PUBLIC BOARD OF DIRECTORS MEETING

Schedule	Thursday 7 September 2023, 10:00 — 13:00 BST
Venue	Forum 1A/B, Learning Centre, Huddersfield Royal Infirmary
Organiser	Kathy Bray

Agenda

10:00	1. Welcome and Introductions: Invited Public Governors: Christine Mills To Note - Presented by Helen Hirst	1
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	STANDING ITEMS	4
10:03	4. Minutes of the previous meeting held on 6 July 2023 To Approve - Presented by Helen Hirst	5
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10:05	5. Matters Arising and Action Log For Review - Presented by Helen Hirst	20
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10:07	6. Patient Story: Surgical Robot - Presented by Nicola Greaves, Patient Experience Lead To Note	22

12:22	26.	Items to receive and note Minutes of Board Committees:- - Finance and Performance Committee 28.6.23, 1.8.23 - Quality Committee 21.6.23, 24.7.23 - Workforce Committee 20.6.23 - Audit and Risk Committee 27.6.23, 25.7.23 - Charitable Funds Committee 9.8.23 Partnership papers: Kirklees Health and Care Partnership Kirklees ICB Committee meetings - NHS Kirklees Clinical Commissioning Group (kirkleeshcp.co.uk) and Calderdale Cares Partnership Meeting papers - Calderdale Cares Partnership To Receive	390
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		APP V3 - FINAL Quality Committee minutes & action log - Wed 21 June 2023 (Approved Mon 24 July 2023).docx	406
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	27.	Date and time of next meeting Date: Thursday 2 November 2023 Time: 10.00 am – 1.00 pm Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary	452

1. Welcome and Introductions:

Invited Public Governors:

Christine Mills

To Note

Presented by Helen Hirst

2. Apologies for absence: Victoria Pickles, David Birkenhead, Andy Nelson, Suzanne Dunkley, Rob Birkett, Pam Robinson

To Note

Presented by Helen Hirst

3. Declaration of Interests

To Note

STANDING ITEMS

4. Minutes of the previous meeting held on 6 July 2023

To Approve

Presented by Helen Hirst

Draft Minutes of the Public Board Meeting held on Thursday 6 July 2023 at 9.00 am, Forum Room 1A / 1B, Sub-Basement, Huddersfield Royal Infirmary

PRESENT

Helen Hirst	Chair
Robert Aitchison	Deputy Chief Executive
David Birkenhead	Medical Director
Rob Birkett	Chief Digital and Information Officer
Lindsay Rudge	Chief Nurse
Suzanne Dunkley	Director of Workforce and Organisational Development (OD)
Kirsty Archer	Director of Finance
Nigel Broadbent **(NB)**	Non-Executive Director
Andy Nelson **(AN)**	Non-Executive Director
Karen Heaton **(KH)**	Non-Executive Director
Peter Wilkinson (**PW)**	Non-Executive Director

IN ATTENDANCE

Jonathan Hammond	Chief Operating Officer
Victoria Pickles	Director of Corporate Affairs
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd (CHS)
Andrea McCourt	Company Secretary*(minutes)*
Liam Whitehead	Head of Apprenticeships and Engagement (item 82/23)
Stevie Cheesman	Volunteer Co-ordinator Project Lead
Chloe Hudson	Ward Helper Volunteer (item 82/23)
Diane Tinker	Director of Midwifery and Women's Services (item 96/23)

OBSERVERS

Christine Mills	Public Elected Governor
Robert Markless	Public Elected Governor
John Gledhill	Public Elected Governor

77/23 Welcome and Introductions

The Chair welcomed everyone to the Board of Directors meeting held in public, in particular those presenting the Staff Story 'Volunteering'.

The Chair welcomed the invited governors Christine Mills, Robert Markless and John Gledhill as observers to the meeting. The Chair noted this was John Gledhill's last Board meeting as governor and thanked him for his contribution. The Chair noted Stephen Baines, Lead Governor, was unable to attend and acknowledged his contribution as Lead Governor and thanked him for his services.

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

78/23 Apologies for absence

Apologies were received from Brendan Brown, Chief Executive, Anna Basford, Deputy Chief Executive/Director of Transformation and Partnerships, Tim Busby, Non-Executive Director, Denise Sterling, Non-Executive Director.

79/23 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.

80/23 Minutes of the previous meeting held on 4 May 2023

The minutes of the previous meeting held on 4 May 2023 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 4 May 2023.

81/23 Matters Arising and Action Log

It was noted that action 71/23, Health and Safety Policy, was complete.

In relation to action 62/23, Quality Report and compliments and feedback, the Chief Nurse advised the Patient Experience and Inclusion Strategy will be presented at the next Quality Committee meeting which will address concerns about collecting compliments and engaging patients in feedback. She advised that she had commissioned a review of patient safety incident levels to identify themes and report to Quality Committee, with exception reporting to Board.

The Chair asked how governor experience could be fed into a central point and the Chief Nurse advised in future this would be via the Quality Improvement Manager.

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

82/23 Staff Story – Volunteering

The Chair welcomed Liam Whitehead, Stevie Cheesman and Chloe Hudson to the meeting.

The Director of Workforce and OD advised that Chloe Hudson was both a volunteer and part of the care club, which forms part of the Trust widening participation programme. She advised we have 230 active volunteers, 22 of whom have become apprentices.

Liam Whitehead outlined the guiding principles of apprenticeships and widening employment programme and the various pathways to “grow our own”, harness local talent and diversify our workforce, which has been in place over the last 18 months. The approach aligns with NHS England’s long term workforce plan, the aim being to remove barriers, raise opportunities and support people to get ready for work. Examples of this noted were the Princes’ Trust, currently we have our seventh cohort, the cadet programme, which supports younger people, for which the Trust has the second highest take up outside London and T level cadets. It was noted that support with employability was also offered by the Trust, such as careers advice and guidance. It was noted that seven of the ten Project Search people had progressed to Trust employment.

The importance of partnerships supporting pre employment through to work to remove barriers and deliver outcomes was noted, such as education providers and the Job Centre.

Data was shared on the progression into apprenticeships from widening participation pathways which demonstrated diversity over the last 18 months, e.g.

84% progression candidates were from the three most deprived areas in Huddersfield and Halifax, 47% had an ethnic minority background, 32% were male participants and 79% were under the age of 30.

Stevie Cheesman talked to Chloe Hudson about her journey from her time before she was supported by the Trust, as a teenager and care leaver and to becoming an apprentice. This included outreach, Princes Trust, progression to ward helper volunteer on ward 20 from March 2023, a complex elderly care ward and identifying and supporting carers. She received support from the widening participation team (employability and mentoring). Her journey has led to her starting as a Healthcare Support Worker apprentice in July with continued support. She spoke of how her work with the carers team highlighted the importance of recognising and supporting young carers and how she had increased her understanding of the NHS. She shared her aspiration to be a paramedic and expressed gratitude for the support and welcome she had received.

Board members thanked Chloe for sharing her story and commented how she was an inspirational and confident speaker and should be proud of her achievements. The Director of Corporate Affairs highlighted the importance of the Board recognising our volunteer workforce and suggested other services across the organisation could also benefit from volunteers, such as the Trust Charity.

Discussion took place about whether media coverage impacted perceptions of the NHS (PW) and consideration of extending the volunteer approach to non-clinical areas such as technology and data science (AN).

In response to a question from RA about further support required, Liam Whitehead suggested looking at a Trust-wide volunteering service and Robert Markless, who is also a volunteer, noted administration resources were stretched. The Chair gave feedback on appreciation visits she had undertaken where she had heard about the contribution of volunteers and commented that the statistics presented clearly showed benefit for under-represented areas of our communities.

OUTCOME: The Board **NOTED** the volunteer story and the work of the Widening Participation Team and thanked the volunteer and colleagues for their presentation.

83/23 Chair's Report

The Chair presented her report detailing activities since the last meeting within the Trust, and local systems, regionally and nationally.

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

84/23 Chief Executive's Report

The Deputy Chief Executive presented the report on behalf of the Chief Executive, which provided strategic and delivery context for the meeting. The report detailed progress against local and national targets and key challenges and activities 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. The paper reflected celebrations of the NHS 75th birthday and local media coverage on the contribution of colleagues in estates and facilities, reception

services and volunteers to the NHS. The Deputy Chief Executive thanked the Communications team for their work on the 75th birthday celebrations.

The following was highlighted:

- upcoming industrial action from both junior doctors and Consultant staff later in July, with an ongoing impact on the financial position
- continued work to deliver an ambitious cost improvement plan
- continued progression of the reconfiguration agenda

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

85/23 Sustainability – Green Plan – Annual Update

The Managing Director of Calderdale Huddersfield Solutions Limited (CHS) presented an update in relation to progress with the Trust's Green Plan and Sustainability Action Plan (SAP) and Travel Plan and work with partners on the wider sustainability agenda. The Board approved strategy runs to 2026, and details the Trust's aims, objectives and delivery plans for sustainable development and targets for carbon reduction. Delivery of the plan is monitored by the Green Planning Committee.

It was noted that 159 of the 206 actions in the SAP were complete. Progress in quarter 2, 2023/24 was shared as well as priorities for quarter 3, 202324. A 60% reduction in CO2 emissions (since baseline of 2013/14) was noted, with examples given of buying renewable electricity and electric / hybrid fleet vehicles, use of local workers and contractors / supply chain. It was noted that a heat decarbonisation plan is now part of the SAP, with a new heat pump planned as part of the new A&E build at HRI.

In terms of the travel plan 41 of 47 actions are complete. A key aim of the plan noted was to reduce single car occupancy journeys, with a 5% reduction by 2026 noted to be challenging; a 2% reduction had been achieved since the travel plan had been adopted. Initiatives and output from the annual travel survey were detailed in the paper. It was noted a car share app was being developed.

Work with partners and membership of local climate and environment groups across Calderdale, Kirklees and West Yorkshire was noted.

Discussion took place on:

- progressing the travel app proposal (KH) which it was confirmed had been approved by the Green Planning Committee
- the reason for a 25% increase in emissions at Calderdale Royal Hospital (CRH) (KH) - the Managing Director CHS advised he was working with partners at CRH on carbon emissions and was confident reasons for higher emissions could be addressed quickly
- the challenge of organisational engagement (AN) – the Managing Director CHS recognised the challenge and advised a calendar of monthly sustainability events had been developed and work was underway with the Communications Team to generate interest. The Director of Corporate Affairs also shared that Communications work was taking place at a West Yorkshire level on sustainability, linked to the positive achievements by CHS with local procurement

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- challenges to deliver the remaining 36 actions (NB) – noted to be how we heat buildings and cladding

The Medical Director queried whether the narrative matched the emissions graph in the paper and the Managing Director for CHS agreed to check this and feedback to the Medical Director after the meeting.

OUTCOME: The Board **NOTED** the progress with the Green Plan and Travel Plan and contribution to the wider sustainability agenda.

86/23 Finance and Performance Chair Highlight Report

AN presented this highlight report with an update from the Finance and Performance Committee meetings held on 30 May 2023 and 28 June 2023. AN noted the positive position on recovery of activity, progress with Consultant recruitment for Emergency Medicine, a deep dive on follow up appointments and the efficiency challenge. The content of the report was reviewed and noted by the Board.

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

87/23 Month 2 Financial Summary

The Director of Finance presented the financial position as reported at Month 2, May 2023.

It was noted that the Trust has reported a £4.58m deficit, (excluding the impact of Donated Assets), a £0.39m adverse variance from plan. YTD 4.6M deficit. The in-month position was a deficit of £1.74m, a £0.21m adverse variance.

Year to date the Trust has incurred higher than planned costs due to higher than planned additional bed capacity of £0.47m (£0.28m surge capacity plus £0.19m slippage on the length of stay cost improvement programme (CIP), the Doctors' industrial action (£0.20m) and higher than expected Utilities costs. These pressures were offset by early delivery of other efficiencies and a higher than planned vacancy rate.

The Trust was forecasting to deliver the planned £20.80m deficit, but the 'likely case' scenario includes £6.3m of unidentified mitigation required to offset forecast pressures and emerging risks including: unidentified CIP, (£2.1m of the £6.5m final plan stretch target); likely slippage on some high-risk efficiency programmes; further strike action; and challenges delivering the bed plan.

It was noted that the CIP programme will become more challenging as the year goes by. In response to a question from the Chair, the Director of Finance confirmed that the financial position at Month 2 was similar to other Trusts.

The Chief Operating Officer gave an update on planning for Junior Doctor and Consultant industrial action in July and advised we aim to minimise the amount of elective work cancelled for patients. He informed the Board that the Trust was doing well maintaining elective work in line with plans and that the impact on finances and targets would be closely monitored.

The Chair acknowledged effective working together across teams to support colleagues and maintain services for patients during the industrial action periods.

OUTCOME: The Board **NOTED** the Month 2 Financial Summary as at May 2023.

88/23 Workforce Committee Chair's Highlight Report

KH presented the Chair's highlight report from the Workforce Committee of 20 June 2023. She drew attention to Fire safety training compliance and noted that short term sickness remains a concern and was being dealt with in a targeted way. Progress with recruitment in nursing, midwifery and international recruitment was positive. The content of the report was reviewed and noted by the Board.

Robert Markless sought assurances that when staff raised concerns they were not discriminated against. KH responded there was no evidence in the Trust to suggest discrimination and expressed her view that there are fewer concerns raised anonymously, suggesting people are confident in speaking up without fear. The Director of Workforce and Organisational Development added there had been a decrease in the number of anonymous concerns and shared that Freedom to Speak Up concerns raised by colleagues in Maternity Services had been embraced and led to training on leadership and improved patient care.

PW queried the staff turnover target of 11.5% (currently 7/8%) and the Director of Workforce and Organisational Development clarified that our turnover is low, generally we aim for 10%, the target needs to be reviewed downwards and the position varies between directorates. The Chief Operating Officer suggested we could establish what level of turnover was appropriate in particular services, and noted that in some services retention was an issue, for example therapy services.

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

89/23 Audit and Risk Committee Chair's Highlight Report

NB presented the Audit and Risk Committee Chair highlight report from the meeting held on 27 June 2023 which signed of the 2022/23 annual report and accounts and annual governance statement, with delegation from the Board of Directors. He noted the Committee had thanked the Finance team and Company Secretary along with other colleagues in preparing the Annual Report and Accounts.

NB advised that a comparison of the financial statements with reports shared with the Finance and Performance Committee and year-end figures were in line with forecasts received by the Finance and Performance Committee over the year. He confirmed Internal Auditors and External Auditors had given assurances that confirmed effective systems of internal control had been in place and supported the approval of the 2022/23 accounts, annual report and annual governance statement. NB confirmed there was some outstanding work by External Audit after the meeting and he had received details of the minor changes.

AN asked about the External Auditor performance and the Director of Finance advised there had been improvements on the 2021/22 process and the usual post accounts review meeting would take place. A discussion on the challenges of the public sector audit market took place.

The Chair extended her thanks to the Finance team and NB.

OUTCOME: The Board **NOTED** the Audit and Risk Committee Chair Highlight Report.

90/23 Quality Committee Chair's Highlight Report

The Medical Director presented the Chair's highlight report from the Quality Committee and the content of the report was reviewed and noted by the Board. He highlighted progress with compliance on health and safety standards, assurance from internal audit on recognition and treatment of sepsis and assurance from the Maternal and Neonatal Oversight report. In terms of performance, he highlighted continued positive cancer performance and challenges with delivery of stroke services, with a high number of patients presenting with stroke.

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

91/23 Infection Control Report, quarter 4, 2022/23

The Medical Director presented the Infection Prevention Control report for quarter 4, 2022/23 and highlighted a general trend of increasing nosocomial infections, particularly C. difficile. He advised an NHS England support visit in February 2023 had been positive with a few minor recommendations made and there would be a continued focus on C. difficile and nosocomial infections to get the basics of infection prevention control right.

In response to a question from AN about the trends in C difficile and nosocomial infections the Medical Director advised the reason for the increase was unclear and this position was seen nationally. He advised C. difficile infections were impacted by patient length of stay and the increased use of antibiotics for respiratory infections over the last three years and advised Covid infections had arisen from community transmission.

OUTCOME: The Board **NOTED** the Infection Prevention and Control report for quarter 4, 2022/23.

92/23 Learning from Deaths, quarter 4 report, 2022/23

The Medical Director presented the Learning from Deaths quarter 4, 2022/23 report. He advised that the target of 50% initial screening reviews being completed had not been achieved due to pressures on Consultant staff and extra capacity was being sought to undertake the reviews. He confirmed learning from reviews was fed into Trust and divisional governance processes. He assured the Board that mortality metrics were within the normal range.

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

93/23 Integrated Performance Report

The Chief Operating Officer presented the Integrated Performance Report for May 2023, noting this was the first of the revised reports presented to the Board, with greater use of Statistical Process Control charts (SPCs) which measure changes in data over time to focus attention where needed. It was noted that data for certain report sections, such as Finance, was presented as narrative rather than SPC charts due to the data collection method.

The following was noted in terms of the revised report:

- positive feedback on the new report received from the Finance and Performance Committee, as the use of SPC charts will ensure focus on the right issues, avoid making judgements on random variation and support identification of patterns of improvement and deterioration

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- context for the use of the phrase “consistently fail” relating to a target was given, noting it can direct effort to services requiring different actions, eg echo- cardiogram and neurophysiology
- certain targets are not what we aspire to, but provide an average figure we would not expect to exceed (eg neonatal deaths)
- the performance matrix summarised data by variance (special cause concern, common cause, special cause improvement) and assurance (pass, hit and miss, fail), with hit and miss meaning a target may be a pass or fail due to normal variation
- a glossary of terms is provided at the bottom of the report

Discussion took place about using more understandable language to describe SPC terms more clearly in the summary page (PW). It was agreed to trial an additional narrative summary sheet focusing on specific variances of concern or note, with evaluation after three months on the two summary pages as well as the report more generally. RA commented the report was a significant improvement and both RA and the Chair commented that the middle box, which showed common cause variation and hit and miss assurance, was helpful. NB commented that the summary report could usefully highlight areas in the common cause variation / hit and miss assurance box which were improving.

The Director of Workforce and Organisational Development assured Board members that staff movement and absence, shown as a special cause concern in the summary, was improving and the data reflected the reporting period and gave assurance this was going in the right direction.

In terms of performance the Chief Operating Officer highlighted ongoing work to achieve the four hour Emergency Department (ED) target of 76% by March 2024, specifically management of admitted and non-admitted patients and a focus on daily breaches. He explained that the Trust’s ability to achieve this was linked to bed base and bed occupancy, which fluctuated around 96%. Supporting work on length of stay and transfer of care reduction, driven by the Urgent and Emergency Care Delivery Group, and a programme of work linked to the Community division and partners was noted. The significant challenge with partners to reduce transfer of care numbers, currently around 120 patients, and capacity issues in the community was noted, with funding to support reablement of patients being explored. Supporting services and initiatives were noted, such as the Same Day Emergency Care service to reduce pressures in ED, well organised ward and planned expansion of the virtual ward beyond frailty and respiratory services.

The Chair noted the actions being taken, that the Finance and Performance Committee would scrutinise these and the significant impact delays had on both patients and finance.

ACTION: Chief Operating Officer to develop additional narrative summary for IPR report and review in three months.

OUTCOME: The Board **APPROVED** the Integrated Performance Report for May 2023.

94/23 Safeguarding Adults and Children Annual Report

The Safeguarding and Children’s Annual Report for April 2022 – March 2023 and presentation pack highlighted key achievements and progress over the year in

relation to Prevent (safeguarding from terrorism), Safeguarding Boards and partnerships, hidden harms, Mental Capacity Act and Liberty Protection Safeguards, training compliance, adult safeguarding, safeguarding children, the Mental Health Act, Children Looked After and maternity safeguarding.

The report had been reviewed by the Quality Committee. AN commented on the positive work described in the report and, in relation to an increase in deprivation of liberties, it was noted that increased awareness of the process and patient complexity had contributed to this increase.

OUTCOME: The Board **NOTED** the Safeguarding Adults and Children Annual Report.

95/23 Complaints Annual Report 2022/23

The Director of Corporate Affairs presented the Complaints Annual Report 2022/23 which detailed a summary of complaints received over the period, themes, performance against key performance indicators and compliments. The report had previously been reviewed by the Quality Committee.

It was noted that a significant amount of work had taken place resulting in improved response times following a focus on improving how complaints were processed, investigated and responded to. This led to significant improvement in complaints response times from 41.7% being responded to within timeframe to 94.4%. Focus on process had been the priority during 2022/23.

In addition to sustaining improved response times, priority work areas for 2023/24 were noted which included reducing the number of re-opened complaints and seeking assurance that learning from complaints has been implemented.

Assurance was given that there was immediate learning for every complaint. The Director of Corporate Affairs described work was underway reviewing themes from complaints which will feed into Patient Safety Incident Response Framework categories. Nutrition and hydration had been identified as a theme and has been agreed as a key quality priority for 2023/24.

KH acknowledge the positive improvement in complaints response times, commented that sustaining these was important and suggested it would be useful to consider learning from compliments.

A discussion took place about routes for patients to share comments and it was noted that current routes include the Patient Advice and Liaison Team and Family and Friends Test. Board members were informed that the Patient Experience lead was developing a process to capture and collate such information. The Director of Corporate Affairs noted that part of the ward development programme was about senior nursing staff regularly having conversations with patients whilst in hospital to resolve issues as they arise and other initiatives, such as the exemplar ward and well organised ward (WOW) support this approach, as well as John's Campaign for carers.

The Chair noted the improvements in complaints response performance and thanked the team.

OUTCOME: The Board **NOTED** the Complaints Annual Report 2022/23**.**

96/23 Maternity Report

The Chair welcomed Diane Tinker, Director of Midwifery and Women's Services to the meeting.

The Director of Midwifery and Women's Services presented the Maternity and Neonatal Oversight Report which gave the Board oversight of quality issues within maternity services. The following was highlighted:

- updated Maternity Transformation Plan reflecting national guidance and three year delivery plan, with oversight by the Maternity Transformation Board
- update on achievement of the Maternity Incentive Scheme for 2022/23, noted 2023/24 scheme will be challenging to achieve
- staffing is the biggest challenge – revisions proposed to the maternity staffing model given reductions in birth rate based on a 1:24 ratio, with a plan to commission another Birthrate Plus report and extend this to other roles
- offered 14 whole time equivalent posts to student midwives qualifying in September 2023
- update given on recruitment including international recruitment, noted staffing was the biggest challenge over the next few years
- 1:1 care in labour was an area of strength that achieved 98%

It was noted that the CQC maternity report following the visit in June 2023 was awaited and feedback on the visit, which was positive, was shared. Three areas for improvement were staffing, guidelines referencing and maternity assessment, the latter was common to all maternity inspections. Positives highlighted included audit work including use of deprivation data, surrogacy pregnancies and the Rainbow Clinic (for previous pregnancy loss), safeguarding, fathers with mental health issues and the donor neo natal milk bank.

The Chair was re-assured by the feedback and commented on the openness of staff that had been visible to her when she had visited Maternity Services. Likewise, KH, Maternity Safety Champion, added that together with the Chief Nurse she had undertaken a walk around maternity and staff were positive about the service.

The Chief Nurse advised that the Quality Committee receive the completed review of themes of neonatal deaths and maternity reviews were being shared with Place Quality Committees.

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The Chair thanked the Director of Midwifery and Women's Services for her leadership of maternity services and wished her well with her retirement.

OUTCOME: The Board **NOTED** the Maternity Report.

97/23 Nursing and Midwifery Staffing Hard Truths Requirement

This report provided an overview of capacity for nursing, midwifery and Allied Health Professional (AHP) staffing capacity and compliance with national staffing guidance, The report noted establishment reviews have been undertaken as required by national guidance based on the principles of the safer staffing triangulation approach which has informed changes.

KH confirmed the report had been previously reviewed by the Workforce Committee and Quality Committee and key points had already been discussed during the Board meeting.

OUTCOME: The Board:

- **NOTED** the on-going plans to provide safe staffing levels within nursing, midwifery and AHP disciplines across the Trust
- **NOTED** the maternity staffing position and local position is similar to the national profile
- **NOTED** the compliance standards in relation to the Clinical Negligence Scheme for Trusts and the ongoing quality of data it provides to underpin the Trust establishment process
- **NOTED** the assurance regarding the daily processes to monitor and manage nurse and midwifery staffing levels at ward level
- **NOTED** the assurance from the Chief Nurse that there is good compliance with Developing Workforce Safeguards

98/23 Health and Safety Annual Report 2022/23

The Chief Operating Officer presented this report which detailed actions taken to meet the requirements of health and safety compliance. The report confirmed assurance regarding compliance with the NHS Workplace Health and Safety Standards and actions underway to meet all requirements yet to be met by October 2023. The revised Health and Safety Strategy for 2023-27 was included as an appendix to the paper.

Key elements noted were collaboration with other professions and departments (eg matrons), with ISS, Practice Managers and building managers in the community as well as Overgate Hospice. Work relating to sharps, ligature risks and moving and handling injury reduction was noted.

The report confirmed governance arrangements for health and safety were in place during the year, with the Health and Safety Committee meeting five times over the year and sub-groups established to monitor the effectiveness of the policies.

AN asked if there was any early evidence in reducing slips, trips and falls and if there had been progress in reducing security incidents relating to patient behaviour. The Chief Operating Officer responded that he would need to review the data and added that Violence and Aggression training was being rolled out for key hotspot areas.

NB queried whether there had been an assessment against the health and safety core actions and best practice for Boards that had been shared via a presentation to Board members from Weightmans in March 2023. The Chief Operating Officer agreed to ask the Head of Health and Safety to undertake this assessment.

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ACTION: Chief Operating Officer to arrange for an assessment against Health and Safety core actions for Boards to identify if any further actions are required.

OUTCOME: The Board **APPROVED** the Health and Safety Annual Report 2022/23 and **NOTED** progress against the action plan.

99/23 Board Assurance Framework

The Company Secretary presented the first update of the Board Assurance Framework (BAF) for the financial year 2023/24 and it will be reviewed by the Audit and Risk Committee on 25 July 2023. She advised that the BAF has been refreshed in line with the new five year and one year strategy agreed by the Board in March 2023 as it captures risks to the Trust's strategic objectives. Five risks have been removed from the BAF with rationale for this given in the paper and three risks were proposed for addition as described. The paper detailed alignment of risks with the one year strategic objectives and confirmed which Board Committee had oversight for each risk.

The following were highlighted:

- 20 risks across the four goals with the highest number of risks and highest scoring risks in the Keeping the Base safe goal
- reconfiguration and financial sustainability remain as top risks
- the third top risk has changed since last reported to the Board - the nurse staffing risk has reduced in score from 20 to 16 for the reasons detailed in the paper and is removed from the top three risks. A new performance risk, risk 1/23 relating to activity has been added, with a risk score of 20 as agreed at the Finance and Performance Committee. This risk is that high demand and patient acuity means opening additional beds, or not being able to close additional beds already open and is impacted by patients who are medically fit for discharge being delayed due to lack of provision elsewhere and having to spend longer in hospital than needed which impacts our financial position
- Two new risks, one relates to social value, key to our sustainability goal and one to partnership governance and the impact on decision-making
- The risk relating to local and national performance targets, risk 8/19 was discussed at the Finance and Performance Committee on 28 June 2023. It will be removed and replaced with a new risk relating to achieving national performance targets, which will be developed for review by the Audit and Risk Committee on 25 July 2023 and reported to Board at its September meeting

NB queried whether it was premature to reduce the nurse staffing risk score from 20 to 16. The Director of Corporate Affairs responded that there were fewer nursing vacancies across all areas, particularly in the Emergency Department and Paediatrics and with this improvement in staffing levels it was not deemed appropriate to retain a risk score of 20, but this will continue to be reviewed with the score increased if needed.

Discussion also took place about the partnership governance risk score of 16 and whether this was too high. The Director of Corporate Affairs explained the rationale for scoring the risk at 16 due to the complexities of multiple layers of governance locally and nationally, changes underway within the Integrated Care Board, duplication which impacts on Executive resource and our limited ability to influence

partnership governance. The risk score was agreed at 16 and would continue to be reviewed.

OUTCOME: The Board:

i. **APPROVED** the removal of five risks scores on the Board Assurance Framework
ii. **APPROVED** the reduction in risk score to 16 of the risk 10b/19 nurse staffing
iii. **APPROVED** the additional risks and updates to the risks on the Board Assurance Framework
iv. **CONSIDERED** if there were any further risks to the achievement of strategic objectives.

100/23 High Level Risk Register.

The Director of Corporate Affairs presented this report which gave an overview of risks scoring 15 or above and themes by each strategic goal were noted, with 52 risks of which 36 were rated as high (36) and very high (16), with five risks having had their risk score reduced.

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. The significant number of risks from the Family and Specialist Services division was noted to be a reflection of both ongoing working with teams on risks and the complex group of high risk services within this division, such as maternity and out patients.

AN commented he felt there could be improvements in updating actions and gaps in actions for risks, which the Director of Corporate Affairs agreed with and advised that the current focus was on supporting teams to review and understand their risks and the purpose of the risk register.

AN felt some areas of concern discussed were not being captured as risks, for example there were no system/Place/ transfer of care/ stroke risks and asked if that triangulation could happen. It was noted that there remain two more areas to review risks, one being clinical and then this could be considered.

The Chair advised of the need to ensure risks presented are current and the narrative regularly reviewed.

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

101/23 2023/24 Financial Plan Overview: Budget Book

The Director of Finance presented to the Board the final financial plan for 2023/24 which had been submitted to NHS England. She noted the delay in presenting this information to the Board was due to the delays in final approval of the annual plan, submitted in May 2023 and that the paper supports the assumptions and key financial statements that form the overall plan for 2023/24.

OUTCOME: The Board **APPROVED** the 2023/24 Budget Book.

102/23 Governance Report

The Company Secretary presented the Governance report which contained annual reports for 2022/23 for the Workforce Committee, Audit and Risk Committee and the Transformation Programme Board, 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 Chair thanked Board Committee Chairs for their annual reports as these are an important part of assurance for the Board.

In relation to the Chair's action for an Urgent and Emergency Care Bid, this had not been successful and the Chief Operating Officer updated the Board that a working group was in place to move the ward-based discharge lounge at CRH from 1 November 2023 to the Learning and Development Centre once vacated in October and co-locate this with the Same Day Emergency Care Service, progressing this development at minimum cost until there are further capital funding opportunities.

OUTCOME: The Board **APPROVED** the Board workplan, Board Meeting Dates for 2024-2025, **NOTED** use of the Trust Seal and Annual Reports for the Workforce Committee, Audit and Risk Committee, Transformation Programme Board and **RATIFIED** the Chair's Action relating to the Urgent and Emergency Care Bid.

103/23 Review of Board Sub-Committee Terms of Reference

The Company Secretary confirmed that the terms of reference had been reviewed by the Workforce Committee of the Board of Directors.

OUTCOME: The Board **APPROVED** the Workforce Committee Terms of Reference.

104/23 Items to receive and note

The following were provided for assurance:

- Minutes of Committee meetings:
  - Finance and Performance Committee: 26 April 2023, 30 May 2023
  - Quality Committee: 17 April 2023, 22 May 2023
  - Workforce Committee: 24 April 2023, 3 May 2023
  - Audit and Risk Committee: 25 April 2023
  - Charitable Funds 10 May 2023
- Partnership papers: Kirklees Health and Care Partnership and Calderdale Cares Partnership

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

105/23 Any Other Business

There was no other business.

106/23 Date and time of next meeting

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at 12.20 pm.

Date: Thursday 7 September 2023
Time: 10.00 am
Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary

DRAFT

5. Matters Arising and Action Log

For Review

Presented by Helen Hirst

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2023

Position as at: 7.8.23

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
6.07.23 93/23	**Integrated Performance Report**	Chief Operating Officer	Develop narrative summary report using non-SPC language and review within 3 months	2 November 2023		
6.07.23 98/23	**Health and Safety Report**	Chief Operating Officer	Positive assurance received from Head of Health and Safety review of Board core actions on health and safety	7 September 2023		6 July 2023
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	7 March 2024		
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	~~7 September 2023~~ 2 November 2023		

6. Patient Story: Surgical Robot - Presented by Nicola Greaves, Patient Experience Lead

To Note

7. Chair’s Report (including Organ Donation report and Charitable Funds report)

To Note

Presented by Helen Hirst

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 September 2023
Meeting:	Public Board of Directors
Title:	Chair's Update
Author:	Helen Hirst, Chair
Sponsoring Director:	N/A
Previous Forums:	None
Purpose of the Report	To update the Board on the actions and activity of the Chair.
Key Points to Note	The enclosed report details information on key issues and activities the Trust Chair has been involved in over the past two months within the Trust, with local system partners and regional and national work.
EQIA – Equality Impact Assessment	The attached paper is for information only and does not disadvantage individuals or groups negatively.
Recommendation	The Board is asked to **NOTE** the report of the Chair.

Calderdale and Huddersfield NHS Foundation Trust

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

It was lovely to be part of the Trust's NHS 75th Birthday celebrations including tree planting with local children and the Big Hospital Walk arranged by the Calderdale and Huddersfield NHS Charity.

Along with Brendan, I was invited to the welcoming and licensing of our new chaplain, Sam Cowling-Green. There was also a formal welcoming of Sue Naughton as Lead Chaplain as she was appointed to this role during Covid. It was lovely to meet a number of members of our chaplaincy team and talk to them about the valuable role they have within CHFT.

Our Annual Members' Meeting was held in the Lecture Theatre at CRH. We discussed the annual report and accounts, Foundations for our Future and Quality priorities and had presentations from Rob Aitchison, Anna Basford, Kirsty Archer and Lindsay Rudge. We had a number of questions from the audience which were mainly about mental health and wellbeing.

I met with Helen Higgs Head of Audit Yorkshire for our annual discussion about the audit activity within the Trust.

Last week I attended the LGBTQ+ pride parade at HRI.

I have continued to meet new governors as they officially start in post. New Stakeholder Governors appointed recently are: Cllr Joshua Fenton-Glynn, Stakeholder Governor from Calderdale Council, Cllr Jo Lawson, Stakeholder Governor, Kirklees Council, Jules Williams, Stakeholder Governor, South West Yorkshire Partnership NHS FT.

Christopher Reeve has resigned as the Stakeholder Governor from Locala. He will be replaced by Victoria Vallance, Director of Nursing, Quality and Allied Healthcare Profesionals in due course. Brian Moore, the new lead governor and I met to discuss the Council of Governors development work.

I chaired the Charitable funds committee where we discussed our refreshed strategy and branding alongside our fundraising activities in the year to date. A report to Board is attached.

I also chaired the organ donation committee whose Annual Report on donation activity is also attached. This comprises a letter to the Chief Executive and Medical Director; a summary report from NHS Blood and Transplant authority and a similar, but more detailed, report.

The Trust continues to perform really well in its category (Level 2 Trust) and benchmarks as exceptional for referral of potential organ donors and at bronze level for other indicators such as presence of a specialist nurse for organ donation, consent etc. Donation activity nationally has not yet returned to pre-pandemic levels and we all continue to make improvements within the Trust as well as raising awareness through publicity and information sharing. Organ Donation Week for 2023 is 18 to 24 September and the key message this year is 'Leave then Certain', i.e. encouraging people to make their wish for organ donation known to their loved ones and families so, should the worse happen, the families and loved ones can support donation at the critical time. Our colleagues in Communications have developed some materials for use during this week and arranged for Trust and some civic buildings to be lit up pink.

2. Health and Care System

West Yorkshire Association of Acute Trusts Committee in Common (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 discussed areas of further collaboration with the new Chair and interim Chief Executive of Yorkshire Ambulance Service and West Yorkshire Community Collaborative. We spent time discussing the financial and performance challenges facing all Trusts. These meetings provide opportunity for sharing and learning from each other.

Brendan Brown, Anna Basford, Stuart Baron and I attended a meeting with Lord Markham, CBE, Parliamentary Under Secretary of State and colleagues from the new hospital programme. The meeting had been arranged by Cathy Elliot, Chair of West Yorkshire Integrated Care Board (ICB) to share the challenges different parts of West Yorkshire were facing in relation to capital developments.

I attended a West Yorkshire Health and Care Partnership improvement half day event. Lis Street, Clinical Director of Pharmacy was at the same event which had been pulled together to support West Yorkshire in terms of improvement and change.

Other system/ partner meetings and events include one to ones with Keith Ramsay, Brendan and I met with Liz Mear, Chair of the Kirklees Health and Care Partnership

and Andrea and I met with Haris Sultan, a NeXt Director with the ICB to discuss governors and membership in Trusts.

National/other

I am a member of the strategic advisory board for the Yorkshire and Humber Academic Health Science Network (AHSN) and attended our quarterly meeting at the digital media centre in Barnsley. As well as having a digital focus to the discussion and digital inclusion/exclusion in particular it was also great to hear about the regeneration and development of Barnsley. The AHSNs have been relicensed for a further five years and will be known as Health Innovation Networks in the future.

Helen Hirst
Chair
31 August 2023

Actual and Potential Deceased Organ Donation 1 April 2022 - 31 March 2023

NHS Blood and Transplant

Calderdale and Huddersfield NHS Foundation Trust

Organ Donation and Transplantation 2030: Meeting the Need

In 2022/23, from 7 consented donors the Trust facilitated 5 actual solid organ donors resulting in 15 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

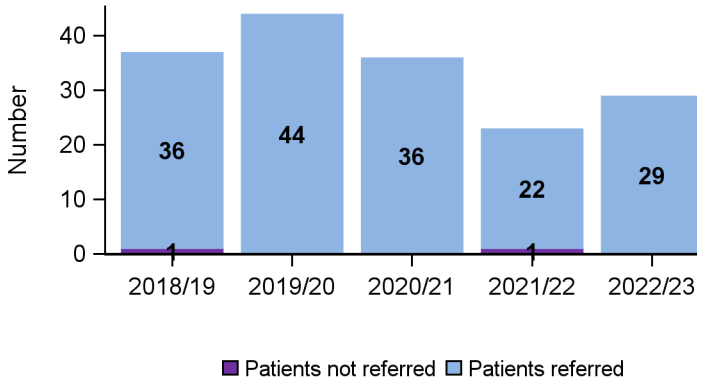
In addition to the 5 proceeding donors there were 2 consented donors that did not proceed.

Best quality of care in organ donation

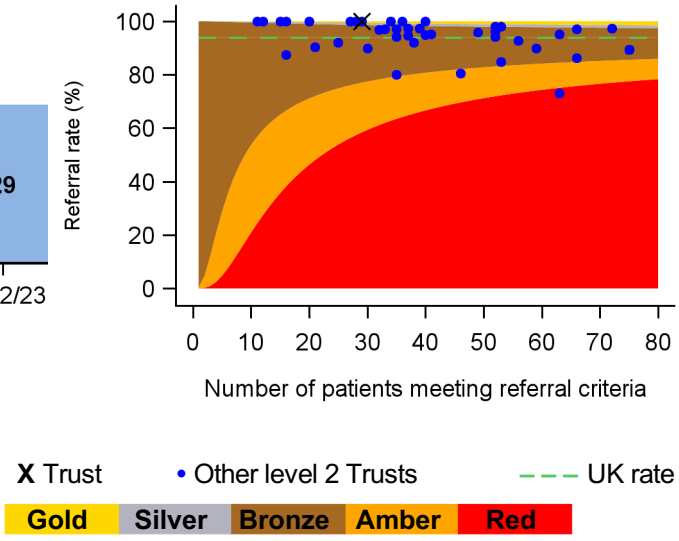
Referral of potential deceased organ donors

Goal: Every patient who meets the referral criteria should be identified and referred to NHS Blood and Transplant's Organ Donation Service

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



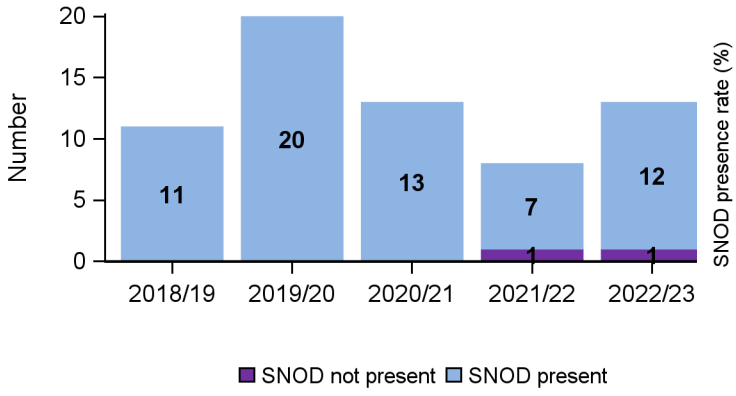
The Trust referred 29 potential organ donors during 2022/23. There were no occasions where potential organ donors were not referred.

When compared with UK performance, the Trust was exceptional (gold) for referral of potential organ donors to NHS Blood and Transplant.

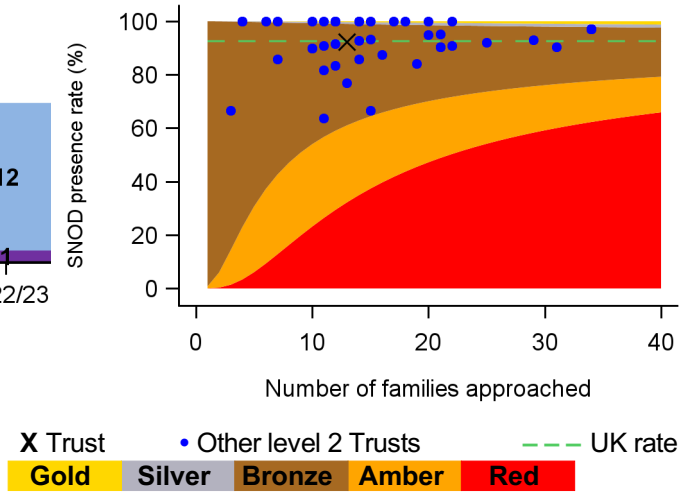
Presence of Specialist Nurse for Organ Donation

Goal: A Specialist Nurse for Organ Donation (SNOD) should be present during every organ donation discussion with families

Aim: There should be no purple on the chart



Aim: The Trust (marked with a cross) should fall within Bronze, Silver, or Gold



A SNOD was present for 12 organ donation discussions with families during 2022/23. There was 1 occasion where a SNOD was not present.

When compared with UK performance, the Trust was average (bronze) for SNOD presence when approaching families to discuss organ donation.

Why it matters

- If suitable patients are not referred, the patient's decision to be an organ donor is not honoured or the family does not get the chance to support organ donation.
- The consent rate in the UK is much higher when a SNOD is present.
- The number of patients receiving a life-saving or life-changing solid organ transplant in the UK is increasing but patients are still dying while waiting.

Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Yorkshire And The Humber*	UK
1 April 2022 - 31 March 2023		
Deceased donors	108	1,429
Transplants from deceased donors	252	3,589
Deaths on the transplant list	29	441
As at 31 March 2023		
Active transplant list	583	6,959
Number of NHS ODR opt-in registrations (% registered)**	2,178,288 (40%)	28,567,574 (44%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 5.39 million, based on ONS 2011 census data

Further information

Further information on potential donors after brain death (DBD) and potential donors after circulatory death (DCD) at the Trust are shown below, including a UK comparison. Data obtained from the Potential Donor Audit (PDA).

Key numbers, rates and comparison with UK data, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	12	1980	18	5307	29	6910
Referred to Organ Donation Service	12	1965	18	4886	29	6482
Referral rate %	G *100%*	*99%*	G *100%*	*92%*	G *100%*	*94%*
Neurological death tested	11	1556				
Testing rate %	B *92%*	*79%*				
Eligible donors[2]	10	1439	9	3467	19	4906
Family approached	9	1244	4	1691	13	2935
Family approached and SNOD present	9	1190	3	1526	12	2716
% of approaches where SNOD present	G *100%*	*96%*	B *75%*	*90%*	B *92%*	*93%*
Consent ascertained	5	846	2	959	7	1805
Consent rate %	B *56%*	*68%*	B *50%*	*57%*	B *54%*	*61%*
- Expressed opt in	4	476	1	578	5	1054
- Expressed opt in %	*80%*	*95%*	*50%*	*84%*	*71%*	*89%*
- Deemed Consent	0	284	1	306	1	590
- Deemed Consent %	*0%*	*63%*	*50%*	*52%*	*25%*	*57%*
- Other*	1	86	0	74	1	160
- Other %*	*100%*	*60%*	*N/A*	*38%*	*100%*	*47%*
Actual donors (PDA data)	5	783	0	636	5	1419
% of consented donors that became actual donors	*100%*	*93%*	*0%*	*66%*	*71%*	*79%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

For further information, including definitions, see the latest Potential Donor Audit report and up to date metrics via our Power BI reports at:
https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2022 - 31 March 2023

Calderdale and Huddersfield NHS Foundation Trust

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report and our Power BI reports with up to date Trust metrics are available at https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2023 based on data meeting PDA criteria reported at 9 May 2023.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2022 and 31 March 2023, Calderdale and Huddersfield NHS Foundation Trust had 5 deceased solid organ donors, resulting in 15 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2021/22. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

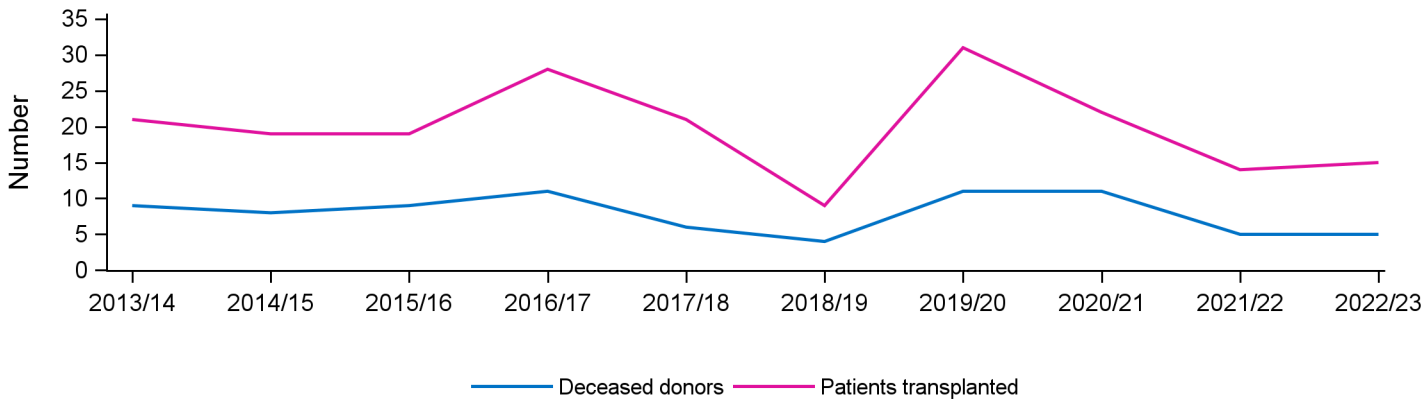
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
DBD	5	(3)	15	(10)	4.0	(4.0)	3.5	(3.4)
DCD	0	(2)	0	(4)	-	(3.0)	2.9	(2.7)
DBD and DCD	5	(5)	15	(14)	4.0	(3.6)	3.2	(3.1)

In addition to the 5 proceeding donors there were 2 additional consented donors that did not proceed, all where DCD donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2022 - 31 March 2023 (1 April 2021 - 31 March 2022 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	9	(6)	0	(1)	4	(3)	1	(0)	2	(2)	0	(0)
DCD	0	(3)	0	(1)	0	(1)	0	(0)	0	(0)	0	(0)
DBD and DCD	9	(9)	0	(2)	4	(4)	1	(0)	2	(2)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2013 - 31 March 2023



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for Calderdale and Huddersfield NHS Foundation Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2022/23 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Note that caution should be applied when interpreting percentages based on small numbers.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2022 - 31 March 2023

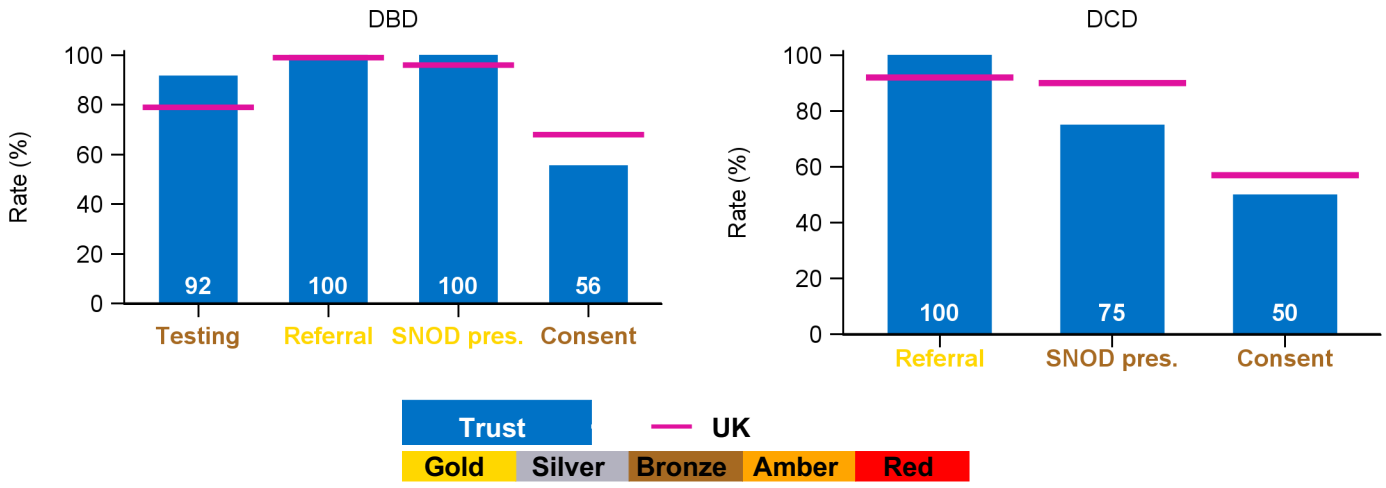


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2018 - 31 March 2023

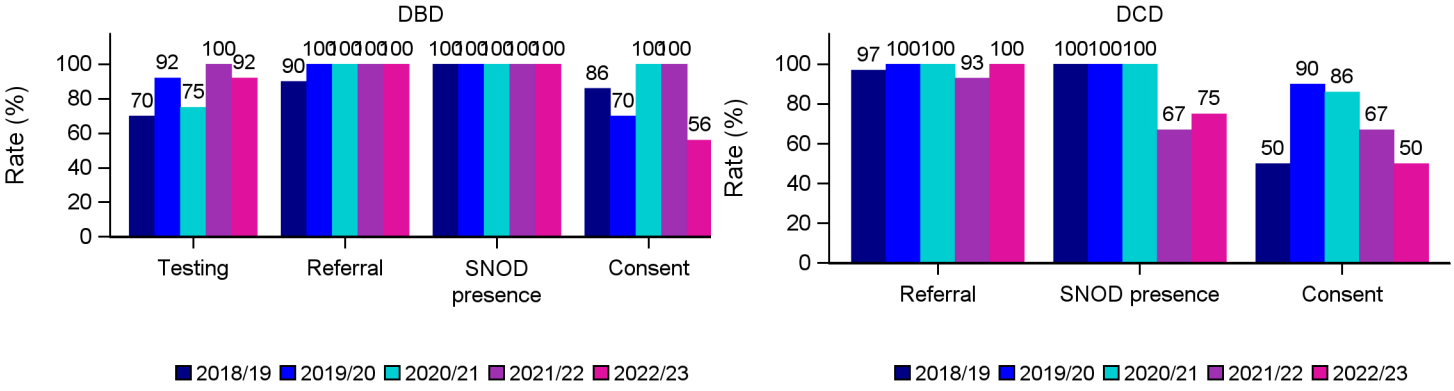


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2022 - 31 March 2023

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	12	1980	18	5307	29	6910
Referred to Organ Donation Service	12	1965	18	4886	29	6482
Referral rate %	G *100%*	*99%*	G *100%*	*92%*	G *100%*	*94%*
Neurological death tested	11	1556				
Testing rate %	B *92%*	*79%*				
Eligible donors[2]	10	1439	9	3467	19	4906
Family approached	9	1244	4	1691	13	2935
Family approached and SNOD present	9	1190	3	1526	12	2716
% of approaches where SNOD present	G *100%*	*96%*	B *75%*	*90%*	B *92%*	*93%*
Consent ascertained	5	846	2	959	7	1805
Consent rate %	B *56%*	*68%*	B *50%*	*57%*	B *54%*	*61%*
- Expressed opt in	4	476	1	578	5	1054
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- Deemed Consent	0	284	1	306	1	590
- Deemed Consent %	*0%*	*63%*	*50%*	*52%*	*25%*	*57%*
- Other*	1	86	0	74	1	160
- Other %*	*100%*	*60%*	*N/A*	*38%*	*100%*	*47%*
Actual donors (PDA data)	5	783	0	636	5	1419
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[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2018 - 31 March 2023

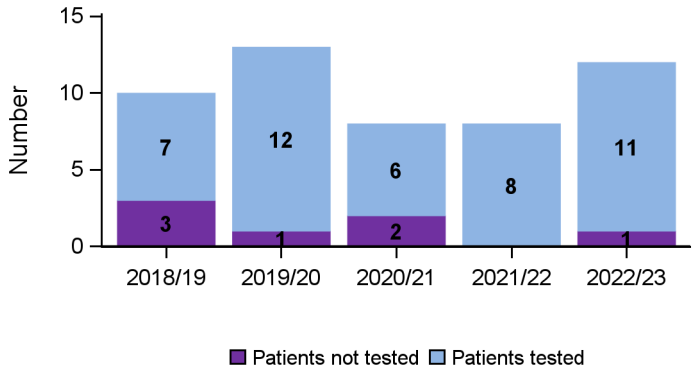


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2022 - 31 March 2023

	Trust	UK
Biochemical/endocrine abnormality	-	29
Clinical reason/Clinician's decision	-	62
Continuing effects of sedatives	-	6
Family declined donation	-	28
Family pressure not to test	-	48
Inability to test all reflexes	-	20
Medical contraindication to donation	-	5
Other	-	43
Patient had previously expressed a wish not to donate	-	2
Patient haemodynamically unstable	1	151
Pressure of ICU beds	-	1
SN-OD advised that donor not suitable	-	8
Treatment withdrawn	-	18
Unknown	-	3
Total	**1**	**424**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2018 - 31 March 2023

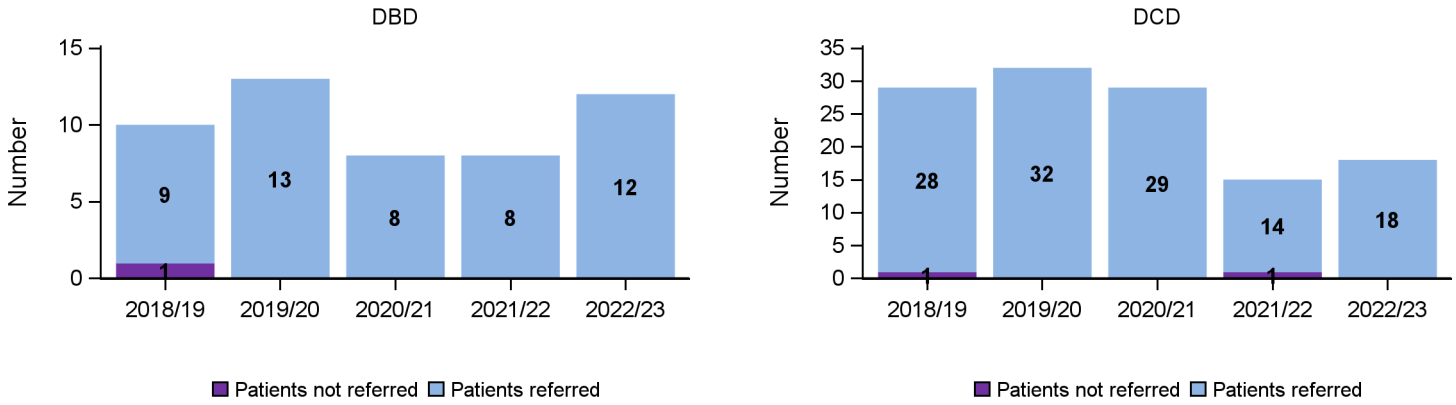


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Family declined donation following decision to remove treatment	-	1	-	15
Family declined donation prior to neurological testing	-	1	-	1
Medical contraindications	-	-	-	28
Not identified as potential donor/organ donation not considered	-	6	-	271
Other	-	-	-	27
Patient had previously expressed a wish not to donate	-	-	-	3
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	1	-	2
Thought to be medically unsuitable	-	1	-	53
Uncontrolled death pre referral trigger	-	5	-	16
Total	**-**	**15**	**-**	**421**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

In 2022/23 there were 9 potential donors in your Trust with an ACI reported, 1 DBD and 8 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

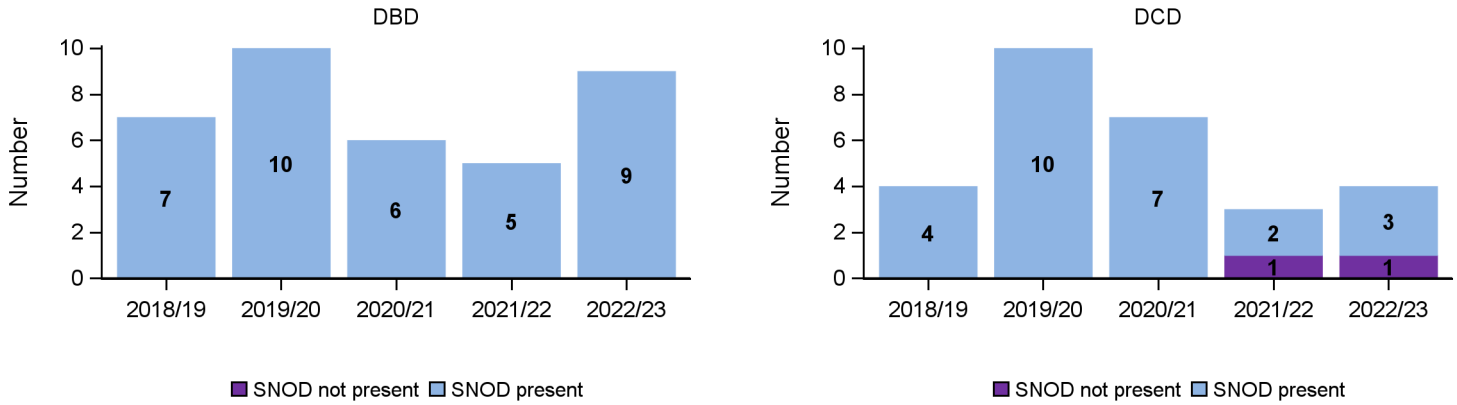
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2022/23, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 31% and 19%, respectively, compared with DBD and DCD consent/authorisation rates of 70% and 61%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known decision of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2018 - 31 March 2023



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2023]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2023]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2023]

3.5 Consent

In 2022/23 less than 10 families of eligible donors were approached to discuss organ donation in your Trust therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2018 - 31 March 2023

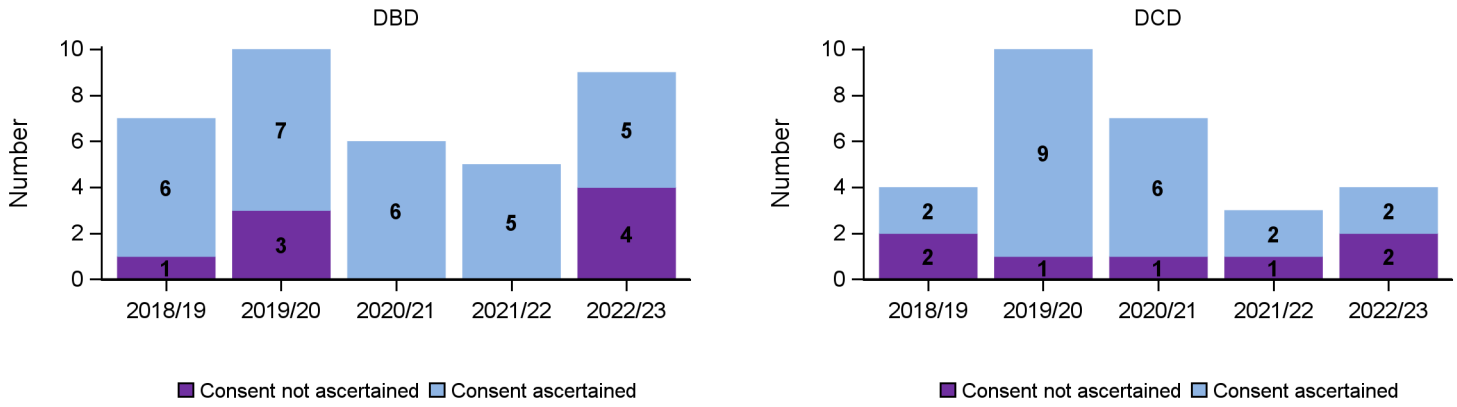


Table 3.3 Reasons given why consent was not ascertained, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Family believe patient's treatment may have been limited to facilitate organ donation	-	1	-	-
Family concerned donation may delay the funeral	-	2	-	1
Family concerned other people may disapprove/be offended	-	1	-	2
Family concerned that organs may not be transplantable	-	1	-	7
Family did not believe in donation	-	4	-	12
Family did not want surgery to the body	-	38	-	51
Family divided over the decision	-	21	-	18
Family felt it was against their religious/cultural beliefs	1	40	-	24
Family felt patient had suffered enough	1	22	-	62
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	20	-	13
Family felt the length of time for the donation process was too long	1	17	1	126
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	2	-	16
Family were not sure whether the patient would have agreed to donation	-	44	-	90
Other	-	22	1	73
Patient had previously expressed a wish not to donate	1	121	-	175
Patient had registered a decision to Opt Out	-	22	-	31
Strong refusal - probing not appropriate	-	17	-	31
Total	**4**	**398**	**2**	**732**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted.

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2022 - 31 March 2023

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	10	-	8
Clinical - Cardiac arrest during referral	-	2	-	-
Clinical - Considered high risk donor	-	7	-	8
Clinical - DCD clinical exclusion	-	-	-	1
Clinical - No transplantable organ	-	6	-	12
Clinical - Organs deemed medically unsuitable by recipient centres	-	10	-	51
Clinical - Organs deemed medically unsuitable on surgical inspection	-	7	-	3
Clinical - Other	-	3	-	10
Clinical - PTA post WLST	-	-	2	165
Clinical - Patient actively dying	-	4	-	19
Clinical - Patient asystolic	-	1	-	-
Clinical - Patient's general medical condition	-	2	-	3
Clinical - Positive virology	-	1	-	3
Clinical - Predicted PTA therefore not attended	-	-	-	3
Consent / Auth - Coroner/Procurator fiscal refusal	-	5	-	10
Consent / Auth - NOK withdraw consent / authorisation	-	5	-	24
Logistical - Other	-	-	-	3
Total	**-**	**63**	**2**	**323**

If 'other', please contact your local SNOD or CLOD for more information, if required.

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

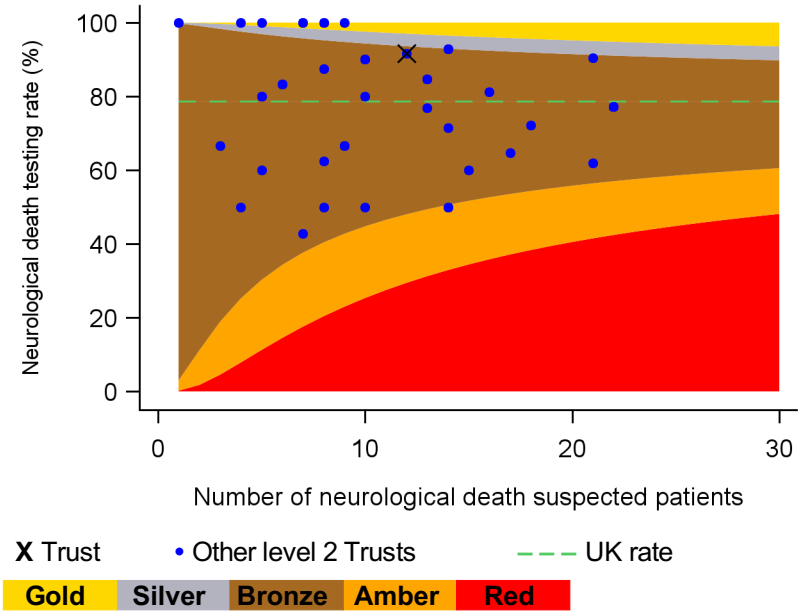
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2022 - 31 March 2023

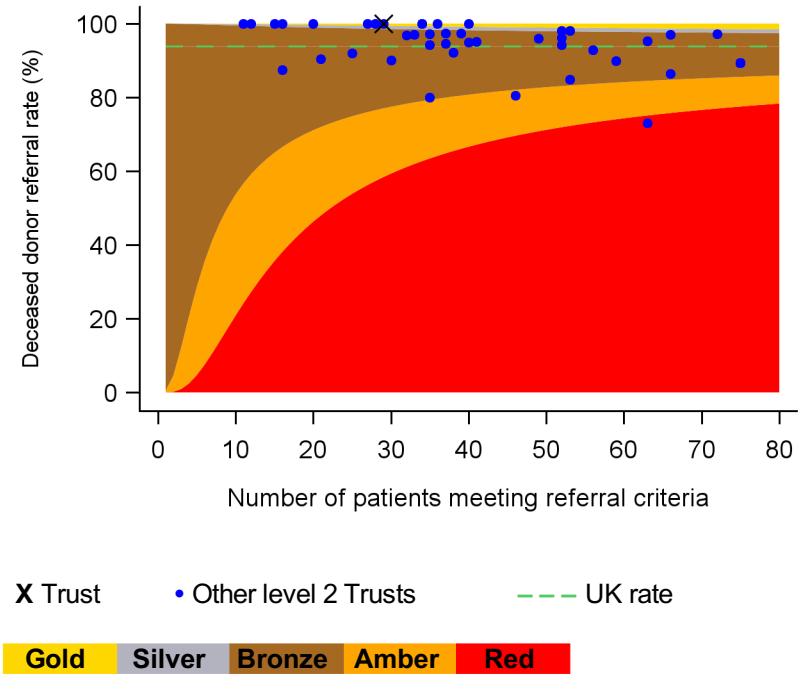


When compared with UK performance the neurological death testing rate in Calderdale and Huddersfield NHS Foundation Trust was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2022 - 31 March 2023

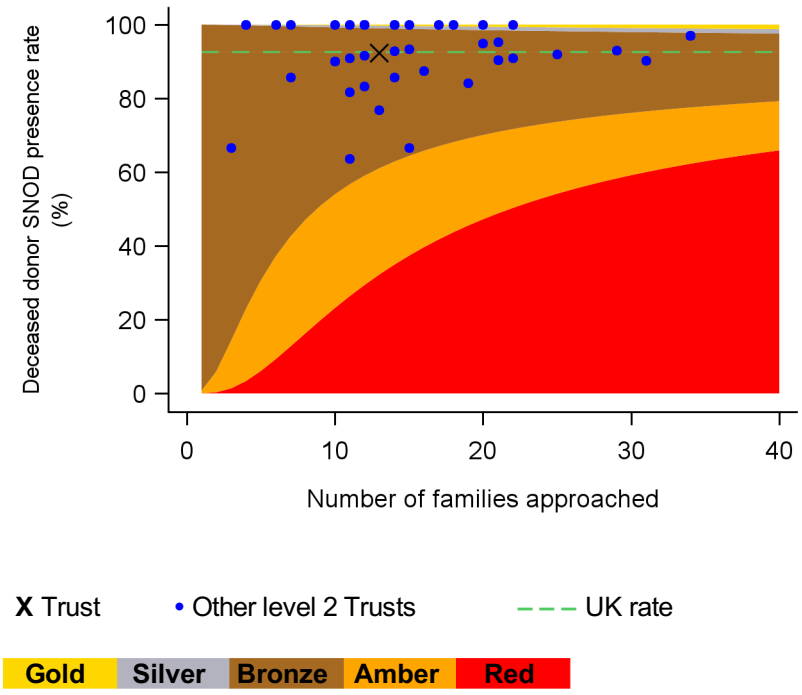


When compared with UK performance Calderdale and Huddersfield NHS Foundation Trust was exceptional (gold) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

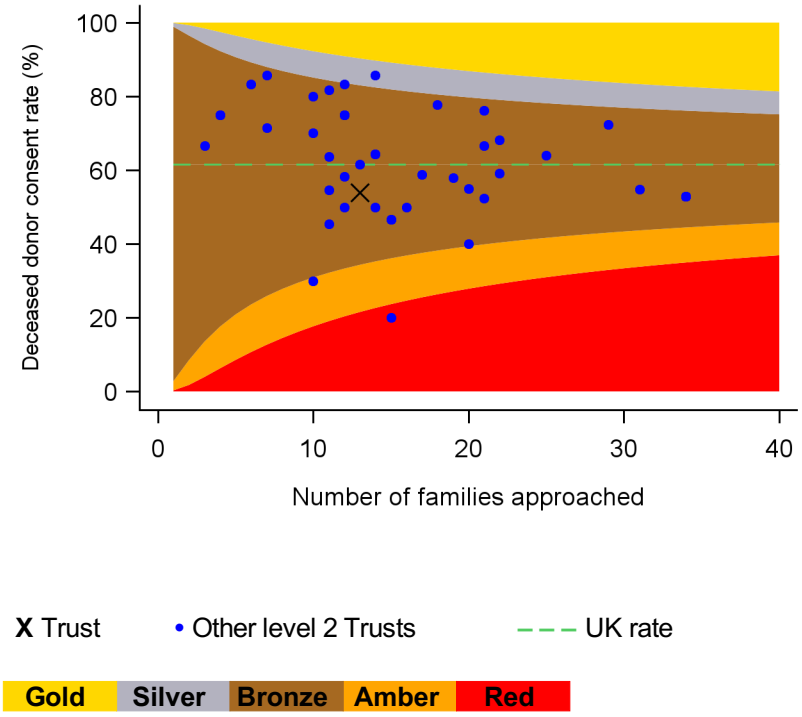
Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2022 - 31 March 2023



When compared with UK performance Calderdale and Huddersfield NHS Foundation Trust was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Figure 4.4 Funnel plot of consent rate, 1 April 2022 - 31 March 2023



When compared with UK performance the consent rate in Calderdale and Huddersfield NHS Foundation Trust was average (bronze).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Halifax, Calderdale Royal Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	8	7	-	8	-	7	6	5	5	-	3	-	3
Huddersfield, Huddersfield Royal Infirmary													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	4	4	-	4	-	4	4	4	4	-	2	-	2

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2022 - 31 March 2023

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Halifax, Calderdale Royal Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	8	8	-	7	5	2	2	-	2	-	0
Huddersfield, Huddersfield Royal Infirmary											
A & E	1	1	-	1	1	1	0	-	0	-	0
General ICU/HDU	9	9	-	9	3	1	1	-	0	-	0

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Calderdale and Huddersfield NHS Foundation Trust in 2022/23 there were 1 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

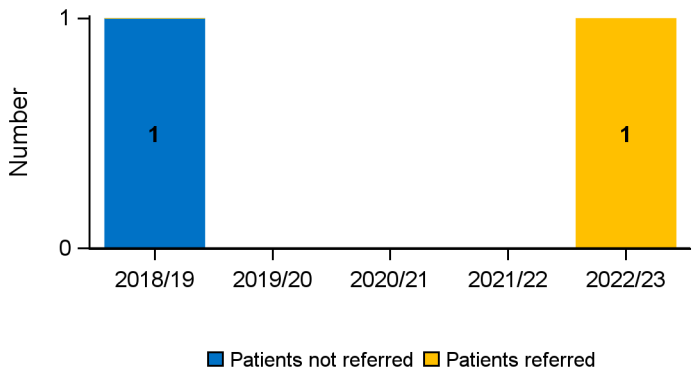
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a decision in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [4] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

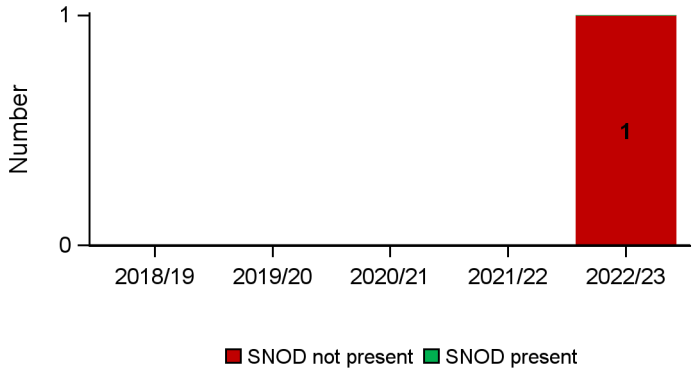
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2018 - 31 March 2023



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2018 - 31 March 2023



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2023]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	Yorkshire And The Humber*	UK
1 April 2022 - 31 March 2023		
Deceased donors	108	1,429
Transplants from deceased donors	252	3,589
Deaths on the transplant list	29	441
As at 31 March 2023		
Active transplant list	583	6,959
Number of NHS ODR opt-in registrations (% registered)**	2,178,288 (40%)	28,567,574 (44%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 5.39 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

Calderdale and Huddersfield NHS Foundation Trust has been categorised as a level 2 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	12	11	92	12	100	11	10	9	9	-	5	-	5
Level 1	1133	896	79	1124	99	879	831	714	677	95	474	66	438
Level 2	441	340	77	439	100	331	307	267	259	97	182	68	171
Level 3	287	229	80	283	99	224	216	188	184	98	135	72	124
Level 4	119	91	76	119	100	90	85	75	70	93	55	73	50

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2022 - 31 March 2023

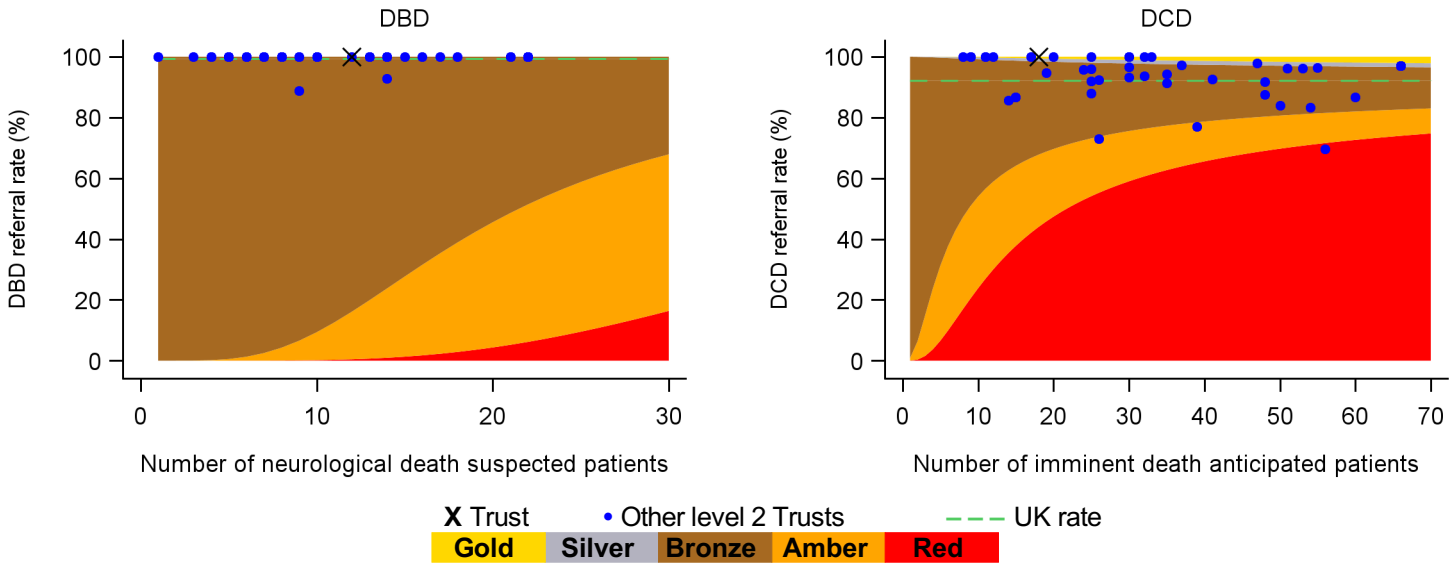
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	18	18	100	17	9	4	3	-	2	-	0
Level 1	2564	2370	92	2464	1772	941	856	91	537	57	369
Level 2	1346	1239	92	1313	841	373	333	89	209	56	132
Level 3	979	910	93	944	571	269	241	90	155	58	97
Level 4	418	367	88	408	283	108	96	89	58	54	38

7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

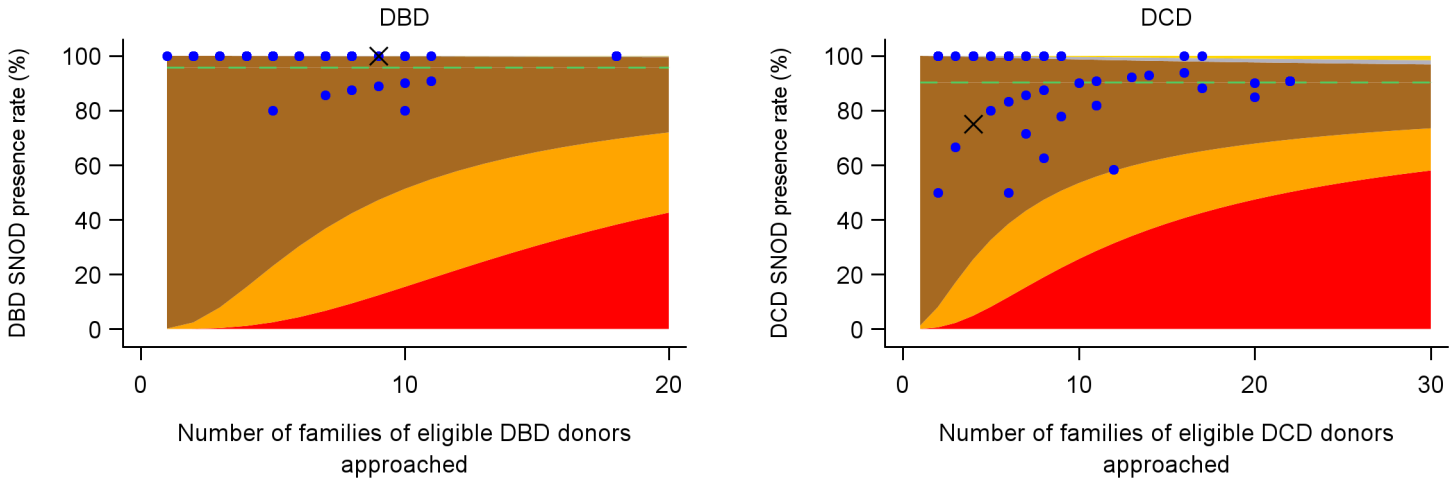
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

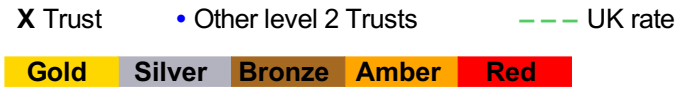
Figure 7.1 Funnel plots of referral rates, 1 April 2022 - 31 March 2023



When compared with UK performance Calderdale and Huddersfield NHS Foundation Trust was exceptional (gold) for referral of potential DBD organ donors and exceptional (gold) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

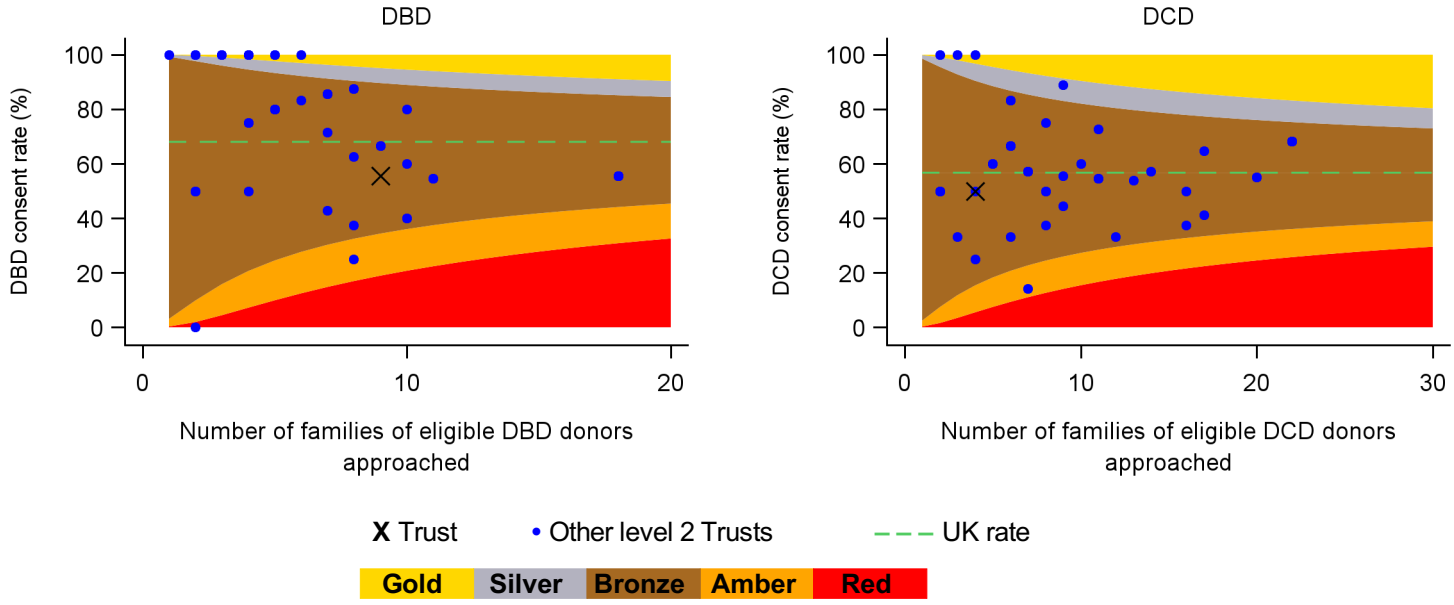
Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2022 - 31 March 2023





When compared with UK performance Calderdale and Huddersfield NHS Foundation Trust was exceptional (gold) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2022 - 31 March 2023



When compared with UK performance the consent rate in Calderdale and Huddersfield NHS Foundation Trust was average (bronze) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data

Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit

Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data

Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

NHS
Blood and Transplant

www.nhsbt.nhs.uk

May 2023

Dear Professor B Brown and Dr Birkenhead,

We continue to see improvements in the number of donors and transplants. In 2022/23 1429 deceased donors proceeded to donation and 3575 patients received a transplant across the UK. We still have a long way to go to return to pre-pandemic activity levels, but we're confident we can get there with your Trust's help. Please accept our recognition and thanks for the effort of your staff as we look to recover further.

This letter explains how your Trust contributed to the UKs deceased donation programme.

Organ and tissue donation and transplantation activity - 2022/23

From 7 consented donors, Calderdale and Huddersfield NHS Foundation Trust facilitated 5 actual solid organ donors resulting in 15 patients receiving a transplant during the time period. Additionally, 8 corneas were received by NHSBT Eye Banks from your Trust.

Quality of care in organ donation - 2022/23

The referral of potential organ donors to our Organ Donation Service and the participation of a Specialist Nurse for Organ Donation in the approach to family members to discuss organ donation are key steps in ensuring the success of organ donation.

- Your Trust referred 64 patients to NHSBT's Organ Donation Services Team; no referrals were missed (100% referral rate) and 29 met the referral criteria for inclusion in the UK Potential Donor Audit.
- A Specialist Nurse was present for 12 organ donation discussions with families of eligible donors. There was 1 occasion when a Specialist Nurse was absent for the donation discussion.

Up to date Trust metrics are always available via our Power BI reports found here: https://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit-report/.

What we would like you to do

- Ensure your Trust supports your Organ Donation Committee and Clinical Lead for Organ Donation in promoting best practice as they seek to minimise missed donation opportunities.
- Discuss activity and quality data at the Board with support from your Organ Donation Committee Chair.
- Recognise any successes your Trust has had in facilitating donation or transplantation, especially during the ongoing NHS pressures.

Deemed Consent Legislation - England

On 20 May 2020 the Organ Donation (Deemed Consent) Act 2019, known as Max and Keira's Law, came into force in England. The societal ambition is that the new law will help save and improve even more lives moving forward. In England, during 2022/23, there were 519 occasions when consent was deemed from 935 occasions where deemed consent applied.

Why it matters

In 2022/23, 252 people benefited from a solid organ transplant in Yorkshire And The Humber. However sadly, 29 people died on the transplant waiting list during this time.

Thank you once again for your vital ongoing support for donation and transplantation.

Yours sincerely,

Anthony Clarkson
Director of Organ and Tissue Donation and Transplantation
NHS Blood and Transplant

Business Disability Forum
Building disability-smart organisations
Positive About Disabled People

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	**Charitable Funds Committee**
Committee Chair:	Helen Hirst
Date(s) of meeting:	9 August 2023
Date of Board meeting this report is to be presented:	7 September 2023

ACKNOWLEDGE

The Committee received a thorough report from the Charity Manager about the development of a new brand identity, refresh of the strategy for the charity and activity undertaken during the first quarter in respect of both grants and fundraising.

ASSURE

The finance report was reviewed with particular attention on unspent allocated resources and the approach the Charity should take. The Committee confirmed that it continued to support the investment approach to invest in an ethical portfolio.

The revised terms of reference have been agreed by the Committee and are attached for the Board's approval.

AWARE

The Charity is undergoing a reset of its strategy and approach. This follows three years of Covid and beyond where the approach was reactive and operational. The revised strategy is in development but the focus is on directing funding where it will have the greatest impact; working in partnership with the Trust and other collaborators in the communities we serve; our long-term sustainability. To complement the revised strategy there has been a review of the branding of the Charity. The colour scheme of the branding will remain orange and yellow but the key message of the brand will be about positivity and making an amazing difference to those we are here for – colleagues and patients.

8. Chief Executive’s Report

To Note

Presented by Brendan Brown

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 September 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	• The events at the Countess of Chester hospital and the Lucy Letby verdict have dominated news headlines. As a Trust we have assessed our approach to how we manage concerns raised through any route within the organisation and continue to consider any early learning from national bodies. We also continue to support our clinical colleagues who may feel personally impacted by these events, and who are dealing with concerns and enquiries from patients and their families. • Our CQC rating of good for maternity services provided both positive feedback and areas to focus on. • We continue to perform well across a range of services, in particular standards relating to cancer and elective care. • Our new accident and emergency department is due to open to patients later in the month. • We have been shortlisted for several high-profile awards relating to our clinical teams leadership and performance.
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
7 September 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. On Monday 21 August 2023, neonatal nurse Lucy Letby was given a whole life sentence after being found guilty of seven counts of murder and six counts of attempted murder for her actions at the Countess of Chester Hospital. As a result of the events at that hospital, the government has ordered an inquiry into the circumstances surrounding the deaths and incidents, to ensure lessons are learned. The shape and type of inquiry is still being agreed but the scope will look not only at how concerns were raised and responded to, but also the wider governance and regulation of leaders within providers, regional and national bodies.

1.3. There has been much written in the media about the trial, the events surrounding the crimes, and the actions of the people involved. It is important that we focus on the culture and environment we have here at Calderdale & Huddersfield Foundation NHS Trust, and how we, as a Board, assure ourselves that people working within, and being cared for by, our organisation have opportunities to speak up, be heard and that actions are taken where appropriate. As an executive team, we looked at a 'True for Us' report in the same week as the verdict and following receipt of correspondence from NHS England , a copy of which is attached at appendix A. This reflects the fact that, since the events at the Countess of Chester in 2015/16, there have been several safeguards brought in to place and embedded in organisations.

1.4. Immediately following the verdict, the Assistant Director of Nursing for Families and Specialist Services Division, wrote to families of children on the paediatric and neonatal ward. We also ensured that there were messages out in to the organisation about the importance of speaking up, wherever you work and whatever role that may be and reminding people of the formal routes for this, but equally emphasising the more informal routes that people can take. As part of our annual cycle of Board business, the Freedom to Speak Up Annual Report is included on the agenda for this meeting. The report will show a positive and proactive speaking up culture within the Trust, with a relatively high number of concerns raised, and a decreasing number of these being made anonymously. In our review of the report, we need to consider where the gaps are and what other sources of assurance we rely on as Board members about people having a voice within the organisation.

1.5. There has been a particular focus as a consequence of these events, on greater regulation of managers. Many senior leaders are already regulated through their medical, nursing and professional bodies. Governance and workforce colleagues are working through the latest Fit and Proper Person guidance, issued on 18 August 2023, and will be discussed at Nominations and Remuneration Committee and with our Council of Governors. The Chair and I have been invited to London on 6 September 2023 to discuss NHS England's response and we will provide a verbal update at the meeting.

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

2.1. Against this background, it was pleasing to receive a Care Quality Commission (CQC) rating of 'good' for our maternity services. The inspection was conducted as part of CQC's national maternity inspection programme which aims to provide an up-to-date view of the quality of hospital maternity care across the country.

2.2. Following the inspection, the overall rating for maternity, as well as the area of well-led, was rated as good. The rating for safe was requires improvement due to staffing levels, however within the report the CQC noted 'that leaders had a responsive approach to these shortages and moved staff between units to ensure people at higher risk were fully supported.'

2.3. In their report published on 25 August, the CQC also highlighted that dignity and respect were intrinsic elements of the unit's culture and all staff observed clearly demonstrated this. The report also praised the service's commitment in trying to tackle health inequalities. Importantly, considering recent events, it was also reported "Staff spoke positively to us about the leadership team and how they were able to speak up about difficult issues."

2.4. There were areas of outstanding practice identified in the report as well as several examples of how the service tackles health inequalities. It is testament to the work of the maternity team, and the wider women and children directorate, to put our people first and receive such a positive report.

2.5. We continue to have strong operational performance. In August we were named in the media as the only Trust nationally to achieve all four key cancer targets. The government has recently announced that the targets will be consolidated into three key standards which will be incorporated into our Integrated Performance Report (IPR):

2.5.1. 28-Day Formal Diagnosis Standard which means patients with suspected cancer who are referred for urgent cancer checks from a GP, screening programme or other route should be diagnosed or have cancer ruled out within 28 days.

2.5.2. 62-day referral to treatment standard which means patients who have been referred for suspected cancer from any source and go on to receive a diagnosis should start treatment within 62 days of their referral.

2.5.3. 31-day decision to treat to treatment standard which means patients who have a cancer diagnosis, and who have had a decision made on their first or subsequent treatment, should then start that treatment within 31 days.

2.6. Colleagues will also see from the IPR that we continue to perform well in terms of elective recovery, although we did see a small increase in 40-week waits due to cancelled lists due to industrial action. For diagnostics we still have challenges in echocardiology and neurology which is impacting on our overall diagnostic performance.

2.7. There is significant work happening to reduce our follow-up backlog. Initiatives such as Patient Initiated Follow-up (PIFU) have been implemented and based on this good performance we are 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.

2.8. Elective and outpatient activity is the subject of an NHS England letter for discussion at this meeting on 'protecting and expanding elective capacity' ahead of winter.

2.9. We continue to make progress against the emergency care standard, which requires us to achieve 76% of patients seen within four hours by the end of March 2024. We remain within the top 13 Acute Trusts nationally for type 1 ED performance. We will need to closely monitor this over the next few months as we see the impact of the opening of our new accident and emergency department at Huddersfield and the ongoing period of industrial action. All of this is captured in the proposed strategic board assurance framework risk on the agenda for this meeting.

2.10. It was also pleasing to see the outcome of the CQC's patient survey on urgent and emergency care, where we were the 11th best scoring trust nationally. Our score for patients being treated with respect and dignity was nine out of ten, with our overall experience scoring an impressive eight out of ten. We also received high scores for our doctors and nurses (scoring 8.5 out of ten overall), with excellent scores in the following areas:

- Time to talk - feeling they had enough time to discuss their condition with a doctor or nurse.
- Clear explanations about condition and treatment - feeling the doctor or nurse explained their condition and treatment in a way they could understand.
- Being listened to - feeling the doctor or nurse listened to what they had to say.
- Acknowledging patients - doctors and nurses not talking in front of them, as if they were not there.

2.11. In relation to broader CQC regulation, the new inspection framework is due to be published in November with first inspections to take place in the South and a plan to roll these out to other regions by the end of March 2024. The new CQC Insight database is delayed and is now expected to be available in September. The new NHS England Single Oversight Framework is also delayed, and we will provide an update on all of this at the Board workshop in October.

2.12. I am also pleased to say that following their recent appearances on national TV, (both the BBC and ITV), colleagues in Radiology, have been reaccredited with the Quality Standard for Imaging (QSI), after their inspection late last year. Their assessment was particularly challenging as, not only was this the first assessment on site for more than three years, but this was the first full re-assessment for more than two years, and the team were also being assessed against two sets of standards.

2.13. NHS England announced on 30 August that the covid 19 vaccination programme would be brought forward to start from 11 September and work quickly to ensure as many eligible people as possible are vaccinated by the end of October. This is in response to the emergence of a new variant and pre-emptive measures the NHS has been asked to take. As frontline health and social care workers are one of the eligible groups, we will be commencing our vaccination programme in September, offering the Covid 19 vaccination as well as the flu vaccine.

3. Transforming services and population outcomes

3.1. Last week the process of formally handing over the new accident and emergency department building to us took place. Over the next few weeks, we will be conducting checks, training colleagues in the new environment, showing round key stakeholders and ensuring everything is in place ahead of the opening to the first patients. We will provide an update on the opening at the meeting. Some of you may have seen that a local care home resident, who used to be

a nurse at Huddersfield Royal Infirmary and who has been watching the new build with interest, was provided with a sneak preview inside the department last week. This was part of the Home's 'make a wish' scheme and Joyce was followed by the BBC on her visit.

3.2. So, by the next meeting, I am hopeful we will have been in the new building for a few weeks, and Board colleagues will have all had an opportunity to see it. Our focus will then turn to the developments on the Calderdale site. As you will be aware, the clearing of the site of the new learning and development centre has been completed and we hope to start the preparatory work for that building in September, along with some of the ground work testing for the new multistorey car park.

3.3. The Trust is in the running for several significant awards reflecting the breadth of our services. Firstly, the BLOSM team have been shortlisted for a Nursing Times Award for the work they do supporting vulnerable young people in A&E, creating a culture that is not about judging people's behaviours and caters to people's individual needs where people feel safe, listened to, and supported.

3.4. Our Gynaecology Cancer Team has been shortlisted in two categories in the Macmillan Professionals Excellence Awards finals, for their work delivering outstanding results in 28-day cancer targets.

3.5. Our work on improving the treatment of Barrett's Oesophagus - a disease of the gullet which can lead to oesophageal cancer - has been shortlisted in the Modernising Diagnostics category at the HSJ Awards. Not least because the team has also completely caught up with assessing these patients since the pandemic – just one of a handful of trusts to do so. More broadly, our work in partnership with external colleagues to dramatically reduce waiting lists for treatment has been shortlisted in the Performance Recovery category at the HSJ Awards. The shortlisting recognises an outstanding contribution to healthcare. A total of 1,456 entries were received for this year's Awards, with 223 projects and individuals reaching the final shortlist.

3.6. Our surgical robot has been in use and the Board will hear from one of the first patients to receive their surgery using the robot. The first operations are being led by our Colorectal team, but the surgical robot will soon be used in other specialties, including urology and gynaecology.

3.7. The Neonatal Unit has become one of the first in the region to install a new EPR, called BadgerNet. BadgerNet EPR provides the unit with a patient record that has been specifically developed for neonatal requirements. It provides a safe way of storing and retrieving patient information, has links to guidelines, provides relevant scoring systems and alerts for patient care, produces unit reports, and is environmentally friendly by completely ending the use of paperwork on the unit. The team are known for their innovation and were the first to go live with BadgerVideo, which means parents can be involved in their baby's care over video link, including getting involved in ward rounds with clinicians. This is especially useful for parents who are not local to the hospital.

4. Inclusive workforce and local employment

4.1. During August there was industrial action by both junior doctors and the consultant work force. The British Medical Association has announced that there will be a 48-hour strike on 19-20 September, followed by three days, between 2 October and 4 October, as part of its ongoing pay dispute. The Junior Doctors ballot closed on 31 August, and we are expecting an announcement on the result of that ballot and any associated action ahead of the Board meeting. A significant amount of work has continued to mitigate the impact of strike action and keep people safe, including the running of urgent and emergency care. There has been an inevitable impact on patients, the public and our communities, as well as our colleagues and services, with a substantial number of appointments and planned procedures having to be rescheduled. While, as previously referenced, we continue to perform well on our elective procedures, ongoing industrial action will inevitably impact on this.

4.2. We will continue to focus on the well being and development of our colleagues. As part of this, we have developed a Staff Psychology Service, which is headed up by Clinical Psychologist, Dr Rebecca Yeates. The new in-house service was a result of feedback from the last staff survey and aims to provide both individual colleagues and teams access to brief psychological assessment and consultation, helping our colleagues both respond to, and cope with challenging clinical dynamics and demands, conflict in teams and distress arising from critical clinical incidents.

4.3. Our annual 'CHuFT' awards have launched with a record number of nominations made into the seven categories already. Nominations close on 17 September with shortlisting taking place during October ahead of the event on 2 November.

4.4. There are a number of leadership development programmes being launched or started over the next couple of months:

4.4.1. Empower for colleagues who would like to grow / invest time in their self-development and who are enthusiastic about making a difference in their role and in our local community.

4.4.2. Shadow Board programme which involves ten colleagues from a range of backgrounds and professions across the Trust, who will develop their skills in a meeting or board room and who will also provide insight to the Board on the items being discussed at each meeting.

4.4.3. North East and Yorkshire aspirant executive director programme which aims to secure the strongest possible pipeline of future executive leaders, increase the diversity of NHS executive director leadership, and strengthen support to people aspiring to be executive directors in the North East and Yorkshire. The Trust has had colleagues go through this programme previously and has been well represented.

All of these are about nurturing talent, increasing diversity of thought and input, and ensuring we have confident, capable leaders at every level of the Trust.

4.5. In a bid to expand our internationally-educated nursing workforce – and to support children's nursing, last week we co-signed a contract with the government of Kerala, which will hopefully see new nurses from the region join us by the end of the year. Recruiting nurses to support our children's wards and departments is a brand-new venture for us and will complement our existing workforce adding even more diversity to CHFT which will help us better understand and respond to the needs of our local communities.

4.6. Our colleagues are also developing profiles at a national level. Matron Charlotte Bowdell, and Head Nurse for Urgent and Emergency Care, Tom Ladlow, are representing CHFT with NHS England as part of the clinical advisory group for urgent and emergency care. The clinical advisory group comprises of representatives from various healthcare professions who are involved in providing care to patients on urgent and emergency care pathways in hospitals and other related services. In addition, Chief Nursing Information Officer Louise Croxall has been voted as one of just 12 representatives on the national CNIO Network Advisory Panel which is part of the Digital Health Network.

4.7. Our Pride month ended on 31 August with a march and celebration at Huddersfield Royal Infirmary. Thank you to all colleagues who took part and supported their colleagues taking part during the month.

5. Financial, economic, and environmental sustainability

5.1. The finance report at this meeting shows a £8.95m deficit, which is a £1.27m adverse variance from plan. The in-month position is a deficit of £1.85m, a £0.29m adverse variance. The reasons for this variance are due to issues already referenced in this report, including the higher than planned bed capacity due to an excess of patients awaiting discharge to another provider and the impact on the required staffing, and the strike costs. While we are still forecasting to deliver the planned £20.80m deficit, these ongoing operational pressures and the further announced strike action will make this extremely challenging.

5.2. The report back from Finance and Performance Committee will reference the results of the financial deep dive conducted by NHS England in June, and our response and learning from this review.

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.

True for us – response to Lucy Letby Case

Findings

- Staff didn’t feel able to speak up
- Those that did felt they weren’t listened to
- Leaders were slow to bring in external review of the neonatal deaths
- Trust had reputation as key factor on its Board Assurance Framework and seemed more concerned about this and losing the NICU level

True for us – NHS England Letter

Ask from NHS E

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

True for us – actions in place

Systems and processes in place now that weren't in place in 2015/6

- Freedom to Speak Up arrangements (2016)
- Health Safety Investigation Branch (2017)
- Learning from Deaths framework (2017)
- Medical Examiners (2019)
- Updated Fit and Proper Person Regulations (2021 and 2023)

Governance

- Mortality Surveillance Group
- Learning from Deaths
- SI Panels
- Fit and Proper Person implementation
- Neonatal death review undertaken

Freedom to Speak Up (FTSUP)

- Use of FTSUP in the Trust is high
- High %age not anonymous
- CQC report references accessibility of leaders, ability to raise issues directly, and responsiveness
- Above average score for raising concerns in Staff Survey

Current actions

- Redoing FPP policy following latest changes
- FTSUP Annual Report coming to Board in Sept
- FTSUP assessment tool to be completed in Sept and discussed at WEB and Board in October
- Reviewed Risk Appetite – reputation currently rated as HIGH – to go to Board in Sept

STRATEGY: TRANSFORMING AND IMPROVING PATIENT CARE

9. Strategic Objectives Progress Report Q1, 2023/24

To Note

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7 September 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 September 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 a summary narrative of the progress and details of where the Board will receive further assurance is provided.

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
Transforming and improving patient care	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.	**GREEN** on track	The new A&E at HRI is scheduled to open at the end of September 2023. The Trust is progressing dialogue with the Infrastructure Project Authority and DHSC to enable Treasury approval of the Reconfiguration OBC and commencement of construction at CRH during 2023-24. Subject to this, plans have been developed to commence enabling works for the MSCP and construction of the new Learning and Development Centre from Autumn 2023.	**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
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 Portal, SDEC module, and ensure the infrastructure and end user devices are secure, current and designed for the role.	**GREEN** on track	Good progress has been made in line with the digital strategy and prioritised against operational demand and clinical requirements (COO, CN, MD). Over the last 12mth key developments within the programme include: - Relaunch of Nursing Documentation - Electronic Controlled Drug Register - NICU EPR roll out - Pharmacy Catalogue upgrade (Multum) - Development of SDEC EPR Module - Point of Care Testing (POCT) - Plan for every patient MPage Our approach to Data Science has been defined through further work on waiting list validation and frailty, alongside initiating a place-based response to a High Risk Adult cohort of patients. Our infrastructure continues to be fit for purpose through the edge device replacement programme and security is assured through a compliant DSPT submission alongside Cyber Essentials accreditation, External testing and ISO 27001.	**Patients and colleagues will be digitally enabled to provide and receive care wherever this is needed.** **Lead: RB** Divisional digital boards Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.	12 BAF risk 02/20 Digital Strategy

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
Transforming and improving patient care	We will: make progress against the Year 1 milestones in the Trust's Health Inequalities Strategy within the four key areas of Communities, Lived Experience, Data and Diversity & Inclusion and provide updates on these to the Board.	**GREEN** on track	Implementation of the year 1 milestones in the Health Inequalities strategy is progressing and on-track. This includes: • work to develop a "Health inequalities vulnerability index" to identify patients at increased risk of experiencing inequalities and take a holistic approach to prioritisation and care • prioritising care for people with a learning disability • continuing work to ensure outpatient referral pathways and communication with patients includes adjustments to ensure inclusive access • continued delivery of the BLOSM service within our emergency departments to tackle health inequalities and engage with vulnerable service users attending ED (BLOSM stands for Bridging the Gap, Leading a change in culture, Overcoming adversity, Supporting Vulnerable People, Motivating Independence and Confidence) The national Director for Health Inequalities at NHS England is scheduled to visit CHFT to learn about the work the Trust has implemented.	**Working with partners we will use population health data to prevent ill health and reduce health inequalities.** **Lead: RA** Health Inequalities Group Executive Board Board of Directors Health Inequalities Oversight Group (England)	12 BAF risk 07/20 Health Inequalities
Transforming and improving patient care	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	**GREEN** on track	The Trust has received a small increase in the NIHR core allocation funding to start this financial year but has also secured extra funding to support further improvements in research delivery and will receive a reset payment as a result of commercial research activity increasing and being on target. Opportunities to increase Commercial research continue to be explored; feasibility for over 66 commercial studies have been assessed since April by a dedicated study set up co-ordinator, an approach being promoted at regional and national meetings.	**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	12 BAF risk 01/20 Clinical Strategy

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
	patients, and further encourage participation in R&D.		We were selected to share tips and real-life challenges with IQVIA – northern prime site, to help them engage with research teams at other sites to improve relationships and performance. Accrual of participants is ahead of plan with 813 participants recruited at the end of June against a year end target of 1450. Our research midwives won 'Research Midwives of the Year' at the Y&H NIHR Research Awards 2023, based on the extent to which they have embedded clinical research within the maternity services (hospital/community) at CHFT. A refreshed Clinical Research Strategy will be launched in September.	Executive Board Quality Committee	
Keeping the base safe	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	**GREEN** on track	We have developed a new patient experience, involvement and inclusion strategy. The Quality and Safety strategy is under review to ensure it is reflective of the Patient Safety Incident Response Framework (PSIRF) and NHSE recommendations from the NHS delivery and continuous improvement review. The trust is progressing with the implementation of the PSIRF framework. The trust quality priorities are reported in the integrated performance report. Trust wide MUST scores and the KPIs for Urgent Care Response and Virtual ward within community services are under performing and actions are in place to improve performance. HSMR/SHMI are within expected ranges. The CQC inspection of Maternity services has continued to rate the service as GOOD and an action plan is in place to respond to the 2 Must Do actions and 5 Should do actions. A quality review summit is planned for October 2023 to review progress against quality and safety indicators and quality improvement priorities with senior leadership team.	**We will be delivering and enabling outstanding quality, safety and experience of care for people needing hospital and community services.** **Lead: LR** Quality Committee Executive Board	12 BAF risk 04/20 CQC rating

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
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 within the top quartile nationally of ED performance, with a focus on ambulance waits over 30 minutes and over 12 hour ED waits.	**GREEN** on track	The Trust 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 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. . For June 2023 the trust was 6th out of 79 trusts for type 1 ED 4 hour performance. This is also the case for over 12 hour waits which from February data showed the trust to be in the top 10% of organisations for low number of 12 hour length of stay The trust also continues to perform well in relation to timely ambulance handover.	**We will be consistently achieving key performance targets that matter most to patients.** **Lead: JH** Integrated Board Report Executive Board Audit and Risk Committee Finance and Performance Committee Access Delivery Group	16 BAF risk 05/20 Recovery
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-assessment and share with Board.	**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
Keeping the base safe	We will: implement the RESPECT programme; deliver	**GREEN** on track	The RESPECT programme continues to progress within the project framework	**Patients will be able to shape decisions about**	12 BAF risk 04/19

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
	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.		The keep carers caring campaign has been hugely successful and continues to be embedded across the organisation. The trust continues to review the birth centre provision with Mid Yorkshire Teaching Hospital Trust and have updated Kirklees health overview and scrutiny panel on current position at CHFT. We have reviewed actions within the Population Health and Inequalities Strategy, 2022 - 24 Health Inequalities strategy. NHSE have asked the trust to undertake brief health inequality audits for maternity and colposcopy services, following inequalities being identified at a national level. This is to review population, uptake, where there are gaps, understanding who's engaging and who isn't and identifying work the Trust can undertake. Maternity services has an established workstream.	**service developments and their personal care based on 'what matters' to them and their individual strengths and needs.** **Lead: LR** Quality Committee Executive Board	Patient and Public Involvement
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. • Refreshed and relaunched appraisal documents across the Trust. • 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. • Monthly Star Awards. • Staff survey hotspots identified, and high impact action plans created. • Review of Health and Wellbeing Risk Assessment tool.	**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

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
			• Recruitment of additional wellbeing and engagement support champions. • 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.		
A workforce fit for the future	We will ensure personal and professional development is accessible and open to all through health academies, apprenticeships, equality, diversity and inclusion education and awareness.	**GREEN** on track	• Increased focus on greater apprenticeship take-up and deployment of levy funds. • Regular case studies to showcase progression. • 'Go see' approach adopted to assess how other organisation measure/ record internal mobility. • Increased promotion of the Care Club promoting colleague personal development. • All Trust colleagues able to access free of charge Maths and English qualifications. • Equality network groups promote development initiatives. • 'Development for all' offer is in place. • ED&I education programme is in development. • Management Fundamentals 'go live' on 14 August 2023 • 'New to Manager' programme launch by 31 August 2023. 'Empower' personal development programme is continuing.	**We will foster an open learning culture that demonstrates lessons learnt, and actively seeks and celebrates best practice.** **Lead: SD** Workforce Committee	12 BAF risk 11/19 Recruitment and Retention
A workforce fit for the future	We will deploy workforce planning tools to design roles and approaches to	**GREEN** on track	• Implementing inclusive recruitment during 2023/2024 to improve representations at all levels in the Trust.	**We will have a diverse and inclusive workforce of the**	12 BAF risk 11/19

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
	deliver our reconfigured hospital and community services and implement an inclusive recruitment approach aligned to our values and behaviours.		• Continued work at Trust and Place to embed annual workforce planning activity and refine Trust reconfiguration workforce requirements. • Reconfiguration Workforce Lead working collaboratively with service leads to design future workforce models. • Local draft action plan in response to NHS Long Term Workforce Plan in place and under consideration by Workforce Committee. • Young Person's Forum established to better inform approaches to Trust employment offer and colleague experience. • Shadow Board 'go live' In Autumn 2023 with participants identified in August 2023. • Inclusion Group formed as a sub-group of the Workforce Committee with work ongoing to formulate agreed priorities and associated workplan. • Board representation action plan is in development inclusive of a requirement for Board members to have a measurable ED&I objective. • Annual engagement and inclusion activity calendar published. • ED&I education suite to be launched by 30 September 2023. • 'Management Fundamentals' and 'New to Manager' programmes include ED&I learning modules. • Equality network groups established and active with visible Executive level sponsorship.	**right shape, size and flexibility to deliver care that meets the needs of patients.** **Lead: SD** Workforce Committee	Recruitment and Retention
A workforce fit for the future	We will increase routes into employment, working with Calderdale and	**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.	**We will work with partners to create local employment, career and**	12 BAF risk 11/19

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
	Kirklees Councils and further education partners to develop a Health Academy for Calderdale and Kirklees.		• Widening Participation in place and operational. • Active engagement with local community groups targeting under representation in our workforce. • Improved utilisation of apprenticeship levy. • Comprehensive employability support including applications and interview techniques is available. • A range of partnerships are in place, for example with the Princes' Trust. • Widening Participation guiding principles established to include harnessing the local talent and diversify our workforce, progression and equality of opportunity (whilst recognising people experience different barriers in accessing employment and education), growing our own through career development/progression and engaging/mobilising partnerships to deliver outcomes. • 304 'live' apprentices (40% 30+ years of age, 35.1% in IMD 1 to 3).	**development opportunities for people.** **Lead: SD** Workforce Committee	Recruitment and Retention
Sustainability	Deliver the ICB and NHSE approved financial plan. Demonstrate improved performance against Use of Resources key metrics and NHSE productivity metrics.	**AMBER** Off track – with plan	**Delivery of plan** The Trust is forecasting to deliver the planned £20.80m deficit, 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 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	**We will be consistently delivering our annual financial plans and demonstrating value for money.** **Lead: GB / KA** Reported to Finance & Performance Committee Monthly regulator discussions	16 BAF risk 07/19 Compliance

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
			of 2019/20 (pre-pandemic), this is in line with peer organisations.		
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 occupancy vehicle journeys by 5% by 2026; make progress towards our targets of a 100% reduction in emissions by 2040 and to convert 90% of our fleet to low, ultra-low and zero emissions vehicles by 2028	**GREEN** on track	The Green Plan was first approved by Transformation Programme Board in March 2021. Delivery is managed by the CHS and progress against the Sustainable Action Plan (SAP) is monitored through the bi-monthly Green Planning sub-group Chaired by the MD of CHS. The Green Plan is a Board approved document which is submitted at ICS level. Some of the key progress this year include: • 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 • 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.	**We will have taken action to reduce our impact on the environment and will be on track to achieve targets for carbon net zero.** **Lead: SS** Transformation Programme Board Trust Board	8 BAF risk 06/20 Climate Action

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
			• 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.		
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 are meeting or exceeding all targets set across the different aspects of Social Value. An overview is provided below. **Jobs** A partnership with Kirklees College has 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 plumbing, electrical and bricklaying. So far, as a direct result of their work placement on the A&E construction site, one talented student has been given a full-time apprenticeship with one of our local partners; Clifford Cooper. 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.	**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

Goal	Deliverable	Progress rating	Progress summary	Outcome Measure & Assurance route	Board Assurance Framework – Risk Score
			• 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. 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 Pump*s*		

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

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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

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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.

INTEGRATED PERFORMANCE

10. Finance and Performance Chair Highlight Report

For Assurance

Presented by Nigel Broadbent

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	Chair's Highlight Report - Finance and Performance Committee - 1 and 30 August 2023
Author:	Andy Nelson, Non-Executive Director/Nigel Broadbent, Non-Executive Director
Sponsoring Director:	-
Previous Forums:	-
Acknowledge	• Continued strong performance in Cancer with CHFT highlighted in a recent Daily Mail article as the only trust in the country hitting the key cancer targets • Recovery performance also remains strong and the best in the West Yorkshire ICS (see table below). We now have no patients waiting over 65 weeks and just 8 52-week waiters. We have delivered 106.3% of our elective recovery plan in the year to date although we are now slightly behind our trajectory for 40-week waiters • As we continue to reduce outpatient follow-ups through admin validation we are also making good progress on our outpatient transformation initiatives with, for example, Patient Initiated Follow-Up where 5% of patients are using this approach for follow-up. This performance means we are one of the trusts selected nationally to see if we can go 'further faster' and share learning • Encouraging signs of improvement in the MUST score and SHMI has continued to improve and is in the expected range nationally
Assure	• At our 1St August meeting we had a presentation/'deep dive' on Diagnostics with a particular focus on the underperforming areas of Neurophysiology and Echocardiography. Neurophysiology has a clear plan to clear the backlog while Echo cardiography will require investment in extra shifts or external suppliers to clear its backlog. • At our 30th August meeting we held follow-up 'deep dives' into Stroke and Neck of Femur (NoF) – both areas the committee has examined in the past. Key points to note are: o It was encouraging to see the NoF performance for 36-hour admission to surgery has improved to 66.7% in the first 6 months of this year vs 61.3% last year although that is still below the target of 70%. Actions now being progressed following go see visits to other trusts

	○ Stroke performance continues to be challenged most notably around the 4-hour admission to a stroke unit target. A WTGR session has generated a 10-point action plan with a key element being implementation of an assessment bed • 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 • The committee reviewed the request for £9.5m of revenue support to be drawn down through quarters 3 and 4 of this financial year and approved the National Cost Collection Pre-Submission report • We also reviewed a report from the recent Deep Dive carried out by NHSE into our financial plans. A draft action plan has been produced in response to the points raised a number of which also require ICB input • We approved the new BAF risk for operational performance
Aware	• The number of Appointment Slot Issues (ASIs) continues to be a concern although the number of new ASIs greater than 18 weeks has reduced. ENT is the main area for concern, but a task and finish group has now agreed some actions • Transfer of Care (TOC) numbers remain a concern being still typically close to or over 100 – the Urgent and Emergency Care Recovery Plan is key to cracking this problem. There is currently more confidence in making improvements within CHFT than across the place/system. This position along with continuing high levels of bed occupancy is feeding through into our adverse financial position • At month 4 we are reporting a £8.95m deficit which is a £1.27m adverse variance to 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 £14.82m and a likely case of a £7.1m adverse variance. This likely case is driven primarily by slippages in the ED and Length of Stay efficiency schemes and some non-pay inflationary pressures. Both these schemes have been undergoing escalation and extra scrutiny in the CIP programme. Current expectation is that a gap will remain in the CIP programme, so a session has been scheduled for the end of September to look at this • The adverse variance to plan across the ICS was £27.1m YTD at month 4; and a forecast likely case of an £89m 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.

How do We Benchmark with West Yorkshire - RTT

Provider	40 Week Waits	52 Week Waits	65 Week Waits	78 Week Waits	104 Week Waits
Airedale	2.060	872	182	5	0
Bradford	1,923	505	78	0	0
Calderdale and Huddersfield	901	8	0	0	0
Leeds	9,704	4,082	1052	81	0
Mid Yorks	5,879	2,165	366	37	0

As of 25/08/2023

11. Month 4 Financial Summary

For Assurance

Presented by Kirsty Archer

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	Month 4 Finance Report
Author:	Philippa Russell – Acting Deputy Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance / Kirsty Archer – Acting 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 M onth 4 (July 2023).
Key Points to Note	**Year To Date Summary** 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). • 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.

Key Variances

- Income is £2.0m 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, offset to some extent by a top-slice of ICB income to support nationally procured Microsoft Licences (no associated cost savings for CHFT). Year to date commercial income is above plan (Health Informatics) 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 £1.29m higher than the planned level. Pay pressures are linked: to higher than planned bed capacity (£1.39m) - £0.49m surge capacity, plus £0.94m 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 (£0.73m impact YTD); supernumerary overseas nurses (£0.43m). 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 £3.68m higher than planned year to date due to: inflationary pressure on utilities, maintenance and rates costs; higher than planned expenditure on clinical supplies including devices, ward consumables, patient appliances and theatre costs; higher than planned insourcing / outsourcing costs associated with Elective Recovery; and commercial contracts in Health Informatics.

Forecast

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 including: unidentified CIP of £2.76m; further slippage on some high-risk efficiency programmes; further strike action (£1.0m for planned Strikes up to the end of August); non-pay inflationary pressures; and challenges delivering the bed plan. The forecast is also impacted by a reduction in ICB funding of £0.4m to fund national Microsoft Licence pressures, which the Trust is unable to benefit from.

Some loss of Elective Recovery funding is likely due to penalties for any patient waiting in excess of 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.
EQIA – Equality Impact Assessment	The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.
Recommendation	The Board is asked to receive the Finance Report and note the financial position for the Trust as at 31st July 2023.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jul 2023 - Month 4

KEY METRICS

	M4				YTD (JUL 2023)				Forecast 23/24			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£1.56)	(£1.85)	(£0.29)		(£7.68)	(£8.95)	(£1.27)		(£20.80)	(£20.80)	(£0.00)	
Agency Expenditure (vs Ceiling)	(£1.06)	(£0.95)	£0.10		(£4.22)	(£3.86)	£0.36		(£12.67)	(£9.99)	£2.68	
Capital	£1.80	£1.55	£0.25		£6.60	£1.73	£4.87		£34.00	£40.92	(£6.92)	
Cash	£27.51	£36.84	£9.33		£27.51	£36.84	£9.33		£2.19	£2.22	£0.04	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	94.6%	0%		95.0%	94.9%	0%					
CIP	£2.21	£2.09	(£0.13)		£6.77	£6.90	£0.13		£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 £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).

- 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.

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- Income is £2.0m 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, offset to some extent by a top-slice of ICB income to support nationally procured Microsoft Licences (no associated cost savings for CHFT). Year to date commercial income is above plan (Health Informatics) 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 £1.29m higher than the planned level. Pay pressures are linked: to higher than planned bed capacity (£1.39m) - £0.49m surge capacity, plus £0.94m 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 (£0.73m impact YTD); supernumerary overseas nurses (£0.43m). 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 £3.68m higher than planned year to date due to: inflationary pressure on utilities, maintenance and rates costs; higher than planned expenditure on clinical supplies including devices, ward consumables, patient appliances and theatre costs; higher than planned insourcing / outsourcing costs associated with Elective Recovery; and commercial contracts in Health Informatics.

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Total Group Financial Overview as at 31st Jul 2023 - Month 4

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M4

CLINICAL ACTIVITY

	M4 Plan	M4 Actual	Var
Elective	1,477	1,564	87
Non-Elective	17,827	17,319	(508)
Daycase	16,082	17,055	973
Outpatient	140,041	151,014	10,973
A&E	58,257	59,120	863
Other NHS Non-Tariff	632,457	704,401	71,943
Total	**866,142**	**950,473**	**84,331**

TOTAL GROUP: INCOME AND EXPENDITURE

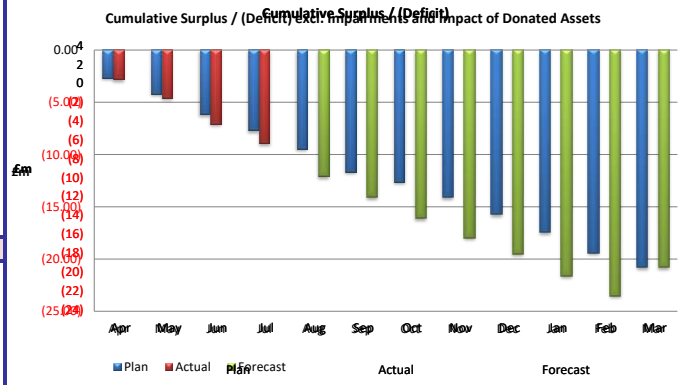
	M4 Plan	M4 Actual	Var
	£m	£m	£m
Elective	£5.66	£6.26	£0.60
Non Elective	£41.97	£41.65	(£0.31)
Daycase	£11.60	£12.21	£0.61
Outpatients	£14.25	£15.63	£1.39
A & E	£10.50	£10.78	£0.28
Other-NHS Clinical	£73.01	£70.93	(£2.08)
CQUIN	£0.00	£0.00	£0.00
Other Income	£18.25	£19.76	£1.52
Total Income	**£175.23**	**£177.23**	**£2.00**
Pay	(£115.61)	(£116.90)	(£1.29)
Drug Costs	(£15.87)	(£15.44)	£0.42
Clinical Support	(£11.20)	(£10.95)	£0.24
Other Costs	(£22.01)	(£26.22)	(£4.21)
PFI Costs	(£5.40)	(£5.53)	(£0.13)
Total Expenditure	**(£170.08)**	**(£175.05)**	**(£4.96)**
EBITDA	**£5.15**	**£2.19**	**(£2.96)**
Non Operating Expenditure	(£12.83)	(£11.13)	£1.69
Surplus / (Deficit) Adjusted*	**(£7.68)**	**(£8.95)**	**(£1.27)**

* 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

	M4 Plan	M4 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£34.33)	(£33.90)	£0.43
Medical	(£43.91)	(£47.44)	(£3.53)
Families & Specialist Services	(£31.41)	(£31.35)	£0.06
Community	(£10.56)	(£10.29)	£0.27
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£19.14)	(£18.98)	£0.16
THIS	£0.44	£0.43	(£0.01)
PMU	£0.29	£0.59	£0.30
CHS LTD	£0.04	(£0.03)	(£0.07)
Central Inc/Technical Accounts	£131.63	£132.30	£0.67
Reserves	(£0.71)	(£0.26)	£0.45
Surplus / (Deficit)	**(£7.68)**	**(£8.95)**	**(£1.27)**

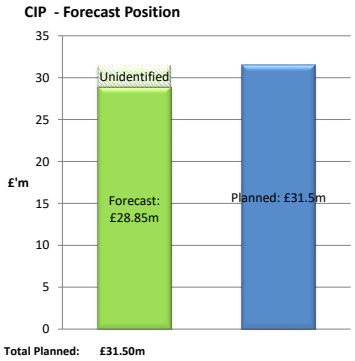
TOTAL GROUP SURPLUS / (DEFICIT)

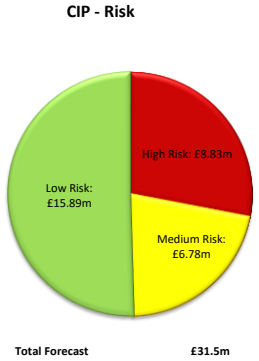


KEY METRICS

	Year To Date			Year End: Forecast			
	M4 Plan	M4 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£7.68)	(£8.95)	(£1.27)	(£20.80)	(£20.80)	(£0.00)	
Capital	£6.60	£1.73	£4.87	£34.00	£40.92	(£6.92)	
Cash	£27.51	£36.84	£9.33	£2.19	£2.22	£0.04	
Invoices Paid within 30 days (BPPC)	95%	95%	0%				
CIP	£6.77	£6.90	£0.13	£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	2,200,359	225,162
Total	**2,692,185**	**2,917,348**	**225,162**

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	£215.62	£213.28	(£2.34)
CQUIN	£0.00	£0.00	£0.00
Other Income	£55.28	£59.88	£4.60
Total Income	**£525.93**	**£528.19**	**£2.26**
Pay	(£346.33)	(£342.97)	£3.35
Drug Costs	(£47.98)	(£47.36)	£0.60
Clinical Support	(£33.63)	(£35.79)	(£2.16)
Other Costs	(£63.88)	(£70.83)	(£6.95)
PFI Costs	(£16.19)	(£16.58)	(£0.39)
Total Expenditure	**(£508.01)**	**(£513.54)**	**(£5.53)**
EBITDA	**£17.92**	**£14.66**	**(£3.27)**
Non Operating Expenditure	(£38.72)	(£35.46)	£3.27
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

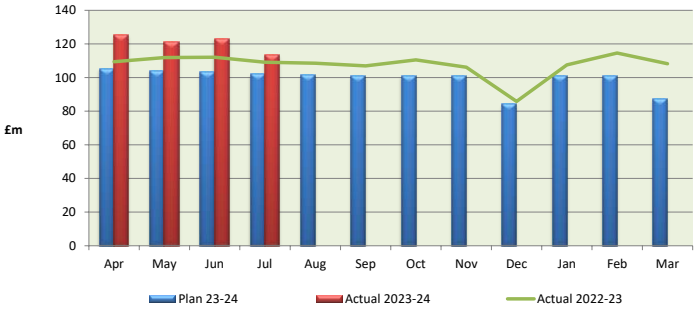
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£102.51)	(£103.87)	(£1.36)
Medical	(£134.22)	(£140.06)	(£5.85)
Families & Specialist Services	(£95.01)	(£95.57)	(£0.56)
Community	(£32.76)	(£32.43)	£0.33
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£56.86)	(£56.77)	£0.09
THIS	£1.28	£1.28	(£0.00)
PMU	£0.87	£1.17	£0.30
CHS LTD	£0.71	£0.47	(£0.24)
Central Inc/Technical Accounts	£399.15	£398.11	(£1.04)
Reserves	(£1.46)	£6.87	£8.33
Surplus / (Deficit)	**(£20.80)**	**(£20.80)**	**(£0.00)**

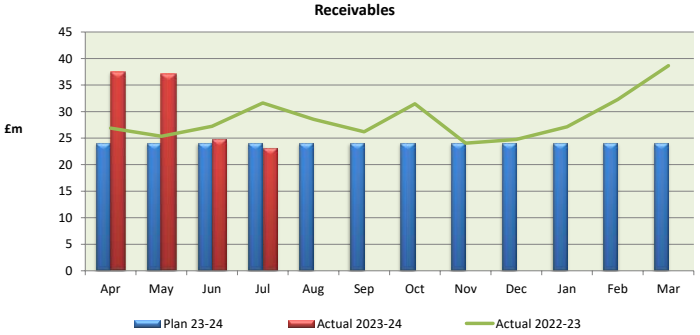
Total Group Financial Overview as at 31st Jul 2023 - Month 4

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

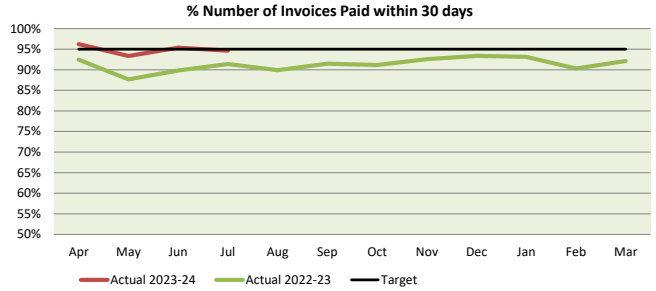
WORKING CAPITAL

	M4 Plan £m	M4 Actual £m	Var £m	M4
Payables (excl. Current Loans)	(£102.01)	(£113.60)	£11.59	
Receivables	£24.04	£23.11	£0.93	



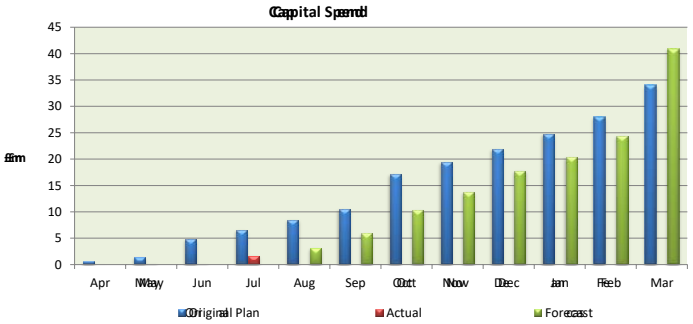


BETTER PAYMENT PRACTICE CODE



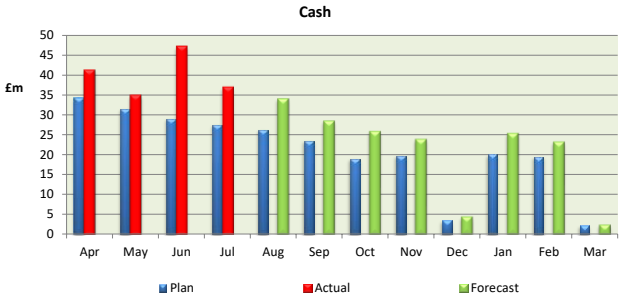
CAPITAL

	M4 Plan £m	M4 Actual £m	Var £m	M4
Capital	£6.60	£1.73	£4.87	

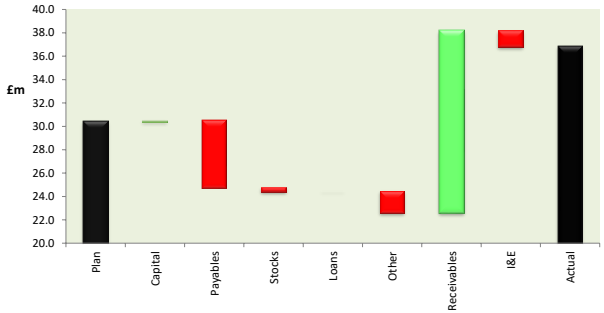


CASH

	M4 Plan £m	M4 Actual £m	Var £m	M4
Cash	£27.51	£36.84	£9.33	
Loans (Cumulative)	£14.36	£14.36	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust is reporting a £8.95m deficit, (excluding the impact of Donated Assets), a £1.27m adverse variance from plan.
- Year to date the Trust has incurred higher than planned costs due to: higher than planned additional bed capacity of £1.39m; Strike costs of £0.73m; non-pay inflationary pressures including Utilities; and a funding top-slice to support nationally procured Microsoft licences. These pressures were offset to some extent by the early delivery of other efficiencies and higher than planned commercial income (HPS).
- £5.01m of Elective Recovery Funding (ERF) has been received as planned.
- 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.

- The Trust has a cash balance of £36.84m, £9.33m more than planned.
- Capital expenditure is lower than planned at £1.73m against a planned £6.60m.
- 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 includes £7.1m of unidentified mitigation required to offset forecast pressures and emerging risks.
- Forecast assumes full receipt of £15.02m of Elective Recovery Funding (ERF)
- The Capital forecast is to spend £40.92m, £6.92m more than planned. Additional PDC funding has been awarded to support the Community Diagnostic Centre. Internally funded capital is forecast at £17.03m as planned.
- The total loan balance is £14.36m as planned. The Trust has not yet required any revenue support in this financial year, but plans for this year drive a planned borrowing requirement of £9.5m. This will be in the form of Revenue Public Dividend Capital (PDC) and will attract an additional charge in year one.
- The Trust is forecasting to end the year with a cash balance of £2.22m, in line with plan.
- The Trust is forecasting a UOR of 3 as planned.

RAG KEY: (Excl: UOR)	Green	Actual / Forecast is on plan or an improvement on plan
	Yellow	Actual / Forecast is worse than planned by <2%
	Red	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	Green	All UOR metrics are at the planned level
	Yellow	Overall UOR as planned, but one or more component metrics are worse than planned
	Red	Overall UOR worse than planned

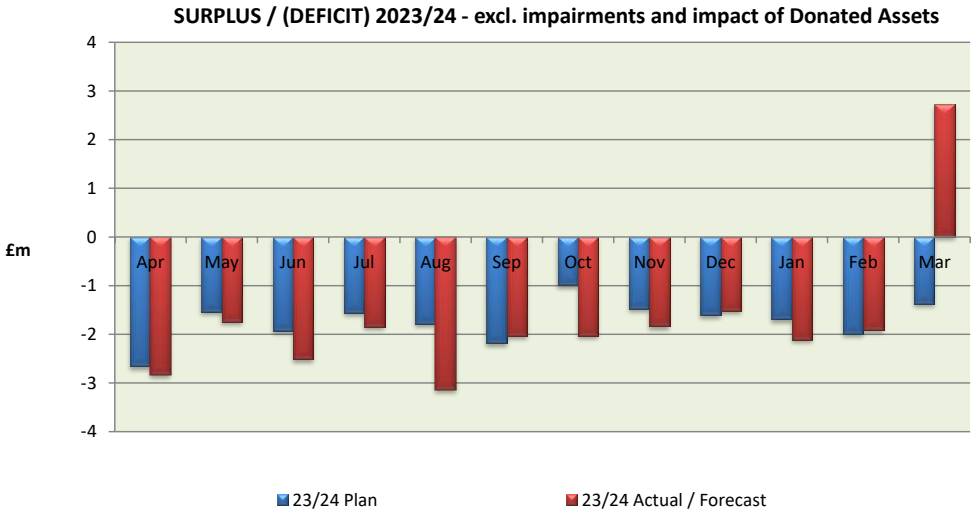
FORECAST 2023/24

23/24 Forecast Position (31 Mar 24)

Statement of Comprehensive Income	Plan £m	Forecast £m	Var £m	
Income	£526.01	£528.19	£2.18	
Pay expenditure	(£346.33)	(£342.97)	£3.35	
Non Pay Expenditure	(£161.68)	(£170.56)	(£8.88)	
Non Operating Costs	(£39.15)	(£36.04)	£3.12	
Total Trust Surplus / (Deficit)	**(£21.15)**	**(£21.38)**	**(£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)	£0.00	£0.08	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Gain on Disposal	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**(£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 £27.9m, £7.1m worse than planned. The Trust needs to act quickly to find mitigations to cover this likely overspend. £6.4m 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. It is likely that mitigation will be found to offset this slippage on efficiency, but there are also other emerging pressures in the forecast which it will be much more difficult to mitigate including: the cost of Strike action up to the end of August of £1.0m (any further future strikes will increase these costs); higher than planned non pay inflationary pressures (£3.1m); additional 'Surge' bed capacity (£1.7m); and top-slicing of ICB income to support national Microsoft licence costs (£0.38m).

The worst case scenario is a £14.1m 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 and Radiology outsourcing.

Some loss of Elective Recovery funding is likely due to penalties for any patient waiting in excess of 52 weeks. Current likely case is a loss of £0.33m of income, with a worst case of £0.66m. 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, which may well mitigate this emerging risk.

Indications are that there will be no significant pressure due to the AfC pay award.

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.
- Remains a risk that any further Pay Award decisions are not fully funded.
- Forecast assumes that the Trust will be access sufficient funding to cover any costs incurred through provision of the Community Diagnostic hubs.

12. Approval of Cash Support

For Assurance

Presented by Kirsty Archer

Calderdale and Huddersfield NHS Foundation Trust

REVENUE SUPPORT REQUIREMENTS – 2023/24

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	Approval of Cash Support
Author:	Philippa Russell – Acting Deputy Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance / Kirsty Archer – Acting Director of Finance
Previous Forums:	Finance & Performance Committee
Purpose of the Report	To provide details of the 2023/24 cash position and Public Dividend Capital (PDC) Revenue Support requirements.
Key Points to Note	The Trust will be required to request cash support in the form of Revenue Public Dividend Capital, with a planned value of £9.5m for this financial year. This does incur an additional PDC Dividend charge in the first year. Current forecast suggests that Revenue support will be required from Quarter 3 therefore an application for Revenue Support will need to be made in September 2023.
EQIA – Equality Impact Assessment	Not applicable.
Recommendation	The Board is asked to approve the Trust's PDC Revenue Support request.

Calderdale and Huddersfield NHS Foundation Trust

REVENUE SUPPORT REQUIREMENTS – 2023/24

Background

The Trust started the financial year with a cash balance of £24.6m. This will be adversely impacted by the £20.80m planned deficit, a planned reduction in creditors and accruals and a Capital funding shortfall of £4.05m.

The Trust will be required to request cash support in the form of Revenue Public Dividend Capital, with a planned value of £9.5m for this financial year. This does incur an additional PDC Dividend charge in the first year. Current forecast suggests that Revenue support will be required from Quarter 3, but the timing of this requirement is being closely monitored.

Forecast Cash Position

The current cash forecast and likely Revenue Support requirements are as shown in the table below:

Month	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Forecast Cash Position (excluding Revenue support)	36.84	33.96	28.36	25.79	21.75	(1.26)	20.27	17.59	(1.22)
Forecast Revenue Support						3.00	1.00	2.50	3.00
Revised Cash Forecast	**36.84**	**33.96**	**28.79**	**25.79**	**21.75**	**2.26**	**21.27**	**20.09**	**2.22**

Total Revenue Support required is £9.5m.

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

A minimum cash balance of £2m is required (£20m prior to payroll leaving the bank) to manage working capital effectively.

Note: Month end ledger close down for Months 1-8, 10 & 11 is in advance of the monthly payroll payment leaving the bank (c.£17-18m). In Month 9 & 12 close down is after this payment has been made.

Public Dividend Capital (PDC) Revenue Support

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

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

Board Approval

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

Recommendation

The Board are asked to approve a request of £9.5m Revenue Support to be drawn down through Quarters 3 & 4 of this financial year in order to maintain minimum required cash balances.

13. Protecting and Expanding Elective Capacity

To Approve

Presented by Jonathan Hammond

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	**Protecting and expanding elective capacity (including RTT data and LUNA update) - Board Assurance**
Author:	**Jonathan Hammond, Chief Operating Officer**
Sponsoring Director:	**Brendan Brown, Chief Executive**
Previous Forums:	None
Purpose of the Report	To request 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.
Key Points to Note	On 4 August 2023, NHSE requested that all Trusts provide assurance against a set of activities that will drive outpatient recovery at pace. All Trusts are required to undertake a Board self-certification process (signed off by Trust Chairs and Chief Executives) by 30 September 2023. Detail of the request and the self-certification template is provided at Appendix 1. CHFT has a strong track record of performance and delivery in relation to Outpatient Transformation and is one of the Trust's that has been selected by the National Director of Clinical Improvement to share good practice to support a pilot to push further and faster on outpatient elective recovery. The Trust's response to the self-certification template will be presented to the Finance and Performance Committee on 26 September 2023 for review. The Chair of the Finance and Performance Committee will subsequently advise the Chair and Chief Executive regarding sign off of the self-certification template prior to submission. Additionally – one of the specific items included in the letter is a requirement that the Board receives a report on data quality and LUNA scores, an overview will be presented.
EQIA – Equality Impact Assessment	The Trust's work to improve outpatient access will address the needs of the whole population, including those who currently experience disadvantage and will help improve access, experience and outcomes for all. New outpatient pathways that have been implemented (such as Patient Initiated Follow Up and remote consultations) have had detailed EQIA

	undertaken, and adjustments made to mitigate any potential discriminatory equality impacts.
Recommendation	The Board is requested to **NOTE** the organisations position in relation to LUNA data quality score and ongoing actions. The Board is requested to **APPROVE:** i. 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 ii. the delegation of authority to the Trust Chair and Chief Executive to sign-off the self-certification on behalf of the Trust Board.

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the ‘call to arms’, colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Publication reference: PRN00673

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

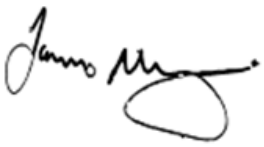
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	**Assured?**
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

14. Workforce Committee Chair Highlight Report

For Assurance

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:	23 August 2023
Date of Board meeting this report is to be presented:	7 September 2023

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 23 August 2023 where the strategic theme was Talent Management.

- The Committee received a presentation on progress against the Recruitment Strategy and noted that international recruitment is expanding to cover more staff groups, recruitment event calendar agreed with key partners and there are four Trustwide events arranged for 2023/24. A "Positive Futures" workshop has been designed and delivered to local students on health- related pathways. This offer has been extended to internal CHFT colleagues.
- The delivery of the Apprenticeship Strategy (grow our own talent) continues to strengthen with 302 apprentices. The trust utilises over 80% of its apprenticeship levy.
- Development for All demonstrated the positive growth in our learning offering and increased usage of "Management Fundamentals." The latter will be analysed to inform the need for additional targeted areas of learning.
- IPR- a revised format was presented to the Committee. Concerns remain over the level of sickness absence particularly at this time of year. Industrial action is impacting on agency and bank spend and turnover has reduced to just under 8%.
- The Quarterly Vacancy data was presented, and it was noted that the turnover rate had decreased. However, the challenge still remains to move closer to the overall planned level of 349.62FTE against an actual of 479 FTE.

ASSURE

- The Committee received an analysis of the Trusts People Strategy against the NHS Long Term Workforce Plan. There is still some more detailed work required at a national level and funding at a national level will need to be provided. Whilst the plan covers a 15-year span there are not yet identified milestones for review. The plan covers key areas – Train, Retain, Reform. The Trust has re-evaluated its plans and strengthened these against the national strategy.
- The Committee received Trust data on the gender pay gap for March 2023 which will be submitted in March 2024. Actions required will form part of the Trust's Equality, Diversity, and Inclusion action plan.
- The Board Assurance Framework covering Colleague Engagement was discussed and it was noted and supported by the Committee that the score remains unchanged. The reports on WRES and WDES were presented with the Committee expressing concerns over the numbers of staff alleging bullying and harassment against the public and staff colleagues. The areas identified for action were agreed.
- Minutes were received from the Education Committee and the Inclusion Group.

AWARE

- The Committee will continue to keep a close watch on the number of colleagues taking up Fire Safety Training
- 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 considered as part of the workforce reports and in discussions.

15. Quality Committee Chair Highlight Report

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

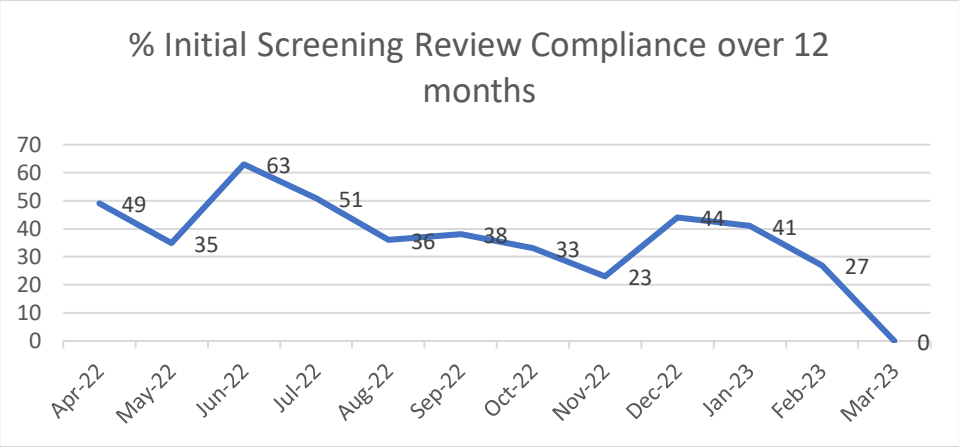
To Approve

Presented by Denise Sterling

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	**CHAIR'S HIGHLIGHT REPORT to the Board of Directors – Quality Committee – 21 June and 24 July 2023**
Author:	Denise Sterling, Non-Executive Director – Committee Chair
Sponsoring Director:	-
Previous Forums:	-
Acknowledge	• Update received on work for the implementation of the Patient Safety Incident Response Framework(PSIRF) focus has been on CHFTs patient safety incident profile the top ten themes have been identified. The next steps have been outlined and the complete PSIRF to be signed off at QC and then submitted to the ICB. • Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Policy and Standard Operating Procedure for implementation and usage received. Terms of reference approved for the internal working group the reporting arrangements for this group to be agreed. • Committee noted Q1 Trust PSQB report • Approved terms of reference for CQC group, Medicines Management Committee and Trust PSQB.
Assure	• Final version of the Quality Account 22/23 approved by the committee • Annual reports received: - Safer staffing – positive assurance provided on progress being made on nurse recruitment and the vacancy position. Quality metrics are being measured alongside the staffing position. - Safeguarding – detailed report provides assurance that the Trust is meeting its statutory responsibilities for child and adult safeguarding. Progress is being made in relation to the Safeguarding Strategy (2022- 2024) through the Safeguarding Committee to monitor our progress in relation to key priorities. - Research and Development – Another successful year with strong evidence of research impact and success. New Research strategy to be launched in September. - Complaints **–** Significant improvement has been made over the year in the overall management of complaints now achieving Trust

	targets for responses. The attention is now on reducing the number of reopened complaints and increased emphasis on implementing the learning from complaints. - Quality Committee – detailing the work undertaken in the year 22/23 and including the self-assessment of committee effectiveness. • Maternity and Neonatal Oversight Report -the new monthly Maternity and Neonatal Transformation Board chaired by the Chief Nurse has oversight of the 3-year delivery plan for Maternity and Neonates. CQC visit took place on the 7th/8th June good feedback on the day. Positive feedback also received the Maternity and Neonatal Board Safety Champions walk abouts. Report received on the deep dive into maternity services for the Calderdale Cares Partnership Board in partnership with ICB colleagues which provided information on maternity services provided in Calderdale. • Midwifery staffing Revised workforce model- update was provided on the review of the current birth rate and the revised midwifery staffing model. A revised paper with full recommendations to be circulated. An external review is to be commissioned by the birth rate plus team. • Quality Report – Highlighted a number of key workstreams, Patient Advice and Complaints Service, lessons learnt from serious incidents and mortality. Detailed update provided on the CQC road map and the review of the trust wide areas of focus June to October 2023 with clear plans. Committee reminded the safety domain is the risk for CHFT. COG update , some areas now achieving 100% MUST compliance and progress with dementia screening. The Quality dashboard was presented and will be used by QC to focus on areas of underperformance, never events, stroke, MUST compliance, serious incidents. The current review and update of policies will be complete by October 2023.The Clinical repository has 300+guidelines past review dates currently deep dive taking place. • IPR- Elective recovery and Cancer progressing well although industrial action will impact. Stroke continuing to deteriorate and plans put in place to improve the position. Virtual ward performance has deteriorated and further work underway as there may be data collection issues.
Aware	• Stroke and Industrial Action has been raised at Calderdale Cares Partnership and Kirklees quality meetings and the risk register has been revised to accept both risks.
One Culture of Care	• One Culture of Care was taken into account in the discussions.

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	Learning from Deaths Q4 2022/23 report
Author:	Mandy Hurley
Sponsoring Director:	David Birkenhead
Previous Forums:	Mortality & Surveillance Group July 2023
Purpose of the Report	To provide the Board with assurance of the Learning from Deaths process
Key Points to Note	Of the **422** adult inpatient deaths recorded in Quarter 4 of 2022/2023, **104** (**25%**) have been reviewed using the initial screening tool. This falls short of the 50% target. Extra capacity for completion of ISRs has been offered by our Trust CT trainees. Trainees are 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.  A total of 38 SJRs were requested in Quarter 4 (Jan to March) of 2022/23 of which **36** have been completed. The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.
EQIA – Equality Impact Assessment	Demographic characteristics relating to age, gender, ethnicity and index of multiple deprivation are included in the report. Deaths of those with learning disabilities aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities are reported externally and reviewed, regardless of the cause of death or place of death. This process runs alongside our internal mortality reviews and does

	not replace out internal process. All deaths are reviewed internally using a SJR. These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group. A review of Learning disability deaths for 2021/22 is presented within this paper
Recommendation	The Board is asked to note the Learning from Deaths Q4 report

Learning from Deaths Report Quarter 4 2022/23

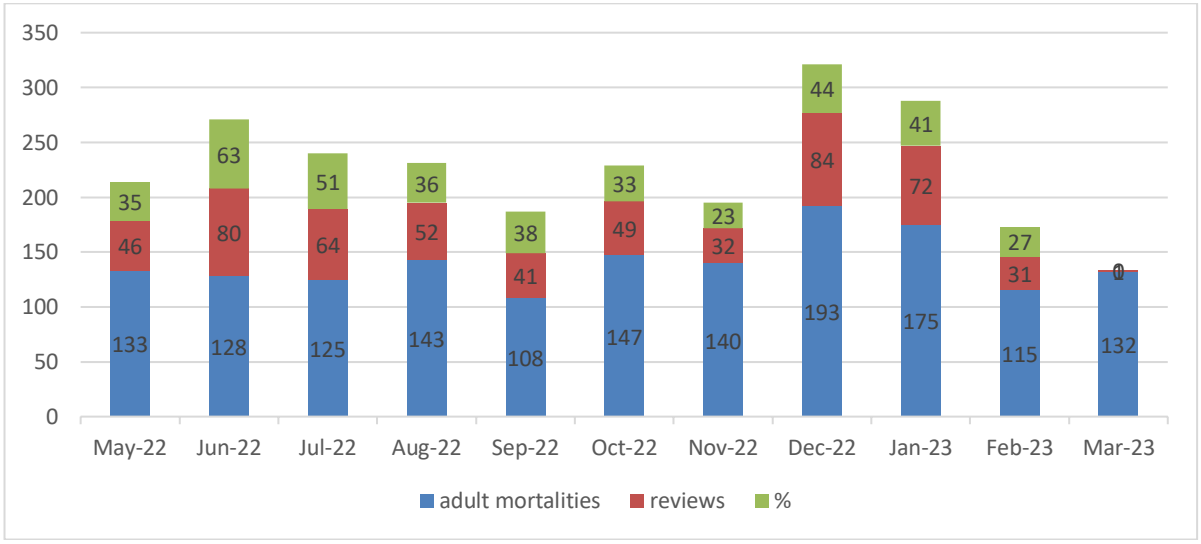
In Quarter 4 (Jan – March 2023), there were **422** adult inpatient deaths at CHFT recorded on Knowledge Portal.

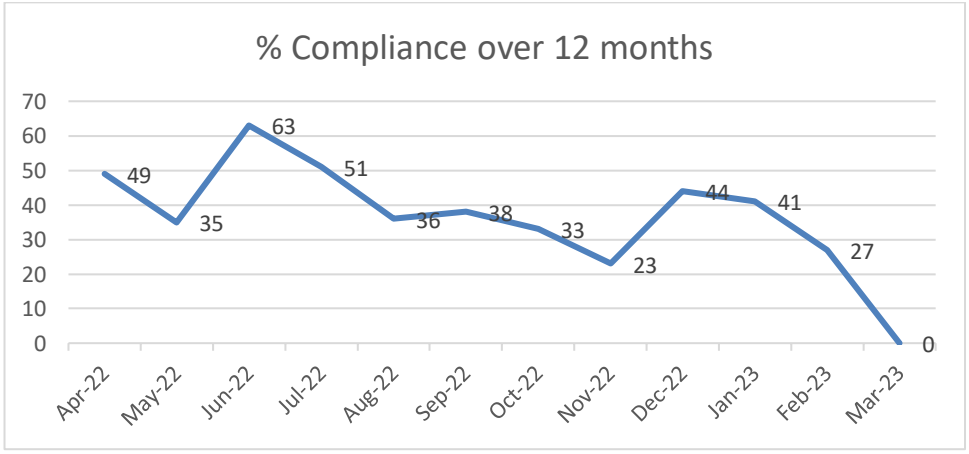
Initial Screening Reviews (ISR)

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 **422** adult inpatient deaths recorded in Quarter 4 of 2022/2023, **104** (**25%**) 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 March 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.

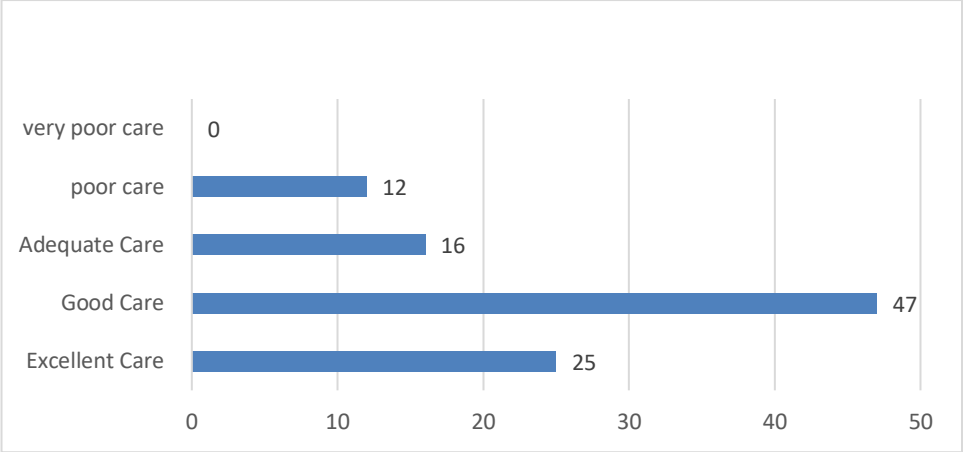
The table below shows the number of adult inpatient deaths reviewed by ISR by month over the last 12 months





Quality of care reviewed

% Quality Care Scores for ISRs completed in Q4 (Jan to March 2022/23) n=104



12% (12 cases) = poor care. 7 of these reviews were deemed poor care, sent for second opinion and resulted in both reviewers agreeing on poor care. All have been reported on datix and are going through the respective divisional orange panels for validation

All ISRs that are escalated to Structured Judgement Review (SJR) have a valid rationale recorded for escalation purposes.

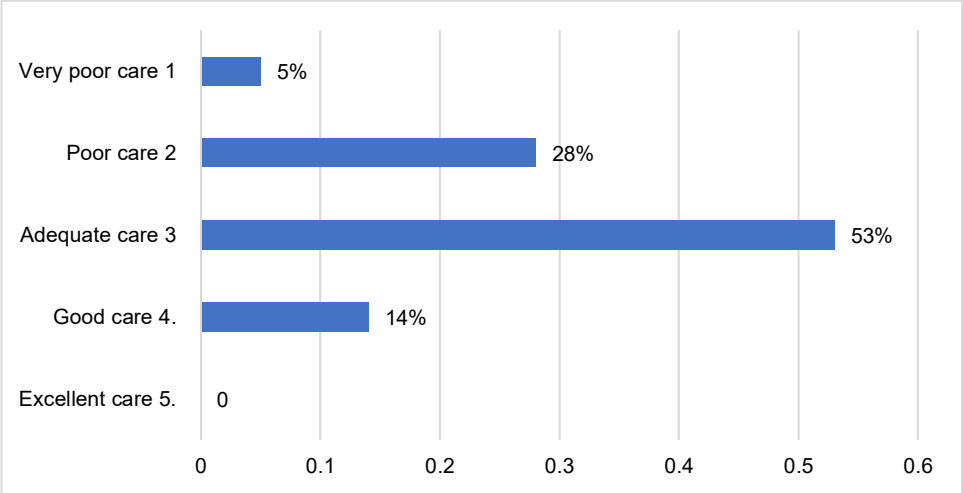
Structured Judgement Reviews Overview

211 SJRs were requested in the last 12 months.

	Escalated from ISR	Escalated by ME	2nd opinion	SI Panel	Elective	LD	Complaint	Coroner	HED Alerts & Spike in deaths	Total
April 22	3	6	2	1	0	1	0	0	0	**13**
May 22	8	10	6	0	1	0	0	0	1	**26**
June 22	5	3	4	1	0	0	0	0	24	**37**
July 22	6	0	1	0	1	0	0	0	0	**8**
Aug 22	8	3	2	0	0	1	0	0	1	**15**
Sept 22	7	0	6	1	0	1	0	0	0	**15**
Oct 22	1	1	3	0	0	1	0	0	9	**15**
Nov 22	2	3	2	0	0	0	0	0	16	**23**
Dec 22	1	10	4	1	0	0	0	0	5	**21**
Jan 23	7	5	1	1	0	1	0	0	0	**15**
Feb 23	3	3	3	0	0	1	1	0	0	**11**
Mar 23	4	4	2	1	0	1	0	0	0	**12**
Total	**55**	**48**	**36**	**6**	**2**	**7**	**1**	**0**	**56**	**211**

A total of 38 SJRs were requested in Quarter 4 (Jan to March) of 2022/23 of which **36** have been completed. The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

Quality of Care score distribution for 36 completed SJRs



Of the 12 reviews deemed very poor care & poor care, 5 cases have been reported on Datix and will be discussed & validated at Divisional Orange Panel

Datix ref: 224722 – Acute Floor HRI – awaiting review at orange panel
Datix ref: 223726 – Acute Floor CRH – awaiting review at orange panel
Datix ref: 222715 – Oncology Ward HRI – awaiting review at orange panel
Datix ref: 221604 – ward 20 HRI – Reviewed at medicine orange panel and downgraded to yellow
Datix ref: 221606 – Ward 7B CRH - Reviewed at medicine orange panel and downgraded to yellow

Of the SJRs completed in Quarter 4 2022/2023 the following learning themes and concerns were identified:

The following good practice was identified:

- Good virtual input from learning disability team and involvement of carers and NOK.
- The input from the palliative care team was excellent – frequent and holistic.
- Excellent aspects of care, particularly regarding identification of ceiling of care, communication with the patient's family, and the involvement of the safeguarding team
- Excellent communication with NoK

The following poor practice was identified:

- Despite a valid DNACPR order in place CPR was started
- Palliative Care Team not involved in patient at End of Life
- 91 year old patient with at least moderate to severe heart failure, did not have a ceiling of care review when they deteriorated
- Poor decision making around DNACPR and escalation.
- Poor communication and delayed decision making led to patient having unnecessary CPR
- Lack of holistic care
- Delay in urgent test such as Ascitic tap on a gastro ward

Recommendation

The Board is asked to **NOTE** the Learning from Deaths Quarter 4 report which was reviewed by the Quality Committee on 24 July 2023.

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	**Director of Infection Prevention Control (DIPC) Q1 2023/24**
Author:	**Belinda Russell, Lead Nurse IPC (Infection Prevention Control)**
Sponsoring Director:	**Dr David Birkenhead**
Previous Forums:	**Dr David Birkenhead, DIPC**
Purpose of the Report	The report provides an update on Infection, Prevention and Control (IPC) Performance and activity for the first quarter of 2023/24.
Key Points to Note	Current targets are within range: National targets no longer set for MRSA bacteraemia or MSSA. ANTT competency is now being assessed at the commencement of emplo yment/training for all medical staff which should give rise of increased com pliance going forwards. The IPC Board Assurance Framework was presented at ICC in April 23. A new IPC BAF was published on the 18/4/23. The Trust BAF will be reviewed and updated in line with the changes. https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.england.nhs.uk%2Fwp-content%2Fuploads%2F2022%2F04%2Fnipc-board-assurance-framework.xlsx&wdOrigin=BROWSELINK
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 Committee is asked to note the content of the report

Calderdale and Huddersfield NHS Foundation Trust

DIPC report Q1 – 1st April 2023 to 31st June 2023

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

1.Performance targets (HOHA = hospital onset, healthcare associated: COHA = community onset, healthcare associated COCA= Community Onset, Community Associated)

1. Indicator	Objective 2023/24	June 23 Q1 performance	Actions/Comments
MRSA bacteraemia	0	1	Not mentioned on this year's targets 0 HOHA 1 COHA
C.difficile (HOHA and COHA)	37	**5**	2 HOHA 3 COHA + 3 COCA
E. coli bacteraemia	67	**6**	. 4 HOHA 2 COHA + 27 COCA.
Pseudomonas aeruginosa	2	**0**	0 HOHA + 3 COCA.
Klebsiella spp.	28	**6**	3 HOHA 3 COHA + 7COCA.
MSSA	0	3	Not mentioned on this year's targets 2 HOHA 1COHA +8 COCA
ANTT Competency assessments (medical staff)	90%	**75.95%**	
ANTT Competency assessments (nursing and AHP)	90%	**90.83**	
Hand hygiene	95%	**100%**	
Level 2 IPC training (Medical staff)	90%	**93.20**	
Level 2 IPC training (nursing and AHP)	90%	**93.20**	

2. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	**92.45%**	**Data issues being investigated. Currently including day case patients.**
Isolation breaches	Non set	Not recorded this quarter	Covid 19 patients remain priority for side room isolation

3. MRSA bacteraemia:

No objective for MRSA cases in year. 1 COHA cases (community onset, healthcare associated) to report during the current reporting period/year to date.

4. MSSA bacteraemia:

There is no objective set for MSSA. The IPC team continue to review these cases. 11 cases in Q1

5. Clostridium difficile:

The objective for 2023-24 is 37 cases, a decrease of 1 case on targets from 22/23. The objective includes both HOHA cases (hospital onset, healthcare associated) plus COHA (community onset, healthcare associated) infections where there has been an inpatient episode within the previous 28days. There have been a total of 8 cases year to date Q1. Each case is being investigated.

6. E. coli bacteraemia:

The Trust is participating in regional improvement work in relation to gram negative bacteraemia. There have been 4 post-admission *E. coli* bacteraemia cases plus 2 COHA cases during the reporting period.

7. Outbreaks & Incidents:

VGE: There has been 1 Rotavirus/Sapovirus affecting ward H5 and 1 Norovirus affecting H6 outbreaks reported during Q1.

Covid-19: There has been a Covid19 outbreak recorded during the reporting period on ward H5, towards the end of the quarter and mitigations remain in place. All Covid-19 outbreaks are managed in line with Covid19 outbreak management guidelines and are monitored for 28 days.

8. Audits

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

Quality Improvement Audits: The programme has resumed. 5 QI audits have been completed in this reporting period, these are dependent on a whole team approach to go ahead and are currently a little behind schedule.

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+.

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	Apr-2023	May-2023	Jun-2023
Total	91.05%	91.94%	92.86%
1. Hand Hygiene	94.10%	93.04%	95.35%
2. General Environment	84.73%	87.44%	89.21%
3. Patient's immediate area/bed space	93.30%	95.25%	96.88%
4. Isolation of Infected Patients	94.39%	97.03%	96.10%
5. Dirty Utility/linen and waste disposal	95.62%	93.89%	93.75%
6. Kitchens	89.43%	89.77%	89.02%
7. Sharps Safety	84.33%	86.20%	86.67%
8. Storage Areas & Clean Utility	92.05%	92.02%	93.95%
9. Patient Equipment	94.12%	93.79%	95.11%
10. Clinical Practice	89.02%	91.37%	92.93%

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

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

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

9. Recommendations

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

16. Integrated Performance Report

To Note

Presented by Jonathan Hammond

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Jonny Hammond, Chief Operating Officer
Previous Forums:	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 July 2023.
Key Points to Note	**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 improving variation 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 following strike action. ENT is the most challenging specialty and a Task and Finish group has already identified a combination of solutions to address the 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 recover due to volume. Neurophysiology trajectory shows that we are expecting to be back to 6 weeks by 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 requests. Initiatives such as Patient Initiated Follow-up (PIFU) have been implemented and based on this 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, 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 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%. 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.
EQIA – Equality Impact Assessment	The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.
Recommendation	The Board of Directors is asked to note the narrative and contents of the report for July 2023.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report
July 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 >40 weeks • Total Patients waiting >52 weeks • Total Patients waiting >65 weeks • Core EST Compliance • Total Patients waiting >40 weeks (LD)	• Diagnostic activity undertaken against activity plan • Falls per 1,000 Bed Days	• No KPI's
COMMON CAUSE/NATURAL VARIATION	• No KPI's	• Total RTT Waiting List • Total Patients waiting > 62 days for cancer treatment compared with February 2020 • Proportion of patients meeting the faster diagnosis standard • ED Proportion of patients seen within 4 hours • Proportion of patients spending more than 12 hours in ED • Hospital Discharge Pathway Activity • Stillbirths per 1,000 total births • Proportion of Urgent Community Response referrals reached < 2 hours • Summary Hospital-level Mortality Indicator • 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) • 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))	• % of patients that receive a diagnostic test within 6 weeks • Early Cancer Diagnosis • Proportion of ambulance arrivals delayed over 30 minutes • Bed Occupancy • % of beds occupied by patients who no longer meet the criteria to reside • ED Proportion of patients seen within 4 hours (LD) • % Outpatient DNAs (IMD 1 and 2)
SPECIAL CAUSE CONCERN	• Staff Movement (Turnover) • Sickness Absence (Non-Covid)	• Transfers of Care • ED Proportion of patients seen within 4 hours (IMD 1 and 2)	• No KPI's

Not included in table – Finance, Virtual Ward, elective activity, follow-up activity, Community Waiting List, Non-Site-Specific Cancer Referrals, Admission avoidance (frailty), neonatal deaths, Outpatient Parenteral Antimicrobial Therapy (OPAT) 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	July 2023	832	0					
Total Patients waiting >52 weeks to start treatment	July 2023	21	0					
Total Patients waiting >65 weeks to start treatment	July 2023	0	0					
Total RTT Waiting List	July 2023	33,265	31,586			32,098	29,595	34,600
Total elective activity undertaken compared with 2023/24 activity plan	July 2023	110%	100%					
Percentage of patients waiting less than 6 weeks for a diagnostic test	July 2023	86.1%	95%			87%	80%	94%
Diagnostic Activity undertaken against activity plan	July 2023	14,738	14,547			13,084	11,146	15,023
Total Follow-Up activity undertaken compared with 2023/24 activity plan	July 2023	101.4%	100%					

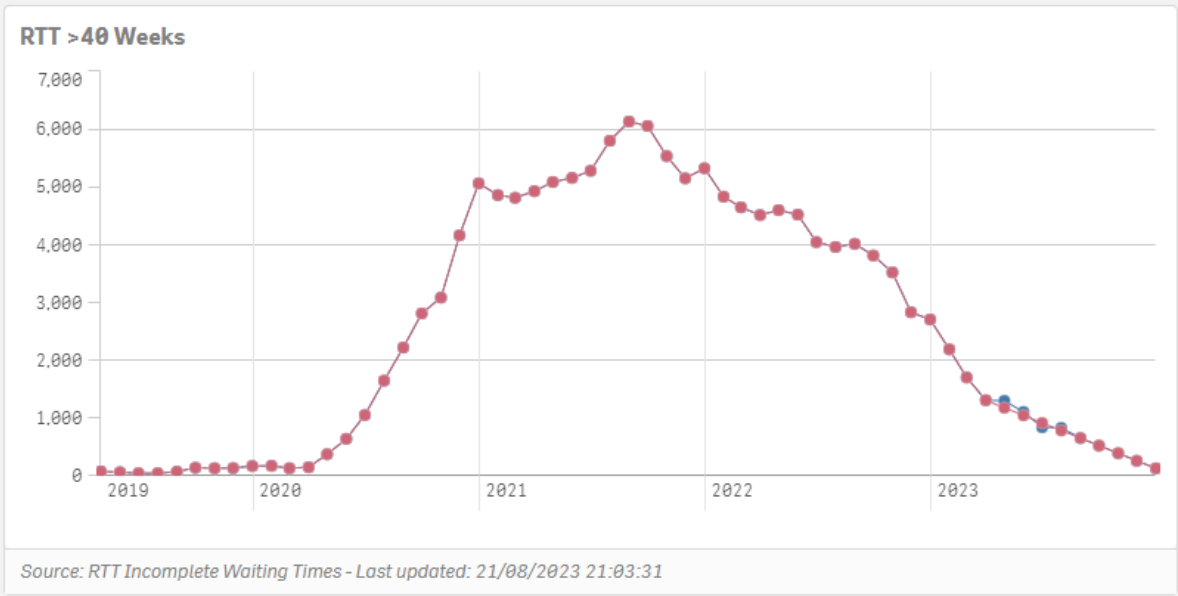
Total Patients waiting more than 40 weeks to start consultant-led treatment

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:
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 monthly from a peak of 6,000 to the current position of 832 at the end of July 2023. Our current trajectory was 785 so we were slightly behind the trajectory.
The majority of our remaining patients who are waiting over 40 weeks are in ENT (123), Max Fax (81), T&O (89), General Surgery (238), Urology (74) and Gynaecology (69).

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 set up and meeting weekly on Fridays.
Actions have been identified in 3 cohort areas:
Demand management
Increasing internal capacity
Increasing external capacity

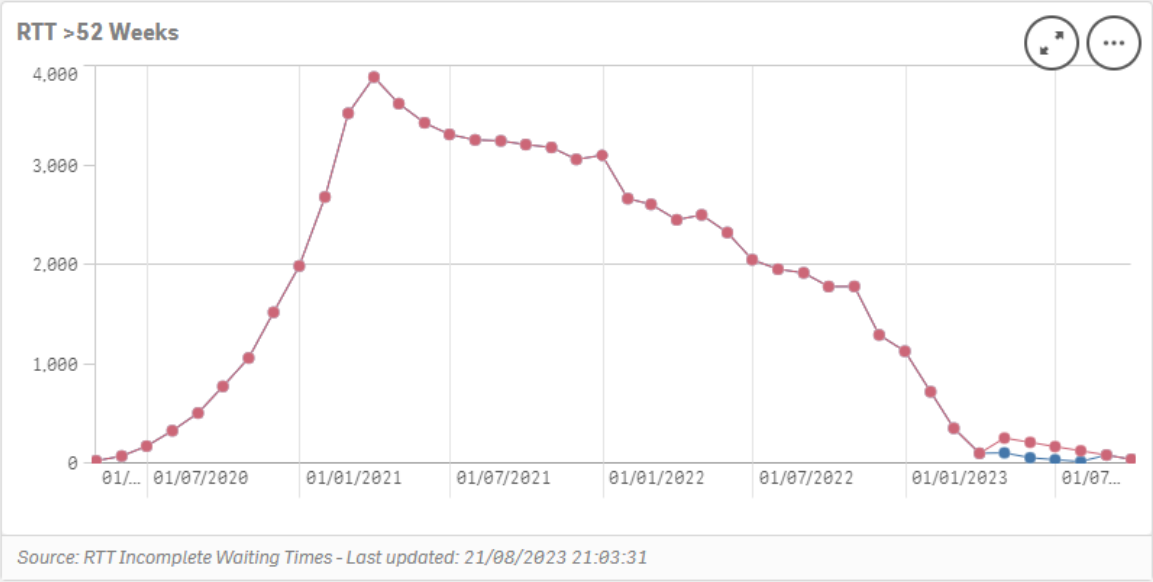
Total Patients waiting more than 52 weeks to start consultant-led treatment

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:
This chart shows the number of patients on the RTT Incomplete Pathways list who have been waiting more than 52 weeks to start treatment. The aim is to show the progress towards 0 patients waiting more than 52 weeks by September 2023 (internal target).
Our 52-week position has been reducing monthly from a peak of 4,000 to the current position of 21.
The majority of our remaining patients who are waiting over 52 weeks are in Gynaecology (5), General Surgery (4) and MaxFax (3), with T&O/Gastroenterology/Neurology (2) and Urology/Cardiology/Clinical Haematology (1).
There are 196 waiting between 46 and 52 weeks, of which General Surgery (56), Max Fax (25), ENT (23) and Urology/T&O (21). No specialty has more than 5 patients waiting over 52 weeks.

Underlying issues:
Of the remaining patients who are over 52 weeks, most have a treatment plan in place before the end of August, 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 set up and meeting weekly on Fridays.
Actions have been identified in 3 cohort areas:
Demand management
Increasing internal capacity
Increasing external capacity

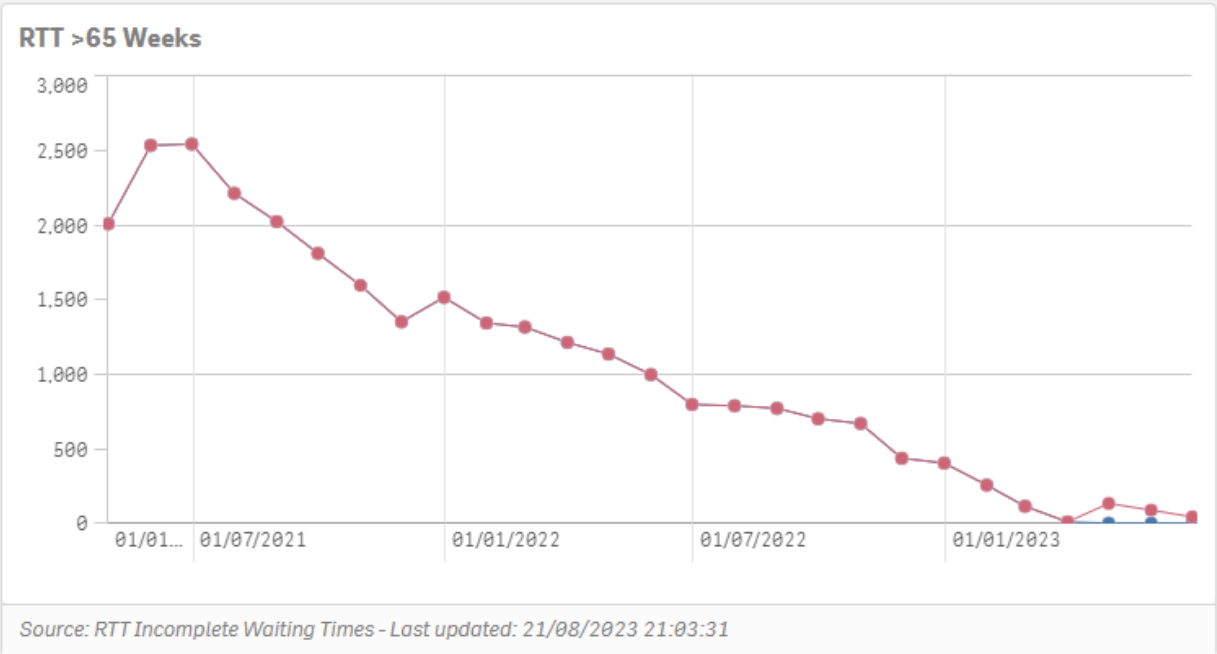
Total Patients waiting more than 65 weeks to start consultant-led treatment

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:
This chart shows the number of patients on the RTT Incomplete Pathways list who have been waiting more than 65 weeks to start treatment. The aim is to show the progress towards 0 patients waiting more than 65 weeks by March 2024 (internal target June 2023). Our 65-week position has been reducing monthly from a peak of 2,500 to the current position at the end of July of 0.

Underlying issues:
Although there were 0 patients at 65 weeks, there was 1 pathway waiting 63-64 week (Neurology).

Actions:
Ensure that ENT Ops/General Manager continue to ensure that these theatre sessions are not cancelled and that patients are pre-assessed in a timely fashion.
Operational teams to be tracking patients to at least 40 weeks to stop patients getting close to 65 weeks in future months.
All patients that could be a 65-week wait by the end of March 2024 need to have a 1st Appointment booked by 31st October (as per NHSE guidance letter 4th August).

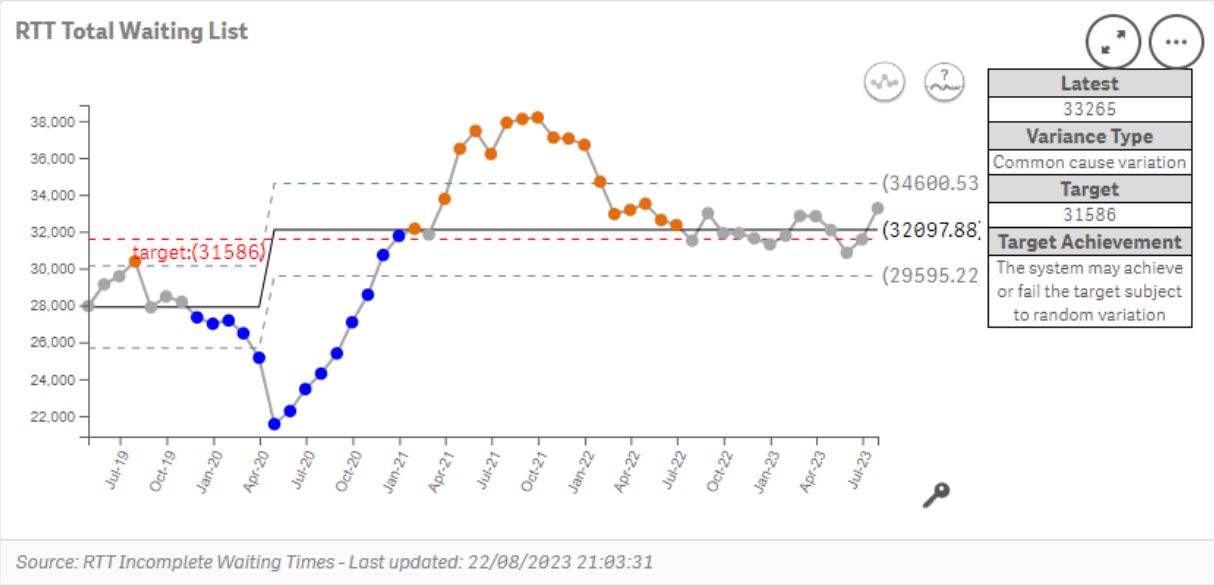
Total RTT Waiting List

Calderdale and Huddersfield NHS Foundation Trust

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:
This chart shows the size of the RTT Incomplete Pathways list as submitted each month on the 18 Weeks RTT PTL.
Our waiting list size has been consistently between 31,000 and 33,500 since February 2022 after increased variation at the start of 2020 (a reduction caused by a number of 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).

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

The National position continues to grow on a monthly basis and 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.

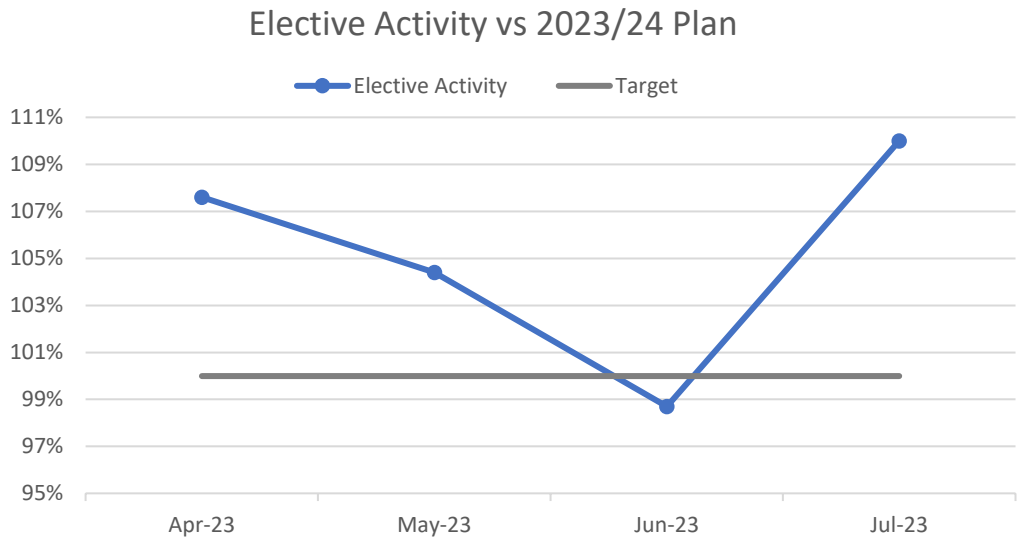
Total elective activity undertaken compared with 2023/24 activity plan

Calderdale and Huddersfield NHS Foundation Trust

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 3 of the 4 months compared with the 2023/24 activity plan. Performance in July 2023 has increased again to 110% in month. Day cases were significantly above the planned position for July, standing at 111.4%. The YTD performance for the elective activity overall remains above the planned position and currently stands at 104.8%, which is a total of 720 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.

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 aim.

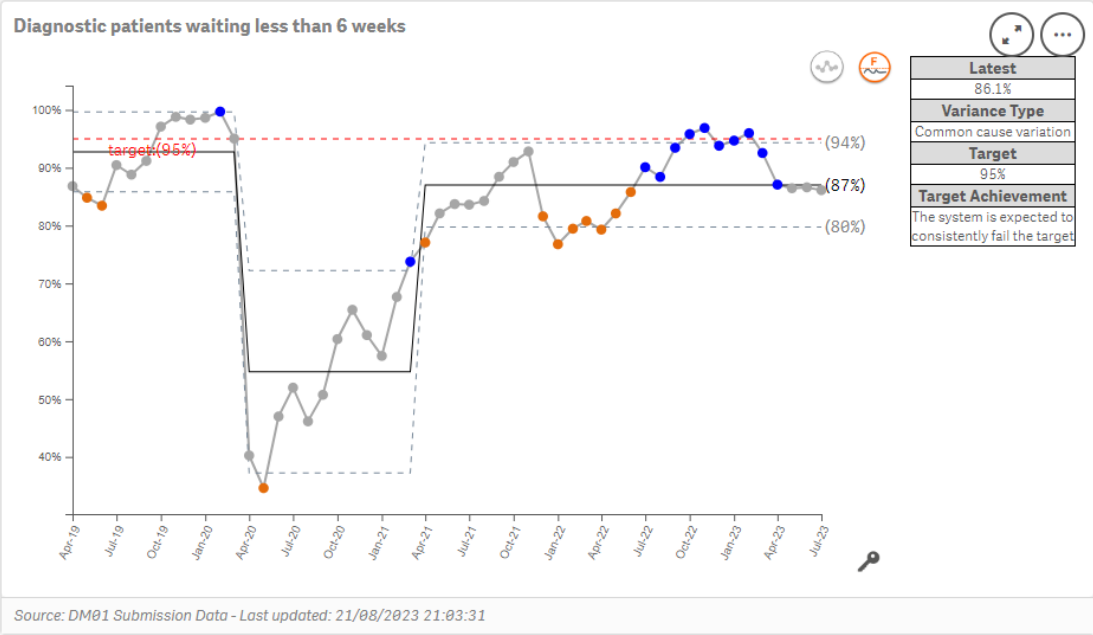
Percentage of patients waiting less than 6 weeks for a diagnostic test

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 79% and 95% however performance is in special cause variation – improvement (where high is good). Whilst the Trust performance is close to meeting the 95% target in most modalities, we are consistently below this for Echocardiography (52.8%) and Neurophysiology (56.3%).

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

- Backlog of 1,413 TTE scans outstanding and 826 TTE reports outstanding. Reporting backlog presents clinical risk which is on the risk register.
- Accredited staff beginning additional sessions to reduce reporting backlog and mitigate risk from end of August.
- Recovery paper for TTE scan backlog sent to divisional SMT and Exec team for approval. Support needed regionally to recover due to volume.
- 2 full-time bank members of staff have recently left due to higher rate at Manchester University FT.
- Annual leave of substantive and bank staff coupled with previous capacity issues due to digitalisation project has led to high volume of scans outstanding.
- High number of trainees without adequate supervision time has caused TTE reporting backlog as these need sign-off from accredited staff.

Neurophysiology

- Extraordinary meetings have also been held with the COO and plans have been highlighted with an action taken to deliver a revised trajectory based on incoming staff.
- Trajectory shows that we are expecting to be back to 6 weeks by November 2023.

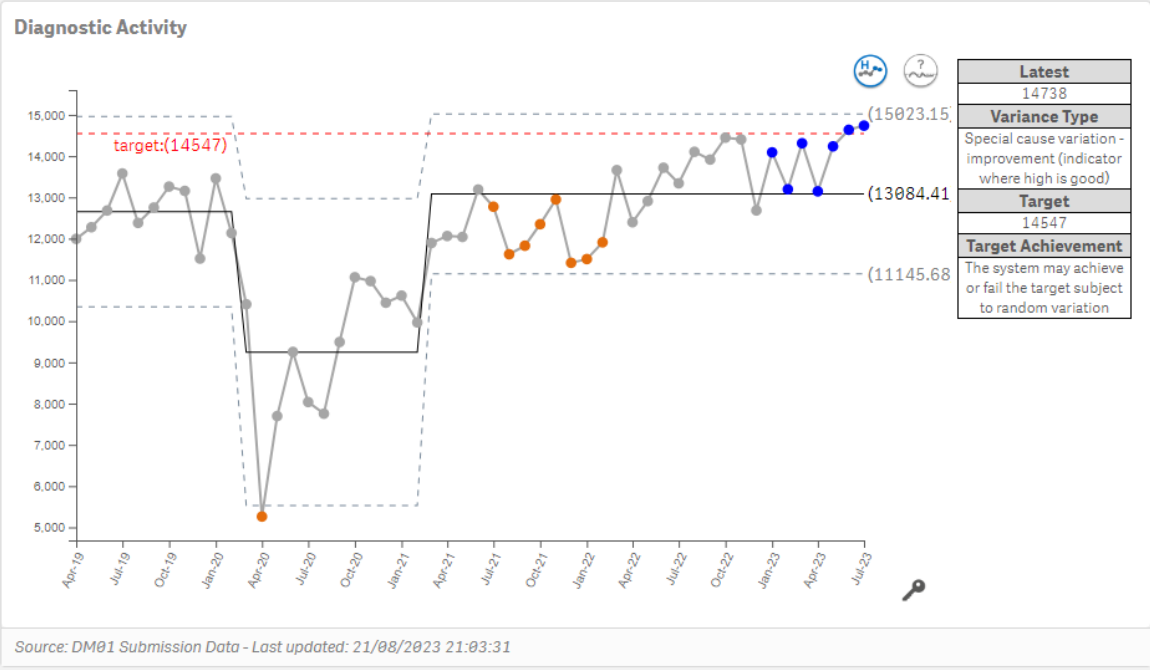
Total Diagnostic Activity undertaken against the activity plan

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 11,145 and 15,023. 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

- Backlog of 1,413 TTE scans outstanding and 826 TTE reports outstanding. Reporting backlog presents clinical risk which is on the risk register.
- Accredited staff beginning additional sessions to reduce reporting backlog and mitigate risk from end of August.
- Recovery paper for TTE scan backlog sent to divisional SMT and Exec team for approval. Support needed regionally to recover due to volume.
- 2 full-time bank members of staff have recently left due to higher rate at Manchester University FT.
- Annual leave of substantive and bank staff coupled with previous capacity issues due to digitalisation project has led to high volume of scans outstanding.
- High number of trainees without adequate supervision time has caused TTE reporting backlog as these need sign-off from accredited staff.

Neurophysiology

- Extraordinary meetings have also been held with the COO and plans have been highlighted with an action taken to deliver a revised trajectory based on incoming staff.
- Trajectory shows that we are expecting to be back to 6 weeks by November 2023.

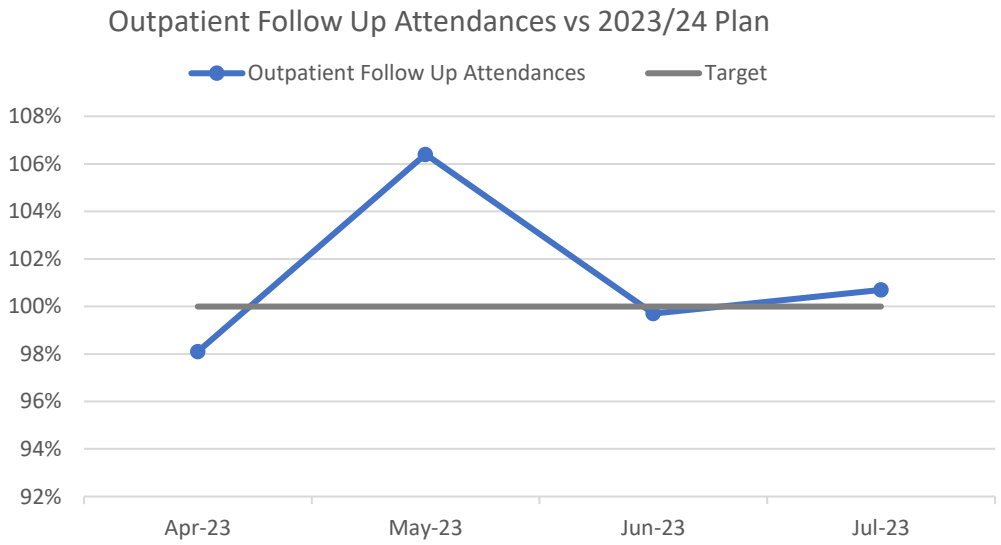
Total Follow-Up attendances undertaken compared with 2023/24 activity plan

Calderdale and Huddersfield NHS Foundation Trust

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

Rationale:
To measure the relative reduction in follow-up outpatient attendances (consultant and non-consultant led) in 2023/24 compared to 2023/24 activity plan

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



What does the chart show/context:
CHFT made the decision at the start of 2022/23 to not adopt the 25% reduction in outpatient follow-up activity, this has continued for 2023/24. Performance has improved for month 4 and CHFT achieved 101.4% of the planned position in month for follow-up attendances. The YTD position still remains above the planned levels standing at 101.5%, this is 1,119 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 (23,900) CHFT have not taken this up. The majority of the backlog has been waiting less than 12 weeks.

Actions:
There are currently 6,899 (of the 23,900 backlog) records that are awaiting a clinical prioritisation within CHFT's MPage system, this is a similar position from last month. Specialties need to have a plan to address this backlog to ensure patients are booked by clinical priority.

Following the narrative from last month the admin validation work has started and cohort 1-3, which is in relation to patients that have a future appointment booked in the same specialty, duplicate requests and past appointments in the same specialty has been completed, resulting in 5,117 requests being closed and the overall Trust backlog reducing from 27,000 to 23,900.

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	11th Aug 2023	38	35			34.62	17.82	51.41
Proportion of patients meeting the faster diagnosis standard	July 2023	66%	75%			76%	66%	86%
Non-Site-Specific Cancer Referrals	July 2023	23	25					
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028	June 2023	52.6%	75%			49%	39%	59%

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

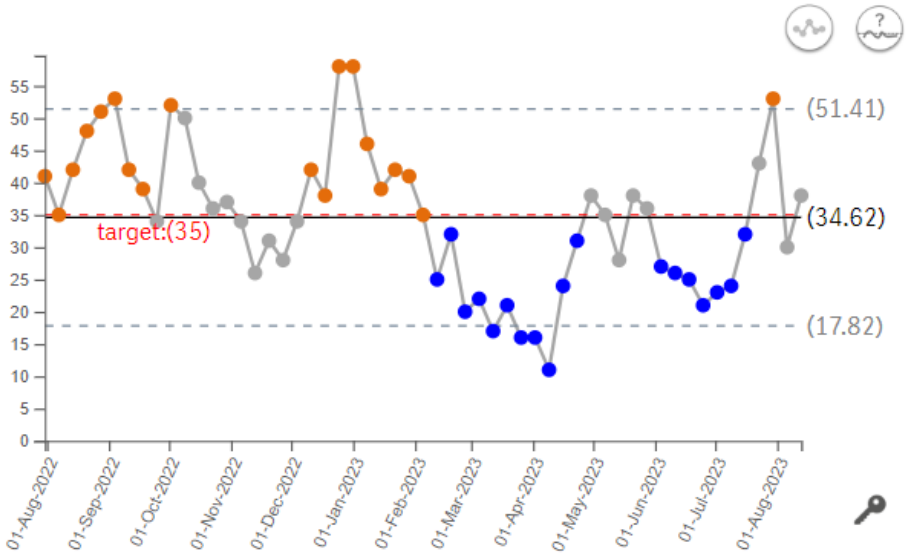
Calderdale and Huddersfield NHS Foundation Trust

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.

People waiting longer than 62 days



Latest
38
Variance Type
Common cause variation
Target
35
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- 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 18 and 52.
- 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. Skin long waiters have recently impacted performance.
- We also do not work at weekends, therefore this report does not take into account Friday's activity, which is captured on Monday's tracking.
- As of Monday 13th August there were 38 patients on the long waiters' report.

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

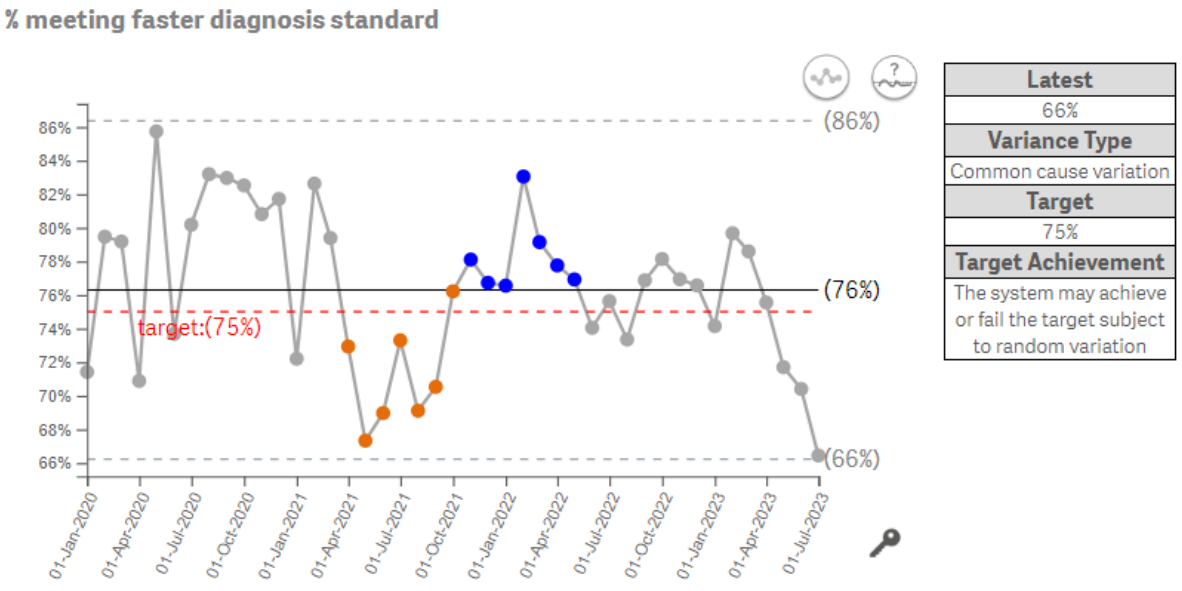
Proportion of patients meeting the faster diagnosis standard

Calderdale and Huddersfield NHS Foundation Trust

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%.



Latest
66%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- Latest monthly performance stands at 66% which is below the NHSE target.
- Performance is variable however as of the latest financial year the Trust meets the target more often than it fails. 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 66% and 86%

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.
- Telederm continues to impact on 28-day performance this month.
- Non-Site-Specific; Sarcoma and ENT have performed below the 75% FDS target during July, as lower volume tumour sites, limited impact on overall performance.

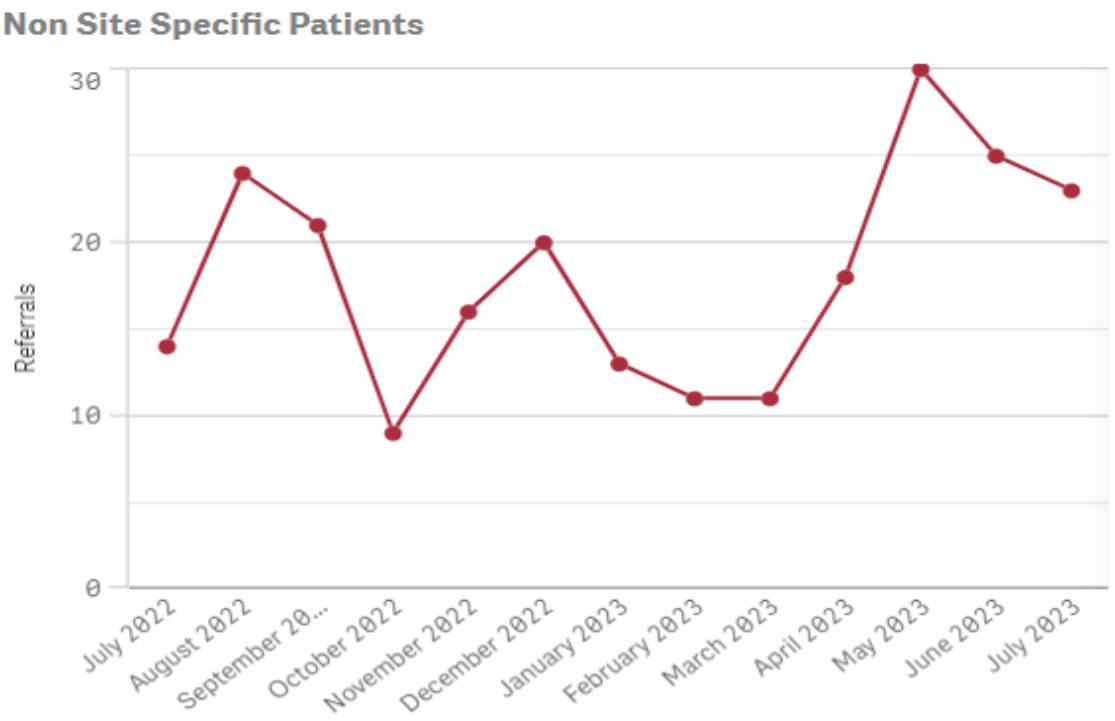
Actions:
- Working with primary care to collaborate and resolve issues with telederm.
- Pathway Navigator has started in post 12th June with a focus on day 0-28 in Lower GI and Upper GI.
- Non-Site-Specific looking at; recording of diagnosis, patient availability for diagnostics.

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:
- Referrals are variable, between 10 to 30 referrals a month.

Underlying issues:
- Referrals have remained steady this month at 23 with a minor decrease on the projected number (25).
- The Physician's Associate started in post during May and is running video/telephone clinics alongside the Specialist CNS.

Actions:
- The Specialist CNS started assessing patients in primary care week commencing 12th June.
- Share quarterly NSS referrals data with PCNs, continuing to raise the NSS service profile.

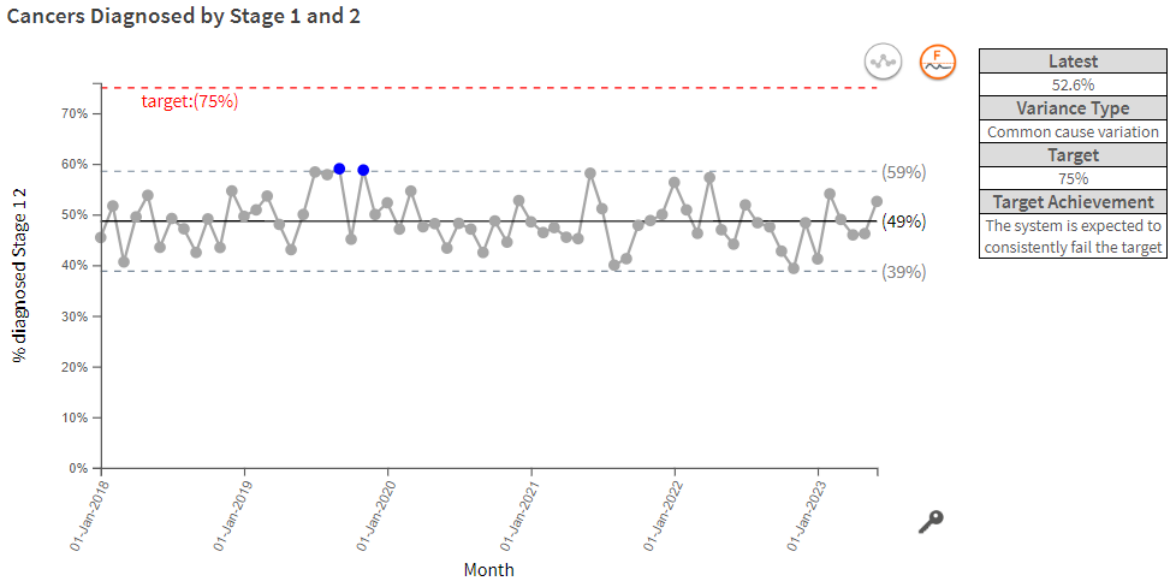
Early cancer diagnosis: 75% of cases diagnosed at stage 1 or 2 by 2028

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 45% and 58%.
- Nationally this metric stands at 52%, and CHFT are around this mark.

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	July 2023	70.61%	76%			69%	58%	78%
Proportion of ambulance arrivals delayed over 30 minutes	July 2023	1.2%	0%			4%	1%	7%
Proportion of patients spending more than 12 hours in an emergency department	July 2023	2.78%	2%			2%	0%	5%
Adult G & A acute bed occupancy adjusted for void beds (Type 1 Acutes Only)	July 2023	97.8%	96%			98%	96%	100%
% of beds occupied by patients who no longer meet the criteria to reside	July 2023	25%	14.21%			22%	18%	26%
Hospital Discharge Pathway Activity – AvLOS pathway 0	July 2023	4.0	4.1			3.99	3.60	4.38
Transfers of Care	July 2023	106	50			88.18	45.82	130.53

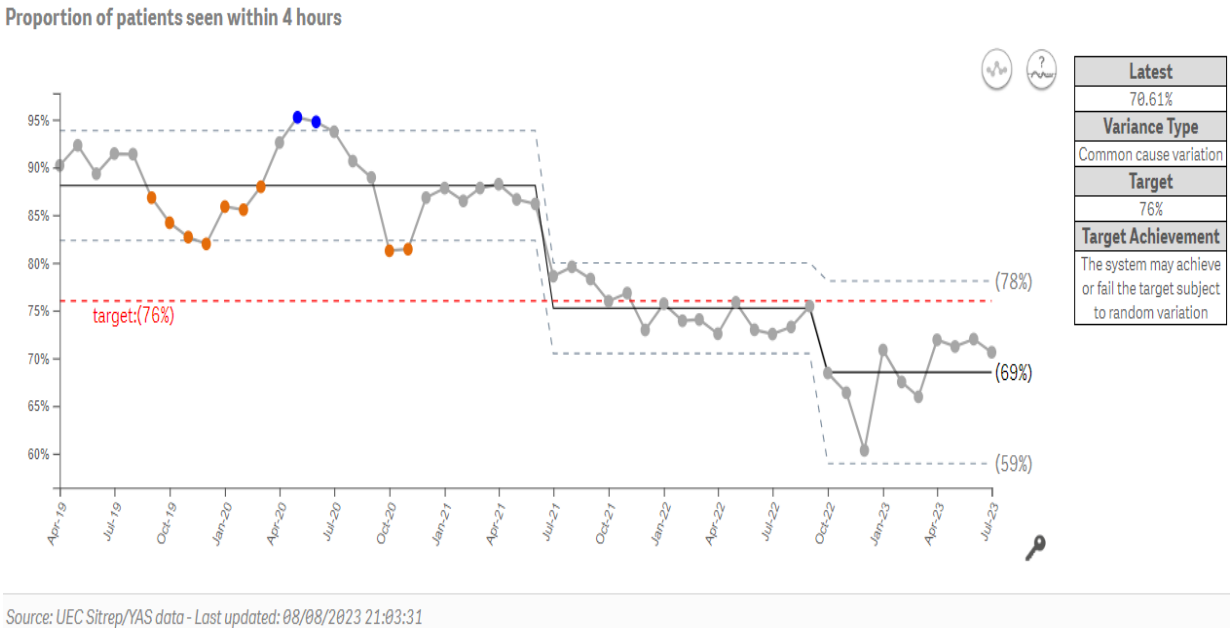
Proportion of patients seen within 4 hours

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.



Source: UEC Sitrep/YAS data - Last updated: 08/08/2023 21:03:31

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 59% and 78%

The performance for July was 70.61%. The average daily attendances for July were 481 which was lower than the 502 average in June. The performance is significantly lower than the 76% target brought in from April 2023 onwards. Nevertheless we were 13th nationally for Acute Trusts for type 1 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.

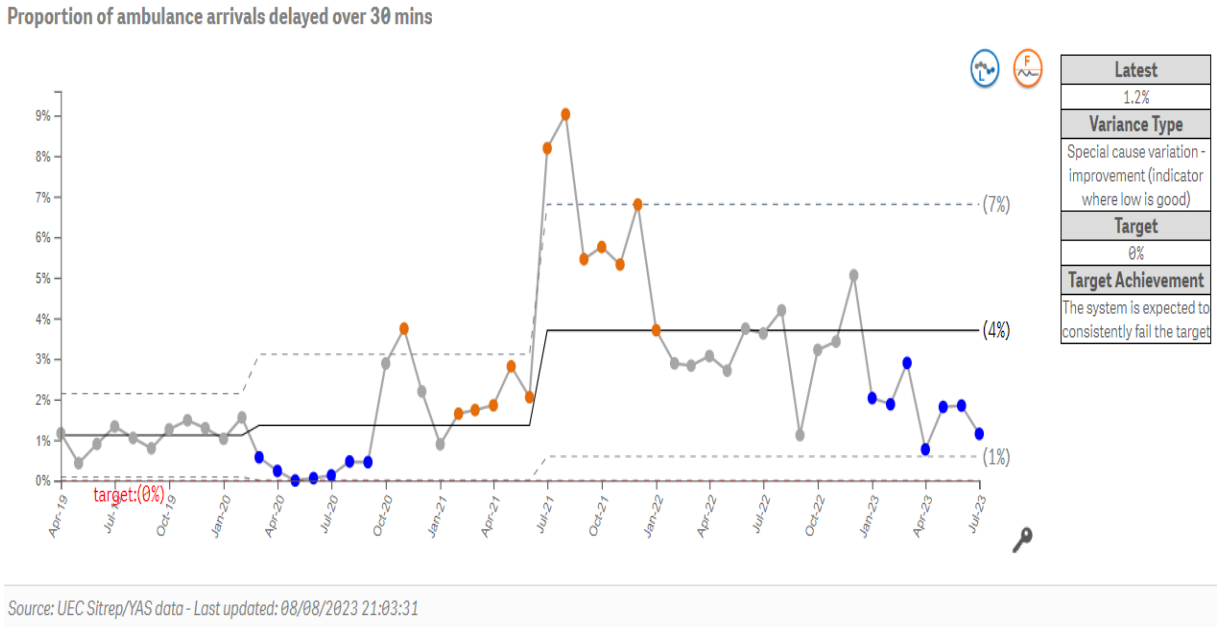
Proportion of ambulance arrivals delayed over 30 minutes

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

We have seen a reduction in the proportion of ambulances which delay by more than 30 minutes in transferring the patient over to care of ED at the start of 2023. 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 and this has had a positive impact with a big reduction in the number of over 30-minute delays as can see from the last 4 points on the graph.

Underlying issues:
- 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.

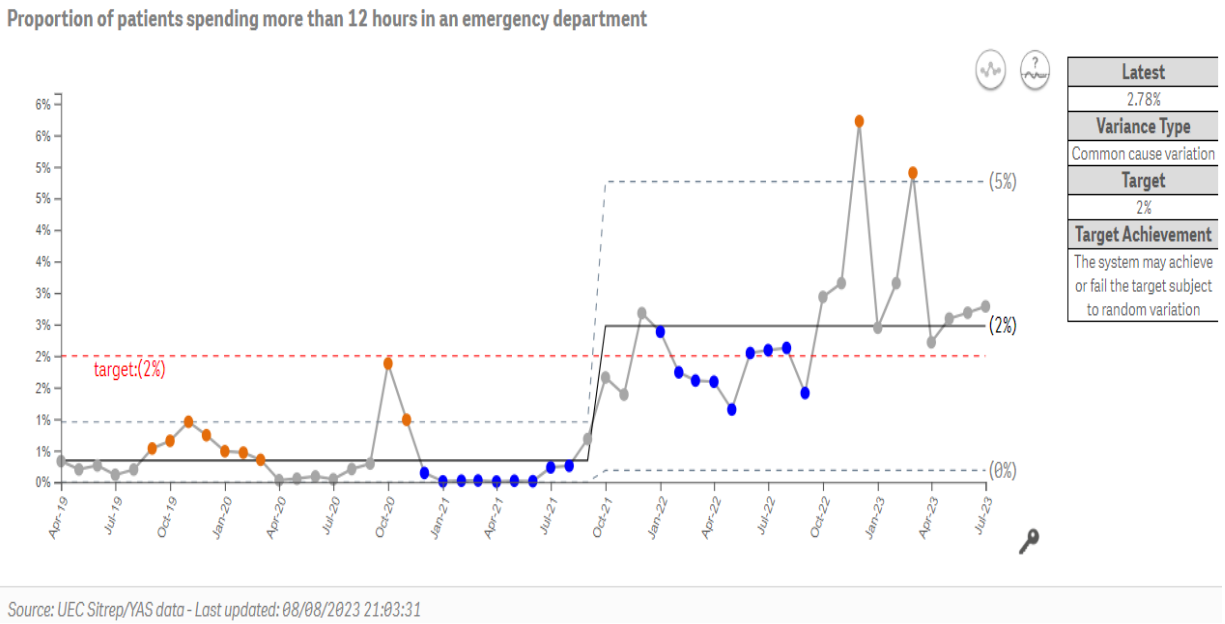
Proportion of patients spending more than 12 hours in an emergency department

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:
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%

In July the performance was 2.78% with 415 patients waiting over 12 hours in ED. This was just above the 2% target.

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.

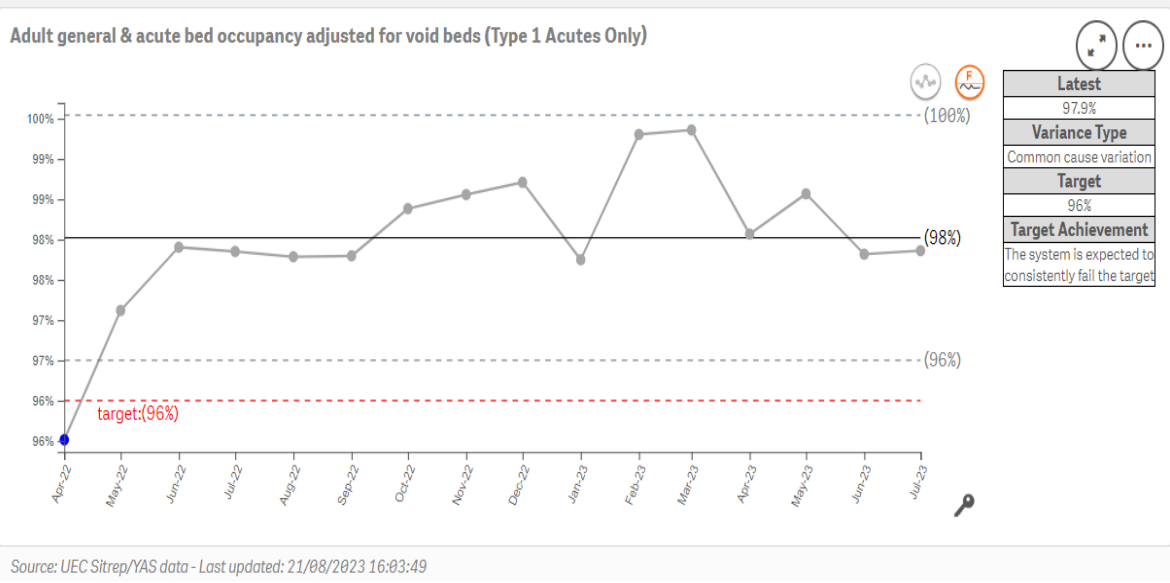
Adult general & acute bed occupancy adjusted for void beds (Type 1 Acutes Only)

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.



What does the chart show/context:
The Trust is expected to consistently fail the target of 96%

Adult bed occupancy remains high with July at 97.9%. It is important to factor in the bed base when analysing this graph. The current internal target for bed occupancy is 96% (internal target).

Underlying issues:
- Large numbers of surge and super surge beds remain open as well as flexed capacity across the Acute Floor and Respiratory floors.
- More clarity required regarding core bed base, surge and super surge beds.
- Keeping beds flexed but empty to drop bed occupancy and maintain flow.
- 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.
- Undertaking work to have a clear core beds base.
- Working with operational site teams to maintain capacity and drop occupancy levels.
- Long length of stay work.
- Trajectory for reducing TOC numbers.

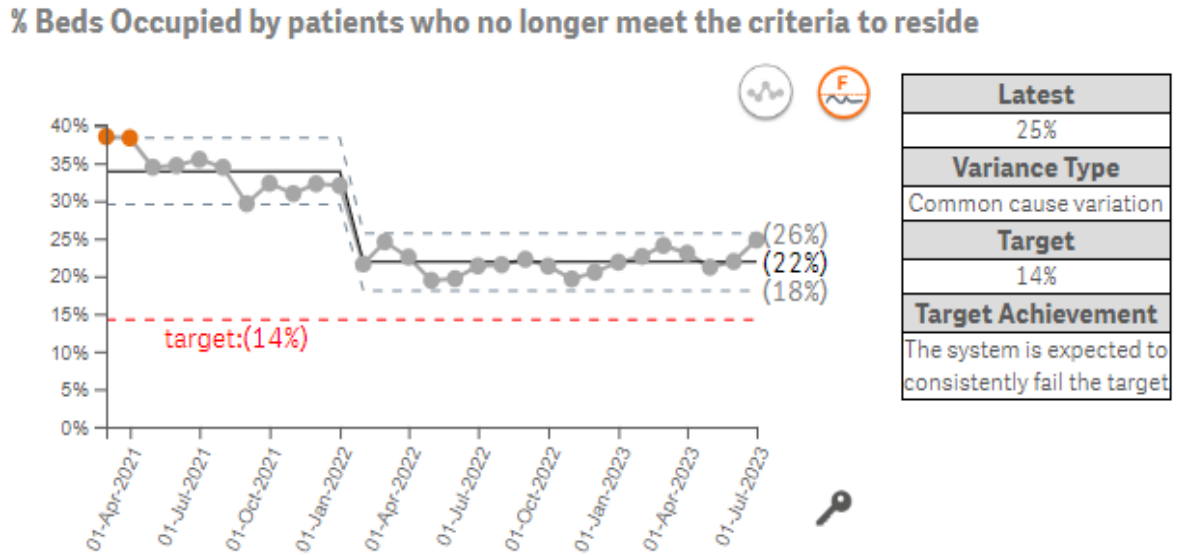
Percentage of beds occupied by patients who no longer meet the criteria to reside

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 July 25% of patients had no reason to reside. Less beds were occupied in July but this was still in line with the amount of patients with no reason to reside, hence the percentage remaining similar to previous months. July'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:

- The new plan is to integrate a R2R discussion into the Board Round SOP and the % target for reporting into the UECDG is <15% of patients. The project will come under the Well Organised Ward (WOW) project and will be monitored as an outcome measure of using digital boards to support patient pathways.

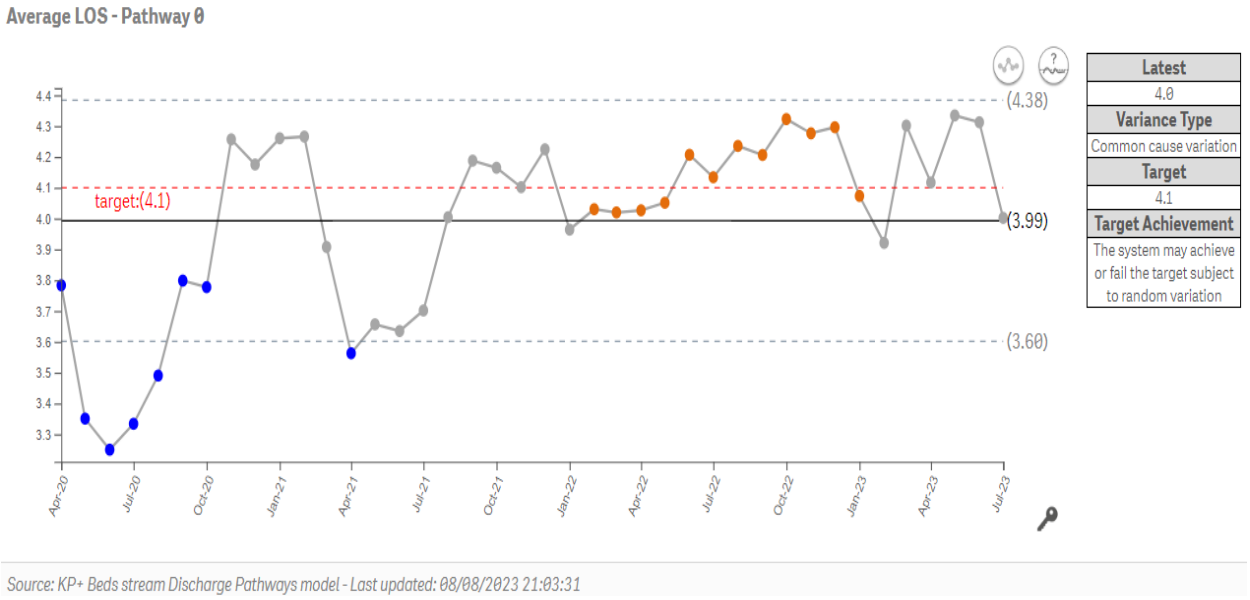
Hospital Discharge Pathway Activity

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.



Source: KP+ Beds stream Discharge Pathways model - Last updated: 08/08/2023 21:03:31

What does the chart show/context:
Performance can be expected to vary between 3.6 and 4.38 days. We saw an increase in the LOS in May and June however as we discharged a number of long stay patients in those months which increased the average LOS. The LOS fell in July and is below the current target at 4.0

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

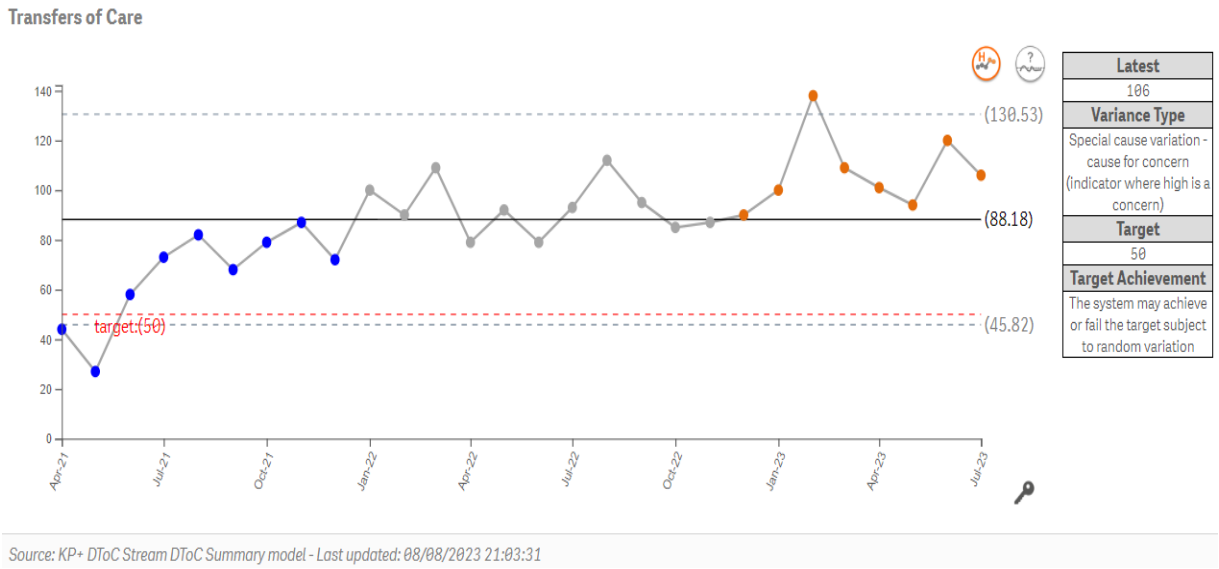
Actions:
- Two Improvement groups commenced, SDEC and LOS working groups to look at
  - Plan for Every Patient/Reason 2 Reside
  - Home First/D2A
  - Criteria Led Discharge
  - UCR/Virtual Ward
- KPIs for each working group
- Feedback to take place monthly at UECDG against the KPIs and available data
- Data to also encompass qualitative data
- Clear project leads and group members
- Monthly working group meetings to be held across the workstreams
- Links with CIP and planning to be in place
- Scrutinising and understanding the data
- Feedback from wards on LOS trajectory
- Data to also encompass qualitative data
- Project roll out on wards 19 and 20 for Home first
- Elderly Care Criteria-Led Discharge roll-out
- New LOS meetings looking at all wards all patients not on TOC (MDT approach)
- Engagement session regarding board rounds

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 July was 106 patients on the TOC which is much 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. Resources to manage TOC have remained the same.

Underlying issues:
- Increasing numbers on TOC
- Increasing referrals to TOC
- Increasing need to 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	July 2023	0	1.53					
Stillbirths per 1,000 total births	July 2023	0	3.33			3.70	0	12.86

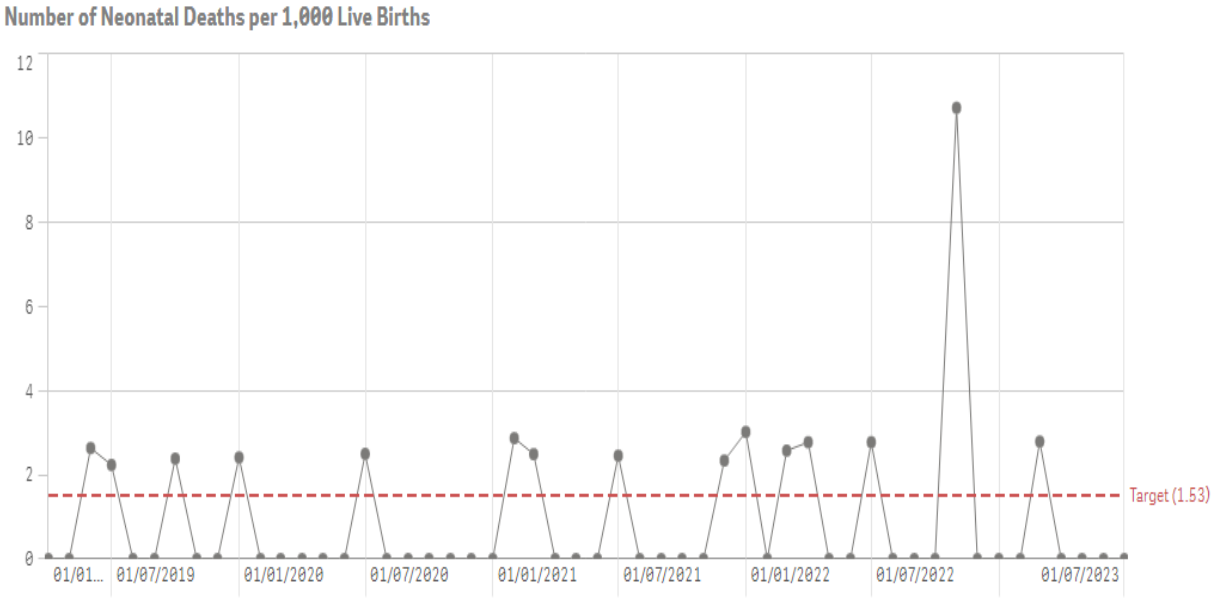
Neonatal deaths per 1,000 total live births

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: David Birkenhead Clinical Lead: Diane Tinker Business Intelligence Lead: Saima Hussain

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

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



Source: Maternity Dashboard - Last updated: 08/08/2023 21:03:31

What does the chart show/context:
The Trust is unable to consistently maintain the minimum number of deaths per 1,000 live births and may achieve or fail the target subject to random variation.

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

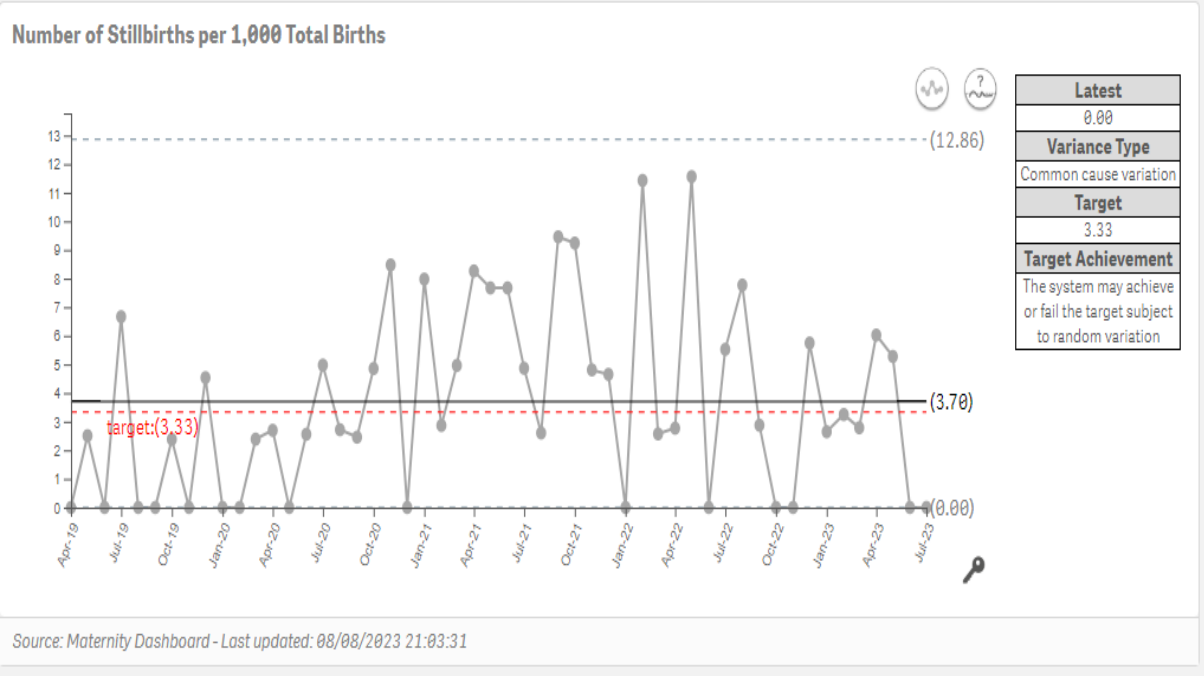
Stillbirths per 1,000 total births

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: David Birkenhead Clinical Lead: Diane Tinker 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:
The Trust is unable to consistently maintain the minimum number of deaths per 1,000 total births and may achieve or fail the target subject to random variation.

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 stillbirths reviewed at Orange Panel and weekly governance meeting
- All stillbirths MDT PMRT completed
- 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	July 2023	60.9%	70%			70%	52%	87%
Community Waiting List	July 2023	6,113	4,387 (end 23/24)					
Virtual Ward	July 2023	37.6%	80%					
OPAT - Outpatient Parenteral Antimicrobial Therapy	July 2023	12.5%	N/A			28%	3%	53%

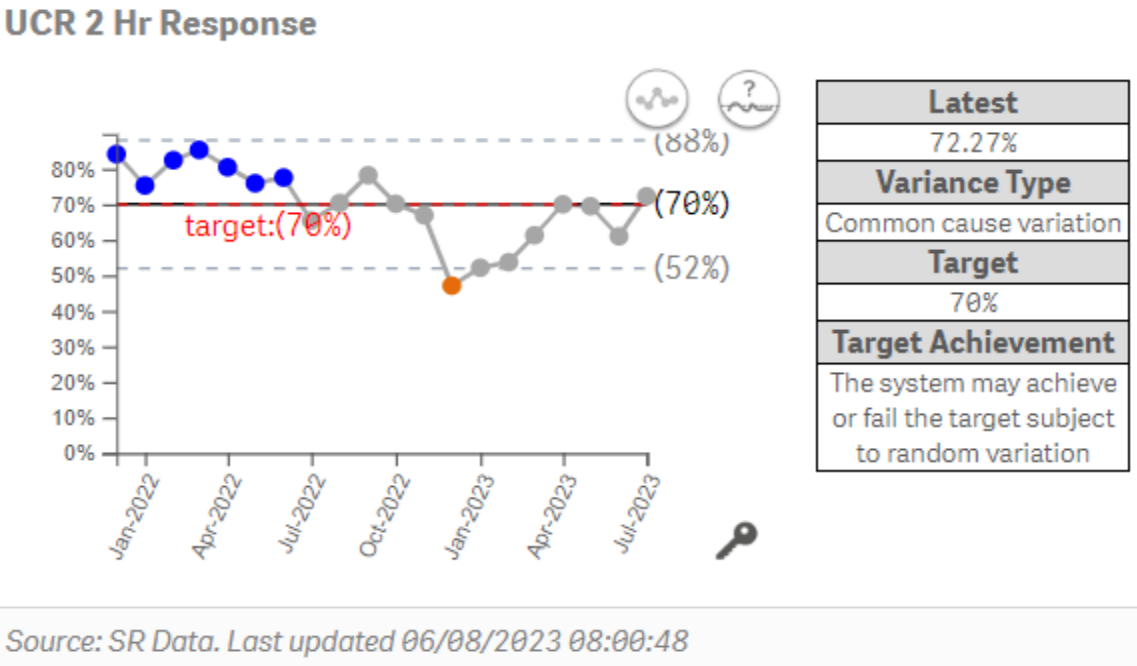
Proportion of Urgent Community Response referrals reached within two hours

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
72.27%
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 06/08/2023 08:00:48

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 improving position trend to July 2023 – now at 72.3%
The Trust is unable to consistently meet the target of 70% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 52% and 88%.
Regionally (NE and Yorks) are showing a response rate achievement of 85% and Nationally the figure shows 84% (April 2023).

Underlying issues:
Change of Service-led SystmOne functionality use in December 2022 resulted in data recording issues with the contact time (Clock stop). Therefore the figures are not a true reflection of the performance – manual audit suggests 84.4% for December 2022, 83.4% for January 2023, 76.1% for February 2023, 87% for March 2023.
Manual audit being completed to examine the different elements of the 2-hour response e.g. how much time there is for Local Care Direct (LCD) to manage triage and call, and then the response time left for UCR to respond - initial findings have seen that in some cases it has taken over an hour for LCD to triage and add to UCR waiting list which significantly reduces the time to get to patient - particularly considering that the journey can take up to an hour if living on the borders of the borough. This is not reflected in LCD's data as they report 100% compliance with meeting the 2-hour target but it is having a knock-on effect on the time left out of that 2 hours for us to respond. Work ongoing around this.

Actions:
Communications to service leads around accurate data recording.
Audit as described above to identify joint improvement work needed with LCD.

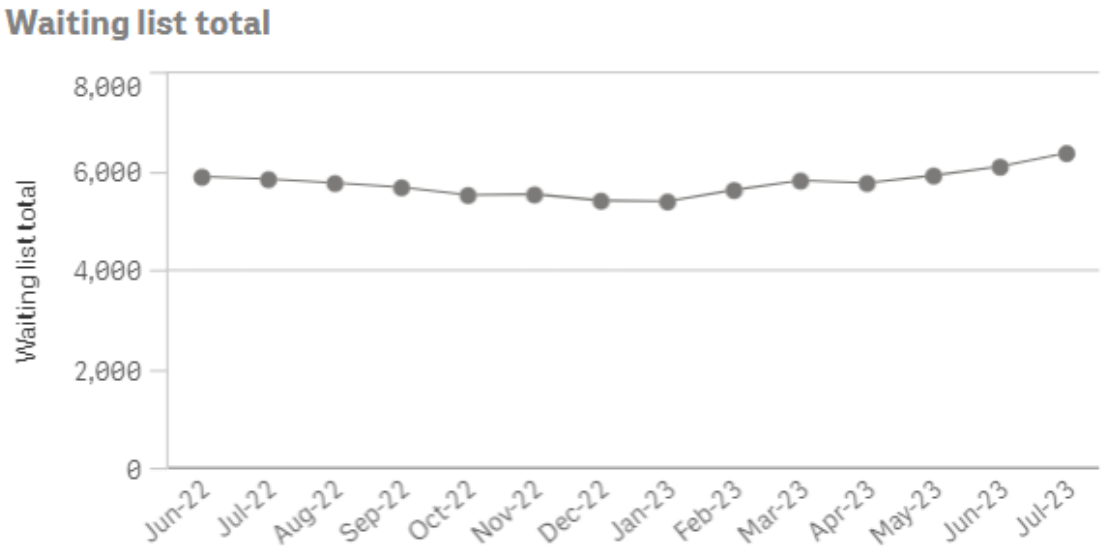
Community Waiting List

Calderdale and Huddersfield NHS Foundation Trust

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

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

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



Source: SR Data. Last updated 06/08/2023 08:00:48

What does the chart show/context:
The overall waiting list numbers trend has seen a slight reduction from when data collection began in June 2022 to January 2023. Since then the trend shows an overall increase in numbers. 6,388 total in July 2023.
Regionally (NE and Yorks) the waiting list numbers have increased by 0.6% and Nationally show a decrease of 1.4% (March 2023 to April 2023).
Regionally MSK, Podiatry and Children's SALT having the highest numbers waiting.
At CHFT Podiatry and Children's SALT are our main concerns however MSK recovered well post-pandemic and now has a reasonably stable waiting list position.
Nationally the main reported reason for preventing reductions in waiting lists are workforce availability (26%) and an increase in demand/referrals (22%).

Underlying issues:
The main reasons for current waiting list position in Children's SALT are workforce availability issues, we currently have 7 band 6 vacancies in that team. 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 2.6 WTE SALT who are soon to be in post 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.

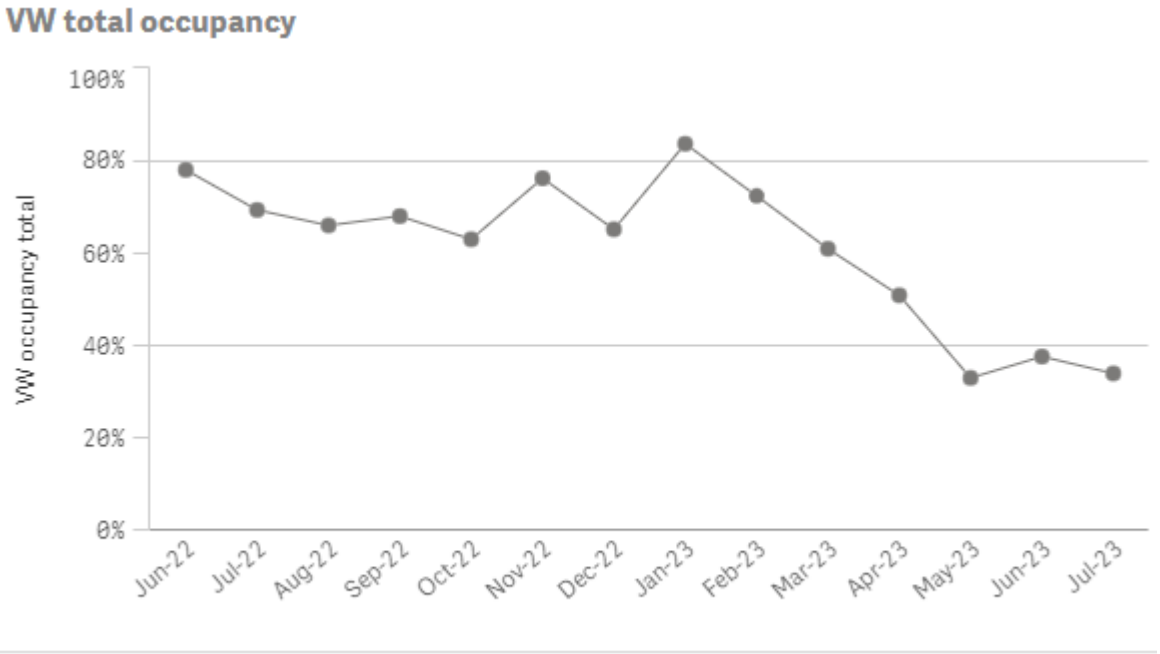
Virtual Ward

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.

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



Source: SR Data. Last updated 17/08/2023 08:00:48

What does the chart show/context:
Achieved target once (January 2023).
4-month decline in occupancy rate to May 2023. Currently at 34% occupancy July 2023.

Underlying issues:
Occupancy caseload cohorts are snapshots at given points in the month and therefore depending on allocation at those moments the % rate can vary significantly.
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.
CHFT VW Foundry submission has bed base at 50, originally based on Early Supported Discharge service activity. The 12 allocated Frailty beds are included in this.
Very few referrals to the team unless from Frailty team.

Actions:
Manual daily occupancy audit commenced alongside development of new reporting model to provide daily occupancy rate.
Audit by team to review outcomes and patient experience.
Medical division reviewing medical cover to support a 7-day MDT for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
ACP working on Frailty SDEC 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 UCR. 12 beds available now for Frailty which is above trajectory.
Respiratory - criteria now changed to include patients requiring oxygen weaning.
Team attend safety huddles each day. Comms with pathways - criteria to go on intranet.

OPAT - Outpatient Parenteral Antimicrobial Therapy

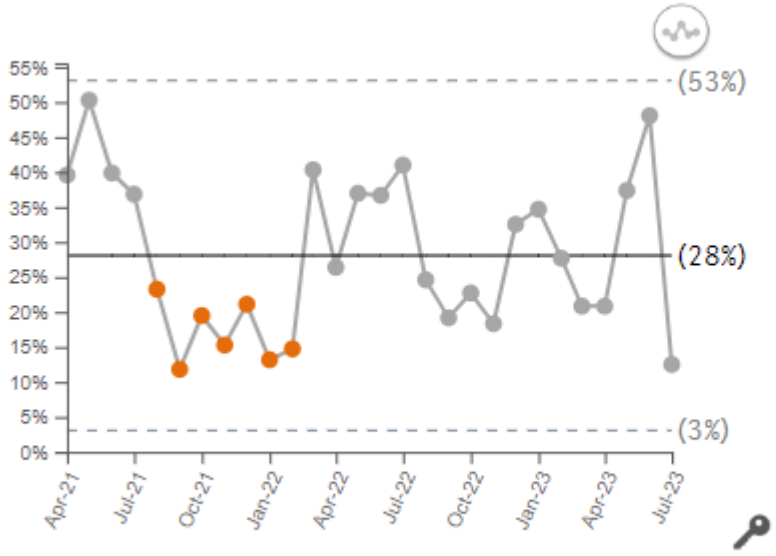
Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Jonathan Hammond Operational Lead: Jayne Woodhead Business Intelligence Lead: Gary Senior

Rationale:
Community based provision of IV antibiotic treatment for patients who otherwise would have received this as a hospital inpatient.

Target:
No Target

% Utilisation of capacity



Latest
12.5%
Variance Type
Common cause variation
Target
N/A
Target Achievement
N/A

Source: OPAT Spreadsheets. Last updated 15/08/2023 08:00:43

What does the chart show/context:
SPC chart shows Common Cause variation with performance expected to vary between 3% and 53%. Currently 12.5% July.

Underlying issues:
OPAT capacity fluctuates on a daily and monthly basis dependant on patient need, a recent review of inpatients showed that all appropriate patients in the hospital are being discharged on OPAT when this is a suitable discharge option. OPAT has been well promoted within the hospital setting and continues to be considered on a daily basis therefore there is not thought to be any suitable patients being missed.
There may be an increase in demand when the Virtual Ward becomes more established but most of the Virtual Ward patients would have been referred for OPAT anyway just via a different source. However there is scope for the Virtual Ward to promote an increase in admissions avoided.
Extra capacity is nearly always available and this has been utilised over previous years to deliver COVID infusions.
Utilisation % is based on a capacity of 24 per day.
Low uptake for July as no suitable patients in the hospital.

Actions:
None

Safe, High Quality Care:

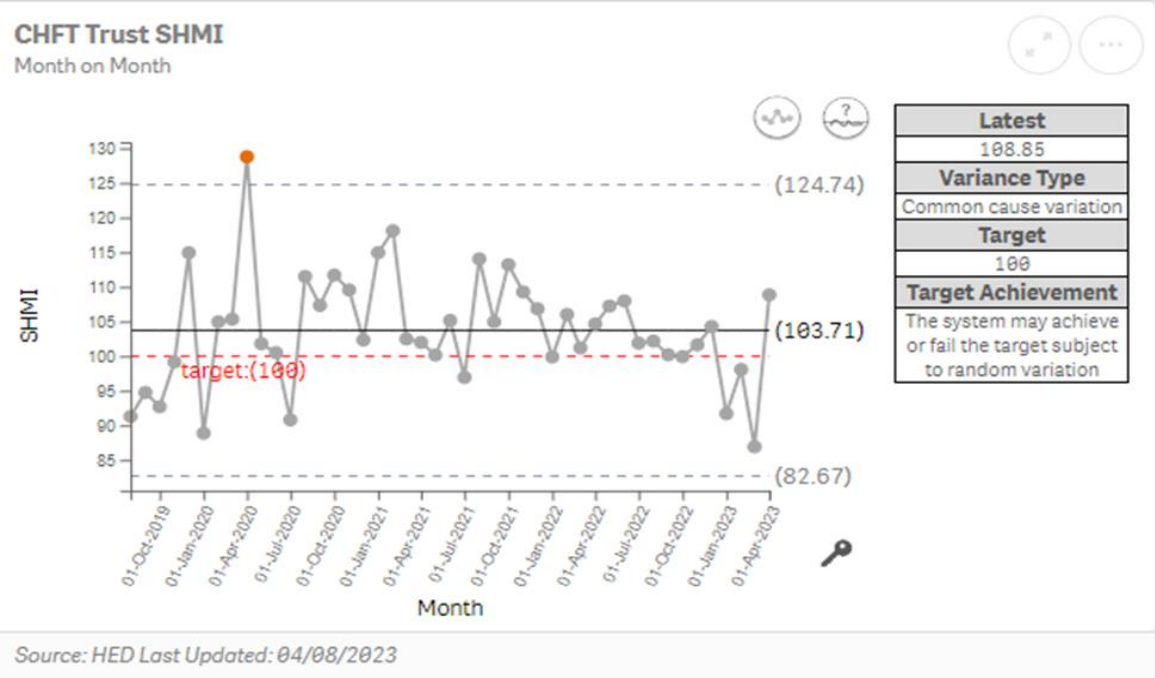
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Summary Hospital-level Mortality Indicator	April 2023	108.65	100			103.71	82.67	124.74
Care Hours Per Patient Day (CHPPD)	July 2023	9.2/8.4	-	-	-	-	-	-
Falls per 1000 Bed Days	July 2023	7	7.02			8.56	5.94	11.18
CHFT Acquired Pressure Ulcers per 1000 Bed Days	June 2023	1.7	1.76			2.04	0.79	3.29
MRSA Bacteraemia Infection	July 2023	0	0			-	-	-
C.Difficile Infection	July 2023	1	3.1			3	0	8.50
E.Coli Infection	July 2023	2	5.6			3.75	0	9.96
Number of Never Events	June 2023	1	0	-	-	-	-	-
Number of Serious Incidents	July 2023	6	0			3.61	0	10.11
% of incidents where the level of harm is severe or catastrophic	July 2023	1.57%	2%			0%	1%	2%
% of complaints within agreed timescale	July 2023	87%	95%			89%	74%	100%

Summary Hospital-level Mortality Indicator

Executive Owner: David Birkenhead Clinical Lead: Neeraj Bhasin 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 100.69. However the latest reporting month of April 2023 does show a performance of 108.85. This is following the national annual rebasing exercise, often with the first reporting month after that rebasing performance can deteriorate due to a new 12-month period dropping out of the expected death calculations, 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. Performance remains within the expected range in the latest release. The latest national SHMI position stands at 100.3, CHFT continues to move towards that position and is comfortably within the expected range nationally

Underlying issues:
Sepsis remains the main alerting condition. 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. Therefore, from February 2023 sepsis deaths will have 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. The first 2 months of this new process have come into the latest data release and the sepsis performance has improved significantly and has dropped below the 100 mark, this is the best performance since 2021.

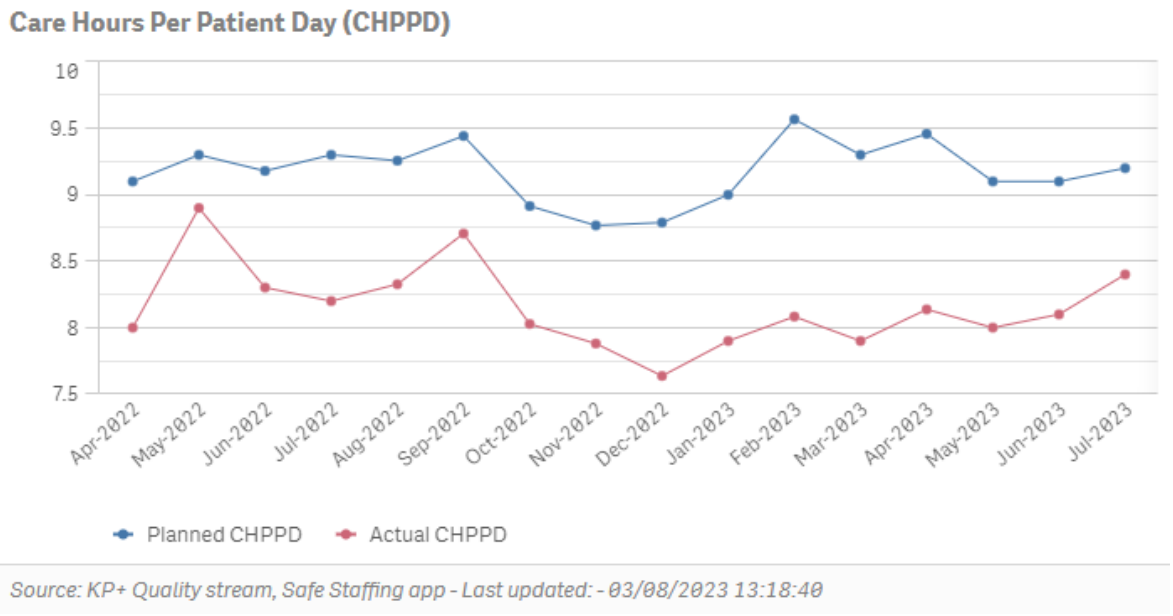
Actions:
As noted above there was an increase in overall deaths in December 2022 and notable increase from the average number of monthly deaths in the Emergency Department. A review of these deaths is being undertaken to clarify that this is due to a spike in acute, co-morbid patients and not due to any issues with care delivery.

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.



Source: KP+ Quality stream, Safe Staffing app - Last updated: - 03/08/2023 13:18:40

What does the chart show/context:
The actual CHPPD is less than the planned. For July 2023 the planned CHPPD was 9.2 and the actual was 8.4. The step change in the planned CHPPD in February reflects the inclusion of additional shifts required for 1:1 care which were previously excluded from the planned data.

The latest data in Model Hospital is from May when CHFT reported providing 8.0 CHPPD against a peer median of 8.8 and a national median of 8.8.

Underlying issues:
The CHPPD deficit reflects unfilled shifts of both the registered and unregistered workforce.

Actions:
Reducing the CHPPD deficit is dependent on having the right workforce aligned to appropriate workforce models.

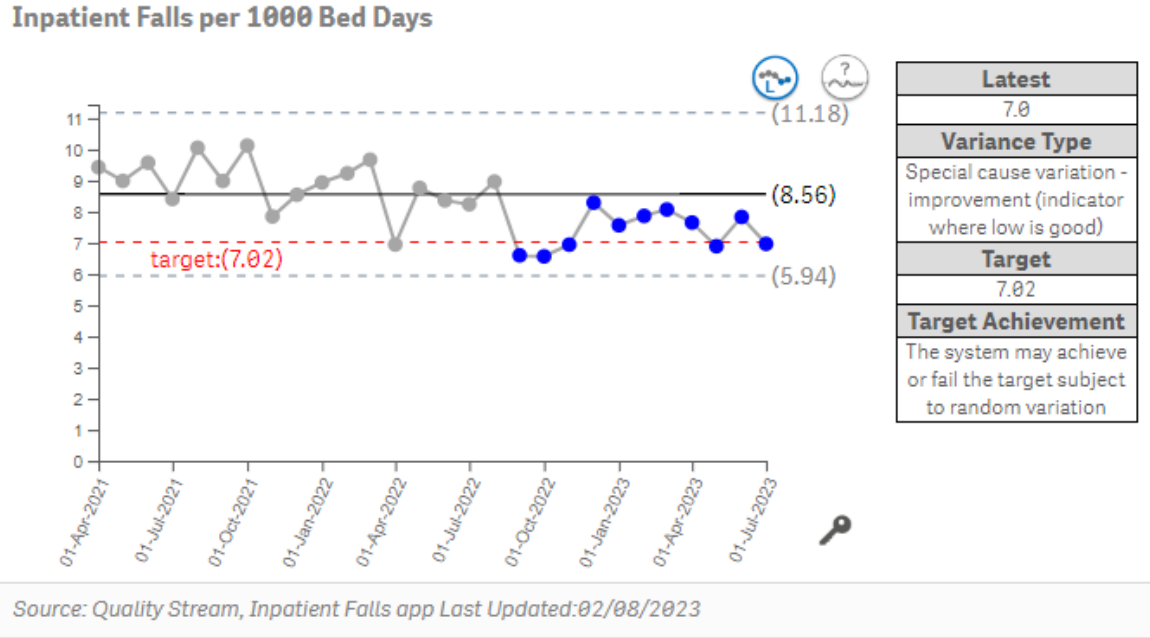
- The recent Safer staffing (Hard Truths) review process provides assurance of the correct workforce models based on evidence-based acuity and dependency data, agreed nurse sensitive quality indicators and professional judgement. In addition to supporting approved changes.
- Recruitment strategies including employment of new graduates; internationally educated nurses, midwives, and AHPs and supporting apprenticeships are focussed on closing the vacancy gap and subsequent agency spend.
- There is a comprehensive retention strategy aimed at preventing attrition of staff overseen by the workforce steering group.
- Strong roster management maximises efficiency of the available workforce.
- Twice-daily staffing meetings 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:
There rate of inpatient falls for July was 7.0. Currently performance can be expected to vary from 5.94 to 11.18. The last 11 months have been under the average and therefore indicate an improvement in performance.

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

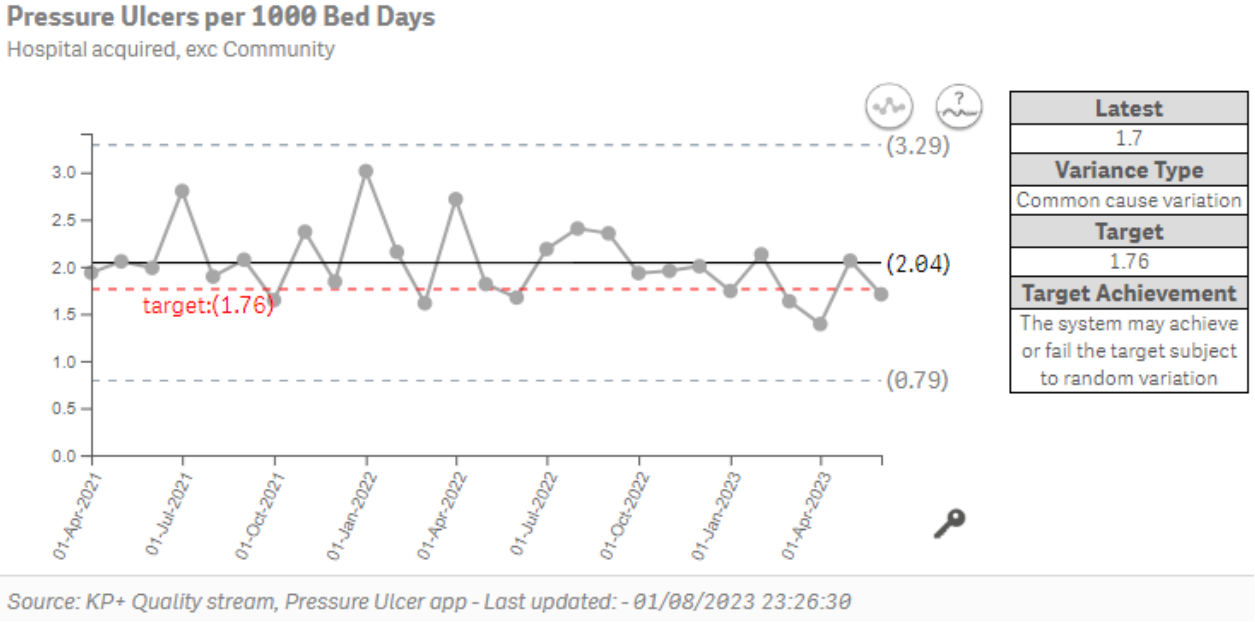
Actions:
- Relook at the TOR of the falls collaborative.
- Falls link nurses to be allocated and invited.
- Appoint a medical lead to lead falls.
- Renee to continue with reconfiguration plan around the enhanced care team.
- Education as part of the revamped Enhanced Care team processes and assessments
- Live dashboard being created by Informatics so we can see patients who have not had assessments completed.
- New nursing admission/assessment documentation launching on 17th July.
- Rhys has now joined a WYAAT falls collaborative and has 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.

Hospital Acquired Pressure Ulcers per 1,000 Bed Days

Executive Owner: Lindsay Rudge Clinical Lead: Judy Harker 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:
There rate of Hospital Acquired Pressure Ulcers for June was 1.7. 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 0.76 to 3.29.

Underlying issues:
A total of 1,187 CHFT newly acquired pressure ulcers occurred in 2022/2023. This compares with 1,008 in 2021/2022. A total of 16% pressure ulcers were associated with a dying patient for 2022/2023. The Trust is not consistently risk assessing patients in a timely manner resulting in a potential delay in initiating preventative care. Medical device related PUs continue to occur. 12% of PUs were caused by devices in 2022/23, some of which were deemed avoidable.

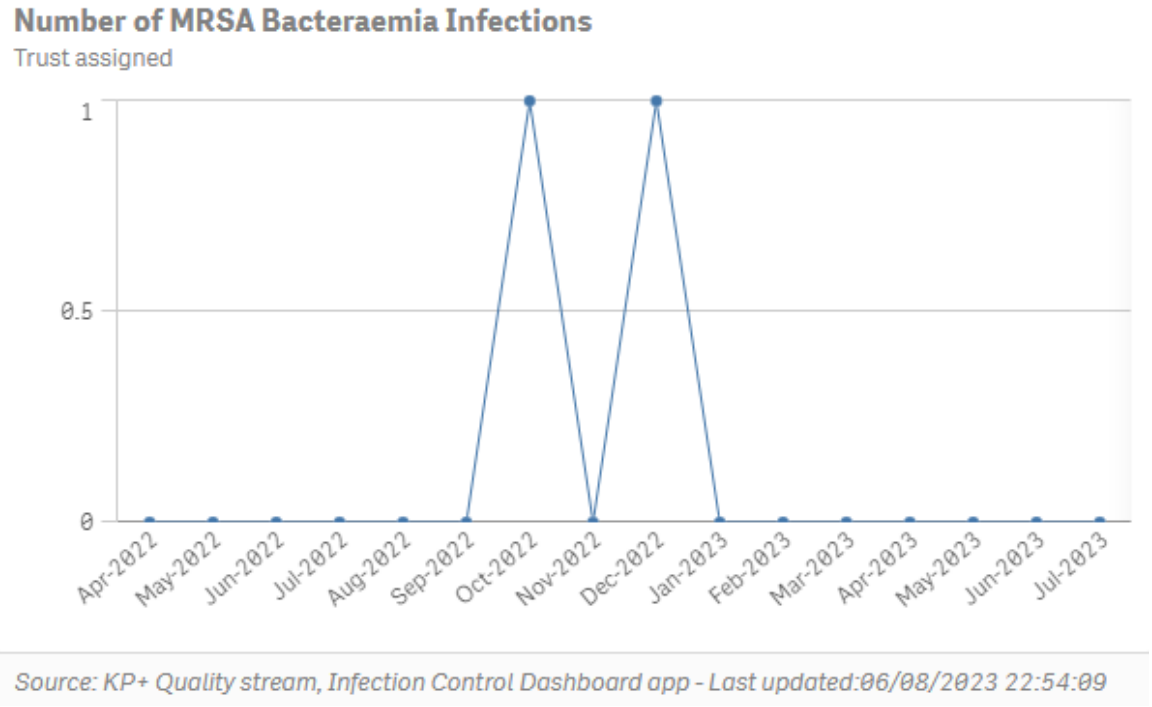
Actions:
- PURPOSE T PU risk assessment tool replacing Waterlow on 17th July 2023
- New revised care plans implemented for hospital and community to align with PURPOSE T
- PU CQUIN data collection has commenced
- Processes for PU investigations and learning being reviewed in line with PSIRF
- Heel PU audit being undertaken in Orthopaedics as part of national PRESSURE 3 RCT
- Ongoing QI work as part of PU Collaborative
- New elfH PU training being rolled out in July 2023
- New dynamic air mattresses have been purchased to replace old stock at CRH

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 July. The Trust is unable to consistently meet the target of 0 infections and may achieve or fail subject to random variation.

Underlying issues:
Staphylococcus aureus (SA) is a common bacteria which many people carry on their skin or in their noses without any symptoms or infections developing. MRSA is an antibiotic resistant SA. MRSA infections associated with deep abscess, pneumonia, invasive devices, prosthetic joints and implants can result in a bacteraemia.
The key control measures are:

- Admission screening and isolation
- Colonisation suppression
- Use of ANTT
- Environmental and equipment disinfection

Actions:

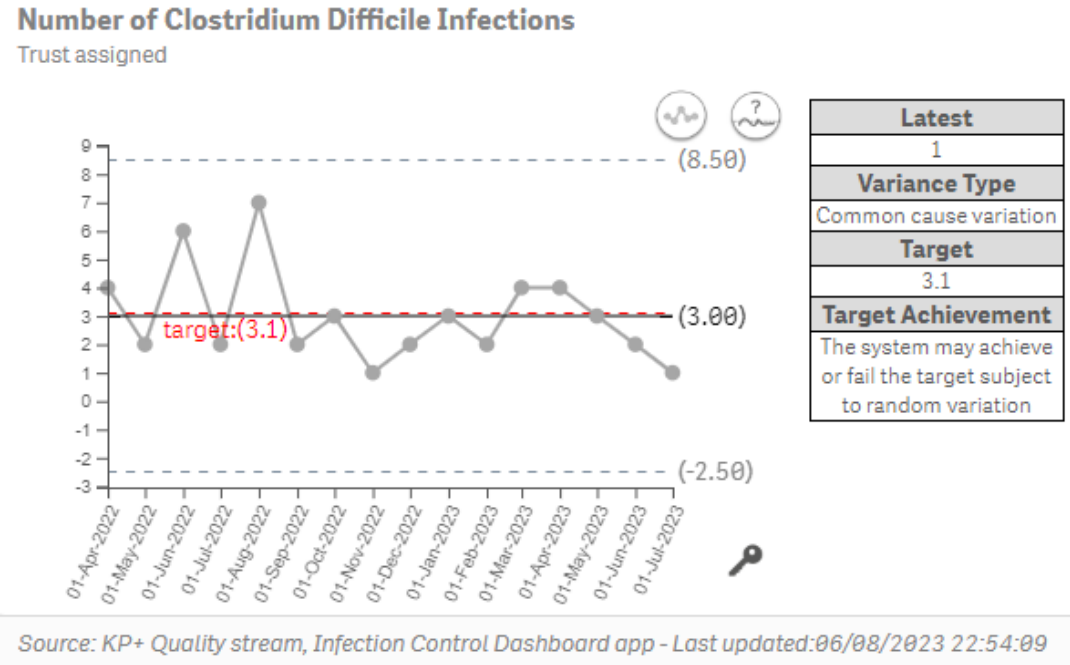
- Admission/pre-admission MRSA screening is monitored. Data accuracy has been an issue. An initial data cleanse has been completed and improvements seen. A further piece of work is underway with FSS.
- Colonisation suppression prescribing is via a POWERPLAN in EPR. Visual user guides are provided to patients to ensure correct application.
- Isolation guidance and signage is in place.
- ANTT and IPC level2 training is mandated for clinical staff and monitored through the divisional PSQBs and IPC Performance Board. Both require improvement.
- Implementation of the National Standards of Cleaning is complete in the hospital sites and rolling out in the community sites. Disinfectant wipes remain in use.
- 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 was 1 C.Difficile infection in July. 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 8.50.

Underlying issues:
Clostridium Difficile is a bacterial infection acquired through the ingestion of spores which readily survive in the environment and are unaffected by standard disinfectants.
Key control measures are:
- Early identification of symptoms, isolation and testing
- Prevention through antimicrobial stewardship.

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.

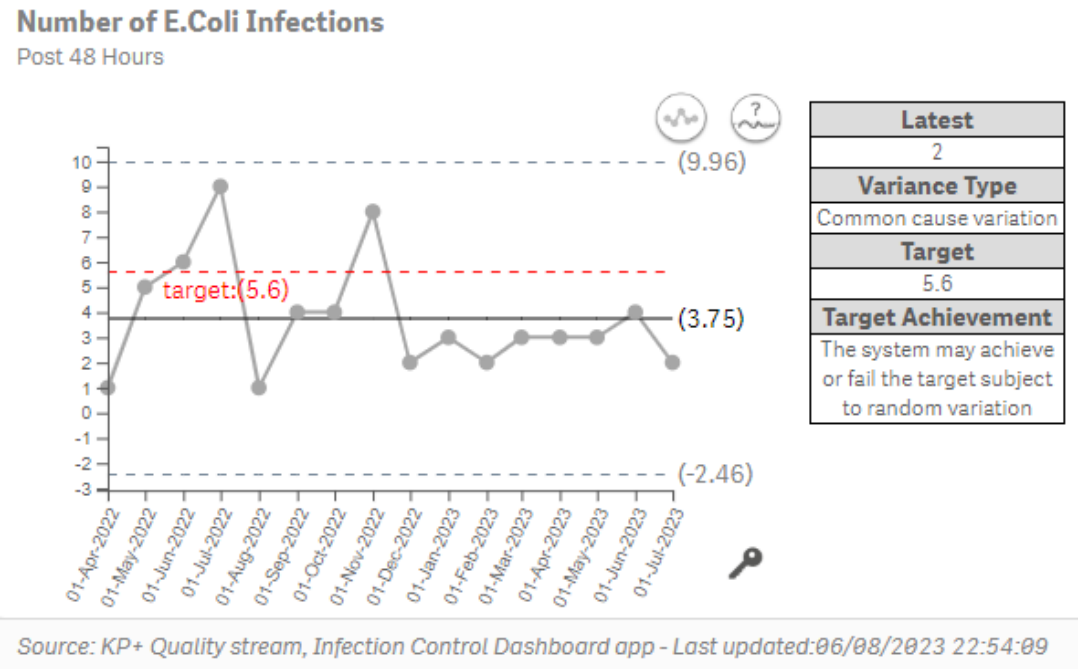
Actions:
The Trust has implemented an improvement plan including a programme of HPV deep cleaning (to be agreed), C.Diff ward rounds, antimicrobial ward rounds and a review of the investigation process for cases. NHSEI has carried out a support visit in March, with positive feedback. Their recommendations 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 were 2 E.Coli infections in July. 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 9.96.

Underlying issues:
Being part of the normal gut flora, E.Coli bacteraemia are often associated with urinary tract infections, hepatobiliary procedures etc. 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.

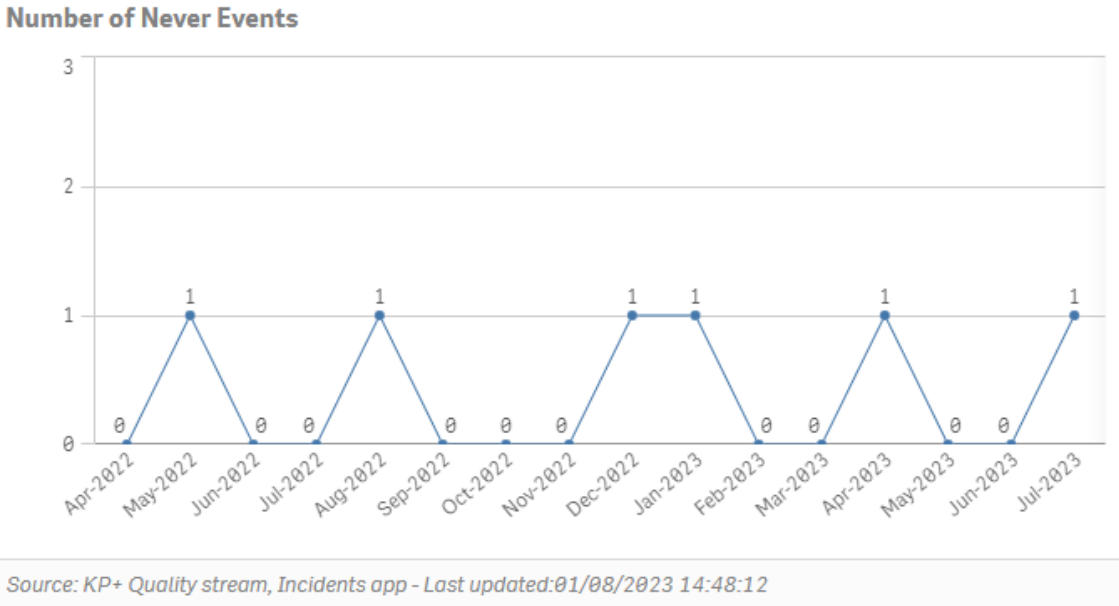
Actions:
- Extended surveillance of all the cases is conducted and uploaded to the UKHSA DCS system for national analysis.
- As part of the workplan of the IPCT, an annual audit of catheter management has been completed and recommendations shared with the divisions for implementation.
- A regional working 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:01/08/2023 14:48:12

What does the chart show/context:
The Trust is unable to consistently meet the target and may achieve or fail subject to random variation month to month.

Underlying issues:
There was 1 never event reported in July 2023 which is currently under investigation.

Actions:
- SWARM huddles are held following all Never Events reported and Immediate learning is identified to keep our patients and staff safe
- 3 x investigations are currently ongoing

Number of Serious Incidents

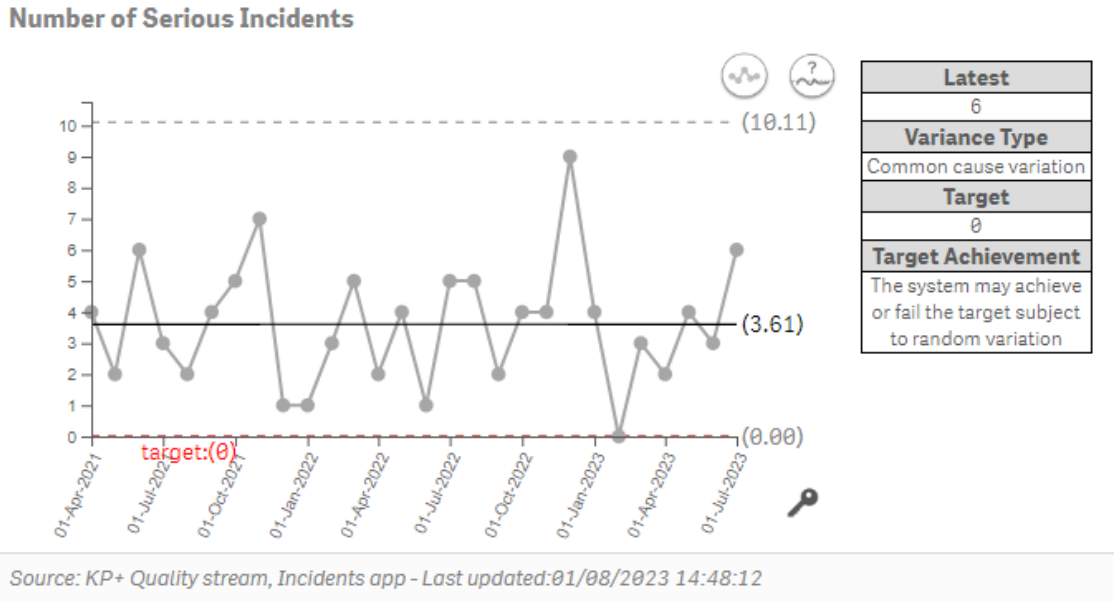
Executive Owner: Lindsay Rudge Anderson

Operational Lead: Sharon Cundy

Business Intelligence Lead: Charlotte

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 was 6 serious incidents reported in July 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 10.11.

Underlying issues:
In total there were 6 incidents validated at SI panel as a serious incident in the month of July that resulted in severe or catastrophic harm to patients meeting the SI framework. These were reported across 3 divisions: 2 for Families and Specialist Services, 3 for Medical and 1 for Surgical & Anaesthetics Services.

The most common reported type of incidents resulting in severe/ catastrophic harm/death to patients is diagnosis, failed or delayed.

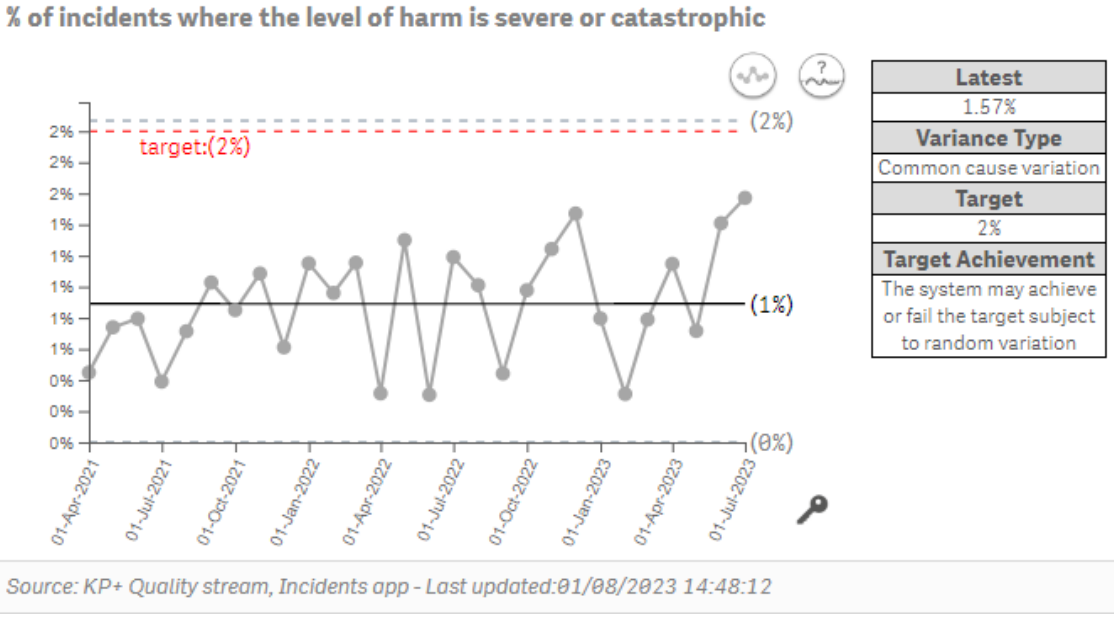
Actions:
Risk management team and Quality Governance Leads continue to support the Divisions to review data for learning. In addition, Quality & Safety Team working with Care of the Acutely Ill Patient Lead to ensure quality improvements are commenced where required. This will align to the Quality Priority for Care of the Acutely Ill Patient and the CQUIN for 2023/24.

% 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



Source: KP+ Quality stream, Incidents app - Last updated:01/08/2023 14:48:12

What does the chart show/context:
1.57% of all harm reported in July 2023 was severe or catastrophic. The Trust may achieve or fail the target subject to random variation. Currently performance can be expected to vary from 0 to 2%.

Underlying issues:
In total there were 6 incidents submitted in the month of July, which included 1 Never Event. All 6 incidents were categorised as severe or catastrophic harm and these were reported across 3 divisions: 1 for Families and Specialist Services, 3 for Medical and 2 for Surgery & Anaesthetics. Not all of these incidents will be validated in July as awaiting presentation at Serious Incident (SI) Panel.

The incidents reported are currently within the upper control limits.

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.

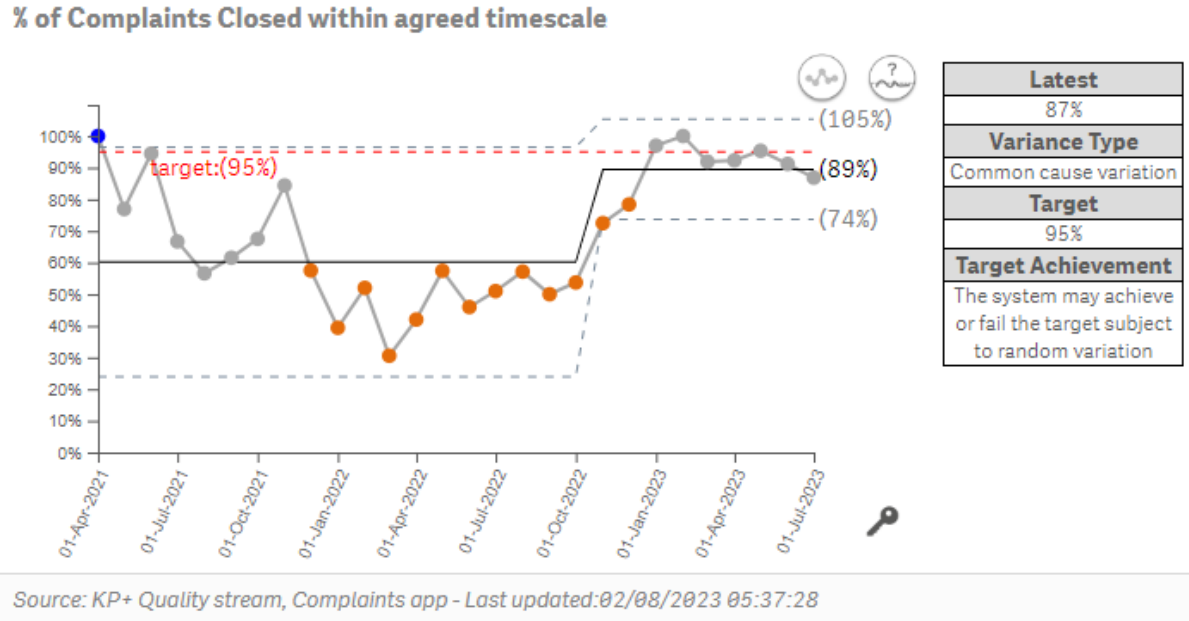
To monitor the trend within the upper controls limits to ascertain reasons for variation.

% 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 July was 87%. The Trust is unable to consistently meet the 95% target however improved performance has been maintained. Currently performance can be expected to vary from 74% to 100%.

Underlying issues:
The Trust's target of 95% has not been met this month. Compared to recent months, 87% is lower than aspired to. Unfortunately the Trust's FSS Division's individual performance of 75% has lowered the Trust's overall performance, however we continue to work collaboratively with Divisions. The Division of Medicine has also seen a slight drop in their performance.

Actions:
Escalated to Divisional Leads for complaints to ensure everything is being done to respond to complainants within agreed timeframes. Continue to monitor Trust performance daily and meet with Divisions on a weekly basis to maintain oversight of performance.

Quality Priorities:

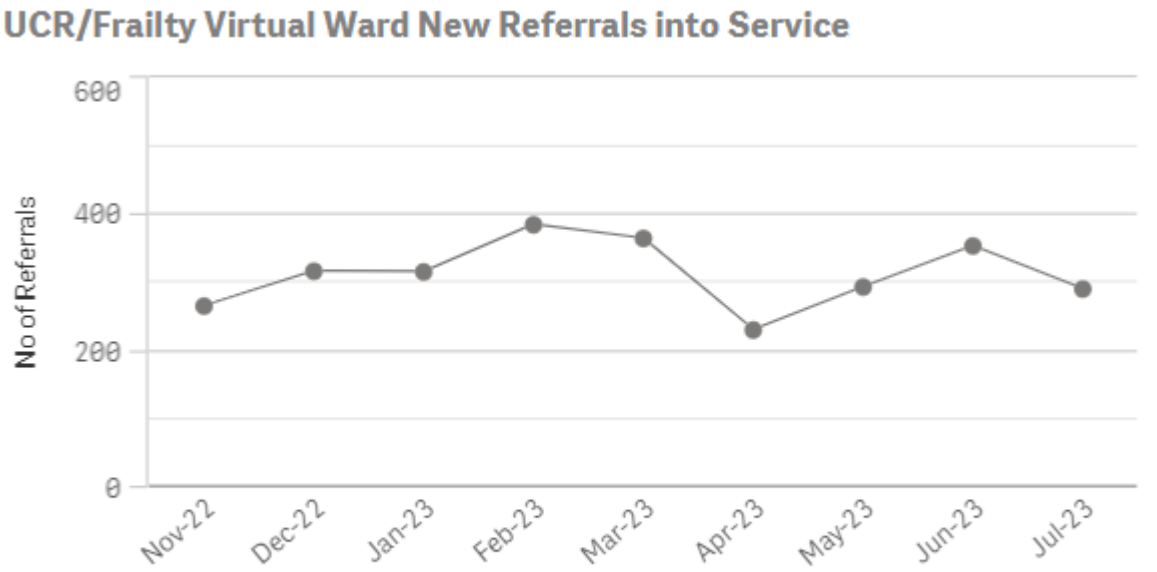
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Alternatives to Hospital Admission – Number of referrals into the Frailty service	July 2023	354	TBC	-	-	-	-	-
% of episodes scoring NEWS of 5 or more going on to score higher	July 2023	30.2%	30%			32%	27%	36%
% of adult patients that receive a MUST assessment within 24 hours of admission/transfer to the ward.	July 2023		95%					

Alternatives to Hospital Admission – Frailty Service

Executive Owner: Lindsay Rudge Clinical Lead: Renee Comerford/ 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 06/08/2023 08:00:48

What does the chart show/context:
New referrals into service for the whole Urgent Community Response / Frailty Virtual Ward service. Average of 313 per month for all. 291 July 2023.

Underlying issues:
Data includes Locala patients referred into CHFT SystmOne unit by CHFT Pharmacists as an interim measure to manage these patients' medication needs until access to Locala SystmOne units was configured for them.
Due to no 7-day consultant cover, the team have to be selective with who they accept onto a virtual ward service towards the end of the week to ensure they do not require an MDT over the weekend.
Staffing across Locala has impacted the number they can safely care for at home, so this has been reviewed weekly.

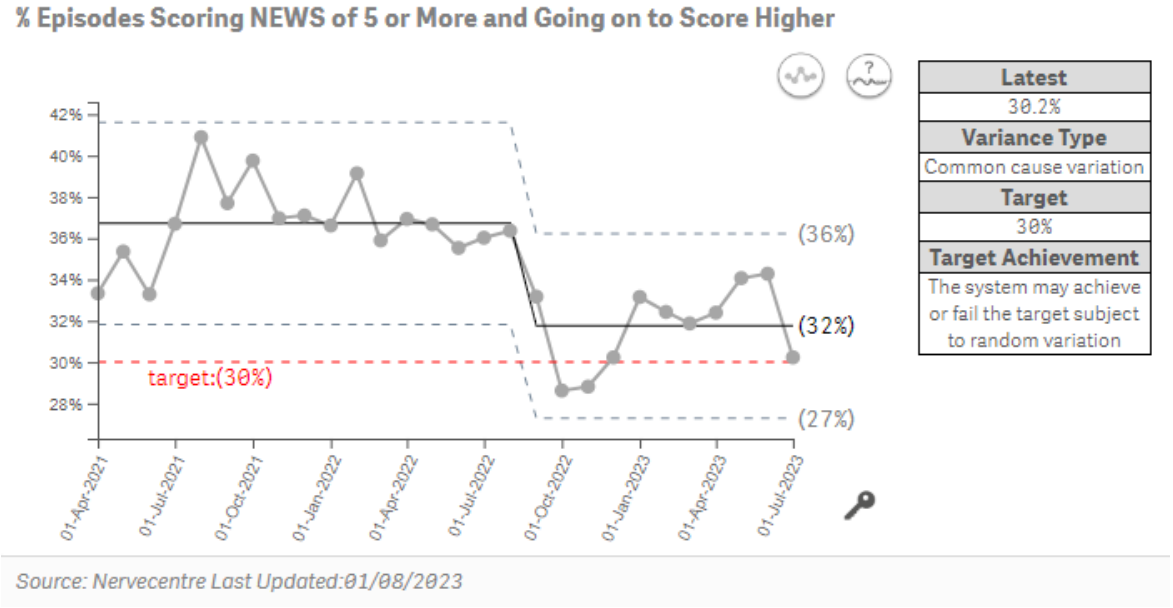
Actions:
Medical division reviewing medical cover to support a 7-day MDT for Frailty virtual ward. Other organisations have not all been able to recruit consultants but backfilled with a registrar.
The Advanced Clinical Practitioner working on Frailty SDEC on a weekend is supporting Kirklees virtual 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 all areas. More comms going out and more engagement planned.
Next phased step-up pathway being designed to take GP and day patients as currently just from UCR. 12 beds available now for Frailty which is above trajectory.
Team attend the safety huddles each day at CRH to support comms and pull patients out.
Recruitment ongoing for Kirklees - this has been successful.

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 30.2% in July. 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 27% to 36%.

Underlying issues:
- Staff training and understanding of escalation parameters
- Doctors do not carry NerveCenter devices "in hours"
- Raised news2 often closed down by the system as not actioned
- Observations not carried out on time in line with policy
- Appropriateness of plan when escalation is raised

Actions:
- All divisions have a consistent representative at the Deteriorating Patient & Sepsis collaborative.
- Ward Managers and Matrons to regularly check KP+ for their Observations on Time performance.
- Deteriorating Patient CQUIN audit will highlight any further actions to be fed through Deteriorating Patient & Sepsis collaborative.

Health Inequalities: Learning Disabilities

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Emergency Care Standard	July 2023	65%	76%		F	62%	48%	75%
Outpatients DNAs	July 2023	9.2%	3%		?	9%	3%	15%
Cancer Faster Diagnosis Standard	July 2023	57.1%	75%		?	62%	0%	100%
% of patients waiting less than 6 weeks for a diagnostic test	July 2023	95.9%	95%		?	87%	74%	100%
Patients waiting more than 40 weeks to start treatment	July 2023	2	0	L	P			

Health Inequalities: Deprivation (IMD 1 and 2)

Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Emergency Care Standard	July 2023	70.2%	76%			72%	65%	79%
Outpatients DNAs	July 2023	9.3%	3%			9%	8%	11%
Cancer Faster Diagnosis Standard	July 2023	68.7%	75%			76%	63%	89%
% of patients waiting less than 6 weeks for a diagnostic test	July 2023	86.7%	95%			88%	74%	100%
Patients waiting more than 40 weeks to start treatment	June 2023		0					

Emergency Care Standard: Learning Disability

Calderdale and Huddersfield NHS Foundation Trust

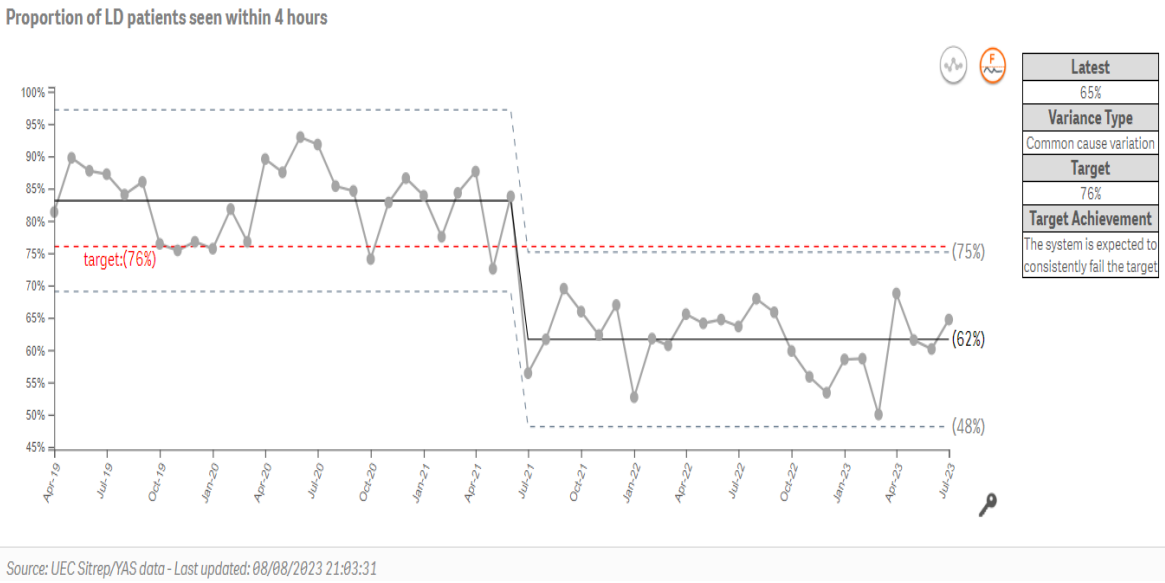
Executive Owner: Rob Aitchison

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.



Source: UEC Sitrep/YAS data - Last updated: 08/08/2023 21:03:31

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 48% and 75%. The performance for July was 65% which is lower than the overall Trust performance of 72% and below the Trust mean of 68% 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:

- Patients who attend the ED and are identified as having a learning disability will be prioritised for cubicle spaces removed them from potentially busy and noisy waiting room environments.
- Patients who attend the ED and are identified as having a learning disability and requiring an invasive procedure, blood, cannular etc. All attempts will be made to full communicate this to the individual in a way that is appropriate and will be performed by two members of staff so distraction and comfort techniques can be performed during the procedure.
- Patients who attend the ED and are identified as having a learning disability will be provided with a learning disability pack, which contains bit of equipment that can be used by the patient during their ED and potential onward hospital stay to reduce anxieties and provide a more comforting environment.
- 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 Learning disabilities in ED and the issues, we can review any improvement work/reasonable adjustments that are required and monitor.

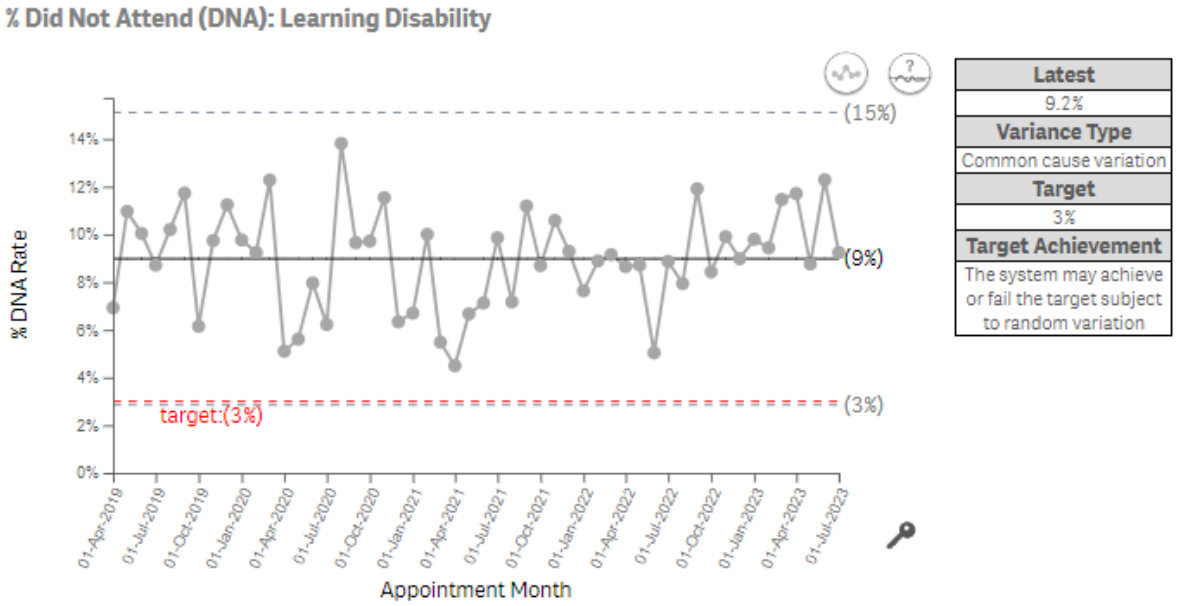
% Did Not Attend (DNA): Learning Disability

Calderdale and Huddersfield NHS Foundation Trust

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.



Source: Cerner EPR Last Updated: 02/08/2023

What does the chart show/context:
The current DNA rate for appointments for patients with learning disabilities stands at 9.2% for July 2023. This performance has remained within the expected range from April 2019 to date and shows consistent common cause variation throughout that time. This sits above the DNA % for the wider population at CHFT for outpatient appointments which currently stands at 6.4% for July 2023. This performance is an improving position from June 2023 which stood at 12.3%.

Underlying issues:
- Need to audit DNAs to understand reasons for high DNA rate for LD 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.

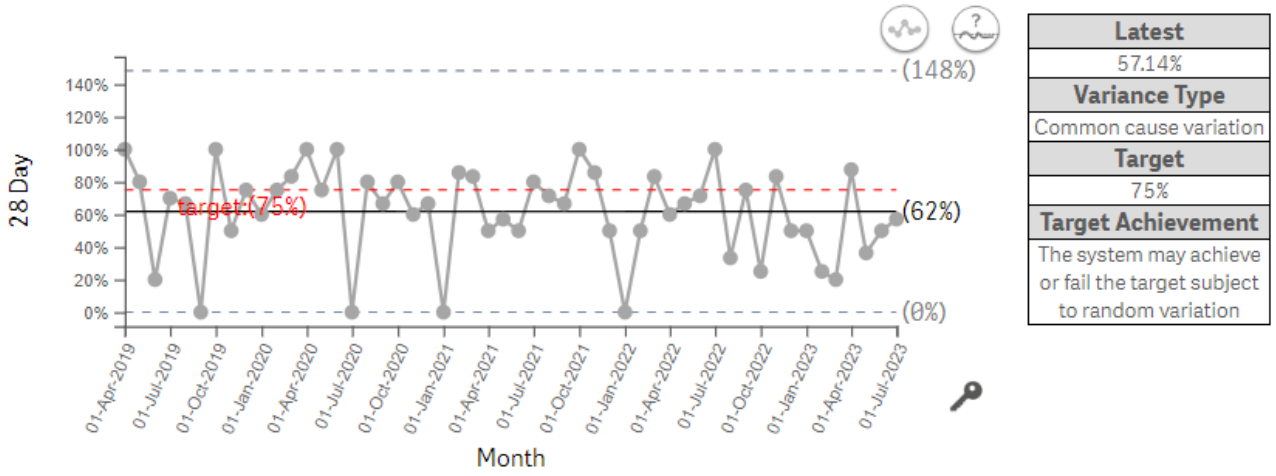
Proportion of patients meeting the faster diagnosis standard: Learning Disability

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 definitely excluded. Target 75%.



Latest
57.14%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- Latest monthly performance stands at 57% which is below the NHSE target and below performance for non-LD 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:
- Need to audit breaches to understand reasons for non-compliance of FDS for LD patients.
- 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.

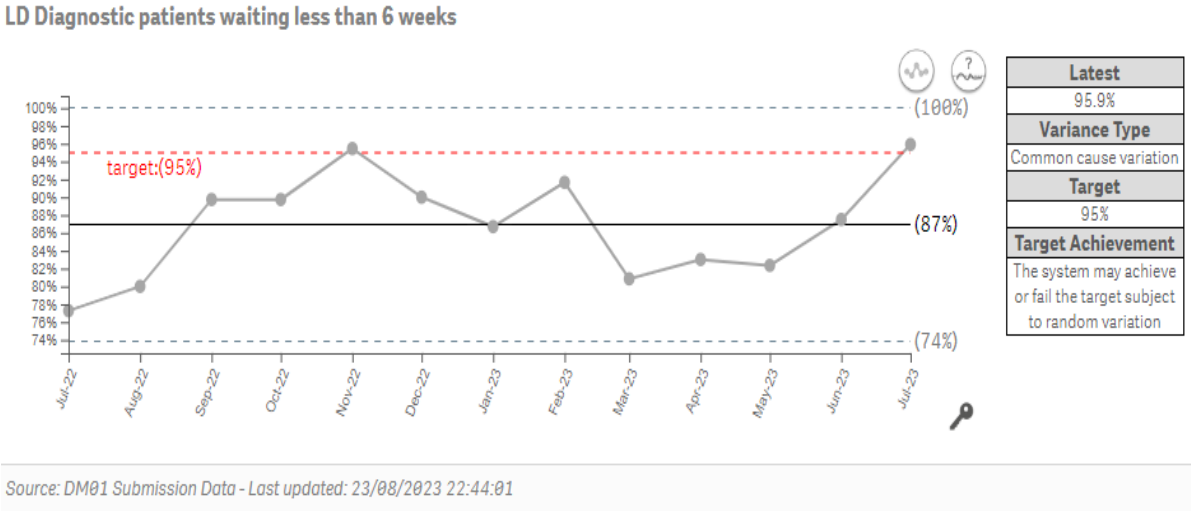
Percentage of patients waiting less than 6 weeks for a diagnostic test: Learning Disability

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: 23/08/2023 22:44:01

What does the chart show/context:
- Latest monthly performance stands at 95.9% 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 74% and 100%.

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

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

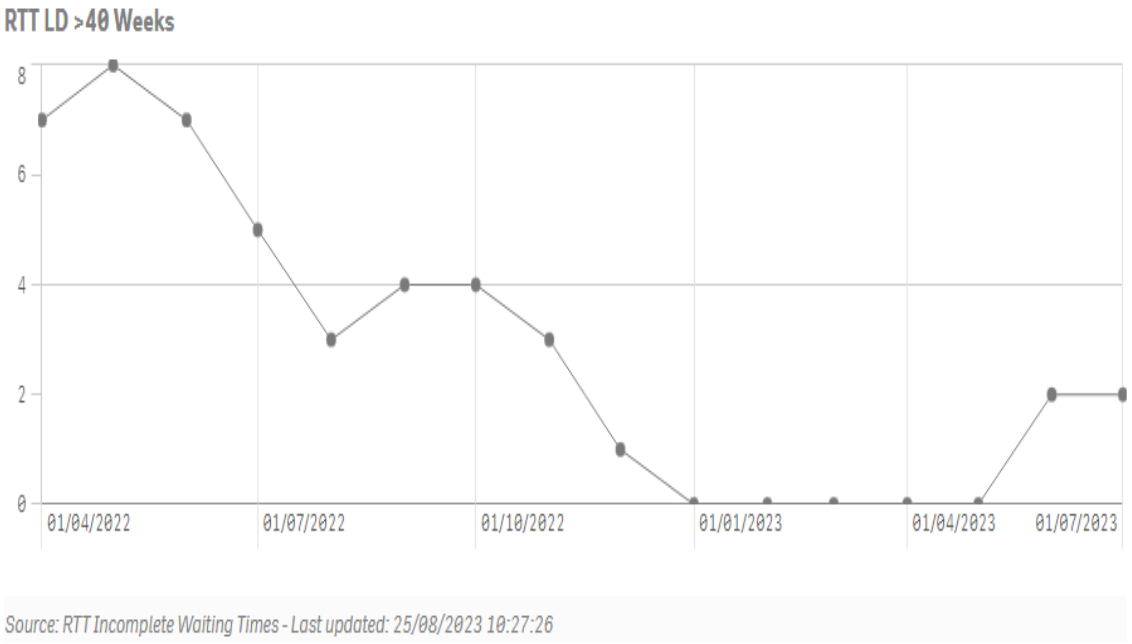
Total Patients waiting more than 40 weeks to start consultant-led treatment: Learning Disability

Calderdale and Huddersfield NHS Foundation Trust

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:

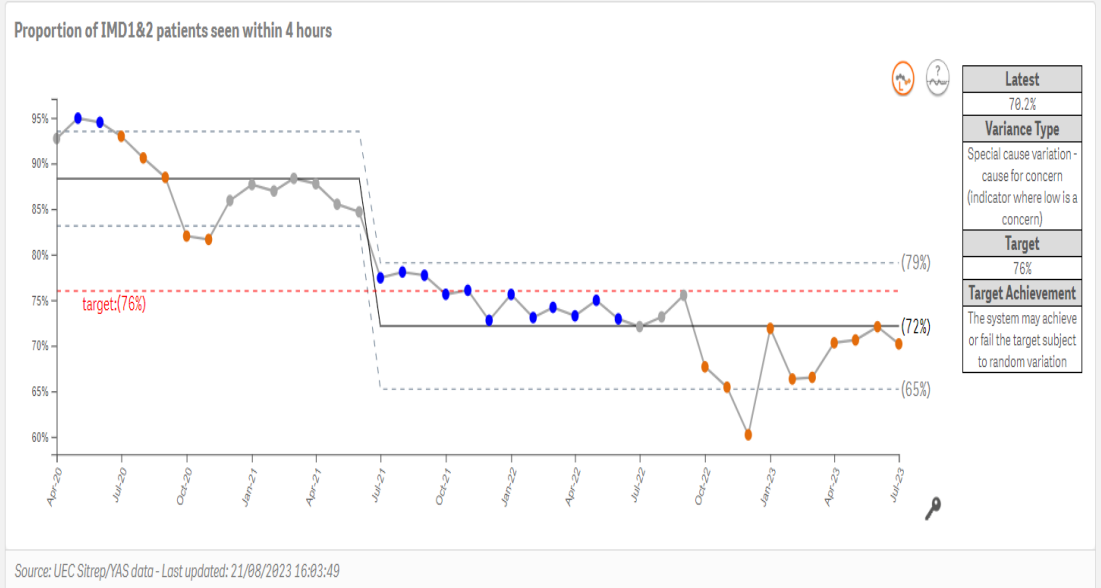
Emergency Care Standard: Deprivation (IMD 1 and 2)

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 48% and 75%. The performance for June was 65% which is lower than the overall Trust performance of 72% and below the Trust mean of 68% 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.

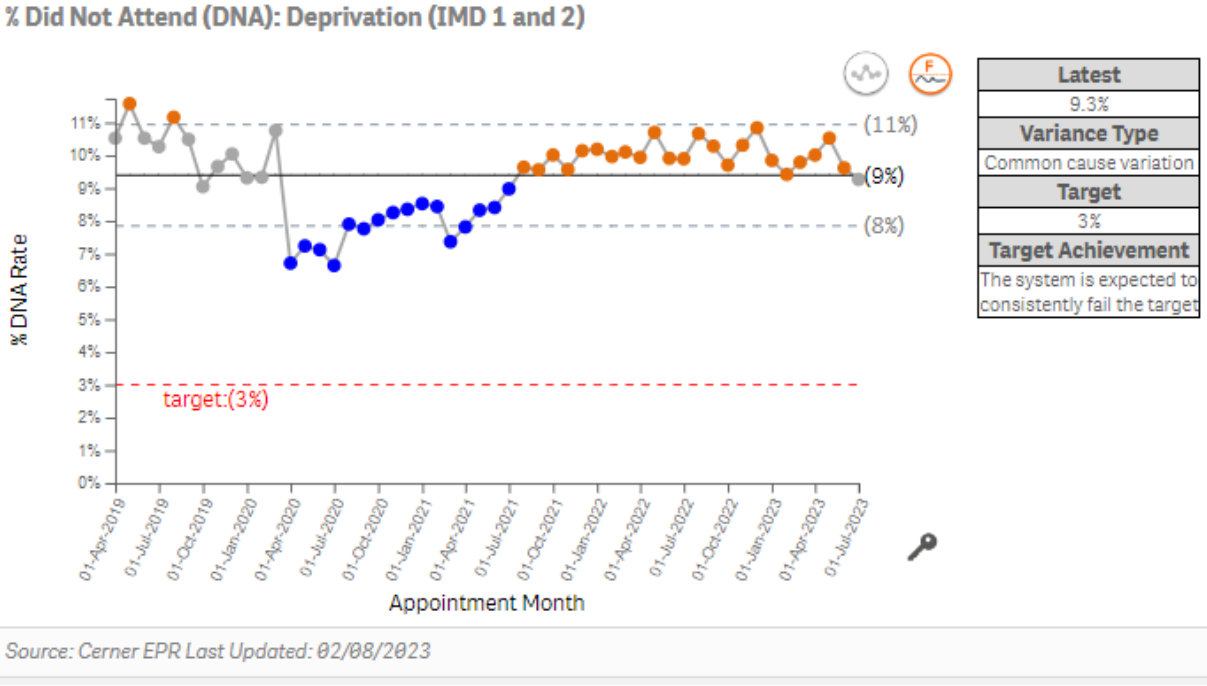
Actions:

% 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.



Source: Cerner EPR Last Updated: 02/08/2023

What does the chart show/context:
The current DNA rate for appointments for patients from the IMD 1 and 2 groups stands at 9.3% for July 2023. This performance has remained within the expected range from April 2019 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 6.4% for July 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.

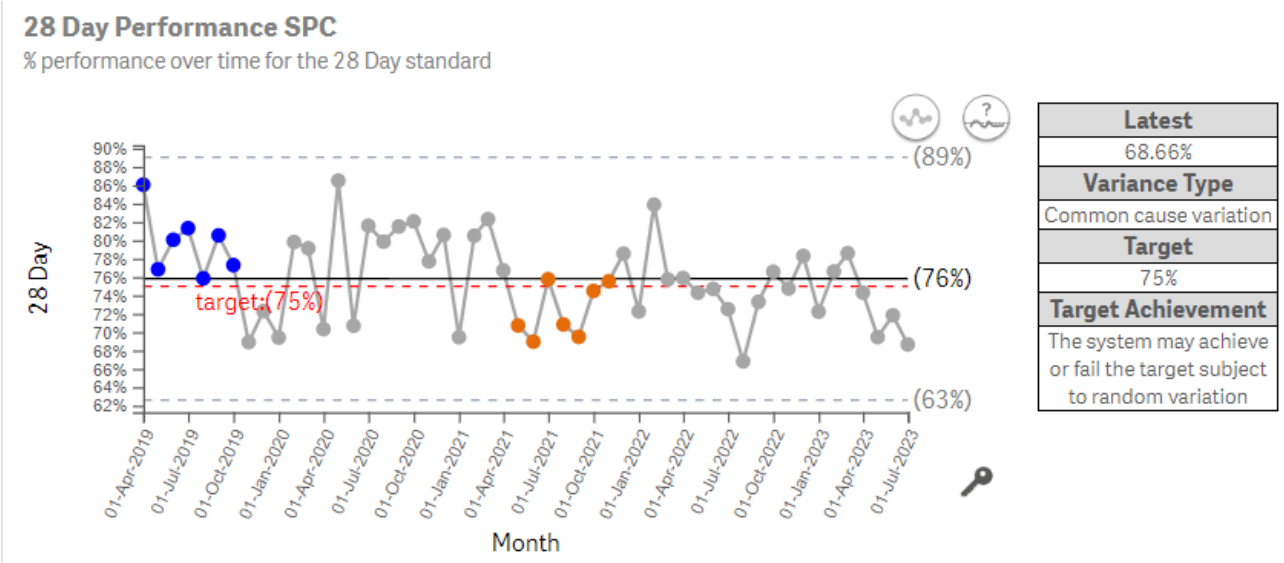
Proportion of patients meeting the faster diagnosis standard: Deprivation (IMD 1 and 2)

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 definitely excluded. Target 75%.



Latest
68.66%
Variance Type
Common cause variation
Target
75%
Target Achievement
The system may achieve or fail the target subject to random variation

What does the chart show/context:
- Latest monthly performance stands at 68.6% which is below the NHSE target however currently performing better than the Trust performance overall.
- The Trust is unable to consistently meet the target of 75% and may achieve or fail the target subject to random variation. Performance can be expected to vary between 63% and 89%.

Underlying issues:

Actions:

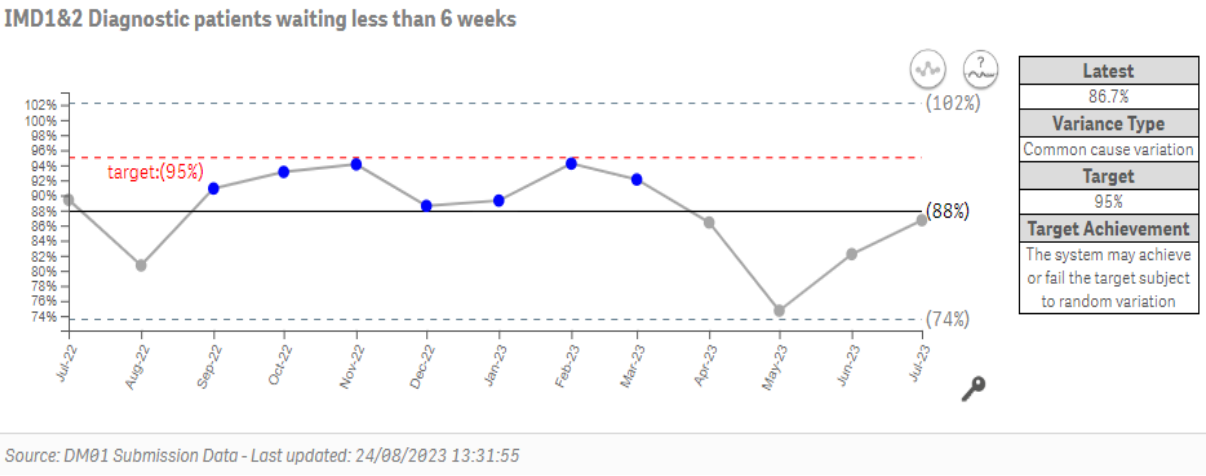
Percentage of patients waiting less than 6 weeks for a diagnostic test: Deprivation (IMD 1 and 2)

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%.



Source: DM01 Submission Data - Last updated: 24/08/2023 13:31:55

What does the chart show/context:
- Latest monthly performance stands at 86.7% 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 74% and 100%.

Underlying issues:

Actions:

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

NHS Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Rob Aitchison 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:

Underlying issues:

Actions:

Workforce:

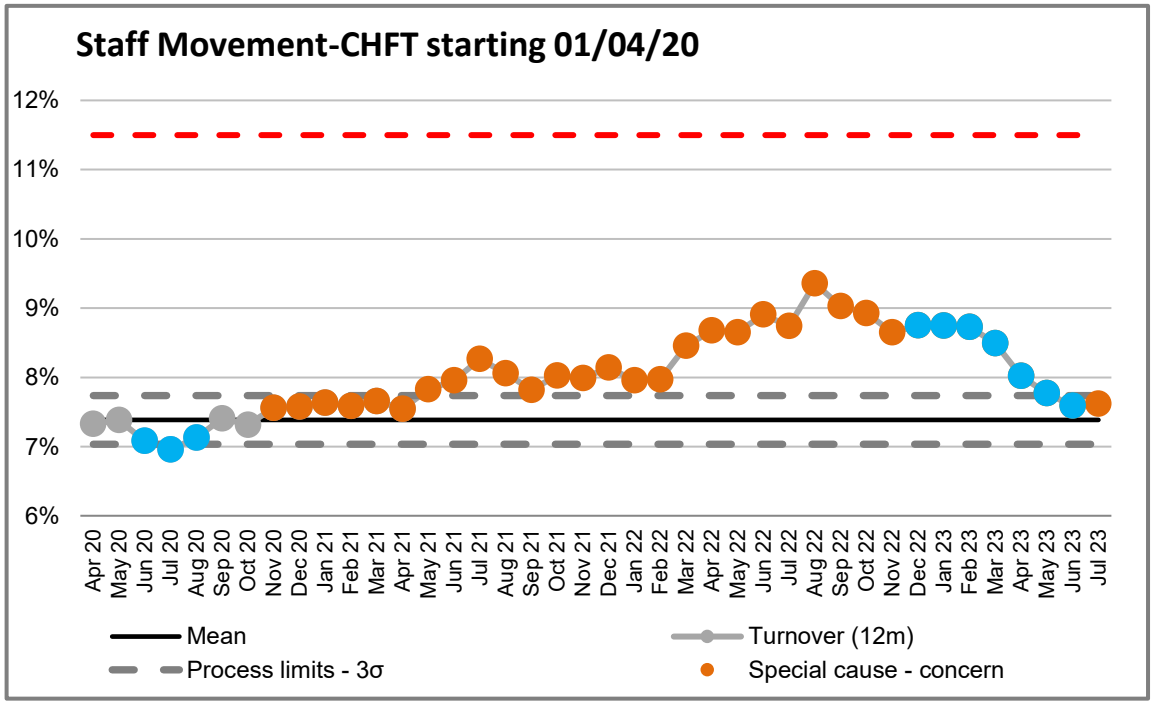
Metric	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Movement (Turnover)	July 2023	7.62%	11.5%			7.38%	7.03%	7.74%
Sickness Absence (Non-Covid)	July 2023	4.80%	4.75%			4.84%	5.48%	4.21%
Appraisal Compliance (YTD)	July 2023	38.37%	95.0%	-	-	-	-	-
Core EST Compliance	July 2023	94.99%	90.0%			93.03%	92.02%	94.03%
Bank Spend	July 2023	£3.14M	£1.60M			£3.14M	£1.57M	£4.70M
Agency Spend	July 2023	£0.95M	£0.53M			£0.97M	£0.65M	£1.28M

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: 7.62%**



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%.
- Turnover rates have continued to be above the mean average.
- July 2023 rolling turnover rate has increased to 7.62% from 7.59% in June.

Underlying issues:
Estates and Ancillary, and Additional Science and Technical staff groups have turnover rates above the Trust target of 11.50%

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.

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.

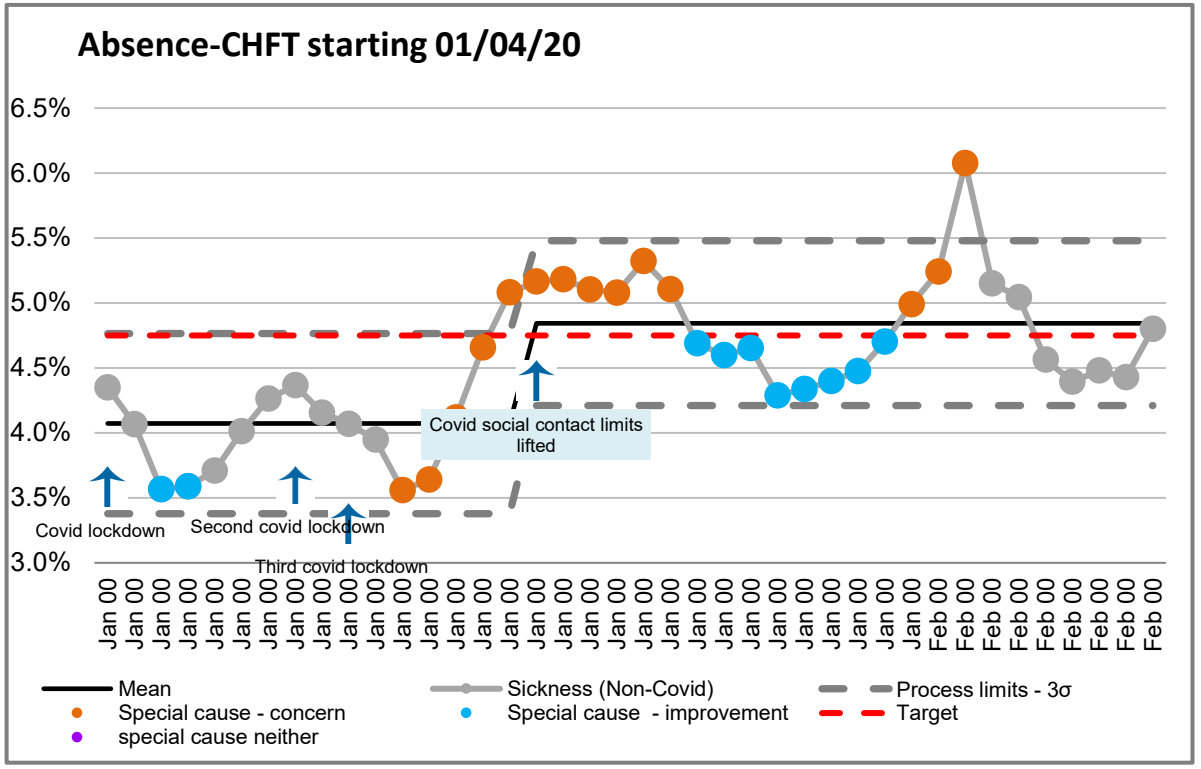
Sickness Absence (Non-Covid)

Calderale and Huddersfield NHS Foundation Trust

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: 4.80%**



What does the chart show/context:

- Absence rate of CHFT colleagues due to non-covid sickness reasons, as recorded in ESR / Allocate. Calculated as a percentage of FTE Days Lost within the reporting month.
- From March 2021 sickness saw an upward trend as Covid restrictions began to be relaxed.
- December 2022 saw unusually high levels of sickness absence due to Cough/Cold/Flu and has since returned to normal seasonal variation as we moved into spring and summer months.
- The mean and target for absence are very similar causing compliance to be hit and miss on a monthly basis.

Underlying issues:
Top 3 reasons for sickness in July 2023 – Anxiety/Stress/Depression, Gastrointestinal problems and Other musculoskeletal problems.

Actions:

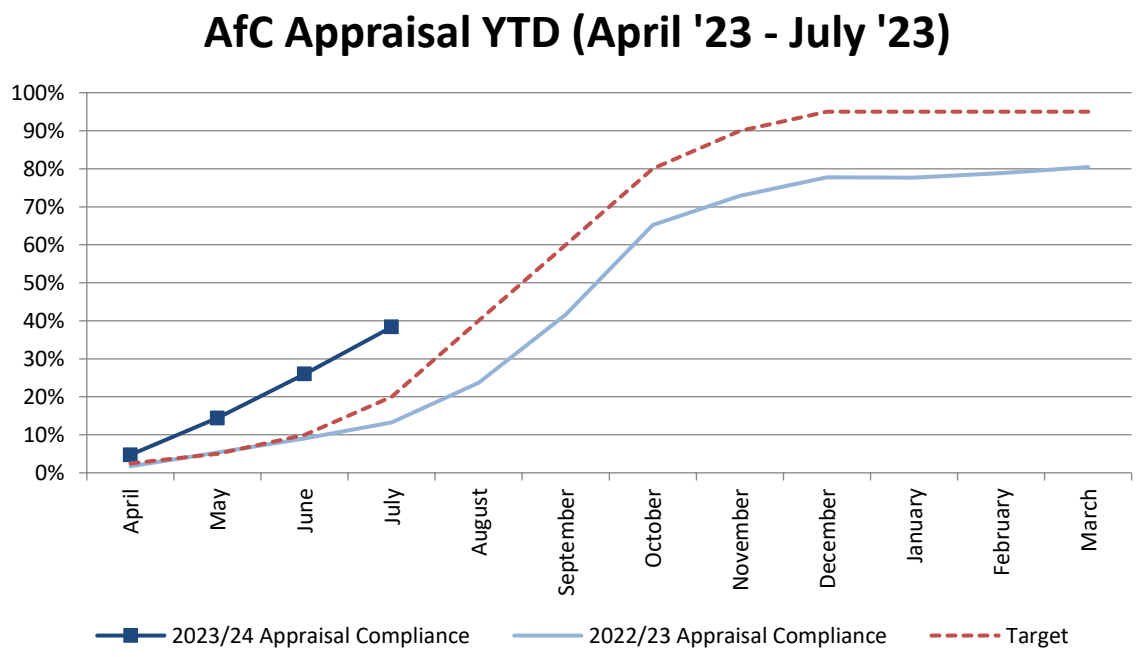
- Identify divisional hotpots for age/gender group and focus on these with line managers to reduce absences, identify and themes or trends and options for supporting colleagues.
- Promotion of physio provision for all MSK absences and reporting on the number of absences prevented because of the MSK intervention and where colleagues have returned to work sooner.
- Roll out of the Menopause policy and support available.
- HRBP's 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.
- To support managers the HR team are developing and recording short video clips of `How to' for managers which is accessible 24/7. HRBPs working with divisions to hold appropriate deep dives into hotspot areas. HR Team holding monthly meetings to discuss every long-term absence case and ensure an appropriate management plan is in place.
- Absence data to be presented at Executive Board meeting on a regular basis to ensure focus on reducing the level of absence.
- Management guidance developed to support manager with reasonable adjustments and how to utilise Access to Work for colleagues with underlying health conditions or a disability.

Appraisal

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

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

Target: 95.0% (Annual), 20.0% (in month) **Current: 38.37% (in month)**



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

Underlying issues:
- Time and availability of colleagues to undertake appraisal.
- Accurate and timely recording of appraisal conversations on ESR.
- Challenge to colleagues around appraisal being a “tick box” exercise.
- Seasonal variance.

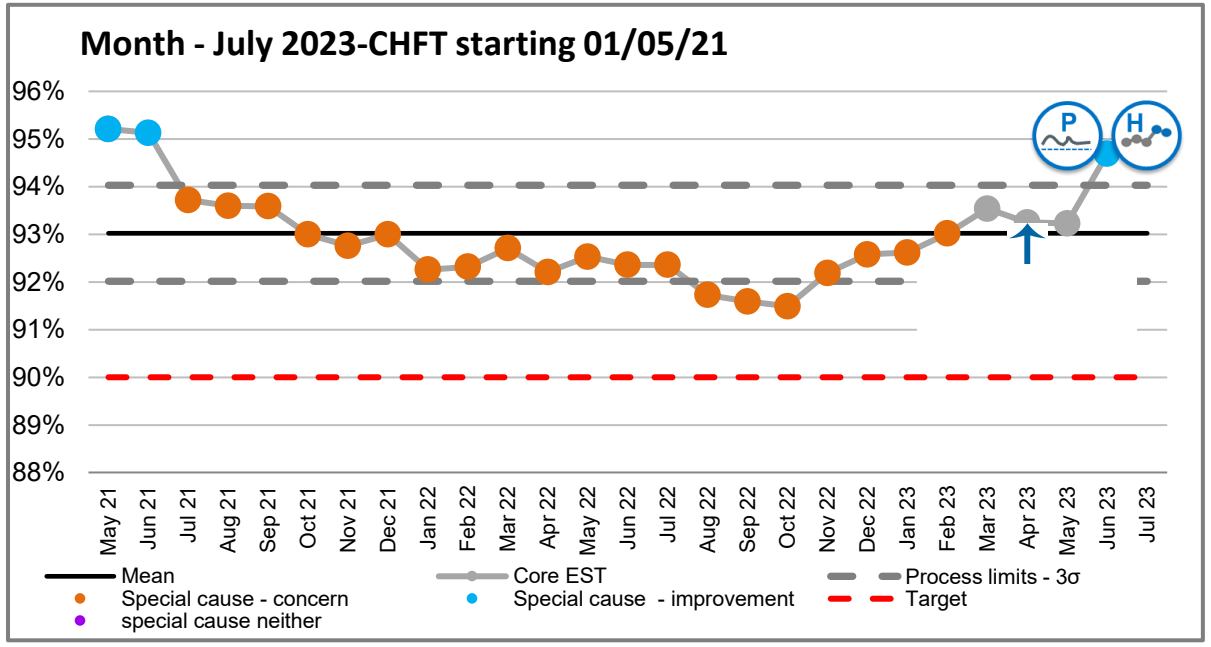
Actions:
- 2023 has seen the development of a ‘how to guide to appraisals’ video as part of our management fundamentals offer to make it a more people centred conversation.
- ESR recording guidance produced to support managers to ensure all activity is captured.
- Targeted approach to support hotspot areas including Connect & Learn sessions (managers’ and appraisees’ guides) to improve the quality of conversations.
- Stakeholder communications plan completed.
- Conduct appraisals in the line with the principles of the recently launched CHFT Leadership framework.
- We go see – areas of good practise for appraisal.

Core EST Compliance

Executive Owner: Suzanne Dunkley Lead: Adam Matthews 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: 95.0%**



What does the chart show/context:
- Total EST Compliance over the reporting period.
- The Trust is currently achieving the 90% target, and 95% stretch target for EST compliance.
- June and July 2023 are subject to high special cause with compliance rates above the mean and outside the process limits.
- From April 2023 Learning Disability Awareness is now included in the overall EST compliance rate.

Underlying issues:
No current issues. Trust compliant with 95%.

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

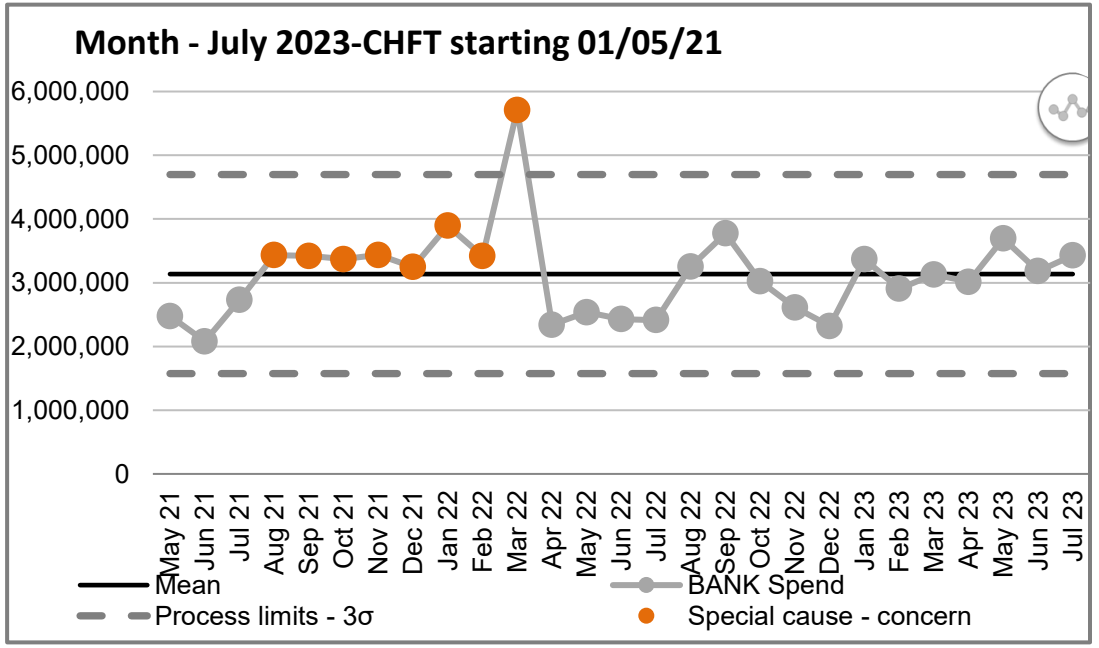
Bank Spend

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Suzanne Dunkley Lead: Jackie Robinson 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: £3.4M**



What does the chart show/context:
- Bank spend over the last 24 months by month.
- The general view is there is a hit and miss result to the target with common cause variation.
- Bank spend has reduced over the last 12 months to the 12 months preceding.
- The spike in March 2022 was due to an accrual of circa £2m for study leave.
- An increase in May 2023 is due to the 5% pay award for April 2023 and May 2023.

Underlying issues:
There is a reliance on bank usage to cover unplanned unavailability and to support the recovery programme. There has been an increase in bank usage during the summer holidays to cover gaps created by annual leave.

Actions:
A deep dive on bank and agency usage was taken to TE on 8th August 2023.

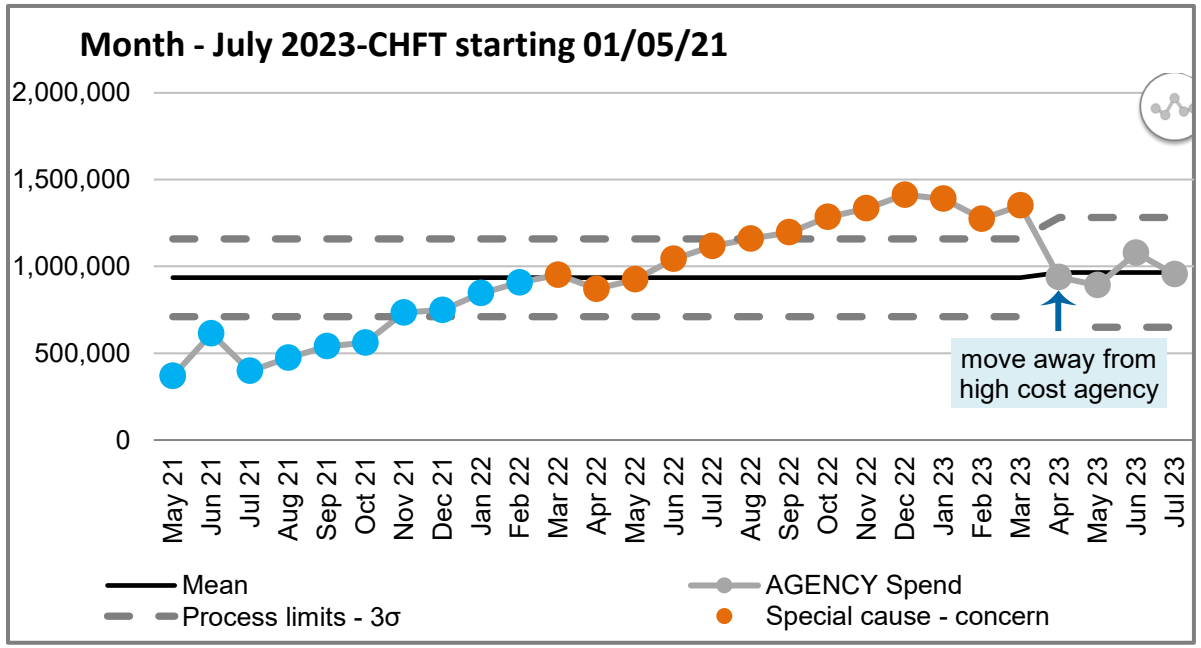
Director approval is required for any variation from agreed bank rates.

Agency Spend

Executive Owner: Suzanne Dunkley Lead: Jackie Robinson 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: £0.9M**



What does the chart show/context:
- Agency spend over the last 24 months by month.
- There had been an increasing trend in monthly Agency spend from May 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. There has been an increase in agency usage over the summer holidays to cover gaps created by annual leave.

Actions:
A deep dive into agency and bank usage was taken to TE on 8th August 2023.

Director approval is required for all agency usage.

Undertake an audit of the agency self-billing process to ensure the Trust is not paying for shifts that were not completed.

Review of all non-clinical agency usage.

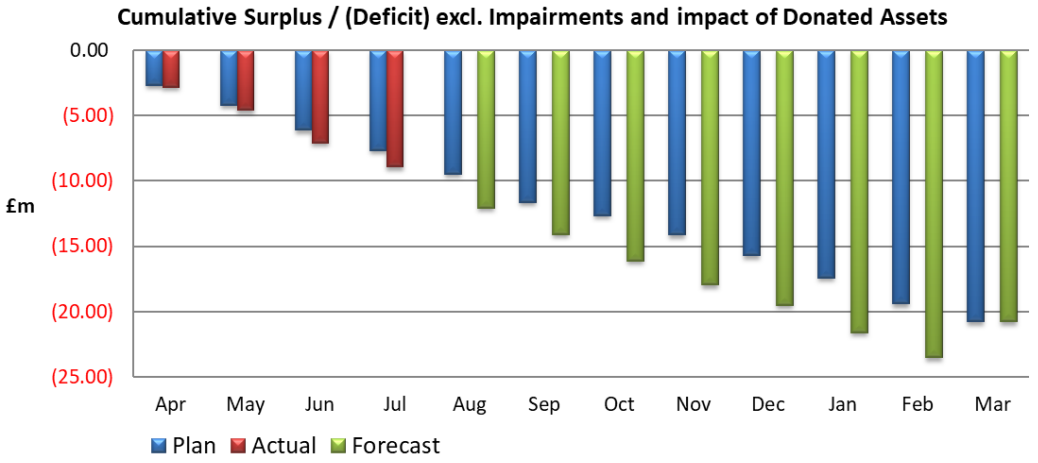
Finance:

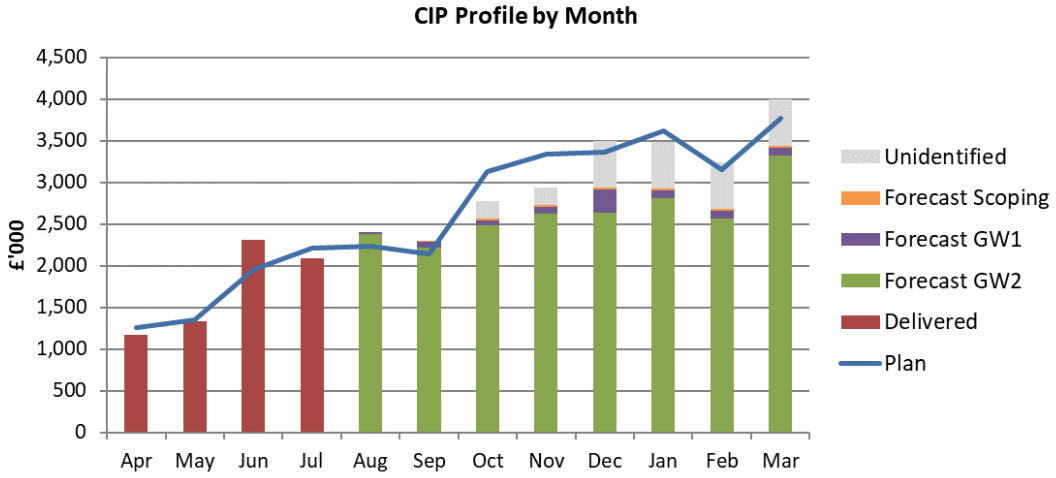
- Cumulative Surplus
- CIP Profile
- Capital Spend
- Cash Balance

Financial Performance

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Gary Boothby / Kirsty Archer 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 £8.95m, a £1.27m adverse variance from plan. The forecast is to deliver the £20.80m deficit as planned. The Trust has delivered efficiency savings of £6.90m year to date, £0.13m higher than planned.

Underlying issues:

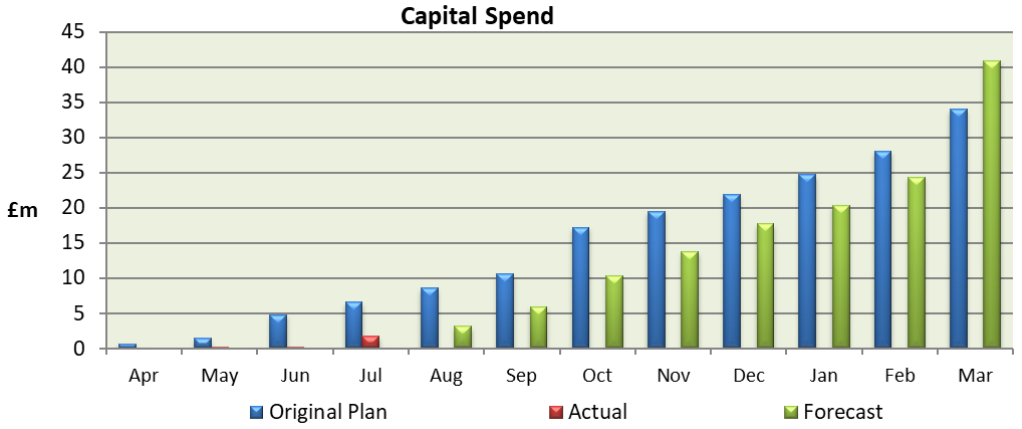
- Key drivers of the adverse variance included: higher than planned bed capacity due to an excess of patients awaiting Transfer of Care (TOC) / higher than planned Length of Stay (LOS), £1.39m pressure due to impact on associated efficiency plans and surge capacity; Strike costs of £0.73m; non-pay inflationary 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).
- 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 including: unidentified CIP of £2.76m; further slippage on some high-risk efficiency programmes; further strike action (£1.0m for planned Strikes up to the end of August); non-pay inflationary pressures; and challenges delivering the bed plan.

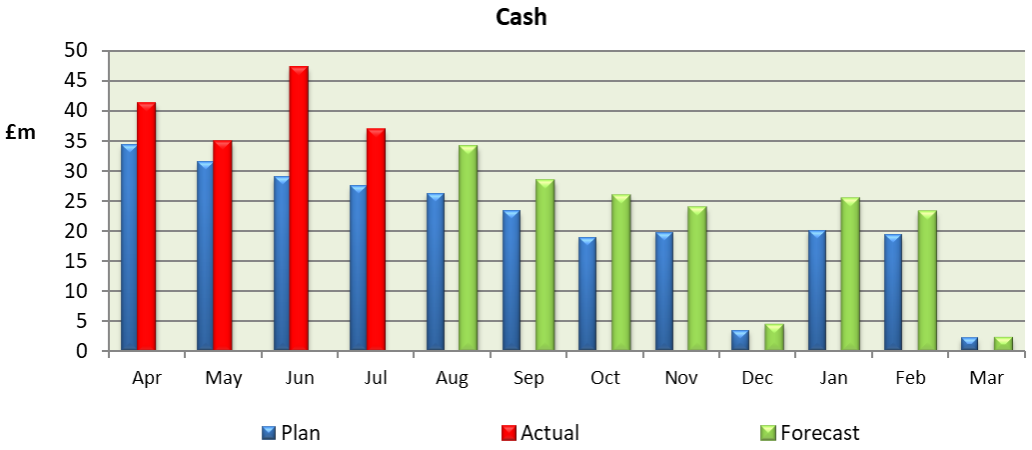
Actions:
To confirm the scale of likely slippage on high-risk CIP schemes and identify mitigations to support this gap, the unidentified CIP and to offset other new cost pressures.

Financial Performance: Capital, Cash and Use of Resources

Calderdale and Huddersfield NHS Foundation Trust

Executive Owner: Gary Boothby / Kirsty Archer 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 £1.73m on Capital programmes year to date, £4.87m lower than planned. Capital Forecast is to spend £40.92m, £6.92m more than planned – additional PDC funding has been awarded to support the Community Diagnostic Centre. At the end of July, the Trust had a cash balance of £36.84m, £9.33m 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 and HRI Reconfiguration. Cash variance is in part due to a higher than forecast year end cash balance (£2.93m); in addition to a favourable variance in cash flow year to date (£6.39m).

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	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.
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)

17. Audit and Risk Committee Chair Highlight Report

1. Approval of Risk Management Strategy

To Note

Presented by Nigel Broadbent

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT

Committee Name:	Audit and Risk Committee (ARC)
Committee Chair:	Nigel Broadbent, Non-Executive Director
Date(s) of meeting:	25 July 2023
Date of Board meeting this report is to be presented:	7 September 2023

ACKNOWLEDGE

- The Committee noted the good progress which has been made in terms of the implementation of recommendations from internal audit reports. 83% of all recommendations (143 in total) over the last 12 months have been completed, a further 9 recommendations have revised target dates (many of which have now been completed) and only one recommendation was overdue.
- The Committee also thanked colleagues for the successes highlighted during the Committee's deep dives into data quality and cyber security.

ASSURE

- The Committee undertook a deep dive into the work of the Data Quality Board. Improvements were noted on the number of patients admitted under the incorrect consultants, the review of the IPR, the data supporting elective recovery and work on health inequalities. Future plans included improvements to the data around timely discharges and A&E spine synchronisation.
- The Committee also undertook a deep dive into the Trust's cyber security arrangements and received a presentation on the monitoring, responses and management of cyber attacks in order to protect the Trust's against these threats. ARC also received assurance from an external review undertaken of our arrangements which assessed our arrangements as being above average in all areas except one on supplier management. Improved arrangements have been implemented since the review was undertaken. Assurance was also gained from the ISO27001 accreditation and the DSPT toolkit.
- The Committee approved the updated risk management strategy for recommendation to the Trust board which clarifies the current roles and responsibilities around risk management and documents the processes in place. ARC was also assured of the training and awareness raising in place around the updated strategy.
- The updated Standing Financial Instructions were approved by the Committee which incorporate and clarify the authorisation limits for expenditure and disposal of assets. There will need to be a read across to the Scheme of Delegation to understand whether any revisions are required

to this and it was agreed that any revisions to the Scheme of Delegation would be brought to the October meeting.

- Internal Audit have completed two reports in the 2023/24 audit plan in relation to vehicle safety and ISO standards in health informatics which have high assurance. Five reports were also highlighted which had been taken into account in the Head of Internal Audit's opinion on the Trust's financial statements. Only one of these reports had limited assurance and this was in relation to the national and local standards on invasive procedures. Although actions have been agreed in response to the recommendations it was agreed that the executive lead for this area would be invited to the October meeting of ARC to provide an update on progress.
- The Committee received a progress report on counter fraud and also the annual report on local counter fraud for 2022/23. It was agreed that the next counter fraud progress report would provide an update on the number of colleagues attending the masterclass awareness programme and specific training around counter fraud.

AWARE

- The Committee approved the losses and special payments and waivers of standing orders for quarter one of the financial year. An update was requested to the next meeting on further work being done to review the processes for reducing the number of losses of patients' personal effects.
- The Board Assurance Framework (BAF) had previously been agreed by the Trust Board at its July meeting but was reviewed by ARC. As previously discussed, the scoring of the risks on nursing staffing and partnership arrangements would be reviewed prior to the update in October but the Chair also asked for the addition of a risk around cyber security to be considered, particularly due to the digital maturity of the organisation.
- The Committee approved the updated terms of reference to reflect changes in partnership arrangements and closer working with other committees, and to the Chair of Audit and Risk Committee job description and personal specification.
- It was agreed that the opportunity to undertake further deep dives would be considered and a mapping exercise of the strategic risks on the BAF be carried out to help identify these.

ONE CULTURE OF CARE

- The Committee thanked colleagues in relation to successes on the deep dives.

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 September 2023
Meeting:	Board of Directors
Title:	Risk Management Strategy
Author:	Victoria Pickles, Director of Corporate Affairs
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Audit and Risk Committee
Actions Requested: The Board is requested to **APPROVE** the revised Risk Management Strategy.	

Purpose of the Report

The attached Risk Management Strategy was reviewed in detail at the Audit and Risk Committee in July and is recommended for approval by the Board.

Key Points to Note

The Trust previously had a combined risk management strategy and policy. To make the risk management arrangements more easily digestible and accessible for colleagues across the Trust, it was agreed to separate these out. The Risk Management Policy – which describes how risks are managed and mitigated - was approved earlier in the year. The Risk Management Strategy sets out the Trust's approach to risk management, risk appetite, the Board Assurance Framework and how these are governed.

The revised Risk Management Strategy was discussed at the Audit and Risk Committee in July where assurance was sought on how the effectiveness of risk management processes are monitored. A dashboard is being developed in the Trust's performance management system with indicators to demonstrate compliance with the strategy. In addition, the annual review of risk management arrangements at the Audit and Risk Committee, will show the movement and review of risks across the organisation.

Also for review on the agenda at this meeting, is the refreshed Risk Appetite Statement, referred to in the Strategy.

EQIA – Equality Impact Assessment

All risks are considered for their impact on equality.

Recommendation

The Board is requested to **APPROVE** the revised Risk Management Strategy. Subject to Board approval this will replace the risk appetite in the strategy

UNIQUE IDENTIFIER NO: G-101-2017
Review Date: July 2023
Review Lead: Head of Risk and Compliance

RISK MANAGEMENT GROUP STRATEGY

2023-2025

Version 3

UNIQUE IDENTIFIER NO: G-101-2017
Review Date: July 2023
Review Lead: Head of Risk and Compliance

Document Summary Table		
Unique Identifier Number	G-101-2017	
Status	Approved	
Version	3	
Implementation Date	January 2017	
Current/Last Review Dates	July 2023	
Next Formal Review	March 2025	
Sponsor	Director of Corporate Affairs	
Author	Head of Risk and Compliance	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Board of Directors		
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Audit and Risk Committee	Non-Executive Director	July 2023
Other Stakeholders Consulted		
N/A		
Does this document map to other Regulatory requirements?		
Regulator details		
CQC	Regulation 12: Safe care and treatment Regulation 13: Safeguarding Regulation 15: Premises and Equipment Regulation 16: Complaints Regulation 17: Good Governance Regulation 19: Fit and Proper Persons	
NHS Improvement	Single Oversight Framework	

Document Version Control	
Version no	
1	Risk Management Strategy incorporating Raising Concerns / Freedom to Speak Up
1.1	Minor amendment made to section 9.5 to include additional information in relation to compliance registers following internal audit report
2	Addition of section relating to Calderdale & Huddersfield Solutions and amendments to roles and responsibilities.
3	Addition of section on Board of Directors (8.1). Additions to roles and responsibilities re Fire Safety, change reference from Head of Governance and Risk to Senior Risk Manager, addition of numbers to risk levels in risk appetite. Updated appendices: 2 - Governance Structure, 3 - Supporting Policies, 4 - Risk Management Specialists, 6 - Incident Grading Matrix, 7 - Risk Appetite

UNIQUE IDENTIFIER NO: G-101-2017
Review Date: July 2023
Review Lead: Head of Risk and Compliance

CONTENTS

1. Introduction

This policy is intended for use across Calderdale and Huddersfield NHS Foundation Trust (CHFT), which includes Calderdale and Huddersfield Solutions Limited (CHS). Where responsibilities state all staff, managers senior managers and directors, this also includes CHS staff groups.

The purpose of this Risk Management (RM) Strategy is to confirm the objectives and organisational framework for risk management systems within the Trust. It details roles, responsibilities, and processes for risk management to reduce harm, create safer environments for care and achieve the Trust's strategic objectives.

The underpinning risk management processes will ensure that risks are identified and managed and reported appropriately through the organisation as part of the Trust's system of internal control. Definitions of risk and risk management are given at Appendix 1.

The strategy is relevant to all staff, including those on temporary contracts, contractors, membership councillors, and bank/agency staff, volunteers, and Private Finance Initiative (PFI) partners. It is also relevant to all those who partner with or work with the Trust.

2. Vision and Statement of Intent

2.1 Risk Management and Strategic Objectives

The stated aim of Calderdale and Huddersfield NHS Foundation Trust is:

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

Our strategic objectives to deliver this aim are to:

- Transforming service and population outcomes
- Keep the base safe – best quality and safety of care.
- Inclusive workforce and local employment
- Financial, economic, and environmental sustainability

Risk management is central to implementing this strategy as the business of healthcare is by its very nature a high-risk activity. The process of risk management is an essential control mechanism to identify and manage risks which may threaten the ability of the Trust to meet its objectives, and consequently it increases the likelihood of the Trust achieving its objectives and strategic aim.

Risk and risk management is not about doing nothing for fear that we might make a mistake. Rather, risk policy and risk management are concerned with promoting an understanding of an organisation's strategy, operating environment and the associated risks and putting in place appropriate processes and procedures to identify, assess and manage risk. Risk identification, assessment, management, and assurance is best understood as a constant cycle of activity: risks emerge, alter their significance and scale, and may disappear without warning. Anticipation and early action to manage risk

is the best defence. Her Majesty's Treasury offers guidance to all organisations in receipt of public funding as to how they may incorporate good practice. This guidance concludes it is essential that an organisation should:

- Understand the risks associated with all elements of its strategy and operating environment.
- Have in place a framework for risk identification, risk assessment, risk management and assurance and the assignment of responsibilities.
- Have a clear policy and attitude to risk appetite and ensure that these are defined and communicated to all relevant parties.
- Review the adequacy and effectiveness of control processes for responding to risks.

The Trust recognises that providing healthcare and the activities associated with the treatment and care of patients incurs clinical and non-clinical risk, both for the organisation and its stakeholders: our patients, staff, visitors, partners in the health and social care community and commissioners.

Risk Management is an integral part of the Trust Board's system of internal control and its effectiveness is reviewed annually by internal and external auditors. Key strategic risks are identified and monitored by the Board and operational risks are managed on a day-to-day basis by staff throughout the Trust. The Board Assurance Framework and High-Level Risk Register provide a central record of how the Trust is managing its risks.

The Trust has a Maternity Risk Management Strategy within the Family and Specialist Services Division which sets out the strategic direction for risk management within maternity services. It details accountability, roles, and responsibilities for the management of maternity risks to ensure that women and their families experience safe, clinically effective care at all times to ensure a positive birth experience and a healthy outcome for mother and baby.

2.2 Risk Management Three Lines of Defence

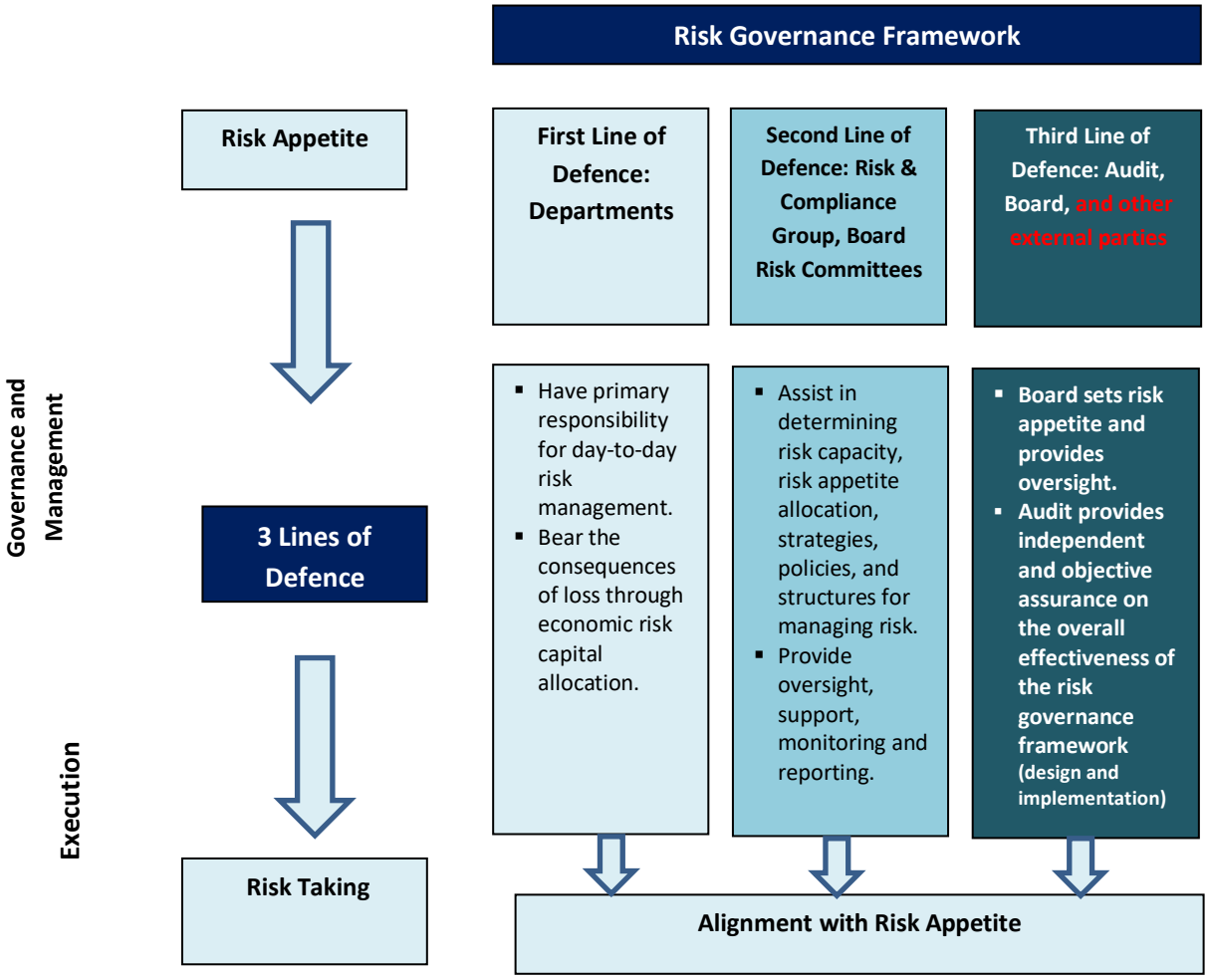
To ensure the effectiveness of the Trust's risk management processes the board and senior management team need to be able to rely on three lines of defence, including the monitoring and assurance functions with the organisation. This is depicted overleaf and explained below:

First line of defence – our front-line staff are the first line of defence. They must understand their roles and responsibilities for risk management using Trust processes and they must own and manage risk, as well as implementing operational management at directorate and divisional level. These are the teams with ownership, responsibility, and accountability for directly assessing, controlling, and mitigating risks.

Second line of defence – the second line of defence consists of the functions that reflect risk management, quality, and compliance (which monitors and facilitates the implementation of effective risk management practices by operational management) and the processes that assist the risk owners to report adequate risk related information up and down the organisation. This line of defence includes the governance and management committees that provide assurance that risks are actively and appropriately managed.

Third line of defence – the third line of defence is provided by independent audit, such as internal and external auditors, who through a risk-based approach provide independent assurance to Board and senior management team about how effectively the Trust assesses and manages its risks, how effective the first and second lines of defence are and looks at all aspects of risk across all organisational objectives.

Figure 1: Three Lines of Defence Model



The Trust will ensure that its risk management arrangements meet the requirements of national bodies including NHS England, Care Quality Commission (CQC), Health and Safety Executive (HSE), Environmental Agency, NHS Resolution, our insurers, other agencies, and systems supporting a safety culture, such as the National Reporting Learning System and all other regulatory and scrutiny bodies.

On behalf of the Board, the Chief Executive signs the Annual Governance Statement, which forms part of our annual reporting requirements, for the Department of Health which outlines how the organisation identifies, evaluates and controls risks together with confirmation that the effectiveness of the system of internal control has been reviewed.

2.3 Vision and Statement of Intent

The Trust's vision for risk management is for it to be regarded as a highly valuable and useful tool to help the Trust achieve its objectives, with:

- **Risk management systems understood by staff.**
- **Risk management systems embedded into everyday working practice across all parts of the organisation.**
- **The Board and its committees assured that risks are managed to achieve the Trust's objectives.**

The Trust will aim continually to improve the content and maturity of the risk management framework.

2.4 Risk Management Objectives

The overall objectives for risk management at the Trust are to establish and support an effective risk management system which ensures that:

- Risks are identified, assessed, documented, and effectively managed locally to a level as low as possible, using a structured and systematic approach. Risk may adversely affect patients, staff, contractors, the public and the fabric of buildings. In managing risks the Trust is providing a safe environment in which patients can be cared for, staff can work, and the public can visit.

- Risks are managed to an acceptable level as defined in the Trust risk appetite (see section 6), meaning that staff have a clear understanding of exposure and the action being taken to manage significant risks.

- Risks are regularly reviewed at team, directorate, division, and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated. A flowchart of risk escalation is given at section 9.4.

- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, manage, and monitor risks effectively – see section 9 for further details.

- All staff recognise their personal contribution to risk management.

- Assurance on the operation of controls is provided through audit, inspection and gaps in control and risks are identified and actively managed.

2.5 Risk Scope

This Risk Management Strategy and the Risk Management Policy apply to all categories of risk, both clinical and non-clinical risks. These include, though are not limited to:

Clinical quality / patient safety risks	Operational / performance risks	Financial risks
Health and Safety Risks	**Project Risks**	**Patient Experience Risks**
Business Risks	**Reputational Risk**	**Regulatory risks**
Governance risks	**Workforce Risks**	**Partnership risks**
Information risks & Digital	**External environment risks**	**Risks from political change / policy**

3. Components of the Trust's Risk Management Strategy

The components of the Trust's Risk Management Strategy to deliver this vision are given below.

These components will enable the organisation to manage inherent risks within the current systems and processes. The organisation will decide how to manage these risks in line with its risk appetite (see section 6) and risk management processes, see Appendix 1. It is acknowledged that risks may emerge from external sources, particularly during times of change or when new systems or revised regulation is introduced, and the organisation will remain alert to these sources of risk.

1. **Embed risk management at all levels of the organisation.**
   The Trust will ensure that risk management forms an integral part of the organisation's thinking, is an integral part of strategic objectives and management systems, including performance management and planning and that responsibility is accepted at all levels of the organisation. It will also ensure that staff are aware of their role, responsibilities, and accountabilities for risk management, and this is embedded at all levels of the organisation.

2. **Develop a culture & governance structure which supports & owns risk management.**
   The Trust is committed to building and sustaining an organisational culture that encourages appropriate risk taking, effective performance management and organisational learning to continuously improve the quality of services provided improve safety and reduce harm.

3. **Provide the tools and specialist advice to support risk management.**
   A range of tools (described at section 9) are in place across the Trust to support risk management which use consistent language to describe risk and provide assurance tools, e.g., risk registers, risk grading and assessment, risk management software, policies, root cause analysis and risk appetite. This is complemented by advice and support from risk management specialists.

4. **Provide training to support risk management.**
   The Trust will provide risk management and awareness training and support staff in their knowledge and understanding of risk management and its concepts (e.g., risk register training, H&S training, RCA training, Information Governance training, Complaints Investigation Training, Risk Workshops, policies).

5. Embed the Trust's risk appetite in decision-making.

A Board approved practical and pragmatic risk appetite statement will enable decision-makers to understand risks in any proposal and the degree of risk to which the Trust can be exposed or extent to which an opportunity can be pursued.

6. Monitor progress in risk management capability across the organisation and effectiveness of control processes.

Ensure a review process is in place to assist in evaluating performance and progress in developing and maintaining effective risk management capability across the organisation and the effectiveness of risk.

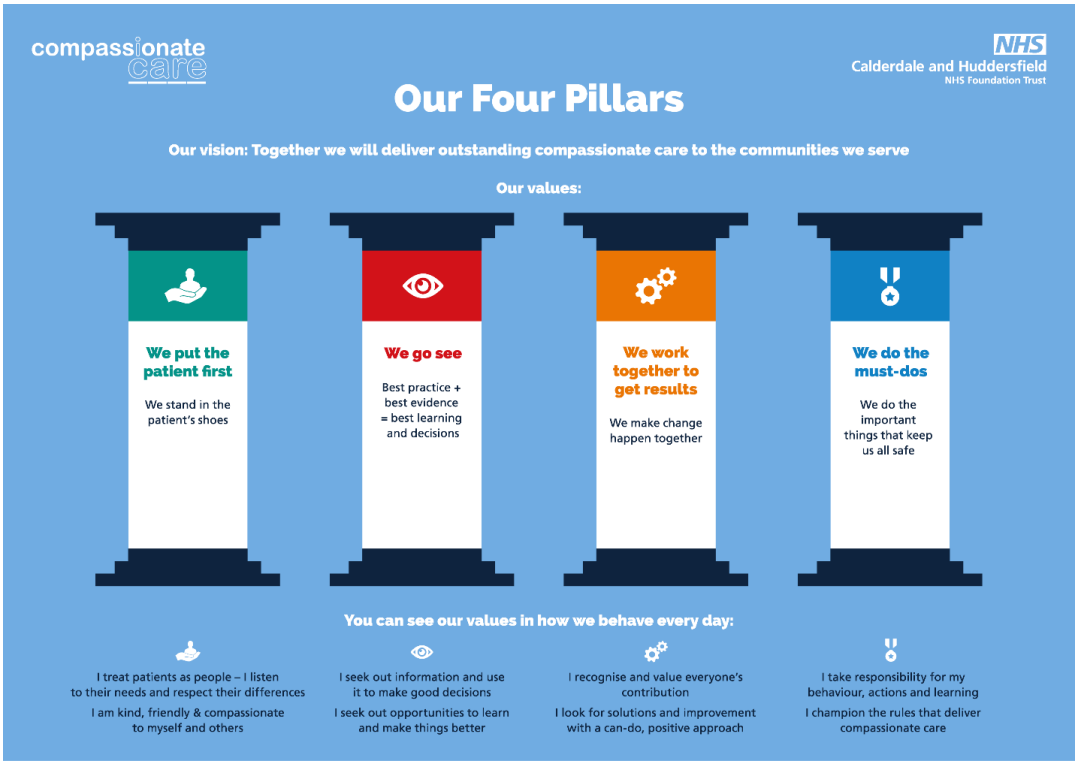
4. Benefits of managing risk

The Trust is committed to the effective management of risks which, among others, has the following benefits for the Trust:

- ✓ Achievement of objectives is more likely.
- ✓ Adverse events are less likely.
- ✓ Opportunities can be better identified and explored.
- ✓ Outcomes are better; safety, effectiveness and efficiency are improved.
- ✓ Performance is improved.
- ✓ We reduce firefighting and fewer costly surprises and re-work.
- ✓ Decision making is better and more transparent.
- ✓ Reputation is protected and enhanced.

5. The way we work.

The four behaviours expected of all staff to deliver our strategic objectives are:



A pro-active approach to managing risk.

The Trust aims to embed a culture in which true pro-active risk reduction takes place by aiming to anticipate and prevent risks, complementing the more traditional reactive approach to risk management by looking ahead and managing upcoming risks. This is achieved by staff and teams identifying pro-actively risks avoiding adverse events or by managing risks as far as reasonably practicable to minimise the consequences of adverse events, for example for patient outcomes or preventing harm and reducing losses for the organisation. A key part of this pro-active approach to risk management is the use of risk assessment which is detailed as a key risk management tool in the organisation (see Appendix 4).

All members of staff have responsibilities and an important role to play in identifying, assessing, and managing risk using the risk management strategy policy and supporting policies and procedures to guide them.

This means:

Staff should pro-actively identify and assess risks and manage these to avoid / minimise adverse events. *(We Do the Must Dos)*

To support staff in their role in managing risk the Trust seeks to provide an open, fair, and consistent environment, encouraging a culture of openness and a willingness to admit mistakes and learn from them.

This means:

Staff are open about incidents they have been involved in and feel able to talk to their colleagues about any incident *(We Do the Must Dos)*

All staff, and others associated with the Trust, should report any situation where things have or could have gone wrong through the incident reporting process. Balanced with this approach is the need for the Trust to provide information, counselling, support, and training for staff in response to such situation.

This means:

The organisation is open with patients, the public and staff when things have gone wrong and appreciates and explains what lessons can be learned (*We Put the Patient First)*

The Trust wants to learn from events and situations to constantly improve management processes, take a systems approach to learning, looking at contributory factors, including human factors to make changes to improve quality and safety. Where necessary and/or appropriate, changes will be made to the Trust's systems to enable this to happen.

The Duty of Candour and Being Open policy is a key tool to support this and to engage with families where things have gone wrong. Staff should be informed of feedback on actions taken because of an incident being reported.

This means:

Staff and organisations are accountable for their actions and are treated fairly and are supported when an incident happens (We Do the Must Dos)

In the interests of openness and candour, responding to concerns raised and learning from mistakes, formal disciplinary action will not usually be taken as a result of an investigation into an adverse event. However, the Trust's Disciplinary Policy outlines circumstances in which disciplinary action will be taken, e.g., professional misconduct. Should disciplinary action be appropriate this will be made clear as soon as the possibility emerges from an investigation and advice would be taken from the Workforce and Organisational Development department.

6. Risk appetite

No organisation can achieve its objectives without taking risks. An organisation's risk appetite is the amount and type of risk that the organisation is willing to take in the pursuit of its strategic objectives.

The risk appetite can help the Trust by enabling the organisation to take decisions based on an understanding of the risks involved. The organisation will communicate expectations for risk taking to managers. The current risk appetite is included on the Trust's website under Publications.

The Trust uses the risk appetite matrix for NHS organisations developed by the Good Governance Institute to express its risk appetite.

There are 5 levels of risk appetite (excluding no risk appetite) which are detailed below.

Risk level	Risk appetite	Key Elements
MINIMAL (as little risk as possible)	**LOW**	
CAUTIOUS	**MODERATE**	Preference for-safe delivery options with a low degree of inherent risk and limited potential for reward
OPEN	**HIGH**	
SEEK	**SIGNIFICANT**	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk
MATURE	**SIGNIFICANT**	Confident in setting high levels of risk appetite because controls, forward scanning, and responsiveness systems. are robust

Expressing the Trust's Risk Appetite

In line with best practice in corporate governance and risk management, the Trust will clearly express the extent of its willingness to take a risk to meet its strategic objectives through a risk appetite statement.

The risk appetite will be agreed by the Board and reviewed at least annually or as needed, as risk appetite levels may change depending on circumstances.

Risk Categories

Risks need to be considered in terms of both opportunities and threats and are not usually confined to clinical risk or finances – they are much broader and impact on the capability of the Trust, its performance and reputation. The risk appetite is also influenced by the overall objectives set by the Trust.

The Trust will agree categories of risk when defining its risk appetite and will publish these, which will cover the over-arching areas of:

- Quality, innovation and improvement, safety
- Financial
- Commercial
- Regulation
- Reputation
- Workforce
- Partnerships

The risk appetite statement will be communicated to relevant staff and risks throughout the Trust should be managed within the Trust's risk appetite. Where this is exceeded, action should be taken to reduce the risk.

The Risk and Compliance Group will review the significant risks on the high-level risk register to ensure that risks are acceptable within the Trust risk appetite.

The Quality Committee (for clinical risk), Audit and Risk Committee (for all clinical and non-clinical risk) and the Board will also review significant risks and ensure that the Trust's overall portfolio of risks is appropriate, balanced, and sustainable.

7. Organisational Structure for Risk Management

7.1 Organisational Structure

A full organisational governance structure, to help manage delegated responsibility for implementing risk management systems within the Trust is available on the Trust's website under Publications.

7.2 Roles and responsibilities of Committees responsible for risk

Board of Directors

The Board of Directors is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to all NHS organisations. This includes the development of systems and processes for financial control, organisational control, governance, and risk management.

Board members must ensure that the systems, policies, and people that are in place to manage risk are operating effectively, focused on key risks, and driving the delivery of objectives.

In the context of this Risk Management Strategy the Board will:

- Demonstrate its continuing commitment to risk management through the endorsement of the Risk Management Strategy, participating in the risk assurance process and ensuring that appropriate structures are in place to implement effective risk management.

- Be collectively responsible for determining the Trust's vision, mission, and values.

- Set corporate strategy and priorities and monitor progress against these; the Board must decide what opportunities, present or future, it wants to pursue and what risk it is willing to take in developing the opportunities presented. The Board is also responsible for ensuring that there are effective systems in place to identify and manage the risks associated with the achievement of these objectives through the Board Assurance Framework and High-Level Risk Register

- Routinely, robustly, and regularly scan the horizon for emergent opportunities and threats by anticipating future risks.

- Set the Trust's risk appetite and review on an annual basis.

- Simultaneously drive the business forward whilst making decision which keep risk under prudent control.

- Effectively hold those responsible for managing risk to account for performance through assurance processes and continuous improvement through learning lessons and ensuring these are disseminated into practice from complaints, claims, incidents, and other patient experience data

- The Company Secretary is responsible for the work of the Board and its Committees and for ensuring integration of their activities, particularly the governance and regulatory responsibilities.

Audit and Risk Committee

On behalf of the Board the Audit and Risk Committee provides an independent and objective review of financial and corporate governance, assurance, systems of internal control and risk management. These activities apply across the whole of the Trust's clinical and non-clinical activities, and they support the achievement of the Trust's objectives. The Audit and Risk Committee also ensures effective external and internal audit, monitors the performance of auditors and re-tenders for auditors' services.

The Risk and Compliance Group, chaired by the Assistant Director of quality and Safety, reports to the Audit and Risk Committee. Its role is to promote effective risk management and to establish and maintain a dynamic Board Assurance Framework and Risk Register through which the Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety, and quality.

The Information Governance Group and Data Quality Board also report to the Audit and Risk Committee.

To ensure that Board Committees are effectively managing risks within their remit, each Committee undertakes a self-assessment of performance annually and share these assessments with the Audit and Risk Committee.

Finance and Performance Committee

The Finance and Performance Committee has delegated authority from the Board to oversee, co-ordinate, review and assess the financial and performance management arrangements. This includes monitoring the delivery of the 5 Year Plan and supporting Annual Plan decisions on investments and business cases. It identifies any financial and performance risks.

Workforce Committee

The Workforce Committee provides assurance to the Board of Directors on the quality of workforce and organisational development strategies and the effectiveness of workforce management in the Trust and is responsible for identifying any workforce and training risks.

Quality Committee

The Quality Committee provides assurance to the Board of Directors that there is continuous and measurable improvement in the quality of the services provided and that the quality risks associated with its activities, including those relating to registration with the CQC are managed appropriately.

There are several groups that support the work of the Quality Committee and directly report to it, including the Health and Safety Committee, as depicted in the governance structure at Appendix 2. The sub–group reporting structure is currently under review and any changes will be reflected in the governance structure.

Transformation Committee

The Transformation Committee provides assurance to the Board of Directors that the transformation and reconfiguration programmes within the Trust are robust and delivering the agreed outcomes and benefits and that the quality, safety, operational and financial risks associated with these significant programmes of work are managed and mitigated.

8. Accountabilities, Roles, and Responsibilities for Risk Management

8.1 The **Chief Executive** is the Accountable Officer of the Trust and as such has overall accountability for ensuring it meets its statutory and legal requirements and has effective risk management, health and safety, financial and organisational controls in place.

The Chief Executive has overall accountability and responsibility for:

- ensuring the Trust maintains an up-to-date Risk Management Strategy, is committed to the risk management principles in the Trust statement of intent and has a risk appetite endorsed by the Board.
- promoting a risk management culture throughout the organisation
- ensuring an effective system of risk management and internal control is in place with a framework which provides assurance to the Trust management of risk and internal control.
- ensuring that the Annual Governance Statement contains the appropriate assurance requirements for risk management.
- ensuring priorities are determined and communicated, risk is identified at each level of the organisation and managed in accordance with the Board's appetite for taking risk.

8.2 **The Chair** is responsible for leadership of the Board and ensuring that the Board receives assurance and information about risks to the achievement of the organisation's strategic objectives.

8.3 **Non-Executive Directors**
All Non-Executive Directors have a responsibility to challenge the effective management of risk and seek reasonable assurance of adequate control.

The Audit and Risk Committee, Quality Committee, Finance and Performance Committees and Workforce Committee are chaired by nominated Non-Executive Directors.

There is a Senior Independent Non-Executive Director who is also the Deputy Chair.

8.4 **Executive Directors**
The following Executive Directors have responsibilities in respect of assurance and the management of risk summarised below. The Chief Executive will delegate responsibilities in relation to partnership working as appropriate.

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Lead Executive Director	Risk Area
Chief Nurse **The Chief Nurse is the Executive lead for risk management and patient safety in partnership with the Medical Director. They ensure organisational requirements are in place which satisfies the legal requirements of the Trust for quality and safety, patients, and staff. This includes delivery of processes to enable effective risk management and clinical standards.** **The Board Assurance Framework lead is the Company Secretary.**	• Board lead for clinical risk management: – Risk Management Strategy and Policies – Risk appetite – Monitoring the management of risks across divisions and escalate as needed. • Serious Incidents and Incident Reporting • Patient Advice and Complaints Service • Patient Experience • Quality and Quality Improvement • Safeguarding and Deprivation of Liberty • Mental health act compliance • Quality regulatory compliance
Medical Director **The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Chief Nurse and leads the quality improvement strategy. Responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision, and revalidation.** **The Medical Director is supported in this by the Deputy Medical Director and Associate Medical Directors.**	• Clinical medical risk • Infection Prevention and Control • Caldicott Guardian information risks – delegated to the Deputy Medical Director • Responsible Officer for GMC • Medicines Management – delegated to Chief Pharmacy Officer • Clinical audit and effectiveness • Compliance with NICE guidance • Quality Improvement • Research & Development – delegated to Deputy Medical Director
Director of Finance **The Director of Finance has executive responsibility for financial governance and financial systems, is the lead for counter fraud and responsible for informing the Board of the key financial risks within the Trust and actions to control these.**	• Financial risk • Procurement risk • Counter fraud and reporting to NHS Protect • Financial regulatory compliance • Estates and Facilities risks provided by the Project company (PFI) and wholly owned subsidiary CHS.

Deputy Chief Executive **The Deputy Chief Executive has executive responsibility for community services, as well as being the executive lead for Huddersfield Pharmaceutical Specials, health inequalities and the operational service change within the reconfiguration programme**	• Community services operational risks • Risks associated with the delivery of the HPS. • Operational risk relating to the reconfiguration
Director of Workforce and Organisational Development **The Director of Workforce and Organisational Development has executive responsibilities which include identification and assessment of risks associated with recruitment, employment, supervision, training, staff development and staff well–being.**	• Freedom to Speak Up Guardian • Staffing risks including training, workforce planning, recruitment, and retention, • Health and Safety, including external reporting for RIDDOR. • Workforce Policies • Professional registration • Staff Well Being

8.5 Board Directors

The following Directors also have responsibilities for assurance and management of risk.

Chief Operating Officer **The Chief Operating Officer has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation and management of performance of all clinical services through divisional management teams.**	• **Performance risks** • **Performance regulatory compliance** • **Safe and sustainable operational services** • **Security Management** • **Trust Resilience** • **Fire Safety**
Deputy Chief Executive / Director of Transformation and Partnerships **The Director of Transformation and Partnerships has lead responsibility for service redesign and reconfiguration and working together with our partners across the local health and social care economy.**	• Risks in relation to service reconfiguration and transformation • Partnership risks
Director of Corporate Affairs **The Director of Corporate Affairs has**	

lead responsibility for the systems of corporate governance and for how we manage our communications and media relations, as well as the delivery of the Charity objectives.	• Risks relating to systems of corporate governance. • Reputational risks around our communications with colleagues, public and the media • Risks relating to the probity of the Charity, fundraising and grant giving.
Managing Director – Digital Health The Managing Director promotes the need to manage information and IT risks, for the security of patient records and IT business continuity arrangements.	• Information governance risks, including general data protection and external reporting to the Information Commissioner • Senior Information Risk Officer – delegated to head of informatics, is responsible for ensuring the Trust manages its information risks, through the development of information asset owners and information asset administrators. • Electronic Patient Record

Calderdale and Huddersfield Solutions Limited, a wholly owned subsidiary by CHFT, provides:

- A comprehensive estates and facilities management service to Huddersfield Royal Infirmary, Broad Street and Beechwood premises
- A medical engineering service.
- A fully managed procurement service for the whole of CHFT
- A property management service for other properties leased by CHFT.

CHS provides advice and management on the following risks:

- Compliance with regulations/guidance on specialised building and engineering technology for healthcare
- Medical Engineering

For these risks there is generally shared responsibility for the risk between CHFT and CHS, with the element of risk that sits with each entity described in the respective risk register. Both entities have governance structures in place to manage these risks.

Accountability for these aspects of risk is via several service level agreements and key performance indicators with Calderdale and Huddersfield Solutions Limited. These are monitored via the Joint Liaison Committee which includes executive and non-executive membership and reports to the Board via a bi-monthly report.

8.6 Assistant Director for Quality and Safety

The Assistant Director for Quality and Safety supports the Chief Nurse and Medical Director in their clinical quality and safety and risk management responsibilities as well as quality improvement. This includes overseeing the risk management function, including the risk register and compliance with the requirements of CQC standards.

8.7 Clinical and Divisional Directors

Clinical and Divisional Directors have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They are responsible for ensuring effective systems for risk management within their division and directorates and ensuring that their staff are aware of the risk management policy and their individual responsibilities.

In addition to Divisional Directors and Clinical Directors the divisional management team includes an Associate Director of Nursing and Director of Operations.

They are responsible for demonstrating and providing leadership of risk management within their division, directorates, and teams. They are accountable for:

- Pro-actively identifying, assess, managing and reporting risks in line with Trust processes – this includes ensuring Divisional Digital Boards identify and describe risks relating to the Electronic Patient Record and other information systems on their divisional risk register and escalate these appropriately in line with the risk management framework.
- Establishing and sustaining an environment of openness and learning from adverse events to prevent recurrence and creating a positive risk management culture.
- Seeking assurance through governance arrangements of the effectiveness of risk management
- Ensuring clinical risks, health and risks, emergency planning and business continuity risks, project and operational risks are identified and managed.
- That general managers, operational managers, matrons, ward managers, departmental team managers are responsible for ensuring effective systems of risk management and risks registers are in place at all levels.

8.8 All Staff

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that are affected by Trust business.
- Be aware of, identify and minimise risks, taking immediate action to reduce hazards or risks.
- Identify, assess, manage, and control risks in line with Trust policies and procedures.
- Be familiar with local policies, procedures, guidance, and safe systems of work.
- Be aware of their roles and responsibilities within the risk management strategy, policy and supporting policies, e.g., comply with incident and near miss reporting procedures.
- Be responsible for attending mandatory and essential training and relevant educational events.
- Undertake risk assessments within their areas of work and notify their line manager of any perceived risks which may not have been assessed.

8.9 Contractors and Partners

It is the responsibility of any member of Trust staff who employ contractors, and their partners, to ensure they are aware of the Safe Management of Contractors' policy and undergo Trust induction via the relevant Estates Department at either HRI or CRH. This will ensure that all contractors working on behalf of the Trust are fully conversant with CHFT's health and safety rules and the staff member responsible is fully aware of the contractor's activity for which they are engaged and, if applicable, are in possession of the contractor's risk assessment and method statement for their activity.

9. SYSTEMS and PROCESSES for MANAGING RISK

9.1 Policies

There are several key policies which support the effective management of risk, including the risk management policy which provides operational details of how we manage risk across the organisation. These supporting policies are detailed at Appendix 2.

All operational policies, procedures and guidance also support the effective management of risk. These can be found on the Trust intranet.

9.2 Incident Reporting

The formal reactive method of identifying risks within the Trust is through the electronic risk management system, Datix where all staff can report incidents accidents and near misses in a timely way, with incidents graded for type and severity. This enables the organisation to investigate and identify learning to make quality improvements in patient safety at all levels of the organisation.

An Incident Reporting Policy is in place which details the processes for grading, reporting, investigating, and learning from incidents and serious incidents and is a key part of our effective risk management processes.

RIDDOR (Reporting of Incidents, Injuries, Diseases and Dangerous Occurrences Regulations 2013) should be reported on Datix and to the Health and Safety Executive (HSE) via the HSE link on Datix.

Staff wishing to raise concerns in accordance with the Freedom to Speak up: Raising Concerns Policy should utilise the reporting facility in that policy.

The Trust is committed to continue to improve its reporting culture throughout all professional groups of staff and others who work with it. It achieves this by ensuring that action is taken, changes in practice are implemented and services are improved as a direct result of the review and investigation of incidents and by identifying and reacting to themes.

9.3 Board Assurance Framework (BAF)

The Board Assurance Framework provides the Board of Directors with an oversight of the strategic risks to meeting the Trust's objectives together with the controls and methods of providing assurance that controls are effective. Risks on the BAF are owned by Trust Directors.

The BAF maps out the controls already in place and the assurance mechanisms available so that the Board can be confident that they have sufficient assurances about the effectiveness of the controls. The risks are cross-referenced to the risks on the corporate risk register.

The Board receives the Board Assurance Framework at its public meetings. All other Board committees may make recommendations for including or amending strategic or significant risks. The BAF forms part of the evidence to support the Annual Governance Statement produced as part of the Annual Report and Accounts.

A standard operating procedure is in place describing the process for managing the BAF and gaining assurance on the management of risk.

The assessment of risk within the BAF is reviewed at the Risk and Compliance Group. The risks on the BAF are scrutinised a minimum of three times a year in line with the

frequency in the Standard Operating Procedure by the Board of Directors with input from the Quality Committee, the Finance and Performance Committee and the Workforce Committee. Oversight of the system of risk management, including the BAF, is provided by the Audit and Risk Committee. The Trust will continue to review and amend both the risk register and the BAF content in line with best practice identified, for example through audit and benchmarking.

The Board Assurance Framework is closely linked with the high-level risk register (HLRR), which reflects significant risks identified at both a corporate department and divisional level. The Company Secretary and the Senior Risk Manager ensure that the link between the High-Level Risk and the Board Assurance Framework is maintained, and that the Audit and Risk Committee is satisfied that this is occurring.

9.4 Risk Registers

All areas assess record and manage risk within their own remit, reporting on the management of risks through the risk register, using the risk grading system detailed at Appendix 4. All risks are linked to strategic objectives.

A database is used to capture all risks to the organisation including clinical, organisational, health and safety, financial, business, and reputational risks. A framework is in place for assessing, rating, and managing risks throughout the Trust, ensuring that risks are captured in a consistent way. Risks can be analysed by risk score, division, directorate, and team. Further detail on the process for populating the risk register is given in the Risk Management Policy.

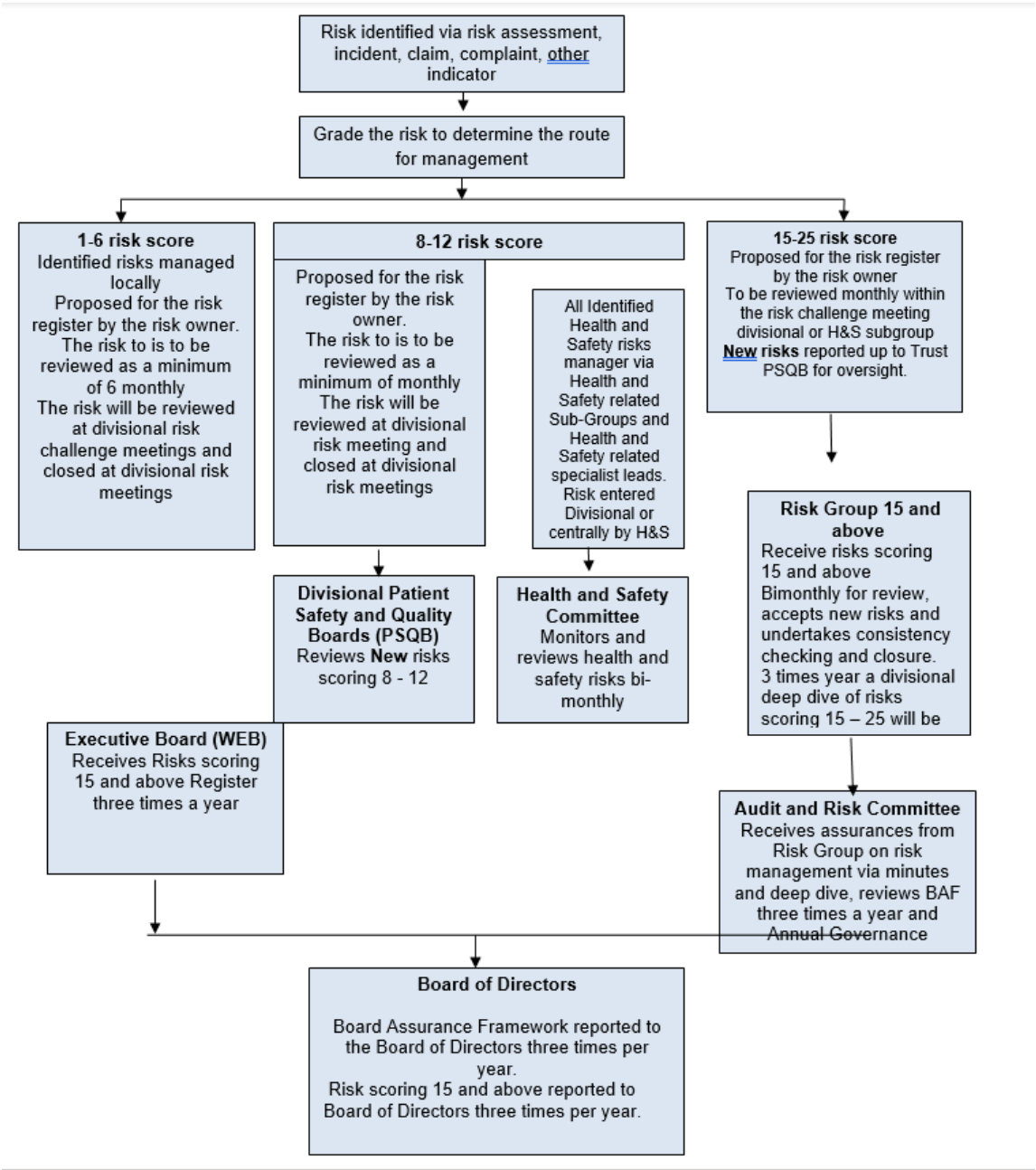
It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the Corporate Risk Register which is an integral part of the Trust's system of internal control.

The high-level risk register includes those significant risks which may impact on the Trust's ability to deliver its objectives, with a risk score of 15 or above. These are reviewed monthly by the Risk and Compliance Group and presented to the Board of Directors.

Divisional, directorate and team risk registers are managed and reviewed by the Divisions, with divisional risk registers reviewed on a regular basis by the Risk and Compliance Group. The performance framework for divisions also includes scrutiny of risks within divisions, including risks regarding technology from divisional Digital Board meetings. The Risk Management Policy details the process for risk register reporting.

The diagram overleaf depicts the flow of risks throughout the organisation from identification to assessment and management according to severity throughout the Trust.

Structure and flow chart for the management of assurance and risk



9.5 Compliance Register

As part of good governance and being a well-led organisation, to ensure that the Trust manages risks and responds to issues highlighted in external reviews, each division and corporate services maintain a register of compliance. This register provides an overview of compliance with regulatory standards, (financial, performance, estates, and quality). Guidance is provided to divisions to ensure consistency of the content of compliance registers.

The register is a systematic approach to recording external assessments of standards through inspections, peer reviews and accreditations, in line with the Trust policy for Managing External Agency Visits, Inspections and Accreditations, ensuring an

organisational overview of any aspects of non-compliance, forward planning for future assessments and identification of potential risks.

The register details the date and type of assessment, level of compliance, actions required, consequence of non-compliance and any associated risks. It also includes the date the next assessment is due.

Each division presents their compliance registers to the Risk and Compliance Group for review every two months. Divisional compliance registers are reviewed at divisional Patient Safety Quality Board meetings to provide assurance that appropriate information is recorded, and actions are being progressed.

9.6 Risk Management Specialists

The Trust has risk management specialists who possess and maintain appropriate qualifications and experience so that competent advice is available to staff. As well as supporting staff manage risks, these specialists create, review, and implement policies, procedures, and guidelines for the effective control of risks.

Responsibilities of staff at all levels for risk are given at section 8. Details of Trust risk management specialists are given at Appendix 3.

9.7 Risk Management Software

The Trust uses two risk management databases, Datix, for incident reporting, complaints, concerns, claims and inquests to support identification, management and investigation into adverse events and a bespoke database for the risk register. The Datix system allows the Trust to share information and triangulate data on an individual and aggregate basis. This provides an easy way for staff to report and get feedback on incidents, ensure an appropriate level of investigation based on severity, capture actions and learning from adverse events and analyse data to identify themes and trends for the whole organisation.
A bespoke database is used for the management of the risk register, which allows reporting and analysis at directorate, divisional and Trust-wide level.

9.8 Risk Identification and Assessment

Risk assessment is a systematic and effective method of identifying risks and determining the most effective means to minimise or remove them. It is an essential part of risk management within the Trust.

The formal pro-active method of identifying operational risks within the Trust is using risk assessments. Clinical and non-clinical risk assessment is used to populate directorate, divisional and corporate risk registers. The Board of Directors is responsible for identifying strategic risks associated with the strategic direction of the organisation.

All risk assessments in all departments should be regularly updated and formally reviewed on an annual basis.

It is essential to identify the scale and significance of a risk. It is important to distinguish between these elements and to provide a clear and applied assessment; a risk may be

extreme in scale without having great significance and vice versa. Equally it is important to assess and manage cumulative risk.

Guidance for staff on risk assessment is given in the Risk Management Policy.

9.9 Risk Grading Matrix

Staff should use the risk grading matrix, adapted from a national model by the National Patient Safety Agency for the NHS, to ensure a consistent approach to assessing risks.

The risk grading matrix provides a description of risk types and defines an impact score from 1 – 5 and a likelihood score from 1 – 5. The impact score multiplied by the likelihood score determines the actual grading of the risk – refer to Appendix 4 for details.

The information produced from the risk assessment is used to populate the risk register.

For assessment of the severity of incidents, the Trust uses the grading scale given at Appendix 4 which grades no harm incidents as green, incidents with minimal harm as yellow, incidents with moderate or short-term harm as orange and incidents where there is severe or long-term harm or death as red incidents.

Complaints are assessed in line with the grading policy within the complaints policy which is based on patient experience.

9.10 Root Cause Analysis / Learning

Formal root cause analysis is used throughout the Trust providing a structured approach for the analysis and identification of learning from incidents, complaints, and claims. This is used in investigations to identify how and why incidents occur and inform actions and learning to prevent harm.

The Trust uses the Yorkshire and Humber contributory factors' framework, a tool from the Improvement Academy with an evidence-base to optimise learning and address causes of patient safety incidents from incidents within hospital settings. It takes a systems approach and identifies situational factors, local working conditions, latent/organisational factors and latent/ external factors and general factors that contribute to error, providing an opportunity to learn from error and prevent factors that cause harm to patients.

The Trust has a clear framework for undertaking root cause analysis for all moderate harm and severe harm incidents. This ensures that action is taken to prevent the potential for recurrence locally and at a corporate level. Specific root cause analysis processes have been developed for specific incidents, i.e., pressure ulcers, infection related incidents. These are detailed in the Incident Reporting Policy.

10. Risk Management Training

To develop a risk aware culture and to ensure successful Implementation of this strategy there needs to be training for staff.

Risk management training and awareness already occurs in several different methods, e.g., Board workshops, risk register training, root cause analysis training, complaints investigation training, Datix training as well as ad hoc training.

11. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, 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, gender reassignment, race, disability, age, sexual orientation, religion, or religious/philosophical belief, marital status, or civil partnership.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

12. Monitoring the Effectiveness of this Strategy

The strategy will be reviewed on a three-year basis or sooner as required.

A review process will be developed to assist in evaluating performance and progress in developing and maintaining effective risk management capability within divisions and corporate functions across the organisation and the effectiveness of risk management control processes. This will include leadership for risk management, local ownership of risk, equipping staff to manage risk well, governance arrangements to support the risk management framework, policies, and procedures.

13. Associated Documents/Further Reading

The relevant policies and procedures listed in section 9.1 should be read in accordance with this strategy.

APPENDIX 1

Definitions

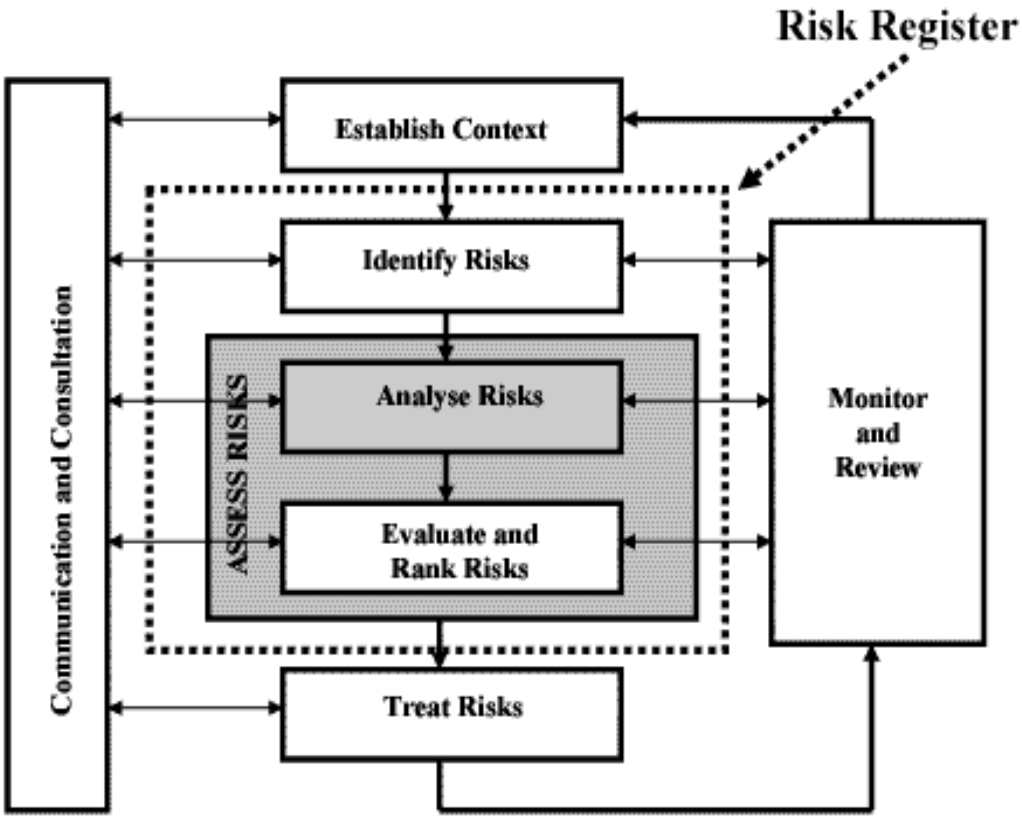
Risk is the chance that something will happen that will have an impact on the achievement of the Trust's aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the risk occurring). See section 9.8 and Appendix 4.

Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

The **risk management process** is the systematic application of management policies, procedures, and practices to the task of establishing the context, identifying, analysing, evaluating, treating, monitoring, and communicating risk. It is described in the diagram below.

Significant risks are those which, when measured according to the grading tool at Appendix 4, are assessed to be significant, with a risk score of 15 or more. The Board will take an active interest in the management of significant risks.

Cumulative risks are individual risks from different areas which, when added together, may combine to become a significant risk.



Risk Management Overview from AS/NZS 4360:19

APPENDIX 2

Supporting Policies

There are several key policies which support the effective management of risk, including the risk management policy which provides operational details of how we manage risk across the organisation. This policy/procedure should be read in accordance with the following Trust policies, procedures, and guidance:

Risk Management / Corporate

- Being Open / Duty of Candour Policy
- Central Alerting System
- Complaints policy
- Conflicts of Interest and Standards of Business Continuity
- Control of Substances Hazardous to Health (COSHH)
- Claims policy.
- Emergency Preparedness, Resilience and Response Policy
- External Visits Policy
- Fire Safety Strategy
- Health and Safety policy
- Incident Reporting, Investigation and Management policy
- Major Incident policy
- Inquest Policy
- Information Governance Strategy and associated policies
- Policy for Developing Policies
- Risk Management Policy
- Safe Management of Contractors
- Security Policy
- Waste Management Policy
- Violence and Aggression in the Workplace

Workforce and Organisational Development

- Capability policy
- Freedom to Speak Up: raising Concerns Policy
- Harassment and Bullying Policy
- Induction policy
- Mandatory Training Policy
- Mental Wellbeing and Stress Management Policy
- Personal Development Review

Clinical

- Blood Transfusion policy
- Consent Policy
- DOLS
- Electronic Patient Record Standard Operating Procedures
- Falls Prevention and Management policy.
- Infection Control policies
- Maternity Risk Management Strategy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Policy on the implementation of NICE guidelines
- Point of Care Testing Policy
- Safeguarding Adults Policy
- Safeguarding Children Policy
- Slips, Trips and Falls Policy

• Policy on the Appointment of Medical locums • Promoting Good Health at Work Policy • Race Equality Scheme		

All operational policies, procedures and guidance also support the effective management of risk. These can be found on the Trust intranet.

APPENDIX 3

Risk Management Specialists

Caldicott Guardian
The Caldicott Guardian is a senior health professional who oversees all procedures affecting access to person-identifiable health data, protecting the confidentiality of patient and service user information.

Senior Information Risk Owner
As the Trust Senior Information Risk Owner (SIRO), the Chief Information Officer is responsible for ensuring that the Trust creates and manages its information risks, through the development of a network of Information Asset Owners (IAAs) and Information Assess Administrators (IAAs).

Information Governance Manager
The Information Governance Manager is responsible for ensuring that the Trust has a robust Strategy of policies and procedures for the management of the Trust's information, both corporate and clinical/patient.

The Information Governance Manager liaises with the Trust's Caldicott Guardian and Senior Information Risk Owner to ensure that the Trust meets and complies with the standards set out in the Information Governance Toolkit.

Data Protection Officer –the data protection officer is responsible for collection and protection of personal data and ensures the Trust follows the law and appropriate regulations.

Company Secretary
The Company Secretary is responsible for ensuring the strategic risks for the organisation are captured in the Board Assurance Framework and that there are effective processes in place for managing central alerts. The role also ensures that the supporting Committee structure of the Board and their terms of reference reflect the Committee's risk responsibilities system. This role also ensures that the Trust is aware of any compliance issues, i.e., via the Single Oversight Framework from NHS Improvement, and that any risks associated with new business or service change which may impact on the Trust ability to adhere to the Single Oversight Framework are appropriately reported throughout the organisation.

Chief Nurse
The Chief Nurse is the Executive lead for risk management and patient safety in partnership with the Medical Director, ensuring organisational requirements are in place which satisfy the legal requirements of the Trust for quality and safety, patients, and staff, including delivery of processes to enable effective risk management and clinical standards.

Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) has the following role and responsibilities: oversee local control of infection policies and their implementation; responsibility for the Infection Prevention and Control Team within the healthcare organisation, report directly to the Chief Executive and the Board, challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions;

assess the impact of all existing and new policies and plans on infection and make recommendations for change; be an integral member of the organisation's clinical governance structures.

Medical Director
The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Chief Nurse and leads the quality improvement strategy. The Medical Director is responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision, and revalidation.

The Medical Director is also responsible for managing safety incidents in NHS screening programmes where the Trust is involved.

Other Executive Directors
Director of Workforce and Development has executive responsibility for health and safety.

Director of Finance has responsibility for managing the PFI provider and Calderdale Huddersfield Solutions to manage estates risks.

Chief Operating Officer has responsibility for security management, Trust resilience and fire safety.

Head of Midwifery
The Head of Midwifery is the professional and management lead for midwives and is responsible for the co-ordination of clinical risk, providing expert advice for risk management within maternity services and responsible for supporting and embedding the implementation of risk management within maternity services. A Maternity Risk Management Strategy supports the continual improvement of the quality of clinical care through effective management of clinical risks and details roles and responsibilities for maternity risk management.

Fire Safety Manager
This includes the provision of a fire safety strategy and fire training for all staff in terms of prevention, fire precautions and safe evacuation. The role also includes ensuring each area has a current fire risk assessment. They also provide specialist advice to design consultant/architects in respect of statutory structural fire safety incorporating the requirements of health technical memorandum 05 Fire Safety requirements.

Health and Safety Advisor
The Health and Safety Advisor is responsible for monitoring all staff related incidents on a regular basis and ensuring this is reported to the Health and Safety Committee. They will organise health and safety training and education of staff to support CHFT's compliance with health and safety requirements. Duties of all employees are detailed in the health and safety policy.

Resilience & Security Manager
The overall objective of the Trust Resilience and Security Management Specialist is to serve two separate functions as a designated Emergency

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Planning/Business Continuity Manager and the Local Security Management Specialist (LSMS) is to identify the work programs required to comply with both the Civil Contingencies Act (2004) and the NHS Protect Security Management Standards, as dictated by national service provision contract standards. The associated corporate work programs will form the basis of ongoing developmental work and an implementation plan to deliver compliance against legislation and standards.

Controlled Drugs Officer
The Clinical Director of Pharmacy is the controlled drugs accountable officer for the Trust (CDAO) in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006) and has responsibility for all aspects of controlled drugs management within the Trust, including standard operation procedures for controlled drugs, procurement and storage arrangements and oversight of the safe practices for prescribing and administration of controlled drugs, investigation of medication incidents.

The Clinical Director of Pharmacy is also the Chief Pharmacist and is responsible for policy and strategy in respect of medicines management.

Medication Safety Officer
The Trust has a Medication Safety Officer who oversees medication error incident reporting and learning to improve medication safety.

Radiation Protection
The Trust has a Radiation Protection Board chaired by the divisional Director, with specialist and technical advice on radiation provided by the Radiology department and external radiation protection advisors.

Freedom to Speak Up Guardian
The Guardian acts as an independent and impartial source of advice for staff on raising concerns and will signpost staff to other sources of advice where necessary. In addition, the Guardian will help to support the Trust to become a more open and transparent place to work.

The Senior Risk Manager has day-to-day responsibility for risk management process, management including:

- the development of risk management strategy and policies
- administration of risk management systems
- oversight of risk exposures facing the business
- provision of risk management training and support to divisions
- the maintenance of the high-level risk register
- support the development of local risk registers.
- lead in triangulating and sharing lessons for learning from adverse events
- risk management training
- management of legal services

The Risk Manager also provides advice and support on risk management to staff.

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Associate Director of Quality and Safety – this role has operational responsibility for risk management, complaints and legal services and is supported in this by a Head of Complaints and Legal Services and Senior Risk Manager.

Head of Safeguarding has day-to-day responsibility for ensuring risks relating to safeguarding adults and children are managed in line with local policies and through collaborative working with other agencies and safeguarding practitioners.

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APPENDIX 4 - RISK GRADING MATRIX

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention. Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention. Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability. Requiring time off work for >14 days Increase in length of hospital stay by >15 days. Mismanagement of patient care with long-term effects	Incident leading to death. Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/ complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards. Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards. Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Extremely low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required. Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage. Loss of contract / payment by results Claim(s) >£1 million

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Review Date: July 2023
Review Lead: Head of Risk and Compliance

Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

2 Likelihood score

What is the likelihood of **the impact / consequence** occurring?

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen?	This will probably never happen/recur.	Do not expect it to happen/recur but it is possible it may do so.	Might happen or recur occasionally.	Unlikely to happen/recur but it is not a persisting issue.	Will undoubtedly happen/recur, possibly frequently.
How often might or / does this happen	Not expected for years	Possible Annual Occurrence	Possible Monthly	Possible to occur weekly.	Expected to occur daily.
Probability	< 1 in 1000 chance	≥ 1 in 1000 chance	≥ 1 in 100 chance	≥ 1 in 10 chance	≥ 1 in 5 chance

Table 3 Risk scoring = Impact / Consequence x likelihood

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risks on the risk register, the scores obtained from the risk matrix are assigned grades as follows.

1- 6	Low Risk
8-12	Moderate Risk
15-25	Significant Risk

UNIQUE IDENTIFIER NO: G-101-2017
Review Date: July 2023
Review Lead: Head of Risk and Compliance

APPENDIX 5

INCIDENT GRADING MATRIX

Degree of Harm	Description	Level of Investigation
No harm / near miss Impact prevented (near miss)	An incident that might have had the potential to cause harm but was prevented, resulting in no harm.	Green (local review)
No harm Impact not prevented	An incident that occurred but no harm resulted	Green (local review)
Low / Minimal harm	An unexpected or unintended incident where patient (s) required extra observation or minor treatment and caused minimal harm to one or more persons.	Yellow (Local investigation)
Moderate / Short term harm	An unexpected or unintended incident where patient(s) required further treatment or procedure which caused significant but not permanent harm (e.g., increase in length of hospital stay by 4-15 days)	Orange Divisional level investigation
Severe / permanent or long-term harm	An unexpected or unintended incident that appears to have resulted in permanent harm.	Red Serious incident investigation
Death caused by the patient incident	An unexpected or unintended incident that directly resulted in death.	Red Serious incident investigation

WORKFORCE FIT FOR THE FUTURE

18. Medical Revalidation and Appraisal Annual Report

For Assurance

Presented by Neeraj Bhasin

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 7th September 2023
Meeting:	Board of Directors
Title:	Revalidation and Appraisal of Non-Training Grade Medical Staff
Author:	Sue Burton, Revalidation and Appraisal Officer
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None
Actions Requested: The report is provided for assurance purposes.	
Purpose of the Report	
To update the Board on the General Medical Council (GMC) revalidation and appraisal compliance for non-training grade medical staff for the appraisal and revalidation year 2022/2023.	
Key Points to Note	
The report also includes 'A Framework of Quality Assurance for Responsible Officers and Revalidation' (NHSE, Version 1.1 February 2023) which requires Board approval prior to submission to NHSE.	
EQIA – Equality Impact Assessment	
The completion of appraisals and the GMC revalidation process make an overall positive contribution to advancing quality in relation to colleague/patient safety across the NHS. The revalidation and appraisal process does not have a negative impact on equality for people with protected characteristics.	
Recommendation.	
This report is submitted to the Board with the assurance that the agreed processes for GMC revalidation and appraisal have been adhered to. The Board is asked to note the contents of the report.	

Signed off by:

Date signed off:

compassionate care

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS – THURSDAY 7th SEPTEMBER 2023

REVALIDATION AND APPRAISAL OF NON-TRAINING GRADE MEDICAL STAFF 2022/2023

1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation. The report will also cover the 2022/2023 appraisal and revalidation year (1st April 2022 – 31st March 2023).

Summary of key points:

- In the revalidation year from 1st April 2022 – 31st March 2023 77 non-training grade medical staff had been allocated a revalidation date by the GMC.
- The completion rate for all appraisals which were required to be completed in the appraisal year was 99.06%. For information our appraisal compliance for each year from 2017/2018 is shown below:

Appraisal Year	Appraisal Completion Rate	Number of Unapproved Missed Appraisals
2022/2023	99.06%	4
2021/2022	99.30%	3
2019/2020	100%*	0
2018/2019	99.70%	1
2017/2018	99.70%	1

* This 100% compliance rate comes with a warning. Appraisals were suspended due to COVID-19 on 23rd March 2020. We were asked by NHSE to record the 16 appraisals which had not been completed by 23rd March 2020 as 'approved missed appraisals'. It is likely that some of those appraisals would not have been completed regardless of COVID-19.

2. Background

2.1 Medical revalidation was launched in December 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of care provided to patients. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

2.2 The Trust has a statutory duty to support the Responsible Officer (Medical Director) in discharging their duties under Responsible Officer Regulations and is expected that the board will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems on place for monitoring the performance and conduct of their doctors;

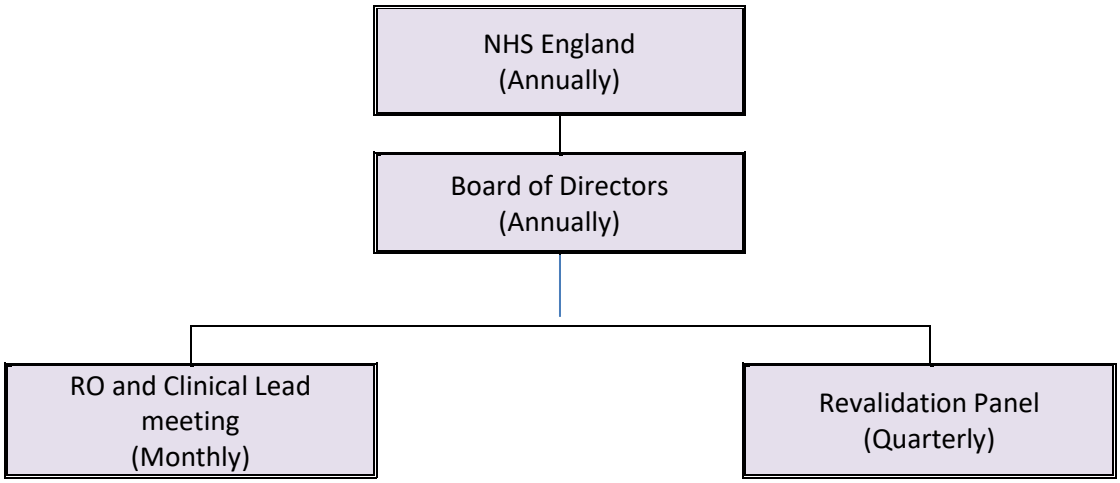
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process;

- ensure that appropriate pre-employment checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

3. Governance Arrangements

3.1 The Trust's governance reporting structure for medical appraisal and revalidation is shown below:



..

3.2 **GMC Connect**

GMC Connect is the GMC database used by Designated Bodies (i.e. Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

GMC Connect is managed by the revalidation administration team on behalf of the Responsible Officer. The Trust's Electronic Staff Record (ESR) is used as the main source in relation to starters and leavers.

4. Medical Appraisal and Revalidation Performance Data for 2022/2023

Revalidation Cycles

4.1 The first revalidation cycle started in January 2013. The majority of doctors (with the exception of new starters and those whose revalidation has been put on hold by the GMC) completed two rounds of revalidation and a positive recommendation made about their fitness to practise by a Responsible Officer (for this Trust this is the Medical Director).

4.2 In the 2022/2023 revalidation year (Year 10) the Responsible Officer has made recommendations for doctors as follows: (see also Appendix A: Audit of Revalidation Recommendations).

Revalidation Cycle (Year 9)	Positive Recommendations	Recommendation Deferred **
Year 10, Quarter 1 (April 2022 – June 2022)	3	0
Year 10, Quarter 2 (July 2022 – September 2022)	16	0
Year 10, Quarter 3 (October 2022 – December 2022)	23	1
Year 10, Quarter 4 (January 2023 – March 2023)	33	1
Total:	**75**	**2**

** The reasons for the two deferrals were long term absence and insufficient evidence being presented. The latter was due to the fact the doctor was relatively new to the organisation and did not provide sufficient or relevant evidence from previous employers for a recommendation to be made.

Medical Appraisal

4.3. Medical Appraisal underpins the revalidation process. Doctors are expected to complete five appraisals within the revalidation cycle.

4.4 The appraisal year runs from 1st April – 31st March (at CHFT we ask that all appraisals be completed by 28th February) . The table below shows the compliance rate at the end of the 2022/2023 appraisal year on 31st March 2023 (see also Appendix B – Audit of all missed or incomplete appraisals).

Grade	Number of doctors with prescribed connection to CHFT	Completed Appraisals	***Approved incomplete or missed appraisal	Unapproved incomplete or missed appraisal
Consultants (permanent)	270	251	17	2
Staff Grade, Associate Specialist, Specialty Doctor (permanent)	83	71	10	2
Temporary or short-term contract holders (all grades)	73	54	19	0
Total	**426**	**376**	**46**	**4**

*** Approved missed appraisals apply to:

- new starters who are not required to complete an appraisal within the specified appraisal year. This number makes up the majority of the approved missed appraisal number.
- non training grade medical staff who have missed an appraisal for a valid reason eg maternity leave, long term absence etc or any other reason deemed valid in consultation with the Clinical Lead for Appraisal and Revalidation.

5. Allocation of Appraisers

5.1 The revalidation administration team allocates appraisers to appraisees and allocates the month the appraisal should take place.

6. Quality Assurance of the Process

6.1 The process used to monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal;
- The appraiser;
- The appraisal discussion.

All appraisals submitted as part of the revalidation process are reviewed thoroughly by the Clinical Lead for Revalidation and Appraisal. This involves a comprehensive review of the appraisal form (appraisal inputs and supporting information).

6.2 The Clinical Lead for Revalidation and Appraisal also routinely quality assures a sample of appraisals submitted in addition to appraiser feedback which is completed by appraisers on the PReP electronic appraisal system.

We quality assure the performance of our medical appraisers by reviewing the appraiser feedback questionnaires completed by each appraisee. Completion of the feedback is mandatory part of the appraisal process for appraisees. Individual feedback is sent to each appraiser for the appraisal year if they completed a minimum of 4 appraisals. Appendix C shows the average scores for each of the domains for active appraisers in the last appraisal year (1st April 2022 – 31st March 2023).

6.3 **Access, security and confidentiality**

Historical appraisal folders, supporting information and all correspondence relating to the revalidation processes are stored on the Trust network drive. Access to the drive is restricted to the Responsible Officer, the Clinical Lead for Appraisal and Revalidation and the Revalidation administrative support. All appraisals since 2017 and supporting information are stored on the PReP system which is ISO27001 accredited, GDPR compliant, 100% IG Toolkit compliant. Access to appraisals is in line with the Appraisal Policy for non-training grade medical staff.

6.4 **Clinical Governance**

Data is provided annually by the Trust to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to CHFT activity data, benchmarking data and attendance at audit.

7. Update

a) Audit of Revalidation and Appraisal Processes

During 2022 Audit Yorkshire undertook an audit of the medical revalidation processes across CHFT. The final report was received in December 2022. The Trust received a high assurance level for each of the control objectives. The summary stated: 'The Foundation Trust has a robust process in place to ensure that its responsibilities for identifying doctors requiring validation are met and that the Responsible Officer has sufficient and timely information with which to make a recommendation to the GMC'.

a) PReP – Appraisal Form

The PReP e-appraisal form was amended in light of NHSE guidance during COVID-19 with , greater emphasis being placed on providing support in light of COVID-19, and to offer an opportunity for a confidential discussion to explore the personal and professional experiences of COVID-19 for the appraisee. We have now reverted to using the former appraisal form focussing more on continuing professional development and quality improvement whilst maintaining the focus on well-being introduced in the COVID-19 amendments.

c) Framework of Quality Assurance for Responsible Officers (NHS)

This report also includes as an attachment, 'A Framework of Quality Assurance for Responsible Officers and Revalidation' (NHSE, Version 1.1 February 2023) which requires Board approval.

8 Action Required of the Board

The report is provided for assurance purposes.

Dr David Birkenhead
Medical Director/Responsible Officer
August 2023

ppendix A

Audit of Revalidation Recommendations (1st April 2022 - 31st March 2023)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Revalidation Recommendations made between 1st April 2022 and 31st March 2023

	Number
Recommendations completed on time (within the GMC recommendation window)	77
Late recommendations (completed but after GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	**77**
Primary reason for late/missed recommendations For late or missed recommendations only one primary reason may be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctors revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for responsible officer role	0
Other	0
TOTAL SUM OF LATE AND MISSED RECOMMENDATIONS	**0**

Appendix B

Audit of all missed or incomplete appraisals audit (1st April 2022 - 31st March 2023)

(Template taken from 'A Framework of Quality Assurance for Responsible Officers and Revalidation – Annex D Annual Board Report Template – June 2014)

Doctors Factors (Total)	**Number**
Maternity leave during the majority of the 'appraisal due window'	3
Sickness absence during the majority of the 'appraisal due' window'	3
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	0
New starter within 6 months of appraisal due date	35
New starter more than 3 months from the appraisal due date	0
Postponed due to incomplete portfolio/insufficient reporting information	0
Lack of time of doctor	0
Lack of engagement of doctor	4
Other doctors' factors (describe)	0
	46
Appraiser Factors (Total)	
Unplanned absence of appraiser	0
Lack of time of appraiser	0
Other appraiser factors (describe)	0
Organisational Factors (Total)	
Administration or management factors	0
Failure of electronic information systems	0
Insufficient numbers of trained appraisers	0
Other organisational factors (describe)	0

Appendix C

Medical Appraiser Feedback Report 2022/2023

All ratings by appraisees have a numerical value and the average for each section is calculated out of 5. Categories determined by Premier IT (PReP) e-appraisal system. The table below shows the average scores for the 65 active appraisers at 31st March 2023.

Period of Feedback Submitted: 1st April 2022 – 31st March 2023

Scores: Poor 1.00 – 1.99 Borderline 2.00 – 2.99 Satisfactory 3.00 – 3.99 Good 4.00 – 4.99 Very Good 5.00

Categories						
Their preparation for my appraisal	**Their ability to conduct my appraisal**	**Their ability to review progress against last year's personal development plan (PDP)**	**Their ability to help me review my practice**	**Usefulness for my professional development**	**Usefulness in preparation for revalidation**	**Usefulness of my new PDP**
Range of Scores: 3.75 (1) – 5.00 (13)	Range of Scores: 4.25 (2) – 5.00 (20)	Range of Scores: 4.00 (1) – 5.00 (16)	Range of Scores: 4.00 (1) – 5.00 (16)	Range of Scores: 3.75 (1) – 5.00 (9)	Range of Scores: 3.80 (1) – 5.00 (10)	Range of Scores: 4.00 (4) – 5.00 (8)
4.72	4.79	4.71	4.72	4.58	4.63	4.59

Classification: Official

Publication reference: PR1844

NHS England

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020 but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board of Calderdale and Huddersfield NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes, Dr David Birkenhead, Medical Director *Action from last year: No specific actions* *Comments: None* *Action for next year: No specific actions*

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes *Action from last year: No specific actions* *Comments: None* *Action for next year: No specific actions*

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Yes *Action from last year: No specific actions* *Comments: The GMC Connect list is regularly reviewed for accuracy.* *Action for next year: No specific actions*

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Yes *Action from last year: No specific actions* *Comments: None* *Action for next year: the Appraisal Policy for Non-Training Grade Medical Staff is due to be reviewed in November 2024.*

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year. An audit of Medical Revalidation processes was undertaken by Audit Yorkshire in 2022. Comments: The final report received in December 2022 gave the Trust a high level of assurance. CHFT was found to have robust processes in place to ensure that the responsibilities for identifying doctors requiring revalidation are met and that the Responsible Officer has sufficient and timely information with which to make a recommendation to the GMC. Action for next year: No specific actions

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Yes *Action from last year: The Revalidation and Appraisal Team continue to offer one to one support to all short-term medical staff.* *Comments: None* *Action for next year: To continue as present.*

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1] *Yes* *Action from last year: No specific actions*

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Comments: The Medical Appraisal Guide 2022 appraisal revisions are being introduced.

Action for next year: To ensure the revised Good Medical Practice Guidelines to be introduced later this year are incorporated into the appraisal process and to provide awareness sessions for medical staff of the changes.

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Not applicable

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Yes

Action from last year: None

Comments: None

Action for next year: The medical appraisal policy is due to be reviewed in November 2024

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Yes

Action from last year: No specific actions

Comments: We organise regular refresher sessions for existing trained appraisers.

Action for next year: No specific actions.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: No specific actions

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Comments: We continue to run refresher training sessions for our existing appraisers. They are sent anonymised feedback from their appraisees at the end of the appraisal year.

Action for next year: No specific actions

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Yes

Action from last year: No specific actions

Comments: A report is submitted to the Executive Board annually highlighting appraisal and revalidation performance.

Action for next year: No specific actions

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	**376**
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	**4**
Total number of agreed exceptions	**46**

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Yes

Action from last year: No specific comments

Comments: All recommendations were made in advance of the revalidation dates

Action for next year: No specific actions

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Yes

Action from last year: No specific actions

Comments: All doctors are contacted in writing regarding the recommendation which is to be made. This is ordinarily within 24 hors of the revalidation panel meeting and prior to the recommendation being made on GMC Connect.

Action for next year: No specific actions

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: No specific actions

Comments: The Trust has robust clinical governance processes (eg supporting doctors with revalidation and appraisal, continuous learning and improvement using mechanisms such as audit/review, patient feedback, investigating concerns, promoting freedom to speak, duty of candour etc)

Action for next year: No specific actions

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Yes

Action from last year: No specific actions

Comments: All doctors are informed in advance of their appraisal month and the appraiser they have been allocated. They are provided with clinical activity data available and details of any complaints, incidents or claims they have been named in.

Action for next year: No specific actions

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: No specific actions

Comments: The Trust has a robust policy in place which complies with national and local MHPS processes.

Action for next year: No specific actions

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: No specific actions

Comments: The Board and the Workforce Committee (a board sub-committee) receives a regular report that captures employees where concerns are raised and formal processes instigated. The Trust is compliant with national and local MHPS processes in accordance with the May 2019 'Improving People Practices' letter from NHSI and has made changes, primarily the support offered to employees, to its formal processes.

Action for next year: No specific actions.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: No specific actions *Comments: We use the MPIT transfer from designed by NHSE for transferring information between Responsible Officers.* *Action for next year: No specific actions*

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: No specific actions *Comments: Safeguards are in place* *Action for next year: No specific actions*

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: No specific actions *Comments: There are systems in place to ensure all appropriate pre-employment checks are undertaken. This is managed by the Workforce and Organisational Development team.* *Action for next year: No specific actions*

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 6 – Summary of comments, and overall conclusion

We are pleased with the level of engagement of our doctors with the appraisal process. We have started to formally use the feedback submitted by our appraisees regarding the appraisal process and the feedback indicates that doctors do value the process.

Over the next 12 months we want to improve our revalidation and appraisal induction for new starters. Whilst all our new starters have a one-to-one meeting with a member of the revalidation and appraisal administration team shortly after joining the Trust we feel this can be improved by running revalidation and appraisal workshops for groups of new starters once they have had a chance to settle into their new roles

Section 7 – Statement of Compliance:

The Board of Calderdale and Huddersfield NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Calderdale and Huddersfield NHS Foundation Trust

Name: Brendan Brown Signed:

Role: Chief Executive

Date:

NHS England
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

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KEEPING THE BASE SAFE

19. Maternity and Neonatal Oversight Report including CQC Maternity Report

For Assurance

Presented by Lindsay Rudge

Date of Meeting:	Thursday 7 September 2023
Meeting:	Public Board of Directors
Title of report:	Maternity and Neonatal Oversight Report
Author:	Diane Tinker, Director of Midwifery and Women's Services Simon Riley-Fuller, Associate Director of Nursing, FSS
Sponsor:	Lindsay Rudge, Chief Nurse, Exec Director Maternity Safety Champion
Previous Forums:	Quality Committee
Purpose of the Report	To provide the Board of Directors with a suite of information that provides an oversight of key quality issues within maternity services.
Key Points to Note	• Monthly Maternity and Neonatal Transformation Board chaired by the Chief Nurse will have oversight of delivery against the 3 Year Delivery Plan for Maternity and Neonates. • Year 5 of the Maternity Incentive Scheme was launched on the 31 May 2023 with a submission date of the 1 February 2024 at 12 noon. • CQC maternity inspection took place on the 7 and 8 June, following notification on the 5 June, with data submitted on the 8 June. • The Trust received the final report which was published on the 25 August 2023. • The Maternity Services maintained the overall rating of Good. • Are services safe was rated a Required Improvement, down from Good in 2018. • Are services well-led was rated as Good, maintained from 2018. • The service currently has 4 HSIB cases open in month and a resume of each case is included within the report. • There were no stillbirths or neonatal deaths in June 2023. • The neonatal unit has recently received Certificate of Commitment from UNICEF for Neonatal Baby Friendly Status, with the aim to achieve Stage 1 by April 2024. Current breastfeeding data: o On day 2 - 35.5% of babies on the neonatal unit are receiving breast milk o On day 14 - 80.8% of babies on the neonatal unit are receiving breast milk o On discharge from the neonatal unit 71.4% of babies are receiving breast milk • The Chief Nurse (Maternity and Neonatal Board Safety Champion) undertook a walk around on the maternity inpatient wards, where there was discussion regarding a recent incident that occurred on the ward and how was the team's wellbeing following the incident. The Chief Nurse also has monthly 'Open

	Door' sessions, the dates and times are shared via the 'Weekly View'. • Midwifery services submit workforce data to NHSEI each month and in May 2023 recorded 147.19 whole time equivalent (WTE) midwives which includes 3 Matrons and the Deputy Director of Midwifery but does not include 3.80WTE staff nurses against a new workforce establishment of 174.63 WTE midwives. • Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. In May 2023 the LDRP co-ordinator was supernumerary on 100% of the shifts and 1:1 care in labour was 99.5%. • There are currently no consultant vacancies, which supports full consultant cover on LDRP. The maternity services are currently reviewing the proposal for a split obstetrics and gynaecology rota, with continued work on a proposal. • There are 3 gaps within the registrar rota due to 2 senior registrars being successful in being appointed to consultant posts at CHFT. Additionally, there are 3 registrars who are on restricted duties or due to start maternity leave. This has impacted significantly on the ability to cover all rotas required, with these rota gaps, acute cover across both obstetrics and gynaecology is always prioritised which results in some planned activity being cancelled. • Latest quarter 2 National Neonatal Audit Programme (NNAP) data highlighted that CHFT neonatal staffing is 60.1% which is below the national average of 74.3%. The expected levels are measured against the British Association of Perinatal Medicine (BAPM) standards. To maintain safety each shift is risk assessed and concerns escalated through the Trust escalation processes. There is a robust mechanism in the division that reviews the staffing position and skill mix, and this is informing ongoing work around neonatal workforce modernisation. • The neonatal unit has received external recurrent funding from the Neonatal Operational Delivery Network (ODN) for 23hours per week Band 7 Governance Lead and 18 hours Band 7 Education Lead, this is currently in the process of job matching prior to the recruitment process. • The neonatal unit has also received recurrent external funding and has successfully recruited to 30 hours per week registrar to cover night shifts. • Successful implementation of Badgernet EPR on the neonatal unit in July, now implementation phase 2 which is the interfacing of the equipment to Badgernet. The interfacing facilitates an automatic pull through of all data from clinical equipment including observations, fluid infusion rates and ventilator settings.
EQIA – Equality Impact Assessment	There is significant evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor.

	Maternity services have an active Health Inequalities work stream to drive improvement work for those most at risk. CHFT's midwifery reader has produced a cultural survey that has been shared with staff to understand knowledge gaps ahead of developing training opportunities for midwives and obstetricians.
Recommendation	The Board of Directors asked to note the assurances provided within the report.

Maternity and Neonatal Report for Quality Committee

1. Maternity Transformation Plan

Action Plan		New Action	Not Yet Started	area of concern	In Progres	On Track	Completed	Total Actions	Comments and exceptions
3 year Delivery Plan for Maternity and Neonates	this is following the Ockenden 2 report and the East Kent review	0	7	0	25	0	7	39	initial benchmarking exercise undertaken against the three year plan. Multi professional MVP and organisation Transformation Board set up to provide oversight of the plan and agree timeframe
Maternity Insentive scheme year 5	provision for the maternity incentive scheme has been built into our CNST maternity pricing for 2022/23. incentivises ten maternity safety actions	0	0	0	13	21	0	34	initial review, a couple of areas that need further work is 1. Compensatory rest for Consutlants following on call this happended in a add hoc way but would need a change in the current roster and job plan and potentailly further investment or reduction - other area is the
Maternity Self-Assessment	A self assessment that is outlined in Ockenden 2	0	0	30	33	0	107	170	Self assessment undertaken initially in June and reassessed in Sept Self assessment reviewed again March 23 will review again in 6 months - seen some progress with Marchs benchmarking
GIRFT Maternity	As above	0	6	0	12	0	5	23	no further updates
GIRFT - Gynae	national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change	0	18	0	17	0	0	35	Newly benchmarked this month further action to be taken
Governance	locally designed plan that addresses governance in Maternity	0	0	0	0	0	18	19	All completed

The monthly Maternity and Neonatal Transformation Board is chaired by the Chief Nurse will have oversight of delivery against the 3 Year Delivery Plan for Maternity and Neonates. The board membership includes safety champions, the Maternity Voice Partnership (MVP) chair and colleagues from the LMNS and ICB.

The last outstanding action on the Governance action plan has now been completed and will be archived.

2. NHS Resolution Maternity Incentive Scheme

Year 5 of the Maternity Incentive Scheme was launched on the 31 May 2023 with a submission date of the 1 February 2024 at 12 noon.

Maternity Incentive Scheme reporting requirement

No concerns or requests for action have been directed to the Trust from HSIB, NHSR or CQC.

The Trust has had no current or new coroner regulation 28's in relation to maternity and neonatal services.

3. Care Quality Commission

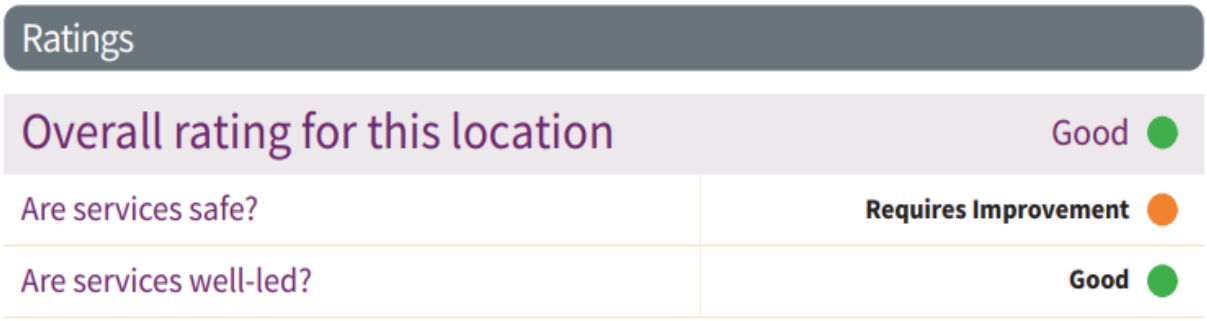
The CQC have been undertaking inspections as part of the national maternity service inspection programme which aims to provide an up-to-date view of the quality of hospital based maternity care and a better understanding of what is working well to support learning and improvement. The inspection focused on Safe and Well Led domains.

CHFT inspection took place on the 7 and 8 June, following notification on the 5 June, with data submission required by the 8 June.

The Trust received the final report which was published on the 25 August 2023.

The Maternity Services maintained the overall rating of Good.

Are services safe was rated a Required Improvement, down from Good in 2018.
Are services well-led was rated as Good, maintained from 2018.



Inspectors found the following during inspection:

- Managers monitored the effectiveness of the service and made sure staff were competent.
- There were additional clinics and support for people who were having a surrogacy pregnancy.
- The service engaged well with women, people using the service and the community.
- A bereavement clinic had been set up by a midwife and consultant obstetrician for people who had a non-viable pregnancy or had experienced a previous baby loss.
- Leaders ran services well using reliable information systems and supported staff to develop their skills.
- The service controlled infection risk well.
- The service managed safety incidents well and learned lessons from them.
- Staff assessed risks to people, acted on them and kept good digital care records.
- Policies did not always reflect the most up to date and appropriate guidance available**.**

Inspectors found the following Outstanding practice during inspection:

- A breast milk donation bank was run by the service, this was both a resource to supply breast milk to pre-term and in need babies within the service and a source of income.
- A Rainbow bereavement clinic was run by a midwife and consultant obstetrician for women and birthing people who had a non-viable pregnancy or had experienced a previous baby loss. The aim of this clinic was to provide a greater level of psychological and clinical support.
- Surrogacy work- the service had introduced additional clinics and support for women and birthing people who were having a surrogacy pregnancy. This included separate appointments for both the parents and the surrogate and joint appointments depending on preferences. Also, the practicalities of the birth plan as well as visiting both during labour and postnatally had been agreed on an individual basis

Action the trust MUST take to improve:

- The service must ensure all staff are up to date with all relevant training, such as training around the emergency evacuation of the birthing pools on the labour ward for midwifery staff and safeguarding level 3 training for all medical staff. Regulation 12(1)(2)(c)

- The service must ensure there are at all times sufficient numbers of suitably qualified staff to meet the needs of women, birthing people and babies across the maternity service. Regulation 18 (1)

Action the trust SHOULD take to improve:

- The service should ensure that they continue to monitor and drive improvement around compliance with documentation such as CTG fresh eyes and MEOWS. Regulation 12 (2)(b).

- The service should consider the location of the bereavement room as part of planned reconfiguration works in line with best practice guidance and the feedback and fundraising efforts of the local community.

- The service should consider the regular reviews of ligature risk assessments across the service.

- The service should continue to improve on the appraisal rates for all staff.

- The service should continue to develop systems to ensure policies reflect current evidence-based best practice.

4. Healthcare Safety Investigation Branch (HSIB)

As of the 23 June 2023 the maternity services position is:

Total referrals	42
Referrals / cases rejected	15
Total investigations to date	27
Total investigations completed	23
Current active cases	4

HSIB are now reporting data the beginning of April 2019 onwards, when the HSIB maternity programme was live across the whole of England.

Current active cases:

HSIB case number: MI-027147

HSIB criteria: Intrapartum stillbirth

Referral date: 22/05/2023

Immediate actions taken
Issue identified with MAC phone lines regarding multiple diverts and loops – actioned to resolve. Upgrade to phone service to include options to select under consideration to support MAC only receiving clinical advice calls rather than all calls including requests to change appointments.

HSIB case number: MI-025530
HSIB criteria: Early Neonatal Death

Referral date: 17/04/2023

Immediate actions taken
No immediate actions identified following initial CHFT review.

HSIB case number: MI-023484
HSIB criteria: Early Neonatal Death

Referral date: 06/03/2023

Immediate actions taken
No immediate actions identified following initial CHFT review

HSIB case number: MI-019964
HSIB criteria: Maternal Death

Referral date: 30/12/2022

Immediate actions taken
Provision of neonatal resuscitation grab bag for use in births outside the maternity service whilst awaiting arrival of full neonatal resuscitation trolley

Perimortem lower segment caesarean section pack accessible via theatre co-ordinator

Closed case in month: None

Rejected cases in last month: None

5. Maternity Incidents

Maternity incidents reviewed at weekly maternity governance MDT meeting. All incidents are reported via Datix and coded as maternity incidents. The comparative data for April, May2 and June 2023 is described below.

	April 2023	May 2023	June 2023
Shoulder Dystocia	**2**	**5**	**4**
Term admission to the Neonatal Unit	**21**	**12**	**26**
2nd Theatre opened	**6**	**6**	**6**
Delay in Emergency Caesarean Section	**15**	**21**	**16**

Month	Maternity SI's (red)	Maternity orange	Maternity Never Events	Open HSIB cases	Total Stillbirth (SB) / Neonatal Death (NND)	Stillbirths Antenatal	Stillbirths Intra-partum	HIE Grade 2/3	Early NND	Late NND	Notification to ENS	Maternal Mortality
June 2023	0	0	0	4	0	0	0	0	0	0	0	0

No red or orange incidents in June 2023.

No stillbirths or neonatal deaths in June 2023

6. Maternity Dashboard

Key Indicators	Thresholds			May 23	Jun 23	YTD
	Green	Amber	Red			
Total Bookings <13 Weeks	>90%	-	<90%	87.6%	90.53%	89.6%
Total Births within Service	Monitoring Only			379	375	1086
Bookings <10 weeks	>90%	-	<90%	63.1%	61.2%	61.4%
Normal births	>57%	-	<57%	55.7%	54.7%	54.67%
Assisted vaginal births	<12.4%	-	>12.4%	7.92%	6.93%	7.83%
Elective C/S deliveries	Monitoring Only			15.20%	14.40%	14.21%
Emergency C/S deliveries	Monitoring Only			21.07%	22.55%	22.34%
3rd/4th degree tear - normal birth	<2.8%	-	>2.8%	0.3%	0.0%	0.4%
3rd/4th degree tear - assisted birth	<6.05%	-	>6.05%	0.0%	7.7%	4.7%
PPH ≥ 1500ml	<3%	<3.0%	>=3.5%	1.9%	1.9%	2.9%
Total stillbirths	0	<3	>=3	2	0	4
Total stillbirths and Perinatal /Neonatal Deaths	0	<3	>=3	2	0	2
Low birth weight at term - live births - % of live babies at term < 2200g	0%	-	>=1%	0.28%	0.30%	0.89%
1:1 Care in Labour	>=98%	>=97%	<97%	98.4%	99.5%	98.8%
Induction Rate	Monitoring Only			39.0%	39.0%	41.2%
Planned Home Birth	Monitoring Only			2.13%	1.09%	1.40%
Smoking at Delivery	< 11%	-	> 11%	4.00%	7.61%	6.36%
Smoking at Delivery (Not recorded)	3%		>3%	4.5%	8.4%	6.5%
CO tested at booking	Monitoring Only			97.4%	97.1%	95.6%
No. Mothers breastfeeding as First Feed	≥ 74.4%	-	< 74.4%	65.7%	67.9%	65.9%
No. Mothers breastfeeding as First Feed Not Recorded	Monitoring Only			13	29	61
CO testing at 36 weeks (35-36.6 days)	≥ 80%	-	< 70%	82.92%	87.39%	84.55%

7. Neonatal data

The neonatal unit has recently received Certificate of Commitment from UNICEF for Neonatal Baby Friendly Status, with the aim to achieve Stage 1 by April 2024.

Current breastfeeding data:

- On day 2 - 35.5% of babies on the neonatal unit are receiving breast milk
- On day 14 - 80.8% of babies on the neonatal unit are receiving breast milk
- On discharge from the neonatal unit 71.4% of babies are receiving breast milk

Previously the neonatal unit was identified as an outlier from National Neonatal Audit Programme (NNAP) data regarding parents being spoken to by a consultant with 24 hours of their baby's admission. This was addressed and has seen an improvement.

- 2021 – 90.4%
- Q1 2023 – 93.5%

8. ATAIN audit

Summary

- There were thirty-seven (≥ 37 weeks) term admissions to NICU April to June 2023
- The rate of term admissions to NICU was 4% April to June 2023, which is lower than the national average of 5% and LMS average 5.1%.
- All cases of term admissions to NICU are discussed at the weekly maternity governance meeting. The audit form is started at the meeting and completed by the ANNPs.
- The most common reason for admission to NICU was respiratory distress.
- It was identified from the March monthly ATAIN meeting that there was an increase in ATAIN admissions following category 4 LSCS since January 2022. Therefore, it was decided to audit 6 months of ATAIN data between October 2022 to March 2023 (n=23). A review of these cases found contributing reasons being linked to a missing ATAIN risk assessment, skin to skin and feeding at birth. There were three potentially four avoidable admissions.

Actions/decisions required

- Continue to discuss all term admissions to NICU at the weekly governance meeting and complete the audit forms.
- Monitor the number and reason of ATAIN babies following category 4 LSCS.
- To present the ATAIN audit at Maternity Forum.
- The action plan for ATAIN is available on the FSS drive. This is updated at the ATAIN meetings and maternity forum.
- The LMNS dashboard to be repeated and sent to the LMNS.

9. Transitional care audit

Summary

- 38 babies received transitional care during this quarter.
- All within the criteria
- The number of transitional care babies for this quarter is lower than the previous 4 quarterly reports. This may be since not all babies are being captured when not being nursed on 4B, the recognised Transitional care ward.
- 4B closed regularly due to cohorting women and babies at times of staffing escalation.

Actions/decisions required

- To reiterate to all staff that babies must be identified in the ward diary if transitional care, irrespective of which ward they are being cared for on.

- Transitional care is part of the Avoiding Term Admissions into Neonatal Units (ATAIN), and meetings are held monthly.
- Repeat the transitional care audit quarterly.
- Informal discussion has been held with consultant neonatologist about their vision and ideas for improved Transitional care, this to be discussed at the next maternity forum and included on the agenda.
- Transitional care lead to visit a local, successful Transitional care unit and bring back the findings with suggestions in line with BAPM, looking at implementation and improvements for CRH.
- Commitment to maintain 4B as the recognised Transitional Care ward as discussed recently.

10. Perinatal Mortality Review Tool (PMRT) quarterly update

Period	Date	Gestation	Date PMRT review started	Draft report due/ completed	Final report due/ completed	Status
Q4 22/23	14.1.23	36+5	23.1.23	27.4.23	26.6.23	Antenatal stillbirth
Q4 22/23	28.1.23	22+3	1.2.23	25.5.23	12.7.23	Neonatal death.
Q4 22/23	1.2.23	31+2	15.2.23	14.3.23	6.7.23	Antenatal stillbirth
Q4 22/23	2.2.23	39	29.3.23	1.6.23	19.6.23	Neonatal death
Q4 22/23	5.2.23	22+0	1.3.23	25.5.23	3.8.23	Neonatal death
Q4 22/23	2.3.23	23+4	8.3.23	26.6.23	6.7.23	Late miscarriage
Q4 22/23	8.3.23	33+5	8.3.23	26.6.23	26.6.23	Antenatal stillbirth
Q4 22/23	30.3.23	28+6	5.4.23	6.7.23	30.9.23	Neonatal death
Q1 23/24	18.4.23	35+4	26.4.23	10.8.23	10.8.23	Antenatal stillbirth
Q1 23/24	20.5.23	41+2	24.5.23	20.9.23	20.11.23	Intrapartum stillbirth
Maternity Incentive Scheme Year 5 30th May	1.8.23	39+2	10.8.23	1.12.23	1.2.24	Neonatal death

Summary:

- 1 case was not notified to PMR within 7 days, booked at CRH but birthed at Leeds due to known fetal anomaly, baby died at Forget-Me-Not Hospice at 28 days. Parents perspective not been sought for this case
- All other cases the parents have been told that a review is undertaken and perspectives, any questions and concerns have been sought
- 100% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool have been started within two months of each death.
- 100% of suitable cases the parents have been told that a review is undertaken and perspectives, any questions and concerns have been sought
- 100% of all suitable completed draft report within 4 months and final report in 6 months

Actions/decisions required

- There is one action on the PMRT action plan which is not yet completed.
- There are 2 actions which are complete with the evidence of this being compiled.
- The remaining actions have been completed and evidence has been compiled.

11. Complaints

Maternity services currently have 6 open complaints as of 1 August 2023, no complaints overdue, extensions have been requested and agreed with 2 complaints. 1 of the extensions is due to a meeting being arranged with the complaint and the clinical investigators. 1 complaint reopened with complaint requesting a meeting.

Neonatal services currently have 1 open complaint.

The division are continuing to work with the Trust complaint's team to improve compliance with timely complaint responses and have a weekly complaints performance meeting.

12. Service user feedback

The Maternity Voice Partnership (MVP) chair, service users and a colleague from the ICB undertook a 15 Step Challenge throughout the maternity unit and neonatal unit in June. There was positive feedback on the day and the MVP is developing an action plan capturing the areas for improvement.

In addition, a 1 Year Plan for Engagement sessions has been planned which includes focus groups, listening events and quarterly 'Walk the Patch'. The first two planned focus groups although advertised by the MVP chair in various arenas had no attenders, therefore the MVP chair is reviewing a different approach.

13. Maternity and Neonatal Board Safety Champion Feedback

Colleague's voices

The Chief Nurse undertook a walkround the maternity inpatient wards. There was discussion regarding a recent incident that occurred on the ward and how the team's wellbeing following the incident. A cold debrief had been arranged and since undertaken led by the Deputy Director of Midwifery. Additional support was offered to the ward manager and Matron and the Chief Nurse also reiterated the organisations wellbeing support offer.

There was also discussion regarding support when new in post to access systems such as E-roster and ESR when moving into senior management/leadership posts and ability to refresh or learn new skills from the outset. This was discussed with the Director of Midwifery with the suggestion of an induction package for new ward managers and Matrons and ensuring that there is enough focus on how to use digital systems effectively.

In addition to regular walkrounds the Chief Nurse also has monthly 'Open Door' sessions, the dates and times are shared via the 'Weekly View'.

14. Staffing

Midwifery Staffing

Midwifery services submit workforce data to NHSEI each month and in June 2023 recorded 147.19 whole time equivalent (WTE) midwives which includes 3 Matrons and the Deputy Director of Midwifery but does not include 3.80WTE staff nurses against a new workforce establishment of 174.63 WTE midwives.

The new workforce model has been revised using the principles of the Birthrate Plus tool and is based on a 1:24 ratio and birth rate of 4313 (22/23) against a previous birth rate of 4902 (2020). The model reflects a skill mix calculation of 90%/10% split between midwives and non-midwifery support staff as recommended by Birthrate Plus. In addition to the clinical midwifery workforce model the model also reflects an additional uplift of midwife roles by 8% with the function of supporting non-clinical management and governance.

A full review by Birthrate plus will be commissioner to ensure acuity and continuity models are reflected in the service workforce model.

The maternity service has been involved in LMNS regional recruitment for student midwives who qualify in September 2023 and has offered 14wte post (16 students).

Following international recruitment 2 midwives have arrived and have attended the regional 4-week OSCE course throughout July. They have been in placement since and are undertaking their OSCE assessment in August. A further 3 have recently been offered posts following the second round of recruitment, with the midwives expected to arrive in September 2023.

In August the new Governance Matron will be commencing in post and in September the new clinical educator will be commencing in post. The clinical educator's role is to support the newly qualified midwives in the clinical areas.

Staffing levels – planned vs actual

STAFFING LEVELS - July 2023

			DAY (Day shifts are all the periods not included in night shift)				NIGHT (Night is defined as the shift period within which midnight falls)				DAY		NIGHT		Care Hours Per Patient Day						
Hospital Site Details			Registered Nurses/Midwives		Care Staff		Registered Nurses/Midwives		Care Staff						Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses		Care Staff		Overall	
Site Code	Hospital Site Name	Ward	Total Daily **PLANNED** Staff Hours	Total Daily **ACTUAL** Staff Hours	Total Daily **PLANNED** Staff Hours	Total Daily **ACTUAL** Staff Hours	Total Daily **PLANNED** Staff Hours	Total Daily **ACTUAL** Staff Hours	Total Daily **PLANNED** Staff Hours	Total Daily **ACTUAL** Staff Hours	Average Fill Rate - Registed Nurses/ Midwives (%)	Average Fill Rate - Care Staff (%)	Average Fill Rate - Registed Nurses/ Midwives (%)	Average Fill Rate - Care Staff (%)		Total **PLANNED** CHPPD	Total **ACTUAL** CHPPD	Total **PLANNED** CHPPD	Total **ACTUAL** CHPPD	Total **PLANNED** CHPPD	Total **ACTUAL** CHPPD
RWY	CHFT	WARD LDRP	4,105.67	2990.167	945.5	771.3333	3897.017	2809.35	713	703.5	72.8%	81.6%	72.1%	98.7%	359	22.3	16.2	4.6	4.1	26.9	20.3
RWY	CHFT	WARD 4ABD	2,377.00	1,752.92	694.83	486.92	1,777.67	1,300.33	705.33	555.83	73.7%	70.1%	73.1%	78.8%	881	4.7	3.5	1.6	1.2	6.3	4.6
RWY	CHFT	WARD 1D	712.50	705.75	444.33	377.17	713.00	716.00	471.50	417.50	99.1%	84.9%	100.4%	88.5%	190	7.5	7.5	4.8	4.2	12.3	11.7

With the continued staffing challenges through the maternity service a review of acuity and staff available occurs each shift, with LDRP completing the Birth Rate Plus acuity tool 4 hourly and staff are redeployed within the hospital setting to appropriate areas to maintain safer staffing levels. Options in escalation also include the utilising of the on-call community midwives and non-clinical midwives, and temporary relocation of Calderdale Birth Centre to LDRP. The service has a robust escalation policy, with responses that include utilising the on-call community midwives and non-clinical midwives, and temporary relocation of Calderdale Birth Centre to LDRP. All episodes of escalation are reported via the incident reporting system and then reviewed at the weekly maternity governance meeting.

Maternity Safe Staffing Indicators

Two of the most important safe staffing indicators relate to the provision of 1:1 care in labour and the supernumerary status of the labour ward (LDRP) coordinator. Although midwifery staffing remains challenging due to vacancies 1:1 care in labour and supernumerary status of the labour ward co-ordinator are prioritised.

In June 2023 the LDRP co-ordinator was supernumerary on 100% of the shifts.

The table below describes the 1:1 care in labour position over the previous 6 months.

Month	Jan 23	Feb 23	Mar 23	April 23	May 23	June 23
1:1 care in labour	98.9%*	100%	100%	98.5%	98.4%	99.5%

Obstetric Staffing

There are currently no consultant vacancies, which supports full consultant cover on LDRP. The maternity services are currently reviewing the proposal for a split obstetrics and gynaecology rota, with continued work on a proposal.

There are 3 gaps within the registrar rota due to 2 senior registrars being successful in being appointed to consultant posts at CHFT. Additionally, there are 3 registrars who are on restricted duties or due to start maternity leave. This has impacted significantly on the ability to cover all rotas required, with these rota gaps, acute cover across both obstetrics and gynaecology is always prioritised which results in some planned activity being cancelled. The next rotation of junior doctors will occur in August for tier 1 (junior doctors) and Sept for tier 2 (registrars). Successful recruitment of 2 specialty doctors to support the gaps who will commence in post in September 2023.

Neonatal Nurse Staffing medical staffing

Currently vacancy rate remains 0.92wte within either the qualified nursing workforce establishment and recruitment is in process.

Latest quarter 2 National Neonatal Audit Programme (NNAP) data highlighted that CHFT neonatal staffing is 60.1% which is below the national average of 74.3%. The expected levels are measured against the British Association of Perinatal Medicine (BAPM) standards. To maintain safety each shift is risk assessed and concerns escalated through the Trust escalation processes. There is a robust mechanism in the division that reviews the staffing position and skill mix, and this is informing ongoing work around neonatal workforce modernisation.

As part of this, the Associate Director of Nursing has reviewed the senior leadership on the neonatal unit, and as such a second Band 7 post has been created to strengthen the structure. One role focuses on the operational management of the unit and the new post supports regulatory and compliance standards both locally and nationally.

The neonatal nursing workforce tool (2020) expectation is that at least 70% of the registered staff hold a post registration qualification in neonatal care (Qualification in Speciality QIS). The rate remains 60% registered staff with QIS in month. However, of the registered staff who are not QIS 54% have now completed the foundation course which is the high dependency and special care modules of the post registration qualification. Following consolidation of practice, they will complete the intensive care module.

Additionally, a staff nurse has successfully completed the enhanced nurse practitioner course and it has been requested by the university that her work regarding neonatal lumbar puncture should be published.

The neonatal unit has received external recurrent funding from the Neonatal Operational Delivery Network (ODN) for 23hours per week Band 7 Governance Lead and 18 hours Band 7 Education Lead, this is currently in the process of job matching prior to the recruitment process.

Neonatal medical staffing

The neonatal unit has also received recurrent external funding and has successfully recruited to 30 hours per week registrar to cover night shifts.

15. Training

Training compliance rates as 14 August 2023.

Midwifery staff role specific training

Compliance %																
372|LOCAL|Antenatal Newborn Screening - 2 year|	372|LOCAL|Anti D training|	372|LOCAL|Avoiding Term Admissions into Neonatal Units - 3 Years|	372|LOCAL|Breastfeeding Update - 2 yearly|	372|LOCAL|CHFT Oxygen Knowledge and Knowledge Assessment|	372|LOCAL|CHFT Safer Insulin Awareness Training|	372|LOCAL|Cleaning Standards - Once only|	372|LOCAL|Female Genital Mutilation|	372|LOCAL|Fire Warden training - 3 year|	372|LOCAL|Pressure Ulcer Care - 2 years|General	372|LOCAL|Safeguarding Supervision|	372|LOCAL|Waste Management|	NHS|MAND|Aseptic Non Touch Technique - 3 Years|	NHS|MAND|Deprivation of Liberty Safeguards - Level 2 - 3 Years|	NHS|MAND|Infection Control - Level 2 - 2 Years|	NHS|MAND|Medicines Management Awareness - 2 Years|	NHS|MAND|Preventing Falls - 3 Years|	NHS|MAND|Resuscitation - Adult Basic Life Support - 1 Year|
81.82%	91.14%	91.56%	85.19%	88.61%	96.84%	95.85%	97.47%	78.95%	86.51%	79.45%	94.50%	84.19%	87.44%	83.87%	86.71%	96.79%	83.11%

Midwifery staff essential training

Compliance %													
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	NHS|CSTF|Fire Safety - 1 Year|	NHS|CSTF|Health, Safety and Welfare - 3 Years|	NHS|CSTF|Infection Prevention and Control - Level 1 - 1 Year|	NHS|CSTF|Information Governance and Data Security - 1 Year|	NHS|CSTF|Moving and Handling - Level 1 - 2 Years|	NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	NHS|MAND|Dementia Awareness - No Renewal|	NHS|MAND|Prevent WRAP - No Renewal|	NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	NHS|MAND|Safeguarding Children Level 2 - 3 Years|	NHS|MAND|Safeguarding Children Level 3 - 3 Years|
98.18%	87.73%	98.64%	91.82%	91.36%	92.73%	94.55%	97.73%	95.91%	88.53%	100.00%	98.36%	67.09%

Medical staff role specific training

Compliance %									
372|LOCAL|CHFT Safer Insulin Awareness Training|	372|LOCAL|Cleaning Standards - Once only|	372|LOCAL|Deprivation of Liberty Safeguards Level 3 - 3 Years|	372|LOCAL|Female Genital Mutilation|	372|LOCAL|Fire Warden training - 3 year|	NHS|MAND|Aseptic Non Touch Technique - 3 Years|	NHS|MAND|Deprivation of Liberty Safeguards - Level 2 - 3 Years|	NHS|MAND|Infection Control - Level 2 - 2 Years|	NHS|MAND|Resuscitation - Adult Basic Life Support - 1 Year|
97.30%	87.18%	93.75%	79.49%	100.00%	84.21%	81.82%	71.79%	82.05%

Medical staff essential training

Compliance %													
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	NHS|CSTF|Fire Safety - 1 Year|	NHS|CSTF|Health, Safety and Welfare - 3 Years|	NHS|CSTF|Infection Prevention and Control - Level 1 - 1 Year|	NHS|CSTF|Information Governance and Data Security - 1 Year|	NHS|CSTF|Moving and Handling - Level 1 - 2 Years|	NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	NHS|MAND|Dementia Awareness - No Renewal|	NHS|MAND|Prevent WRAP - No Renewal|	NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	NHS|MAND|Safeguarding Children Level 2 - 3 Years|	NHS|MAND|Safeguarding Children Level 3 - 3 Years|
97.44%	89.74%	97.44%	87.18%	87.18%	64.10%	92.31%	92.31%	74.36%	89.47%	100.00%	80.00%	92.86%

Compliance	PROMPT	K2 Fetal monitoring
Midwives	87%	85%
Maternity Support Workers	77.8%	N/A
Consultants	92.8%	85%
Junior Doctors	95.4%	95%

Following recent recruitment of large number of additional MSWs to support the skill mixing for maternity workforce we have seen a fall in the compliance. Due to the nature of PROMPT being MDT we have been unable to allocate all the MSWs to the same PROMPT session but all MSW's are booked on sessions to increase trajectory. This has seen an increase in from 65% to 77.8%.

All staff who are non-compliant with PROMPT have been booked on sessions.

Work has been undertaken to ensure that all staff groups have the same role specific and essential training allocated on their ESR.

All staff are reminded about the importance of undertaking their essential and role specific training and it is discussed at their annual appraisal.

16. Developments

Successful implementation of Badgernet EPR on the neonatal unit in July, now implementation phase 2 which is the interfacing of the equipment to Badgernet. The interfacing facilitates an automatic pull through of all data from clinical equipment including observations, fluid infusion rates and ventilator settings.

Calderdale and Huddersfield NHS Foundation Trust

Calderdale Royal Hospital

Inspection report

The Calderdale Royal Hospital
Salterhebble
Halifax
HX3 0PW
Tel: 01422357171
www.cht.nhs.uk

Date of inspection visit: 07.06.2023
Date of publication: N/A (DRAFT)

Ratings

Overall rating for this location	Good
Are services safe?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at Calderdale Royal Hospital

Good 

Pages 1 and 2 of this report relate to the hospital and the ratings of that location, from page 3 the ratings and information relate to maternity services based at Calderdale Royal Hospital.

We inspected the maternity service at Calderdale Royal Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.

Calderdale maternity service has approximately 4000 births a year across the labour ward and co-located birth centre. The labour ward had 11 birthing rooms, one of which had a birthing pool and the birth centre had 7 birthing rooms, 2 with birthing pools. The service also had 4 transitional care beds and a neonatal unit. There was 1 dedicated maternity theatre and a second that could be used in an emergency.

We will publish a report of our overall findings when we have completed the national inspection programme.

We carried out an announced focused inspection of the maternity service, looking only at the safe and well-led key questions.

Calderdale Royal Hospital maternity service is rated Good.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Good ➔➔

Our rating of this service stayed the same. We rated it as good because:

Staff completed training to ensure they had training in key skills, they worked well together for the benefit of women and birthing people and understood how to protect women and birthing people from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to women and birthing people, acted on them and kept good digital care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.

Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Managers monitored the effectiveness of the service and made sure staff were competent. Staff felt respected, supported and valued. They were focused on the needs of women and birthing people receiving care and creating an inclusive environment to meet people's needs. Staff were clear about their roles and accountabilities. The service engaged well with women and birthing people and the community to plan and manage services. Staff were committed to improving services and addressing health inequalities for women and birthing people.

However:

- Staffing levels did not always match the planned numbers required which at times put the safety of women and birthing people and babies at risk.
- Medical staff had not all completed mandatory training such as safeguarding training to the correct level.
- Midwives on the labour ward had not all completed training on how to evacuate the birthing pool in an emergency.
- Safety checks, such as CTG fresh eyes and MEOWS, were not always recorded to have been completed on women and birthing people in line with best practice. Further work was needed to improve compliance in this area.
- Whilst there was a bereavement suite available the location of this was on the labour ward which is not in line with best practice.
- Policies did not always reflect the most up to date and appropriate guidance available.
- Ligature assessments had been carried out and staff were aware of where emergency equipment was but the risk assessment needed reviewing.

Is the service safe?

Requires Improvement ↓

Our rating of safe went down. We rated it as requires improvement.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. However, not all staff had completed mandatory training in line with trust targets.

Maternity

Medical staff overall compliance with training targets was 90% which met the trust target. Nursing and midwifery staff compliance with training targets was 92%, this also met the trust target of 90%. The service had a training guideline; it was in date, version controlled and next due for review in January 2026. The guideline included a training needs analysis which outlined all training required to be completed by maternity staff. The training needs analysis linked to national recommendations and showed the compliance required to meet the recommended standards and outlined how learning from incidents should be managed.

The service made sure that staff received multi-professional simulated obstetric emergency training (PROMPT). PROMPT training had been completed by 100% of consultants, 95% of registrars, 93% of midwives and 75% of midwifery support workers. The service told us the low numbers for midwifery support workers was due to a recent increase in recruitment to the role and further training was booked to increase the number of people attending this training.

The service provided training and competency-based assessments on the use of Cardiotocography (CTG); a technique used to monitor the fetal heartbeat and the uterine contractions during pregnancy and labour. Nursing and midwifery staff compliance was 90% and medical staff compliance was 94%. Staff completed skills and drills training regularly. Records showed staff completed skills and drills training monthly on scenarios such as eclamptic seizure (a rare occurrence of seizures in those suffering with pre-eclampsia), baby abductions and abnormal CTGs. There was an emphasis on multidisciplinary training leading to better outcomes for women and birthing people and babies.

Staff had completed adult life support training. For adult life support medical staff compliance was 84% and nursing and midwifery staff compliance was 80%. This meant that not all staff had training to provide lifesaving treatment to women and birthing people and this was below the trusts target of 90%. 86% of midwives had neonatal life support training, with 75% of community midwives having completed this training.

The service provided pool evacuation training to staff working in the co-located Calderdale Birth Centre and there were enough staff trained to evacuate women, birthing people, and babies from the birthing pool on the birth centre in an emergency. It was not clear from speaking to staff on the labour ward that all staff knew how to evacuate a birthing pool and the training evidence provided by the service did not evidence that staff on the labour ward had received training for pool evacuations. There was one birthing pool room on the labour ward and staff told us this was used. We found no evidence that women and birthing people had been harmed as a result.

The service had a team of specialist midwives across the hospital services including a practice development midwife who was also the lead midwife for monitoring fetal wellbeing. Their remit covered, monitoring of training compliance, conducting audits, supporting delivery of PROMPT training, and promoting and supporting professional and clinical development. They were involved in governance meetings within the service to understand areas of improvement needed and to provide feedback of training compliance.

Managers and the specialist midwife monitored mandatory training and alerted staff when they needed to update their training. Training was recognised as a key factor in the safety of the service, so steps were taken to prevent training being cancelled or delegates pulled due to staffing pressures. Additional training available to staff was advertised on a weekly newsletter which was sent to all staff and updates on compliance with training was provided at the governance meetings.

Safeguarding

Some staff groups had not received training on how to recognise and report abuse. However, staff understood how to protect women and birthing people from abuse and the service worked well with other agencies to do so.

Maternity

Not all staff received training specific for their role on how to recognise and report abuse. Level 3 safeguarding training was provided to midwifery staff however this was not included for all medical staff which is not in line with national intercollegiate guidelines. The trust told us they only required consultants to complete level 3 safeguarding training and only consultant in sexual health had to complete the Safeguarding adults level 3 training. This meant that registrars and other medical professionals had not received the relevant safeguarding training as required.

Not all staff received safeguarding training at a level suitable for their role. Level 3 safeguarding children's training was completed by 92% of consultants and all trust grade doctors, this met the trust's target for safeguarding training which was 90%. Nursing and midwifery staff compliance was 83% for adults safeguarding and 66% for children's safeguarding (level 3). This did not meet the trust target of 90% and not in line with national guidance (Intercollegiate Document (2019). Support staff/unregistered nursing staff compliance with training targets was 86% for safeguarding adults, this did not meet the trust target and 93% for safeguarding children which did meet the trust target. The service had recently changed how they deliver safeguarding training which was split training across 3 modules including 1 face-to-face session; the aim was to make it more comprehensive and tailored to the needs of staff. Leaders told us this had impacted on their training compliance figures but training was booked to ensure staff received this training and improve compliance. The Adult Safeguarding Team also provided a 'Lunch and Learn' training session within wards and departments to further supplement the mandatory training, informed by recognised emerging themes, trends and gaps in knowledge which has been positively received.

Staff could give examples of how to protect women and birthing people from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff understood the importance of supporting equality and diversity and ensuring care and treatment was provided in accordance with the Act. Staff gave examples which demonstrated their understanding and showed how they had considered the needs of women and birthing people with protected characteristics.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff asked women and birthing people about domestic abuse, and this was a mandatory field in the electronic records system. Where safeguarding concerns were identified women and birthing people had birth plans with input from the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff explained safeguarding procedures, how to make referrals and how to access advice. The service had a safeguarding team who staff could turn to when they had concerns or complex situations and staff told us about a recent example where they had received support to ensure the safety of women and birthing people. The safeguarding team regularly attended the different units and staff told us they were visible, approachable, and supportive. Care records detailed where safeguarding concerns had been escalated in line with local procedures.

Staff followed safe procedures for children visiting the ward.

Staff followed the baby abduction policy and undertook baby abduction drills. Staff explained the baby abduction policy and we saw how ward areas were secure, and doors were monitored. The service had conducted a tabletop, interactive session around what would happen if a baby was abducted within the 6 months before inspection. Security across the maternity service had improved since our last inspection however this remained on the risk register as a low risk.

Maternity

The service used serious case reviews from other areas to learn and improve their safeguarding practices and raise awareness. For example, following high profile safeguarding cases and lessons learnt, training and awareness had been raised around “the myth of invisible men and significant others”. The trust had looked at work to support the role of Fathers in the care of a newborn which led to funding being secured to introduce educational resources called “DadPad”. The DadPad is a guide developed with the NHS to support Dads in providing knowledge and practical skills needed.

Examples were shared evidence of pro-active support provided by midwives in identifying women and birthing people experiencing domestic violence. This resulted in multi-agency working to help these people escape their abuser.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect women and birthing people, themselves and others from infection. They kept equipment and the premises visibly clean.

Maternity service areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Cleaning checks were completed by both ward managers and matrons at different intervals. The service performed well for cleanliness on audits completed. The service audited the environmental cleanliness every month. We looked at audits for the last 3 months across the different areas of the service and found that the service performed well across all areas.

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. In the last year compliance was consistently above 95%.

Staff cleaned equipment after contact with women and birthing people. Staff cleaned equipment between uses and a sticker system in place made it was clear equipment was clean and ready for use.

Environment and equipment

The maintenance and use of facilities, premises and equipment kept people safe, staff were trained to use them and managed clinical waste well. However, the layout and design of the service was identified as an area for improvement.

The service acknowledged and were addressing issues with the design and layout of the environment. The service was spread across a large area and across multiple floors. The trust had approved structural changes to the layout to ensure a better flow and easier access between units. The current bereavement room was based on the labour ward and whilst consideration had been given to its location, in terms of impact of noise and reducing contact with others, its location did not meet department of health best practice guidance on maternity care facilities. The planned structural changes had not included relocating this facility. Fundraising work in the local community had raised money specifically for improving the bereavement room, however there were no current plans to implement any changes.

The maternity unit was fully secure with a monitored entry and exit system.

Call bells were accessible to women and birthing people if they needed support and staff responded quickly when called.

Staff carried out daily safety checks of specialist equipment. Records checked showed that emergency equipment and emergency trolleys used for adult and neonatal resuscitation were regularly checked and equipment was present and in date.

Staff regularly checked birthing pool cleanliness and the service had a contract for legionella testing of the water supply.

The service had suitable facilities to meet the needs of women and birthing people's families. The birth partners of women and birthing people were supported to attend the birth and provide support.

The service had enough suitable equipment to help them to safely care for women and birthing people and babies. For example, there was a dedicated sonographer located in the maternity assessment to take on the day referrals from both community and triage. However, the service had requesting funding for new scanning equipment that would reduce the risk of human error when measuring and tracking growth scans.

There was a portable ultrasound scanner, computerised cardiotocograph machines and observation monitoring equipment readily available.

Staff on the labour ward were not familiar with the location and use of pool evacuation nets where there was 1 birthing pool in use, we raised with the leaders in the service at the time of the inspection who told us they would ensure all staff were provided with an update.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly and not over-filled. Staff separated clinical waste and used the correct bins. They stored waste in locked bins while waiting for removal.

The service had completed a ligature risk assessment in all areas of the service; however, this had not been reviewed since completion in 2021. A training package was in place around ligature prevention and rescue and staff we spoke to could identify where the necessary equipment was located.

Assessing and responding to risk

Staff completed and updated risk assessments and took action to remove or minimise risks. Staff identified and quickly acted upon women and birthing people at risk of deterioration

The service used a nationally recognised tool called the Modified Early Obstetric Warning Score (MEOWS) in detecting the seriously ill and deteriorating women and birthing people using the service. The MEOWS chart is used to enable early recognition of deterioration, advice on the level of monitoring required, facilitate better communication within the multidisciplinary team and ensure prompt management of any person whose condition was deteriorating. It was recognised that early recognition of critical illness, prompt involvement of senior clinical staff and authentic multi-disciplinary team working remain the key factors in providing high quality care to sick pregnant and postpartum women (MBRRACE 2016). Audit results showed that 60% of women had a MEOWS chart completed and 62% of MEOWs observations requiring escalation were escalated appropriately. The MEOWs observations were reviewed for 5 antenatal and 5 postnatal woman and birthing people each month between October 2022 and December 2022. Observations were consistently performed on women post caesarean section, but an audit of notes found that post spinal anaesthesia observations for any other procedure were not undertaken appropriately. There were no common themes for or trends

for failures in escalation. An action plan was put in place to refresh staff's knowledge on the current policy in place and for specific training to be implemented with further audits to be carried out in July-September 2023. We saw how the audit outcomes and guidance had been fed back to staff in the weekly newsletter. Records reviewed as part of the inspection were all completed and escalated appropriately.

Women and birthing people were triaged on arrival to the hospital when they were not attending for a planned birth. The service had implemented clear guidance to help midwives and medical staff determine the clinical urgency in which women and birthing people need to be seen. The service audited the use of the triage tool monthly. We looked at audits for the last 3 months and found that there had been noted improvements. The percentage of records with no recorded risk assessment ratings for women and birthing people attending triage fell from 27% to 8%. The number of women and birthing people waiting for over 30 minutes to be triaged had also reduced from 44% to 32%. The service was working towards all women being seen within 15 minutes. The service had recognised that improvements were needed in triage and had introduced a dedicated registrar Monday-Friday, 9am-5pm, at times when activity was highest. The actual midwifery staffing levels in the triage area did not always meet the planned staffing levels and staff told us this had the biggest impact on waiting times. Planned staffing levels in this area was currently 2 midwives which did not allow for a dedicated midwife to cover the telephone triage. The service was trying to allocate 3 midwifes to allow for this but this was not always possible due to staffing shortages.

The service was also working towards allocating a dedicated midwife to cover the triage telephone calls away from the main clinical area. However, this was not yet fully embedded, and staff were not always available to cover this role. Staff told us that managing the telephone calls at the reception area as well as triaging and assessing women impacted on the overall care and treatment provided to women and birthing people including the triage and assessment times. They also told us they felt under increased stress and pressure during these times. Staff told us they would benefit from a team of core staff in the triage area, but this was still under review by leaders in the service. Leaders told us this was still under discussion as they did not want to de-skill midwives by removing them from triage. Both these areas for improvement had been identified in an independent, external review of triage carried out in February 2023. In response the service had developed a working party and allocated a band 7 midwife to oversee triage and support in implementing the improvements needed.

The service demonstrated how training had been implemented to address timely transfers from the maternity assessment unit to theatre. This was carried out in a timely manner with staff after it was identified as an area for improvement at the weekly meeting reviewing incidents.

The World Health Organisation (WHO) Surgical Safety Checklist is a tool which aims to decrease errors and adverse events in theatres and improve communication and teamwork. The service audited WHO checklists monthly and fed the findings into the maternity forum where findings were shared with staff. There was 99.8% compliance with the tool.

During this inspection we reviewed the service's maternity quality dashboard. The dashboard included thresholds and regional indicators and provided target figures for monitoring purposes and as a benchmarking tool. The service used the dashboard template which was developed and supported by the local maternity and neonatal system (LMNS). The dashboard reported on clinical outcomes such as level of activity, maternal clinical indicators (mode of delivery), trauma during delivery (including postpartum haemorrhage and perineal trauma), neonatal clinical indicators (preterm delivery) and public health information. The service had a service specific quality dashboard to maintain oversight of the entirety of the care provided to women. The dashboard showed that there was a high number of smokers at booking and delivery, and a higher number of women and birthing people booking after 13 weeks. However, these were not outliers in comparison to regional or national figures and both in-house and external smoking cessation pathways were in place. The variety of smoking pathways available were also audited for effectiveness.

Maternity

The regional maternity dashboard enabled clinical teams in maternity services to compare their performance with their peers on a series of Clinical Quality Improvement Metrics (CQIMs) and National Maternity Indicators (NMIs), for the purposes of identifying areas that may require local clinical quality improvement. The service submitted data to the regional maternity dashboard. This meant they could benchmark against other services in the region and contribute to system wide improvements.

Leaders audited how effectively staff monitored women and birthing people during labour having continuous cardiotocograph (CTG). CTG is used during pregnancy to monitor fetal heart rate and uterine contractions. It is best practice to have a "fresh-eyes" or “buddy” approach for regular review of CTGs during labour. We looked at the CTG and fresh eyes audits from November 2022 to April 2023 and found that compliance was initially poor. Each month 10 records were reviewed, in November 2022 only 3 of the 10 records reviewed were compliant with the regular fresh eyes reviews, this gradually improved over the next 5 months but still had not gone above 8 out of 10 records being fully compliant.

Safety recommendations had been made by HSIB in relation to the CTG monitoring in reports shared from January and May 2023. Specifically, that CTG monitoring is commenced as soon as concerns are identified that action is taken recognise, escalate, and expedite the birth as soon as possible and that the recordings are of high quality or action is taken to address the quality of recordings. The trust had purchased and received 30 new CTG machines in January 2023 which addressed the issues with availability of machines and quality of the recordings.

Staff had the support of a perinatal mental health lead and a perinatal mental health midwife; staff knew who to contact out of hours if there was a concern. Staff explained when and how they could seek assistance to support women and birthing people with mental health concerns and how any information was recorded and accessed on the care records.

Staff shared key information to keep women and birthing people safe when handing over their care to others. The care records were on a secure electronic care record system used by all staff involved in the person’s care. Each episode of care was recorded by health professionals and was used to share information between care givers.

Shift changes and handovers included all necessary key information to keep women and birthing people and babies safe. During the inspection we attended staff handovers and found all the key information needed to keep women and birthing people and babies safe was shared. Staff had 2 safety huddles a shift to ensure all staff were up to date with key information. Each member of staff had an up-to-date handover sheet with key information about women and birthing people. The handover shared information using a format which described the situation, background, assessment, recommendation for each person.

The service did not currently audit newborn risk assessments when babies were born using recognised tools such as newborn early warning trigger and track (NEWTT). The service had identified an increase in the number of neonatal deaths from 8 in 2021 to 18 in 2022. This prompted a more in-depth audit to be carried out which showed in 9 of these deaths, the cause of death was severe prematurity. The service provided assurances that all deaths were reviewed thoroughly to ensure the service had a good understanding of the circumstances surrounding each loss. However, it was not clear from the information provided how the trust was monitoring signs of a deteriorating baby and whether audits of such monitoring were completed.

The service provided transitional care for babies who required additional care, this allowed enhanced levels of care whilst remaining with the parent on the postnatal ward.

Staff completed risk assessments prior to discharging women and birthing people into the community making sure third-party organisations were informed of the discharge. The service had identified incidents where appointments had not been scheduled correctly with the community midwife particularly out of area and were looking to improve the technology in place to prevent such incidents.

Leaders monitored waiting times and made sure women and birthing people could access services in a timely manner when needed and received treatment within agreed timeframes and national targets. This was an area the service recognised needed to make further improvements and steps had been taken ensure appropriate staff cover was provided at all times.

Midwifery Staffing

Staffing levels did not always match the planned numbers putting the safety of women and birthing people and babies at risk.

Staffing levels did not always match the planned number of staff. We reviewed the planned versus actual staffing presented to the board for the month of August 2022. On average for August 2022 there were 49% occasions the actual staffing did not meet the planned numbers. This meant there was not always enough staff to care for women, birthing people and babies. We saw staff reported incidents appropriately in relation to staffing.

On the day of inspection there were 8 midwives instead of the planned 10 across the labour ward, plus 1 midwife allocated to answering triage call on the maternity assessment unit. In addition to the supernumerary labour ward coordinator there was also a band 7 midwife who had a helicopter view of staffing across the service. This was a role rotated amongst the band 7 specialist midwives Monday-Friday. We found that there was a responsive approach to the shortages with staff moving between units to ensure that women at higher risk were supported. We also saw how non-clinical staff stepped in to provide support and cover when midwives needed to support a birthing person.

Staff told us that at times it felt unsafe in the maternity assessment centre and staff would often work on their own or with 1 other midwife when ideally there should be 3 midwives in this area. Staff told us they felt that the labour ward was always prioritised over triage. Staff had reported this on the incident reporting system and to leaders and this was included on the risk register as a high risk. We saw that working party had been established to try and address the issues within the maternity assessment centre. Leaders told us how they were trying to ensure 3 midwives were working in this area rather than the 2 currently planned, however this was not always possible due to staff shortages.

We also found that the postnatal ward was short staffed by 1 midwife. This resulted in 1 midwife working alone caring for 7 women and birthing people at the time of the inspection, as well as supporting women attending the ward who were starting process of induction of labour, after which they would go home. The midwife working told us they felt this was safe and they were clear on the escalation plan should this change. They also told us they felt supported by the ward manager and matrons.

Some women and birthing people told us that care outside of the labour ward was not always person centred and dignified due to a lack of staff available to support and monitor them. For example, one person told us how the level of support provided on the post-natal ward was not sufficient and that support to bathe after labour was not provided. They also told us that observations on their baby was not as frequent as they were told it would be and discharge was

delayed due to staffing levels. Another person told us how they waited for long periods in the triage area and were monitored for longer than they were told they would be and felt "forgotten". They also told us they felt this was impacted by a shift change. However, we also reviewed a high number of positive comments and compliments which were shared on the service's social media pages about the care across all areas of the maternity service.

The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings (2015)'. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Between December 2022 and May 2023 there were 90 red flag incidents, which related to delays in antenatal care due to high levels of acuity and delays to emergency caesarean c-sections. Weekly meetings were held and attended by a multi-disciplinary team in which all reported incidents including those related to staffing were discussed to ensure they were documented, graded, and managed appropriately. This included delays to induction of labour and delays to caesarean sections. The reviews analysed day of the week, time of day and whether escalation was appropriate at that time to on-call medical staff in line with the trust policy.

Women and birthing people received 1:1 care and the labour ward coordinator was supernumerary. The 1:1 care of women in labour and the supernumerary status of the labour ward coordinator were used as safe safety indicators which were shared at the monthly maternity quality committee meeting and the board. The labour coordinator role was consistently supernumerary 100% of the time for the past 3 months and they had oversight of staffing, acuity, and capacity on the labour ward. The 1:1 care for labouring women year to date was reported to be in place in 99% of cases.

Following an initial staffing review in November 2020 changes to staffing in maternity were made in line with recommendations from the Ockenden report. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The service completed a staffing and acuity review in June 2023. It said the service did not have enough staff to meet the planned needs of women. There were plans in place to address the shortfall to provide safe care to women who used the service. This included the successful recruitment of 14 newly qualified midwives and 2 international recruits with a further 3 planned. This review recommended based on a decreased birth rate of 4313 a total of 174.63 WTE staff which includes 161.73 WTE midwives and 12.9 WTE non-clinical midwives. The total midwifery establishment including non-clinical in March 2023 was 149.64WTE, a shortfall of 24.99 WTE staff.

The staffing proposal shared with the chief nurse, reviewed the current skill mix options and proposed 10% of midwifery posts would become either maternity support workers or staff nurse positions. These posts would include maternity support workers working in community, on the transitional care pathways and staff nurses working on both the labour ward and postnatal ward. The birth rate plus report advised that non-clinical staff worked in postnatal care only, it wasn't clear from the proposal whether this would therefore be a move away from national best practice guidance.

The ward managers did not always have the resources to adjust staffing levels daily according to the needs of women and birthing people. Managers moved staff according to the number of women and birthing people in the different clinical areas based on the presenting risk. Some staff told us this was at short notice and could at times leave other areas low on staff.

A recruitment and retention midwife was in post on a part time basis. This was alongside a clinical midwifery educator to support newly qualified midwives and a clinical midwifery support worker (MSW) educator to support newly qualified MSW's.

The service completed exit interviews with staff to try and retain staff. Workforce data collected between April 2022 and March 2023 showed that 23% of midwives left to take up jobs of the same grade in another trust, 20% left the midwifery

profession and 13% left for promotion. Sickness and maternity leave also accounted for other vacancies within the service. A recruitment and retention working party and strategy was established to support the retention and recruitment of midwives and the trust told us there was an active midwifery recruitment programme with a rolling advert as well as work with the LMNS.

The service used bank staff when needed and increased the pay offer as an incentive for staff to cover shifts when risk was high.

Managers requested bank staff familiar with the service and made sure all bank and agency staff had a full induction and understood the service before working within maternity.

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisal Rates for 2022-23 were completed with 83% of midwives overall.

A practice development midwife worked part-time alongside their work as the fetal monitoring midwife to support the development of midwives.

The service was keen to offer developmental opportunities such as developmental labour ward coordinator and clinical manager posts to encourage succession planning. They had also appointed to several specialist roles from within, such as band 7 bereavement lead midwife, public health midwife and governance midwife roles. The service had recently approved funding for a midwifery apprentice for a midwifery support work and were looking to continue with this offer of support to further MSW's.

Medical staffing

The service did not always have enough medical staff to meet the demands of the service. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service did not have enough medical staff to keep women and birthing people and babies safe. The number of weekly consultant hours were less than the nationally recommendation based upon the number of babies born. However, the service told us they had recently had agreement to recruit more doctors within the Doctor trainee rotational programme. There were 2.6 WTE vacancies to meet the planned numbers of doctors needed.

The Ockenden Review 2020 recommendations state there should be a separate consultant rota for obstetrics and gynaecology medical staff. However, due to the current lack of consultants the service had not been able to create a separate rota. The service acknowledged the risk this presented to women and birthing people, and this was recorded on the risk register a case for additional funding for more consultants had been submitted but not yet received approval from the trust.

Shortage of consultants also had an impact on the scanning capacity in the service and cover for antenatal clinics. Doctors were stretched to ensure cover was provided across the service and this increased the risk of burnout and errors.

Maternity

The service always had a consultant on call during evenings and weekends. However, due to the staffing pressures, medical staff did not take compensatory rest days following a busy on call shift. Whilst doctors acknowledged that in theory this could happen, they felt this was not normal practice due to the negative implications this had on meeting the needs of women and birthing people in the service. Rest facilities were not available at the time of inspection for the on-call consultants as these had been allocated to junior doctors in response to feedback from them. The service acknowledged this, and we saw this was discussed in governance meetings and they had sourced facilities which they were in the process of discussing with the consultants to make available.

Doctors told us they did not always have protected time to complete investigations which impacted on the timeliness of reports being completed.

Medical staff told us they were able to use locum doctors but that this rarely happened as shortfalls were often covered by existing staff or doctors on bank who are familiar with the service.

The service had a good skill mix of medical staff on most shifts however difficulties were presented when there was short notice sickness or there were high levels of acuity. We observed this on the second day of our inspection and as a result there was no doctor within the triage unit.

Medical staff told us that they felt supported to do their job through clinical supervision and were given the opportunities to develop. Junior doctors told us they were well supported with their training but that the rota was not always flexible to ensure protected or paid time for teaching. junior doctors felt there was an expectation for this to be done in their own time.

All medical staff we spoke to felt there was a positive working relationship between medical staff and midwives and there was an open culture that promoted the safety and care of women and birthing people.

Records

Staff kept detailed records of women and birthing people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Women and birthing people's notes were comprehensive, and all staff could access them easily on digital systems. The trust used electronic records across all areas of the service. We reviewed 10 sets of records and found records were clear and complete.

When women and birthing people transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely electronically. Staff locked computers when not in use and security systems such as fingerprint recognition, were in place to access these records.

We saw recorded incidents in which care for women and birthing people had not been correctly recorded electronically to enable the community midwives to pick up postnatal care following discharge. No harm had occurred as women had communicated missed appointments with the maternity service who then acted, however, this was an area of risk especially for out of area women and birthing people.

Medicines

Maternity

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Women and birthing people had electronic records for medicines that needed to be administered during their admission. We reviewed 5 sets of medication records on the electronic system and found staff had correctly completed them.

Staff reviewed each person's medicines regularly and provided advice to women and birthing people and carers about their medicines. The pharmacy team supported the service and regularly reviewed medicines prescribed. These checks were recorded in the records we checked.

Staff completed medicines records accurately and kept them up-to-date. The service used an electronic prescribing system. Midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

Staff stored and managed all medicines and prescribing documents safely. The clinical room where the medicines were stored was locked and could only be accessed by authorised staff. Medicines were in date and stored at the correct temperature. Where medication fridges were out of range, we saw that appropriate action had been taken and documented to mitigate the risk of compromising medicines. Staff checked controlled drug stocks daily.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women and birthing people honest information and suitable support. Managers ensured that actions from safety alerts were implemented and monitored. However, learning and recommendations from incidents were not always embedded.

Staff knew what incidents to report and how to report them and there was a good reporting culture within the service. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff could describe what incidents were reportable and how to use the electronic reporting system. We reviewed incidents reported in the 3 months before inspection and found them to be reported correctly.

Leaders in the service met weekly to discuss incidents to ensure they were appropriately reported. graded and escalated as needed and to identify any immediate action required. Records were also checked electronically to pick up any concerns that had not been recorded as an incident. Actions were monitored to ensure they were allocated to the appropriate person and completed in a timely manner. There was a weekly meeting to discuss all new and on-going serious incident cases.

We reviewed 4 serious incidents and found staff had involved women and birthing people and their families in the investigations. In all investigations, managers shared duty of candour, reports are routinely shared with families. However, a staff member who was part of the PMRT team told us that PMRT investigation reports were only shared if requested by families.

Managers reviewed incidents taking into account the impact of health inequalities. We saw how specific audits had been carried out to review the impact of health inequalities on still births and neonatal deaths and how current and on-going work was already in place to try and mitigate risks identified, this included those related to health inequalities.

We found that serious incidents reviewed by the trust were not always robust in identifying concerns. Issues identified from an external body review carried out by the health safety investigation board (HSIB) had not been picked up by the trust. For example, in one case issues identified by HSIB around appropriate monitoring and quality of CTGs was not identified by the trust. Action however had already been taken to replace 30 CTG machines by the time the report was published, as there was a known issue with the quality and availability of CTG monitoring equipment which had been identified in previous serious incidents and HSIB reports. We also found that findings identified by HSIB had not been used to improve practice and the focus was solely on the safety recommendations made. In one case staff did not use the emergency crash call to alert medical staff as they did not want to alarm the mother which was against trust guidance. A concern was then identified 5 months later by the service when staff did not follow guidance in using the crash call to summon assistance. Neither incident had impacted the outcome, but learning should have been taken to mitigate potential future risk. However, we also found that the trust had identified issues which had not been identified and addressed as part of the HSIB investigation.

The service had a 'risk and governance' midwife who was responsible for sharing learning from incidents. Learning was shared with all staff in a one-page weekly newsletter, which staff spoke about positively in terms of accessibility and relevance of the content. The 'professional development midwife and fetal monitoring lead' also ensured that learning from incidents and audits were embedded in to training and updates. We saw how a near miss had been discussed at the weekly governance meeting and then training was provided to staff in the relevant areas of the service in the same day.

Staff reported serious incidents clearly and in line with trust policy. Referrals to external partners were also made appropriately to ensure an open transparent culture and appropriate external scrutiny.

Staff understood duty of candour. They were open and transparent and gave women and birthing people and families a full explanation if things went wrong. Governance reports did not always explicitly evidence the involvement of women and birthing people and their families in investigations but did include evidence that duty of candour had been completed.

Staff received feedback from investigation of incidents, both internal and external to the service. For example, staff discussed a serious incident and shared learning at clinical governance meeting. We reviewed meeting minutes from the last 3 meetings and saw how leaders addressed areas for improvement with staff across disciplines and worked with other teams to improve outcomes. For example, a medication error was shared at the meeting and work was done with midwives and the pharmacy department to increase checks and awareness to prevent reoccurrence. This was then shared in the staff weekly newsletter for learning.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. Quality improvement projects had been supported by senior leaders to review better systems and processes for the induction of labour with the aim of reduce delays and improving the outcome for women and birthing people.

Managers debriefed and supported staff both immediately after a serious incident and then again once staff had time to reflect and initial investigations had been completed to review good practice and areas for improvement. Staff told us they had the opportunity to talk about incident with their direct line managers and the person allocated to investigating the concern. Staff told us this felt supportive and not punitive.

Maternity

The service had no ‘never’ events on any wards.

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and birthing people and staff. They supported staff to develop their skills and take on more senior roles.

The service was led by a director of midwifery, clinical director, and deputy director of operations. The triumvirate were supported through clear professional arrangements. The director of midwifery was line managed by the divisional director and the deputy director of operations and clinical director were line managed by the divisional director. The director of midwifery also worked closely with and reported to the chief nurse.

Attendance at weekly maternity governance meetings consisted of the patient safety and quality midwife, the obstetric lead for safety, the consultant of the week (where possible), the deputy head of midwifery, maternity ward matron, the matron for the community and the birth centre, and the labour ward and maternity ward managers. Incidents and activity across maternity were reviewed and discussed to look for themes, trends, learning and improvement. Incidents were then escalated to the Divisional orange panel in which incidents rated orange (indicating moderate risk) and above would be reviewed with investigations allocated and completed investigations shared for approval and/or further action.

Leaders understood and managed the priorities and issues the service faced. They had a clear understanding of the challenges to quality and sustainability within the service and plans to manage them, which were shared with staff. Leaders were well respected, approachable, and supportive. Staff told us they were well supported by their line managers, ward managers and matrons. The executive team visited wards on a regular basis. Staff told us they saw the executive team regularly and spoke of how accessible and encouraging they were. We also saw how the chief nurse for the service held open-door drop-in sessions for staff to raise issues with them directly.

Leaders in the service completed a piece of work which looked back over the last 3 years at all the action plans, learning and changes that had been implemented to bring about positive change. The aim was to review if changes had been fully embedded and were now part of good practice within the service. The leadership team were passionate about the work they had done to drive improvement.

The service was supported by maternity safety champions and non-executive directors who regularly visited the unit. Following feedback from staff that they were not always aware who the safety champions were, the role and identity of the safety champions was better communicated to staff by way of the newsletter. The safety champions were clear about their role and responsibilities and were aware of the challenges faced by maternity services. They were also aware of the demographics of the community they served and the associated risks. The clinical safety champion and chief nurse had introduced an open-door maternity session every month to give staff an opportunity to provide feedback and share any concerns or areas of improvement.

Maternity

Senior leaders in maternity services met weekly. We looked at meeting minutes for the last 6 months. Issues such as training compliance, recruitment, incidents, staff well-being and strategic issues were discussed with actions allocated.

Leaders encouraged staff to take part in leadership and development programmes to help all staff progress. We saw how midwives took positions in development roles for labour ward co-ordinators and clinical lead roles as part of succession planning. Midwives had also undertaken additional training to upskill them in areas such as sonography.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Leaders had considered the recommendations from the Ockenden 2020 and 2022 reports on the review of maternity services and the strategy and actions taken had addressed these recommendations.

The service had a vision for what it wanted to achieve and a 1-year, 5-year and 10-year strategy to turn it into action, which was developed with relevant stakeholders. They had developed the vision and strategy in consultation with staff and the values of the service underpinned vision for the service. Staff could explain the vision and values and what it meant for women, birthing people and babies.

The vision and strategy focused on sustainability of services and aligned to local plans with a specific focus on safe care addressing health inequalities in the local population. The service also had a separate health inequalities strategy and plan.

The maternity service strategy was part of the overarching trust strategy and the nursing and midwifery strategy.

There was a process in place to measure progress annually with updates provided to staff. The strategy had also been condensed to a one-page overview to make this more accessible.

Culture

Staff felt respected, supported, and valued. They were focused on the needs of women and birthing people receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women and birthing people, their families and staff could raise concerns without fear.

Staff were overall positive about the department and its leadership team and felt able to speak to leaders about difficult issues and when things went wrong. Staff gave us examples of issues they had raised around the induction of labour process and how their well-being had impacted because of abuse from patients. As a result, a quality improvement piece of work was undertaken by midwives to look at improving the process and reducing delays faced by women and birthing people.

Maternity

Staff worked within and promoted a culture that placed peoples' care at the heart of the service and recognised the power of caring relationships between people. Dignity and respect were intrinsic elements of the culture and all staff we observed and spoke with clearly demonstrated this. Staff demonstrated a passion to improve the service to improve the experience for women and birthing people.

Leaders understood how health inequalities affected treatment and outcomes for women and birthing people and babies from ethnic minority and disadvantaged groups in their local population including the differences within the local population. The service had a health inequalities strategy with a working group established to drive improvements and initiatives. Outcomes for women and birthing people were monitored and data interrogated to identify when ethnicity or disadvantage affected treatment and outcomes. For example, the service set up a Task & Finish group to conduct a deep dive into why rates of stillbirth in some of the areas where women and birthing people lived were higher than others and whether there were modifiable risk factors linked to health inequalities that could be addressed. Findings from this were then shared with staff. Additional educational resources for women, birthing people and partners were made available to try and reduce some of these inequalities. For example, in partnership with a local college an English to Speakers of Other Languages (ESOL) for pregnancy antenatal classes were run. The aim was to improve patient awareness and experience of maternity services, to reduce health inequalities and improve pregnancy outcomes for women who do not speak English.

A neonatal death audit was also undertaken due to the increase in deaths in 2022. The audit highlighted that 61% (11/18) of mothers who had a neonatal death lived in the most deprived areas. The audit has been presented at the Maternity Health Equalities Workstream and further analysis is being undertaken.

Staff had also completed a cultural competency training package as part of the strategy with the impact and effectiveness measured as part of a staff survey following completion of the training.

Several initiatives were also in place to support a diverse and inclusive workforce such as developing a Cultural Awareness digital education booklet, a suite of financial wellbeing support for colleagues and an international nurse's support event was held.

Women and birthing people, relatives, and carers knew how to complain or raise concerns. All complaints and concerns were handled fairly, and the service used the most informal approach that was applicable to deal with complaints. The service clearly displayed information about how to raise a concern in women and birthing people and visitor areas. Staff understood the policy on complaints and knew how to handle them.

The service received 6 complaints in the 3 months before the inspection. Themes included Staff - Values & Behaviors, Patient Care and Clinical treatment. Out of the 6 complaints 1 was closed, 2 were overdue at the time of the data being shared and 3 were still within the allocated timeframes. Feedback was shared with staff to improve the service once investigations were completed. Complaints was a fixed item agenda on the Maternity Safety Champions Meeting and Perinatal Quality Surveillance Meeting held monthly.

The trust told us how the progress of open complaints was discussed weekly with the trust's complaints team to offer further scrutiny and challenge.

The service provided an overview of the main themes from the most recent staff survey in 2022 which was also compared to findings in 2021. In 2021 there had been a decline in the scores for the women's directorate and so a focus

piece of work took place to look at the 'One Culture of Care Charter' which aimed to establish a set of agreed upon values and behaviours with staff. While the service acknowledged there was further work to do, improvements were seen in the 2022 survey; in particular for the questions around learning, engagement and morale. Participation with the survey had also improved in 2022 compared to 2021.

The "People Promise" scores improved overall, the element with the biggest improvement was "We are always learning." Although this element had the biggest improvement, it was still the lowest scoring of the 8 elements. The highest scoring element was "We are compassionate and inclusive."

We also reviewed the free text submitted by staff as part of the maternity survey 2022. There were 55 responses, the main themes were around unsafe staffing levels, poor managerial support, lack of flexibility with shifts impacting on well-being and a lack of appropriate equipment and facilities. The service did not send us analysis of these comments or actions plans around how they had addressed these comments. There was also reference to a poor culture and favouritism in relation to certain staff by managers which some staff felt impacted on their progression within the trust.

A monthly safety champions meeting was attended by the executive and non-executive safety champions, maternity and neonatal safety champions, the ICB and LMNS. Standing items on the agenda included audits, exception reports, outcomes from external investigations (HSIB), a review of the risk register and complaints and compliments.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a strong governance structure that supported the flow of information from frontline staff to senior managers. Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings.

The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders and managers were clear on the links to trust wide groups and committees to escalate risks and issues.

A maternity forum meeting was held monthly to support the Patient Safety and Quality Board by managing a program of performance monitoring and continuous improvement, to provide assurance that the essential levels of quality and safety were being met. A 6 monthly assurance report was shared with the Women's Directorate Governance meeting.

Monthly Women's directorate governance meetings were held and chaired by the Clinical Director. The deputy divisional director/general manager, senior finance officer, deputy head of midwifery and maternity and gynecology matrons also attended.

Relevant information was escalated to the Trust Divisional board which was chaired by the divisional director.

There were opportunities for managers to meet with the senior management team on a regular basis, and key areas including staffing, performance against national requirements and incidents were discussed in these meetings.

Maternity

Senior leaders in maternity services met weekly. We looked at meeting minutes for the last 6 months. Issues such as training compliance, recruitment, incidents, staff well-being and strategic issues were discussed with actions allocated.

Staff and leaders could clearly articulate the governance framework for the directorate and how information flowed between maternity services and the board.

Maternity Clinical governance meetings were held weekly. We looked at meeting minutes for the last 3 months. Activity across the maternity service was discussed which included number of births, births before arrival, incidents, delays, whether processes were followed, and any action required to address shortfalls. We found that staffing levels had impacted on delays to induction of labour, but that individual risk was reviewed to ensure women and birthing people were prioritised appropriately. We saw that doctors and medical staff had not always recorded their decisions in records and this was fed back to individuals.

The maternity and neonatal safety oversight report was presented monthly. We looked at meeting minutes for the last 3 months which provided an update on transformations programs, compliance with national reporting and safety reporting to HSIB, updates on staffing and audits, activity and external reports in neonates. Discussions and further audits were carried out where there were outliers in data collected. For example, there was an increase in shoulder Dystocia and so an audit was carried out to identify any trends and patterns to account for the increase. Findings were presented but there were no trends or patterns identified.

Staff understood their role within the wider team and took responsibility for their actions. They knew how to escalate issues to the clinical governance meetings and divisional management team. Information was shared back to sub-committees and all staff in the form of the weekly newsletters sent out by the governance midwife.

Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to make sure they were up to date. We found that all policies were up to date, however the references did not always reflect the most up to date guidance and best practice available. We raised this with leaders who told us they would address this.

Managers and staff carried out a programme of repeated local audits to check improvement over time and ensure compliance with national guidance. Additional audits were requested following an incident, changes to practice or due to changes on the maternity dashboard. For example, when there was an increase from one month to the next in stillbirth rates and shoulder dystocia additional audits were conducted. Audits were also carried out to review effectiveness of changes to practice around mechanical induction of labour. The leadership team were responsive when staff identified where improvements could be made and took action to make changes. Managers shared and made sure staff understood information from the audits in meetings and weekly newsletters.

There was a clear schedule of audits for the year set out which looked at both national priorities and local priorities with staff allocated to complete the audits, timeframes and the forum or meeting that the findings would be presented to.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

The service participated in relevant national clinical audits. Outcomes for women and birthing people were positive, consistent and met expectations, such as national standards. Managers and staff used the results to improve women and birthing people's outcomes.

Maternity

Leaders had identified and escalated relevant risks and issues and identified actions to reduce their impact. Risks were identified through the incident management system and were reviewed and recorded in meeting minutes for the monthly risk assurance meeting. The leadership team took action to make change where risks were identified. However, the service did not currently audit new-born risk assessments when babies were born using recognised tools such as new-born early warning trigger and track (NEWTT). Despite a deep dive in to increase number of neonatal deaths being carried out this was not identified as an area for improvement.

There were plans to cope with unexpected events. They had a detailed local business continuity plan.

The service had an escalation policy to proactively manage activity and acuity within maternity and across the trust. They followed a standard escalation policy across the local area. The service had not deemed it necessary in the past 12 months to divert services or close the unit. The trust had however taken the decision to close the stand-alone Huddersfield birthing centre and keep the co-located birth centre at Calderdale open. This allowed a more responsive model to women and birthing people's needs at a time when there are national and local midwifery staffing pressures. The change in how women were supported had led to an increase in births from 3 births in April 2023 to 40 births in May 2023.

The service had a risk register with 21 risks listed. We reviewed the risk register and saw 2 very high risks, 4 high risks, 9 moderate risks and 6 low risks. There was evidence of mitigation and controls in place with regular reviews and discussion. We saw evidence of some risks reducing over time. There was a clear owner assigned to each risk with an executive director also allocated for oversite. Target dates were in place and the risk register was clear and easy to understand. The main risks related to workforce and the knock-on effects as a result of staffing shortages. For example, workforce was listed at a high risk and delays to induction of labour, inability to adequately staff the maternity assessment unit and insufficient scanning capacity were all listed as a high risk which were linked to workforce.

The trust had an Incident Reporting, Management, and Investigation Group Policy which showed the trust process for reporting and managing incidents included the grading and assurance process, escalation processes and investigation process. When we reviewed incidents and meeting minutes, we saw the service followed the trust wide policy and this was well embedded.

Where there was a critical incident within maternity ‘hot and cold debriefs’ with staff would be carried out. A standard operating procedure was in place to provide guidance on how, where and when these should be conducted. ‘Hot de-briefs’ were carried out immediately after a critical incident had been stabilised and ‘cold debriefs’ were to take place within 2 weeks. Debriefs were recorded using the incident reporting system and we saw evidence that these had been carried out following a serious incident within maternity with learning taken to improve practice in the future.

The Maternity Incentive Scheme is a national programme that rewards trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. The service complied with 9 out of 10 safety initiatives. We saw they had provided sufficient evidence of their compliance to the trust board in January 2023. The trust had an action plan to meet the 1 safety initiative they were not compliant with which was around CO2 monitoring. This was subsequently achieved, and the Trust submitted compliance with all 10 safety actions.

The service provided up to data to the national MBRRACE -UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) survey. We looked at actions from the survey and saw the information was

presented to the LMNS (Local Maternity and Neonatal Systems) board in June 2023. They identified the complexities of the cases dealt with at the service for a level 2 local neonatal unit (This is typically for babies who need a higher level of medical and nursing support for babies born between 27 and 31 weeks). The findings were all within the group averages, but the service had identified upward trends and were looking to address these.

The service had a peer review around the model used for the triage or maternity assessment unit in February 2022. From the review we saw that there were positive findings in relation to the engagement and training with the implementation of a new national model and the commitment from leaders to further improve the implementation of the model. Areas for improvement included improving staff cover for the telephone triage, a dedicated staff team and lead to work within the triage area and improving the recording of data on the electronic system to provide more accurate data. At the time of inspection, we found that progress had started to action the recommendations, but further work was still required.

The service complied with all 5 of the saving babies lives care bundle. We saw they had completed relevant audits to check their compliance and provide safe care. We saw how audits had taken into account health inequalities for the local population.

We reviewed the trust's compliance with the perinatal clinical quality surveillance model and found the trust was compliant. The board were well cited on the maternity service, challenges faced, findings from audits and ongoing projects of work and information shared with the LMNS.

The service had an Ockenden assurance visit in June 2022 to assess compliance with the 7 immediate and essential actions from the interim Ockenden report 2020. The visit findings confirmed that all immediate and essential actions were met and included 10 recommendations for the trust to consider making further improvements. The service shared actions taken to meet these recommendations and work that was still on-going.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a live dashboard of performance which was accessible to senior managers. Key performance indicators were displayed for review and managers could see other locations across the region for internal benchmarking and comparison.

The service had digital care records across maternity which were well embedded and understood by staff. Staff had a good understanding of how to use the systems and the service continued to improve systems where issues were identified or could be improved on.

The service had an electronic patient records specialist midwife who took a lead on the digital strategy within midwifery.

The service launched “My Pregnancy Notes” which was a “single point of access” patient interface to enable women and birthing people to make online bookings for pregnancy care and access to maternity notes.

The systems and data collection allowed for reports to be generated for auditing purposes and we saw how information on demographics and ethnicity for women and birthing people had been used to look at health inequalities.

The information systems were integrated and secure and staff used fingerprint recognition to access computers quickly and securely**.**

Data or notifications were consistently submitted to external organisations as required.

Engagement

Leaders and staff actively and openly engaged with women and birthing people, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women and birthing people.

Leaders worked well with the local Maternity Voices Partnership (MVP) to contribute to decisions about care in maternity services. The MVP told us they felt heard, valued and the benefits of their role and contributions recognised.

Maternity Voices Partnership engagement meetings were scheduled monthly. There was a mix of focus groups, walk arounds of the service and listening events scheduled for the next 12 months. Meetings covered service user voice and experience, current workstreams, co-production, future plans and general updates and learning. We looked at minutes and action plans from the most recent meetings and saw there was a clear direction of work to improve the way service user voice was heard and increasing the voice and involvement of those at greater risk due to health inequalities. The MVP and service recognised that those women and birthing people at greater risk due to health inequalities were also the hardest to reach to obtain feedback and so feedback gathering through Discovery Interviews had been introduced both in the service and in the community. The findings of which were presented to the trust and action plans formed. Efforts had also been made to establish connections with several community groups and resources. A Gap Analysis of the CHFT Maternity Services website was completed and the Chair acted as part of the visiting team in the June 2022 Ockenden Assurance visit.

A patient experience group helped the maternity service to improve the service by capturing women and birthing peoples experience. As a result of the feedback a “you said, we did” report was shared. This included improving the information and resources available around feeding and tongue tie following a complaint. Feedback on the usability of the family and friends test also led to improvement in the layout and information collected on the cards.

The maternity service received 37 posts over a 3-month period of positive feedback and compliments via their social media page which was shared with staff.

We saw how feedback around breast feeding and tongue tie was raised by the MVP following feedback obtained at a discovery meeting. The service then took action to feed this back to staff in the weekly newsletters and to the NIPE midwife.

Both the service and the MVP were keen to further improve the involvement of the MVP in co-production and plans were in place for the MVP to be part of the complaints process and attend more maternity meetings. The MVP told us about how they were attending a community centre to meet with, harder to reach women and birthing people from ethnic minority backgrounds. This was being supported by a bilingual member midwife who would act as a translator to reduce communication barriers. The MVP did not have access at the time of the inspection to interpreter services but had raised this with the trust and was awaiting feedback.

Maternity

The service made available interpreting services for women and birthing people and pregnant people and collected data on ethnicity and deprivation based on postcode. The service made the decision to stop telephone consultations with women and birthing people where English was not their first language as it was acknowledged the difficulties with accessing effective interpreting services over the phone.

Leaders understood the needs of the local population, which was both rural and urban, both of which presented with individual challenges. They acknowledge the disparity between the local areas of Huddersfield and Calderdale and used audits to evidence the impact on women and birthing people. A vitamin D / Healthy Start Scheme was being promoted by Midwifery teams to increase uptake of Vitamin D and access to healthy food 'vouchers' for pregnant women and new mothers on very low incomes to spend on veg, fruit and milk.

They were aware of the ethnicity of population they served and how women and birthing people who were black or of an ethnic minority were more likely to experience poor outcomes. This was made clear within polices, meetings and findings from audits so it remained a focus.

Deep dives were conducted which had a specific focus on health inequalities. The service had recently, alongside the local college, conducted a pilot of English as a Second Language pregnancy antenatal classes, and this was proposed to continue. The service had improved included welcome signs produced in top 10 local first languages and there was mapping of multi-lingual resources available.

They had also carried out a staff survey on cultural competence with maternity staff and piloted rollout of a cultural competence training package. At the time of the inspection these results were not available.

The service held regular engagement sessions with staff. We saw that communication on updates took a range of formats across maternity, there was a regular weekly newsletter and emails shared with updates and the service had also held open days with existing maternity staff to share updated and seek feedback on issues. We also saw a schedule for staff meetings for maternity support workers, the birth centre (which included skills and drills sessions) and band 7 midwives.

An engagement session with community midwives for the Huddersfield and Calderdale areas had led to changes in practice around rotas, on-call and additional admin/non-midwifery support provided. This had positively impacted on workload and morale.

We saw that staff raised concerns at the open day about staff ability to raise concerns with the senior leadership team and a proposal was made to introduce staff representatives, this was on-going at the time of the inspection. The service was also investing in digital platform to support staff engagement.

The director and deputy director of midwifery also took part in listening events with student nurses and the university to ensure student midwives are heard and improvement where possible to their learning experience are made.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Maternity

The service was committed to improving services by learning when things went well or not so well and promoted training and innovation. A quality improvement meeting to ensure oversight of ongoing quality improvement projects and actions was established in May 2023. Whilst there wasn't a quality improvement specialist midwife there was an overall commitment from the service to drive improvement which was part of the Journey 2 Outstanding program.

The introduction of a midwife sonographer clinic within maternity assessment centre in 2020 led to significant increases of women being scanned on the same day as the referral, this increased from 21% (2019) to 41% (2020) and the longest delay reduced from 11 days to 4 days.

The service showed innovation around the workforce and learning from other initiatives. For example, a Maternity Support Worker Clinical Educator had been introduced to develop the role of the MSW and provide support and recognition for the work they did. This was alongside the already established midwifery clinical educator role. Support for MSW included ensuring sufficient and effective training was available with assessment of competency requirements; with the aim of upskilling MSWs from band 2 to band 3. One MSW had recently enrolled on the midwifery apprenticeship university course funded by the Trust.

The service had been reviewing the workforce to use non-midwifery staff wherever possible to reduce the pressure on midwife's workload. The service was also using registered nurses within maternity and feedback from midwives was that this was working well with the skill sets of midwives and nurses complimenting each other.

The service introduced a Maternity Health Adviser to provide in-house stop smoking advice from October 2022 as the service found there was a poor uptake of generic stop smoking services by women and birthing people. In the first 6 months 149 out of 175 women and birthing people offered the service accepted it. The Maternity health advisor also provided more holistic advice on healthy eating, vitamins, and exercise in pregnancy.

The service collaborated with regional universities and charities to support research studies including participation in a smoking in pregnancy research which was undertaken and published.

The service ran a breast milk donation bank which was pasteurised in service with a pasteuriser recently being purchased. This was used not only for babies requiring this at Calderdale Royal Hospital but also as a source of income for the service.

The manager of the birth centre told us about the work carried out to improve the overall experience of the birthing person and parents of surrogate pregnancies. This included ensuring that parents were able to be present at the birth both antenatally and postnatally and there was an increased awareness amongst staff around the process.

The service also started a rainbow clinic in May 2021, this was designed to support women and birthing people who had suffered previous baby losses either due to miscarriage, stillbirth, or a neonatal death or where to the pregnancy had to be terminated due to medical complications. The clinic was run by a consultant and the bereavement midwife, and the focus was providing additional emotional, psychological, and clinical support to women and birthing people. This included additional assurance scans from 8-9 weeks.

We saw that there were on-going projects and proposals to further improve the service which included a business case to purchase more ultrasound equipment which would reduce the risk of human error and future reviews of elective caesarean sections.

The service had adapted leaflets and the language used to be more inclusive of LGBTQ+ couples and communities.

Maternity

Outstanding practice

We found the following outstanding practice:

A breast milk donation bank was run by the service, this was both a resource to supply breast milk to pre-term and in need babies within the service and a source of income.

A Rainbow bereavement clinic was run by a midwife and consultant obstetrician for women and birthing people who had a non-viable pregnancy or had experienced a previous baby loss. The aim of this clinic was to provide a greater level of psychological and clinical support.

Surrogacy work- the service had introduced additional clinics and support for women and birthing people who were having a surrogacy pregnancy. This included separate appointments for both the parents and the surrogate and joint appointments depending on preferences. Also, the practicalities of the birth plan as well as visiting both during labour and postnatally had been agreed on an individual basis.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

- The service must ensure all staff are up to date with all relevant training, such as training around the emergency evacuation of the birthing pools on the labour ward for midwifery staff and safeguarding level 3 training for all medical staff. Regulation 12(1)(2)(c)
- The service must ensure there are at all times sufficient numbers of suitably qualified staff to meet the needs of women, birthing people and babies across the maternity service. Regulation 18 (1)

Action the trust SHOULD take to improve:

Location/core service

- The service should ensure that they continue to monitor and drive improvement around compliance with documentation such as CTG fresh eyes and MEOWS. Regulation 12 (2)(b).
- The service should consider the location of the bereavement room as part of planned reconfiguration works in line with best practice guidance and the feedback and fundraising efforts of the local community.
- The service should consider the regular reviews of ligature risk assessments across the service.
- The service should continue to improve on the appraisal rates for all staff.
- The service should continue to develop systems to ensure policies reflect current evidence-based best practice.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, and 5 other CQC inspectors, 2 specialist midwifery advisors and an obstetric specialist advisor. The inspection team was overseen by Carolyn Jenkinson, Deputy Director of Secondary and Specialist Care.

20. Freedom to Speak Up Annual Report

For Assurance

Presented by Jason Eddleston

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	Freedom to Speak Up Annual Board Report
Author:	Andrea Gillespie, Freedom to Speak Up Guardian
Sponsoring Director:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee 20 June 2023
Purpose of the Report	This paper provides information to the Board in respect of the Freedom to Speak Up (FTSU) arrangements at CHFT and FTSU activity in the Trust from the 1st April 2022 to the 31st March 2023.
Key Points to Note	• The number of concerns raised in 2022/2023 and the number of concerns raised as per the National Guardian's Office submission categories and by staff groups. • The themes of concerns. • The ethnicity of the colleagues that have raised their concerns via FTSU at CHFT. • The work being undertaken to create a culture where staff feel safe to speak up and make FTSU business as usual at CHFT.
EQIA – Equality Impact Assessment	The equality impact for specific actions arising following consideration of the report will be assessed, considered, and mitigated as appropriate.
Recommendation	The Board of Directors is asked to **NOTE** the contents of the Freedom to Speak Up Annual Report, the number of concerns raised in 2022/2023 and the work of the FTSU Guardian and Ambassadors.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

7 SEPTEMBER 2023

FREEDOM TO SPEAK UP ANNUAL REPORT

1. PURPOSE

This paper provides information to the Board in respect of the Freedom to Speak Up (FTSU) arrangements at CHFT and FTSU activity in the Trust from the 1st April 2022 to the 31st March 2023.

2. BACKGROUND

Freedom to Speak Up is vital in healthcare if we are to continually improve patient safety, patient experience and the working conditions for colleagues. The National Guardian's Office (NGO) believes a positive speaking up culture makes for a safer workplace, for workers, patients, and service users. At CHFT we are working towards speaking up becoming business as usual.

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led Trust. The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections within its Key Line of Enquiry (KLOE) approach as part of a Well-Led review.

3. PROGRESS UPDATE

3.1 The FTSU Network at CHFT

The Trust has one FTSU Guardian (FTSUG), Andrea Gillespie who works 18.75 hours per week. The FTSUG attends the FTSU Yorkshire and Humber network monthly meetings where there is regular attendance from the NGO and buddies the FTSU Guardian at Bradford Teaching Hospitals. The Guardians meet monthly via MS Teams for peer support.

Suzanne Dunkley, Director of Workforce and Organisational Development is the Executive Sponsor for FTSU, Karen Heaton is the non-Executive Sponsor for FTSU. Jason Eddleston, Deputy Director of Workforce and Organisational Development is the FTSU Champion and there are 22 FTSU Ambassadors. The Ambassadors promote the FTSU agenda in their areas of work and are a point of contact and source of support for any colleague who wants to discuss, raise and escalate a concern. The Ambassadors currently have no protected time to dedicate to FTSU within their substantive roles which significantly limits the support they provide to the FTSUG and colleagues, and the opportunities they have to raise the FTSU profile within the organisation. As a result, a review of the FTSU Ambassador network is planned. The review will look at the expectations and effectiveness of the role, the network size and will seek feedback from the current Ambassadors.

The FTSUG and the FTSU Ambassadors meet bi-monthly. The meetings are chaired by the FTSUG, and regular agenda items include updates and minutes from the Regional Meetings, data submissions and national reviews, i.e. case reviews completed by the NGO in other organisations. Attendance at the meetings has recently been poor as it has become more difficult for the Ambassadors to attend due to operational pressures impacting upon their substantive roles.

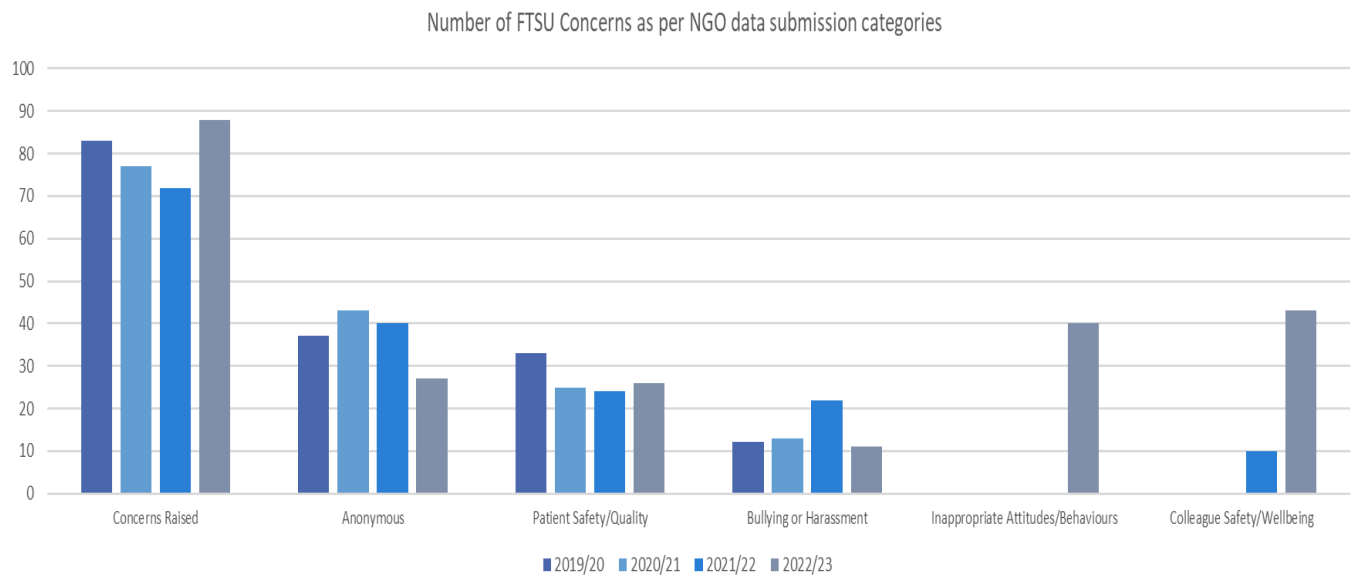
3.2 FTSU concerns raised from the 1st April 2022 to the 31st March 2023

In February 2022 the NGO revised the guidance for recording cases and reporting data which took effect from the 1st of April 2022. The new guidance added a new category of 'inappropriate attitudes or behaviours' which prompted the adoption of the Advisory, Conciliation and Arbitration Service

(ACAS) definitions of bullying and harassment. The new category is to be selected when there is risk of other attitudes or behaviours that do not constitute bullying and harassment. In addition, the 'colleague safety' category was extended to include colleague wellbeing.

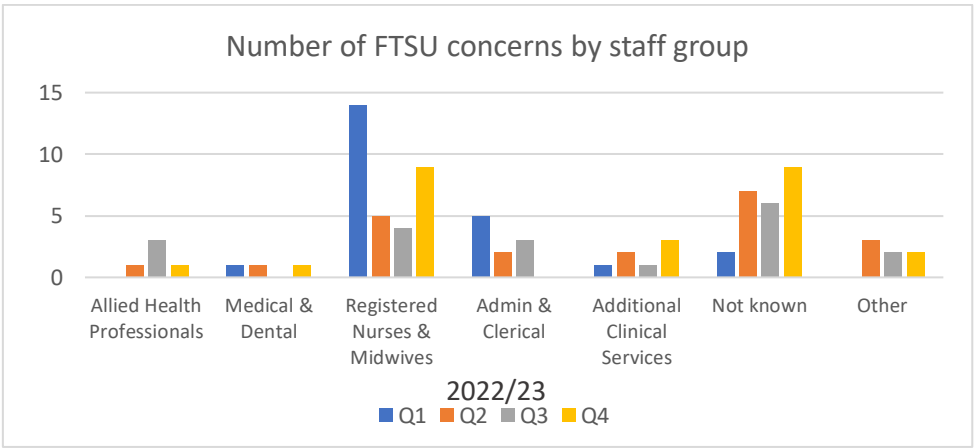
The graph below shows the total number of concerns raised in 2022/2023 and the number of concerns raised as per the NGO's submission categories. Please note that multiple categories can be selected for each individual concern. Data for 2019/2020, 2020/2021 and 2021/2022 has been added to provide a comparison.

No colleagues have reported suffering any detriment or demeaning treatment as a result of speaking up.



Colleagues raising FTSU concerns are requested to indicate which professional/ worker group (as defined by the NGO) that they belong to. The NGO revised the groups to take effect from 1st April 2022. The 'corporate services' and 'healthcare assistants' groups have been discontinued and a new group 'additional clinical services' has been added. The definitions for all groups have been revised.

The graph below indicates the number of concerns raised per quarter by staff group at CHFT. Registered nurses and midwives have submitted the highest number of concerns. The data is utilised to identify staff groups where more FTSU promotion and education is required. The 24 'not known' are colleagues who have raised their concerns anonymously.



Colleagues raising their concerns require different levels of support due to the complexity and level of sensitivity of their concern and their emotional state at the time of contacting FTSU. As a result, the FTSUG is spending a larger proportion of time listening and supporting colleagues, referring them for counselling where appropriate.

The subjects of the concerns raised are extremely varied however there are some common themes. The attitudes and behaviours of colleagues remains one such theme. Colleagues raising their concerns describe colleagues being unkind and unsupportive of each other.
This reporting period has also seen an increase in concerns related to patient safety and the quality of care being delivered. The increase correlates with the high operational activity experienced by the organisation. The FTSUG has connected with Divisions for assurance that they are aware of the types of issues being raised, they are listening to their teams, they are taking steps to address the multiple issues and monitoring the effectiveness of their actions.

Multiple concerns raised in maternity and theatre services has been referred to in previous FTSU reports. Theatre colleagues who had raised their concerns described improvements in the workplace and all their concerns have now been closed. In maternity some concerns have been closed but additional concerns continue to be raised in this area via FTSU. The concerns raised around maternity continue to be addressed as part of a larger Maternity Improvement plan by the Division with support from members of the Executive Board.

The table below illustrates the ethnicity of the colleagues that have raised their concerns via FTSU at CHFT. The numbers recorded in the unknown category include the concerns raised anonymously and concerns received via other routes, such as email, that are added to the portal by the FTSUG.

The data collection exercise for the purpose of this report has informed an action for the FTSUG, that is to revisit and update the ethnicity section of the portal when in receipt of the information. This will lead to more robust and comprehensive data in the future which can be used to identify barriers and target promotion.

2022/2023	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
White British	3	7	7	7
White Irish	1			
White Scottish		1		
Any other whist background				1
Asian British	1		1	
Asian Bangladeshi				1
White & Black Caribbean	1			
Unknown	15	12	8	11
Not stated/ prefer not to say	2	1	4	6

In June 2023 the NGO published, ‘Fear and Futility, what does the Staff Survey tell us about speaking up in the NHS?’. The report and graph below illustrate the national picture in relation to the speaking up of black and minority ethnic health workers and states that inclusion is essential for a healthy speak up, listen up and follow up culture and being heard increases a sense of belonging for colleagues.

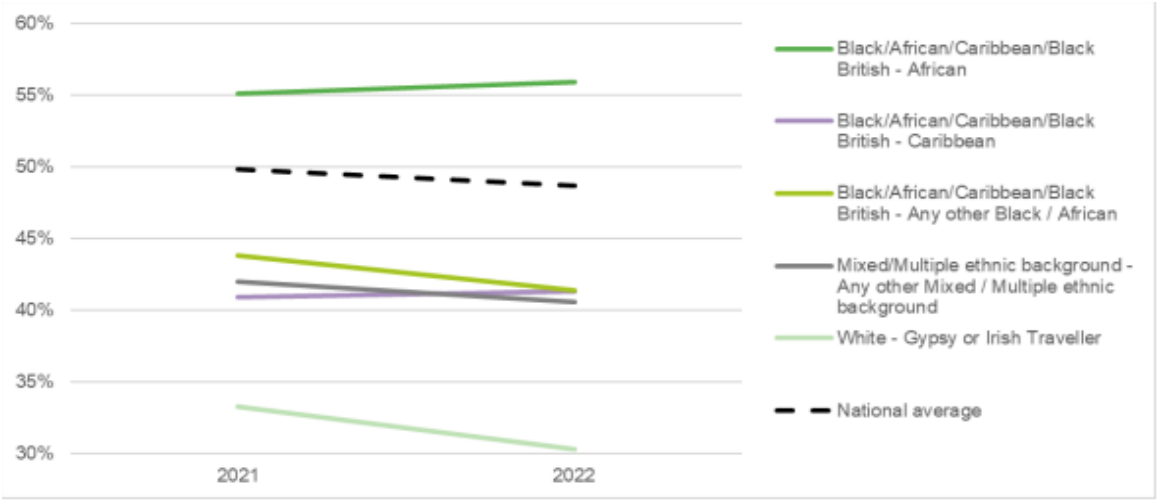
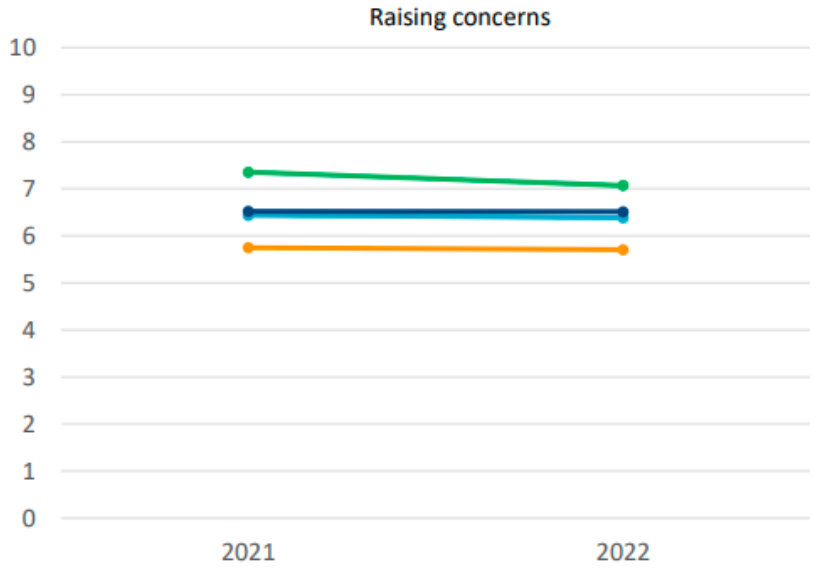


Figure 16. Change over time for the question 'If I spoke up about something that concerned me I am confident my organisation would address my concern' – responses by ethnic backgrounds

From 2019-2021 the NGO brought together the questions in the staff survey relating to speaking up to form a 'FTSU index' which could be used for the purpose of benchmarking. This has now been replaced by the 'FTSU sub-score' and sub-scores have been calculated for both the 2021 and 2022 surveys.

The graph below illustrates CHFT position. The sub-score of 6.5 has remained static from 2021 to 2022.



	2021	2022
Your org	6.5	6.5
Best	7.4	7.1
Average	6.4	6.4
Worst	5.7	5.7
Responses	2645	2651

The table below provides a comparison with other West Yorkshire Acute Trusts.

	2021 Sub-score	2022 Sub-score
Leeds Teaching Hospitals	6.7	6.6
Bradford Teaching Hospitals	6.4	6.4
Airedale NHS FT	6.9	6.6
Mid Yorkshire Hospitals	6.4	6.2
Harrogate & District FT	6.4	6.6

Feedback from colleagues raising their concerns continues to be positive. Here are some examples:

- 'Yes, I would speak up again. Thank you for your generosity, kindness and help. You've helped me in difficult times.'

- 'I would definitely speak up again – I felt the FTSUG dealt with my concern with compassion and directed it in a timely manner to the appropriate personnel.'

- 'It is an easy 'Yes' for me, I would speak up again. This is what you did for me:
    1. You listened
    2. You calmed me down and gave me focus
    3. You asked me what outcome I wanted, and we both agreed what the best outcome would be
    4. You kept checking in at all times

  I can now feedback to say that with your help and sign posting me to the right people, I am now in a good place mentally and physically'.

4. NGO UPDATE

The NGO has requested that organisations complete the actions below and provide evidence of completion before the end of January 2024:

- Update their local Freedom to Speak Up policy to reflect the new national policy template. A first draft of this has been produced and is awaiting review before submission for ratification.

- Complete an assessment of the organisations Freedom to Speak Up arrangements using the revised guidance and template produced by the NGO. Currently the FTSUG is reviewing the revised guidance and will facilitate completion of the assessment over the next 3-6 months.

- Create an improvement strategy that addresses the results of the assessment. This will be developed when the assessment has been completed.

All CHFTcolleagues now have access to the NGO FTSU e-learning package via ESR. The package includes 3 modules, Speak Up, Listen Up and Follow up which were developed by the NGO in collaboration with Health Education England. The Speak Up module is designed to be completed by all colleagues, the Listen Up module is to be completed by managers of all levels and the Follow Up module is for senior leaders to complete. In May 2023 communications were produced to inform colleagues of its existence on ESR. The training is not included as part of an essential safety training core package therefore it is predicted that there will be poor uptake of the training. Details of the training has been added to the FTSU pages and training pages on the intranet and the FTSUG promotes the training at any opportunity. More ways in which the training can be promoted, and colleagues regularly prompted of the training are to be explored.

5. RISK ASSESSMENT

Regular evaluation of the number and complexity of concerns received is essential for assurance that the resource available to lead, manage and co-ordinate FTSU at CHFT ensures a timely, appropriate, and supportive response for colleagues raising a concern and enables a full and proper enquiry and resolution of the concern. A sudden increase in the number and/or complexity of concerns or an increasing trend that is not appropriately considered and attended to could create risk to the integrity and credibility of FTSU at the Trust. FTSU activity is reviewed regularly by the FTSUG in conversation with others and any additional resource requirements and/or different ways of working that can be applied are considered. Continuing development of FTSU is vital if the service is to grow and reach out to all our colleagues.

6. CONCLUSION

The Board of Directors is asked to note the contents of the report, the number of concerns raised in 2022/2023 and the work of the FTSU Guardian and Ambassadors.

Andrea Gillespie
Freedom to Speak Up Guardian

August 2023

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Freedom to Speak Up
Annual Report 2022/2023

Board of Directors

7 September 2023

One Culture of care

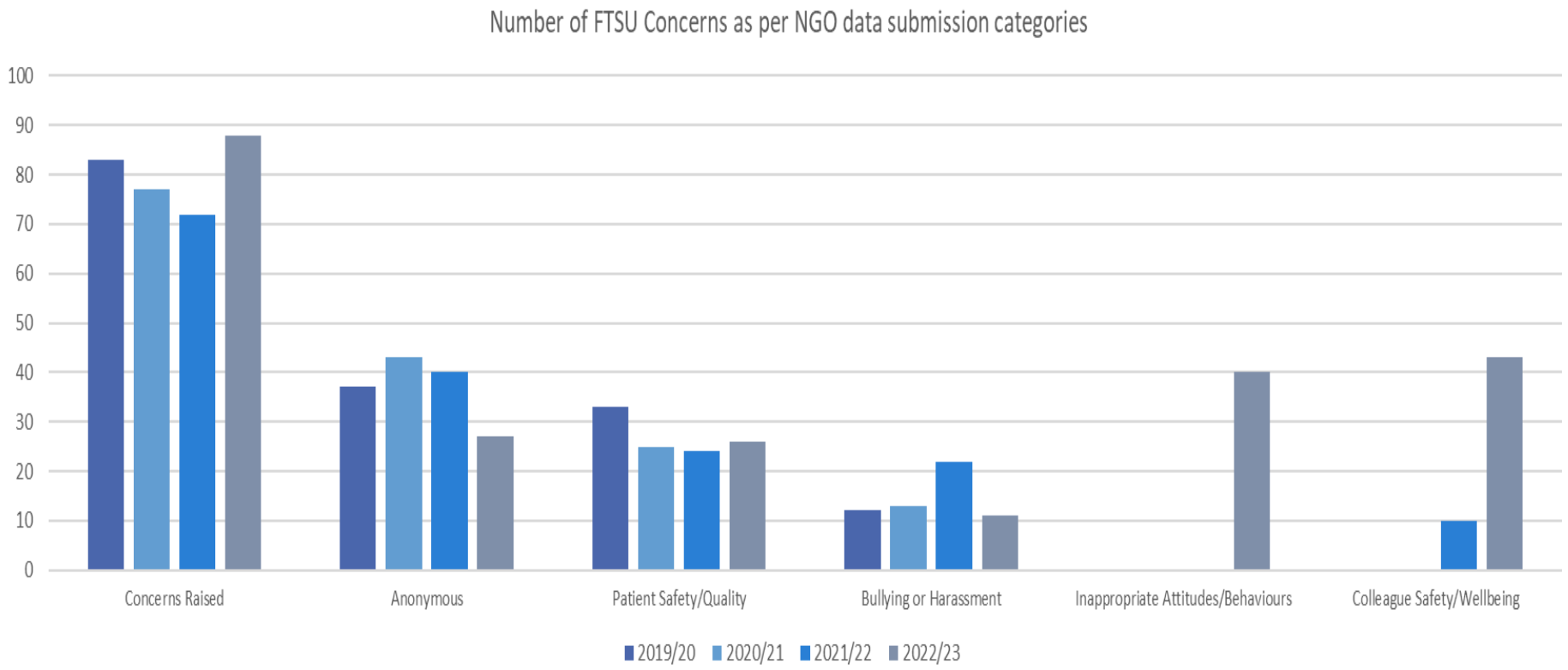
FREEDOM TO SPEAK UP NETWORK
WE'RE HERE TO LISTEN

compassionate care

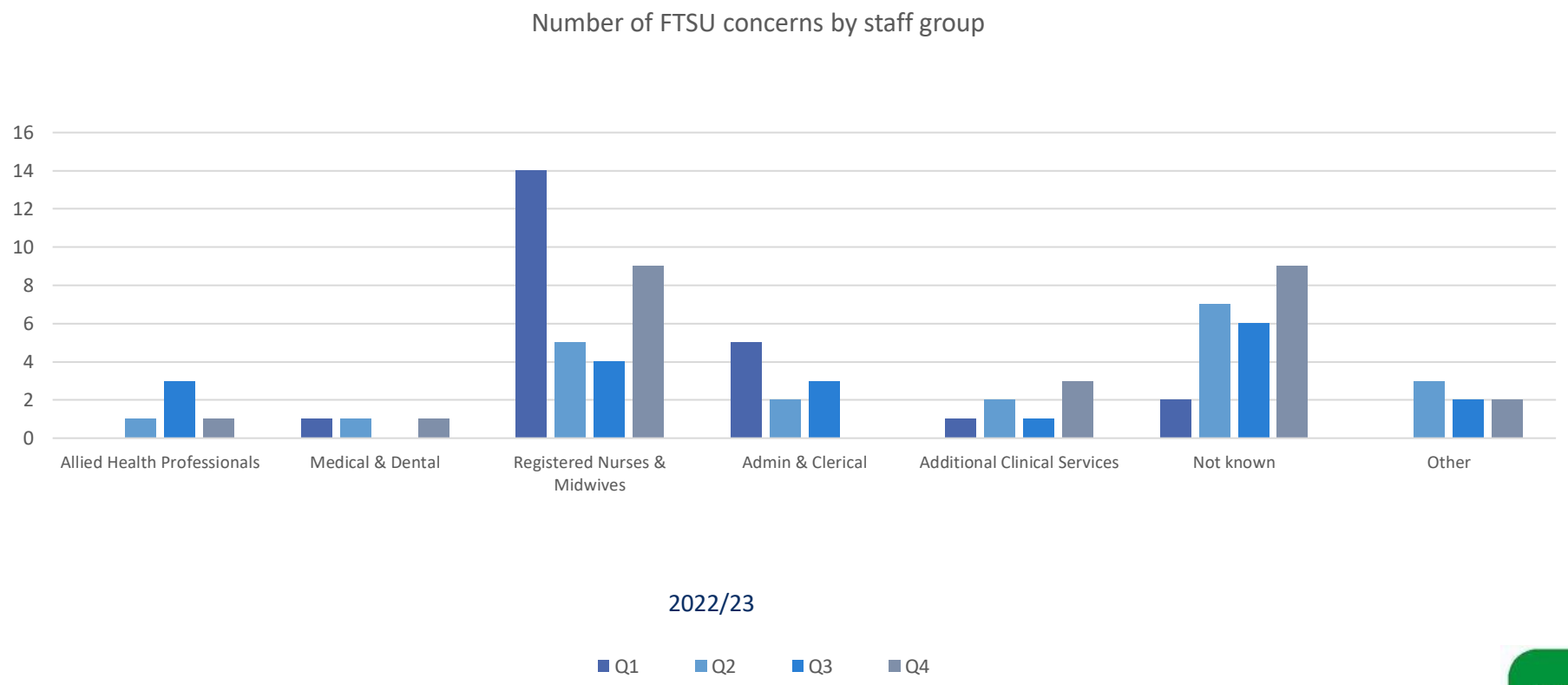
Key points/themes

- total of 88 concerns raised in 2022/2023 (highest across the last 4 years), indicative of a positive reporting culture
- nurses/midwives is the biggest reporting group, medical and dental is the lowest
- 24 anonymous concerns, representing an improving position
- primary concern reporting issues are colleague safety and well being (42), inappropriate attitudes and behaviours (40), patient safety and care quality (26) and bullying and harassment (11). Please note, a concern can be recorded in multiple categories

FTSU concerns – numbers/themes

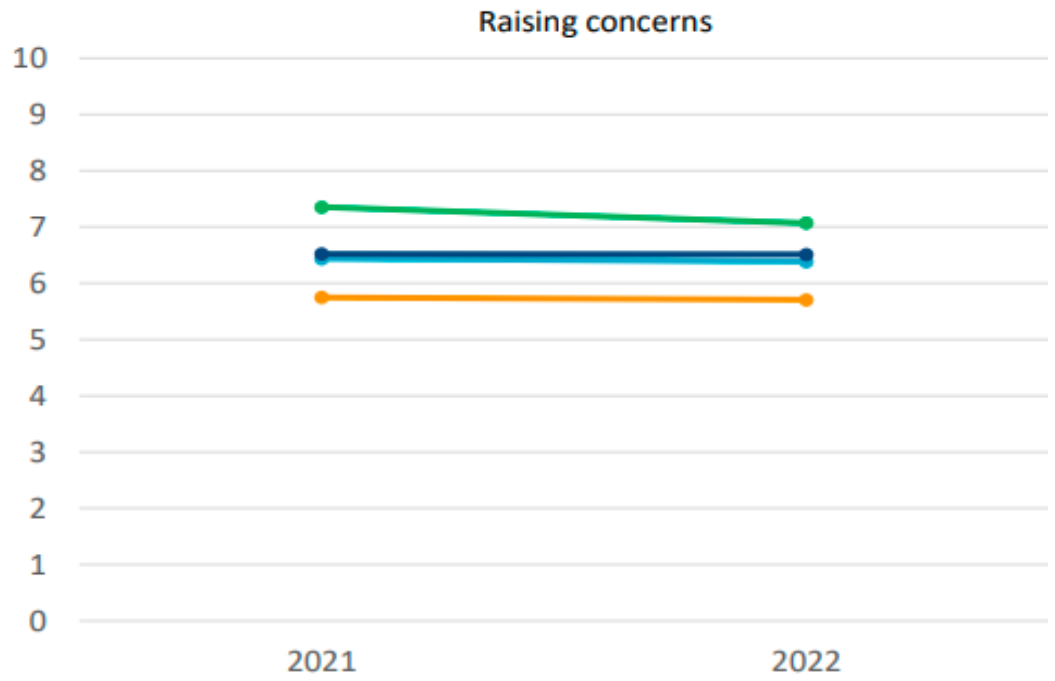


FTSU concerns by staff group



FTSU score – 2022 staff survey

Calderdale and Huddersfield NHS Foundation Trust



	2021	2022
Your org	6.5	6.5
Best	7.4	7.1
Average	6.4	6.4
Worst	5.7	5.7
Responses	2645	2651

One Culture of care

FREEDOM TO SPEAK UP NETWORK

WE'RE HERE TO LISTEN

compassionate care

2023/2024 action focus

Calderdale and Huddersfield NHS Foundation Trust

FTSU national policy/local policy alignment

FTSU NGO e-learning packages

Education/awareness/publicity/engagement

FTSU Board assessment of our existing arrangements with an action plan based on its outcome

One Culture of care

FREEDOM TO SPEAK UP NETWORK

WE'RE HERE TO LISTEN

compassionate care

21. Board Assurance Framework – Performance Risk

For Assurance

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 September 2023
Meeting:	Board of Directors
Title:	Board Assurance Framework – Performance Risk
Author:	Victoria Pickles, Director of Corporate Affairs
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Finance and Performance Committee
Actions Requested: The Board is requested to **APPROVE** the new strategic risk relating to performance	
Purpose of the Report	
At the July meeting, the Board received and approved the Board Assurance Framework, which had been updated to take account of the new five year strategy. As part of this and subsequent discussions at Finance and Performance Committee, it was agreed to close the risk relating to performance, and consider a new risk, which reflected the Trust's approach to the targets set by NHS England and the impact of the Place and Integrated Care Board.	
Key Points to Note	
A new risk is attached which takes these into account and sets out the controls and sources of assurance. The risk focuses on where the Trust has taken a decision, in line with the risk appetite, not to agree to achieve the NHS England targets or where these are challenging based on the work required with partners. For example, the bed occupancy percentage has not been accepted by the Board.	
EQIA – Equality Impact Assessment	
All risks are considered for their impact on equality.	
Recommendation	
The Board is requested to **APPROVE** the revised performance risk	

BOARD ASSURANCE FRAMEWORK
JUNE 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 September 2023 Risk category: Regulation Risk appetite: Moderate**		
								Initial	**Current**	**Target**
04/23	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	**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 - October 2023 Strike action impacting on delivery of elective, diagnostics, outpatients and non-elective activity - Strike planning meetings in place internally and with partners COO - 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 - October 2023	Still not meeting A&E wait time target of 75% 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

Action	**Timescale**	**Lead**
Deliver action plan to address waiting times in neurophysiology and cardiology	October 2023	Chief Operating Officer
Strike action planning	Ongoing	"
Monitor impact of opening new A&E and model resulting performance	October 2023	"

Links to risk register: 7615 - 4 hour Emergency Care standard, 6453 delay of surgical repair of fractured neck of femur, 7454 Radiology performance targets

22. Risk Appetite Statement

For Assurance

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 September 2023
Meeting:	Public Board of Directors
Title:	Annual Review of Risk Appetite
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	None
Purpose of the Report	This paper confirms the Trust risk appetite following an annual review of the existing risk appetite.
Key Points to Note	An annual review of the risk appetite has taken place resulting in minor changes to the wording within the risk appetite as shown in red in the enclosed paper. The upcoming review of all Board Assurance Framework risks (update 2) will include a review of the target risk score against the risk appetite.
EQIA – Equality Impact Assessment	Any issues will be identified when applying the risk appetite.
Recommendation	The Board is asked to **APPROVE** the updated risk appetite.

ANNUAL REVIEW OF TRUST RISK APPETITE

1.1 Risk Appetite

Risk appetite is "the amount and type of risk that the Trust is prepared to pursue, retain or take" in pursuit of its strategic objectives and is key to achieving effective risk management.

The Board needs to understand, set and apply the risk appetite as a key element of its strategic approach to risk management as it explicitly articulates the Board's attitude to and boundaries of risk. Risk appetite also provides clear expectations for staff and managers regarding the management of risk. It allows for controlled risk taking. The risk appetite also supports the Board by ensuring that they do not expose the Trust to risks it cannot tolerate, it can choose to take opportunities when they arise and the Board is not over cautious or stifles innovation and development.

One of the key roles of the Board is to ensure that the Trust is taking the right level of risk within which to meet its strategic objectives and understand it's risk management boundaries.

All risks on the Board Assurance Framework have an identified risk appetite and the Board reviews its risk appetite annually. The amount of risk the Trust is prepared to accept or be exposed to will vary according to the perceived significance of risks, timing and regulatory or legislative constraints. Each risk requires the exercise of judgement and risk appetite levels may need to be re-assessed and amended to reflect new and changing circumstances.

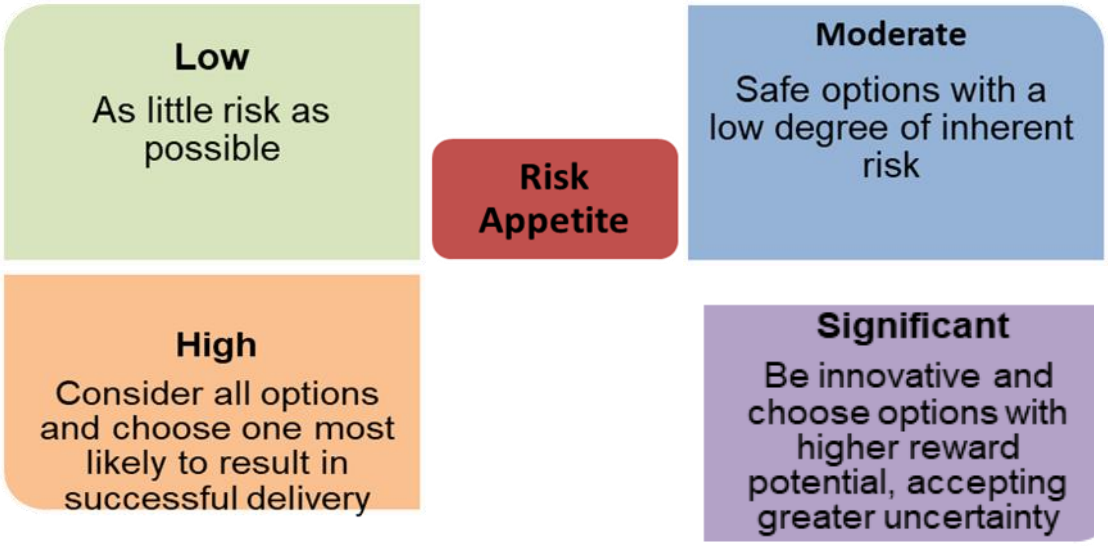
When balancing risks, the Trust will tolerate some risks more than others, for example we have a low appetite for risk relating to harm and safety whereas for quality, innovation and improvement we have a significant risk appetite allowing the Trust to pursue areas with a higher reward potential.

The Trust has a qualitative risk appetite statement reflecting the context within which the Trust works and enabling well calculated risks to be taken to improve delivery when opportunities arise.

The risk appetite is based upon the Good Governance Institute (GGI) Risk Appetite for NHS Organisations Matrix.

1.2. Trust Risk Appetite

The Trust has four levels of risk appetite as depicted below:



1.3 Risk Appetite Statement

The Trust's risk appetite is structured around the following key risk categories:

- Strategic / organisational
- Reputation
- Financial/assets
- Regulation
- Legal
- Innovation/technology
- Commercial
- Harm and safety
- Workforce
- Quality, innovation and improvement
- Partnership

TRUST RISK APPETITE STATEMENT

Risk Category / Type	Description	Risk Appetite
Strategic / Organisational	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
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	**SIGNIFICANT**

	support service transformation and operational delivery, **within agreed financial limits.**	
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**
Reputation	**Where required, we** will ~~not shy away from~~ make difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Commercial	We explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value, benefits, local **and system** impact, aiming to deliver our services within our **ICS approved** financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**

Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our **patients and colleagues** safe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety, **appropriate staffing levels** and promoting the well-being of our staff.	**LOW**
Legal	We will comply with the law.	**LOW**

The Board has previously agreed how risks on the Board Assurance Framework (BAF) are deemed to have breached their risk appetite level, using the 5 x 5 risk scoring matrix. This continues to be used to identify whether BAF risks are within a risk tolerance level or have become areas of risk exposure, requiring greater oversight by the Board and its Committees.

Recommendation

The Board is asked to **APPROVE** the risk appetite statement.

23. High Level Risk Register

To Approve

Presented by Lindsay Rudge

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	High Level Risk Report
Author:	Saj Rahman, Risk Manager
Sponsoring Director:	Victoria Pickles, Director of Corporate Affairs
Previous Forums:	Risk Group

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. The Risk Manager has developed a project plan to review all risks on the Trust risk register with Divisions to ensure that they are recorded and used effectively. Within this project plan, stratified risk register training will be delivered to all Trust staff.

Current risk process and position
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.

Currently there are 50 high scoring risks on the Trust risk register:

- 11 are scored as very high.
- 39 are scored as high.
- 11 have had their risk scores reduced.
- 1 has 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:

- Transforming care:
  - The capacity of the pharmacy department in relation to the British Oncology Pharmacy Association (BOPA) standards

- 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 (PCI), angiogram waiting times, and national radiology targets.
  - There is a risk due the capacity available to validate outpatient appointments.

Themes of risks scoring high (15-16) are:

- Transforming care:

  - Follow-Up Appointments – A risk of being unable to provide sufficient appointments for patients requiring OP follow-up.
  - Workforce capacity to meet the needs of individual care for the most vulnerable patients.
  - Medical cover for maternity assessment centre
  - Scanning capacity for rescanning within maternity
  - Prolonged patient length of stay within the ED and the impact this has on ED flow.

- Keeping the base safe:

  - The number of referrals into services; appointment availability; level of unplanned and emergency care activity; demand on inpatient capacity; lack of theatre capacity to meet recovery plans; support for mental health patients; health inequalities because of the elective recovery and follow up back log.
  - Children and young people who require medical or safeguarding appointments being cancelled on the booking system without clinical oversight.
  - Potentially unable to provide a CT scanning service in the event of a fatal breakdown of the CT scanner at CRH.
  - Non-compliance with Ockenden 2 recommendations
  - Insufficient corneal appointments available for patients
  - The provision of plain film radiology due to age of equipment
  - Staffing - vacancy issues across midwifery
  - The inability to deliver a two site Blood Transfusion / Haematology service.
  - High volumes of patients awaiting a follow up appointment within Colorectal surgery
  - There is a risk of human error in transcribing information, due to the lack of maternity reporting software.
  - Fire safety
  - Medication storage on ward nine

These risks reflect the key areas of challenge reflected in the Board agenda today and align to the strategic risks set out on the Board Assurance Framework.

The high level risk register will be presented to the Board at its meeting on 2 November 2023.

Future development work
An options appraisal and business case has been developed to move the risk register to a new IT provider. The system is designed to triangulate data gathered within the organisation to provide a clear and detailed evidence of the risk posed to the Trust. A new IT system is being reviewed to ensure new Patient Safety Incident Reporting Framework (PSIRF) requirements are met, whereby risks and serious incidents will be brought together so that learning can more easily be identified and shared. The business case will be presented at this month's Business Case Approvals Group.

EQIA – Equality Impact Assessment
Risks are assessed considering any impact on equality.
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	8316	Family & Specialist Services	Pharmacy	Pharmacy	Transforming and improving patient care	There is a risk of systemic anti-cancer therapy prescriptions containing errors.	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	8578	Family & Specialist Services	Children's Services	Paediatrics Out Patients CRH/HRI	Keeping the base safe	There is a risk of appointments for children and young people who require medical or safeguarding attention being cancelled without clinical oversight.	16 4 x 4
High	8306	Medical	Emergency Care	Accident & Emergency CRH/HRI	Keeping the base safe	There is a risk of a reduction of operational performance and maintenance of the 4 hr Enhanced community service due to an increase of Medical and Nursing staffing gaps especially out of hours.	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	8358	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Keeping the base safe	There is a risk of significant harm due to insufficient corneal appointments available to cope with demand.	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	8438	Family & Specialist Services	Women's Services	All Departments	Keeping the base safe	There is a risk of noncompliance with Ockenden 2 recommendations in relation to provision of separate consultant rota for obstetrics and Gynaecology medical staff due to lack of consultants to create a separate rota.	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	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	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	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	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	8421	Family & Specialist Services	Women's Services	Antenatal clinic	Transforming and improving patient care	There is a risk that currently the service does not have enough capacity to meet scanning requirements in line with clinical pathways.	15 5 x 3
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	8361	Surgery & Anaesthetics	Critical Care	Pain Clinic	Keeping the base safe	There is a risk of disruption to services in the pain clinic due to impending retirement of staffs	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	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

24. Governance Report

a) Board Workplace

b) Board Committee Annual Reports:

- Quality Committee
- Finance and Performance

To Approve

Presented by Andrea McCourt

Draft BOARD PLAN 2023/2024 – as at 30.08.23 V19

PUBLIC BOARD WORKPLAN 2023-2024

DATE OF MEETING	4 May 2023	6 July 2023	7 Sep 2023	2 Nov 2023	11 Jan 2024	7 Mar 2024
Date of agenda setting/Feedback to Execs	5 April 2023	31 May 2023	19 July 2023	11 Oct 2023	15 Nov 2023	10 Jan 2024
Date final reports required	21 April 2023	23 June 2023	25 August 2023	20 October 2023	29 December 2023	23 February 2024

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				✓		
Risk Management Strategy	✓RM Policy			Deferred July to Sept 23 ✓		✓
Charity Strategy				✓		
Annual Plan	✓ for 2023/24					✓
Capital Plan					✓	
Winter 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			✓ Annual Report			
Freedom to Speak Up Annual Report			✓ Annual Report		✓ 6 month report FTSU themes	
Public Sector Equality Duty (PSED) Annual Report						✓

GOVERNANCE & ASSURANCE AGENDA ITEMS						
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		✓QC ✓ NRC BOC
Constitutional changes (+as required)	✓	✓	✓	✓	✓	✓
Compliance with Licence Conditions (final year 2022/23)	✓					
Huddersfield Pharmaceuticals Specials (HPS) Annual Report				✓		
Fire Strategy 2021-2026	✓ (B/f from March 2023 BOD)					✓
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		Deferred to Sept '23	✓			
Quality Committee Annual Report 2022/23		Deferred to Sept '23	✓			
Transformation Programme Board Annual Report				✓(TPB review Sept)		
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)

Date of Meeting:	Thursday 7 September 2023
Meeting:	Public Board of Directors
Title:	Quality Committee Annual Report 2022/2023
Author:	Michelle Augustine – Governance Administrator Denise Sterling – Chair of Quality Committee
Sponsoring Director:	Denise Sterling - Non-Executive Director and Chair of Quality Committee Chair
Previous Forums:	Quality Committee members
Purpose of the Report	This annual report is for information and assurance to the Board of Directors.
Key Points to Note	This annual report describes the activities of the Quality Committee between April 2022 and March 2023, describing how the Committee met the duties within the terms of reference. The report includes: ▪ An overview of the role of the Quality Committee ▪ Details of membership and attendance between April 2022 and March 2023 ▪ Information of the work of the Committee in the following areas: - quality improvement - governance and risk / patient safety - audit and assurance - quality and safety reporting ▪ Effectiveness of the Committee – this section summarises the response of the self –assessment by members which reviewed the committee's focus and objectives, committee team working, committee effectiveness, committee engagement and committee leadership. 10 members completed the assessment, and the summarised findings can be found at the end of the report (appendix 1).
EQIA – Equality Impact Assessment	The report references equality issues and the need for enhanced future regular reporting to the Committee regarding patient care and the Public Sector Equality Duty.
Recommendation	The Board is asked to **NOTE** the assurances in the Annual Report that the Committee met its duties for the reporting period of 2022/2023.

Quality Committee Annual Report 2022 / 2023

This Quality Committee annual report for 2022 / 2023 details:

- The role of the Quality Committee, membership and attendance between April 2022 and March 2023 and the terms of reference
- The activities of the Quality Committee between April 2022 and March 2023
- Self- assessment of the effectiveness of the committee
- The Committee's commitment and focus on key priorities, additional scrutiny into subgroups and assurance to the Trust Board.

1. Introduction

Purpose of the Quality Committee

The purpose of the Quality Committee is to provide assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care; and to ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

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

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

1. Terms of Reference

Following a review of the governance reporting structure, the terms of reference were amended in February and March 2023 to include the removal of the following sub-groups: Clinical Ethics Panel, Cancer Delivery Group, Clinical Effectiveness and Audit Group, and Medical Gases and Non-Invasive Ventilation (NIV) Group. The Chair of the Trust Patient Safety and Quality Board was also amended to the Chief Nurse; The Chair of CQC Group was amended to the Director of Corporate Affairs; The Compliance Group was added as sub-group, and the Associate Director of Allied Health Professionals (AHPs) were added to the membership.

Further amendments were made throughout the year to the terms of reference, including:

- **June 2022** – Addition of Director of Corporate Affairs into core membership
- **October 2022** - Addition of Head of Quality and Safety into core membership
- **December 2022** - Addition of Deputy Chief Executive into core membership
- **February 2023** - Addition of Deputy Medical Director onto membership; Removal of Legal Services Report and Cancer Board Minutes, and the quoracy amended.

Version 7 of the terms of reference were approved by the Trust Board on 2 March 2023.

2. Quality Committee Membership and Attendance in 2022/2023

The Quality Committee met on 11 occasions between April 2022 and March 2023, with the December 2022 meeting being cancelled.

The membership and attendance at the Quality Committee between April 2022 and March 2023 is given below, with one member of the Council of Governors invited to attend and observe each meeting.

Role	Number of meetings attended
Non-Executive Director **(Chair)**	11 / 11
Non-Executive Director **(Vice-Chair)**	10 / 11
Non-Executive Director	7 / 11
Executive Director of Nursing	8 / 10
Deputy Director of Nursing	6 / 9
Medical Director	10 / 11
Associate Director of Quality and Safety	7 / 11
Deputy Medical Director	6 / 10
Deputy Director of Workforce & Organisational Development	7 / 11
Chief Operating Officer	7 / 11
Head of Risk and Compliance	4 / 8
Clinical Director of Pharmacy	9 / 11
Governance Administrator	10 / 11
Public Elected Governor **(Observer)**	10 / 11
Staff Elected Governor **(Observer)**	0 / 11

- The role of Executive Director of Nursing was vacant in July 2022
- The role of Deputy Director of Nursing was vacant from August to September 2022
- The role of Deputy Medical Director was vacant from July to August 2022
- The role of Head of Risk and Compliance was vacant in July 2022

4. Quality Committee Activities 2022 / 2023

The principal activities of the Quality Committee during April 2022 and March 2023 are detailed below within the areas of quality improvement, risk, patient safety, audit and assurance and quality and safety reporting from sub-groups.

4.1 Quality Improvement

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

- **Split Paediatric Service** – The Committee received an update in May 2022 on work of the paediatric pathways on both the HRI and CRH sites; ongoing reconfiguration processes in relation to the paediatric pathways; the associated risks in both the Emergency Department and paediatrics, and the patient experience vision for children and young people. External support on quality improvement methodology with paediatrics and the Emergency Department was suggested, to produce outcome measures.

- **Learning Disabilities Mortality Report** – the Committee received a report highlighting the Structured Judgement Reviews (SJRs) of deaths reported to the Learning Disability Morality review programme (LeDeR) in May 2022. A clear plan on a page of action taken

was requested in order to assure the Trust Board of the governance structure and clear actions in place. This was brought back to the Quality Committee in July 2022, with actions ongoing and achieved.

- **Learning from Deaths** – the Committee received the annual report in June 2022, with the progress from the 2020-2021 recommendations achieved. Recommendations for 2022 - 2023 were set out, which link with existing reports into the Quality Committee from the Medical Examiner Service, Learning Disabilities and the deteriorating patient. Quarterly reports were also received in August 2022, October 2022 and February 2023.

- **Divisional performance against 36 hour admission to surgery target within best practice tariff** – An assurance update was provided in July 2022 stating that performance in all the aspects of best practice has taken place along the pathway and has shown improvements.

- **Medicines reconciliation** – an update was provided in July 2022 on the performance target for medicines reconciliation within 24 hours. Recommendations for a business case to increase staffing levels to enable consistent ward cover was supported by the Committee.

- **Medical Examiner Update –** the Committee receive six monthly updates from the service, which scrutinise a high number of deaths within the organisation. There were several challenges with medical examiner availability, conflict with clinical duties and a period of high activity in the numbers of deaths in August 2022. Further medical examiners were in the process of being appointed, which were due to take place by April 2023. During the February 2023 update, it was highlighted that the service has expanded, with an extra three medical examiners being appointed, and a recent expansion of the team to include a band 7 manager and a band 6 team leader.

- **CQC Children's and Young People Survey** – an updated action plan was provided in August 2022, following the March 2022 summary of progress, with a further update provided in February 2023 on how the action plan has now been incorporated into the overarching transformation plan, which will continue to be presented to the Committee on six-monthly basis.

- **Never Event** - Assurance was provided to the Committee in August 2022 on a never event in relation to the misidentification of a patient regarding do not resuscitate. Immediate learning was identified, and communicated to all colleagues via a red border email, via matrons and ward manager meetings, shared at CQC and Compliance huddles, and across all divisions via the Patient Safety and Quality Board meetings.

- **Dementia options appraisal** – The Committee received a presentation in September 2022 and were in support of the preferred option for the task of dementia screening to be moved from medical colleagues to nursing colleagues, with a swift decision to support the work required.

- **Care Quality Commission (CQC)** – the Committee continues to have oversight of improvement work to address CQC recommendations and to ensure essential standards are embedded across the organisation via the Quality Report. An update on the preparation for the CQC ED visit was provided in April and May 2022, with focused Journey 2 Outstanding visits taking place on relevant ward areas and departments. The Trust had good systems in place for focused project management support, and next steps were continuous rounds of business as usual, compliance assessments. A paper was also taken to the Executive Board in May 2022.

- **Legal Services Report** – The quarter 4 report was received in April 2022 and the quarter 1 report received in July 2022, with a significant reduction in the claims portfolio. Following a review of the Quality Report, it was agreed that the legal update will be incorporated into the Quality Report from October 2022.

- **Seven Day Service Assurance Report** – The Committee received this report in June 2022, which provided assurance of compliance with four key standards for seven day services as required by NHS England and NHS Improvement. CHFT demonstrated continued compliance with all standards.

- **Health and Safety assurance report** – The first report was received in October 2022, following a change to the Quality Committee's terms of reference with a requirement to receive assurance on health and safety regarding colleague and patient safety, focusing on learning from incidents. Six-monthly updates have been received by the Committee on projects taking place during the year, and compliance demonstrated against each.

- **End of Life Care CQC Report** – Following a CQC engagement visit in October 2022, an update was provided to the Committee. The end of life care team provided assurance by identifying and addressing areas of weakness which were highlighted to the CQC as concerns.

- **Annual Reports** – These were received by the Committee at various intervals throughout the year. The end of life care annual report was received in September 2022; the complaints annual report received in October 2022; and the annual patient experience report received in February 2023.

- **Public Sector Equality Duty (PSED) annual report** – Following a report received at Trust Board with a request to strengthen the patient element, it was agreed that contributions to the PSED annual report should be presented periodically throughout the year to Quality Committee. It was agreed that a quarterly update will be provided from the Patient Experience and Caring Group into the Quality Committee.

- **Place-based arrangements for Quality Assurance** – an update on the integrated quality framework was received by the Committee in November 2022, which outlined the principles of how quality oversight, surveillance and assurance will take place in between the Calderdale and Kirklees places into the Quality Integrated Care Board Committee.

- **Patient Stories** – Updates and learning from patient stories are provided on a quarterly basis to the Committee, which have included a story on motor neurone disease received in November 2022 and a story on carers received in March 2023.

- **Follow-up appointment concerns** – An update on the work of the task and finish group on improvements made to the functionality of the Electronic Patient Record with the follow-up pathway management was provided in January 2023. Further updates on recommendations are provided on a quarterly basis.

- **Hospital Standardised Mortality Ratio** – A stand-alone update was provided in January 2023 on the position of the Hospital Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator data.

- **Maternity Reports** – monthly updates were provided to the Committee by maternity services, and subsequently submitted to the Trust Board. An additional paper on the service's position prior to submission of the Trust's declaration for Year 4 of the Maternity Incentive Scheme was received in January 2023.

- **Getting It Right First Time (GIRFT)** – the Committee received an update in February 2023 on the developments within the GIRFT programme, which is now embedded in the Trust. Further updates are provided on a six-monthly basis.

- **Maternity Transformation Plan** – the Committee received an update on the different areas of work which was compiled into one maternity transformation plan.

- **Safer Staffing Report** – the Committee receives as six-month update on an overview of Nursing, Midwifery and Allied Health Professional (AHP) staffing capacity and compliance within CHFT in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce Safeguards guidance. This report is also submitted to the Workforce Committee and Trust Board.

4.2 Risk and Patient Safety

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

- **Risks** – Regular reviews of the high-level risk report took place, with the last report received in August 2022, due to reporting being fed into the Audit and Risk Committee from October 2022.

- **Patient Safety Incident Response Framework** – a presentation was provided in September 2022 and the 12-month timeframe for implementation across the organisation.

4.3 Quality and Safety Reporting

- **Quality reports** – these were received on a bi-monthly basis, including the reporting of the three quality account priorities, and seven focussed quality priorities. All priorities required three key indicators in order to clearly measure outcomes. Individual updates on quality priorities were also provided throughout the year.

- **Quality and Safety Strategy** – a draft strategy was received by the Committee in June 2022, with a further update provided in January 2023 on the progress so far and the forward plan, with implementation expected in April 2023.

- **Quality Account** - The 2022-2023 Quality Account timeline was provided in February 2023, for final approval to take place in June 2023. The Trust Board agreed delegated authority to the Quality Committee for sign-off of the Quality Accounts in March 2023.

4.4 Audit and Assurance

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

    - Patient and Public Involvement (4/19) – update received in July 2022, with the risk articulation remaining relevant and accurate; key controls reviewed, refreshed and relevant; gaps in control remaining relevant, and the risk rating reduced to a score of 12 due to increased level of control and assurance in place.
    - Compliance with quality & safety standards (6/19) – update received in September 2022, with the risk being reduced to a score of 12, as a result of an improvement in the key controls, and assurances received around the work ongoing to ensure patients receive high, quality, safe care.
    - CQC rating (4/20) – update received in November 2022, with the rating for the risk remaining at a score of 12. A follow-up was also provided in January 2023, on the

detailed review of the original 'must do' and 'should do' CQC actions and how they will be monitored going forward.

- **Integrated Performance Reports** – The Committee considers the Integrated Performance at every meeting with particular focus on the metrics relating to the quality agenda, including deep dives on stroke, fractured neck of femur, complaints and dementia screening. Presentations have also been received on the correlation between increased length of stay and the impact on quality and safety indicators.

- **Internal Audit Reports** – The complaints report received in August 2022, resulted in limited assurance. A further update was requested for assurance, which was provided in September 2022, with extensive work carried out on the complaints process, complaints training and quality monitoring.

- **External Reviews Report** – an update on upcoming and completed external reviews was received by the Committee in November 2022.

4.5 Sub-group Reporting

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

- Infection Prevention and Control Board
- Trust Patient Safety and Quality Board
- Safeguarding Committee
- Patient Experience and Caring Group
- Clinical Outcomes Group reports and minutes
- Medical Gas and Non-Invasive Ventilation Group Report
- Research and Innovation Committee Report – annual update received in January 2023
- Medicine Management Committee minutes

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

5 Effectiveness of Quality Committee

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

On an annual basis, the Committee undertakes a self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place in April 2023 (Appendix 1).

The Committee continues to review and update the associated work plan.

6. Conclusion

The Quality Committee has been active during the 2022/2023 year in the carrying out of its duties. Assurance can be provided to the Trust Board that systems and processes are in place for the delivery of safe quality services and the delivery of the quality improvement priorities.

The annual self-assessment of the committee's effectiveness was undertaken in April 2023, the themes and learning will be presented to the committee with an action plan .

7. Next Steps 2023 / 2024

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

- Implementation of the Quality Strategy. This was deferred due to alignments required with the 1 and 5 year plan.

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

- The implementation of Patient Safety Incident Response Framework

Denise Sterling
Non-Executive Director / Quality Committee Chair
June 2023

Appendix 1

Self – assessment of effectiveness of Quality Committee (1 April 2022 to 31 March 2023)

10 responses were received out of 13, with the findings outlined below:

1. COMMITTEE FOCUS: The Committee has set itself a series of objectives it wants to achieve this year

More Details Insights

Strongly Agree	1
Agree	6
Disagree	1
Strongly Disagree	0
Unable to answer	2

2. COMMITTEE FOCUS: The Committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.

More Details

Strongly Agree	2
Agree	7
Disagree	0
Strongly Disagree	0
Unable to answer	1

3. COMMITTEE FOCUS: Committee members contribute regularly across the range of issues discussed.

More Details Insights

Strongly Agree	3
Agree	7
Disagree	0
Strongly Disagree	0
Unable to answer	0

4. COMMITTEE TEAM WORKING: The Committee has the right balance of experience, knowledge and skills.

More Details Insights

Strongly Agree	5
Agree	4
Disagree	0
Strongly Disagree	0
Unable to answer	0

5. COMMITTEE TEAM WORKING: The Committee ensures that the relevant executive director/manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.

More Details Insights

Strongly Agree	2
Agree	8
Disagree	0
Strongly Disagree	0
Unable to answer	0

6. COMMITTEE TEAM WORKING: Management fully briefs the Committee via the assurance framework, in relation to the key risks and assurances received and any gaps in control/assurance, in a timely fashion, thereby eradicating the potential for 'surprises'.

More Details Insights

Strongly Agree	2
Agree	8
Disagree	0
Strongly Disagree	0
Unable to answer	0

7. COMMITTEE TEAM WORKING: The sub-groups report timely and clear information in support of the Committee, thereby eradicating the potential for 'surprises'.

More Details Insights

Strongly Agree	0
Agree	10
Disagree	0
Strongly Disagree	0
Unable to answer	0

8. COMMITTEE TEAM WORKING: I feel sufficiently comfortable within the Committee environment to be able to express my views, doubts and opinions.

More Details Insights

Strongly Agree	9
Agree	1
Disagree	0
Strongly Disagree	0
Unable to answer	0

9. COMMITTEE TEAM WORKING: Members hold their assurance providers to account for late or missing assurances.

More Details Insights

Strongly Agree	1
Agree	7
Disagree	2
Strongly Disagree	0
Unable to answer	0

10. COMMITTEE TEAM WORKING: When a decision has been made or action agreed, I feel confident that it will be implemented as agreed and in line with the timescale set down.

More Details Insights

Strongly Agree	1
Agree	8
Disagree	1
Strongly Disagree	0
Unable to answer	0

11. COMMITTEE EFFECTIVENESS: The quality of Committee papers received allows me to perform my role effectively.

More Details Insights

Strongly Agree	2
Agree	8
Disagree	0
Strongly Disagree	0
Unable to answer	0

12. COMMITTEE EFFECTIVENESS: Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.

More Details Insights

Strongly Agree	3
Agree	7
Disagree	0
Strongly Disagree	0
Unable to answer	0

13. COMMITTEE EFFECTIVENESS: Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.

More Details Insights

Strongly Agree	4
Agree	6
Disagree	0
Strongly Disagree	0
Unable to answer	0

14. COMMITTEE EFFECTIVENESS: Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored.

More Details

Strongly Agree	0
Agree	10
Disagree	0
Strongly Disagree	0
Unable to answer	0

15. COMMITTEE EFFECTIVENESS: At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc.

More Details

Strongly Agree	3
Agree	7
Disagree	0
Strongly Disagree	0
Unable to answer	0

16. COMMITTEE EFFECTIVENESS: The Board of Directors challenges and understands the reporting from this Committee.

More Details Insights

Strongly Agree	1
Agree	7
Disagree	0
Strongly Disagree	0
Unable to answer	2

17. COMMITTEE EFFECTIVENESS: There is a formal appraisal of the committee's effectiveness each year which is evidence based and takes into account my views and external views.

More Details Insights

Strongly Agree	4
Agree	4
Disagree	0
Strongly Disagree	0
Unable to Answer	2

18. COMMITTEE ENGAGEMENT: The Committee actively challenges both management and other assurance providers during the year to gain a clear understanding of their findings.

More Details Insights

Strongly Agree	0
Agree	9
Disagree	0
Strongly Disagree	0
Unable to Answer	1

19. COMMITTEE ENGAGEMENT: The Committee is clear about the complementary relationship it has with other committees that play a role in relation to clinical governance, quality and risk management.

More Details Insights

Strongly Agree	3
Agree	6
Disagree	0
Strongly Disagree	0
Unable to Answer	1

20. COMMITTEE ENGAGEMENT: I can provide two examples of where we, as a Committee, have focused on improvements to the system of internal control as a result of assurance gaps identified.

More Details Insights

Strongly Agree	1
Agree	7
Disagree	0
Strongly Disagree	0
Unable to Answer	2

21. COMMITTEE LEADERSHIP: The Committee Chair has a positive impact on the performance of the Committee.

More Details Insights

Strongly Agree	4
Agree	6
Disagree	0
Strongly Disagree	0
Unable to Answer	0

22. COMMITTEE LEADERSHIP: Committee meetings are chaired effectively and with clarity of purpose and outcome.

More Details Insights

Strongly Agree	3
Agree	7
Disagree	0
Strongly Disagree	0
Unable to Answer	0

23. COMMITTEE LEADERSHIP: The Committee Chair is visible within the organisation and is considered approachable.

More Details Insights

Strongly Agree	4
Agree	5
Disagree	0
Strongly Disagree	0
Unable to Answer	1

24. COMMITTEE LEADERSHIP: The Committee Chair allows debate to flow freely and does not assert his/her own views too strongly.

More Details Insights

Strongly Agree	6
Agree	4
Disagree	0
Strongly disagree	0
Unable to Answer	0

25. COMMITTEE LEADERSHIP: The Committee Chair provides clear and concise information to the Board on the activities of the Committee and the implications of all identified gaps in assurance/control.

More Details Insights

Strongly Agree	2
Agree	7
Disagree	0
Strongly Disagree	0
Unable to answer	1

Anonymous additional Comments

"Would be nice to see board to ward feedback more often. Items are escalated upwards but feedback not always relayed downwards."

"There is more to do to get papers to be more focussed and easier to digest - this is a work in progress. The extra time now provided for the meeting should allow proper debate to happen on key issues."

The attendance at the Committee can be variable and I think this impacts on the overall discussion. I think the Committee needs to decide (and regularly review) where it wishes to focus its time in order to get good assurance on the key quality and safety risks impacting on the organisation in order to be most effective"

"I'm not sure that there is a way around it but very difficult to stay focused and maintain energy for the full duration of the meeting due to the length of the meeting and the vast number of sometimes very long papers"

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	7 September 2023
Meeting:	Public Board of Directors
Title:	Finance and Performance Committee Annual Review 2022/23
Author:	Andy Nelson, Chair Finance and Performance Committee
Sponsoring Director:	Andy Nelson, Chair Finance and Performance Committee
Previous Forums:	None
Purpose of the Report	Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2022/23 setting out how it has met its Terms of Reference and key priorities
Key Points to Note	The Committee has carried out its business in the last 12 months in accordance with the terms of reference and the meetings have been well attended. A good balance has been achieved between financial and operational matters and there has been valuable input from other executives, clinicians and managers outside the Committee. In year regular updates have been provided overall operational and financial performance and performance against our elective recovery plans. The committee has conducted regular deep dives into aspects of operational performance. A self-assessment for the year was completed in June 2023 and actions agreed
EQIA – Equality Impact Assessment	Individual decisions made by the committee during the year will have been required to undergo a QIA and EQIA as appropriate
Recommendation	The Committee is asked to NOTE the attached report.

Calderdale and Huddersfield
NHS Foundation Trust

Finance and Performance Committee
Annual Review 2022/23

1. Background

Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2022/23 setting out how it has met its Terms of Reference and key priorities. These were reviewed and updated in December 2022.

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

2. Finance and Financial Performance

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

The committee also receives summary information on the Place and overall Integrated Care Board financial positions in order to understand the system position.

3. Performance Delivery and Assurance

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

In 2022/23 further information has also been regularly received by the Committee on the Trust's elective recovery trajectories, detailing progress to date and future forecasting. These have been presented and discussed drawing out the particular challenges and achievements in specific specialty areas.

During the year the Committee has requested a number of deep dives into specific clinical specialties or areas of performance. Examples include deep dives into the performance of the

stroke, neck of femur and cancer specialities as well as ED and a more detailed review of elective recovery plans. These presentations have been made directly to the Committee by subject matter experts who were able to bring the topics to life and answer questions which was well received by committee members.

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

4. Business and Commercial Development

The Committee's prior understanding of the long-term plan set the context for the operational and financial plans ratified in year. The committee reviewed the draft financial plans for 2023-24 and approved these for submission to the Board.

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

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

5. Treasury Management

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

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

6. Procurement

The Procurement service is provided under contract from Calderdale and Huddersfield Solutions (CHS). The Committee receives minutes on a quarterly basis from the CHFT/CHS Joint Liaison Committee.

7. Membership, Attendance and Monitoring Effectiveness

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

A self-assessment questionnaire in relation to the effectiveness of the committee is carried out on an annual basis but this was delayed and was completed and discussed at the Committee in June 2023.

Summary and Recommendation

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

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

APPENDIX 1

FINANCE & PERFORMANCE ATTENDANCE – 2022/23

Calderdale and Huddersfield NHS Foundation Trust

	May M 1 7 June	June M 2 5 July	July M 3 2 Aug	Aug M 4 6 Sep	Sept M 5 07 Oct	Oct M 6 1 Nov	Nov M 7 06 Dec	Dec M 8 10 Jan 2023	Jan M 9 31 Jan	Feb M10 28 Feb	March M11 4 Apr	April M12 3 May	
MEMBERS													
Jo Fawcus	√	√	√	Apols	Left the Trust								
Jonathan Hammond					√	Apols	√	√	Apols	√	Dep		
Anna Basford	√	√	√	√	√	√	Apols	√	Apols	Apols	√		
Gary Boothby	Apols	√	√	Apols	absent	absent	absent	absent	√	Apols	√		
Victoria Pickles	Apols		Apols	Apols	√	√	Apols	√	Apols	√	√		
Richard Hopkin Non-Exec (Chair)	√	√	√	Retired									
Peter Wilkinson Non-Exec (Vice-Chair)	√	Apols	Apols	No longer on the Committee									
Andy Nelson (Chair)			√	√	Apols	√	√	√	√	√	√		
Nigel Broadbent Non-Exec (Vice-Chair)		√	√	√	√	√	√	√	√	√	√		
Karen Heaton (Non-Exec)					√			-	-	-	-		
Rob Birkett						√	-	√	Apols	√	Apols		
Rob Aitchison							√	-	Apols	√	√		
Kirsty Archer	√	√	Apols	√	√	√	√	√	√	√	Apols		
IN ATTENDANCE													
Stuart Baron	Apols		Apols	√	-	-	-	√	√	-	√		
Philip Lewer	Apols	Retired											

Helen Hirst		√	Apols	Apols	√	-	-	-	-	-	-		
Andrea McCourt	√	√	√	√	√	√	√	√	√	√	√		
Peter Keogh	Apols	√	Apols	√	√	√	√	√	√	√	√		
Robert Markless (Governor)	√	Apols	√	√	√	√	√	√	√	√			
Brian Moore (Governor)	√	√	√	√	√	√	√	√	√	√	√		
Isaac Dziya (Deputy Governor)	-	-	-	-	-		√	-	-	-	-		
Philippa Russell					√	√	√	√	√	√	√		
Adam Matthews							√	√	√	√	Apols		

Calderdale and Huddersfield
NHS Foundation Trust

25. Review of Board Committee Terms of Reference

1. Charitable Funds Committee
2. Audit and Risk Committee

To Approve

Presented by Andrea McCourt

Terms of Reference

1. Constitution

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

2. Authority

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

3. Purpose

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

4. Duties

The Committee will:

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

5. Membership

The Committee will comprise:

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

6. In attendance

- Director of Corporate Affairs
- Charity Manager
- Charitable Funds Manager

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

7. Quoracy

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

8. Attendance

All members are expected to attend a minimum of 75% of meetings. A register of attendance will be maintained, and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardize the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

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

9. Reporting

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

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

10. Review

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

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

Version:	6
Approved by:	Board of Directors
Date approved:	Audit and Risk Committee – 25 July 2023 Board of Directors – 7 September 2023
Date issued:	7 September 2023
Review date:	July 2024
Next review:	July 2024

AUDIT and RISK COMMITTEE TERMS OF REFERENCE

1. Authority

1.1 The Audit and Risk Committee is constituted as a standing committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit and Risk Committee shall not have executive powers in addition to those delegated in these terms of reference.

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

1.3 The Audit and Risk Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The Audit and Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls, corporate governance and assurance frameworks of the Trust and its subsidiary(ies).

2.2 The Audit and Risk Committee will have close working relationships with Quality Committee which has responsibility for oversight and monitoring of clinical risks and clinical audit.

2.3 The Board of Directors is responsible for ensuring effective internal control including:

- Management of the Foundation Trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Audit and Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control. In addition, the Audit and Risk Committee shall:

- Ensure independence of External and Internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Audit and Risk Committee; and
- Monitor corporate governance (e.g. Compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

3. Membership

3.1 The Committee shall be composed of not less than three Non-Executive Directors, at least one of whom should have recent and relevant financial experience. The Trust Chair will not be a member of the Audit and Risk Committee.

3.2 A quorum shall be two members.

4. Attendance

4.1 Only members of the Committee have the right to attend. The Director of Finance, Deputy Finance Director, Director of Corporate Affairs, Company Secretary, Assistant Director of Quality and Safety , Head of Internal Audit and the Managing Director for Digital Health of the Foundation Trust shall generally be invited to routinely attend meetings of the Audit and Risk Committee.

4.2 A representative of the External Auditors may normally also be invited to attend meetings of the Audit and Risk Committee.

4.3 The Chief Executive should be invited to attend at least annually to discuss the assurance supporting the Annual Governance Statement and when considering the Internal Audit plan. Other Directors are expected to attend as required by the Audit and Risk Committee and where items relating to their areas of risk or responsibility are being considered.

4.4 The Foundation Trust Chair may be invited to attend meetings of the Audit and Risk Committee as required.

4.5 A representative of the Local Counter Fraud Service is invited to attend all meetings of the Audit and Risk Committee.

4.6 The Chair of the Board of Directors will appoint up to two Governors to observe the public meetings of the Audit and Risk Committee. The appointment will be reviewed each year.

4.7 Attendance is required by members at 75% of meetings. Members unable to attend should inform the Corporate Governance Manager as soon as possible in advance of the meeting except in extenuating circumstances.

4.8 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

5. Administration

5.1 The Corporate Governance Manager shall be the secretary to the Audit and Risk Committee and will provide administrative support and advice. Their duties include but are not limited to:

- Agreement of the agenda with the Chair of the Audit and Risk Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and

- Maintaining a record of attendance.

6. Frequency of meetings

6.1 Meetings shall be held quarterly, with an additional meeting to review the annual accounts, with other meetings arranged where necessary. The Committee must consider the frequency and timing of meetings required to discharge all of its responsibilities on a regular basis.

6.2 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

6.3 The Internal Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

7. Duties

7.1 Governance, internal control and risk management

7.1.1 To ensure the provision and maintenance of an effective system of integrated governance, risk identification and associated controls, reporting and governance of the Trust and its subsidiary(ies), unless otherwise identified in the governance reporting structure.

7.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

7.1.3 To review processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other board committees in relation to the Trust's overall internal control and risk management position.

7.1.4 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

7.1.5 To review the adequacy of the Foundation Trust's arrangements by which Foundation Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

7.1.6 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

7.1.7 The adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements. Policies for approval by the Committee are identified in the Audit and Risk Committee annual workplan including Standing Financial Instructions, Scheme of Delegation and Standing Orders.

7.2 Internal audit

7.2.1 To review and approve the internal audit strategy and programme, and counter-fraud plan, ensuring that these are consistent with the needs of the organisation.

7.2.2 To oversee on an ongoing basis the effective operation of Internal Audit

including:

- Adequate resourcing, capacity and capability;
- Its co-ordination with External Audit;

Complying with the Public Sector Internal Audit Standards

- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

7.2.3 To consider the major findings of Internal Audit investigations and management's response and their implications and monitor progress on the implementation of recommendations. Where such matters fall within the scope of other Board Committees, the Audit and Risk Committee may require feedback from these Committees on their review of internal audit work.

7.2.4. To review procedures for detecting and preventing fraud, bribery and corruption and receive reports of any instances

7.2.4 To consider the provision of the Internal Audit Service annually, the cost of the audit and any questions of resignation and dismissal. The appointment/dismissal of Internal Audit remains the responsibility of the Director of Finance.

7.3 External audit

7.3.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.3.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with internal audit and other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the Foundation Trust associated impact on the audit fee.

7.3.3 To assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.3.4 To oversee the conduct of a market testing exercise for the appointment of an Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

7.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.3.6 To ensure national guidance is followed on the engagement of the External Auditor to supply non-audit services.

7.3.7 To consider the provision of the External Audit Service, the cost of the audit and any questions of resignation and dismissal.

7.4 Annual accounts review

7.4.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Significant adjustments resulting from audit ;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.2 To review the Foundation Trust annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

7.4.3 Where required by national guidance in the NHS Foundation Trust Annual Reporting Manual, seek assurances regarding scrutiny and review of specific areas by External Audit

7.4.4 To review all accounting and reporting policies and systems for reporting to the Board of Directors.

7.5 Standing orders, standing financial instructions and standards of business conduct

7.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct. Standards of Business Conduct and Declarations of Interest; including maintenance of Registers.

7.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

7.5.3 To review the Scheme of Delegation.

7.6 Other

7.6.1 To review performance indicators relevant to the remit of the Audit and Risk Committee.

7.6.2 To examine any other matter referred to the Audit and Risk Committee by the Board of Directors and to initiate investigation as determined by the Audit & Risk Committee.

7.6.3 To ensure that the Quality Committee performs at least an Annual Review of the clinical audit plan and considers the findings and recommendations of in-year reports, ensuring the plan and extras are consistent with the strategic direction of the Trust.

7.6.4 To develop and use an effective assurance framework to guide the Audit and Risk Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

7.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

To review the work of all other Board sub-committees as part of the Audit and Risk Committee assurance role. The Audit and Risk Committee will receive a self-assessment and annual report from each of the committees for approval.7.6.7 Liaise with other Audit Committee chairs within the ICS about system wide control and governance issues.

7.6.8 Review of losses and special payments and waivers of Standing Orders.

8. Reporting

8.1 The minutes of all meetings of the Audit and Risk Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Audit and Risk Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes via the Chair's highlight report.

8.2 The Audit and Risk Committee will report by a Chair's highlight report to the Board of Directors and Council of Governors in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the governance statement; the assurance framework; the effectiveness of risk management within the Foundation Trust; the integration of and adherence to governance arrangements; ~~its view as to whether the self-assessment against standards for better health is appropriate~~; and any pertinent matters in respect of which the Audit and Risk Committee has been engaged.

8.3 The Committee will report to the Board annually on its work and delivery against the terms of reference.

8.4 The Foundation Trust's Annual Report shall include a section describing the work of the Audit and Risk Committee in discharging its responsibilities.

8.5 The Committees that report into the Audit and Risk Committee are the Risk Group, Information Governance and Risk Strategy Committee, Data Quality Board, Health and Safety Committee and the CQC and Compliance Group.

9. Review

9.1 The effectiveness of the Audit and Risk Committee will be reviewed by members on an annual basis.

9.2 The Terms of Reference of the Audit and Risk Committee shall be reviewed by the Board of Directors at least annually.

26. Items to receive and note

Minutes of Board Committees:-

- Finance and Performance Committee 28.6.23, 1.8.23
- Quality Committee 21.6.23, 24.7.23
- Workforce Committee 20.6.23
- Audit and Risk Committee 27.6.23, 25.7.23
- Charitable Funds Committee 9.8.23

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

To Receive

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Wednesday 28th June 2023, 10.30am – 12.30pm Via Microsoft Teams

PRESENT

Andy Nelson (AN)	Non-Executive Director (Chair)
Nigel Broadbent (NB)	Non-Executive Director
Kirsty Archer (KA)	Director of Finance

IN ATTENDANCE

Philippa Russell (PR)	Deputy Director of Finance
Andrea McCourt (AM)	Company Secretary
Rochelle Scargill (RS)	PA to Director of Finance (Minutes)
Peter Keogh (PK)	Assistant Director of Performance
Vicky Pickles (VP)	Director of Corporate Affairs
Karen Heaton (KH)	Non-Executive Director
Adam Matthews (AM)	HR Business Partner
Jonathan Hammond (JH)	Chief Operating Officer
Stephen Shepley (SS)	Director of Operations - FSS
Kimberley Scholes (KS)	General Manager Planned Access and Data Quality
Rob Aitchison (RA)	Deputy Chief Executive
Robert Birkett (RB)	Managing Director of THIS
Brian Moore (BM)	Public Elected Governor

APOLOGIES

Gary Boothby (GB)	Director of Finance
Stuart Baron (SB)	Associate Director of Finance
Robert Markless (RM)	Public Elected Governor
Anna Basford (AB)	Director of Transformation and Partnerships

104/23 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

105/23 DECLARATIONS OF INTEREST

106/23 MINUTES OF THE MEETING HELD 30th May 2023

The minutes were approved as an accurate record.

107/23 MATTERS ARISING

108/23 ACTION LOG

The Action Log was reviewed as follows:

096/23 – Finance risks - leave risk description as is for cash flow but add more to narrative. This has been updated. Action complete.

099/23 – New BAF risk 1.23 to be updated to a score of 20 from 16. This risk has been amended and is due to be presented at Trust Board in July. Action complete.

109/23 OUTPATIENT FOLLOW-UPS

The Director of Operations for FSS and General Manager Planned Access and Data Quality gave a presentation on Outpatient Follow-Ups.

There is no external target for Outpatient Follow-Ups however the planning guidance contained a line around reducing the number of overdue follow-ups by 25%. This would be a difficult target to achieve from the current position. Overdue can range from a patient who is one week overdue to two years overdue. There are different workstreams tasked with reducing the number of overdue appointments and an internal target created to reduce the number from 26000 to 21740 by the end of March 2024. Patients on a Referral to Treatment pathway are treated separately from those awaiting outpatient follow-up so the backlog on outpatient follow-ups should not impact waiting times for treatment and our 40-week target.

Pre-covid patients waited up to 12 weeks for an outpatient follow-up. 55% of the current patients waiting have been waiting less than 12 weeks.

The three workstreams to tackle the number of follow ups are

- Admin validation – removal of duplicate/superseded appointments etc. Some extra training around EPR appointment creation has been put in place as a result of this validation work.
- Transformation – implementing new ways of working e.g., PIFU and benchmarking against other trusts.
- Booking process – New patient portal.

There is a need to set a realistic waiting target which can be achieved using existing resource and is considerate of the weariness of existing staff. They need to feel supported. The focus is on changing the mindset of colleagues to create a sustainable plan rather than providing a target that must be met.

Plans are not inclusive of strike action which will have an accumulative impact going forward.

The committee welcomed the update and discussed some points of learning from the work to date. A request from the committee for a 2-3 slide update to be included in the monthly Elective Recovery pack. SS and KS to return in the second half of the year with a progress update against these plans.

FINANCE & PERFORMANCE

110/23 INTEGRATED PERFORMANCE REVIEW (IPR) – MAY 2023

Producing papers in the timescale for this meeting has been difficult this month due to the timing.

The Assistant Director of Performance (PK) gave an update using the new format IPR report.

Key points highlighted:

- Elective recovery is doing well.
- Cancer performance is still strong however we missed the faster diagnosis target in May.
- ED has seen an increase in attendances with over 600 some days. The performance for May was 71.22% against a target of 76%.
- Looking at separate targets for length of stay for admitted and non-admitted patients.
- Acuity of patients continues to have a significant impact and is showing no sign of reducing.
- Community – 3 indicators are measured currently but the team are considering several new ones to include in the IPR moving forward.
- Currently there is further work being carried out around the data for Proportion of Urgent Community Response referrals reached within two hours. A manual audit is being completed to examine the different elements of the 2-hour response and this has identified joint improvement work needed with LCD.
- For the Quality metrics the number of metrics has been increased.
- SHMI - we are slightly above the national position but still within the expected range. We are moving to the national average.
- The has been an improvement in sepsis performance which is now below 100.
- Complaints closed within timescale continues to perform well following matrix working between the corporate team and divisions.
- There is a quality target where 95% of adult patients should receive a malnutrition universal screening tool (MUST) assessment within 24hours of admission and transfer. Following a task and finish group and a change to the policy in place, all assessments will take place before the patient leaves the assessment area from September.
- Workforce - further metrics have been included around training, appraisals and bank and agency spend.

There have been some notable changes in some areas on the summary chart. This is due to them being new metrics and nothing to previously mark them against. Going forward any notable changes will be highlighted as part of the narrative. There was some discussion of the challenges of reducing the Delayed Transfer of Care list which still typically stands at over 100 patients.

The committee **RECEIVED** the Integrated Performance Report for May.

111/23 RECOVERY UPDATE

The Assistant Director of Performance presented the recovery update. This included the usual slides and highlighted the following:

- CHFT is still performing well across WYATT.
- Activity – in terms of elective recovery monitoring against the activity plan

108.6% of plan was delivered in month 2 and 107% of plan YTD.

- Elective recovery position against 2019/20 – 111.2% for planned inpatient against the baseline of 106.5% and 113.9% for outpatient against a baseline of 104.8%.
- RTT 65 weeks – Only one patient has an open pathway of over 65weeks.
- RTT 52 weeks – There are a small number waiting over 52 weeks with a plan to clear these by the end of July 2023. The majority are in ENT.
- RTT 40 weeks are slightly ahead of the planned trajectory. The plan remains to reach zero by January 2024.
- Outpatients New – ASI's. There is no external target and no requirement to report centrally. However, CHFT have set an internal target to reach pre-covid levels. Current ASI's had reduced but increasing again mainly in ENT.
- Outpatients New more than 18 weeks This was previously 22weeks. ENT have 1173 and is worsening which accounts for 65% of ASIs over 18 weeks.

Going forward the recovery actions will include some of the detail mentioned in the earlier deep dive.
Diagnostics – ECHO and Neurophysiology are still a problem. New trajectories are to be created taking into consideration the challenges being experienced by both.

Different ERF funding agreed for West Yorkshire related more to performance. For months 1 and 2 it has been agreed not to reclaim ERF funding due to strike action.

ENT – The service is being supported by Leeds and we have recently recruited an additional locum. KS is working closely with Surgery. ASI issues need to be addressed. A separate group has been created to focus on ENT. CHFT continue to talk through possible solutions with other Trusts who are having the same challenges.

The Committee **RECEIVED** the Recovery Update.

112/23 MONTH 2 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

The Deputy Director of Finance presented the Month 2 Finance Report.

Key points-

- £4.6m deficit position YTD and a £0.39m adverse variance from plan
- Additional bed capacity, slippage in the Length of Stay scheme, doctors strike and higher than expected utility costs key contributors to the deficit.
- Deficit offset by higher than planned vacancy rate and efficiency savings
- Agency spend positive YTD £1.8m lower than planned. Challenging target in future months. Price down and volume down.
- Bank expenditure higher than planned with some at premium rate. Strike action impacted bank spend.
- New overseas recruits passing through the exams is now coming through

- ERF above plan in recovery costs in first two months but ahead of plan in activity. Not expecting an overspend.
- Forecast to deliver planned £20.8m deficit. Risk from latest divisional forecast of a 'likely case' £6.3m gap. Bed capacity pressures and high-risk CIP schemes underpin this case alongside risks of further strike action.
-
- Capital spend £22k in first two months which is £1.2m lower than planned. Slippage on Pharmacy robot and HRI reconfiguration.
- CASH £34.8m in the bank at end of May £3m; higher than planned carried over from last year but this is just phasing and still expect to borrow money near the year end as per the financial plan.
- Aged debt just over £4m which is an improvement on month 12 last year. Nitespharma invoice still a problem. SBS had a problem with the process for invoices which is now resolved, and we should see a reduction in the debt.
- Use of Resources measure is currently at level 3 as per the plan.

The overall system position in the West Yorkshire ICB as at month two is a £14m adverse variance to plan in the year to date, and the forecast variance for the full year is £25m.

We have been flagged as one of 15 ICS's which are under further national and regulatory scrutiny based on their year-to-date position. There are a set of actions to be addressed which have been shared with the executives in the first instance.

There was a discussion around non-recurrent CIP.

The Committee **RECEIVED** the Month 2 financial report.

113/23 TURNAROUND EXECUTIVE

The Deputy Chief Executive gave a quick update with the key messages included in the papers. Compared to other trusts, CHFT has a really strong CIP programme with a high level of detail.
Since several of the schemes are non-recurrent it is expected there will be a challenge again next year. The big risks have been identified around the Length of Stay and ED schemes. Some slippage and mitigation are expected.
There have been some ED consultants recruited over the last few weeks which will help deliver the ED savings target.

The Committee **RECEIVED** the Turnaround Executive update.

114/23 SELF ASSESSMENT

The responses from the annual self-assessment had been collated and shared with the committee, along with any points of note. These will be considered for future committee meetings.

One of the notes refers to future planning and a request that more time is spent on this as part of the workplan. More projecting forward and looking into future challenges and opportunities.

The question that all committee feedback has struggled with is “Can I give two examples of where this committee has made a difference?” A suggestion that towards year end a period of reflection takes place to look back on what has been achieved before moving into a new financial year.

VP will look at the feedback from all the committees to see if there any lessons to be learnt.

Obtaining the papers from the sub-committee meetings is improving but needs on on-going monitoring.

ACTION – to schedule some time at future meetings for future planning. The work plan should be amended accordingly.

The **COMMITTEE** received the self-assessment and agreed more time should be given to future planning.

115/23 BAF RISKS – Possibly under action log

At the last committee meeting the decision was made to close risk 8/19 around the risk of achieving local and national performance targets.

Following a review outside of the meeting it was questioned if this should have been left on the BAF risk register as a strategic risk in relation to current plans and challenges particularly around the ED target, length of stay and transfer of care.

ACTION: A revised strategic risk around performance to be drafted and returned to this committee.

The **COMMITTEE** agreed to have a newly written risk to return to this meeting.

116/23 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 – A regional workshop has been planned. Feedback at the next meeting.
- CHFT / CHS Joint Liaison
- CHFT / PFI Meeting
- THIS Executive Group
- Urgent and Emergency Care – Nothing received**.**

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

117/23 WORKPLAN – 2023/24

The workplan for 2023/24 has been brought to this meeting for review.

HPS Annual Plan postponed to next month due to the number of items on the agenda this month.

Committee **APPROVED** the work plan for 2023/24.

118/23 ANY OTHER BUSINESS
None.

119/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Deep dive key points.
- General performance and challenges.
- Financial plans getting external scrutiny.

DATE AND TIME OF NEXT MEETING:
Tuesday 1st August 09:30 – 12:00 MS Teams

DRAFT

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Tuesday 1st August 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

IN ATTENDANCE

Philippa Russell (PR)	Deputy Director of Finance
Rochelle Scargill (RLS)	PA to Director of Finance (Minutes)
Peter Keogh (PK)	Assistant Director of Performance
Adam Matthews (AM)	HR Business Partner
Robert Birkett (RB)	Managing Director of THIS
Andrea McCourt (AM)	Company Secretary
Chris Roberts (CR)	Deputy Director of Operations – Medicine
Helen Rees (HR)	Director of Operations – Medicine
Dominic Bryan (DB)	General Manager - Medicine

OBSERVERS

Brian Moore (BM)	Public Elected Governor
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
Rob Aitchison (RA)	Deputy Chief Executive

ITEM

120/23 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

121/23 DECLARATIONS OF INTEREST

122/23 MINUTES OF THE MEETING HELD 28th June 2023

The minutes were approved as an accurate record.

123/23 MATTERS ARISING

124/23 ACTION LOG

The Action Log was reviewed as follows:

115/23 – BAF risks – A revised strategic risk has been drafted between VP and JH. To be circulated outside of the meeting.
ACTION: Comments to be sent to VP in preparation for submission to the September board meeting.

114/23 – Self Assessment – The self- assessment highlighted the need for more future planning at this meeting. The committee discussed the items that need to be looked at as part of this.

- what next year's position might look like – This is normally reported in January, but the ICB medium term plan can be shared around September or October. Some of the non-recurrent CIP is expected to create a pressure next year if everything stays the same.
- Performance – More clarity on how achievement or not of our current performance targets, such as the TOC target, affect future performance.
- Transformation – The terms of reference for the Transformation Programme Board (TPB) are being updated to reflect the scope of the transformation work it looks at - it does not solely look at reconfiguration. A broad overview of the benefits over the next three to five years will also be reviewed at TPB.

Looking at all these together would be a useful exercise later this year.

125/23 DIAGNOSTIC DEEP DIVE

The Director of Operations, Deputy Director of Operations and the General Manager of Medicine presented a review of some of the challenging diagnostic services.

RADIOLOGY – The current position is very good with all scan types performing above 99%. MRI performance has improved dramatically after the installation of two new scanners.

ECHOCARDIOGRAM (Echo) – There are currently 974 patients awaiting a transthoracic echocardiogram (TTE) giving a 6-week diagnostic performance of 54%. There was a 5-year plan within Echo to train our own physiologists and accredited staff. Three years into this plan there are 6 trainees in post. This had led to a slight reduction in capacity as the BSE guidance advises trainees require 60 minutes slots to perform the scan as opposed to the 45minutes for accredited staff. The installation of an electronic system to replace the existing paperwork systems led to bookings being placed on hold for two weeks.
There are approximately 200 referrals to TTE per week and a new rota template is to be put in place from w/c 4th September when there will be 210 slots per week to slowly reduce the backlog. WYAAT are unable to provide any support as they are having the same challenges. There are two different options being explored to provide additional resource. Both options would have financial implications and consideration is being given to divert the ERF funding. There are pros and cons to both options. If one of these options is approved, then the trajectory for reducing the backlog would be reviewed to give a more positive position.

Fortunately strikes are not currently affecting this service.

Further discussion took place around Option 1 – enhanced pay – and the requirement to not set a precedent. There will be a time limit on the enhanced pay, but it may also have an added benefit in that colleagues from WYAAT may do weekend bank shifts to help with recovery.

NEUROPHYSIOLOGY – The service is now back to a position where existing capacity meets demand. Previous challenges were around vacancies and not being able to achieve certain levels of insourcing or outsourcing. There is still a gap with vacancies for a physiologist and a consultant, both of which are planned to be filled later in the year. Performance has increased from 48% to 55% against the six-week diagnostic target. There are currently 369 patients wating longer than six weeks which has reduced from 392 the month before. Once the vacancies are filled this is expected to improve further.
The team are now contacting each patient prior to their appointment to confirm their attendance and to maximise capacity. The trajectory has been updated and the team are now on track to have cleared the backlog by November 2023. This is being monitored on a weekly basis at the departmental performance review meeting.

FINANCE & PERFORMANCE

126/23 INTEGRATED PERFORMANCE REVIEW (IPR) – JUNE 2023

The Assistant Director of Performance (PK) gave an update on performance:

Following a request from the last meeting the performance matrix month on month metrics changes have been highlighted. Some of the indicators have moved but there has not been any dramatic change. At the last meeting, there was a presentation on outpatient follow-ups and the work that has been in put in place in that area which has reduced the backlog by 4500 and further reductions are expected.
There is still a strong performance against cancer targets however, the faster diagnosis target was missed in June. The nationally challenged pathways are reflected at CHFT in Upper and Lower GI and Urology; however, a pathway navigator was recruited to post in June, so improvement is expected.
ED performance in June was 72% with the average daily attendances resembling more winter numbers at 502. CHFT is still performing within the top 10 acute trusts nationally for type 1 activity.
Several additional metrics for Community are currently under consideration for inclusion in the next IPR. The two-hour target for community response referrals has been audited and performance is better than it appears, but further work is required with Local Care Direct whose triage process takes up a large part of the two hours.
The Summary Hospital level Mortality Indicator (SHMI) is showing a consistent improvement with the current 12 month rolling figure standing at 101.01 and the most recent figure for March 2023 at 95.41. Work on more detailed coding around sepsis has meant a significant improvement in performance.

Complaints continue to perform well though is still slightly below target.
The target of 95% of adult patients to receive a **MUST** assessment within 24 hours of admission/transfer to the ward is a particularly difficult challenge for the Trust. Policies and a task and finish group are in place, but a key piece of work is the request for stop moments before any patient is transferred off the assessment units to ensure that all assessments have been completed and that work is ongoing to reconfigure the admission workflow on EPR to support documentation and the nursing process during admission. This is expected to Go Live in with September and engagement work with teams has started in preparation.

Learning disabilities has been reintroduced to the IPR and highlights the differences in performance in comparison to the trust figures. More metrics will be included next month.

Bank spend is above target due to a reliance to cover unplanned unavailability and to support recovery.

The committee asked PK to consider adding a bullet point where appropriate against each metric stating we are aiming for " **% by ****** date". i.e. showing how much improvement is expected by when.

PK asked to find out if any investigation work has been carried out as to why the number of attendances at ED is so high. It was noted that the rate of admittance to beds is not increasing.

The did not attend (DNA) target was highlighted as a challenge. The target is 3% but is currently at 12%. Kim Scholes is leading some work to try and understand why people DNA. This has involved calling the patients for feedback using some of the volunteers. The Trust has been awarded some funding for a new patient portal which is more user friendly and is expected to be in operation by November.

The staff turnover target has been set at 11% for the last few years but we have been significantly below this for a couple of years. The committee asked that this considered for reduction to match more closely current performance.

Bank and agency spend is above target and a deep dive on this is due to go to TE next week. Strikes and surge capacity are driving this.

There is a plan to review and refresh the IPR if required in October.

The committee **RECEIVED** the Integrated Performance Report for June.

127/23 RECOVERY UPDATE

The Assistant Director of Performance presented the recovery update. This included the usual slides and highlighted the following:

- CHFT is still performing well across WYATT.

- There are now 24 patients who have been waiting for 52 weeks or more.
- Activity is down slightly in comparison to April and May which had a very positive performance. But there is nothing of concern. This is being monitored at the Access Delivery Group.
- Performance against the 2019/20 baseline is included for comparison though not a measure that is being monitored this year.
- Patients waiting 65 weeks is now at 2 and 4 more in the 63-64 week category.
-
- Patients waiting over 40 weeks is currently below trajectory but ENT has the bigger numbers which a task and finish group are looking at. Access Delivery Group monitors this work.
- Outpatients – New ASI's over 18 weeks. ASI's the plan is to reduce to 18 weeks from the current 22 weeks. Almost half of these are in ENT.

Work is ongoing to reduce the number of people waiting for follow up appointments. Initiatives such as PIFU have been put in place and CHFT is one of the Trusts selected nationally to see if we can go "further faster". Guidance has been issued around what good looks like and we do benchmark well.
ACTION: PK to add a page covering initiatives such as PIFU.

Consultant strikes are expected to impact activity.

There is an expected update on the actions being taken around ENT next month.

The Committee **RECEIVED** the Recovery Update.

128/23 MONTH 3 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

The Deputy Director of Finance presented the Month 3 Finance Report.

Key points –
Year to date we are reporting a £7.1m deficit which is 0.98m adverse variance from plan. Key drivers of the variance include higher than planned bed capacity/length of stay, strikes and non-pay inflationary pressures.
CIP is slightly ahead on plan but some of the schemes are non-recurrent.
Agency spend is higher than planned but below the ceiling at around £80k year to date and bank costs are also higher than planned. Several CIP schemes are linked to bank and agency spend which is linked in turn to bed capacity.
Officially reporting the achievement of the planned £20.8m deficit in the forecast.

The ICB is still forecasting a £25m adverse variance which reflects the additional system risk that they were required to plan for. This translates as a £6.4m adverse variance for Calderdale and Kirklees Places. The ICB as a whole will be expected to find the £25m which could impact CHFT.

Capital – Year to date only 180k has been spent against plan of £4.8m. There have been delays on the pharmacy robot, CDC and reconfiguration project costs. There is a timing issue with the renewal of some leases. Due to additional funding that we have been awarded for the Halifax CDC, the forecast for capital spend is now £40.9m.

The Cash position is better than expected with £18m more in the bank which is also as a result of the funding for the Halifax CDC and the unconsolidated pay award going through month 3 as well as the pay arrears for 2023/24.
Aged debt – If the Nitespharma debt was not included then we are on target with £3m of aged debt. HPS and THIS aged debt has reduced slightly except for Nitespharma. We are trying to mitigate this by clearing debt in other areas.
There has been no requirement to borrow at this point and we are at 95.4% against the better payment practice code target.
The use of resources metric is at level 3 as planned, with just the year date variance being off plan.

NHSE required all organisations to complete a control checklist which looked at elements of Finance and Workforce particularly around the governance. The first requirements have been reported back at the ICS forum after being RAG rated. All the CHFT returns had been rated as green as all the correct controls are in place. A summary will be shared at a future meeting once all the returns have been reported back by the ICB.

FORECAST SCENARIOS

The forecast scenarios now have to be submitted to the ICB on a monthly basis showing our Best, Mid and Worst-case scenarios. We are currently assuming that the Mid case point is our likely case. The categories shown on the paper are specified by the ICB. The impact of industrial action costs only take account of strikes up to July.

Possible mitigations include:
Educations and Training income
Depreciation
PDC Dividend
Vacancies / further reduction in Agency spend.

Even with the mitigations there is a challenge of £7m which is a significant risk and due, in part to events beyond our control such as system action around length of stay.

The mid or likely case for all organisations across the West Yorkshire ICB is £93.7m adverse variance from plan. The in-year challenge is more provider based.
Where the biggest risks to our CIP are highlighted, they are progressing through the CIP governance processes with escalation if there is a problem with the delivery of the forecast. The first one of these escalations took place with length of stay and the next scheme to go through the escalation process is the ED one. There is a second program of reviews in place around budget holder accountability which are also escalated through TE. Thresholds are monitored and go into an escalation process. The medicine division are the first to go through this process. The discussion was split into two halves of overspend on wards and medical staffing and other issues.

The Committee **RECEIVED** the Month 2 financial report.

129/23 TURNAROUND EXECUTIVE

A number of points have been raised earlier in the meeting notably that the escalations processes are now being enacted for some high-risk CIP schemes and involving the Chief Executive.
There is still a £1.8m gap in the current program which has yet to be filled alongside £9.1m of high-risk schemes.
The ideal would be to create replacement recurrent schemes rather than non-recurrent mitigations.

The Committee **RECEIVED** the Turnaround Executive update

130/23 HPS ANNUAL REPORT

There had been a reduction in contribution year on year following changes to the business. This year a contribution target was set based on the last year's performance and so far HPS are surpassing that target.
Looking forward there is a focus to develop some core areas of the business and we are currently exploring the possibility of funding from NHSE for capital investment subject to a business case demonstrating the required return on investment.
NB is no longer a member of the HPS board since April. The commercial strategy was presented to this committee earlier this year which had an emphasis on business-as-usual growth. Wholesaling has now ended but the plan is to grow the clinical trials and product licensing sides of the business.

The Committee **RECEIVED** the HPS Annual Report

131/23 F&P ANNUAL REVIEW

This report will go the September board.
There is an error on the attendance list, which shows RM as blank, but apologies were received. RLS has updated the attendance list.
To be consistent with other committees the governors are to be listed as observers rather than attendees.

The Committee **NOTED** the Annual Review.

132/23 DRAFT MINUTES FROM SUB-COMMITTEES

The following minutes and summaries thereof were received by the Committee:

- Access Delivery Group
- Business Case Approvals Group -
  Are business cases reviewed to see if there is any potential for mitigation. Need to consider splitting the cases into internally and

externally funded. Look at which ones would provide a bottom-line benefit.
The conversation is still ongoing around the replacement for Datix. The case did not articulate the benefits and was not clear on the time of implementation. The two parties who would use the new system need to work together on the business case.

- Capital Management Group –
  Underspent in plan. This follows the same pattern each year. It would be useful if operational colleagues could bring some of the capital plans towards the beginning of the year.
- CHFT / CHS Joint Liaison
- HPS Board
- THIS Executive Group
- Urgent and Emergency Care.

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

133/23 WORKPLAN – 2023/24

The workplan for 2023/24 has been brought to this meeting for review.
ICB midterm update to be added to the workplan.
Next deep dive on stroke and neck of femur.
JH and AN to speak to around deep dives for 2nd half of year.
Changes to the CHFT / CHS meeting schedule now bi-monthly so workplan updated accordingly.

Committee **APPROVED** the work plan for 2023/24.

134/23 ANY OTHER BUSINESS
Next meeting NB possibly chairing as AN will be travelling.

BM apologies for the next meeting as on leave.

135/23 MATTERS TO CASCADE TO BOARD inc. ONE CULTURE OF CARE

- Deep dive on Diagnostics
- Operational Performance and recovery a strong story.
- Finance - highlight risk around forecast and current likely case.

DATE AND TIME OF NEXT MEETING:
Wednesday 30th August 09:30 – 12:00 MS Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Wednesday, 21 June 2023

STANDING ITEMS

93/23 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Jennifer Clark **(JC)**	Head of Therapies
Lucy Dryden **(LD)**	Quality Manager for Calderdale Integrated Care Board
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jonathan Hammond **(JH)**	Deputy Chief Operational 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
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Andrea Dauris **(AD)**	Associate Director of Nursing – Corporate **(item 96/23)**
Alison Edwards **(AE)**	Safeguarding Lead **(item 97/23)**
Diane Tinker **(DT)**	Head of Midwifery **(items 99/23 and 100/23)**

Apologies

Mr Neeraj Bhasin **(NB)**	Deputy Medical Director
Sharon Cundy **(SC)**	Head of Quality and Safety
Elisabeth Street **(ES)**	Clinical Director of Pharmacy

94/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

95/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 22 May 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 96/23

SAFER STAFFING ANNUAL REPORT

Andrea Dauris was in attendance to present the report as circulated at appendix B, which has previously been presented to and approved at the Workforce Committee.

AN commented on the improvement in the turnover position for community nursing, and asked if there were any particular actions taken which will be useful learning; and whether the red flags include the reality of the operational pressures faced in the organisation or whether it is improved governance. In relation to improved turnover, **AD** reported that local work within the Community to develop the district nursing qualification will be fed into the retention strategy; and in relation to the red flags, **AD** reported that this is two-fold. Time has been spent revisiting what red flags mean and when they should be used as clear escalation. This is good practice of increased awareness and colleague understanding to identify red flag issues.

DS asked what unmet care needs meant in relation to the red flags. **AD** stated that this may relate to a request for a one-to-one which is not being met, or a general shortfall in the workforce model and delays in delivering care. There may also be an impact on patient experience, and teams are being asked to look at care needs. There is a system within safe care which calculates the care needs based on on-day acuity of patients, and rated as red, amber or green. This will allow areas to see how many hours short they are, and respond to the situation by looking at other areas which have excess hours, rather than looking at the workforce model.

DS also commented on the progress being made with international recruitment, and asked, following concerns raised in reports from the International Council of Nurses about where international nurse recruitment is taking place, and that some countries are being put at risk due to the percentage of nurses travelling abroad, how does the organisation in terms of due diligence, ensure that the countries that international nurses are being recruited from are not struggling in terms of their own healthcare provision. **AD** stated that there is a register that identifies areas which can and cannot be recruited from, and takes into consideration the ethical issues. **JE** also noted that there is an expansion of countries for international recruitment compared to five years ago, and that international recruits are only expected to work in the NHS in England for a limited period of time. It is also expected that those recruits are upskilled and take their learning back to enhance their health service, which will however, leave a gap in the NHS once they return.

DS thanked **AD** for the report, which remains challenging, however, there is evidence of mitigation in place to ensure risks are minimised to patients when staffing levels are not where they should be. Thanks were also conveyed to colleagues involved in the work.

OUTCOME: The Quality Committee noted the report.

SAFE 97/23

SAFEGUARDING COMMITTEE ANNUAL REPORT

Alison Edwards was in attendance to present the report as circulated at appendix C highlighting the work and commitment to safeguarding children and adults by the Safeguarding Team.

AE commented on PREVENT Training and the issue highlighted by the Race Equality Network (REN) about the concerns relating to prevent training have not yet been resolved. The reason was that the training package which CHFT colleagues access is a national package, and there was a delay in the NHS England and the Home Office representative being able to meet to ensure that these views were heard. There has been a proposal to the Education Committee to increase PREVENT training, which was accepted, however, the ask was that Safeguarding meet with the REN, which will take place in September 2023 to further ensure that their voice is being heard in relation to the PREVENT Training.

AN commented on the thorough report and the Deprivation Of Liberty Safeguards (DoLS) increase, and asked if this was worsening due to seeing more mental health issues versus colleague awareness and confidence in the process. **AE** stated that it was a bit of both, as a lot of work has gone into Mental Capacity Act (MCA) / DoLS and there is an increased awareness amongst colleagues, however, there are more complex cases coming through the organisation.

AN stated that safeguarding issues are being identified which are dealt with outside of the organisation, and asked how we measure our success as a safeguard organisation. **AE** stated that outcomes are difficult in safeguarding, however, more could be done to look at outcomes, for example, making safeguarding personal. There is a safeguarding dashboard, which is seeing an increase in referrals in relation to patients seen, and less referrals against the organisation. **LR** reported on several qualitative outcomes around people's lived experiences, which will be included in the next Safeguarding report.

DS also commented on the comprehensive report and was pleased to see the powerful Independent Domestic Violence Advisor (IDVA) success story included. **DS** referred to the Kirklees Joint Targeted Area Inspection (JTAI) which took place in June and July 2022, and asked what the three outstanding actions were in relation to. **AE** reported that work was required with the local authority on a system relating to referrals made into children's social care; the flagging of records of children who live out of the area that are at risk of exploitation and the requirement of notification from other local authorities, and a review of the under 18 and vulnerable adults at risk proforma, following the JTAI inspection, which transpired that a review was needed prior to getting onto the electronic patient record and embedding through the organisation.

DS also asked about the Liberty Protection Safeguards (LPS) which has been delayed beyond the life of this Parliament, and how the organisation is keeping on top of what needs to be done. **AE** stated that the organisation is still working towards the LPS and expecting a significant change at some point, and ensuring that colleagues understand mental capacity and have a good understanding of the current process for DoLS, which will prepare for the transition into LPS once further guidance is available. **LR** stated that LPS is unlikely with the current Parliament, however, it is recognised regionally that the code of practice needs updating.

OUTCOME: **AE** was thanked and the Quality Committee noted the report.

98/23 Q4 INFECTION PREVENTION AND CONTROL REPORT

David Birkenhead presented the report as circulated at appendix D, highlighting concerns with the Clostridium difficile position with a significant breach of the target, with 59 cases through the year. There is a robust plan around Clostridium difficile and its management, which was assessed independently by NHS England/Improvement in February 2023 providing a positive report with some minor recommendations.

Work continues around training, with a different approach to medical induction, moving to a two-day induction programme, on a pilot basis. Within that there will be a requirement for new medical colleagues attending CHFT to complete mandatory training within that two day period, which will hopefully show an increase in medical colleague compliance.

There has been an independent review by internal audit of our approach to the Board Assurance Frameworks, which reported significant assurance, with some minor recommendations.

Acknowledgement was given to Gillian Manojlovic (Lead IPC Nurse) who produced this report and has worked at CHFT for many years, and retired recently. Belinda Russell will be taking over as lead infection control nurse.

AN reported on the positive Aseptic Non-Touch Technique assessments and the national trend in increased Clostridium difficile cases, and asked if there was any learning from this. **DB** stated that this is in part related to COVID-19 and the changes in the hospital population, the number of patients in hospital and length of stay. It is known that there has been an increase in antimicrobial usage following COVID-19 and broad spectrum antibiotics to manage respiratory infections, which has partly driven this increase, however, it is not clear why it is still happening.

OUTCOME: **DB** was thanked and the Quality Committee noted the report.

99/23 MIDWIFERY STAFFING REVISED WORKFORCE MODEL

Diane Tinker presented the above report, circulated at appendix E, which updated on the review of the current birth rate and revised midwifery staffing model.

LR provided assurance to the Committee of the recommendations missing from the report, and now being in a position to commission a full external review by the birth rate plus team.
Action: That a revised paper including the full recommendation is re-circulated.

AN asked about the 90/10 split and whether this could be pushed further; and also queried whether the improving position in recruitment was due to the reduction in vacancies versus turnover. In relation to the 90/10 split, **DT** stated that recommendations state an 80/10 split can be used and decided by individual Trusts, however, the comfortable position for CHFT at this moment in time is the 90/10 split. In relation to recruitment, there were not as many as midwives as expected, however, 35 midwives are being trained in March 2024, who will predominantly, at the moment work between CHFT and Mid-Yorkshire, and there should be a much improved position.

KH was supportive of the new model and asked if there was approval to carry out the additional work. **DT** stated that the birth rate plus work can be decided by the organisation and will be commissioned when necessary.

JE noted concern expressed by midwives in terms of staffing arrangements, and asked if they were involved in the revision to the model. **LR** stated that this will be part of the external review and will be beneficial to colleagues across the service.

DS asked where the service would like to be in a years' time. **LR** stated that by March 2024, the service would like to be in a position of a clear external review, a further internal review, that the trajectory allows the delivery of choice across the services, and that the vacancy position is in line with the Local Maternity and Neonatal Systems (LMNS), and turnover remains low. **LR** also noted that maternity services recognise, are engaged, and have a shared common understanding of the position.

OUTCOME: **DT** was thanked for the update and the Committee noted the report.

100/23 MATERNITY SAFETY AND NEONATAL REPORT

Diane Tinker presented the above report, circulated at appendix F, highlighting the key points and also noting the CQC maternity inspection took place on 7 and 8 June 2023.

DT noted that a responsive model on the birth centre has been carried out, and that during times when staffing has been challenged, the birth centre was relocated to the labour ward, where women could still have a low risk birth. Following a review of processes and guidelines, a responsive model follows women, rather than staffing a building. This resulted in three women giving birth in the Calderdale birth centre in April, and 40 in May, which was a positive for the women and also for colleagues. It is hoped that by trialling this model, there can be a community-based responsive model for the Huddersfield birth centre going forward.

DS commented on the amount of work which can now be archived in relation to the transformation plan.

OUTCOME: **DT** was thanked for the report and the Committee noted the report.

RESPONSIVE

101/23 QUALITY REPORT

Lindsay Rudge presented the report as circulated at appendix G, and stated that a review will take place on how this report going forward, as the two main sub-committees of the Quality Committee (Trust Patient Safety and Quality Board and the Clinical Outcomes Group) broadly focus on the quality report.

AN commented on the challenge of the Malnutrition Universal Screening Tool scores, which **LR** stated that the clinical site matron team are now supporting the clinical oversight, and that the stop before transfer is important and similar to getting it right first time. Some well organised ward (WOW) sessions will be taking place with clinical teams around patient individualised care and ensuring a plan for every patient, a daily ward round and multi-activities. Work has also been taking place to re-organise the workflow of the Electronic Patient Record.

AN and **DS** commented on the style of the report which feels better than the previous lengthy document.

OUTCOME: The Quality Committee noted the report.

102/23 QUALITY DASHBOARD

The Quality Dashboard as circulated at appendix H was to note, as it has already been submitted to the external place-based Quality Boards.

OUTCOME: The Quality Committee noted the report.

103/23 QUALITY ACCOUNT

Lindsay Rudge stated that the current version of the Quality Account has been revised and is now a condensed version of the Account.

OUTCOME: The Quality Committee signed off the Account.

104/23 INTEGRATED PERFORMANCE REPORT

Dr David Birkenhead and Lindsay Rudge presented the report as circulated at appendix J, highlighting the key points of good progress with recovery.

OUTCOME: The Quality Committee noted the report.

CARING

105/23 ANNUAL COMPLAINTS REPORT

Victoria Pickles presented the report as circulated at appendix K, highlighting that current figures for complaints are 99.1% closed within timescale. The next steps are to review the quality of responses and how learning from complaints is more visible.

LD asked if there was any learning which could be shared with other organisations on how CHFT have improved with complaints. **VP** and **LR** stated that this is due to the divisions' collaborative work.

OUTCOME: The Quality Committee noted the report.

SUB-GROUP TERMS OF REFERENCE

106/23 CQC GROUP

Victoria Pickles presented the CQC terms of reference as circulated at appendix L.

OUTCOME: The Quality Committee ratified the terms of reference.

107/23 MEDICINES MANAGEMENT COMMITTEE

The terms of reference were circulated at appendix M.

OUTCOME: The Quality Committee ratified the terms of reference.

ITEMS TO RECEIVE AND NOTE

108/23 CLINICAL OUTCOMES GROUP MINUTES

The minutes were circulated as at appendix N.

OUTCOME: The Quality Committee noted the minutes.

109/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix O for information, with work still to simplify the plan.

110/23 ANY OTHER BUSINESS

There was no other business.

111/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

- Positive annual complaints report (item 105/23)
- Maternity Report and Neonatal Workforce model (item 99/23 and 100/23)
- Assurance from the safer staffing report and strong progress and actions, and assurance that the quality metrics have been measured alongside the staffing position (item 96/23)
- Assurance from the safeguarding report and progress and actions (item 97/23)
- New style of quality reporting and actions taking place on long-standing issues (item 101/23)

POST MEETING REVIEW

112/23 REVIEW OF MEETING

This item was not taken

NEXT MEETING

~~Monday, 21 August 2023~~ **(amendment noted at 24 July 2023 meeting)**
Monday, 24 July 2023
2:30 – 5:00 pm
Microsoft Teams

QUALITY COMMITTEE ACTION LOG

Following meeting on Wednesday, 21 June 2023

Overdue | New / Ongoing | Closed | Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING / DUE DATE
UPCOMING ACTIONS				
22.05.23 (88/23)	**Clinical Outcomes Group Report**	**Catherine Briggs**	**LR** commented on the business case which was submitted to the Business Case Approval Group for the 24-hour response team and noted that this was approved in principle and hopefully towards the end of the year, this will be completed. This is in relation to deteriorating patients and extending the provision of the HOOP (hospital out of hours programme) service and merging it with critical care outreach, to provide a more comprehensive review of those patients in a more rapid response. It was requested that an update is provided at a future meeting for the Committee's understanding of the purpose and intended outcomes. **Action 22 May 2023**: Update to be provided on business case. **Update June:** Update to be provided at the 24 July meeting	**Update due Monday, 21 August 2023**
24.10.22 (168/22)	**Split Paediatric Service**	**Elena Gelsthorpe-Hill / Venkat Thiyagesh**	**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 due Monday, 21 August 2023**
24.10.22 (171/22)	Integrated Performance Report **Length of stay update**	**Charlotte Anderson**	**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	**To be confirmed**
CLOSED ACTIONS				
21.06.23 99/23	**Midwifery staffing revised workforce model**	**Diane Tinker**	**LR** provided assurance to the Committee of the recommendations missing from the report, and now being in a position to commission a full external review by the birth rate plus team. **Action 21.06.23**: That a revised paper including the full recommendation is re-circulated. **Update**: See end of action log	**CLOSED**

Date of Meeting:	**June 2023**
Meeting:	**Quality Committee**
Title of report:	**Midwifery Staffing Revised Workforce Model proposal**
Author:	**Diane Tinker, Director of Midwifery and Women's Services**
Sponsor:	**Lindsay Rudge, Chief Nurse, Exec Director Maternity Safety Champion**
Previous Forums:	**None**

Actions Requested
To note the new workforce model for Midwifery staffing.

Purpose of the Report

To provide an update on the review of the current birth rate and revised midwifery staffing model.

Key Points to Note

- The revised maternity staffing model has been calculated using the principles of the Birthrate Plus tool and is based on a 1:24 ratio and birth rate of 4313 (22/23). This is a decrease against the previous birth rate of 4,902 (2020)
- The model reflects a skill mix calculation of 90%/10% split between midwives and non-midwifery support staff as recommended by Birthrate Plus
- In addition to the clinical midwifery workforce model the model also reflects an additional uplift of midwife roles by 8% with the function of supporting non-clinical management and governance.
- The new model **total** midwifery establishment is therefore **174.63wte** which consists of:
    - **161.73wte** clinical midwives following skill mix
    - **12.9wte** non-clinical midwives
- The current **total** midwifery vacancy rate against this revised staffing model is **14.31%** (149.64wte of 174.63wte employed at March 2023) and the current **clinical** midwifery vacancy rate against revised staffing model is **13.70%** (142.24wte of 161.73wte employed at March 2023).

EQIA – Equality Impact Assessment

There is significant evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor.

Maternity services have an active Health Inequalities work stream to drive improvement work for those most at risk. CHFT's midwifery reader has produced a cultural survey that has been shared with staff to understand knowledge gaps ahead of developing training opportunities for midwives and obstetricians.

Recommendation

To note the revised workforce model for clinical midwifery staffing

Midwifery establishment

Birthrate plus was completed at CHFT in 2020, when completed the birth rate was 4902.

The clinical midwifery establishment recommended from Birthrate plus for 4902 births was calculated at 206 whole time equivalent (wte) clinical midwives.

Historically, the workforce model was only funded at 186wte for total midwifery establishment and following the publication of the Ockenden report and the associated funding for clinical midwifery staff the establishment funding increased to 198wte.

Since this time, CHFT has since seen a reduction in births at 4313 (as of March 2023).

Due to the decrease in the Birthrate the workforce model has been recalculated using the 1:24 ratio as recommended in the Birthrate Plus report.

Using the 1:24 ratio the new clinical midwifery establishment is 179.7wte (4313 divided by 24=179.7).

Evidence-based skill mix calculation

- Once the clinical midwifery establishment has been calculated a skill mix percentage can be applied.
- The decision to replace midwifery time with maternity support workers, nursery nurses or staff nurses must be a local decision.
- A professional consensus of expert midwifery opinion is that a 90%/10% split between midwives and non-midwifery support staff allows for flexible and sustainable services.
- This skill mix adjustment is based on the support staff replacing midwifery hours only in postnatal services, including transitional care of babies.
- In recent years the role and scope of support staff has been evolving and, in many services, they now play a part in providing direct care to women antenatally, such as in providing parentcraft advice and in delivering public health interventions and even during labour, for example by accompanying an experienced midwife to a home birth. This would suggest that a split of 85:15 or even 80:20 might be appropriate in some services.

At CHFT at **10% skill mix** will be applied, therefore 17.97wte (10% of 179.7=17.97wte) midwifery posts will be replaced with maternity support workers and staff nurses. These posts include maternity support workers working in community, on the transitional care pathways and staff nurses working on both the labour ward and postnatal ward.

Addition of non-clinical midwifery roles

All maternity services require additional roles to manage and provide maternity services, over and above that of clinical care. Such roles include senior midwifery management, governance and risk, practice development and any other role which involve considerable liaison with other services and co-ordinating care plans rather than providing direct clinical care.

Following the calculation of the clinical midwifery establishment and the applied skill mix, Birthrate Plus recommends assessing these roles by adding a percentage of the total clinical midwifery establishment.

For tertiary maternity services it recommends 10% and 8% for all other units. Therefore, for CHFT it would recommend an 8% addition, which would equate to 12.9wte (8% of 161.73 = 12.9). However, it remains a local decision as to the percentage to add into the total clinical establishment.

Workforce model summary

Based upon the historic number of **4902** births, the clinical midwifery establishment recommendation from Birthrate plus in 2020 was 206wte.

The current funded establishment is 198wte based on 4902 births (previous 186wte funded and the Ockenden uplift applied).

The below information summarises the proposed midwifery establishment based upon the current birth rate of **4313.**

Workforce model based on 4313 births	Calculation	Proposed wte
Clinical Midwifery establishment based on 1:24 ratio consisting of:	4313 divided by 24 =179.7wte	**179.7**
Maternity support workers / staff nurse (based on skill mix of 90/10 split	10% of 179.7 = 17.97	**17.97**
Clinical Midwifery establishment following skill mix	179.7–17.97 = 161.73wte	**161.73**
Non-clinical midwifery establishment (additional to clinical establishment)	8% of 161.73 = 12.9wte	**12.9**
Total Midwifery established (clinical and non-clinical)	161.73+12.9 =174.63	**174.63**

The new proposed **total** midwifery establishment is therefore **174.63wte** which consists of:

- **161.73wte** clinical midwives following skill mix
- **12.9wte** non-clinical midwives

Revised vacancy position for midwifery establishment

Following review of above this results in an overall reduction on the midwifery vacancy position as detailed below:

Current clinical midwifery establishment 142.24wte (March 2023)
New **clinical midwifery** vacancy 19.49wte = **13.70%**

Current total midwifery establishment including non-clinical 149.64wte (March 2023)
New **total midwifery** including non-clinical midwifery vacancy 24.99wte = **14.31%**

Planned recruitment

Following a successful regional recruitment process 14wte newly qualified midwives offered posts.

Following successful international recruitment 2 midwives have been offered post and are due to arrival in the end of June, with further interviews planned aimed at recruiting to 3 further posts.

Further action

A full review by Birthrate plus to be commissioned to ensure acuity and continuity models are reflected in the maternity service workforce model.

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 24 July 2023

STANDING ITEMS

113/23 WELCOME AND INTRODUCTIONS

Present

Denise Sterling (DS)	Non-Executive Director (Chair)
Mr Neeraj Bhasin (NB)	Deputy Medical Director
Dr David Birkenhead (DB)	Medical Director
Gina Choy (GC)	Public Elected Governor
Jennifer Clark (JC)	Head of Therapies
Jason Eddleston (JE)	Deputy Director of Workforce & Organisational Development
Karen Heaton (KH)	Non-Executive Director
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

Matthew Robinson (MR)	Clinical Research Team Leader (item 123/23)
Lucy Dryden (LD)	Quality Manager for Calderdale Integrated Care Board
Gemma Berriman (GB)	Director of Operations
Diane Tinker (DT)	Head of Midwifery (item 118/23)

Apologies

Sharon Cundy (SC)	Head of Quality and Safety
Jonathan Hammond (JH)	Chief Operating Officer
Joanne Middleton (JMidd)	Deputy Chief Nurse

114/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

115/23 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Wednesday, 21 June 2023, circulated at appendix A, were approved as a correct record, with the exception that the date at the end of the minutes for the next meeting is changed from Monday, 21 August 2023 to Monday, 24 July 2023.

The action log can be found at the end of these minutes.

116/23 PATIENT STORY

This item was not taken.

SPECIFIC REPORTS

117/23 RECOMMENDED SUMMARY PLAN FOR EMERGENCY CARE AND TREATMENT (ReSPECT) POLICY, TERMS OF REFERENCE AND STANDARD OPERATING PROCEDURE

The reports were circulated at appendix B.

DRAFT

LD stated that the Chair of the ReSPECT Internal Working Group will be contacted in order for a colleague from the Calderdale Quality Team to be involved in the working group, as there will be implications for care homes.

LR asked whether the ReSPECT Internal Working Group would be a direct report into the Quality Committee, or whether it should report into the Clinical Outcomes Group. **LR**, **DB** and **VP** agreed to discuss the reporting of this working group

UPDATE: It was agreed that the ReSPECT Internal Working Group will report into the Clinical Outcomes Group.

SAFE

118/23 MATERNITY SAFETY AND NEONATAL REPORT

Diane Tinker presented the above report, circulated at appendix C1, highlighting the key points.

DT mentioned the Trust's work as part of the LMNS 'Book by 10 weeks' campaign' to improve bookings, and the creation of a poster by public health midwives, which will be translated into five different languages. **LR** stated that this is a regional issue, and can be seen within the system based report to the Calderdale Partnership Group.

DT also described the work from the East Kent report. Themes from the East Kent report related to embedded learning, and two events took place, one in April and one in May, with midwives, obstetricians, members from the Integrated Care Board, the Local Maternity System, service users, Safety Champions (**KH**) and the Legal services team in attendance. Three years' worth of coroners', Healthcare Safety Investigation Branch, Serious Incident (SI) and orange investigation case action plans were reviewed to determine whether learning was truly embedded. It was a positive event, and it was realised that a lot of learning does takes place, and areas to strengthen were also realised. **DT** also provided a presentation at the Transformation Board last month, and will include a full update in next month's maternity and neonatal report.

AN asked if there was a timeline for the review for the birth rate plus model. **DT** stated that the review will take some time, however, the 1 in 24 workforce model will be used, as per calculations.

In relation to the CQC visit, **AN** asked about colleagues' perspectives of the visit. **DT** stated that colleagues responded positively, and feedback from the CQC were that colleagues were very welcoming and interested in communicating with them.

With regard to the maternity dashboard and the key indicator of smoking at delivery (not recorded), **AN** asked if there was any further work to be done to achieve the target. **DT** stated that reminders have been sent to colleagues to ensure that the data is correct.

LR noted that the current report is a revised report, which includes data to become compliant with the Year 5 of the published maternity incentive scheme. It was also noted that **LR** and **KH**, as Board Safety Champions, have completed registration in line with the timescale provided.

In relation to staffing levels, planned versus actual, there may be some concerns regarding the red scores, however, 1:1 labour was maintained, and although the fill rate is against planned staffing, mitigations are put in place on a day-to-day basis against the actual requirements, based on the number of women accessing the service and the acuity across the service. One of the main concerns remains, as extended waits for the induction of labour, which is a regional issue as all maternity units go into escalation, therefore, resources are managed and mitigated.

LR stated that the content and recommendations within the appended report (*Appendix C2 - Calderdale Cares Partnership Quality Group - Maternity and Neonatal Services Update and Overview*) is very useful to observe the broader aspects of maternity services, women's, and child health across the system for the local place, which was the intention of the deep dive. The report will also be provided for the Kirklees Cares Partnership Quality Group.

JE asked whether the maternity and neonatal report is an opportunity for the colleague voice to be heard about maternity and neonatal services, for example, Freedom to Speak Up (FTSU) concerns. **DT** stated that FTSU concerns have not been included on a regular basis, but has been done in the past when there were a number of FTSU concerns. **DT** stated that colleague voices are heard through **LR** and **KH** walk rounds. **LR** stated that this is an evolving and sometimes lengthy report, and that colleague voices, as well as FTSU, Friends and Family Test (FFTs) and actions from the national survey will be included.

GC queried the delays in emergency caesarean sections within the maternity incidents section of the report, which have increased, and whether there were any mitigations in place. **DT** stated that all delays are reported, down to the minute, however, a deep dive can take place if necessary. All delays are reviewed within the weekly governance meeting, and any harm is escalated to the orange panel.

DS noted the responsiveness to the initial CQC feedback, and the work already underway to address recommended areas of improvement.

OUTCOME: **DT** was thanked and the Committee noted the report.

119/23 PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF)

Lindsay Rudge provided a presentation, as circulated at appendix D, highlighting what is changing around the investigation framework.

KH asked whether the specific and targeted learning involves equality and diversity. **LR** stated that incidents are viewed and triangulated from a broad equality, diversity, and inclusive perspective, as well as through the health inequality lens.

AN asked if there was a regulatory aspect for the implementation of PSIRF. **LR** stated that the implementation has shifted, due to a national problem of the Datix incident systems not being fit for purpose to deliver some of the elements of the framework. A date has not been set; however, it is envisaged that most of the framework will be in place in 2024/2025.

DS noted that the change and culture shift from where the Trust is now, to the implementation of the PSIRF principles will be everyone's responsibility, and asked how the Patient Safety Partner role will be developed. **LR** and **VP** are working on this from what has been learned from the national early implementer sites, and work with each Place in developing the role. **VP** stated that lots of different options have been tested nationally, and further understanding is needed on what has worked best before a solution for the Trust is sought. An options appraisal is being developed for submission to Executive Board for an initial discussion.

DS asked if there are currently any dedicated roles for the PSIRF implementation and rollout. **LR** stated the framework has been reviewed and working with available resources across the Quality Directorate in terms of shifting roles, and creating roles for an Associate Medical Director for Patient Safety, and a Lead Nurse. Maternity also requires a resource for PSIRF, and it is ensuring that the structure and portfolios for the Quality Governance Leads, the Governance Team, the Associate Medical Director and Deputy Medical Director for Quality are realigned.

DS noted from the Calderdale Cares Partnership Quality Group minutes that this is on their risk register, but not on the Trust risk register. **LR** stated that one of the pieces of work being done on the back of the orange incidents is to review the CHFT Board Assurance Framework risk on quality and safety, which is considered the risk which needs to be amended. **VP** stated

that for CHFT, it would be part of a broader risk around managing the quality agenda, and the fact that PSIRF is required across multiple providers, not just the Acute Trust, as to why the risk features prominently for the Calderdale Cares Partnership.

OUTCOME: **LR** was thanked and the Committee noted the report.

120/23 Q1 TRUST PSQB REPORT AND TERMS OF REFERENCE

Lindsay Rudge presented the above report, circulated at appendix E1, highlighting the work undertaken in the Trust Patient Safety and Quality Board during April to June 2023.

LR noted one of the observations since taking over as Chair of the Trust Patient Safety and Quality Board is that issues are described and not outcome focused through the divisional reports. The current function of the Trust Patient Safety and Quality Board will require further discussion with **DS** and **DB**, as it is undecided as to whether the divisional quality reports which were previously submitted directly into the Quality Committee should return moving forward.

DS noted a continued increase in prescribing incidents in Community, which have previously been reported to the Quality Committee, and asked what specific actions the Local Medical Committee and the Integrated Care Board are taking to help address the situation. **LR** stated that this is in relation to some of the GP prescribing incidents, and Abbie Thompson (Matron for End of Life Care and CHFT Calderdale Community Specialist Palliative Care Team) has been working on this through the primary care networks, however, more detail can be provided within the next Trust PSQB report on the work undertaken.

LR stated that a proposal on what the Trust PSQB needs to look like going forward will be provided for a future Quality Committee, and that the current terms of reference, as circulated at appendix E2, are how the current Trust PSQB exists. A revised set of terms of reference will be provided over the coming months, as the structure is reviewed.

OUTCOME: The Committee approved the current terms of reference, and noted the report.

121/23 QUALITY SLIDES

Lindsay Rudge presented the above report, circulated at appendix F, highlighting the revised report which now includes key performance from areas including Never Events, Serious Incidents, orange incidents, safety alerts, complaints and Patient Advice Liaison Service (PALS), compliments, legal, Policies and clinical repository, CQC, the Clinical Outcomes Group dashboard, NICE guidance and Quality Priorities.

AN noted that there were some encouraging signs that the STOP process works in relation to assessments, and asked whether a similar process will be used for dementia screening. **LR** stated that there are early positive signs and engaging the Multi-disciplinary Team. Dementia screening has been predominantly moved to nursing, and the aim is for 90% compliance by the end of August 2023.

AN asked if there were any plans on improving the pressure ulcers. **LR** stated that a move to a new tool (Purpose T) has taken place, which is a new assessment tool for pressure ulcers. This has just gone live and the impact will need to be assessed. There has been a slight improvement in the number of pressure ulcers, however, Purpose T should make it clearer around assessing equipment.

AN commented on the consistent work on complaints and asked about the learning. **VP** stated that there is a plan for the next six months and features as part of the Patient Safety Incident Response Framework work. The themes from complaints will form part of the category themes which will be discussed for Patient Safety Incident Response Framework. There is a timeline for an event later in Autumn, which will bring together the broader learning.

LR stated that as part of the slide pack and the move to a different Integrated Performance Report, a monthly performance update will be provided to the Quality Committee to capture progress against issues which need the Committee's attention.

OUTCOME: **LR** was thanked and the Committee noted the update.

CARING

122/23 PATIENT EXPERIENCE AND CARING GROUP REPORT

Lindsay Rudge presented the report as circulated at appendix G, highlighting activity through the Patient Experience Group.

LR noted that the Group have approved the Patient Experience Involvement and Inclusion Strategy, which will be submitted to the next meeting.

OUTCOME: **LR** was thanked and the Committee noted the report.

WELL LED

123/23 RESEARCH AND DEVELOPMENT ANNUAL REPORT

Matthew Robinson was in attendance to present the report as circulated at appendix H, highlighting key notes from the report.

KH conveyed congratulations to the two colleagues who won the 2023 'Research Midwives of the Year' at the Yorkshire and Humber National Institute of Health Research (NIHR) Research Awards.

KH also stated that Research and Development is a good success story, which goes from strength to strength and conveyed thanks to the Team.

AN asked whether the commercial research activity provides any income. **NB** stated that the activity is income generating, and any profit can go back to the division, some can be retained within Research and Development.

In terms of next steps, there are two aspects. A number of Research Nurses are on fixed term contracts and have been for a number of years, and have a stable income from the Research Network has been demonstrated, therefore, those fixed term posts will be turned into substantive posts. The governance structure is another aspect in terms of next steps, and the ceiling has been hit in terms of commercial studies, and by restructuring with some of the return, this should then be able to create more income and studies.

AN asked what the long-term goal ambition for the Research Strategy. **NB** stated that, ultimately, it is for the Research Department to continue being proactive, dynamic, building commercial research, building the research portfolio internally across specialties, getting different roles involved (Pharmacists, Advanced Clinical Practitioners, Physician Associates, Therapists, etc), and increasing external partnership work.

OUTCOME: **MR** and **NB** were thanked and the Committee noted the report.

EFFECTIVE

124/23 Q4 LEARNING FROM DEATH REPORT

David Birkenhead presented the report as circulated at appendix I, highlighting minimal changes since the last report presented in May 2023.

The Chair asked how the Trust benchmarks with peer organisations. **DB** stated that there is no standard approach to structured judgement reviews or learning from deaths. The quality of care review is the approach of the Trust and could be different in other Trusts. There is no national target, and the process has been developed at CHFT in part, from the Care of the Acutely Ill Patient (CAIP) programme.

In relation to poor practice from the structured judgement reviews, **AN** asked whether there was any learning from this in relation to the implementation of the ReSPECT policy. **DB** stated that the function of the ReSPECT policy was not the issue, however, it was in regard to a DNACPR form being in place and correctly completed, albeit resuscitation was started. This will go through an orange panel review in order for the learning to be developed, as well as an action plan.

LR reported that Eilidh Gunson (End of Life Care Clinical Advisor) has shared the learning from the National Audit of Care at the End of Life (NACEL) Audit through the End of Life Care (EoLC) Group, which picks up some of the points from the learning from structured judgement reviews. An update on the work done within the EoLC Group will be incorporated into the next quarterly Learning from Deaths report due in October 2023.

GC asked about the process of the timeline for orange incidents and the expected time to see the implementation of the learning from those incidents. **DB** stated that that there are a number of outstanding orange incidents which are beyond time, and targeted work is to take place on the orange processes within divisions. The orange incident meetings take place on a weekly basis; however, the completion of the action plans are not being met or signed off in a timely manner. The timeline for each incident will vary on how complex they are.

OUTCOME: **DB** was thanked and the Committee noted the report.

RESPONSIVE

125/23 INTEGRATED PERFORMANCE REPORT

The new style report was circulated at appendix J for information, as most of the content of the report has been covered.

LR noted that a risk has been flagged through the Calderdale Cares Partnership around stroke, which is deteriorating. A meeting took place with the medical division's leadership team and the leadership team for Stroke, and a number of plans have asked to be put in place to revise the position.

Further work has been requested to understand the virtual ward performance which has deteriorated. It is understood that there are issues with the data collection, therefore a manual review is taking place.

AN commented on the cross-over of work, due to the deep dive in Stroke which will take place at the Finance and Performance meeting in August.

OUTCOME: The Quality Committee noted the report.

126/23 QUALITY COMMITTEE ANNUAL REPORT

The Chair presented the report as circulated at appendix K, for information, which outlines what has been covered during the year within the Quality Committee. An action plan will be provided at the next meeting.

OUTCOME: The Quality Committee noted the report.

ITEMS TO RECEIVE AND NOTE

127/23 CALDERDALE CARES PARTNERSHIP QUALITY GROUP MINUTES

The minutes were circulated as at appendix L.

LR noted that the issue of stroke was raised at both the Calderdale and Kirklees Care Partnership Quality meetings, and asked for it to be revised on the risk register. An increase of the risk around industrial action for both urgent and emergency care and elected care was requested, with a view of further prolonged industrial action. Both risks were accepted onto the Committees.

OUTCOME: The Quality Committee noted the minutes.

128/23 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the above was available at appendix M for information.

129/23 ANY OTHER BUSINESS

There was no other business.

130/23 MATTERS FOR ESCALATION TO THE TRUST BOARD

- ReSPECT Policy and terms of reference (item 117/23)
- Research and Development Annual Report (item 123/23)
- Update on Patient Safety Incident Response Framework (item 119/23)
- Maternity Report and Neonatal Workforce model (item 118/23)
- New elements from the Integrated Performance Report (item 125/23)
- Key improvements from the Quality Report (item 121/23)

POST MEETING REVIEW

131/23 REVIEW OF MEETING

- The Committee got through the agenda in good time
- The receipt of good, detailed reports
- The easier format of the Quality report

NEXT MEETING

Monday, 21 August 2023
2:30 – 5:00 pm
Microsoft Teams

DRAFT

QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 24 July 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 (168/22)	**Split Paediatric Service**	**Venkat Thiyagesh**	**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 at Quality Committee yet to be confirmed**
24.10.22 (171/22)	Integrated Performance Report **Length of stay update**	**Charlotte Anderson**	**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	**To be confirmed**
CLOSED ACTIONS				
22.05.23 (88/23)	**Clinical Outcomes Group Report**		**Business Case** **LR** commented on the business case which was submitted to the Business Case Approval Group for the 24-hour response team and noted that this was approved in principle and hopefully towards the end of the year, this will be completed. This is in relation to deteriorating patients and extending the provision of the HOOP (hospital out of hours programme) service and merging it with critical care outreach, to provide a more comprehensive review of those patients in a more rapid response. It was requested that an update is provided at a future meeting for the Committee's understanding of the purpose and intended outcomes. **Action 22 May 2023**: Update to be provided on business case. **Update June:** Update to be provided at the 24 July meeting **Update**: To be picked up by the Clinical Outcomes Group as part of operational business	**CLOSED**

DRAFT

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE: ENGAGEMENT CHAPTER

Held on Tuesday 20 June 2023, 2.00pm – 4.30pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Nigel Broadbent	(NB)	Non-Executive Director
Suzanne Dunkley	(SD)	Director of Workforce and OD
Karen Heaton	(KH)	Non-Executive Director (Chair)
Lindsay Rudge	(LR)	Chief Nurse
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Rob Aitchison	(RA)	Deputy Chief Executive
Peter Bamber	(PB)	Governor
Mark Bushby	(MB)	Workforce Business Intelligence Manager (for item 49/23)
Jenny Clark	(JC)	Associate Director of Therapies
Jason Morris	(JM)	Head of Quality, Huddersfield Pharmacy Specials (for item 71/23)
Sarah Eastburn	(SE)	Governor
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Nikki Hosty	(NH)	Assistant Director of HR (for item 68/23)
Azizen Khan	(AK)	Assistant Director of HR (for item 67/23)
Helen Senior	(HS)	Staff Side Chair
Gemma Ellis	(GE)	Radiology Operations Manager
EI Tint	(ET)	Pathology Operations and Business Manager (for item 69/23)
Georgina Turner	(GT)	Research Team Leader (for item 72/23)
Beckie Yeates	(BY)	Workforce Psychologist (for items 65/23 66/23)

60/23 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

61/23 **APOLOGIES FOR ABSENCE**

Jonny Hammond, Chief Operating Officer
Vicky Pickles, Director of Corporate Affairs

62/23 **DECLARATION OF INTERESTS**

There were no declarations of interest.

63/23 **MINUTES OF MEETING HELD ON 3 MAY 2023**

The minutes of the Workforce Committee held on 3 May 2023 were approved as a correct record.

64/23 **ACTION LOG – MAY 2023**

The action log was received.

65/23 **THE PSYCHOLOGY OF ENGAGEMENT**

BY explained the psychology behind colleague engagement.

- Defining characteristics are vigor, absorption and dedication
- Dominant predictors of emotional engagement
  - Conciliation (flexibility, work-life balance)
  - Cultivation (growth and development)
  - Confidence (trust, health and safety)
  - Compensation (feedback, pay, rewards)
  - Communication (honesty, clarity)

- Wellbeing, particularly in emotionally taxing jobs like healthcare, is a key determinant of an employee's ability to be passionate, productive and effective in their work, even when other traditional predictors like compensation and cultivation are present. Optimal wellbeing and optimal engagement ultimately lead to better organisational outcomes.

- Good emotional regulation depends on a balanced three-way system – Drive, Soothing and Threat. The most common source of imbalance is an enlarged threat system and an underactive soothing system.

- To cultivate soothing systems we need to nurture a psychologically safe working environment by recognising that safety is a multi-layered experience. Investment of the six layers of safety should be considered.

OUTCOME: The Committee **NOTED** the presentation.

66/23 **EVOLVING THE WELLBEING OFFER**

BY explained she was appointed as the Trust's Workforce Psychologist in November 2023 on a part-time basis. A part-time Assistant Psychologist is due to commence in the next few weeks. Currently the majority of the psychology service provides one-to-one psychological therapy to colleagues who are experiencing psychological distress linked to workplace experiences. The service also provides peer-support debriefs to teams affected by critical incidents at work and also consultation to leaders across the Trust to help with challenges they are facing. A three-tiered psychological service is being developed with support from funding from the Trust's Charity. A bottom tier of offers that all colleagues are encouraged to engage with when requiring wellbeing support. A middle tier of offers to support colleagues who are feeling the acute impact of workplace incidents. A top tier that provides specialist one-to-one assessment and therapy for colleagues experiencing prolonged distress.

SD gave huge thanks to BY. SD recognises that engaging colleagues is a real challenge and noted this response demonstrates that as an employer we are doing the best we can to engage colleagues and keep them well. KH agreed this is a really strong offering.

OUTCOME: The Committee **NOTED** the presentation.

67/23 **DIRECTORATE HEALTH HEAT MAP**

AK presented the Directorate heatmap. The heatmap presents a rag rated 'ranking' visual of health scores against 9 metrics (NHS staff survey response rate; NHS staff survey engagement score; EST compliance; appraisal completion rate; sickness absence; return to work completions; annual leave; turnover; vacancy rate). AK highlighted the correlation between colleague engagement and those teams that are well managed.

KH said this is a really useful visual. She asked if there is a buddying system across divisions. AK responded the health score ranking highlights lower performing areas provoking a level of

competition. Long-standing low health score positions identify to divisions where action is required to drive improvement. JE advised managers can access the live data via the knowledge portal at any point. In response to NB's query about targets, AK confirmed divisions are working towards Trust targets noting action plans will be specific for each area.

OUTCOME: The Committee **NOTED** the Directorate Heat Map.

68/23 **STAFF SURVEY HIGH IMPACT ACTION PLAN**

NH presented the action plan which focuses on 5 key priority areas:-

- People Centred Leadership & Management Programme
- Evolve Health & Wellbeing Offer
- Development for all
- Togetherness & Belonging
- Staff Survey Hot Spot Focus

NH described the specific actions and confirmed good progress is being made.

KH asked if there was good participation at the events. NH confirmed participation has been great. Guests such as Andy's Man Club and PAT dogs have been amazing in supporting the events giving a next level of engagement. NH added that all events now connect to one culture of care, there is the same consistent messages throughout.

OUTCOME: The Committee **NOTED** the action plan.

69/23 **HOT SPOT PROGRESS**

GE explained in response to the staff survey results a plan on a page was created by service leads. The plan detailed the bottom 5 scores in the Radiology Directorate. The plan on a page was shared with all colleagues at 'hear to listen' sessions. Outputs from the 3 sessions supported the development of the action plan. Response to communication concerns has been immediately addressed by the launch of an employee forum, daily huddles, regular staff meetings, weekly communication and a monthly newsletter. TED training is being rolled out to managers and service leads. The employee forum is concentrating on 3 of the bottom 5 scores – incidents of harassment, bullying, abuse not being reported, staff with disabilities do not feel the organisation made adequate adjustments for them to carry out their work and Radiology staff are not reporting physical violence.

KH asked if there has been any visible progress. GE responded there is more in-depth work to capture the whole of Radiology. The employee forum sessions will be recorded and shared with colleagues. Groups such as the Disability Network will be invited to the forums.

EI presented the actions and progress in response to hot spot areas in the Pathology Directorate. The Directorate had a staff survey engagement score of 6.4. The main focus areas are:-

- E&D
- Senior visibility
- Wellbeing
- Communication
- Career progression

HS noted the involvement of managers and asked about engagement with all colleagues. EI confirmed all colleagues will be involved adding that the change management tool TED has

been implemented to support next steps. As HS had been out of the organisation for a period of time she would welcome a conversation outside of the meeting to catch up on progress.

LR advised she is one of the executive sponsors for Pathology and is looking forward to supporting colleagues.

KH thanked GE and ET for attending the meeting and looks forward to seeing both areas progress well.

OUTCOME: The Committee **NOTED** the progress against action plans.

70/23 **STAFF SURVEY ACTION PLAN CASE STUDY**

Allied Health Professionals

JC explained that recognising a national shortage of regional AHPs, in 2021 a national project funded by HEE was undertaken to draw up where pressures exist and enable response. CHFT's report was quite cutting with significant issues identified. The staff survey results reflected the report findings. Turnover was at 15%. In response, JC recognised that a change in culture was needed and described in detail the programme of initiatives to support recovery.

LR said this is a great piece of work in pulling various strands together and has seen a lot change in a short space of time. JE endorsed that point adding this is a really well led piece of work, it has true visibility. Hard measure regarding turnover is good to see. It will be interesting to see the results from TED results and next year's survey results. These comments capture DS thoughts too. She added this is quality work and is encouraged by grow our own and early engagement with schools. KH echoed these comments congratulating all colleagues involved.

Huddersfield Pharmacy Specials

JM presented a slide that compared the HPS overall engagement scores against the Trust's scores. The HPS score has constantly been below average. To tackle this a number of workshops took place involving all the team. Three key areas for improvement were identified:-

- Communication
- Collaboration
- Career and personal development opportunities

In response, a comprehensive action plan was developed. A back to basics approach was adopted to add value such as the introduction of a monthly newsletter, employee of the month, refresh of job descriptions. JM highlighted long term strategic actions including process mapping and the redefining of the team structure with clear career path and opportunities.

JE liked the focus on the fundamentals and felt it important that HPS builds on that. JE asked how colleagues are feeling now and how is this being tested. JM responded local surveys are being undertaken. RA advised he is the executive sponsor for HPS. He noted HPS engagement score will have flagged previously. RA pointed out there is lots of uniqueness about HPS. He agreed there were basics to get right and felt JM and the team are grabbing this and have made a really great start and is encouraged and confident about the work they are doing. KH agreed and looks forward to receiving a future update.

KH thanked JC and JM for attending the meeting and commended the teams on the excellent work.

OUTCOME: The Committee **NOTED** colleagues for telling their stories.

71/23 **RECOGNISING COLLEAGUE CONTRIBUTION**

Research and Development Team
GT attended the meeting to share how they demonstrate the value of the team. She said the team has a real positive can do attitude that mirrors the environment we encourage. GT presented examples of colleague contribution:-

- Encourage ideas, guidance and involvement of the whole team
- Focus on initiatives and what it means to us as a team
- Opportunities to lead projects to develop skills
- Opportunities to present at internal and external meetings to share our practice/success
- Robust mentoring and buddy system
- Star of the month/appreciation month/REN inclusion/thank you cards

NB commented as Director of R&D he is massively proud and pleased to be part of this team. The team have developed an exceptional external reputation. He thanked the Committee for giving the team opportunity to highlight what they do. KH endorsed NB comments agreeing the team absolutely punches way above their weight.

OUTCOME: The Committee **NOTED** the presentation.

72/22 **MATTERS ARISING**

EST Fire Safety Training

KR and KZ provided a comprehensive update on fire safety training compliance. The Committee noted currently there are 660 non-compliant colleagues. A paper describing how to maximise training is to be presented to the Executive Board.

JE suggested KR and KZ pick up a conversation with the Directors of Operations following discussions held this morning. KH commented 1,000 trained fire wardens is impressive. She recognises the seriousness and importance notwithstanding the challenges. KH requested the Committee receives a compliance summary table is provided to the Committee on a monthly basis. JE advised output from the Education Committee confirms our core training programme is sound and compares favourably with other Trusts. The challenge is more around the role specific EST which has grown significantly.

ACTION: 3 x monthly updates to be provided to the Committee (KR)

OUTCOME: The Committee **NOTED** the update.

73/23 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – MAY 2023**

Summary
Performance on workforce metrics is now back to amber and the Workforce domain has increased to 63.8% in April 2023. This is due to the inclusion of the non-medical colleague appraisal compliance and the improvement in all other EST modules including Learning Disabilities. 7 of the 14 current metrics that make up the Workforce domain score are not achieving target – Non Covid Sickness Absence, Non Covid Long Term Sickness, Data Security Awareness EST compliance, Fire Safety EST Compliance, Safeguarding EST Compliance, and Medical & Non-Medical appraisals.

Workforce – April 2023
The Staff in Post has decreased slightly at 6276 which, is due, in part to 20.57 FTE leavers in April 2023. FTE in the Establishment was 6091.4 and along with student nurses.
Turnover decreased to 7,92% for the rolling 12-month period May 2022 to April 2023. This is a decrease on the figure of 8.07% for March 2023.

Sickness absence – April 2023

Please note, from 1 April 2022 the workforce domain 12-month rolling, and in-month absence target is 4.75%. This relates to non-Covid absence only, albeit a rate inclusive of Covid related absence will continue to be reported. The target for non-Covid long term absence is 3.00% and 1.75% for non-Covid short term absence.

The in-month Non Covid sickness absence decreased to 4.38% in April 2023. However, the rolling 12-month rate for Non Covid sickness also decreased to 4.80% in April 2023

Stress, anxiety, and depression problems were the highest reason for sickness absence, accounting for 32.66% of sickness absence in April 2023, with Chest and respiratory problems second highest at 13.96% in April 2023. The RTW completion rate has been removed as a target metric from November 2022 although will continue to be monitored.

Essential Safety Training – April 2023

Performance has increased in all but 1 out of 10 of the core suite of essential safety training. With 9 out of 11 above the 90% target with 3 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%, but has increased to 90.91%

Learning Disabilities Awareness EST commenced from 10 May 2022, however, is now included in Overall EST Compliance score or Domain Score totals

Overall compliance decreased to 93.46% from 93.82% and is the first decrease month on month. It is however also no longer above the stretch target of 95.00%.

Workforce Spend – April 2023

Agency spend decreased for the month to £0.94M, whilst bank spend decreased in month by £0.12M to £3.01M.

Recruitment – April 2023

2 of the 5 recruitment metrics reported reached target in April 2023. The time for Unconditional offer to Acceptance in April 2023 increased to 4.7 days.

MB advised from this date forward the report will be presented in a changed format.

PB noted the 60% medical appraisal figure (rolling data). DB confirmed appraisal was 99% as at 31 March 2023. The recording discrepancy will be discussed at the next Medical Workforce Programme meeting.

KH commented on the high sickness rates in Estates & Ancillary. MB responded this is a small staff group that has some long-term sickness absence.

NB referenced the requirement to fill 100 vacancies to reduce agency to zero and asked if that is before a further 106 fte is added to the establishment. MB stated potentially this would be the case as the 106fte has been added to budget. LR added explanation that extra capacity that has opened across wards has been budgeted for which has increased the vacancy rate.

OUTCOME: The Committee **NOTED** the workforce report.

74/23 **QUARTERLY VACANCY DATA**

LW summarised the quarter 4 report.

- Overall Trust position 356 fte
- Medicine and FSS continues to have majority vacancies
- Trust turnover reduced to 7.98%

Hotspot focus

- Deep dive into qualified nurse vacancies. Report to be submitted 21 June 2023 to Nursing Steering Group
- Ongoing recruitment for Band 5 nurses
- ED – Refreshed adverts have generated more interest
- Radiology – good success
- Stroke Medicine – unable to source suitable candidate. Appointment of Specialty Doctor with the intention to support through CESR programme to Consultant position.
- Neurology – Consultant resignation. Post advertised and interview scheduled. Further appointments required to sustain the service.

KH thanked LW for the in-depth report which demonstrates focus to ensure we get good quality candidates into the Trust. KH congratulated colleagues on the progress made.

OUTCOME: The Committee **NOTED** the presentation.

75/23 **DEVELOPING WORKFORCE SAFEGUARDS**

NB and AD provided an update on the 14 key recommendations as set out in the Developing Workforce Safeguards (2018).

- Of the 14 recommendations, 10 recommendations are now fully compliant. This is an improving position since the last update (recommendation 5 now compliant)
- 4 recommendations remain partially compliant, with recommendation 8 progressing to green for nursing and midwifery.
- Effective workforce planning has a positive impact on quality of care and patient, service user and staff experience, while ensuring financial resources are used efficiently.
- Accurate plans will help predict the numbers of healthcare workers required to meet future demand and supply and help with improvements in safe and effective care delivery.

NB explained in planning for the industrial action each directorate determined safe staffing levels for their areas which can be translated through the Medical Workforce Programme group formalise as local benchmarking. A wider piece of work around Royal College of Physicians standards and GIRFT benchmarking measures can also be used as proxy measures for safe staffing. NB commented on the recruitment focus in ED and the WYAAT led work to address some of the fragile specialties.

AD confirmed the position has been maintained since last reporting into the Committee and confirmed recommendation 8 has now been completed. Good progress has been made. KH was pleased to see the improving position. The Committee agreed it no longer required to receive a regular report and confirmed an exception report should be received regarding any escalated issues. LR confirmed an annual statement is required.

OUTCOME: The Committee **NOTED** the report.

76/23 **NURSING AND MIDWIFERY SAFER STAFFING REPORT**

AD presented the key points of the report.

- Based on the current Nursing and Midwifery recruitment strategies, May's vacancy position sits at 201.28 FTE, a deteriorating position since the last report. This position does not include the planning assumptions associated with the bed retraction plans.
- Whilst noticeable peaks in sickness absence are reported during the 12-month reporting period, there is a positive reduction in sickness absence for Month 12 across both workforce groups

- Staffing fill rates continued to fluctuate between 82% - 90% during the day. A position reflective of ongoing sickness/absence, additional capacity areas and enhanced service delivery in some areas
- The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs. Benchmarking from the Model Hospital suggests at a Trust level CHFT sits in the upper part of quartile 2, positioned between peers. This is reflective of the ongoing fill rate position.
- During the reporting period 284 Nursing and Midwifery staffing related incidents were reported through the Datix reporting system. Two hundred and eighty-two (282) of these incidents were reported as no harm and 2 as minor harm. There was appropriate escalation when the incidents occurred.
- The Trust's International Registered Nurse recruitment campaign continues at pace with ongoing success, expanding into both Midwifery and AHP services
- The Trust remains committed to reviewing the roles and function within teams, demonstrated through approval in providing ongoing investment for a further 19 registered nurse degree apprenticeships.
- The retention initiatives that have been identified
- The continued focused leadership to support this agenda.
- The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas.
- Risk 6345 describes the current risk associated with insufficient Nursing, Midwifery and Health Care Support workers and is reported at level 20

LR added for assurance there is an additional recommendation that will be added to the Maternity appendix to commission a full review by birth rate to ensure acuity and continuity models are reflected in the service.

KH thanked AD for a thorough and comprehensive report.

OUTCOME: The Committee **NOTED** for assurance and **APPROVED** the content of the report prior to presentation at the Board of Directors.

77/23 **TRADE UNION FACILITY TIME**

JE presented a report that set out reporting requirements for public sector organisations in relation to paid trade union facility time and the Trust's data for the period 1 April 2022 to 31 March 2023.

- The Regulations require public sector employers (including NHS Foundation Trusts) to publish the cost of paid facility time taken by employees acting as staff side representatives
- Employers must report the required information for each 12-month period from 1 April to 31 March on public websites, in annual reports and via gov.uk
- The Trust introduced a Recognition and Facilities Agreement in January 2019 which sets out clear procedures on time off for trade union duties
- For 2022/2023 the Trust is reporting 1312.5 hours for 20 representatives with an estimated cost of £44,339.12
- According to NHS Employers the unofficial benchmark set by Government is 0.06% of the paybill. This year the Trust's percentage is 0.012%

OUTCOME: The Committee **NOTED** the report.

78/23 **FREEDOM TO SPEAK UP ANNUAL REPORT**

JE presented the report which outlined FTSU activity in the Trust from 1 April 2022 to 31 March 2023.

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

The subjects of the concerns raised are extremely varied however there are some common themes. Attitudes and behaviours of colleagues remains one such theme. This reporting period has also seen an increase in concerns related to patient safety and the quality of care being delivered. The increase correlates with the high operational activity experienced by the organisation. An NGO FTSU e-learning package has been developed in collaboration with Health Education England. A communication was produced to inform colleagues of its existence on ESR and details of the training has been added to the FTSU pages and training pages on the intranet.

NB noted the common theme of attitudes and behavours in colleagues and asked if a reduction in the number of concerns expressed as we embed one culture of care across the organisation. JE feels more people are coming forward as a consequence of one culture of care and expectations of behaviour. In addition, demands on people inside and outside the workplace appear to have an effect on people's behaviours. We need to use the information available to further inform the importance of one culture of care. AG supports colleagues and underpins their concerns and focuses on demonstrating a full response to the concerns. As Board Safety Champion for Maternity services, LR is positive about the colleagues speaking up as it is important they do have a voice and feel listened to.

OUTCOME: The Committee **NOTED** the contents of the report, the number of concerns raised in 2022/2023 and the work of the FTSU Guardian and Ambassadors.

79/23 **BAF DEEP DIVE 12/19 COLLEAGUE ENGAGEMENT**

SD presented the deep dive. Key controls have been examined and a summary of progress was provided. Hot House events, walkarounds, appreciation and wellbeing events and surveys will ensure that the activity that we are focussing on is the right intervention to support colleagues at the appropriate time. One Culture of Care charters have been developed and adopted by all service teams across the Trust. A structured leadership visibility programme that aligns to the inclusion and engagement event calendar is in place. A Leadership Framework has been developed with input from colleagues.

Gaps in Control - Colleagues work in a busy, challenging environment. Colleagues' mental health has been impacted post pandemic. Cost of living challenges have also had a huge impact on colleague sense of wellbeing.

Gaps in Assurance - Staff Survey results identified that a number of hot spot service areas require intensive support. High impact action plans have been developed. One high impact action is to ensure colleagues are supported to work on their people priorities, have a robust action plan in place to improve employee engagement, appoint a local engagement lead who is accountable to implement change and an executive buddy to guide, coach and connect them to areas of good practice. The Team Engagement and Development (TED) diagnostic tool will be deployed to drive/support conversation and improvement.

The risk rating has been reviewed and remains the same.

KH noted the updated actions and the positive progress made.

OUTCOME: The Committee **NOTED** the deep dive.

80/23 **WORKFORCE COMMITTEE ANNUAL REPORT**

JE presented the report for consideration and approval prior to submission to the Board of Directors in July 2023. An associated action plan will be developed and brought to the next Committee meeting.

ACTION: Develop Workforce Committee Action Plan (JE/TR)

OUTCOME: The Committee **AGREED** the content of the Annual Report.

81/23 **WORKFORCE COMMITTEE WORKPLAN**

KH referenced the themed approach at the Committee.

OUTCOME: The Committee **REVIEWED** the Workplan.

82/23 **ONE CULTURE OF CARE – MEETING REVIEW**

JE noted the excellent time keeping of a compact agenda.

One culture of care has been woven in through every aspect of every agenda item.

83/23 **ANY OTHER BUSINESS**

No other business was discussed.

84/23 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

KH will present the highlight report to the Board capturing the key engagement themes along with the staffing reports, FTSU, BAF and the Committee's annual report.

85/23 **DATE AND TIME OF NEXT MEETING:**

Workforce Committee Hot House:
13 July 2023, 2.00pm – 4.00pm
Theme: Colleague Engagement/Recognition/ Appreciation/Staff Survey

Workforce Committee:
23 August 2023, 2.00pm – 4.00pm
Chapter: Talent Management

DRAFT

Minutes of the Extra-Ordinary Audit and Risk Committee Meeting held on Tuesday 27 June 2023 commencing at 2:00 pm via Microsoft Teams

PRESENT

Nigel Broadbent **(NB)**	Non-Executive Director **(Chair)**
Denise Sterling **(DS)**	Non-Executive Director
Peter Wilkinson **(PW)**	Non-Executive Director

IN ATTENDANCE

Helen Hirst	Chair
Brendan Brown	Chief Executive
Andrea McCourt	Company Secretary (minutes)
Kirsty Archer	Executive Director of Finance
Helen Higgs	Head of Internal Audit, Audit Yorkshire
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Ric Lee	Audit Director, KPMG
Matthew Moore	Senior Manager, KPMG
Victoria Pickles	Director of Corporate Affairs
Zoe Quarmby	Assistant Director of Finance
Liam Stout	Staff Governor

Chair Approved Minutes

36/23 APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the extra-ordinary Audit and Risk Committee meeting to sign off the Annual Report and Accounts for 2022/23 which has been delegated to this Committee by the Board of Directors.

37/23 DECLARATIONS OF INTEREST

The Chair reminded the Committee to declare any items of interest at any point in the agenda.

38/23 MINUTES OF THE MEETING HELD ON 25 APRIL 2023

The minutes of the meeting held on 25 April 2023 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 25 April 2023.

39/23 ACTION LOG AND MATTERS ARISING

The action log was reviewed and updates were noted.

Item 26/23 Internal Audit revised template for reports – it was noted that we would continue with current reporting and review during the year.

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

40/23 ANNUAL REPORT AND ACCOUNTS

a) Going Concern Report

The Director of Finance presented the Going Concern report which refers to the basis on which an organisation's assets and liabilities are recorded and included in the accounts. The Director of Finance confirmed it remains appropriate to prepare the accounts on a going concern basis.

OUTCOME: The Committee **APPROVED** the Going Concern Report.

b) Audited Annual Accounts and Financial Statements

The Director of Finance presented the Audited Annual Accounts and Financial Statements for the year ended 31 March 2023. KPMG colleagues have had the opportunity to review and comment on the accounts and statements.

The Director of Finance highlighted the difference in the financial information presented to the Board and the Finance and Performance Committee as a regulatory position, compared to the year-end accounts position, with the key material difference being the impact of net impairments at £7.4m, which are excluded from regulatory reporting performance to NHS England (NHSE).

The Director of Finance celebrated achievement of the final position in line with the financial plan during a challenging year, but noted this had largely been achieved by non-recurrent solutions which poses a financial challenge for 2023/24. It was also noted that some technical changes to the accounts have been made since the draft submission to NHSE; these are detailed in KPMG's ISA 260 report but do not change the revenue position reported at the end of month 12.

PW asked what the big shift and changes in non-current assets had been between 2021/22 and 2022/23. The Director of Finance responded that a significant change related to the implementation of IFRS 16 which changes the accounting of lease transactions, which previously were an annual revenue charge (income and expenditure) and are now treated as an asset, akin to a capital purchase with depreciation and interest. Other reasons noted by the Director of Finance were capital in-year purchases and year end revaluations. The Assistant Director of Finance commented the revaluation of buildings had increased the building values in year.

It was noted that national guidance was awaited on the impact of IFRS 16 on PFI accounting.

The Chair had undertaken a detailed review of the accounts and financial statements with the Director of Finance prior to the meeting. The Director of Finance shared further details on the £7.4m impairment in response to a question from the Chair. The Assistant Director of Finance confirmed, in response to a question from the Chair, that following a review of the potential impact of IFRS17 on insurance contracts we were not expecting a material change in 2023/24. The Chair queried whether there was any concerns relating to recovery given the increase in receivables in 2022/23. The Director of Finance responded that this related to timing at the year end, with the material change being the Agenda for Change pay award which was in flux at the year end.

OUTCOME: The Committee **APPROVED** the Audited Annual Accounts and Financial Statements for the year ended 31 March 2023.

c) Letter of Representation

The Director of Finance presented the letter of representation that the Trust is required to submit and includes standard wording on how the accounts have been prepared and on what basis. The Letter of Representation will be signed off by the Chief Executive.

AM advised of two changes required to the final Letter of Representation post-meeting, the first being that the letter was tabled at an Extra-Ordinary meeting of the Audit and Risk Committee (rather than the Board), the second being the addition of the Chief Executive's name as signatory.

Matthew Moore, KPMG highlighted that Appendix 1 regarding unadjusted mis-statements referred to in the letter needed to be copied across from the draft letter.

Action: Company Secretary to amend the Letter of Representation

OUTCOME: The Committee **APPROVED** the Letter of Representation as amended.

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d) Annual Governance Statement (AGS)

The Company Secretary reported that the 2022/23 Annual Governance Statement (AGS) was reviewed and approved by the Audit and Risk Committee on 25 April 2023. The Annual Governance Statement has been developed in line with NHS England guidance.

The statement described the Trust's system of internal control that has been in place during 2022/23. It has been reviewed at various stages by the Chief Executive, Executive Directors, Internal and External Audit as well as the Audit and Risk Committee.

The Annual Governance Statement confirmed the Trust had no significant control issues in the financial year 2022/23, a position consistent with the Head of Internal Audit Opinion and KPMG Year End Report detailed in the papers. The statement references the six internal audit reports with a limited assurance opinion as advised by Internal Audit. Subject to approval the statement will be uploaded to NHS England by Friday 30 June 2023.

A discussion took place about whether to include work underway on the Risk Management Strategy and it was agreed that this was ongoing and would be reflected in the 2023/24 Annual Governance Statement.

In response to a question from the Chair regarding collaborative procurements by groups or a number of Trusts, the Director of Finance advised that governance arrangements were followed by individual Trusts in parallel to the collaborative arrangements to ensure all parties had approved decisions prior to procurement.

The Chair and Chief Executive thanked colleagues for the work on the year end statements on their behalf.

OUTCOME: The Committee **APPROVED** the Annual Governance Statement.

Liam Stout left the meeting.

e) Annual Report 2022/23

The Company Secretary presented the Annual Report for 2022/23 which has been developed in line with the NHSE Foundation Trust Annual Reporting Manual.

There were three changed requirements from national guidance that have been included in the annual report which were:

- addition of reference to joint forward plans and capital resource plans of the system
- information on the Trust's approach to tackling health inequalities
- fair pay disclosures - addition of prior year comparatives

The final annual report and accounts include a Performance report, Accountability report, annual accounts and auditor's report that will be added subject to approval today.

A detailed review has taken place by NB, DS and PW and their feedback is incorporated which has been helpful in ensuring the information is understandable for the public.

External Audit has completed their audit review of the annual report. Queries and changes arising from this review have been incorporated. The Company Secretary advised that, following advice from Information colleagues received after the papers were issued, there was one final change to the quality account priority section in relation to one of the targets for treatment of sepsis (p 170 Convene) which changed from being partially met to not being met. This was as follows:

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The target of 80% for the administration of antibiotics within an hour of clinical assessment in the Emergency Department (ED) was not achieved with average compliance at 49.1%.

A minor addition to the Remuneration report within the annual report was noted, with information on benefits in kind in relation to salary sacrifice to be included.

The Company Secretary confirmed an annual report summary is being developed which it is intended to publish on the Trust website at the same time as the annual report. This was welcomed by members.

External audit has confirmed the content of the annual report meets all requirements and, subject to approval, the plan was to submit this to NHSE by Friday 30 June 2023.

The Company Secretary confirmed the Annual Members Meeting where the accounts are formally shared will be held on Thursday 25 July 2023, subject to the annual report and accounts being laid before Parliament by 14 July 2023.

PW advised he had had the opportunity to comment on the draft annual report and felt it was a great document, with the visuals enhancing the readability of the document. DS confirmed that Non-Executive Director comments on the draft report had been incorporated into the report and she was pleased with the final version. The Company Secretary acknowledged and thanked the finance, workforce and quality and safety team and Directors for their contributions to the report. The Chair confirmed he had also commented on the draft and reviewed national guidance, which explained the length of the report, and echoed the thanks to all involved.

OUTCOME: The Committee **APPROVED** the Annual Report 2022/23 with the amendments noted.

f) Head of Internal Audit Opinion and Annual Report

The Internal Audit Manager presented the Internal Audit Annual Report and highlighted the following key points:

- original audit plan included provision for 365 internal audit days for 2022/23 with eight days carried forward from 2021/22, giving a total of 373 days
- delivered 366 out of 373 days and the remaining seven days have been carried over to 2023/24
- 31 audit reports were finalised during the year (four high assurance reports, 19 significant assurance reports, six limited assurance reports)
- complied with the public sector internal audit standards throughout the year
- all three Internal Audit targets for 2022/23 were achieved
- the 90% target KPI in respect of receiving management responses within 15 working days of a draft report being issued was not met, at 84% - it was noted this was difficult to achieve, particularly for limited assurance reports with numerous staff to liaise with about recommendations. Actions had been taken in year at draft report stage which had improved compliance (no Audit Yorkshire clients had achieved 100%)
- positive progress with follow up of recommendations and tracking updates with support from the Chief Executive which meant no recommendations overdue at the year end, twenty with revised target dates, eleven of which are now implemented and nine on track

It was confirmed that six limited assurance reports was an acceptable number and confirmed that the selection of audit topics was appropriate.

Helen Higgs presented the Head of Internal Audit Opinion for 2022/23 which concluded an overall opinion of significant assurance for 2022/23 based on three criteria: assessment of the effectiveness of Board Assurance Framework and risk management systems, results of individual

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reviews within the audit risk-based plan and Internal Audit's assessment of the Trust's response to recommendations.

PW queried the no opinion Financial Sustainability Report and Helen Higgs confirmed that this was an advisory piece of work across all clients. Leanne Sobratee confirmed NHSE had given advice not to give an opinion. The Director of Finance gave context for the NHSE's request post pandemic when different funding regimes had been in place and advised that the report confirmed CHFT's self-assessment. In response to a query from DS it was confirmed that the self-assessment had been reviewed by Directors at the Turnaround Executive meeting and the Financial Sustainability Report (CH/11/2023) was shared at the 31 January 2023 Audit and Risk Committee.

It was noted that achieving a higher rated Head of Internal Audit Opinion (high assurance) was virtually impossible and a significant assurance opinion was a positive outcome.

OUTCOME: The Committee **NOTED** the Head of internal Audit Opinion with a significant assurance overall opinion and **NOTED** the Internal Audit Annual Report.

g) Year End Audit Report 2022/23 – ISA 260

Ric Lee, Audit Director KPMG and Matthew Moore, Senior Manager, presented the key findings within the ISA 260 Year End Audit Report for 2022/23.

The Finance team, particularly Zoe Quarmby and Kirsty Archer were thanked their co-operation during the audit process.

Ric Lee and Matthew Moore advised:

- audit work was substantially complete, with a number of final matters to be signed off, and an unqualified opinion on the accounts was anticipated as well as a clean commentary on value for money
- materiality level remains £13.6m
- outstanding areas noted in the paper were financial statements audit, final manager and Director review and agreement of the final approved financial statements
- the main area to conclude was floor area on the valuation and this was not expected to be an issue
- in terms of significant audit risks there were no issues in terms of fraud risk (expenditure) and management override of controls
- one mis-statement has been clarified
- mandatory communications were positive
- confirmation of audit independence given
- outstanding matters were not material and should be concluded by the submission deadline of noon on 30 June 2023
- recommendations were given in Appendix two, no issues re: fraud risk, recommendations included management review of journal entries and related parties and management review of the land and building valuation which had a control weakness relating to floor space inputs
- audit differences were noted in Appendix three, with two unadjusted differences that were not material and referenced in the Letter of Representation – a projected sampling error (capital creditors) and a historic difference related to the EPR system and an adjusted difference relating to HRI as an asset.

The Chair noted a past due date on the recommendation relating to land and buildings and KPMG advised that this would be corrected.
The Director of Finance was asked whether there were any other data sources that might have a material impact on the accounts that the Trust should review pro-actively in advance of next year's audit, given the Trust use of systems for data and the new standard this year, which had led to extra scrutiny and highlighted issues. She noted the contrast between areas where information was only

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available once a year (eg land and buildings) compared to other systems where more regular data allowed for continuous improvement work and cross checking. The Chair agreed we should return to this in a few months and the Director of Finance requested that Internal Audit focus on those systems we place reliance on as part of routine audits, such as the management account audit. Ric Lee supported this approach given the wider scope of the new standards to enhance the system of internal control. The Director of Finance commented that even when the action re: land and buildings re inputs is complete it will provide assurance but is unlikely to remove the recommendation.

The Chair clarified the capital creditors unadjusted difference and Matthew Moore confirmed this related to the sampling technique and advised there may be a better way to test this in future.

The Company Secretary confirmed that as these were group accounts, CHS had met earlier that morning and their 2022/23 accounts had been signed off, with some final statements to be issued. Given the ongoing queries by external audit, the Company Secretary requested that KPMG be mindful of the need to meet the noon deadline on 30 June 2023 and the work involved at the Trust formatting documents prior to submission.

The Director of Corporate Affairs left the meeting during this item.

Action: KPMG to amend due date for recommendation relating to land and buildings.

OUTCOME: The Committee **NOTED** the External Auditor's Year-End Report ISA 260.

h) Auditor's Annual Report 2022/23

Ric Lee, Director KPMG presented the draft Auditor's Annual Report which summarised the conclusion of the value for money work undertaken, noting this is a public document to be added to the Trust website by September 2023. He confirmed the report does not highlight any issues of concern to be reported to the public and was a positive report.

Ric Lee noted the purpose of the report is to provide a high level commentary on the accounts process and detailed three significant risk areas, financial sustainability, governance and improving economy, efficiency and effectiveness. He assured the Committee that no significant risks or weaknesses against these domains had been found. He highlighted a change to the paper originally presented to the Committee on 25 April 2023, relating to financial sustainability which now reflected the full year position and balanced 2023/24 financial position of the Integrated Care System, with a Trust deficit plan of £21M and challenging efficiency savings, of which £4M is yet to be identified.

OUTCOME: The Committee **NOTED** the External Auditor's Annual Audit Report.

41/23 ANY OTHER BUSINESS

The Chair formally thanked the finance team and everyone involved in the financial statements, accounts and annual report for all their hard work in preparing and completing this work. He also thanked Audit Yorkshire and KPMG and colleagues for their work in getting us to this position. This was endorsed by DS and PW.

The Director of Finance noted that with final checks outstanding, it would be prudent to advise the Chair of changes made post meeting. It was agreed that a copy of the final documents would be sent to him with the changes highlighted and, should there be anything significant, he would circulate to other members of the Committee.

42/23 MATTERS TO CASCADE TO BOARD OF DIRECTORS

The Board of Directors will be updated in due course via the Chair's highlight report of the approval of the financial statements, clean audit opinion from Audit Yorkshire and KPMG.

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43/23 DATE AND TIME OF THE NEXT MEETING

Date: Tuesday 25 July 2023
Time: 10.00 am
Via: Microsoft Teams

Chair Approved Minutes

Calderdale and Huddersfield NHS Foundation Trust

Draft minutes of the Audit and Risk Committee Meeting held on Tuesday 25 July 2023, at 10am via Microsoft Teams

PRESENT

Nigel Broadbent (NB)	Chair, Non-Executive Director
Denise Sterling (DS)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director

IN ATTENDANCE

Kirsty Archer (KA)	Director of Finance
Rob Birkett (RB)	Chief Digital and Information Officer
Victoria Pickles (VP)	Director of Corporate Affairs (minutes)
Richard Dalton (RD)	Head of Risk and Compliance
Steven Moss (SM)	Local Counter Fraud Specialist, Audit Yorkshire
Leanne Sobratee (LS)	Internal Audit Manager, Audit Yorkshire
Richard Lee (RL)	Senior Manager, KPMG
Philippa Russell (PR)	Deputy Director of Finance
Keith Redmond (KR)	Chief Technology Officer, The Health Informatics Service (for item 6)
Julian Bates (JB)	Assistant Director, Information, The Health Informatics Service (for item 6)
Peter Keogh (PK)	Assistant Director, Performance (for item 6)
Liam Stout (LS)	Staff Governor

44/23 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the Audit and Risk Committee.

45/23 APOLOGIES FOR ABSENCE

Apologies were received from Shaun Fleming, Local Counter Fraud Specialist and Andrea McCourt, Company Secretary.

46/23 DECLARATIONS OF INTEREST

There were no declarations of interest.

47/23 MINUTES OF THE EXTRA-ORDINARY MEETING HELD ON 27 JUNE 2023

The minutes of the extra-ordinary meeting held on 27 June 2023 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 27 June 2023.

48/23 MATTERS ARISING AND ACTION LOG

The action log was reviewed and updated accordingly. There were no other matters arising.

OUTCOME: The Committee **NOTED** the updates to the Action Log and matters arising.

DRAFT

49/23 DEEP DIVES

DATA QUALITY

JB gave a presentation on the annual review of the Data Quality Board (DQB). He highlighted that the Board meets every six weeks and has several standing agenda items including audit of key performance indicators, exception reports on mandatory notices, clinical quality audits, areas of data quality concern from the chief clinical information officer and chief nursing information officer, clinical coding, and information standard notices.

JB set out the key successes achieved through the work of the DQB including upkeep of external mandatory returns and a robust audit process of these; the implementation of the new Integrated Performance Report (IPR); a road show of the work of data quality and the policy which had good attendance and engagement; and specifics relating to completion of activity data by the clinicians working on the acute floor. He added that the DQB continues to be well attended and there is good engagement in its work.

JB described the future priorities of supporting timely discharges using the capacity management functionality in the Electronic Patient Record (EPR) and improving the process that links the EPR to the national spine.

PK referenced the positive impact that data quality has had on the Trust's recovery position and the significant progress the Trust has made in addressing health inequalities in access to elective care.

DS commended the work of the DQB and the improvement that has been made in activity capture and asked about the benefits of the new benchmarking package. PK responded that the package is easily searchable and clearly broken down into topics that can then be compared using Statistical Process Control (SPC) charts against a variety of groupings such as regional organisations, all acute trusts, or outstanding organisations. PW commented on the new IPR and the impact that this has had on focusing board discussions.

It was agreed that further discussions were needed to consider the financial information reviewed through the DQB and how this could be broadened. JB highlighted that the new sources of financial information were being considered by the DQB including the Private Health Information Network data and best practice tariff.

NB asked how the DQB determines its priorities. JB responded that there was a plan on a page setting out the key objectives to be addressed, alongside issues identified through inquiries and other sources. PK added that the data quality policy also identifies areas for focus.

CYBER SECURITY

KR gave a presentation on how the Trust approaches cyber security. He set out the range of activity to identify, manage and mitigate the Trust's vulnerability to cyber activity. He explained that The Health Informatics Service (THIS) is credited to ISO27001, the national standard, and that there is a range of work associated to maintain compliance with this and other standards.

KR set out the key threats to the Trust including malware emails, and more recently supply chain attacks, and explained the external and internal security arrangements in place. The Committee noted the volume of potential cyber threats that take please each month, including over 240,000 emails which are blocked. He highlighted the risks and in particular the human factors involved.

KR explained that an external review had been undertaken of the Trust's cyber security arrangements which demonstrated that the Trust has all but one control area above the average score for the NHS. This relates to supplier control management and significant progress has been made to ensure that contract management has been strengthened as a result.

PW asked about the external review timescales. KR responded that the external review was an annual one but that internal reviews are done regularly, and there are further reviews in line with the Data Security and Protection Toolkit (DSPT), which identify opportunities for improvement.

NB asked about other suppliers. KR responded that nationally there is a set of standards and criteria for suppliers. NB also asked about resources to respond to and manage the threats. RB explained that there has been significant investment in the team and tools to support this work. Areas to be strengthened include work to protect clinical systems further and recruitment is underway for a Clinical Systems Officer.

PW asked about the risks associated with being part of the wider NHS. KR replied that the communication with the wider network is tightly controlled and there are several fire walls in place.

OUTCOME: The Committee **NOTED** the deep dive information on data quality and cyber security and the progress made in both areas.

50/23 APPROVAL OF STRATEGY AND POLICIES

Risk Management Strategy
RD presented the revised Risk Management Strategy, which had been updated to include the revised information flows, roles, and risk appetite.

NB asked about how the effectiveness of risk management processes are monitored and assurance received. RD replied that there is a dashboard being developed in KP+ which will set out some indicators to demonstrate compliance with the policy. He added that dedicated risk management resource had been put in place and that revised training was being rolled out widely across the Trust. VP added that the Committee assurance on compliance with risk management processes would be through data to demonstrate that risks are being regularly reviewed, risk scores adjusted, new risks being identified, and risks closed.

OUTCOME: The Committee **APPROVED** the Risk Management Strategy.

51/23 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review of Losses and Special Payments
The Director of Finance noted that the largest sum related to pharmacy wastage, which is closely monitored, and that there would be a special focus on this at Cash Committee. She highlighted the small increase in loss of personal affects and that there is work to implement measures to reduce these losses. Further information has been sought on the IT losses relating to a flood, however this is not a significant sum.

NB asked about the losses relating to personal affects and requested that further information to be brought back on the actions to mitigate these losses. NB also asked for a previous year comparator to be included in future reports relating to both the number and the value.

ACTION: KA

OUTCOME: The Committee **NOTED** the review of Losses and Special Payments report

2. Waivers of Standing Orders Report

The Director of Finance presented the waivers of standing orders report and highlighted that the contract management systems had supported the reduction in single sources over the threshold. She explained that the single sources below threshold related to GP contracts for contraceptive services which were call off orders and therefore not of concern.

OUTCOME: The Committee **NOTED** the waivers of standing orders.

3. Revisions to Standing Financial Instructions

The Deputy Director of Finance set out the revisions to the Standing Financial Instructions in relation to authorisation of expenditure. She explained that these have been split out into new expenditure and authorisation of transactions within budget. In addition, any reference to Estatecode has been removed and updated with the relevant current terminology. She referenced that there would be an update to the Scheme of Delegation because of these changes to be included on the work plan for October.

ACTION: VP

NB asked a question in relation to asset disposals and the requirements around best value. KA responded that the exceptional nature of agreeing anything other than best value would require committee approval. A typo was also noted in appendix 2 to be amended from £50,000 to £500,000.

ACTION: PR

OUTCOME: Subject to this small amendment, the Committee **APPROVED** the revisions to Standing Financial Instructions.

52/23 INTERNAL AUDIT

1. Review Internal Audit Follow-up Report

LS presented the report and commented on the significant progress made on updating recommendations – 143 (83%) had been completed; 10 were past the original target date, many of which related to policy or strategy approval which has since taken place and only one was overdue. NB commented that it was good to see the positive movement in recommendation compliance.

OUTCOME: The Committee **APPROVED** the Internal Audit Follow-up Report

2. Internal Audit Progress Report

LS explained that the audit plan was on track, with 10% of the audit days being used to date in line with the phasing of the plan. Two reports had been completed relating to vehicle and compliance with an ISO standard, both of which had achieved high assurance. LS noted that key performance indicators were good.

OUTCOME: The Committee **RECEIVED** the Internal Audit Progress Report

3. Limited assurance report

LS explained that there were five internal audit reports not previously seen by the Audit and Risk Committee, but which had been included in the Head of Internal Audit Opinion. One report had received limited assurance in relation to systems and processes for people undergoing invasive procedures. The audit had identified several actions including

updating of the handbook, training, completion of checklists and audit. LS referenced similar audits in other Trusts which had also received limited assurance.
It was agreed that, as many of the actions were due in October, the executive lead for this audit would be invited to attend the next meeting to provide an update on progress.

ACTION: AMc

OUTCOME: The Committee **NOTED** the Limited Assurance Report

4. Internal Audit Monthly Insight Report 2023

The Monthly Insight Reports were provided for information. NB highlighted that there may be areas that the Committee would like to consider and include on future workplans, for example around sustainability reporting.

53/23 BOARD ASSURANCE FRAMEWORK

VP highlighted that, due to timing of meetings, the current Board Assurance Framework had been signed off by the Board of Directors in July, except for new risk 04/23 relating to compliance with national performance standards. NB added that the Board had also asked for the scoring of risks 03/23 Partnership Governance and 10/19 Nurse Staffing to be reviewed ahead of the next meeting in October.

NB asked whether a strategic risk relating to cyber security should be added. It was agreed to consider this particularly in relation to the Trust being a digitally mature organisation and present this for review at the October meeting.

ACTION: RB / VP

OUTCOME: The Committee **RECEIVED** the Board Assurance Framework

54/23 COMPANY SECRETARY BUSINESS

1. Terms of reference

NB confirmed that the terms of reference had been updated to reflect partnership arrangements and working with other committees, alongside other minor changes.

OUTCOME: The Committee **APPROVED** the Terms of Reference

2. Audit Chair Job Description and Role Specification

The job description had been updated to include working with the Quality Committee Chair and responsibilities in relation to leadership.

OUTCOME: The Committee **APPROVED** the Audit Chair job description and role specification

3. Audit and Risk Committee meeting dates

OUTCOME: Subject to an amendment to the July date, the Committee **NOTED** the future meeting dates

4. Work plan

It was noted that some of the dates needed to be adjusted on the work plan, that the date of review of Standing Orders, Standing Financial Instructions and Scheme of Delegation should be moved to 2025, and that a series of deep dive topics should be added.

OUTCOME: The Committee **AGREED** that an updated work plan should be circulated.

55/23 LOCAL COUNTER FRAUD

1. COUNTER FRAUD ANNUAL REPORT 2022/23

SM presented the annual report setting out the Trust's compliance with the 13 standards and progress against these over the last three years. He explained that the Trust is fully compliant with 12 of the requirements. Partial compliance related to embedding the prescribed fraud risk assessment. It was noted that the assessment had been signed off by the Director of Finance and Chair of the Audit and Risk Committee.

OUTCOME: The Committee **RECEIVED** the Counter Fraud Annual Report 2022/23.

2. LOCAL COUNTER FRAUD PROGRESS REPORT

SM reported that work in the first quarter of the year has focused on awareness and referenced issues that are identified across Audit Yorkshire. He referenced that cyber crime has arisen as a risk and there is a range of activity being undertaken in relation to highlighting awareness of cybercrime.

PW asked for clarification on secondary working. SM responded that this is in relation to working for other organisations while at home or on sick leave.

NB asked about the masterclass programme and the outcomes in relation to referrals and reports of fraud. KA confirmed that these are promoted specifically to teams and more generally to the wider organisation, however given that the Trust has a relatively stable workforce, there needs to be consideration of how frequently people should undertake this training, alongside the essential safety training. SM agreed that more information would be included on who has completed this training and who has attended more specific meetings or briefings.

ACTION: SF

OUTCOME: The Committee **RECEIVED** the local Counter Fraud progress report.

56/23 EXTERNAL AUDIT

RL confirmed that KPMG had completed the report, with no change in the final opinion, no significant issues, and a clean audit, in line with the deadline.

OUTCOME: The Committee **NOTED** that the external audit had been completed with no change to the opinion.

57/23 SUMMARY REPORTS

A summary report of work undertaken since April 2023 for the following groups and minutes of these meetings were made available in the review room:

1. Information Governance and Risk Strategy Group
2. Health and Safety Committee
3. Data Quality Board

It was noted that reports from the CQC Group, Compliance Group and Risk Group had not been received and would be requested for the next meeting.

OUTCOME: The Committee **NOTED** the summary reports for the above groups.

58/23 ANY OTHER BUSINESS

There were no other items of business

59/23 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Work of the data quality board and cyber security and successes achieved.
- Approved the Risk Management Strategy
- Approved the revisions to the Standing Financial Instructions
- Reviewed the BAF and consideration of a risk in relation to cyber security.
- Approved the TORs and Chair's job description.
- Approved the Counter Fraud annual report.
- Process on clinical audit to be reviewed at Audit and Risk Committee
- Progress on internal audit recommendations compliance

60/23 REVIEW OF MEETING

Attendees of the committee commented on the good work demonstrated through the deep dives. It was agreed to build more of these into the work plan. VP suggested that these be mapped against the strategic risks on the Board Assurance Framework. It was noted that the timing of the meeting meant that the agenda would be lighter given the point in the year.

DATE AND TIME OF THE NEXT MEETING

Tuesday 24 October 2023 10.00 – 12.30 pm – MS Teams

The meeting closed at approximately 11:55.

Attendance log 2023/24

	April	June (ARA)	July	Oct	Jan	Total
Member						
Nigel Broadbent (Chair)	x	x	x			
Denise Sterling	x	x	x			
Peter Wilkinson	x	x	x			
Attendee						
Kirsty Archer	x	x	x			
Rob Birkett	x	-	x			
Gary Boothby	-	-	-			
Richard Dalton	x	-	x			
Andrea McCourt	x	x	-			
Victoria Pickles	x	x	x			
Leanne Sobratee (Audit Yorkshire)	x	x	x			
Richard Lee (KPMG)	x	x	x			
Shaun Fleming (Counter Fraud)	x	-	Steven Moss			
Liam Stout (Governor)	-	x	x			

Minutes of the Charitable Funds Committee meeting held on Wednesday 10 May 2023, 11.00 – 12.30pm via Microsoft Teams

Present

Helen Hirst (HH)	Chair
David Birkenhead (DB)	Medical Director
Nigel Broadbent (NB)	Non-Executive Director
Lindsay Rudge (LR)	Chief Nurse

In attendance

Vicky Pickles (VP)	Director of Corporate Affairs (Minutes)
Emma Kovaleski (EK)	Charity Manager
Zoe Quarmby (ZQ)	Asst Director of Finance – Financial Control
Carol Harrison (CH)	Charitable Funds Manager

13/23 **Welcome and apologies for absence**

The Chair welcomed everyone to the meeting. Apologies were received from Kirsty Archer and Adele Roach.

14/23 **Declarations of interest and independence**

All present declared their independence and there were no declarations of interest.

15/23 **Minutes of the meeting held on 10 May 2023**

Outcome: The Committee **APPROVED** the minutes of the last meeting.

16/23 **Action log and matters arising**

The following items from the action log were discussed:

- 15.02.23 – 6 Steering Group: Awaiting names to finalise the Steering Group invitations.
- 15.02.23 – 10 Hospital Radio: The original request had been rejected. This action was therefore closed. Further discussions would take place with Hospital Radio colleagues about any future support. This action was closed.
- 10.05.23 – 3 Bereavement support service: CH confirmed that the approval had been set up for a further six months to March 24. This action was closed.
- 10.05.23 – 4 Terms of reference: these had been included with the papers for the meeting. This action was closed.

17/23 **Terms of reference**

VP highlighted that, subject to the terms of reference being approved, the Chief Operating Officer would be invited to join the Committee. It was agreed to amend the reference to Operational sub group to Steering Group. The Steering Group terms of reference would be updated to reflect the equality network groups.

ACTION: VP / EK

Outcome: Subject to these amendments, the Committee **APPROVED** the terms of reference.

18/23 **Charity Manager's Report**

EK presented the report and highlighted the overview against the action plan which demonstrated progress against the brand identity, fundraising, grant operations and collaboration during quarter one. She explained that quarter two will look at diversifying income, donor acquisition and continuing internal and external collaboration.

EK highlighted the proposed brand refreshed and that this had been developed using a consultative approach with internal and external stakeholders. The new brand provides an opportunity to reset post covid and uses 'amazing' and 'positivity' as the key hooks.

EK referred to the draft Strategy which sets the goals and purpose of the Charity EK pointed out that the brand is more than a logo and is part of a whole new approach to the management and impact of the Charity that will also demonstrate case studies as to how the Charity has impacted on improvements in patient care and cost efficiencies. She referenced the new kit funded by the Charity in the MRI department at Calderdale providing distraction which had resulted in a general anaesthetic not being required for 27 patients.

It was noted that the Strategy will support conversations with community partners going forward.

VP reinforced the message that the brand provided an opportunity to reset the Charity and its purpose moving forward. LR added that she liked the simplicity of the message of the brand and that it sets the context for the Charity.

HH asked a question about the implementation of the branding and the need to ensure that there is not waste of existing branded information. VP responded that the Trust does not carry significant levels of stock and there is a plan to implement from January which means that there is six months to phase out the new brand. EK there is an implementation plan that considers all the resources that will be phased out and that focuses on internal and external communication.

ACTION: EK

The Committee discussed the draft Strategy. HH asked about the read across to the Trust strategy in relation to the four pillars. EK responded that it was purposefully different to the Trust Strategy but that we would include reference to the Charity's position within the Trust. She explained that a feasibility study had been commissioned from Gifted Philanthropy as part of the development grant from NHS Charities Together which would also provide feedback on and input to the Strategy.

Other comments included:

- Rewording in relation to being lucky to have the NHS.
- Review of wording relating to going above and beyond and comment about others within the organisation
- Ensuring the imagery and photography is representative of the Trust and its communities.
- Clarity on four or five priorities.

Overall, the Committee were supportive of the Strategy and liked its clarity and purpose.

EK provided an overview of the fundraising activity during the previous quarter including the Big Walk which had doubled in participants over the previous year and commented that there had been a good start to the year. She also set out the planned events over

the remainder of the year. HH recognised the importance of these events for profile raising and the inclusive nature for colleagues.

EK highlighted the work to formalise the new governance arrangements and that a new suite of documents, guides and forms will be launched. She added that budget is monitored as to where donations are coming from to learn from and focus future efforts, for example in memoriam giving is one of the biggest sources of funding and there will be a legacy campaign later in the month. Further work is required to develop impact reporting.

It was noted that the Charity works well with NHS Charities Together, which is supporting NHS Charities with support and development. EK reported that, along with VP, she would be presenting at the Leadership Conference on 28 September on collaboration in smaller charities. EK pointed out that a stage three grant had been received for a wellbeing garden at Huddersfield Royal Infirmary and that this was progressing. A further green space grant was being sought for the spaces at Calderdale Royal Hospital.

NB asked about grant funding in NHS Charities together and their monitoring of grants. EK confirmed that they ask for updates and evidence against the allocated funding but are also helpful in terms of repurposing grants and supporting the Trust to spend the money.

OUTCOME: The Committee **RECEIVED** the report and **APPROVED** the proposed brand. The Committee **COMMENTED** on the Strategy and noted that it would come to the November meeting prior to presentation to the Board.

19/23 **Finance Report**

CH presented the finance report which showed £50k received in donations and that there had been an investment gain. She highlighted that the overall movement is a decrease of £30,774, which is positive as it demonstrates that the funds are being used.

Discussion took place on the outstanding commitments report which showed the commitments made, when these had been approved and whether these had been spent. NB asked what happens when there is no movement in a fund after an approval has been made. CH confirmed that these are all followed up and if there is no response after contact has been made three times, the funds are repurposed.

HH suggested that approvals included a timeline for approval. CH explained that the new guidance has a time limit around the spend of 12 months. EK commented that new grants arrangements will be more of a managed process with clear monitoring and approval. HH commented that in future reports running costs and salary costs should be pulled out separately.

ACTION: CH

NB highlighted the need to take a longer-term view of the financial plan. EK responded that this would be picked up as part of the development work commissioned for the Charity as referenced in the Charity Manager's report.

VP raised the issue of inactive funds. CH responded that she used to do an inactive fund review every two years, but that EK had now picked this up in conversation with individual fund advisors. CH highlighted the need to consider what is an active fund. HH commented that there is a need to ensure that funds are being spent appropriately and are working for the Trust.

LR commented on the funds and the need to look at a more strategic view across the Trust and develop spend plans so that there is greater equity across specialties. CH responded that the new scheme of delegation and approvals process should help in managing this. EK suggested that the next report include an example spending plan.

ACTION: EK

LR asked a question about the ethics of the investments. NB commented that it is for the Committee to set the ethical investment approach and ensure that the reports reflect this strategy. ZQ responded that there had been a decision by the Committee to invest in the ethical fund, recognising that this gave a lower return. The Committee agreed that it wished to continue with the investment in the ethical fund.

OUTCOME: The Committee **NOTED** the finance report and **APPROVED** continued investment in the ethical fund.

20/23 **Minutes of the staff lottery committee held on 13th June 2023**

The Committee **NOTED** the minutes.

21/23 **Any other business**

There were no other items of business.

Date and time of the next meeting

Wednesday 1 November 2023 at 11am via Microsoft Teams

Attendance Log 2023/24

	10 May	9 August	1 Nov	Feb	Total
Member					
Helen Hirst (chair)	✔	✔			/4
Nigel Broadbent	✔	✔			/4
Kirsty Archer	✔	x			/4
Gary Boothby	-	-			/4
David Birkenhead	x	✔			/4
Lindsay Rudge	x	✔			/4
Adele Roach	✔	x			/4
Jo Kitchen	x	x			/4
Attendance					
Carol Harrison	✔	✔			/4
Emma Kovaleski	✔	✔			/4
Victoria Pickles	✔	✔			/4
Zoe Quarmby	✔	✔			/4

27. Date and time of next meeting

Date: Thursday 2 November 2023

Time: 10.00 am – 1.00 pm

Venue: Forum Room 1A & 1B, Learning Centre, Sub-Basement, Huddersfield Royal Infirmary