The organisation is looking at PIRSEF later this year. Sharon Cundy leading on project. February 2022: Improved position with 38 open investigations. SI investigation progress flow chart now in place to support timely investigations. Serious incident report going to Quality Committee for oversight 21/2/22. Risk score reviewed and reduced due to systems and processes now in place.	Oct-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	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	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 June 23 - Update GH, LD, JM - propose reduction in score following review of WFM and existing controls. Reduction in birth rate and quality matrix supporting controls working May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Staffing levels same, no change to risk, shared recruitment across LMS - Currently at the right level, hoping for better recruitment of students this year. Offering posts on 8/6/23, when in post look to reduce risk in September. May 23 reviewed by LD and GH Work ongoing to review workforce model calculations due to fall in birth rate being presented at Hard Truths May 23 - ongoing recruitment in place.	Oct-2023	Mar-2024		NWG	Gemma Puckett	Laura Douglas
High	6949	Family & Specialist Services	Pathology	Blood sciences	Mar-2017	Active	Keeping the base safe	The inability to deliver a two site Blood Transfusion / Haematology service due to being unable to recruit and retain sufficient numbers of HCPC Biomedical Scientists to maintain two 24/7 rotas, resulting in a potential inability to provide a full Blood Transfusion / Haematology service on both sites	1. Substantive Biomedical Scientists are working additional shifts to cover gaps in the rotas. 2. Staff rotas changed to a block pattern for night shifts. 3. All substantive vacancies are being advertised and gaps backfilled with locum staffing. 4. Staff development plan in place for training Biomedical Scientists 5. Existing business continuity plan in place	1 & 2. 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. 3. Delay in recruiting locums due to impact of Flexible workforce procedures. 4. 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 - further work required to establish contingency plan if rota was unfilled at any point in time.	10 5 x 2	16 4 x 4	4 4 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 3. Understand blockers to the recruitment process and determine options to expedite the process. Completed and posts filled 5. Organise 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.	Sept 28/09 - Further difficulty in covering shifts due to lack of staffing capacity, BCP has been close to being activated on numerous occassions, working with S Rothery around the Trust's ability to react to Transfusions BCP. Shifts currently being covered by OT. Locum request accepted, currently trying to locate appropriate locum. Aug 16/08- Increased difficulty in covering shifts due to lack of staffing capacity, two occasions BCP has been close to being activated. Shifts currently being covered using OT. Consider increasing risk if BCP requires activation. Request for locum cover has been submitted to SER - awaiting outcome. July 27/7 - Confirm & Challenge Risk Meeting Attending: SS, JE, LR, NB, SRF, CC, SR, EZ Discuss in Pathology Directorate the Likelihood scores of possible and impact. Review the time frame on the staffing requirements of change of service. July Update - High number of shifts unable to cover at the last minute due to increased levels of sickness within the department. Number of staff struggling with Mental Health issues, increased pressure on staff to cover more shifts is cause increased levels of sickness and absence. Increased pressure and time spent trying to cover shifts. Proposal to increase risk score to 16 as the likelihood is increasing. June Update - No progress made regarding authorisation of 2 x BMS staff to back fill for the 2 x New Band 7 BMS that have vacated their original positions. Urgently require authorisation to progress with recruitment, as the 2 Band 7's are having to continue supporting the 24/7 rota and not fore filling the Band 7 role effectively. Confirm & Challenge Meeting 17/5/23 Present: SS, SRF, NB, SR, ET, TO, LH, NV, AR, LR Score now based on a lower tier of staffing (as below), describe in DATs PSQB. Update narrative. Establish the workforce strategy across labs - link in with other risks currently at score 12 - 8219, 8384 and 8428	Oct-2023	Dec-2023		DB	STEPHEN SHEPLEY	HAYLEY BAKER

High	7640	Family & Specialist Services	Pharmacy	Pharmacy	Feb-2020	Active	Keeping the base safe	There is a risk that patients do not receive appropriate medication because of the the current staffing which results in a lack of assurance that patients are receiving an appropriate level of pharmacy input. Pharmacy service to ITU is not compliant with national standards for provision of intensive care services. We have 1.0 WTE B8a pharmacist in post (approx 0.7 WTE of time is dedicated to ICU delivery). There is reduced cover from existing band 7 pharmacists due to current vacancies. In the NHS England Critical Care specification document it states that pharmacy cover should be provided: "Clinical pharmacists supporting delivery of medicines optimisation in critical care areas must provide patient-centred care, including: medicines reconciliation (on admission and discharge), independent patient medication review with attendance of multi-professional ward rounds and professional support activities, including: clinical guidelines, medication-related clinical incident reviews and clinical audit and evaluation." In The Intensive Care Society and the Faculty of Intensive Care Medicine Version 2.1 of the Guidelines for the Provision of Intensive Care Services (GPICS); it states the following - CHFT data include below each standard: 1. There must be a designated intensive care pharmacist for every critical care unit. CHFT: currently 1.0 WTE B8a pharmacist - 1 individual to cover both sites. 0.16 WTE B7 also job planned to cover ICU. Thus not physical cover on both sites Mon-Fri. Remote cover provided on regular occasions - approximately 2 days a week. 2. The critical care pharmacist must have sufficient job time within which to do the job. There should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and for every two Level 2 beds for a 5/7 a week service. CHFT currently have 13 ICU beds - mixture of level 2 and level 3. This would equate under these guidelines to have a minimum requirement of 1.3 WTE B8a pharmacist (this figure does not account for annual leave or training time). The true figure is thus 1.56 WTE B8a pharmacist (accounting for 20% of time extra vs. basic WTE). Thus we are short of 0.86 WTE B8a to cover the bare minimum 5/7 as described above. 3. Clinical pharmacy services should be available seven days per week. However, as a minimum, the service must be provided five days per week (Monday-Friday) with plans to extend the ward service to seven days a	A number of experienced pharmacists are available to provide cover to ITU on both sites - and there is some ward round attendance.	We do not meet the national standard outlined above. Additional resource required with reconfiguration and the planned bed new bed base. Lack of resilience to meet any COVID surge Limited cover available for sickness/leave without impacting on other service areas	6	2 x 3	15	3 x 5	1 1 x 1	See details in risk above. Business case for expanded service to be submitted in Spring 2024 as part of pressures for 2024/25	STANDARDS 1. There must be a designated intensive care pharmacist for every critical care unit. 2. The critical care pharmacist must have sufficient job time within which to do the job. There should be 0.1 whole time equivalent (WTE) pharmacist for every Level 3 bed and for every two Level 2 beds for a 5/7 a week service. 3. Clinical pharmacy services should be available seven days per week. However, as a minimum, the service must be provided five days per week (Monday-Friday) with plans to extend the ward service to seven days a week before 2020. 4. The most senior pharmacist within a healthcare organisation who works on a daily basis with critically ill patients must be competent to at least Advanced Stage II (excellence level) in adult critical care pharmacy. 5. Other clinical pharmacists who provide a service to intensive care areas and have the minimum competencies to allow them to do so (Advanced Stage I) must have access to an Advanced Stage II (excellence-level) intensive care pharmacist for advice and referrals. 6. As a minimum, the pharmacist must attend daily multidisciplinary ward rounds on weekdays (excluding public holidays). 7. There must be sufficient patient-facing pharmacy technical staff to provide supporting roles. June 2023 No update on issues. Risk remains the same. Plan to review in 6 months July 2023 - Risk Confirm & Challenge session Attending: SRF, LS, SP, JE, LAH, LR No funds offered from Surgery, once reconfiguration occurs, should be easier as service will be merged. Look at at narrative as discussed in C&C session. Risk remains	Dec-2023	Dec-2023		DB	Nikhil Bhuskute	Katherine Cullen
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 individualised patient centred 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 inabiliy 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	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.	Sept 23 Action plan revised as above 12/01/2023 Currently have 16/07 WTE B2s in post. 4.64 B2s sick. 1 WTE B2 maternity. 0.8 WTE B6 post vacant from 03/02/2023. This post is currently awaiting review from panel. Continuing to work with recruitment as retention of B2s is poor. Organising a recruitment day in March 2023. Nursing students introduced into the team Sept 2022 - this has been successful. Volunteers due to recommence end of Jan 2023.	Oct-2023	Mar-2024		WF	Lindsay Rudge	Renee Comerford
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	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.	Sept 23 Estates awaiting a meeting with contractor to discuss a way forward August 23 Still awaiting the full survey June 23 Awaiting survey from surveyors March 23 Survey by CHS to understand the scale of the works required on the compartmentation is being carried out, Sept 2022 Drawings continue to be reviewed	Oct-2023	Nov-2023		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, change in the national screening programme, reduced nurse staffing and lack of equipment) the wait for colposcopy is 17 weeks and the wait for hyst is 10 weeks this is further compromised when the hyst is required as a GA due to a number of factors (choice comfort and requiring more therapeutic procedure) this could impact on patients receiving prompt and ongoing care and management resulting in potential patient harm leading to delayed Diagnosis	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	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	Sept 23 - Review GH, LD, MW - risk reviewed. Current wait time 25 weeks low grade colposcopy (KPI 6 weeks). Delay in nurse in training completion due to lack of placement on examination pathway. All urgent and fast track cases continue to be seen in timescale. Given increase in wait time score reviewed and increased to 15. July PSQB - Risk 7874: Risk merged with 7762 - Due to a number of factors, the wait for colposcopy is 17 weeks and the wait for hyst is 10 week. This is further compromised when the hyst is required as a GA due to a number of factors. (Increased from 9 to 12 – Gynaecology OPD HRI/CRH) OUTCOME: Risk to remain as current, and to be discussed at confirm and challenge meeting next week. May 23 - Risk Register Confirm & Challenge Meeting 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Working with NHS England and contracting, looking capacity and demand. May 23 low grade cases KPI remain at over 16 weeks, no additional funding agreed with commissioners which has supported the issue not deteriorating - discussed with NHS e who commission the service, increased risk as the currently position is expected to worsen. Escalated via PSQB and Directorate PRM, score increased Jan 23 - review by DT LD and GH still waits for low grade colp cases - case put in for additional nurse colposcopist to Division awaiting feedback	Oct-2023	Dec-2023		PSQB	stephen Shepley	Gill harries
High	8259	Family & Specialist Services	Women's Services	MAC	Feb-2022	Active	Transforming and improving patient	There is a risk of not meeting the required triage times of women attending our Maternity Assessment Centre for emergency assessment and treatment in line with the new standardised triage tool, due to the lack of dedicated obstetric medical cover. This may result in potential harm and deterioration of the patient if not seen and treated in a timely manner due to a breach in triage review time.	Current process is that MAC is covered by the on-call acute obstetric team covering labour ward. They attend MAC to review women when they are available. Implementation of new standardised triage tool (BSOTs) to ensure women are being appropriately risk assessed and prioritised for review approariately. Escalation process for delays in MAC is to the obstetric on call consultant.	When labour ward is busy often the obstetric team, including consultant are not available to review women.	15 3 x 5	15 3 x 5	2 1 x 2	Require a focus on identifying a dedicated obstetric registrar to cover MAC . - Doctor allocation from 15 May 23 Task and Finish group Review SOP's Link with ED, radiology, ANC, gynae Monthly MAC triage time audit Monitor datix through weekly governance	August 23 - reviewed GH LD ongoing challenges linked to risk 8006 - new rotation starts in Sept and additional recruitment occurred so improved position is predicted in Oct. July 27/7 - Confirm & Challenge Risk Meeting Attending: SS, JE, GH,FA, DT, LD, AF, LR, NB Close risk down as completed intended process, doctor has been moved by HRI, covered in overall staffing risk. July 23 reviewed by GH and LD - risk has been reviewed with the gaps in tier two rota 8006 unable to reduce score at this time due to inconsistencies in cover May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Potential to reduce score or close, now have a Registrar (Mon to Fri) and a Band 7 Service Lead, will consider score/re-audit at Womens Directorate PRM.	Aug-2023	Sep-2023		PSQB	Stephen Shepley	Gill Harries
High	8107	Family & Specialist Services	Radiology	Mammography	Jul-2021	Active	Keeping the base safe	Objective - Patient Safety Risk: Risk: Risk of delay in reporting mammograms Cause: Mammography scanning equipment is at the end of it's life span (the equipment is over 8 years old and the manufacturer is unable to service/maintain/obtain spare parts in the event of a breakdown) Effect: Delays in reporting breast imaging Impact: Patients will experience a period of extended waits for follow up appointments only during the time the equipment is replaced. The wait will extend the 12 month follow up appointment to approximately a 13 month follow up.	- The existing server has just been updated. However, we will be unable to do this again. - Images are stored on our main PACS system.	Siemens Healthineers are no longer able to offer any support for the Mammo reporting kit. There are no longer any migration opportunities as these have now expired too.	9 3 x 3	15 3 x 5	2 1 x 2	- To migrate the Mammography reporting onto the main Trust AGFA PACS system. Planned to do as soon as is possible with the appropriate internal and external engineers/expertise. - Works to take place 3 November 2021	August 2023 Update: The server supporting the reporting element system has failed. This has resulted in staff using an alternative reporting package. In the meantime, funding was approved to replace the whole of the existing breast imaging x-ray equipment, the equipment has been purchased and has been delivered. One room is currently being replaced (this will be complete end September). A second machine will be replaced (October 2023). All reporting hardware/software will be replaced by end October 2023. This has resulted in an extension to the risk in that by replacing the equipment will require downtime of one machine at a time. As a result, we have temporarily increased the risk score. This will be for the period of time to replace the equipment, following which this risk will be closed. The additional risk to patient has been added to the description.	Sep-2023	Nov-2023		PSQB		Nicola Stephenson
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	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.	September 2023: The injector at CRH is now broken and out of use. CRH are using ECHO as an alternative. In the new Cath Lab plan the injector is included as part of the costings - plan to be in place Autumn 2024. Business Case for replacement cost of one only for the HRI site drafted for Dragon's Den (13 October 2023). The risk score has been revised and increased as we are now unable to image patients at CRH and should the injector fail at HRI (our current contingency) we would not be able to perform these scans at all in which case the patient would be required to be emergency transferred to Bradford Hospital.	Sep-23	Mar-24		PSQB	Stephen Shepley	Ameet Uppal
High	8429	Medical	Medical Specialities	Cardiology	Oct-2022	Active	Keeping the base safe	PCI waiting time (19 weeks) and angiogram (15 weeks) waiting time >6 weeks. There is a significant risk that chest pain patients (NOAC and Elective) may have a heart attack (STEMI or NSTEMI) whilst awaiting their procedure. This is because once diagnosed from clinic (2 week wait for NOAC) and a further test such as CT angio (7 week wait) to diagnose, the total time from referral to treatment will be 30 weeks. This could have a significant impact on acute admissions and the bed base over time and may be worse through the Winter period. This could also have a significant impact on patients as they may have a heart attack that results in significant damage, and/or could lead to death if left untreated. At present, the waiting list continues to expand due to the current acute pressures, demand, and the increase in the complexity of cases. As a result, the risk has now become significant and urgent action is required.	Referrals to be validated on urgency, however there are too many patients at present with similar clinical histories. Patients rang if any spare capacity on a list, e.g cancellation	No more capacity, therefore unable to bring waiting list down. 1 x lab Lack of cross-cover in job plans.	20 5 x 4	15 5 x 3	4 2 x 2	- Requested extra lists, but no agreement on payment. - Continue to maximise capacity where possible.	July 2023 - risk discussed with directorate team and plan in place to do a deep dive of 100 patients to determine if any harm has occurred. This will then give us an indication of the risk scoring.	Aug-2023			DB		James Batlye
High	8453	Family & Specialist Services	Pharmacy	Pharmacy	Nov-2022	Active	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 ATOs. There is a 20% vacancy in the Clinical Pharmacist workforce and in the Pharmacy Dispensary Team. This shortage means that there can be delays or omissions in medication drug history checks, reconciliation, screening of inpatient medicine orders and follow up of pharmacy interventions, coupled with an impact on the dispensing and release of medication for inpatient and at discharge.	Prioritization of core medicines areas (1) discharge turnaround (2) medicine supplies. Prioritization of DWP and Safari cover to support patient flow. Staff with substantive posts undertaking additional hours as bank staff. Use of bank Pharmacist and Pharmacy technician where available to support gaps in the rota Staff recruitment to vacant posts. Training for new starters which priorities roles. Flexible working with the Pharmacy Team to priorities patient facing roles. Recruitment of locum pharmacists which has been unsuccessful to date.	Cannot resource all available vacancies even with bank staff	15 3 x 5	15 3 x 5	1 1 x 1	Recruitment Plan to address vacancies Discussion of stepping down functions and activities Discussion re restriction of leave /study time Review of co-coordinator Roles to support junior work force and patient flow Testing of a different weekend model of working across CRH and HRI sites	July 2023 - Risk Confirm & Challenge session Attending: SRF, LS, SP, JE, LAH, LR Check current vacancy rate - SP Re look at the current impact and likelihood scores, adjust where required.	Sep-2023	Sep-2023		PSQB	Elisabeth street	Katherine Cullen
High	8468	Family & Specialist Services	Pharmacy	Pharmacy	Nov-2022	Active	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 (Opel 4).Additional inpatient beds (> 90) have been opened to cope with system pressures. These extra capacity beds require additional pharmacy input, both for new patient admissions and discharges. The combination of increased bed base,increased acuity of patients and increased number of discharges without additional pharmacy staffing results in delays in TTOs, reduced % of meds rec completion and increase in medication errors.Over patient experience on discharge poor. Critical medication could be delayed or omitted either as an IP or due to discharge without medication.	We cancel all non essential work so that patient flow / TTOs are the priority however for prolonged periods of times this results in some must does not being done. This includes increase in risk of medication safety issues, reduced % of patients with completed Meds rec, poor compliance with meds safety audits and poor meds stock management with increased risk of medication waste. Since 2020 there has been temporary funding provided for pharmacy dispensaries to be open from 5-6pm at both HRI and CRH (average time staff leave = 6.30pm). This has allowed staff to cover by working additional bank hours to provide the service. However this lead to staff working additional hours above their contracted hours on mandated basis. Some staff have adjusted their hours on a contractual basis to finish later. The option to start later and finish later has been adopted by some staff but this means there are less staff available at the start of the day which can slow the response to demands for medicines (IP and TTO) work in the morning. These approaches are not sustainable.	Less staff available in the morning to cover work demands Finishing times are becoming progressively longer after 6pm/ impact on health and well being of staff Pharmacy not always informed if additional consultants employed at weekends to increase number of discharges Reduced job satisfaction and risk of retention issues due to staff feeling that they don't have the time do to their job properly (as seen in staff survey results) Lack of access to quality locum pharmacy staff to boost WTE available	15 3 x 5	15 3 x 5	1 1 x 1	Within departmental pressures for 2023-24 funding requested to staff the service long term. Request funding for Rowland's to open additional hours at weekends during winter period to support dispensing of ED and outpatient prescriptions allowing the inpatient pharmacy to focus on inpatient medication requirements.	July 2023 - Risk Confirm & Challenge session Attending: SRF, LS, SP, JE, LAH, LR Awaiting a conversation with SS regarding the 2 week ask to stay open until 6pm due to recent strikes, further direction needed. As discussed 8468 is taking on the Trust operational responsibilities, agreed to merge with Risk 8453 - add in relevant pressure info, then close 8468.	Sep-2023	Mar-2024		NA	Elisabeth Street	Katherine Cullen

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	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	August 23 GH LD GW reviewed no change in risk status identified July 27/7 - Confirm & Challenge Risk Meeting Attending: SS, JE, GH,FA, DT, LD, AF, LR, NB Review the controls July 23 - case submitted to the Division signed off in principle now awaiting Dragons Den May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Maternity reporting electronic software to improve patient safety and metrics, once approved by Division, may need to go through Dragons Den.	Aug-2023	Sep-2023		HSC	Gill Harries	Emma Burbidge
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	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	20/7/2023 - Paed Consultant interview for locum due to take place 3/8/23. Ms Gogi continues to support with WLI and ROP cover when needed. 1/9/2023 - agency paeds appointed, still in HR process. Mr Bekir has dropped 1 day therefore there is an increased riskl to the serivce should the agency consultant not confirm start date.	Oct-2023	Nov-2023		PSQB	Aletta Carbone	Natalka Drapan
High	8595	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Jul-2023	Active	Keeping the base safe	Financial Risk We are unable to replace the fluoroscopy equipment due to there not being any dedicated allocated funding resulting in a) a limited service being provided/reduced capacity; b) a continued unfunded cost pressure relating to the ongoing rental cost of the temporary c-arm solution and c) room refurbishment cost and equipment costs will increase over time. This risk replaces risk 8415 which related to the risk of failure of the equipment and links to risk 8146.	- Rental of c-arm to enable the service to continue providing a limited service (at a cost of £6,270k + VAT per month - set for 6 months, due to expire September 2022). - Some work is diverted to the Calderdale Fluoroscopy room, however this offers limited capacity due to existing demand.	- No dedicated funding to replace the equipment. - Inability to provide assurance that the c-arm will be available to hire until replacement equipment has been bought/installed.	15 3 x 5	15 3 x 5	1 1 x 1	- To develop a joint business case with the Endoscopy service for the replacement costs (estimated to be in excess of £500k).	18.07.2023: Risk approved at Radiology Board. To be accepted at next PSQB. August 2023: Accepted at August PSQB.	Oct-2023			PSQB		Emma Hurst
High	8568	Family & Specialist Services	Radiology	Medical Illustration	May-2023	Active	Keeping the base safe	Service Delivery Risk: 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% resulting in the inability to provide all medical illustration services and possible delays. Objective: Service Delivery Risk Risk: Risk of being unable to provide a full medical illustration service Cause: • reduction in Medical Illustration clinical photography staff by 50% • Staffing sickness and staff leavers Effect: Inability to provide all medical illustration services Impact: Delays in medical illustration imaging and delayed diagnosis. These impacts would need to be considered by the relevant clinical specialists. Clinical Impacts: The risk is low to eye clinic patients as they are all seen within 7 days of intended date. Ward rounds are currently reduced by 50%, potential risk to patients who are discharged before being imaged. Potential risk to Research patients, due to upload of image delays Potential harm for Dermatology and Plastics patients who attended unmanned studio. Potential risk of further service reduction due to annual leave over the summer	- Remaining staff had re-scheduled their working patters to provide cover on each site Monday - Friday. On some days this may be half day rather than full day. - To cancel/put on hold non-clinical imaging work/projects (i.e posters, staff portraits).	- Inability to provide cover for annual leave/unexpected sickness. - Inability to seek support from external agencies/organisations (none available that have appropriate medical photography qualifications).	15 3 x 5	15 3 x 5	2 1 x 2	- Current staff sharing workload between all sites. Staff changed working patterns to facilitate this. - To limit work to clinical work only, all non-clinical projects either not accepted or put on hold. - Prioritisation of all clinical work. - To continue to undertake all clinical work linked to research studies where financial penalties will be imposed if not undertaken. - Use of an appointment system to manage workloads (where this is applicable) - To continue to support existing planned clinics. - To split current two members of staff across CRH and HRI sties to ensure availability of the service on most days. - To recruit 1 x wte Trainee post.	26/7 - Confirm & Challenge Meeting Attending: SRF, SS, JE, CG, GE, LR Review the score and what the risk is describing in relation to harm that is currently been described every week. Given that we don't know which patients are being missed at the moment, review. JE will chase up with GE September 2023 Update: The position did improve when the long term sick member of staff came back to work and successfully recruited to the training post (commenced 14 August 2023). However, a member of staff is leaving on 6 October 2023. Another member of staff has asked to reduce their hours. A part Band 5 is awaiting approval along with another trainee post. Score left the same due to the imminent departure which will leave the team in the same position as when this risk was added.	Oct-2023	Jan-2024		PSQB		Jane Armitage
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	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.	21/07/2023- New consultant started and training implemented to use the next 7 weeks of designated time to reduce the volume of 900 patients on the Incomplete Orders (IO) and holding list overdue by 90 days. To monitor performance and review at the end of August . 31/05/2023 - Still high volume of patients, unable to identify quick wins and learning to help with backlog. We will need to review once the new consultant starts to free up some time for the clinicians 20/03 Current position statement, still with high volumes of patients awaiting validations. Appointed additional consultant due to start July 2023. Work ongoing with admin teams to see if can validate using trends to present at the consultant meeting once work has been completed. 07/02/2023- Current position statement. 1103 patients overdue for follow up appointment of which 112 52+ weeks 121 over 39 weeks Shortlisted x3 candidates for interviews to be penciled in for End Feb / early March. Current referrals for 2ww are consistent at 110 per week, however this was around 80 pre the pandemic. 74 patients are still awaiting definitive treatment over 52 weeks RTT. 22 Patients are being tracked over 62 days cancer target.	Sep-2023	Sep-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 Yorkshire Fertility patients to have a semen analysis. Once results are back its then a further 8 weeks wait for follow up (24 week wait) This is resulting in a direct impact on the business as clinics are under utilised due to the wait for the test, as next stages of investigations cannot happen without the result and also direct impact on patient outcome due to time limited activities for fertility patients and 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	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	September 23- updated as wait times now up to 24 weeks while awaiting semen analysis and then follow up with consultant. August 23 GH LD GW no change in status of risk July 27/7 - Confirm & Challenge Risk Meeting Attending: SS, JE, GH,FA, DT, LD, AF, LR, NB Update narrative with a Business perspective and reflect already on Pathology risk register. May 23 - Divisional Risk Register confirm and challenge update 23/5/23 Present: SRF, NB, TO, LM, GH, FA, NV, RR, DT, LR Met with Pathology with regards extra shifts at weekends (post VAS clinics), 8 samples a day via Pathology was 25, looking at figures and reviewing. GH speak to SR, should this risk be on the Pathology Risk Register. May 23 Review LD / GH continues to be challenges with wait times escalated to GM for pathology re next steps Feb 23 - Review LD / GH - score reviewed and unable to reduce from 15 due to frequency / likelihood and the length of the delay obtaining results. May 23 - wait no 14 weeks, meeting with service leads to add additional weekend appointments to reduce back log, a/w divisional approval June 23 - a/w bank shifts in patholgy to increase mid week capacity	Oct-2023	Dec-2023		PSQB	Gill Harries	Helen Gibbons

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 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 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	15 3 x 5	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.	Approved at PSQB April 23 July 2023 - still remains a risk as we are not meeting the 76% target on a daily basis and this is dependant on attendances to ED. 21/07/2023 reduction of risk score 16 - 15 was accepted at PSQB	Aug-2023	Jun-2024		DB		Tom Ladlow

24. Governance Report

a) Annual Review of Non-Executive Director Roles

b) Revisions to Standing Financial Instructions and Scheme of Delegation

c) Use of Trust Seal

d) Board Workplan

e) Board Committee Annual Reports:

• Huddersfield Pharmacy Specials (HPS) Annual Report

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Revisions to Standing Financial Instructions and Scheme of Delegation – Audit and Risk Committee 25 July and 24 October 2023 Huddersfield Pharmaceutical Special Annual Report – Finance and Performance Committee 1 August 2023
Purpose of the Report	This paper presents the following governance items to the Board: a) Annual review of Non-Executive Director roles b) Notification of revisions to Standing Financial Instructions and Scheme of Delegation c) Use of the seal report d) Board workplan for 2024 e) Annual Report for Huddersfield Pharmacy Specials
Key Points to Note	**a) Annual Review of Non-Executive Director roles** The Trust has seven Non-Executive Directors (NEDs) as follows: • Helen Hirst, Chair • Karen Heaton, Senior Independent Non-Executive / Deputy Chair • Andy Nelson • Denise Sterling • Peter Wilkinson • Nigel Broadbent • Tim Busby NEDs are members of the Trust Board of Directors but are appointees rather than employees. Their role is to contribute to the strategic direction and leadership of the Trust, to provide challenge to the Directors and bring independence to the Board. **Board Committees** NEDs chair and attend Board Committees. During the year NED input to Board Committee's was strengthened with three NED members (rather than two) joining the Finance and Performance Committee, Quality Committee and Workforce Committee. The current Committee membership is given below at Appendix T1.

NED Champion Roles
In line with guidance from NHS England that NHS Trusts have five NED champion roles, the following NEDs are confirmed as undertaking these roles within the organisation:

- Maternity Board Safety Champion – Karen Heaton
- Well-Being Guardian – Denise Sterling
- Freedom to Speak Up – Karen Heaton
- Security Management – Andy Nelson
- Doctors Disciplinary **–** all Non-Executive Directors

Succession Planning

The Trust Constitution sets out the details of the tenure of NEDs and the Nominations and Remuneration Committee of the Council of Governors is responsible for the recruitment of new NEDs. There are two NEDs who are due to leave in Spring 2024 and the Nominations and Remuneration Committee met on 31 October 2023 to agree the recruitment process for the two roles that will become vacant. The recruitment process will reflect the Board's aim to attract an increasingly diverse range of candidates in line with its Board Diversity Plan.

Once the new NEDs are recruited a review of NED roles and Committee membership will take place, which is expected to be in spring 2024.

Diversity- Non-Executive Director Development
The Trust has piloted for nearly two years an Associate Non-Executive Director role which was focused on supporting the quality agenda and has now ended.

The Trust has reviewed its approach to support diversity at Board level and, to support Board diversity, the Trust has joined the Insight Programme which gives prospective NEDs from under-represented groups first-hand experience of how Boards in the public sector work. The Trust has a participant from the programme, Krish Pilicudale, Director of Digital Information at the University of Huddersfield, who is attached to the Board for nine months, with a "buddy" arrangement with the Trust Chair, who oversees the attachment and provides mentoring support. This role is not an Associate Non-Executive Director role and does not have voting rights at the Board.

RECOMMENDATION: The Board is asked to **NOTE** the annual Non-Executive Director review and Board Committee membership, noting that Committee membership will be reviewed in Spring 2024 following completion of the recruitment process for two Non-Executive Directors.

b) Revisions to Standing Financial Instructions and Scheme of Delegation

Updates to the Standing Financial Instructions and Scheme of Delegation, which are key governance documents for the Trust, were presented for approval to the Board on 2 March 2023. At the time it was noted that further work was needed on an appendix within the Standing Financial Instructions.

This further work is now complete and, as reported in the Audit and Risk Committee highlight report, the Committee agreed changes to the Scheme of Delegation at its meeting on 24 October 2023. This was to reflect changes agreed by the Committee to the Standing Financial Instructions on 25 July 2023 which impact on the scheme of delegation, which predominantly relate to changes to authorisation limits. There were also minor updates to Appendix D, Mental Health Act 1983: Scheme of Delegation by the Hospital Managers and Training. Revised documentation will be made available on the intranet to colleagues. Board members may request a copy of the changes via the Company Secretary.

RECOMMENDATION: The Board is asked to **NOTE** the Audit and Risk Committee has agreed changes to the Standing Financial Instructions and Scheme of Delegation as described.

c) Report on Use of the Seal

The Trust Seal has been used on a further five occasions since the report to the Board in July 2023 of the seal being used twice since January 2023.

These five occasions related to:

- Lease agreement for Broad Street Plaza, Halifax with extension for Community Diagnostics facility
- three variation orders with Calderdale Hospital SPC for work at Calderdale Royal Hospital relating to the Pharmacy robot
- Pathology Service Agreement and Guarantee (Lot 1)

Further details are provided in Appendix T2.

RECOMMENDATION: The Board is asked to **NOTE** the use of the Trust Seal since July 2023.

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 workplan is presented for approval.

RECOMMENDATION: The Board is asked to **NOTE** the Board workplan for 2024.

e) 2022/ 23 Huddersfield Pharmacy Specials Annual Report

Huddersfield Pharmacy Specials (HPS) is a division of the Trust and manufactures and distributes a range of medicines under licences and authority from the Medicines and Healthcare Products Regulatory Agency (MHRA). The annual report for 2022/23 was reviewed by the Finance and Performance Committee on 1 August 2023 and is presented to the Board for information.

RECOMMENDATION: The Board is asked to **NOTE** the HPS Annual Report.

EQIA – Equality Impact Assessment	The content of this report does not adversely affect people with protected characteristics.
Recommendation	The Board is asked to: a) **NOTE** the annual review of Non-Executive Director roles and Board participation in the Insight Non-Executive Director development programme b) **NOTE** revisions to the Standing Financial Instructions and Scheme of Delegation have been approved on behalf of the Board by the Audit and Risk Committee c) **NOTE** the use of the seal d) **NOTE** the Board workplan for 2024 e) **NOTE** the 2022/23 HPS Annual Report

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APPENDIX T1 BOARD COMMITTEE MEMBERSHIP 2023

Committee	Chair	Non-Executive Directors	Executive Directors	Standing Invites (non-voting Directors)	Governor Observer (Non-voting)	Quoracy
Finance and Performance Committee	Andy Nelson	Nigel Broadbent Karen Heaton	Director of Finance	Deputy Chief Executive/ Director of Transformation & Partnerships Chief Operating Officer	Robert Markless Pam Robinson Deputies: Isaac Dziya, Brian Moore	4 members including Chair or Vice Chair and 1 Executive Director
Quality Committee	Denise Sterling	Karen Heaton Andy Nelson	Chief Nurse Medical Director	Chief Operating Officer Director of Corporate Affairs	Gina Choy Lorraine Wolfenden Deputies: Kate Wileman	4 members of the Committee and must include at least three Board members of which one must be a Non-Executive and 1 Executive Director
Workforce Committee	Karen Heaton	Denise Sterling Nigel Broadbent	Director of Workforce & OD Medical Director Chief Nurse		Kate Wileman Dr Sara Eastburn Deputies: John Richardson, Lorraine Wolfenden	4 members and must include at least 1 Non-Executive Director and one Executive Director
Audit and Risk Committee	Nigel Broadbent	Denise Sterling Peter Wilkinson	*In attendance*: Director of Finance	Chief Digital Information Officer Director of Corporate Affairs	Isaac Dziya Liam Stout Deputies: Tony Wilkinson, Jonathan Drury	2 of the 3 NED members

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Transformation Programme Board	Peter Wilkinson	Helen Hirst Andy Nelson	All Executive Directors including Chief Executive	All Directors		4 members, of which at least 1 Non-Executive and 1 Executive Director
Organ Donation Committee	Helen Hirst		Director of Finance		John Richardson Jonathan Drury Deputy: TBC	2 core members and 1 other member
Charitable Funds Committee	Helen Hirst	Nigel Broadbent	Director of Finance Chief Nurse Medical Director	*In attendance* Director of Corporate Affairs	Governor member: TBC	3 members of the Committee, this must include at least 1 Non-Executive Director and 1 Executive Director

In addition Tim Busby, Non-Executive Director, chairs the meetings of the Board of Calderdale Huddersfield Solutions Limited.

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS

REPORT FOR THE PERIOD JANUARY – OCTOBER 2023

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
03-23	4 September 2023	4 September 2023	The Trust signature and seal for a 15 year lease agreement for Broad Street Plaza in Halifax, with extension to next door unit for Community Diagnostics Facility	NAME: Gary Boothby TITLE: Executive Finance Director NAME: Andrea McCourt TITLE: Company Secretary Date: 4 September 2023
04-23	11 September 2023	11 September 2023	Signing to confirm the Trusts governance process for signature of the above Variation and confirms Chief Executive is authorised to sign the Variation on behalf of the Trust *Contractor's Collateral Warranty to NHS Foundation Trust relating to a project at CRH among Equans Buildings Limited and CHFT and Calderdale Hospital SPC Limited* **X 3 identical copies sealed**	NAME: Brendan Brown TITLE: Chief Executive NAME: Kirsty Archer TITLE: Acting Director of Finance Date: 11 September 2023

05-23	11 September 2023	11 September 2023	Signing to confirm the Trusts governance process for signature of the above Variation and confirms Chief Executive is authorised to sign the Variation on behalf of the Trust *Sub-contractor's Collateral Warranty to NHS Foundation Trust relating to a project at CRH among Heat Works Limited and CHFT and Equans Buildings Limited* **X 3 identical copies sealed**	NAME: Brendan Brown TITLE: Chief Executive NAME: Kirsty Archer TITLE: Acting Director of Finance Date: 11 September 2023
06-23	11 September 2023	11 September 2023	Signing to confirm the Trusts governance process for signature of the above Variation and confirms Chief Executive is authorised to sign the Variation on behalf of the Trust *CHFT and Calderdale Hospital and SPC Limited Confirmed Works Variation 73 relating to a Pharmacy Dispensing Robot CVI 73* **X 2 identical copies sealed**	NAME: Brendan Brown TITLE: Chief Executive NAME: Kirsty Archer TITLE: Acting Director of Finance Date: 11 September 2023
07-23	Legally enacted 6 October 2023	6 October 2023	Lot 1 Pathology Services Agreement and Parent Company Guarantee with Calderdale and Huddersfield NHS Foundation Trust, Mid Yorkshire Teaching NHS Trust, Leeds Teaching Hospitals NHS Trust and Siemens Healthcare Diagnostics Ltd	NAME: Gary Boothby TITLE: Executive Director of Finance 25.9.23. NAME: David Birkenhead TITLE: Medical Director 29.9.23. Company Secretary present for legal enactment meeting on 6 October 2023

			Completion documents issued electronically on 25 September 2023 and updated Schedule 9 Future of Management Fees also issued later on 25.9.23. 7 year contract length (plus 7 years). Contract value £14,041,950 over 7 years.	with authority from Director of Finance and Medical Director.

Previously reported to Board:

01-23	18 May 2023	18 May 2023	The Trust signature and seal for the Lease agreement for Westgate House, Halifax. The property is the new central Halifax location for Community Division offices following the vacation of Lister Lane as approved by business case with Michael Folan, Director of Operations.	NAME: Gary Boothby TITLE: Executive Finance Director NAME: Lindsay Rudge TITLE: Chief Nurse Date: 18 May 2023

02-23	18 May 2023 2023	18 May 2023	The documents required Trust signature and seal for the renewal lease and license for Lindley GP, 62 Acre Street, Lindley HD3 3DY. CHFT currently lease the property to Lindley GP and the lease is up for renewal. The partners have now formed Lindley Group Practice Limited and the license to assign is the document used to assign the lease from the partners names to the company. The lease term runs until 31 March 2028.	NAME: Gary Boothby TITLE: Executive Finance Director NAME: Lindsay Rudge TITLE: Chief Nurse Date: 18 May 2023

PUBLIC BOARD WORKPLAN 2024-2025

DATE OF MEETING	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	TBC	TBC	TBC	TBC	TBC	TBC
Date final reports required	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					✓	
Digital Update (Digital story and an update on the broader THIS work, not just the CHFT aspects)					✓	

DATE OF MEETING	2 May 2024	4 July 2024	5 September 2024	7 November 2024	9 January 2025	6 March 2025
Risk Management Strategy	✓RM Policy		✓			✓
Charity Strategy				✓		
Annual Plan	✓ for 2024/25					✓
Capital Plan					✓	
Resilience / Surge & Escalation Plan				✓		
Green Plan (Climate Change)		✓				
Reconfiguration (commercial)			TBC AB			
QUALITY AGENDA ITEMS						
Quality Board update	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓Q3	✓Q4	✓Q1	✓Q2		✓Q3
DIPC Annual Report		✓				
Learning from Deaths Quarterly Report		✓ Q3	✓Q4 Annual Report	✓Q1	✓Q2	✓ Q3
Maternity Incentive Scheme					✓	
Safeguarding Adults and Children Annual / Bi-Annual Report		✓ 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 (quarterly)	✓Q4		✓Q1	✓ Q2	✓Q3	
Guardian of Safe Working Hours Annual Report	✓					
Diversity				✓ Board Diversity Action Plan		✓
Medical Revalidation and Appraisal Annual Report			✓			

DATE OF MEETING	2 May 2024	4 July 2024	5 September 2024	7 November 2024	9 January 2025	6 March 2025
			Annual Report			
Public Sector Equality Duty (PSED) Annual Report						✓

GOVERNANCE & ASSURANCE AGENDA ITEMS						
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 2023)	✓					
Health and Safety Annual Report		✓				
Board Assurance Framework		✓ 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	✓ NRC	✓ Workforce	✓ARC	✓ TPB review Sept		✓QC ✓ 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					✓	
Committee review and annual reports		✓				
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)

Annual Report FY2023
Huddersfield Pharmacy Specials

1. Introduction

Huddersfield Pharmacy Specials (HPS), also referred to as the Pharmacy Manufacturing Unit (PMU), is a division of Calderdale & Huddersfield NHS Foundation Trust. HPS is a manufacturer of unlicensed sterile and non-sterile products known as Specials. Additionally, HPS provides a medicines over-labelling and re-packing service to hospitals and private providers, both contract manufacturing and research and development, and wholesaling of licenced medicines. We present below key achievements and the division's operational and financial performance during the financial year FY23 (1st April 2022 to 31st March 2023).

2. Structure, Governance and Management

HPS trades from purpose built facilities (33,000 sq. ft. of space) located at Acre Mill (School Street West), Huddersfield. The unit operates under the authority and licences issued by The Medicines and Healthcare Products Regulatory Agency (MHRA), the UK medicines regulator. The licences the unit have which permit it to operate, manufacture and provide services are listed below; no additional licences were added to the list during FY23.

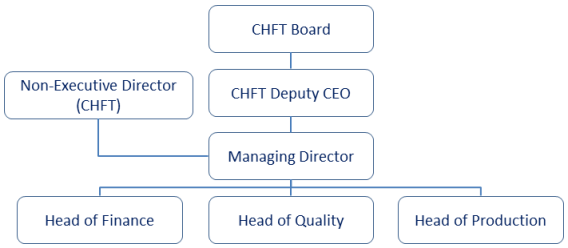
Table 1: HPS licences and certifications

Activity	Licence/Certificate	Authorisation/Licence /certificate no.	Most recent Issue Date	Expiry Date
Specials/Unlicenced medicines manufacture	Manufacturers "Specials" Licence	MS 19055 version 21	07/12/2022	Ongoing
Licenced medicines (non-sterile) manufacture	Manufacturers/Importer's Licence (MIA): Certificate of GMP Compliance of a Manufacturer UK MIA	UK MIA 19055 Insp GMP 19055/431097-0011	Inspection 04/02/2020 issued 23/04/2020	Ongoing
	Manufacturers/Importer's Licence (MIA): Manufacturer's/Importer's Licence	MIA 19055 Version 6	19/12/2022	Ongoing
Medicines for clinical trials manufacture	Investigational Medicinal Products: Certificate of GMP Compliance of a Manufacturer UK MIA (IMP)	UK MIA(IMP) 19055, Insp IMP 19055/431097-0013	Inspection 12/01/2022, issued 07/02/2022	Ongoing
	Investigational Medicinal Products: Manufacturers Authorisation - IMP	MIA (IMP) 19055 Version 23	15/12/2022	Ongoing
Storage and Distribution of medicines	GDP Compliance of a Wholesale Distributor	UK WDA (H) 19055 Insp GDP 19055/431097-0008	Inspection 04/02/2020, issued 10/03/2020	Ongoing
	Wholesaler Distribution Licence WDA(H)	19055 version 04	26/05/2023	Ongoing
Handling of controlled drugs	United Kingdom Controlled Drug Licence	2042/1272044	14/03/2023	13/03/2024
Handling of alcohols	Authorisation to receive duty free spirits	DFS/020537	23/12/2016	Ongoing
Handling of alcohols	Industrial denatured alcohol (IDA)	DNA/138430	17/04/2020	Ongoing

On a day to day basis, HPS is run by a Senior Management team headed by a Managing Director who in turn reports into the Trust's Deputy Chief Executive; the Senior Management Team meets at least once a week formally and at other times on a specific project by project basis. The board of HPS consists of the Senior

Management Team, the Trust's Deputy Chief Executive (also the board chair) and a Trust Non-Executive Director. Board meetings are held every two months although management and financial reports are produced on a monthly basis and the Managing Director and Trust's Deputy Chief Executive meet monthly. The current board governance structure is given below.

Figure 1: HPS Governance structure



3. Workforce

During FY23 the current Managing Director completed his 7th year in post. Overall, staff in post at the commencement and end of FY23 numbered 73 and 64 respectively. On a whole time equivalent basis, HPS employed 58.95 WTE at the beginning of FY24 (a decrease of 6.96 WTE's during FY23).

Table 2: HPS staff numbers

	End of							
	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
No. staff in post (SIP)	56	64	63	62	69	66	72	64
No. WTE	51.45	59.60	58.44	57.72	64.71	61.12	65.91	58.95

During period, HPS was unable to recruit to the post of Head of Regulatory Affairs and Clinical Trials; accordingly, the MD of HPS is deputising with support from external contractors. Overall, the staffing structure (figure 2) remained largely unchanged from previous years with manufacturing and production being delivered through teams working in the distinct operational areas of sterile, non-sterile and tablet packing; staff in these areas were supported by teams from regulatory, clinical trials, quality (including new product development), customer services, warehousing and cleaning (see table 3 below for staffing number splits by function).

Figure 2: HPS staffing by band

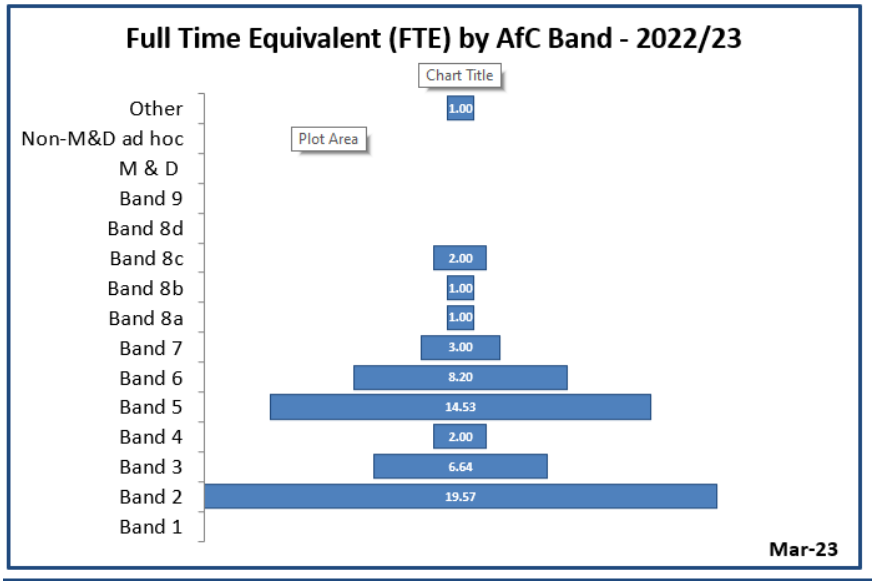


Table 3: HPS staff numbers by function (March 2023)

Function	SIP	WTE
Quality Control and Assurance	13	10.8
Sterile production	12	11.2
Tablet packing	9	8.2
Non-Sterile Production	7	6.6
Sales, customer services and warehouse	5	4.55
New product Development	4	3.6
Cleaning/domestics	4	4
Senior Management Team	4	4
Finance	2	2
Clinical Trials	2	2
Administration	1	1
Project Management	1	1
Regulatory Affairs	0	0
Total	**64**	**58.95**

SIP=staff in place, WTE = whole time equivalents

Appraisals and mandatory training: At the commencement of FY23, HPS reported 98.11% completion of staff appraisals covering FY23 (above the 95% target). Mandatory training completion rates ranged from 95.31% to 100% across the 10 training requirements (all well above the 90% target).

Sickness: At the end of FY23, HPS had an annual sickness rate of 4.48% (long term 4.17%, short term 0.31%) versus a Trust target rate of approx. 4.00%; the estimated cost to HPS of this sickness was £90K.

Staff survey: During FY23 HPS received staff feedback arising from the Trust wide staff survey and accordingly further consulted with colleagues; at the time of writing HPS is engaged in a program of change to implement recommendations derived from the staff survey results.

4. Finance

During FY23 HPS delivered income of £9.6m and returned to the trust a contribution of £1.6m, as is shown below (table 4).

Table 4: HPS financial results FY23

	FY16	FY17	FY18	FY19	FY20	FY21	FY22	FY23
Income	£7.1m	£7.8m	£9.8m	£12.4m	£15.3m	£15.4m	£12.0m	£9.6m
Contribution	£2.2m	£2.3m	£2.8m	£2.9m	£3.4m	£3.4m	£2.6m	£1.6m

The main contribution generating functions within HPS during FY23 were sterile and non-sterile production, and tablet packing. Furthermore, from a cost perspective staff continue to contribute to the process of reviewing all business expenditure (for example, historic plant and equipment maintenance contracts which were identified as an area of review in-order to decrease operational cost).

Revenue wise, sales were split across our functions as set out below (table 5) during FY23.

Table 5: HPS revenue analysis FY23

Function	% of FY17	% of FY18	% of FY19	% of FY20	% of FY21	% of FY22	% of FY23
Tablet packing	29.8%	42.9%	29.9%	27.0%	18.22%	21.00%	21.5%
Sterile production	36.9%	25.4%	21.4%	14.7%	15.94%	23.39%	35.5%
Non sterile production	27.0%	20.2%	16.8%	14.2%	10.81%	15.74%	18.3%
Contract manufacturing*	-	6.3%	4.6%	2.6%	2.52%	2.56%	2.6%
Wholesaling	-	2.0%	24.2%	38.3%	46.42%	26.17%	18.3%
Contract research	3.0%	1.0%	0.1%	0.2%	0.46%	0.66%	-
Clinical trials	-	0	0.9%	1.1%	3.01%	8.86%	1.7%
Others**	3.3%	2.2%	2.1%	1.9%	2.62%	1.60%	2.1%

* Included in sterile production figures in FY17

** Delivery charges and small order handling charges

Agency spend: There was no spend on agency at close of FY23 and there is no planned agency spend for FY24.

Capital Expenditure: During period HPS drew/was allocated approximately £50K of capital spend (£100K in FY22) to purchase two floor platform scales.

Aged debt: The aged debt position for the unit improved by £102K from period opening and closing values of £1.91m and £1.79m respectively, mostly due to more close monitoring of accounts receivable. The senior team monitor aged debt on a monthly basis and continue to pursue mitigation measures such as requesting card payment at the point of customer order and a formal process of debt "chasing" where customers have had accounts put on stop until monies owed have been paid.

Table 6: HPS aged debt position FY23

	FY17	FY18	FY19	FY20	FY21	FY22	FY23
Period opening value	£0.92m	£1.08m	£1.32m	£1.72m	£1.89m	£2.41m	£1.91m
Period closing value	£1.08m	£1.32m	£1.72m	£1.89m	£2.41m	£1.91m	£1.79m
Change in period	+£160K	+£240K	+£440K	+£170K	+£520K	-£500K	-£102K
Current debt (%)*	61%	52%	33%	26%	23%	64%	18%

*invoices issued that are less than 30 days old

5. Business activity and strategy

Historically, HPS has supplied product to every NHS Trust in the UK. During period, HPS traded with 264 NHS organisations and approximately 278 private company sites (mainly corporate/independent pharmacies). Some 67% of revenue was derived from NHS organisations; revenue originating from private customers decreased from 44% (FY22) to 33% in FY23. Based on our underlying strategy, we anticipate that over the coming years the share of revenue from the private sector will increase due to HPS diversifying into contract research and manufacturing (where the customer typically will be pharmaceutical companies), clinical trials, licensing of products and exporting (of licenced medicines) etc.

HPS throughout FY23 pursued and delivered a business strategy that sought to enhance or develop sales in the following areas;

i) Maximise sales of existing products (across sterile, non-sterile and tablet packing)
ii) Obtain Licences (marketing authorisations) for existing products
iii) Manufacture new products where competitors can no longer service the market (opportunity lead sales)
iv) Introduce new products where demand and a business case have been proved
v) Contract manufacturing for third parties
vi) Contract Research for third parties
vii) Clinical Trial supplies (the manufacture of investigational medicinal products and sourcing of clinical trial comparators)
viii) Wholesaling (non NHS contract lines) of medicinal products

Overall, the strategy is proving to be successful with the unit now having identified and developed a strong pipeline of licensable products which are being progressed through regulatory licensing/approval procedures.

Clinical Trials: The manufacturing of medicines to be used in clinical trials (investigative medicinal products (IMPs)) and related services to deliver clinical trials was a business area that HPS did not actively participate in historically. However, in-line with our strategy this was identified as a business opportunity for HPS and accordingly through renewed focus and recruitment of delivery resource HPS has continued during FY23 to deliver clinical trial services to the NHS, academia and industry.

Engagement with clinicians: The unit continues to increase its visibility and interactions with clinical colleagues based at CHFT and the wider region; this work will result in new products being developed that will be launched in FY24/25. Such activity forms a sound basis for the future growth of HPS.

Accordingly, HPS will continue business activity in the above areas and commences FY24 with a strong sales pipeline.

6. Forward plan and strategy for FY24

Looking forward HPS has embarked upon FY24 with a similar strategy as that set out above for FY23 and we expect to report significant progress against each strategic aim during the course of the coming year. In particular during the course of FY24 HPS is seeking approval of marketing authorisations submissions that are being reviewed by the UK medicines regulator. Equally important (and fundamental to ensuring the future performance of HPS) is obtaining financing that allows the delivery of identified strategic objectives.

25. Transformation Programme Board Terms of Reference

To Approve

Presented by Peter Wilkinson

Date of Meeting:	Thursday 2 November 2023
Meeting:	Public Board of Directors
Title of report:	Transformation Programme Board – Terms of Reference
Author:	Anna Basford, Deputy Chief Executive and Director of Transformation and Partnerships
Sponsor:	Peter Wilkinson, Chair of the Transformation Programme Board and Trust Board Non-Executive Director
Previous Forums:	Transformation Programme Board – 18 October 2023
Purpose of the Report	To request Trust Board approval of the updated Terms of Reference for the Transformation Programme Board.
Key Points to Note	The Transformation Programme Board (TPB) was established in 2019 to provide oversight and assurance to the Trust Board on strategic developments including- strategic capital investments, the programme of service reconfiguration, digital transformation and climate change. The Terms of Reference for the TPB have been reviewed annually and updated in 2023. The updated Terms of Reference were agreed by the TPB in October, the purpose of this report is to request Trust Board approval of the refreshed Terms of Reference.
EQIA – Equality Impact Assessment	The proposed Terms of Reference for the Transformation Programme Board will address the needs of the whole population, including those who currently experience disadvantage and are intended to help improve access, experience and outcomes for all. The proposed changes to the Terms of Reference for the Transformation Programme Board do not generate differential discriminatory equality impacts.
Recommendation	The Trust Board is requested to **APPROVE** the refreshed Transformation Programme Board Terms of Reference.

Calderdale and Huddersfield
NHS Foundation Trust

TRANSFORMATION PROGRAMME BOARD TERMS OF REFERENCE
October 2023

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Transformation Programme Board.

2. Authority

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

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

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

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

3. Purpose

The purpose of the Transformation Programme Board (TPB) is to oversee and provide assurance on the delivery of complex transformation programmes described in the Trust's Five Year Strategic Plan. This includes:

- The TPB will provide oversight and assurance to the Trust Board on all strategic capital investments that are high value and of significant strategic importance. This includes the programme of service and estate reconfiguration.

- The TPB will provide oversight and assurance to the Trust Board of elective, non-elective, and community transformation programmes of work that will

deliver the Trust's Future Target Operating Models to improve the quality, safety and experience of patient care.

- The TPB will provide oversight and assurance to the Trust Board on delivery of the Trust's Digital Strategy that patients and colleagues are digitally enabled to provide and receive care, in any location this is needed, to improve patient experience and outcomes.

- The TPB will provide oversight and assurance to the Trust Board on delivery of the Trust's Green Plan. To achieve reduction in the Trust's impact on the environment and delivery of carbon net zero.

- The TPB will provide oversight and assurance to the Trust Board on work undertaken as an 'Anchor Partner' to generate social value and support local economies in Calderdale and Kirklees.

- The TBP will provide oversight and assurance to the Trust Board on involvement and communication with internal, place, regional and national stakeholders in relation to the issues described in this ToR.

4. Duties

The Transformation Programme Board will meet on a monthly basis and will manage a programme plan reflecting the scope of areas described in section 3. The Committee will scrutinise and provide assurance to the Trust Board on:

- stakeholder involvement and communication
- quality and equality impact assessments
- financial plans and budgetary control
- programme risk management

5. Membership and attendance

5.1 The Transformation Programme Board shall consist of the following members:

- Two Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee
- Chair of the Trust Board
- Chief Executive / Senior Responsible Owner for Programme of Reconfiguration (SRO)
- Chief Operating Officer
- Medical Director & Director of Infection Prevention and Control
- Chief Nurse
- Director of Workforce and Organisational Development
- Director of Finance

- Deputy Chief Executive & Director of Transformation and Partnerships (Programme Director)
- Deputy Chief Executive & Director of Operations for Reconfiguration
- Director of Corporate Affairs
- Chief Digital and Information Officer
- Managing Director – Calderdale and Huddersfield Solutions.

5.2 The following shall be required to attend all meetings of the Committee:

- Transformation Programme Manager
- Transformation Programme Governance Lead (notes)
- Associate Director of Finance

5.3 Other attendees may be co-opted or requested to attend as considered appropriate and may include external advisors. The Trust's Lead Governor will be invited to attend all meetings as an observer.

5.4 A quorum will be four members of the Committee and must include at least one Non-Executive and one Executive Director.

5.5 Attendance of members or their nominated deputy is required at 75% of meetings. Members unable to attend should indicate in writing to the Chair and Committee Administrator of the meeting. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.6 A register of attendance will be maintained, and the Chair of the Transformation Programme Board will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Committee shall be supported by the Transformation Programme Governance Lead, whose duties in this respect will include:

- In consultation with the Chair, develop and maintain the reporting schedule to the Committee.
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Ensuring a highlight report is produced and sent to the Trust Board in line with the reporting arrangements.

- Advising the group of scheduled agenda items,
- Agreeing the action schedule with the Chair and ensuring circulation.
- Maintaining a record of attendance.

7. Frequency of Meetings

7.1 The Committee will meet monthly. Additional meetings may be scheduled if required.

8. Reporting

8.1 The Transformation Programme Board will provide a report to bi-monthly meetings of the Trust Board and provide an annual report of work undertaken by the Transformation Programme Board. Any urgent matters requiring Trust Board approval should be discussed with the Company Secretary and Chair of the Trust Board.

8.2 The Transformation Programme Governance Lead will produce and maintain a standard agenda; any additional agenda items must be sent to the Governance Lead no later than ten working days prior to the meeting, urgent items may be raised under any other business.

8.3 An action schedule will be articulated to members following each meeting and must be duly completed and returned to the Governance Lead for circulation with the agenda and associated papers.

8.4 The agenda will be sent out to the Transformation Programme Board members five working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.5 Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will inform the Chair's highlight report which will go to the next Trust Board of Directors meeting.

8.6 In considering reporting to the Trust Board, the Transformation Programme Board will consider Guidance for Reserving Matters to a Private Session of the Board of Directors.

9. Review

9.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2 The terms of reference of the Committee shall be reviewed by the Trust Board of Directors at least annually.

10. Monitoring effectiveness

10.1 In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled
- Members' attendance was achieved 75% of the time
- Agenda and associated papers were distributed five working days prior to the meetings
- The action points from each meeting are circulated within two working days, on 80% of occasions.

These Terms of reference will be reviewed after three years to determine if there is a continued need for the Transformation Programme Board.

26. Items to receive and note

1. Minutes of Board Committees

- Finance and Performance Committee 30.8.23, 26.9.23
- Quality Committee 21.8.23, 25.9.23
- Workforce Committee 23.8.23

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 (https://www.calderdalecares.co.uk/about-us/meeting-papers/)

To Receive

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Wednesday 30th August 2023, 09.30am – 12noon Via Microsoft Teams

PRESENT

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director **CHAIR for this meeting**
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

IN ATTENDANCE

Rochelle Scargill (RLS)	PA to Director of Finance (Minutes)
Peter Keogh (PK)	Assistant Director of Performance
Adam Matthews (AM)	HR Business Partner
Andrea McCourt (AM)	Company Secretary
Helen Rees (HR)	Director of Operations – Medicine
Tom Strickland	Director of Operations – Surgery

OBSERVERS

Robert Markless (RM)	Public Elected Governor

APOLOGIES

Gary Boothby (GB)	Director of Finance
Stuart Baron (SB)	Associate Director of Finance
Jonathan Hammond (JH)	Chief Operating Officer
Philippa Russell (PR)	Deputy Director of Finance
Brian Moore (BM)	Public Elected Governor
Robert Birkett (RB)	Managing Director of THIS

ITEM

136/23 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

137/23 DECLARATIONS OF INTEREST

138/23 MINUTES OF THE MEETING HELD 1st August 2023

The IPR section stated that the May IPR was approved instead of June which was the one presented. There was also a statement that the IPR would be reviewed and refreshed in September, but it will be October with September's data used.

Other than the above the previous minutes were approved as an accurate record.

139/23 MATTERS ARISING

140/23 ACTION LOG

The Action Log was reviewed as follows:

115/23 – BAF risks – Later on the agenda.

114/23 – Self Assessment – Future planning has been added to the workplan for October 2023 as discussed at the last meeting.

Both items are now closed.

141/23 STROKE and NECK OF FEMUR DEEP DIVE UPDATES

Stroke – The Medicine Division Director of Operations presented a brief update on the position of the stroke service since the last update to this committee in February. A ten-point action programme has been developed and is monitored regularly and we are starting to see improvements. Task and finish groups have been established and escalations take place when required.
The team are also working with the ICB to see what can be done differently e.g., discharge process. The expectation is to see more of an improvement in the SSNAP score by September/October.

The committee asked for further clarification around recruitment. The team are still to recruit the consultants and are still reliant on locums, which we have been unsuccessful in transferring over to become substantive members of staff. Thrombolysis has had recruitment challenges, but improvements are expected now that the new recruits are settling in.

Admission within 4 hours is still the biggest challenge. There used to be an assessment bed within the ED at CRH where patients would be assessed then transferred to the stroke ward if required. Since Covid this capacity has not been available. The team are now looking into the possibility of an assessment area within the Stroke unit. Those presenting with suspected stroke would then be fast tracked direct to the ward for assessment. The pathway for blue light patients with suspected stroke is to go direct to CRH. Self-presenters at HRI would be fast tracked to the unit at CRH.

The team have reached out to Mid Yorkshire to share learning but there are no formal regional groups that meet.

ACTION: AN to look at the plan for future deep dives with JH when they both return. It may be that just a short written update on Stroke performance is required instead of a deep dive update as in this meeting.

Neck of Femur (NoF) – The Surgery Division Director of Operations gave an update since he last attended this committee. The target is to get all patients with a fractured NoF into theatre within 36hours which has been proven to improve patient outcomes and mortality rates. Historically the performance since the pandemic has not been where it was hoped it would be. Performance is on an

upward trend with 2022 increasing to 61.3% from 57.3% in 2021. During the first 6 months of 2023 this has increased to 66.7%.

Some months have very high admission numbers. However, there is no direct link between volume and performance numbers. In March 2023 there were just under 60 admissions, but performance was really high at 78%. In June the number of admissions was lower at 47 and performance was also significantly lower at 53%

The challenge is trying to get patients into theatres within 36 hours of admittance. For example, if 6 NoFs present overnight it is challenging trying to get all those into theatre. Mortality rates have a target of below 5% which is the national average. In the first six months of 2023 the figure has increased to 7% with January and May as statistical outliers. For each of these there is a governance process in place with a review of each event.
A trauma improvement programme was set up within the division in March 2023. This is a formalised improvement programme with two different workstreams. One is around length of stay and the second looking at systems and processes for patients going in and out of trauma theatres. At the last update there was talk of the trauma team undertaking go see visits. The team have been on visits to Barnsley and Rotherham and good relationships have been built with both trusts and the visits were very positive.

CHFT has been rated 1st out of 116 trusts in March 2023 in terms of SHMI deaths following NoF.

FINANCE & PERFORMANCE

142/23 MONTH 4 FINANCE REPORT

The Trust is reporting a £8.95m deficit, (excluding the impact of Donated Assets), a £1.27m adverse variance from plan. The in-month position is a deficit of £1.85m, a £0.29m adverse variance.

Key drivers of the adverse variance included: higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £1.39m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £0.73m; non-pay inflationary pressures including Utilities; and an unplanned funding top-slice to support nationally procured Microsoft licences. These pressures were offset to some extent by early delivery of other efficiencies and higher than planned commercial income (HPS). Other key points to note are;

- Full receipt of the year-to-date Elective Recovery Funding (ERF) allocation has been assumed (£5.01m).
- West Yorkshire mechanism for allocating Elective Recovery Funding (ERF) focuses on targeting achievement of waiting list performance rather than activity volumes. Financial penalties will be imposed for any

patients not treated within the 52-week target. Year to date the Trust has delivered its Elective Recovery Plan and has therefore not assumed any penalties.

- Overall Weighted Elective Recovery Position as a percentage of plan was 109.0%.
- The Trust has delivered efficiency savings of £6.90m, £0.13m higher than planned.
- Agency expenditure year to date was £3.86m, £0.36m lower than the Agency Ceiling, (3.7% of total pay expenditure) but £0.68m higher than planned.

A pressure has been identified in relation to the strikes within the figures presented but there is going to be further work carried out to make sure that the correct costs are being attributed to the strikes.

Capital is currently underspent but planned spending has started within month 4. £1.73m has been spent against a plan of £6.6m with the material differences being timings on the pharmacy robot, HRI reconfiguration and leases. Consequently, this has an impact on the cash position with £9m more in bank than planned. We are still forecasting a requirement for cash support later in the year.

CIP better than planned with a focus on schemes which are high risk.

Year-end forecast scenarios are not in the pack but have been seen at this group before. CHFT are forecasting to deliver the planned £20.80m deficit, but the likely case scenario included £7.1m of unidentified mitigation required to offset financial pressures.

The adverse variance contains the strike costs for the planned strikes that were known about at month end. Any announced since then have not been included.

The “likely” case forecast already includes a certain amount of mitigation. There have been two escalations so far through TE, ED and Length of Stay, have any actions been identified to close the gap. The teams have clear guidance when attending the escalations which is provide detail on what they require to deliver the position originally stated. There is another session planned at the end of September which will look to address the expected overall CIP gap.

Graduate nurses started in September, and we have overseas nurses coming off supernumerary which should boost the substantive workforce and enable us to move further away from use of high-cost agency staff.

Allocations national or regional don’t seem to be fair towards CHFT but are decided on an issue-by-issue basis. The medical pay award has not yet been transacted so unable to announce the potential budgetary pressure. This is not a unique position to CHFT. The Microsoft licences was an error. The decision was oversimplified and assumed that the savings would benefit everyone which they have not. This has now been reviewed.

In relation to the ICB financial position the adverse variance to plan varies by organisation. The ICB are looking at the themes behind the variances as well as each organisation. The overall ICB variance to plan is £27.1m year to date.

In order to apply for cash support Trust Board approval is required. This committee is asked to give assurance to the Board that the relevant planning has taken place. The full paper is included in the meeting pack. We currently have more cash in the bank than originally planned but this is due to a timing issue with some of the capital spend. The forecast is that the capital spend will return to plan.
We are looking for cash support as per our plan.
The committee asked what would happen if more cash was required later in the year. We have the opportunity in quarter 4 to revisit our cash support requirement. This will be minimised as much as possible. You are not allowed to draw down more than you require to maintain the minimum cash balance.

The committee questioned why, in the planned position, there is such a difference in the cash position between November and December. This is partially due to when payroll is paid out. There is also an anomaly which only occurs in Month 9 and Month 12 which is that the cash position is recorded on the last calendar day of the month. In all other month's closedown occurs a few days before the end of the calendar month in order to report month end as soon as possible and sometimes occurs before payroll is run. The other dynamic is the diminishing cash balance that you would expect to see month on month. These together create the difference in December.

The chair of the committee asked that if we applying for cash support this year where does this leave us in terms of the next financial year? This is assessed on a quarter-by-quarter basis and would depend on the cash, capital and planning guidance issued nearer the time.

The committee **RECEIVED** the Month 4 Finance Report and approved the application for cash support.

143/23 2022/23 NATIONAL COST COLLECTION PRE-SUBMISSION REPORT

The National Cost Collection submission is due to be submitted in November 2023. Prior to that a paper has been submitted to this committee in relation to this which will be passed to Board to give them assurance.

Support will be required to the costing team from the divisional teams to complete some of the actions in the plan.

A future paper will be brought to this committee describing some of the outputs from this submission.

The data provided in this report informs the model hospital data. The committee asked if PFI costs are included. CHFT always have higher costs due to having a PFI. When looking at the benchmarking it is possible to pick relevant costs per organisation who also have a PFI. The data is not used by the ICB for resource

allocation. When operating on a payment by results system this information could be used when determining the tariff rates.

The committee questioned if appendix B contained longer term actions or items that have to be done for the paper. It is made up of a mixture. Where possible as many actions will be completed prior to the submission.

ACTION: When the final paper comes to this committee can the cover page include 2-3 sentences explaining what has been done.

The committee asked how do we ensure consistency across the region such as allocations of overheads being done in the same way? There are a lot of rules and expectations within the submission process and the costing lead has a lot of experience. Various costing forums also work together to tease out any issues. Not everyone in WYAAT uses the same software.

The Committee **APPROVED** the 2022/23 National Cost Collection pre-submission report to go to board.

144/23 NHSE FINANCIAL DEEP DIVE AND REPORT

A paper was provided to the committee to describe the output of the Financial Deep Dive carried out by NHSE on 7th June 2023. This was for information only and future updates will be brought to this committee. The deep dive consisted of a one-day visit by NHSE with a national and regional NHSE rep, the ICB director of Finance and colleagues from local Places.

There was no set agenda, but the plans were discussed in detail. Feedback was received in July.

The recommendations cover three themes: actions that can be done directly by CHFT, some which are more generic around budgetary management etc, and some around the ICB and partnership working. This last theme is the reason that the action plan is in draft form as there is a meeting planned with the ICB Director of Finance to review the plan.
Subject to any changes the plan will become more formal and shared. The high level information has been shared through the ICS Finance forum and with the Regional Finance Directors.

The regional NHSE team alongside the ICB will be responsible for monitoring CHFT against this action plan.

AB asked for it to be noted that CHFT has had a number of deep dives over the years. On each occasion they have not revealed any big opportunities that are being missed. None of the comments made in this report were unknown to the Trust and none that would affect the underlying position.

The reconfiguration plans will make a difference to the financial position but is it possible to include on the plan any short-term actions that are in place until reconfiguration is complete. Nationally the ICB's are being tasked with managing

the financial position more than individual organisations. Something will come back to this committee as work starts on next years financial plan which will look at our medium-term financial position.

The Committee **NOTED** this report.

145/23 TURNAROUND EXECUTIVE 2023/24 CIP PROGRESS

There are areas going through the TE escalation process and the revised positions will be accepted or rejected at the CIP mitigation session at the end of September. There is a lot of positive work being done and CHFT is in a strong position in terms of the rigour of its management of the cost improvement plan.

The Committee **RECEIVED** the Turnaround Executive update

146/23 IPR

Performance Matrix Metrics Changes

Diagnostic activity undertaken against activity plan – this is the only movement in the matrix for July which has gone from common cause variance hit/miss to special cause improvement and hit/miss target.

For July 2023 we continue to perform well in terms of **elective recovery** 65/52/40 weeks although we did see a small increase in 40-week waits due to cancelled lists caused by strike action. ENT is the most challenging specialty and a Task and Finish group has already identified a combination of solutions to address their capacity deficit:

- Demand management through an effective referral triage service.
- Return to pre-pandemic capacity through template and on-call review / changes.
- Recruitment into current workforce gaps.
- Short-term increase in independent sector use to mitigate current workforce gaps and support reduction in ASI backlog.
- Improved productivity to ensure all available capacity is fully utilised.

For **diagnostics** we still have challenges in Echo and a Recovery paper for TTE scan backlog has been sent to the Exec team for approval with support needed regionally to needed to get back on track due to the size of the current backlogvolume. Neurophysiology trajectory shows that we are expecting to be back to the targeted 6 weeks wait time by the end of November 2023.

There is significant work happening to reduce our **follow-up** backlog. Admin validation has managed to reduce the backlog from 27,000 to 23,900 by closing appointment requests that are not needed. Initiatives such as Patient Initiated

Follow-up (PIFU) have been implemented and based on our good performance CHFT is one of the Trusts selected nationally to see if we can go “further faster” and share learning. CHFT is the only Trust in West Yorkshire to reach 5% PIFU.

Cancer performance continues to be strong although the faster diagnosis performance reduced further in July following the impact of Telederm which is being addressed.

ED performance for July was 70.61% with a drop in daily attendances but still high numbers of TOC patients and high bed occupancy. We were still within the top 13 Acute Trusts nationally for type 1 ED performance.

For **Community** we have introduced a metric on OPAT - Outpatient Parenteral Antimicrobial Therapy – this is Community-based provision of IV antibiotic treatment for patients who otherwise would have received this as a hospital inpatient.

In terms of **SHMI** the latest reporting month of April 2023 does show a performance of 108.85. This is following the national annual rebasing exercise where the first reporting month after that rebasing performance can deteriorate. This is updated as we move through the year and we would expect this performance to improve as has been seen with the HSMR performance being over 100 for April 2023 but has come back to the 94 range for May 2023.

There was 1 **never event** reported in July 2023 which is currently under investigation.

Complaints closed within timescale at 87% is lower than aspired to due to FSS Division’s individual performance of 75% but is still strong.

The target of 95% of adult patients to receive a **MUST** assessment within 24 hours of admission/transfer to the ward is still a particularly difficult challenge for the Trust although there have been improvements in performance in the last 2 months. Protected mealtimes are not yet embedded in ward areas following the audit carried out in June. This has also been identified via the Observe and Act part of the Journey to Outstanding work and will be discussed again at the N&H group meeting with actions agreed.

For **Health Inequalities** metrics have been further expanded with the introduction of key indicators for Deprivation (IMD 1 and 2 patients). Further work continues for these patients alongside patients with Learning Disabilities to try and reduce the disparity in waits and DNAs.

In **Workforce** Sickness Absence went above target for the first time in 5 months. This is short term sickness.

CHFT had a visit from the head of health inequalities for NHSE yesterday who was very impressed by the work we are doing. Our reporting is being used as an example for other boards on how to report their health inequalities data.

AN questioned the target for workforce turnover which is still at 11%. This was to be discussed at the last workforce meeting. AM did not attend.
ACTION: AM to find outcome of discussion around turnover target.

The Committee **RECEIVED** the IPR for July

147/23 RECOVERY UPDATE

Assistant Director of Performance gave a quick update on the recovery position. CHFT is still clearing the backlog faster that other trusts in WYATT and have been selected at a national level to assist other organisations to improve their performance.

Activity – For three out of four months CHFT has been above the planned activity target for the year.

40week waits have had a slight increase over the last few weeks but still only just above the trajectory. Work is being done to try and quantify if we had not had the strikes what would the difference have been?

ASI's have been impacted by the strikes and ENT has the highest number.

Follow up backlog – The reduction in numbers following the work done by the admin validation is reflected in the report. There are a mixture of specialities with big numbers which are being addressed. PIFU is being rolled out across more specialities and there is a system wide transformation programme to tackle the position. CHFT have been asked to share learning at national conferences and have been shortlisted for 3 Health Service Journals awards for the work done.

There are some financial decisions to be made in the future where there could be a clash between performance and the financial position.

Every Trust that has been selected to be a part of the further faster programme is eligible to receive a £80k allocation of funding to support a specific action plan. The ENT action plan has been submitted as a basis to draw down that funding.

The Committee **RECEIVED** the Recovery Update

148/23 STRATEGIC BAF RISK

Following previous discussions at this committee, an updated BAF risk in relation to performance has been presented to the committee. This will be presented to Board next week. This has considered things like the bed occupancy level and now includes the assessment of the risk on ED performance after the opening of the new ED. In recognition of the possibility of not achieving local and national targets it has been scored at 16.

Re-assess the score once the new ED is open.

The committee **APPROVED** the new BAF risk.

149/23 DRAFT MINUTES FROM SUB-COMMITTEES

The following minutes and summaries thereof were received by the Committee:

- Access Delivery Group
- Business Case Approvals Group -
- Capital Management Group –
- CASH Committee – There is a typo in the cover sheet relating to the percentage in non-NHS invoice paid.
- Pennine Property Partnership
- THIS Executive Group
- Urgent and Emergency Care.
- THIS SLA

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

150/23 WORKPLAN – 2023/24

Deep dives have historically been focussed on areas where performance is not where we expect to be. Can we also have a look at areas that are performing well. Community is considering bringing something to a future meeting.

Committee **APPROVED** the work plan for 2023/24.

151/23 ANY OTHER BUSINESS

Challenge keeping to time. Good level of discussion.

Level of information in the deep dives was correct.

12 months on from when the work started on the IPR and it is in a good place with new metrics now being added.

152/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Deep dive updates.
- Financial position noting the likely position with pressures.
- Approved national cost collection report.
- Noted need for cash borrowing for remainder of year.
- Content of NHS deep dive and action plan.
- IPR noting PIFU progress among other good news items
- BAF Performance risk approved
- Reflect on the level of detail in the follow up deep dives.

DATE AND TIME OF NEXT MEETING:

Tuesday 26th September 09:30 – 12:00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Tuesday 26th September 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
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)	Deputy Director of Finance
Kimberley Scholes (KS)	General Manager, Planned Access
Gemma Berriman (GBE)	Director of Operations, RAFT
Leanne Elder (LE)	Future Leader Fellow (Shadowing)

OBSERVERS

Robert Markless (RM)	Public Elected Governor
Isaac Dziya (ID)	Public Elected Governor

APOLOGIES

Stuart Baron (SB)	Associate Director of Finance
Brian Moore (BM)	Public Elected Governor
Adam Matthews (AM)	HR Business Partner

ITEM

153/23 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

154/23 DECLARATIONS OF INTEREST

155/23 MINUTES OF THE MEETING HELD 30th August 2023

The previous minutes were approved as an accurate record.

156/23 MATTERS ARISING

157/23 ACTION LOG

The Action Log was reviewed as follows:

Deep dives will be planned for the rest of the year. Any suggestions for subjects please contact the committee Chair.

158l/23 APPOINTMENT SLOT ISSUES DROP OFF

A presentation was given explaining the problem that had been discovered on the system that records patient appointments. The presentation covered the issue, investigation, actions taken and the current position.

Patients who are unable to get an appointment slot sit on the national e-Referral System (ERS). If there is no activity within six months the patients drop off the system and should be moved on to a spreadsheet. Colleagues monitor this spreadsheet and add the drop offs back onto our Appointment Slot Issue (ASI) system.

This has been highlighted as a risk to NHS England (NHSE) and during Covid the timeframe was able to be extended to two years. However, this reverted back to six months once the worst of Covid was over. NHSE have been approached to amend the timeline back to two years again but there has been no response to this.

In June 2023, a patient contacted CHFT for an update on their treatment. It was discovered that they had dropped off the system onto the spreadsheet but because the person responsible for adding them back into the system had been off a number of patients had been missed. This was initially identified as 80 patients.

JH requested an investigation of all drop off patients. This was time consuming and extra resource was provided along with a deadline of 4-6 weeks in which to complete it. Initially 20,000 patients were thought to be at risk. Once the various risks had been ruled out and admin validation had taken place this was reduced to 237 patients. No patients have been identified as being at risk of harm.

These patients have been rebooked where possible and we currently have 40 still waiting. NHSE have been kept updated throughout and are fully supportive of the actions taken by CHFT.

Actions have been put in place to prevent this happening in the future and the approach taken by CHFT has been shared with other Chief Operating Officers. All organisations could be affected in this way.

Consideration is being given to automating the process of adding patients back onto the list.

159/23 NHSE PROTECTING AND EXPANDING ELECTIVE CAPACITY

NHSE have asked Trusts to undertake a self-assessment to provide assurance on recovery plans in relation to the letter received from Sir James MacKey and Professor Tim Briggs on 4th August 2023. Nationally and regionally, the submission will be used to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. The Trust are asked to return this to NHS England by 30 September 2023.

The areas to cover are:

- Validation
- First appointments
- Out-patient follow-ups
- Another one

JH and KS shared a presentation covering in of these areas which will form part of the response.

JH is meeting with the Chief Executive and Trust Chair tomorrow for sign off.

The Committee recommended reviewing the presentation to eliminate CHFT specific acronyms that may not be identifiable outside of the Trust.

Through the presentation the committee were assured that CHFT are in a strong position and can provide assurances that suitable processes are in place against all the points raised in the letter.

FINANCE & PERFORMANCE

160/23 MONTH 5 FINANCE REPORT

The Deputy Director of Finance presented the financial position as reported at Month 5, August 2023.

It was noted that the Trust has reported a £11.08m deficit, (excluding the impact of Donated Assets), a £1.61m adverse variance from plan. The in-month position was a deficit of £2.13m, a £0.35m adverse variance.

Year to date the Trust has incurred higher than planned costs due to an excess of patients awaiting transfer of care and higher than planned length of stay, £1.85m pressure due to the 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 Trust is forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario is an adverse variance to plan of £7.24m. The Trust needs to identify mitigation of this scale to offset unidentified CIP / expected slippage on high-risk efficiency programmes (£5.10m) and industrial action (£1.95m). Some potential mitigation has already been identified to offset other forecast pressures including non-pay inflationary pressures and additional bed capacity.

Some loss of Elective Recovery funding is likely due to penalties for any patient waiting more than 52 weeks. Current likely case is a loss of £0.33m of income. However, discussions are currently underway to agree what slippage in the agreed waiting list targets might be allowable as a result of the impact of Industrial action. The forecast assumes that any required activity catch up as a result of Industrial action will not incur additional costs but will be contained within the planned cost envelope agreed for Elective Recovery.

The Trust has submitted a request for funding for quarter 3 of £1m in order to maintain a balance of £1.9m cash position in the bank. Further borrowing is planned for quarter 4.

The committee raised some questions around some of the non-pay costs which were answered to their satisfaction.

The committee were asked to note the risk around elective recovery funding (ERF). There are lots of unknown variables around ERF and any penalties will be levelled at system level. There is yet no agreement as to what the plan across Yorkshire would be.

Forecast Scenarios were briefly shared with no significant change from previous months. The strikes risk only includes any strikes announced until the end of October.

NB asked about the level of confidence around achieving the potential mitigation against agency staffing.
CHFT are recruiting more student nurses into posts this year than ever before and will be in the system in the next couple of months. Which should allow agency spend to be reduced significantly.

The committee **RECEIVED** the Month 5 Finance Report.

161/23 TURNAROUND EXECUTIVE 2023/24 CIP PROGRESS

The Deputy Chief Executive gave a verbal update on the current CIP position. There are £23m worth of schemes that have been identified. There is a gap of £8-9m as a result of two high risk schemes Length of Stay and ED. ED will deliver approximately 50% of what was requested in year, but the actions taken should deliver the full year affect in future years. Length of stay is more challenging and has been undergoing deep dives and escalation workshops. There will be a deep dive into this scheme at the next meeting of this committee.
Overall, this leaves in a position where we are likely to have a £5-7m shortfall in achievement of our CIP. A mitigation workshop has been scheduled for this

afternoon to look at this shortfall and identify other ideas/schemes to close the gap. The workshop will also include a run rate discussion as we are currently spending £1m more a month than we planned.

Any outcomes of this workshop will continue to be monitored through TE.

The Committee **RECEIVED** the Turnaround Executive update

162/23 IPR

The Assistant Director of Performance covered the highlights of the August IPR, including changes to the performance matrix metrics.

For August 2023 we continue to perform well in terms of **elective recovery** 65/52/40 weeks although we have started to see the impact of the Industrial Action and the ENT ASI position starting to impact on the > 40- week position. ENT has received £80k from the 'Further Faster' fund to improve its position and has been given the green light by Procurement to start with Consultant Connect this week. The last Task and Finish group concluded on Friday as all the actions have been identified and teams are now on with completing them.

For **diagnostics** we still have challenges in Echo where Elective recovery funding has been diverted within directorate to support recovery. Neurophysiology has also had staffing issues, but plans are in place to achieve the November trajectory.

There is significant work happening to reduce our **follow-up** backlog. As of 22nd September following the introduction of Targeted Admin Validation of the Holding List, we now have over 25,362 follow-up patients past see by date (gradually increasing weekly after the 3,000 admin validation reduction) and we now have an increasing position of 4,204 Incomplete Orders awaiting Clinical prioritisation over 90 days – both areas are being addressed as part of our Access Delivery Group.

Cancer performance continues to be strong with an improvement in-month for the faster diagnosis performance although it remains below target. Total Patients waiting over 62 days to begin cancer treatment compared with February 2020 baseline increased due to the impact of skin long waiters.

ED performance for August was similar to July at 70.32%. We were still in the top 10 Acute Trusts nationally for type 1 ED performance. A recent analysis of admissions via A&E shows an increase in acuity of 30% and an increase in bed days of 24% for April to July 2023 compared to the same period for 2019 although numbers of admissions have stayed around the same therefore with the increase in attendances we have seen a drop in the conversion rate from attendance to admission.

For **Community** Virtual Ward occupancy has improved from July as figures are now based on a 14-day average rather than snapshots. The CHFT plan in line with CKW currently has a bed base of 24 (12 Frailty and 12 Respiratory). The plan started in January 2023 with 5 beds each and will rise progressively to 22 Respiratory and 20 Frailty by the end of March 2024. Frailty occupancy figures combined with Respiratory from July 2023 onwards.

In terms of **SHMI** performance has shown a continuous improving position with a 12-month rolling figure standing at 100.11. Performance did deteriorate in April 2023 to 108.85 and as predicted following the national annual rebasing exercise has improved in May with performance standing at 96.82. CHFT now sits below this national position and remains comfortably within the expected range.

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 the Task and Finish group have developed a MUST dashboard on KP+ to aid compliance with the MUST assessments. This is working really well and we have seen a significant improvement in performance over the last few months to the current position of 82%.

For **Health Inequalities** further work continues for these patients reduce the disparity in waits and DNAs. Our IPR reporting methodology is being used nationally to show what can be achieved when systems are in place to monitor this performance.

The governors noted that there was no longer an overall performance score on the IPR. This is no longer possible as a result of the various ways in which our performance is now monitored. If the narrative can be adjusted to make it clearer when the IPR is reviewed, then it will be done.
Benchmarking will be included which gives an overview of how CHFT is performing against other trusts.

ACTION: VP to add action to the next governors meeting to discuss the overall performance score and what they would like to achieve by having this.

The committee commented on the number of performance improvements in the report.

The Committee **RECEIVED** the IPR for July

163/23 RECOVERY UPDATE – Including impact of strikes on elective recovery and forward modelling.

Assistant Director of Performance gave an update starting with the fact that CHFT is still performing well and have been above plan for the four out of five months.
Elective recovery performance:

- 65 weeks no patients
- 52 weeks – 10 patients (longest 54 weeks)
- 40 weeks – There has been an increase over the last few weeks and we now have 1134 patients which is some way off trajectory. This is as a result of the combination of strikes and ENT's position.

The impact of the strikes and the current ENT position on our 40-week trajectory was highlighted on one of the slides. Without the strike action but with the ENT position we would still have been above the trajectory though not as high as we currently are. If ENT is removed from the figures as well as the strikes, then we would have been able to maintain performance below the trajectory. The first combined consultant and junior doctor strike has just taken place and the impact of this will need to be monitored.

Regarding outpatient first attendances and procedures there is a variance of 1200 over plan which equates to 111% pf plan delivered. However, in comparison ENT are only managing to do 85% of plan. Actions have been put in place to improve this following the creation of a task and finish group. It was noted that ENT is a national challenge, so support is not available from other trusts.

The target is to have no ASI's over 18 weeks. Currently there are 2867 patients waiting the majority of which are in 5 areas with ENT having 1957.

Work continues to reduce the follow-up backlog.

Diagnostics – The challenges continue with Echocardiology and Neurophysiology although Neurophysiology is expected to be back on track at the end of November.

The Committee **RECEIVED** the Recovery Update

164/23 BAF RISKS

The Company Secretary provided the second update of the Board Assurance Framework risks that this committee is responsible for. These have been reviewed and updated by JH and KA. There has been no change to any of the scoring since the last update. A lot of the risk is because of issues discussed earlier in this meeting. Three out of four of the risks have a score which is higher than our risk tolerance levels and will incur greater scrutiny.

The Committee questioned if any of the risks should reference the ICB and that CHFT's position can be affected by the position of the ICB.
The BAF will go for review to Trust Board in November.

ACTION: Give consideration to including the ICB and include in the report for November.

The committee **APPROVED** the BAF report.

165/23 SURGE AND ESCALATION PLAN AND FULL CAPACITY PROTOCOL AND THE RESILIENCE PLAN (PREVIOUSLY KNOWN AS THE WINTER PLAN)

The Director of Operations, RAFT presented the Escalation and Resilience plans for CHFT. It was highlighted that this is the first of its kind for CHFT as it has been identified that pressures are not only limited to Winter. The plan also includes a full capacity protocol.

OPEL scoring has changed nationally and now scores on 9 parameters. Due to this, CHFT have made the decision to also keep the original OPEL scoring of 22 parameters, alongside the new national scoring, which will be known as LOPEL (Local OPEL) going forward. The new national OPEL tends to score lower than LOPEL. Some other trusts are following the same plan.

As well as the full plan and protocol, action cards have been created to make it easier for colleagues to follow when required.

The document also supports the management of risk in relation to surges in acute patients through ED that require beds. Site Matrons are now onsite 24/7 and site management meetings take place multiple times per day which will continue as part of this plan.

The intention is to review these plans every six months and update to incorporate any learning.

GBE has spoken to Amy Campbell to arrange for some communications to go out to all staff. GBE is also arranging briefing sessions for November / December.

The committee were assured by the thoroughness and rigour of the plans presented and supported the implementation of the Resilience Plan as opposed to just a Winter Plan.

The committed **RECEIVED** the plans.

166/23 DRAFT MINUTES FROM SUB-COMMITTEES

The following minutes and summaries thereof were received by the Committee:

- Access Delivery Group
- Capital Management Group –
- CHS / CHFT Joint Liaison Committee
- HPS Board Meeting
- Urgent and Emergency Care.

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

167/23 WORKPLAN – 2023/24

Deep dive on TOC/LOS was due today has been moved back to next month.

Committee **APPROVED** the work plan for 2023/24.

168/23 ANY OTHER BUSINESS

169/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Continued positive performance in elective recovery and cancer
- Assurances around the Escalation and Resilience plans and our responses to the ASI issue and the NHSE letter on Protecting and Expanding Elective Capacity
- Recovery and IPR key areas to note are ENT and the strike impact
- Continuing concern about our financial position and a likely adverse variance to plan of £7m

DATE AND TIME OF NEXT MEETING:
Tuesday 25th October 09:30 – 12:00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 21 August 2023

STANDING ITEMS

132/23 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jonathan Hammond **(JH)**	Chief Operating Officer
Karen Heaton **(KH)**	Non-Executive Director
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Andy Nelson **(AN)**	Non-Executive Director
Victoria Pickles **(VP)**	Director of Corporate Affairs
Lindsay Rudge **(LR)**	Chief Nurse
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Liz Pepper **(LP)**	Medical Examiner Service Manager **(item 141/23)**
Gillian Sykes **(GS)**	End of Life Care Facilitator **(item 136/23)**
Nicola Greaves **(NG)**	Quality Improvement Manager (Patient Experience) **(item 136/23)**
Dr Tim Jackson **(TJ)**	Lead Medical Examiner **(item 141/23)**
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
Abbie Thompson **(AT)**	Matron – Community Division **(item 136/23)**
Diane Tinker **(DT)**	Head of Midwifery **(item 139/23)**

Apologies

Mr Neeraj Bhasin **(NB)**	Deputy Medical Director
Gina Choy **(GC)**	Public Elected Governor
Jennifer Clark **(JC)**	Head of Therapies
Sharon Cundy **(SC)**	Head of Quality and Safety
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board

Gemma Puckett, who joined the Trust on Thursday, 17 August 2023, was introduced and welcomed to the Quality Committee as the incoming Director of Midwifery and Women's Services, once **DT** retires on Thursday, 28 August 2023.

133/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

134/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 24 July 2023, circulated at appendix A, were approved as a correct record. The action log can be found at the end of these minutes.

SPECIFIC REPORTS

135/23 FOLLOW-UP ON APPOINTMENT CONCERNS

Jonathan Hammond presented the above update as circulated at appendix B, highlighting the progress of the recommendations following a task and finish group set up at the end of 2022, in response to concerns raised around specific patients who had the potential to be lost to follow-up.

A closing paper of the actions was also included, which went to the Executive Board in June 2023 and accepted. The recommendations in today's report describe how the actions are being taken forward through different governance structures.

KH asked about the overall oversight of follow-up appointment concerns, to ensure there is progress and improvement. **JH** stated that the risk will be reduced with the continued decrease in the length of waiting times, which will be overseen by the Access Delivery Group, the Finance and Performance Committee, and through to the Trust Board. The challenge is the volume of patients, and in order to reduce those volumes, additional validation processes are taking place for follow-up patients.

AN asked about the training element and the ambition of the development of 'super-users'. **JH** stated that some areas will be easier than others, with some motivated colleagues, however, there is a challenge with junior doctors who rotate every six months, however, there is a shift to use those change agents for focussed periods of time during the start of the rotations to ensure early good habits, which would hopefully start to make a difference. There is some variability in being able to have 'super-users', however, there is further work to be done to give people time to get to a point where they can then share that skill set and knowledge.

DS also asked about the training, and whether there were any hotspots which would be prioritised before the rollout. **JH** stated that there were no particular hotspots, however, there is variability within specialties, with clusters of clinicians who do it really well, and some who do not. **DB** stated that there are challenges in areas with capacity where there is a shortage of medical staff.

DS stated that it was very encouraging to see the amount of work being done to progress with all the recommendations, and the report clearly states the routes for assurance and ongoing monitoring. **JH** asked whether a specific update in relation to the training, Electronic Patient Record and Cerner should return to the Quality Committee at a later date, due to the impact on quality and safety throughout the organisation, which was agreed.

OUTCOME: **JH** was thanked for the report, and the Quality Committee noted the report.

136/23 LEARNING FROM PATIENT STORY – END OF LIFE CARE

Nicola Greaves, Gillian Sykes and Abbie Thompson were in attendance to present the above learning, as circulated at appendix C.

Three of the four soundbites (feedback from findings of the National Audit of Care at the End of Life audit) were played during the meeting:

- *"My 93 year old mother was able to stay by his side in a bed for the whole time. This was such a comfort for us all. The hospital treated my dad and ourselves with care and dignity. We are very grateful that my dad could pass in the best place for him"*

- *"My mother deteriorated quite unexpectedly in hospital. When it became clear she was dying, staff were clear, but sensitive on the matter. Whilst I was present, the nurses were amazingly sensitive and respectful of my mother, and I think the nurses did their duties exceptionally. Even after my mum died, the nurse still spoke to my mum, explaining that she was removing her jewellery which was at my request. This was amazingly touching and beautiful. I will remember it always. Everything was carried out with dignity and respect. I will be forever grateful to those that Huddersfield Royal, they deserve the highest praise in my opinion".*

- *"We were not hold of my mother's imminent death at all. In fact, two days earlier, quite the opposite. I knew from two days before that something was not quite right, so I travelled for hours by car to see her. No one listened to me, or a nurse who agreed that she'd rapidly declined. I wasn't allowed to see my mum in spite of the distance I travelled and she died*

a few hours later. I did manage to barge in and see her for 5 minutes while collecting my dad. Mum died in the night and dad was not well enough to get back to the hospital and consequently never saw mum again. We were entitled to more than one visitor for an hour, given that my mum was at end of life, but no one communicated this to us and deliberately restricted our time with her. We cannot get that time back. Some nurses were lovely and communicated on the phone to us, but clearly no information of use, as no one told us she was about to die. There were health issues but the notes had not been uploaded when a doctor was asked to give us an update. She died that morning but no one updated us, or gave us end of life opportunities in the days before her death. My dad is still suffering guilt today of the fact that my mum died alone without a family member and that he couldn't get to see her in death. This could so easily have been avoided with better communication and less rigid adherence to the rules that were enforced by the hospital, not the NHS per se, as at the time COVID restrictions were being lifted".

From all strands of feedback, three key areas were identified – improving communication, involvement of loved ones and carers in decision-making, and identifying end of life sooner and more efficiently. The work done by the end of life team over the past year was also highlighted.

AN asked if there were a set of outcomes or improvements for this work. **GS** responded that monitoring takes place through audits on a local level, however, the National Audit of Care at the End of Life is carried out every two years, and results are a key measure of improvement in outcomes, which are hoped to be shown by 2024. **AN** asked if any measures have been picked from the last audit. **GS** stated the key measures are recognising end of life and clear, outcomes from the end of life care strategy, which is nearing completion.

LR commented that the recognition of dying and taking appropriate treatment has been a challenge for clinical teams for a number of years, however, there are also organisational challenges and it is envisaged that the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) improvement programme will help. **JMidd** also commented that work is ongoing within the end of life care steering group around the last 12 months of life.

VP stated that a dying well event in October 2023 is due to be publicised across Kirklees, which will bring organisations together and look at unblocking barriers to work better together and share information which will be crucial to people dying in the place they want to die and the interventions and support around them.

AT also provided assurance on work taking place within various local and regional workstreams on benchmarking outcomes, with dashboards for each workstream showing patient outcomes achieving preferred place of death; the utilisation of care plans appropriate for the last days of life, and recognising that early recognition by clinicians is important. These are reported on a monthly basis through the Patient Safety and Quality Boards.

OUTCOME: **NG**, **GS** and **AT** were thanked for the update.

SAFE

137/23 NATIONAL IMPROVEMENT BOARD

Lindsay Rudge presented the above as circulated at appendix D, providing the Committee with an overview following the review undertaken by Anne Eden and the subsequent formation of the National Improvement Board and NHS Impact.

The background of the National Improvement Board was provided, as well as the NHS Improvement approach (drivers and enablers), the leadership for improvement programme and the scope and remit of the National Improvement Board.

The proposed timeline for implementing the actions were highlighted, with the transition into the new operating model becoming business as usual from Autumn 2023 onwards. This will

align with the publication of the new single assessment framework for CQC, including the new well-led framework.

In terms of the national shared priorities, **DS** asked whether Trusts are given an opportunity to influence these. **LR** stated that the link provided gives varied case studies, with no evident priorities as yet.

KH asked if there was a role for the Integrated Care Board in this. **LR** stated that Integrated Care Boards are expected to have system improvements, and the Quality Committee within the Integrated Care Board are yet to establish their performance data framework.

AN queried whether the National Improvement Board will be a genuine adaptation for the Trust, or whether there will be key gaps where work is required to get to an expected level. **LR** stated that there will be a mix of both, with being able to adapt recognised methodologies, and also an opportunity to drive the quality improvement programmes further, through more visibility and becoming more embedded in the organisation.

LR noted that a facilitated Quality Summit has been scheduled for 11 October 2023 to enable discussion with divisional leadership teams, collaborative leads, quality leads, Clinical Directors, Matrons, senior leadership teams and Quality improvement leads to discuss priorities and reset the quality and safety agenda.

OUTCOME: **LR** was thanked for the update and stated that quarterly progress updates will be provided to the Quality Committee.

138/23 Q1 INFECTION PREVENTION AND CONTROL REPORT

David Birkenhead presented the above report as circulated at appendix E, highlighting that the Clostridium difficile position has improved from previous years, with eight cases to date, with three of those being community acquired cases, which will not contribute to the Trust's ceiling of 37.

Aseptic Non-Touch Technique (ANTT) competency assessment for medical staff currently sits at 96%, and the induction programme has been changed for the intake of new junior doctors in August, whereby they now have a two-day induction programme, which includes ANTT competency checks. It is hoped that the metric will improve by the next quarter's results.

There have been a limited number of outbreaks associated with norovirus, and COVID-19 numbers have been relatively low during quarter 1.

The Infection Prevention and Control (IPC) Board Assurance Framework (BAF) continues to be revised, and ongoing Quality Improvement audits and Frontline Ownership (FLO) audits are positive.

DB mentioned that Gillian Manojlovic (Senior Infection Control Nurse) has now retired and Belinda Russell is now the lead Infection Prevention Control Nurse.

KH asked about the Healthcare Associated Infections (HCAI) data, and that four of the five national objectives have been breached. **DB** stated that those objectives have not yet been breached for this quarter, however, they were breached last year, and there are some challenges which require the development of an action plan and try to improve. It was noted that CHFT is not unique in those challenges, particularly post-COVID.

DS noted being over the 50% target for Escherichia coli (E.coli) in quarter 1, and asked if this was a concern at this point. **DB** stated that unfortunately, 27 of those were community onset, healthcare associated (COHA) E.coli cases, where there is little direct influence on them other than working with community partners to improve. The COHA Clostridium difficile cases do not contribute to the CHFT ceiling, however, the hospital onset, healthcare associated (HOHA)

cases do, but clarification will be sought as to whether the 27 COHA E.coli cases will be measured against the Trust's metric.

OUTCOME: **DB** was thanked for the update and the Quality Committee noted the report.

139/23 MATERNITY SAFETY AND NEONATAL REPORT

Diane Tinker presented the above report, circulated at appendix F1, highlighting the key points.

Copies of the embedded learning event, a report on Avoiding Term Admissions in Neonatal Unit (ATAIN) – April to June 2023, the ATAIN action plan, a Transitional Care report – April to June 2023 and a Perinatal Mortality Review Tool (PMRT) action plan were also available within the appendices of this report.

In relation to the three gaps within the registrar rota due to two senior registrars being successful in being appointed to consultant posts, **AN** asked whether there were any plans to address the gaps. **DT** stated that this will be short-term, due to the new rotation of trainees in September 2023.

AN also asked about the transformation programme and whether there were any target dates for clearing all the actions. **DT** stated that the Maternity Incentive Scheme is in year 5 and being started again; the 3 year delivery plan is a three year plan and will run for that length of time; the maternity self-assessment was part of Ockenden 2 as a 'should do', however, the actions will be revised to ensure whether they need to be part of the transformation plan, or whether they are covered by the 3 year delivery plan; the Getting It Right First Time (GIRFT) maternity and GIRFT gynaecology are both ongoing and will always be reviewed on an annual basis. All actions will adapt, and updates will be provided when available. **LR** stated that once the Maternity Transformation Board has been developed, there will be a separate, detailed report on the transformation programme.

In relation to training, **DS** noted that the medical staff role specific and essential training were reporting red, and whether there were any reasons for that and whether it was being addressed. **DT** stated that there has been a focus on training, which will now be part of appraisals and will be further discussed with consultants and midwives.

In relation to the ATAIN report, **DS** asked about the 46% of women who had their labour induced, and asked whether this was a national average or if this was a large amount. **DT** stated that this is discussed in many forums, and unfortunately, this is a rising national rate due to the recommendations from NICE. Many years ago, induction was offered at term plus 14, which then was reduced to term plus 10-12. Currently, national recommendations are to offer inductions at term plus 7. It was stated that inductions are proposed to women as an 'offer', not mandatory. A piece of quality improvement work is now being done around inductions.

The Committee wished **DT** a happy retirement, and thanked her for the work done and the immeasurable impact provided through leadership and assurance from maternity services.

OUTCOME: **DT** was thanked and the Committee noted the report.

140/23 ESSENTIAL TRAINING - PATIENT SAFETY

Joanne Middleton provided a brief update on the circulated paper at appendix G in response to the Patient Safety Incident Response Framework (PSIRF) preparation, which has been signed off at the Education Committee and the Weekly Executive Board.

OUTCOME: **JMidd** was thanked and the Committee noted the report.

EFFECTIVE

141/23 MEDICAL EXAMINER UPDATE

Tim Jackson and Liz Pepper were in attendance to provide an update on the above as circulated at appendix H.

DB commented on the great progress over the past two years and mentioned a suggestion from a colleague that there was an expectation that there would be a weekend service run on Saturday and Sunday mornings, and payments were available. **DB** asked about the position in relation to that. **TJ** stated that one of the reasons there has been pressure to get the routine community scrutiny on board by October 2023, is that it allows the winter months and up to April 2024 to fine-tune what is being done. The three requests are (1) an extended hours service which will cover weekends and bank holidays; (2) urgent releases for our faith communities; and (3) extending the service to paediatrics and other partner organisations, such as the private sector and the hospices. There is an explicit aim to carry out these requests, and currently the first iteration of the financial envelope has been shared in the last week, which is being reviewed and how it translates into providing a service. Nominally what has been proposed is that an availability on a Saturday or Sunday or bank holiday morning will be provided when cases can be received. If done in a reasonable time, it can be scrutinised, and if not, will roll over to the next day. There will be some communications circulated once final clarity has been reached.

DS commented on the really good service provided by the team and it is hoped that the work to be undertaken in the Community runs as smoothly as expected.

OUTCOME: **TJ and LP** were thanked and the Committee noted the report.

RESPONSIVE

142/23 QUALITY REPORT

Lindsay Rudge presented the above report as circulated at appendix I.

With regard to highlights from the Clinical Outcomes Group, **DB** reported challenges with attendance at the meeting, which will require strengthening. Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio are within the expected ranges; In-hospital crude mortality remains the same; there is good progress and work ongoing within sepsis and learning from deaths, with clear challenges in relation to activity seen in A&E and pressures on colleagues relating to managing and dealing with strikes in a safe manner. It is hoped that the Quality Summit in October 2023 will reset some of this work moving forward.

AN commented on the incident data and being a long way from the 95% target, and asked if there was further work to be done to manage this better. **LR** stated that the fundamental work is the Patient Safety Incident Response Framework, and the medical division will be used as a test area for clustering themes, address underlying issues, and learning from them. **JMidd** stated that with Patient Safety Incident Response Framework, there will be a suite of learning response tools, and from looking at current data around incidents for the last three years, most fit into existing quality improvement collaboratives, which will allow for embedded learning to not seeing recurring incidents.

AN asked whether there were any early signs of the stop process in the dementia screening compliance. **LR** stated that there has been progress in some areas, with the stop process now being reinvigorated on the Acute Floor at Huddersfield, via a task and finish group.

KH commented on the clear report and the consistency in relation to complaints, and asked that compliments are categorised in order to have a sense of which areas are doing well.

OUTCOME: **LR** was thanked for the update and the Quality Committee noted the report.

143/23 GOVERNANCE ACTION PLAN

Vicky Pickles presented the above as circulated at appendix J.

As a result of the Committee's self-assessment, there were some areas where responses were *'did not agree'* or '*do not know'*, therefore, some proposed actions have now been put in place to address those.

One of those areas was the Committee not having any objectives, however, the next steps following the completion of the annual report, are proposed as Quality Committee objectives for the next 12 months:

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

OUTCOME: The Quality Committee were in agreement with the actions.

144/23 INTEGRATED PERFORMANCE REPORT

The report was circulated at appendix K for information, as most topics within the report have been discussed throughout the meeting. The good performance in cancer was noted.

OUTCOME: The Quality Committee noted the report.

ITEMS TO RECEIVE AND NOTE

145/23 HEALTHCARE SAFETY INVESTIGATION BRANCH AND MATERNITY ANNUAL REPORTS 2022-2023

The following links were provided for information:

https://www.hsib.org.uk/news-and-events/maternity-investigation-programme-year-in-review-202223/

https://www.hsib.org.uk/news-and-events/annual-review-202223/

146/23 ANY OTHER BUSINESS

CHFT response to the Lucy Letby verdict

Vicky Pickles summarised the actions agreed with Directors, regarding the CHFT response to the Lucy Letby case. A 'true for us' report will be done to test how the Trust fits against the learning from the case.

It is important to recognise that a significant amount of time has passed since the crimes were committed and processes that are in place now, were not in place at that time, for example, Freedom To Speak Up was not embedded in the same way that it is now; the fit and proper person guidance has recently been strengthened and the Healthcare Safety Investigation Branch (HSIB) is now in place. It is important to carry out a review and provide assurance that services are safe for patients and colleagues, and what the Trust's position would be if a concern was raised as described at the Countess of Chester Hospital.

The True for Us report will be submitted to Trust Board in September 2023.

147/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

- Information on the National Improvement Board (item 137/23)
- Update on end of life care (item 136/23)
- Maternity and Neonatal Report and discussion on training element and oversight that this improves (item 139/23)
- Update from Medical Examiner Service (item 141/23)
- Key updates from the Quality Report (item 142/23)
- Updates from the Integrated Performance Report (item 144/23)

148/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix M for information.

POST MEETING REVIEW

149/23 REVIEW OF MEETING

- Full and thorough meeting
- Good discussion
- Good receipt of assurance in a number of areas

NEXT MEETING

Monday, 25 September 2023
2:30 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 21 August 2023

Overdue	New / Ongoing	Closed	Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING / DUE DATE
UPCOMING ACTIONS				
24.10.22 (171/22)	Integrated Performance Report **Length of stay update**	**Gemma Berriman**	**LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence. **Action**: Presentation to be requested for Quality Committee **Update:** Charlotte Anderson (Performance and Intelligence Lead) will attend the April meeting to present. **Update 17.4.23:** See item 58/23 **DS** asked about the current length of stay. **CA** stated that further work with another colleague will be required in order to provide this data. **Update**: Availability of report to be confirmed **Update 21.08.23**: **LR** reported on a new programme now set up on length of stay as part of the delivery across the Turnaround Executive Programme. An update can be requested from Gemma Berriman (Chair), due to current presentations on key highlights. It was also stated that an update on the Well Organised Ward (WOW) can also be included. **AN** also reported that a deep dive into length of stay will be provided at September's Finance and Performance meeting. **Action 21.08.23:** Update to be requested from Gemma Berriman (Director of Operations) on length of stay and WOW	**October 2023**
CLOSED ACTIONS				
24.10.22 (168/22)	**Split Paediatric Service**		**LR** commented on the risk relating to the APNP model at Huddersfield, which is at a score of 16 on the risk register, stating that Simon Riley-Fuller (ADN in FSS) has been asked to review this. It was also noted that the Emergency Department (ED) are also looking at the impact of any incidents or near misses that have occurred as a result of the described risk, the results of which can be returned to a future Quality Committee for oversight and assurance to ensure that the risk is not tolerated. **Action 24.10.22**: For any results of the review of the risk and impact of incidents and near misses to be returned to the Quality Committee **March Update**: Followed-up with **SRF** as to whether the risk reviews have taken place, and also with the Risk Management Team as to whether there have been any reports from ED in relation to the impact of incidents or near misses as a result of the above risk. Awaiting responses on both. Update: Risk 7776 was originally scoring 20, and reduced to a 16 as there are not gaps every day for the PNP cover. Of note, a trainee has handed in their final dissertation and if successful, will be able to add as part of the PNP rota later this year. It is anticipated at this point, that the risk score will reduce further. The Children's Directorate and ED team have collated a paper that has been presented to WEB in terms of plans for urgent care delivery for CYP on both hospital sites. If approved this will cumulate in the APNP's being based on the CRH site. Dr Morris, Tom Ladlow, Fiona Stuttard, Chloe Gough and Julie Mellor are aiming to meet to try to progress this work. **April Update:** Awaiting an executive sponsor. Division escalated to Performance Review Meeting and awaiting response. **Update 17.4.23: LR** stated that Venkat Thiyagesh and Helen Barker presented a paper to the Weekly Executive Board around the staffing model, which was approved. **Action 17.4.23:** Update to be provided at future meeting. **Update**: Pending agreement of Executive Sponsorship and phased approach to delivery (escalated by directorate at February through to June Performance Review Meetings, May Patient Safety and Quality Board and May Weekly Executive Board. Awaiting confirmation on Executive Sponsor, however, Lead Nurse and Consultant supporting Paediatric ED work and progressing plans. **Update 21.08.23**: **LR** reported that an Executive Sponsor is now in place, and a Children's Board is being set up, with Rob Aitchison (Deputy Chief Executive) as lead, and **LR** as Deputy Chair. The first meeting is due to take place in the first week in October, and a decision is needed as to how this will report into Quality Committee, either directly, or via a sub-committee. OUTCOME: Will close this action and add as an item to the workplan. Frequency of reporting will be amended once decision has been made.	**CLOSED August 2023**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 25 September 2023

STANDING ITEMS

150/23 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Neeraj Bhasin **(NBha)**	Deputy Medical Director
Nikhil Bhuskute **(NBhu)**	Deputy Medical Director
David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Sharon Cundy **(SC)**	Head of Quality and Safety
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director
Joanne Middleton **(JMidd)**	Deputy Chief Nurse
Andy Nelson **(AN)**	Non-Executive Director
Gemma Puckett **(GP)**	Director of Midwifery and Women's Services
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

Apologies

Jennifer Clark **(JC)**	Head of Therapies
Jonathan Hammond **(JH)**	Chief Operating Officer
Jo Kitchen **(JK)**	Staff Elected Governor
Victoria Pickles **(VP)**	Director of Corporate Affairs
Lindsay Rudge **(LR)**	Chief Nurse
Elisabeth Street **(ES)**	Clinical Director of Pharmacy

Nikhil Bhuskute, recently appointed Deputy Medical Director, was introduced and welcomed to the Quality Committee.

151/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

152/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 21 August 2023, circulated at appendix A, were approved as a correct record. The action log can be found at the end of these minutes.

SAFE

153/23 MATERNITY AND NEONATAL OVERSIGHT REPORT

Gemma Puckett presented the above report, circulated at appendix B.

AN noted from the CQC Report the plan of the must do actions, and asked what is done with the should do actions. **GP** stated that the actions are being put into a plan, and will be monitored at the Maternity and Neonatal Board.

AN commented on the Healthcare Safety Investigation Branch (HSIB) investigations, and asked how the investigations are completed and closed, and how it is ensured that learning is taken from them. **GP** stated that the approach to HSIB investigations are the same as all learning from incidents. An action plan would be developed when the report is received, and is monitored through the orange panel and the maternity forum for completion of actions. Learning is shared in several ways, including an embedded learning event which was held

recently where actions were taken away on how to improve services. The investigation would be closed once the actions have been completed.

AN also asked if there were opportunities to learn from others. **GP** stated that actions and recommendations are reciprocal and shared into the Local Maternity and Neonatal System (LMNS).

KH asked whether the actions from the CQC will be highlighted within the Transformation Action Plan, as opposed to having a separate plan. **GP** stated that the actions would be included to minimise duplication.

The LMNS assurance visit on 28 November 2023 was also mentioned, which will be to reassess compliance to the original Ockenden Report and the seven immediate essential actions. Evidence is currently being submitted.

GC asked for an update on the Maternity Incentive Scheme. **GP** reported that there are 10 safety actions and all elements need to be compliant. This was added to the risk register due to the concerns around training. This is beyond the Trust's control, and has been escalated to LMNS colleagues, regional officers and nationally to NHS Resolution, as CHFT are not the only organisation challenged by this.

The Chair asked about the Healthcare Safety Investigation Branch case linked to an off-pathway breech homebirth and asked how it is ensured that mothers who are off pathway are monitored by minimising risk. **GP** stated that maternity is a challenging environment with women who may seek care outside of recommended clinical guidance, therefore, a referral to be seen in obstetric clinics is made to ensure an informed risk and benefit discussion with mothers takes place, in order for them to make an informed choice. Once a choice is made, this is then supported, which is a national requirement.

Copies of the Avoiding Term Admissions in Neonatal Unit (ATAIN) report and action plan, a Transitional Care report and a Perinatal Mortality Review Tool (PMRT) action plan were also available within the appendices of this report.

OUTCOME: **GP** was thanked for the update and the Committee noted the report.

CARING

154/23 ANNUAL PATIENT EXPERIENCE REPORT

Joanne Middleton presented the report as circulated at appendix C.

One of the discussions through the Patient Experience and Caring Group has been what can be taken in terms of learning with the approach and methodology of the well-received Quality Improvement initiative, which can be used across the organisation.

The Chair commented on the comprehensive report and the amount of work undertaken in the last year.

With regard to complaints and the survey identifying some improvements, **AN** asked whether there is an action plan to address these issues. **JMidd** stated that one of the measures is to look at how many complaints have been re-opened, and involvement with patients and relatives is one of the areas for improvement.

AN commented on the three year strategy, and asked whether the measures would be included in a dashboard. **JMidd** stated that the outcome measures are a focus of the Patient Experience and Caring Group and will be used to report back into the Quality Committee.

The Chair commented on the maternity survey and asked **GP** whether the 'speak to a midwife' initiative would address the 'somewhat worse than expected' responses in relation to mothers

having the opportunity to ask questions about their labour and birth, or whether there was another initiative in place to respond to that. **GP** stated that the 'speak to the midwife' campaign is more aimed at getting people into the service as early as possible in their pregnancy, and hopefully the score should improve as more discussions are had with every contact made.

The Chair also noted that the amputee rehabilitation service survey, which showed 100% of responses from white patients, and queried whether this could be looked into as there will be amputees across diverse communities, which **JMidd** agreed to pick up.

The Chair also commented on the inclusion of an update on Observe and Act and would have liked to see that Non-Executives and Governors who are involved in the process, included in the update, as they provide an independent, external view on what is taking place at ward level.

OUTCOME: **JMidd** was thanked and the Committee noted the report.

WELL LED

155/23 GETTING IT RIGHT FIRST TIME (GIRFT) REPORT

Neeraj Bhasin presented the report as circulated at appendix D.

KH commented on the consistent good news story with GIRFT, and the recognition for the good work. With regard to the impact of the GIRFT agenda, and evolving to a national approach, **KH** asked whether this would be a step back rather than step forward.

NBha agreed on the consistent story and on the local process becoming the national toolkit. This is a change which cannot be controlled, therefore, the national GIRFT team have been contacted, stating that the process created locally needs to adapt to match the national central approach. Inputs are no longer co-ordinated through the former central GIRFT team, as work is undertaken through different routes, therefore, changes are needed to ensure that the reporting, oversight and benefits and capture are maintained.

In relation to the Further Faster Programme, **AN** asked whether there were any examples of where CHFT could go further. **NBha** provided an example around reducing variation, where the Programme will give clear national guidance, which can then be embedded into the organisation, creating standardisation, and reducing outpatient demand.

The Chair reiterated that this continues to be positive good news, and asked that some examples of good impact, improvement in patient care, value for money and cost effectiveness is added to the next GIRFT report.

OUTCOME: **NBha** was thanked for the update and the Committee noted the report.

EFFECTIVE

156/23 CLINICAL OUTCOMES GROUP 6-MONTH REPORT

David Birkenhead presented the report circulated at appendix E.

There have been some challenges with the Clinical Outcomes Group as well as its reporting workstreams, and it is one of the areas where industrial strikes had an impact; not through loss of activity, however, where colleagues had limited capacity to take work from the meeting to implement, due to forward planning for upcoming strikes. The departure of two key colleagues also impacted on the delivery of work of the Group, however, this is being progressed, firstly with the appointment of **NBhu** as Deputy Medical Director to take oversight of some of this work, and secondly, with appointment into the Associate Director of Quality and Safety post in the New Year.

Progress is being made through the workstreams with significant assurance; however, Stroke continues to be a challenge across most of the West Yorkshire Association of Acute Trusts. The Sentinel Stroke National Audit Programme data is not where the Trust would want it to be, and challenges relate to an increased number of patients presenting with stroke and increased morbidity of those patients. There is a challenge with getting CT scans done within one hour and having those patients on the stroke unit for the right period of time. There are also challenges with the therapy services and gaps in services, which means a seven day service is not available, due to resource issues. Work is ongoing as a priority with the division to improve stroke performance.

There is still limited assurance around dementia, and changes have been made in terms of the dementia screening process, which is beginning to see improvement, however, there are challenges to appoint into the Dementia Lead post, which was recently vacated. Amanda McKie (Consultant Nurse for Learning Disabilities) is providing interim oversight into this work.

The Nutrition Operational Group also has limited assurance with two Never Events relating to Nasogastric feeding tubes, with actions relating to improving the reliability of the feeding modalities moving forward. Some good work has taken place around the Malnutrition Universal Screening Tool, which has shown improved compliance in the last six months, and work on protected mealtimes continues.

End of Life Care also has limited assurance and the main issue relates to the recognition of the dying phase, which impacts on the ability to provide the support required for patients through the end phase of their lives, and some education training is planned for this. The roll out of the Recommended Summary Plan for Emergency Care and Treatment process will hopefully help with making it clear as to what people's wishes are toward the end of their lives.

The Falls Collaborative also shows an improved position via the Integrated Performance Report, however, there are challenges with attendance at meetings and the stepping down of the Clinical Lead.

In terms of falls and the issue in relation to an inconsistency at ward level with the practices of bay tagging and cohorting, the Chair asked how this is picked up across the wards. **JMidd** stated that there has been a focus on walkrounds with Matrons revisiting risk assessments of safety issues.

The Chair acknowledged the challenges of the Clinical Outcomes Group and noted the upcoming Quality Summit, where there will be an opportunity to discuss the best way forward for this Group.

It was also noted that there will be an overview report on Nasogastric tubes at the next Quality Committee.

OUTCOME: **DB** was thanked and the Committee noted the report.

RESPONSIVE

157/23 INTEGRATED PERFORMANCE REPORT

The report was circulated at appendix F for information, and **DB** mentioned the impact of strikes on quality improvement projects, and the measurable impact on waiting lists, and the expectance of further disruptions with upcoming strikes.

There are some small increases in the 40-week waits which are being monitored by putting on extra lists to mitigate those developing any further. There are main concerns with the Ear, Nose and Throat (ENT) team and this is managed through a task and finish group, led by the Surgical division, to source some external support to reduce the appointment slot issues (ASIs).

The Chair commented on the inclusion of the health inequalities metrics, which are in an early stage of development.

The safe metrics show a good overall position.

OUTCOME: The Quality Committee noted the report.

ITEMS TO RECEIVE AND NOTE

158/23 ANY OTHER BUSINESS

There was no other business.

159/23 BOARD TO WARD FEEDBACK

One of the responses from the Committee's self-assessment on effectiveness was to have more Board to Ward feedback, therefore, going forward, this will be an agenda item and an opportunity to feed back any information from the Board that the Committee needs to be shared with a department or team.

The Chair shared that following the last Board meeting, there was a discussion with the Chair who challenged the Quality Committee to ensure there is a level of rigour around neonates and neonatal deaths, as the minutes were not very explicit that the audit was submitted in April 2023 meeting. It was suggested that **GP** and **KH** ensure that during any go sees, that any progress made with the recommendations which came out of the neonatal audit report return to the Quality Committee.

160/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

- Maternity Incentive Scheme and challenges with achieving some standards (item 153/23)
- Updates from the Clinical Outcomes Group (item 156/23)
- Updates on the comprehensive Patient Experience Annual Report (item 154/23)
- Changes from Getting It Right First Time and how it may affect CHFT (155/23)
- Update from the Integrated Performance Report (item 157/23)

161/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix G for information.

There are no new amendments, however, this may change as a result of the upcoming Quality Summit.

POST MEETING REVIEW

162/23 REVIEW OF MEETING

- Good to see a holistic approach taken and prioritisation of care where health inequalities are concerned
- Meeting done in record time
- Presenters have assumed that papers have been read and able to succinctly provide any highlights, which worked well

NEXT MEETING

Monday, 23 October 2023
2:30 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 25 September 2023

Overdue	New / Ongoing	Closed	Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING / DUE DATE
UPCOMING ACTIONS				
24.10.22 (171/22)	Integrated Performance Report **Length of stay update**	**Gemma Berriman**	**LR** also stated that it would be helpful to bring a presentation on the data to see the broader impact of all the increased activity and that expanded bed base to see what that means in terms of harm and incidence. **Action**: Presentation to be requested for Quality Committee **Update:** Charlotte Anderson (Performance and Intelligence Lead) will attend the April meeting to present. **Update 17.4.23:** See item 58/23 **DS** asked about the current length of stay. **CA** stated that further work with another colleague will be required in order to provide this data. **Update**: Availability of report to be confirmed **Update 21.08.23**: **LR** reported on a new programme now set up on length of stay as part of the delivery across the Turnaround Executive Programme. An update can be requested from Gemma Berriman (Chair), due to current presentations on key highlights. It was also stated that an update on the Well Organised Ward (WOW) can also be included. **AN** also reported that a deep dive into length of stay will be provided at September's Finance and Performance meeting. **Action 21.08.23:** Update to be requested from Gemma Berriman (Director of Operations) on length of stay and WOW **Update**: Deferred to the November meeting	**November 2023**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE: ENGAGEMENT CHAPTER

Held on Tuesday 23 August 2023, 2.00pm – 4.30pm
VIA TEAMS

PRESENT:

Nigel Broadbent	(NB)	Non-Executive Director
Suzanne Dunkley	(SD)	Director of Workforce and OD
Karen Heaton	(KH)	Non-Executive Director (Chair)
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Peter Bamber	(PB)	Governor
Rob Birkett	(RB)	Chief Digital Information Officer
Mark Bushby	(MB)	Workforce Business Intelligence Manager (for item 94/23)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Terry Gamble	(TG)	Staff Side Chair
Nikki Hosty	(NH)	Assistant Director of HR (for item 93/23)
Rebecca Armitage	(BA)	OD Practitioner
Andrea McCourt	(AMc)	Company Secretary
Rachael Pierce	(RP)	Recruitment Manager (for item 91/23)
Jackie Robinson	(JR)	Assistant Director of Human Resources (for items 95/23 and 97/23)
Liam Whitehead	(LW)	Head of Apprenticeships & Widening Participation for item 92/23
Jan Mounkala	(JM)	Apprentice

86/23 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

87/23 **APOLOGIES FOR ABSENCE**

Rob Aitchison, Deputy Chief Executive
David Birkenhead, Medical Director
Jonny Hammond, Chief Operating Officer
Vicky Pickles, Director of Corporate Affairs
Lindsay Rudge, Chief Nurse
Helen Senior, Staff Side Chair

88/23 **DECLARATION OF INTERESTS**

There were no declarations of interest.

89/23 **MINUTES OF MEETING HELD ON 20 JUNE 2023**

It was clarified that on page 7, under the item Developing Workforce Safeguards, 'NB' is Neeraj Bhasin.

The minutes of the Workforce Committee held on 20 June 2023 were approved as a correct record.

90/23 **ACTION LOG – AUGUST 2023**

The action log was received.

91/23 **REVIEW PROGRESS ON RECRUITMENT STRATEGY**

RP presented an update on progress against the strategy. The following was highlighted:-

Attraction and recruitment
- Recruitment event calendar agreed with key partners.
- 4 Trustwide recruitment events arranged for 2023/4
- Employability SOP drafted.

Developing our workforce
- Creation of "Positive Futures" workshops and piloted delivery to local students on Health related pathways.
- Offer has been extended to internal CHFT colleagues Application video created with interview video planned in September 23.

Widening participation
- Expansion of international recruitment to more staff groups including Radiographers.
- Stay and Thrive event held at University of Huddersfield.

Why we are CHuFT about CHFT
- Colleague benefits are promoted at marketplace event during induction and welcome to CHFT

KH enquired about expanding international recruitment to more staff groups. RP confirmed two occupational therapists have already commenced. Two midwives commenced in July and a further three are to start in September. A radiographer is to start in September with more radiographers in the pipeline.

JE suggested future updates should include outputs and outcomes in order to strengthen activity information and how that activity has improved the recruitment position.

KH asked if there was any data around the take up of colleague benefits. JE confirmed some data is available and discussions are currently taking place regarding customer service KPIs particularly in relation to some of the salary sacrifice schemes. KH agreed it would be useful to see what the benefits package captures and take up.

OUTCOME: The Committee **NOTED** the progress against the Recruitment Strategy.

92/23 **REVIEW PROGRESS ON APPRENTICESHIP STRATEGY**

LW and JT presented progress against the strategy. The headlines were:-

- Employer Provider continued strong performance (achievement & low attrition, income generation).
- Focus on learner experience and OCOC.
- Curriculum development and audit readiness.
- Apprenticeship Levy spend development linking to wider workforce strategy & OD
- Created Apprenticeship levy dashboard – Trends and mobility
- Trends include increased uptake of L5+ apprenticeships (make up 49.6 % of all CHFT Apprenticeships).
- Increased Apprenticeship Levy spend by 8% on 22/23 (72% overall).
- Further embedded Widening Employment pathways (30% enter HCSW pathways)
- Created additional WP pathways (T levels) and income generation (NHS England)
- EDI measurable impact
- Maths & English offer
- Team structure and development (grow our own, OCOC, integration with Widening Participation, OD, Engagement, Health and Wellbeing)

JM introduced herself as an apprentice at the Trust. She described her journey into CHFT which commenced via a placement through the Prince's Trust. JM explained she was initially anxious but soon felt very supported and was really happy during the process. She overcame her anxiety and her confidence has boosted. JM has been at CHFT for 6 months and was awarded Apprentice of the Month in June. She is yet to decide which career path to follow as there are so many apprenticeship opportunities at the Trust.

KH thanked JM for telling her story and wished her all the very best in her future career.

DS thanked Liam for a positive report. In terms of the stable attrition rates she asked if data is captured as a tool to ensure people stay in the programme. LM responded that the early preparation in supporting people is key and confirmed apprentice feedback is sought throughout the journey and used to develop the programmes. DS noted the significant difference in take up between the 2 colleges. LW responded that people's choice of programme is a factor. JE commented that in order to better understand the learner's perspective, the Education Committee is looking to expand its membership to a learner colleague. It was noted the July 2021 OFSTED assessment was rated as Good (Outstanding in the area of leadership, management and learner support). OFSTED assessment visits are usually between 3-5 years. Evidence across the 4 main areas of assessment is being collated in readiness of the next visit. KH stated it is a positive story and asked if the 302 apprentices are supernumerary. Approximately two thirds of apprentices are employed by the Trust.

OUTCOME: The Committee **NOTED** the progress against the Apprenticeship Strategy.

93/23 **DEVELOPMENT FOR ALL**

NH and RA presented the key headlines:-

- Level 5 Management & Level 7 Strategic Leadership Programmes; Huddersfield Business School
- Level 3 & Level 5 Aspiring Leaders Programme – Calderdale College
- Management Fundamentals & New to Manager Network; Process, Systems, Me as A Manager
- CHFT Operational Leadership Management Programme & Leadership Framework & Conferences
- NHS Leadership Academy – Online curriculum; leadership masterclasses, compassionate leadership etc
- PLACE based development programmes (WYAAT, ICS – BAME Fellowship Programme, Executive Director Pathways, WYAAT Senior Leadership programmes etc
- Executive Leadership CHFT Conferences
- EDI Education Suite
- Bespoke OD Interventions
- EMPOWER / WTGR / TED Team leader / OCOC Charters / 3 Rs workshops, Connect & Learn, Hot Houses
- Personal Development – Care Club Experiential Learning, Targeted employability interventions, Engagement ambassadors
- Wellbeing development opportunities (Ambassadors, Schwartz round facilitators, mental health)

NB was impressed by the range of development opportunities available. He asked about the prime purpose of the Management Fundamentals tool. LW explained the programme centralises resources. It is an intuitive tool and by monitoring usage of each section further learning programmes can be developed in response to popularity of topics. KH commented on the suite of activity adding that Management Fundamentals consolidates learning and resources that will support a consistent management approach.

OUTCOME: The Committee **NOTED** the extensive development programme.

94/23 **WORKFORCE REPORT (July 2023 data)**

MB presented the workforce report explaining this is the first iteration of the new style report. The report aligns to the 6 chapters of the People Strategy. Direct links between metrics and chapters of the People Strategy are highlighted in the report.

Headline summary:

- Staff in post figures for headcount and FTE have seen increases by 5 and 76.85 respectively. This in part will be due to the 38.81 FTE starters in July 2023, and changes to working hours during the month.
- Overall budgeted establishment dropped slightly by 3.99 FTE, this in conjunction with the FTE increases to actuals has seen vacancies drop to 405.32 FTE (6.69%).
- Substantive recruitment has not progressed at the rate predicted during the planning rounds earlier in the year; while FTE does continue to increase the Trust is ~197 FTE away from the planned substantive workforce level. This has in turn lead to a slower than anticipated reduction to bank staffing and an upturn in agency staffing.
- Turnover remains low at 7.62%, reducing from a peak of over 9% in August 22 to sub 8% in July 23.
- Appraisal compliance increased by 7.4% from 26.0% in June 23 to 33.4% in July 2023. This is above the planned trajectory of 20%.
- Core EST for All shows strong performance across the board with the Trust achieving an overall rating of over 95%. All modules show improving positions with Data Security Awareness continuing to achieve the national 95% target, and Fire now above the 90% threshold.
- Role Specific EST also shows continued improvement moving from 86% to 87% overall compliance. 15 of the 36 Role Specific Essential Safety Training modules are achieving the Trust target of 90%, an increase of 4 from the previous month. 11 modules are achieving less than 85% compliance, a decrease of 4 from the previous month.
- In month sickness increased in July 2023 due to an increase in both the short-term sickness rate of 0.24% and long-term by 0.13%.
- The top 3 reasons for absence in July 23 are Anxiety/Stress & Depression (35%), Musculoskeletal problems (10.2%) and Cold/Cough/Flu (9.5%).
- Estates and Ancillary staff group is an outlier with 13.28% sickness. E&A is a small group containing only 64 colleagues, 21 of which reported absence in July 2023; top reasons for absence mirror that of other staff groups (Anxiety/Stress/Depression, MSK, Cold/Cough/Flu). The number of absence occurrences increased from 10 in June to 24 in July 2023.
- Bank spend increased by £0.25M in July 2023. However this is normal monthly variation.
- Agency spend dropped by £0.12M to £0.95M. This is £0.11 below the agency ceiling set at £1.06M. There had been an increasing trend in monthly Agency spend from May 2022 with a peak in March 2023. This has since fallen due to the Trust moving away from high-cost agency use.

- The Trust has returned to pre pandemic levels in terms of apprenticeship starts (Employer Provider) and increased apprenticeship take up Trust wide. The Trust has over 304 Apprentices in total with a strong growth in those accessing Level 5+ apprenticeships (49.6%).
- 84% of widening participation candidates who progressed into CHFT apprenticeships live in the highest deprivation IMD deciles (1-3).

KH commented on the increase in sickness absence. JE responded the data describes a trend of the last three years. The forward position anticipates maximum intervention to tackle sickness absence. NB enquired if some benchmarking could be shown in the data. MB confirmed this is currently being looked at and is very possible for sickness and turnover. In

terms of Freedom to Speak Up themes, PB questioned if more information could be given. JE responded the slide can be developed and reminded members the annual Freedom to Speak up report routinely shared with the Committee provides greater detail.

OUTCOME: The Committee **NOTED** the report.

95/23 **QUARTERLY VACANCY DATA (APRIL TO JUNE 2023)**

JR presented a comprehensive report. The planned vacancy position using the year end estimated budget figure and in month planned actuals was 349.62 FTE (5.76%) in June 2023 and is currently 479.93 FTE (7.91%). Medicine and FSS have the majority of vacancies which is consistent with previous quarters. The Trust turnover has decreased from 8.91% in June 2022 to 7.66% at the end of June 2023 (excludes Trainee Doctor rotations and employee transfers).

ES provided an example of a specialty where other professional roles can support gaps. JR will facilitate the conversation to progress this. KH thanked JR for the very detailed report. KH commented on the decrease in turnover and asked if this was a concern. SD confirmed the People Heat Map shows in some areas an association between very low turnover and low people metric scores. 10% turnover is seen as a healthy base.

JE confirmed future vacancy reports will include a headline summary page.

OUTCOME: The Committee **NOTED** the Vacancy report.

96/23 **INDEX OF MULTIPLE DEPRIVATION**

MB presented information reviewed as part of regular Workforce Monitoring meetings detailing the Trust breakdown by Indices of Multiple Deprivation deciles for both BAME and white colleagues.

- The majority of BAME colleagues within the Trust live in IMD deciles 1-4 (higher deprivation areas), compared to white colleagues who are more evenly spread across IMD deciles 2-8.
- 51% of BAME colleagues live in deciles 1-3 (highest areas of deprivation), compared to 25.6% of white colleagues.
- 14.1% of BAME colleagues live in deciles 8-10 (lowest areas of deprivation), compared to 26.1% of white colleagues.
- Long and short term absence rates reduce as deprivation level decreases.

SD highlighted the importance of this data in that it determines where to target interventions. JE confirmed the Inclusion Group as part of its priorities will undertake deeper analysis. He added the data also feeds discussions led by the Health Inequalities Group.

OUTCOME: The Committee **NOTED** the report.

97/23 **NHS LONG TERM WORKFORCE PLAN**

JR presented the NHS Long Term Workforce Plan published in June 2023. The Plan sets out how the NHS will address existing and future workforce challenges by recruiting and retaining significant numbers of healthcare professionals and working in new ways to improve the colleague experience and ultimately patient care. The report summarises key points from the plan and provides an analysis of national, regional and Trust activity against the plan. The NHS Long Term Workforce Plan has a 15-year life cycle and focuses on 3 key areas – train, retain and reform. The Plan aims to increase the number of training places for doctors and nurses to increase the substantive workforce by 2031/2032.

JE stated this is an early assessment of how the Trust will map across the NHS Workforce Plan. Development work by NHS England will be tracked and responded to. Joint working will be required to deliver the organisational aspects of the plan. KH asked if any funding has been identified. It is not clear at this point if ICB funding will filter down. KH queried if review milestones have been factored in. An implementation plan is expected however there are clear delivery points that extend to 2030/2031 in terms of additional medical and nurse training places. Discussion took place regarding the plans to increase the workforce giving consideration to current recruitment challenges.

OUTCOME: The Committee **NOTED** the NHS Long Term Workforce Plan.

98/23 **GENDER PAY GAP**

MB presented a paper that outlined Trust data on the gender pay gap for March 2023 that will be submitted in March 2024. The Trust is required to publish data through the Government online reporting service, and on its own website. As at 31 March 2023, 80.9% of the Trust's workforce were female and 19.1% of the Trust's workforce were male. Due to the Trust employing fewer men overall, the number of male consultants as a proportion of the overall male workforce means that the male consultant workforce will significantly contribute to the pay gap for CHFT. The Bonus pay gap is also driven by the higher proportion of males in receipt of Clinical Excellence Awards (CEAs) as well as the fact they are traditionally in receipt of the higher level CEAs.

NB noted the action plan has focus on addressing CEAs and asked how big an impact CEAs have on actual pay gap. MB responded that medical and dental is a considerable disparity factor adding that the high proportion of males receiving CEAs significantly effects the pay gap. NB commented on the benchmarking information in that one other trust's median data differs hugely. MB stated it absolutely depends on what that middle point value is. He placed emphasis on more females in receipt of CEAs will reduce the median and increase the mean average. NH referenced the specific action to develop a new inclusive CEA process.

OUTCOME: The Committee:

a) **REVIEWED** and **DISCUSSED** the content of the proposed action plan
b) **NOTED** an ethnicity and disability pay gap analysis is being designed
c) **APPROVED** the ongoing monitoring of the relevant actions through the Women's Voices staff network

99/23 **WRES PUBLICATION**

MB presented the data. Areas of improvement have been made in:-

- Overall BME workforce, 23.3% of the Trust representation is BAME an increase of 3% from 2022
- Slight improvement when it comes to shortlisting where all applicants have equal opportunity to be appointed from shortlisting

The Committee noted there is more work to do and areas of focus for 2022/23 will be:-

- Career progression
- Understand why a higher % of BAME colleagues enter into a formal disciplinary process
- Bullying/harassment and discrimination campaign for both patients/service users and colleagues
- Board representation where all members of the Trust Executive Board are white

NH presented the action plan describing the focus on both the NHS and the EDI long term plans. Activities will be overseen by the Inclusion Group. The Committee noted a clear focus on career progression, bullying and harassment and talent pathways.

KH was pleased to see the increase in BAME colleagues joining the Trust. She did express concern in the increase of colleagues experiencing bullying from other colleagues and welcomed actions to tackle this. DS added that whilst it is great to see the percentage increase of posts being offered to individuals from BAME communities she fully endorsed the action to support career progression.

OUTCOME: The Committee **NOTED** the report.

100/23 **WDES PUBLICATION**

MB presented the data. Areas of improvement have been made in the following areas:-

- Self declaration rates, overall 5.2% of colleagues within the Trust have a disability, an increase of 0.7% from the previous year
- Disabled applicants have a slightly higher chance of appointment from shortlisting
- Although there continues to be a gap when it comes to shortlisting (9.3%) the position has improved from 2022 (9.7%)
- There has been a decrease in disabled colleagues feeling pressured to come into work even while unwell from 25.1% to 21.5%
- Results of the latest staff survey show disabled colleagues have an improving engagement score of 6.5% an improvement of 0.2%
- Although bullying and harassment from public and staff data significantly differ compared to non disabled colleagues we have seen an improving position

The report highlighted there is progress that needs to be made:-

- Continue efforts to promote self declaration
- Continue efforts to support a bullying/harassment campaign for public and colleagues
- Regarding disabled colleagues feeling the Trust values their work, the data highlights this is an improvement but the divide between disabled and non disabled colleagues have widened from 10% to 11.5% in 2023

NH described focus has been centred on career pipelines, education, career pathways, disability passport and Board representation. She presented the action plan which has been developed to align to NHS England best practice guidance and the five year ED&I plan. Progress will be overseen by the Inclusion Group.

KH thanked MB and NH for the detailed reports.

OUTCOME: The Committee **NOTED** the report.

101/23 **BAF DEEP DIVE 1/22**
COLLEAGUE ENGAGEMENT AND WELLBEING

SD presented the report to provide assurance in terms of risk and mitigation. The Committee noted risk 12/19 Colleague Engagement is now merged with risk 1/22 Colleague Wellbeing. The report set out activities that seek to properly engage colleagues, our development opportunities and health and wellbeing support offer. In addition to the report the Committee noted that an Executive sponsor is designated to each staff survey hot spot area. RB and AM as the Executive Sponsors for Community commented they had worked together with the Head of Therapies to develop a clear plan that engages colleagues.

The risk score was reviewed and remains the same.

OUTCOME: The Committee **NOTED** the BAF Deep Dive.

102/23 **EDUCATION COMMITTEE UPDATE**

The notes of the Education Committee had been circulated with papers. Following an external review of the Committee, a half day workshop is taking place on 29 September that will revisit the Committee's purpose, priorities and objectives. It is likely the meetings will move from bi-monthly to monthly. Notes of meetings will be shared with the Workforce Committee

OUTCOME: The Committee **NOTED** the update.

103/24 **INCLUSION GROUP UPDATE**

The notes of the Inclusion Group had been circulated with papers. The Group's meeting on 24 August is dedicated to ensure its plan on a page is properly focused, in particular against the NHS EDI Improvement Plan. Notes of the meetings will be shared with the Workforce Committee.

OUTCOME: The Committee **NOTED** the update.

104/23 **WORKFORCE COMMITTEE ACTION PLAN**

The Committee will maintain focus on core membership and attendance. It will keep to its workplan and ensure challenge is given to items discussed at Committee meetings.

OUTCOME: The Committee **NOTED** the action plan.

105/23 **WORKFORCE COMMITTEE WORKPLAN**

JE confirmed the workplan will be revised so that the WDES, WRES and Gender Pay Gap data/information for publication is received by the Committee for approval in late April/May followed by a 6 month progress update.

The Committee noted that work is underway to design an ethnicity and disability pay gap analysis. It is anticipated these will be a statutory requirement at some point.

OUTCOME: The Committee **REVIEWED** the Workplan.

106/23 **ONE CULTURE OF CARE – MEETING REVIEW**

No comments were made.

107/23 **ANY OTHER BUSINESS**

No other business was discussed.

108/23 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

KH will present the highlight report to the Board capturing:-
Continuing success of apprenticeships
Development for All suite of offerings
New format of workforce report
Some concerns in vacancy data
NHS Long Term Plan
WRES and WDES
Colleague Engagement BAF

Pivotal role of Inclusion Group.

109/23 **DATE AND TIME OF NEXT MEETING:**

Workforce Committee Hot House:
19 September 2023, 2.00pm – 4.00pm
Theme: One Culture of Care

Workforce Committee:
17 October 2023, 2.00pm – 4.30pm
Chapter: Workforce Design

27. DATE AND TIME OF NEXT MEETING

Date: Thursday 11 January 2024

Time: 10.00 – 2.00 pm

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

To Note

Presented by Helen Hirst