Public Board of Directors

Schedule	Thursday 5 November 2020, 9:00 — 12:00 GMT
Venue	Microsoft Teams
Organiser	Jacqueline Ryden

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Date and time of next meeting
Thursday 14 January 2021, 9:00 am
Venue: Microsoft Teams tbc

1. Welcome and Introductions

To Note

Presented by Philip Lewer

2. Apologies for Absence

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

STANDING ITEMS

4. Minutes of the previous meeting held on 3 September 2020

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 3 September 2020 at 9:00 am via Microsoft Teams

PRESENT

Philip Lewer	Chair
Owen Williams	Chief Executive
Ellen Armistead	Director of Nursing/Deputy Chief Executive
Gary Boothby	Executive Director of Finance
Suzanne Dunkley	Director of Workforce and Organisational Development
David Birkenhead	Medical Director
Helen Barker	Chief Operating Officer
Alastair Graham **(AG)**	Non-Executive Director
Andy Nelson **(AN)**	Non-Executive Director
Peter Wilkinson **(PW)**	Non-Executive Director
Denise Sterling **(DS)**	Non-Executive Director
Richard Hopkin **(RH)**	Non-Executive Director

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Managing Director, Digital Health
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd
Jackie Ryden	Corporate Governance Manager (minutes)
Stephen Baines	Lead Governor
Sheila Taylor	Public Governor
James Lendon (Item 88/20)	Lead Respiratory Physiotherapist
Philip Finch (Item 88/20)	Patient
Kate Horne (Item 91/20)	Senior Programme Manager Public Health, Calderdale Council
Deborah Harkins (Item 91/20)	Director of Public Health, Calderdale Council

OBSERVING

Christine Mills	Public Governor

81/20 Welcome and introductions

The Chair welcomed everybody to the meeting and introduced Philip Finch and James Lendon who were attending to present a patient/staff story on community physiotherapy and Deborah Harkins and Kate Horne who were attending to present a paper on Engagement and actions related to the impact of Covid-19 on BAME communities in Calderdale.

82/20 Apologies for absence

Apologies were received from Karen Heaton and Andrea McCourt.

83/20 Declaration of Interests

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

84/20 Minutes of the previous meeting held on 2 July 2020.

The minutes of the previous meeting held on 2 July 2020 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held 2 July 2020.

85/20 Action log and matters arising

The action log was reviewed and updated.

Both items were closed and there were no other outstanding actions.

Matters Arising – Item 667/2020
The Director of Workforce and Organisational Development advised that since the last Board meeting on 2 July 2020 when the Board approved time for staff wellbeing and engagement activities (minute item 67/20), it has been confirmed that this agreement includes staff attending the BAME network, estimated at two hours per month and affecting 65 colleagues.

Non-Executive colleagues have supported allowing time for staff governors, of which there are three at present, to undertake their role. Following discussions, it has been agreed that this also falls within the category of engagement activities with an agreement between the Chair and the Director of Workforce & Organisational Development to provide three hours per month, up to a maximum of 36 hours a year.

OUTCOME: The Board received and **NOTED** the updates to the action log and **NOTED** the update regarding approved time for staff well-being and engagement.

86/20 Chair's Report

The Chair reported that he had attended the West Yorkshire Association of Acute Trusts (WYAAT) Committee in Common meeting on 28 July 2020 and the West Yorkshire & Harrogate Partnership Board meeting on 1 September 2020. Both sets of papers had been circulated to the Non-Executive Directors by the Chair. He advised that he continues to share information and intelligence with the Chairs of the other Providers, across West Yorkshire via regular meetings, and through a national Chairs WhatsApp group. The Chair is in the process of joining a meeting with a number of partners to re-look at working with Place in both Kirklees and Calderdale.

OUTCOME: The Board **NOTED** the update from the Chair and the involvement with the Chairs of the West Yorkshire Trusts.

87/20 Chief Executive's Report

The Chief Executive explained that some of the key components in the letter received from Simon Stevens and Amanda Pritchard on Phase 3 of the NHS response to Covid-19 will be covered under agenda items 12, 13 and 14. He pointed out that the context of the third phase is related to the impact of Covid-19 on service delivery but also relates to the necessity of returning to the levels of provision for all care groups, in particular the aspects related to health inequalities.

The Chief Executive noted the national work that the he led, on behalf of the NHS on health inequalities, has identified eight action areas and highlighted the importance for the Trust, and the integrated care services the Trust provides, in having an Executive at Board level providing leadership and being accountable for health inequalities . Ellen Armistead, Director of Nursing, will undertake this role for the Trust. The Chair added that both he and Peter Wilkinson will represent the Non-Executive Directors and will work with the Director of Nursing on health inequalities and the places and people we serve. It was also noted that the Board has undertaken development work in relation to health inequalities at a Board development session in August 2020.

The Chief Executive advised that following his involvement in the national work on health inequalities, he has been asked by NHS England / Improvement (NHS E/I) to continue to chair a national oversight group on health inequalities. This will involve a bi-monthly meeting incorporating a variety of leaders from various sectors who will monitor progress against the eight identified actions from the initial work. This will begin in late September 2020 and will run until March 2022.

The Chief Executive advised that for this year's NHS Parliamentary Awards (where local MPs nominate individuals or organisations), four areas have been put forward by local MPs in recognition of work in the Trust on the following: Digital Me, work undertaken on the Relatives Line during Covid 19, Microbiology and the approach to in- house testing and the work carried out in the Trust on wellbeing and support to staff.

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

88/20 Patient/Staff Story – Community Physiotherapy

The Chair introduced James Lendon, Clinical Lead Physiotherapist, with a focus on pulmonary rehabilitation and Philip Finch, a patient, who attended to provide the Board with details of work undertaken on the rehabilitation of patients who have suffered from Covid-19. James explained that prior to the pandemic he worked on rehabilitation of critical care patients but was redeployed to the Intensive Care Unit at HRI during April and May in response to the pandemic. At his request, James returned to the Community Division in order to lead on the rehabilitation of patients who had survived Covid-19, taking a multi-disciplinary team approach involving dieticians, occupational therapists, respiratory consultant input and students to help patients with their recovery.

Philip Finch, one of these patients, expressed his thanks to the NHS and Trust staff for saving his life after he contracted Covid-19 and had approximately 10 weeks in hospital, including a 6 week period in critical care and for giving him a quality of life that he had not envisaged when he became infected with Covid-19. Philip outlined his journey following discharge when James visited him at home and supported his goal to return to his pre-Covid levels of fitness with a plan of care, including diet to regain lost weight, physiotherapy and management of new symptoms as these appeared. Philip explained how his frightening experience was helped by the motivational support and excellent communication from staff at all levels. His level of fitness has gone from strength to strength and he is now confident he can enjoy a better quality of life.

The Chair Philip on behalf of the Board for sharing his personal and inspirational journey and wished him well for the future.

DS acknowledged that that the primary focus is on pulmonary rehabilitation but agreed that it is becoming clear there are a growing number of patients who have longer term Covid related issues. She asked what the Trust could do to support this. James responded that this is being discussed with colleagues as there are many patients who have not accessed the services, and that work with colleagues in primary care is needed. The Chief Operating Officer advised that as part of the Phase 3 planning work, the Trust is focussing on Community services as it is recognised that this is where capacity is needed to increase both for the post Covid patients and patients with long term conditions.

The Chair thanked both James and Philip for attending and sharing the details of the caring and compassionate work being done in the rehabilitation of Covid-19 patients.

OUTCOME: The Board **NOTED** the work carried out in CHFT and the support for rehabilitation of post Covid19 patients.

89/20 Business Better than Usual Service Transformation

The Director of Transformation and Partnerships provided an update on Business Better than Usual (BBTU) for service transformation, describing the methods used to engage stakeholders, identifying learning themes and new ways of working and outlining the next

steps and governance to take forward a strategic programme of transformation based on the learning.

The report has two sections, the first describing the learning that has been fed back where there is support to sustain the changes to minimise loss of life, protect colleagues and patient safety and improve quality. The second section describes the programme management and governance arrangements that will be established to take forward the BBTU programme of work. It is proposed that the Trust Board will have overall responsibility for delivery of the programme and regular written update reports will be provided.

The programme will be led by and report into the Transformation Programme Board (a formal sub-committee of the Trust Board) and there will also be regular dialogue and input of specific expertise or assurance from other formal sub-committees of the Trust Board. PW added that due to the commonality of issues between the BBTU programme and the Transformation Programme Board it makes sense to link the two and consider them concurrently.

The Board was requested to support the strategic learning themes that have been identified and approve the establishment of a the BBTU programme management and governance arrangements.

The Chief Executive asked for an explanation of the broader economic impacts of some of this work and the ongoing role of Healthwatch. The Director of Transformation and Partnerships explained that including the BBTU programme governance into the Transformation Programme Board aligns with its broader remit. At a previous meeting of the Transformation Programme Board a report had been received from Calderdale Council on the wider economic impact of Covid on employment and education and a number of other factors, and it fully recognised that the Trust has a wider role, in addition to its day to day remit, as a large employer in local Places and the ability to help support economic regeneration in a variety of ways. Kirklees Council has been contacted to request similar data on the economic impact. The Transformation Programme Board is the correct forum to lead on this work due to the synergy between the programme of estate investment and reconfiguration, BBTU and economic regeneration.

AG welcomed the extensive consultation and asked about the role of the voluntary and community sector (particularly in terms of equality impact) and the balance between needs-based consideration against the adherence to timescales on some of the targets in the Phase 3 letter. The Director of Transformation and Partnerships agreed that it will be necessary to be explicit about the criteria used to assess need and that this is a key theme to take forward on how the prioritisation is applied. The Chief Operating Officer added that 50% of additional activity will be focussed on the longest waiters and 50% on patients who have a different clinical need.

AN queried whether there is funding available to support additional resources for people working from home. The Director of Finance advised that any funding for working from home is being considered in the working from home policy, which is currently in draft and has been shared with Trade Unions.

The Director of Transformation and Partnerships explained that is envisaged that a blueprint will be established on the critical success factors for implementation of each of the areas. This will allow an understanding of the costs, quality, equality impact and workforce factors. Each of the themes will be defined more fully in terms of critical success factors and benefits in order to quantify what will be required for their delivery. This has the potential to start to define the future cost model going forwards.

The Director of Transformation and Partnerships advised previous collaborative work with Healthwatch is informing some of the themes included in the BBTU transformation and close collaboration will continue going forwards.

OUTCOME: The Board **SUPPORTED** the strategic learning themes identified and **APPROVED** the establishment of the BBTU programme management and governance arrangements.

90/20 Month 4 Financial Summary

The Director of Finance presented the Month 4 Financial Summary and highlighted the following key points.

Year to date the Trust has delivered a balanced financial position after assumed additional funding of £9.65m over and above that previously anticipated. Year to date the Trust has incurred costs of £11.97m in relation to Covid-19, offset to some extent by underspend in some specialties due to reduced activity. The paper reports a balanced financial position at the year end, although this is a holding position as the financial regime for the remainder of the year from 1 October 2020 is still not clear, with guidance awaited.

A plan has been submitted for the remainder of the year from 1 October 2020 for additional funding, which picks up on additional activity expected to be delivered for the remainder of the year. The plan submitted suggests an additional £110m will be required for the remainder of the year. This includes a number of large items that were planned, for example the financial recovery fund (£33m). Costs are broadly running at an extra £50m over and above plan.

For the remainder of the year the allocation is to be given via the Integrated Care System (ICS) and some discussion will be required across the ICS on how the funding is to be allocated to individual Trusts.

Final submission of the plan is due by 27 September 2020. Once details of the allocated funding are received, discussions may be required, and it may be necessary to delegate authority to Finance and Performance Committee depending on the approval process.

RH explained that he felt it important for all Board members to be aware of the cost implications of Covid-19 and the proposed additional activity, which will only increase over the next few months. Activity recovery targets are set and there will be an element of income allocated or withdrawn based on performance against those targets. The Director of Finance explained that an incentive letter had been sent to organisations. There is still a lack of clarity on the details, but in the Trust's submission it has been assumed that no penalties will be levied for any failure to deliver targets.

OUTCOME: The Board **NOTED** the information provided in the Month 4 Financial Summary.

91/20 Health and Well-being Risk Assessment – Overview of Responses and Proposed Mitigations

The Director of Workforce and Organisational Development presented a progress report on the Covid-19 Health and Well-being Risk Assessment, the responses to date and the proposed mitigations arising from the responses received.

Following a request from NHSE/I in June 2020 to risk assess all BAME colleagues due to physical attributes that might make them more at risk of harm from COVID 19, a series of collaborative sessions were held with colleagues to seek their views and incorporate them into a CHFT risk assessment process approach. The Trust took the decision to risk assess

all colleagues, for physical risks, mental health and personal circumstances. The national approach has since changed and also now requests all staff to be risk assessed.

The Director of Workforce and Organisational Developed explained that some of the results were surprising, for example white colleagues are responding more than BAME colleagues, younger groups are more anxious than older groups and clinical colleagues are showing greater levels of anxiety. One of the biggest risks in the Trust is the mental well-being of colleagues. Most of the colleagues with high risk factors were captured in the first couple of weeks and followed up.

The Director of Workforce and Organisational Development emphasised the importance of achieving a high response rate before October, both for physical and mental health factors and a number of actions to increase the response rate were highlighted in the report.

The Director of Workforce and Organisational Development advised that she is currently in discussions with NHSE/I as the Trust would like to run a psychological or mental health assessment annually following feedback from colleagues and the follow up calls made evidencing the levels of anxiety in colleagues. A series of proposed mitigations have been included in the report including the decision at the previous Board meeting in July to keep the24/7 counselling line open; 11,000 calls have been made through this line.

PW asked if the response rate of 43% was surprising and what plans are in place to increase this. The Director of Workforce and Organisational Development agreed the result was surprising, particularly when compared to the uptake of antibody testing by colleagues which was 90%+. She added that there is some scepticism in some groups regarding the use of the information. It was identified through the BAME network that the network members will engage in individual discussions with BAME colleagues in the Trust to encourage completion of the assessment. It may be necessary to make the assessment mandatory if the response rate does not increase before October.

AN asked if there are sufficient resources and time to address all of the issues outlined in the mitigations section of the report. The Director of Workforce and Organisational Development advised that a request is to be submitted to the Commercial and Investment Strategy Group (CISG) to keep the 24/7 counselling line open. Further engagement work will take place regarding the staff well-being hour.

The Medical Director pointed out that the knowledge of risk factors is constantly changing and asked if there are plans to revisit the risk assessment based on new knowledge. The Director of Workforce and Organisational Development advised that the Occupational Health team regularly update the risk assessment based on national guidance.

Following a query from AG, a discussion took place on the timing of the staff survey. Confirmation was given that the risk assessment will take precedence over the staff survey, which will be more low-key than in previous years. There is a plan in place for September/October to ensure that messaging to colleagues is tactically planned.

The Chief Executive echoed the importance of risk assessments being completed in order to gain a deep understanding of the well-being of individual colleagues and the impact on all colleagues. He added that the issue of the longer term impacts of Covid-19 on staff require continual monitoring through risk assessments in order to keep staff as safe as possible and minimise loss of lives and this will require additional capacity and resources.

OUTCOME: The Board **NOTED** the findings of the assessment to date, **AGREED** the proposed Trust wide mitigations and **SUPPORTED** the next steps identified in the report.

91/20 Engagement and Actions Related to the Impact of Covid-19 on BAME Communities in Calderdale

The Director of Workforce and Organisational Development introduced Deborah Harkins, Director of Public Health, Calderdale Council and Kate Horne, Senior Programme Manager Public Health, Calderdale Council who provided a report on the insight gathered through engagement with BAME communities regarding the impact of Covid-19 and outlined a series of actions that will address the inequality. Partnership organisations were asked to support the delivery of Action Plan to Reduce the Impact of Covid-19 on the BAME Communities plan and the Board was asked to identify how the Trust can be an advocate/key enabler to the successful delivery of the plan.

The Director of Workforce and Organisational Development advised that she had met with Deborah and Kate the previous week and shared the Executives' ideas on how the Trust could support the councils and engage with the communities.

Deborah outlined the background to the work, which began in May 2020 when evidence began to be seen of the disproportionate impact of Covid-19 on BAME communities. The Council wanted to understand and listen to communities in Calderdale about what could be done to mitigate the impacts of Covid-19 on those communities. An action plan was formed, which covers three phases of action and will impact over different timescales:

- Actions that will protect our communities from the current phase of Covid-19
- Actions that will reduce the impact of a second wave of Covid-19 on BAME communities
- Actions that aim to address the root causes of inequalities in health experienced by Calderdale's BAME communities.

Kate Horne added that when engaging with communities it is important to recognise the link between wider determinants and poverty is significant. It is important to continue engagement with the communities as the pandemic continues to present new challenges in the communities.

PL asked for some indication of some of the initial successes. Deborah described the work with Park and Whalley wards. There are Covid Community Champions in those areas and proactive work has been undertaken with local businesses and engagement with communities door to door. The reduction of infections is significant and the targeted engagement approach has been successful. The value of CHFT staff helping and engaging will be incredibly powerful. Kate highlighted the trust issue and the value of the Trust and the Council working together on this to improve trust in the communities.

OW thanked Deborah and Kate on the good work and commented that would like to see similar work from Kirklees Council. A discussion took place on how the developing 'co-production' approach particularly around BAME communities and poorer white communities be used to increase the uptake in those groups for the flu jab and Covid immunisation further down the line. Kate agreed that the collaborative 'working with' approach that has commenced is the right route to do this.

The Director of Transformation and Partnerships is keen to work with the Council on digital inclusion given the increased access to healthcare going forwards through remote consultation, which could lead to widening of health inequalities, and will follow up with Deborah outside of the meeting.

Deborah advised that Kate regularly meets with the Trust's Community staff in CRH, which is proving to be extremely valuable. Kate added that is providing greater insight and opportunities to help communities.

The Chair thanked Deborah and Kate for attending and providing a detailed report.

OUTCOME: The Board **NOTED** the findings outlined in the report and **SUPPORTED** the delivery of the plan and key contributory actions identified in the plan.

92/20 We are the NHS: People Plan for 2020/21 – Actions for us All

The Director of Workforce and Organisational Development provided an update on the NHS People Plan which was published on 30 July 2020 and identified the impact on the Trust and the West Yorkshire and Harrogate Health and Care Partnership including actions for NHS England, NHS Improvement and Health Education England. The report included specific actions under the nine headings of the People Plan, showing the Trust's current position against the actions and what actions are needed where gaps have been highlighted. The NHS: People Plan 2020/21 replaces the Interim People Plan published on 3 June 2019. The updated plan is a good match to the Cupboard and the Trust's One Culture of Care with equal importance given to staff health and well-being and patient care.

A gap analysis has been carried out against the People Plan and the report shows the Trust's current position against the actions and what actions are needed where gaps have been highlighted. All actions related to CHFT are either green or amber. The plan makes clear the intention to see an increased role for systems to work with its constituent parts to use the data to understand workforce and service requirements and support the attraction and deployment of staff within the systems. The Trust welcomes the plan's approach to the health and well-being for colleagues.

RH commented that the gap analysis looks favourable with the only red areas waiting for national guidance and input. He asked if the Plan will be regularly re-visited at Workforce Committee and the Director of Workforce and Organisational Developed confirmed this will be regularly tracked by the Workforce Committee with the intention of turning some of the green actions to blue as they become embedded.

RH asked if guidance had yet been received on competency frameworks for Board level positions and an NHS leadership observatory and the Director of Workforce and Organisational Development advised this has not yet been received but would be welcomed by the Trust.

Following a query from AH, a discussion took place on leadership roles and the pathways and development programmes available for colleagues to progress within the organisation.

OUTCOME: The Board **NOTED** the update on the NHS People Plan for 2020/2021 and the associated action plan.

93/20 Stabilisation and Reset Plan and Winter Plan

The Chief Operating Officer noted that the plan had been discussed in detail recently at the Finance and Performance Committee.

The Chief Operating Officer described the process and key principles of stabilisation and reset planning with patient and staff safety the key priority to ensure resilience for a potential surge and winter. A draft plan was submitted to the Integrated Care System (ICS) on 27 August and feedback will be provided on 11 September 2020. A final submission is due to the ICS on 17 September 2020.

The plan is based on the key principles of stabilisation and reset agreed by the Board at the meeting on 2 July 2020, with patient and staff safety paramount and noting increased staff anxiety about being at work.

The national phase 3 plan activity expectations and projections for Trust activity were outlined with other elements still to be built into the work programme for the next six

months. A number of assumptions have been made which have been RAG rated according to risk. The Chief Operating Officer highlighted the red rated assumptions in particular:

- Non electives to be managed to 82% of last year's numbers
- Bed modelling – Covid numbers have been built in and a system response is expected. An improvement to the transfer of care is also required.
- The financial envelope supports the plan.

Details of general and nursing specific workforce were provided, and the Chief Operating Officer pointed out that the bed model which has been submitted specifies that at times we are up to 77 beds short of safe staffing levels. The number of registered nurse vacancies has increased by 18 compared to the pre-Covid figures at 158 vacancies, a large cohort of staff remain redeployed and we need to continue to support new workforce models in Emergency departments, critical care and respiratory care. Community provision needs to be reflected appropriately and work is still to be done on the staffing models.

EA advised that there are a number of nursing workforce challenges to be addressed including community staffing models which keep patients in the community rather than in hospital and extra nursing support to care homes. EA noted the balance between restoring elective activity based on clinical priority and having limited staffing resource, with flexibility to use student nurses and closing elective activity no longer an option.

The Chief Operating Officer advised that this year Winter is likely to be the most challenging yet and the development of the winter plan has taken account of intelligence, insights and modelling work that exists in the system and some of the learning from last year. The presentation highlighted differences this year. As requested previously information on paediatrics and community has been included in the plan and was shared during the presentation, including that paediatrics bed modelling is in progress. It was noted that new infection control guidance needs to be factored in and further work is needed on the baseline.

There are both challenges and opportunities available including ensuring the right patients are treated, affordability, nurse staffing and recruitment and system response. The Chief Operating Officer highlighted fatigue and anxiety amongst staff around winter planning, particularly amongst leadership. It was noted that some scenario testing will take place.

RH referred to the target of 82% for non-elective activity and asked if sensitivity analysis had been undertaken and also asked if the requirement for 77 more beds was a worst-case scenario or reasonably realistic and what additional staffing would be needed. The Chief Operating Officer explained that the plan is based on what we can safely staff and the figure of 77 beds is the most likely scenario but could possibly be higher. The 82% requirement takes it to 77 beds more than can be safely staffed according to our current safe staffing level.

Following a further query from RH, the Director of Nursing explained that nursing colleagues have been asked to consider what an early warning system would look like and what the implications would be of reducing staffing levels and the mitigations that would be needed. The Board would have to make a decision on what the implications would be of moving to reduced staffing levels, with discussion of risk appetite and any risk mitigation that would need to be in place.

AN referred to theatre productivity and asked if the key limiting factor to operate in a safe fashion was staff. The Chief Operating Officer advised that staffing is the main issue, with further work being undertaken on theatre productivity and the length of theatre sessions.

AN asked if any forecasting on the backlogs had been undertaken, given the plan to operate below 100%. The Chief Operating Officer described some work is being done to

proactively pick up housebound over 75 patients who are now presenting to the frailty team with an element of deconditioning and noted further work is needed with partners. As 50% additional activity is for long waiters to enable the right patients to be treated the 52 week position at the end of March 2021 is expected to be about 1000. From the outpatient perspective, a buddying system has been introduced where staff contact patients on the follow up list proactively. This will help to get back on track, but it will potentially take a couple of years to get back to the pre-Covid position.

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The Medical Director put forward a note of caution around the infection control guidance and the difference between approaches of guidance for low and high prevalence areas, which might be the case through winter.

The Chief Operating Officer advised that it might be necessary to convene an extraordinary Board of Directors or Finance and Performance Committee to approve the final submission of the plan. This may not be fully compliant with the targets from NHSE/I and therefore it will be necessary to reaffirm the Board's position.

OUTCOME: The Board **NOTED** the update on the Stabilisation and Reset Plan and Winter Plan and **NOTED** the possibility of arranging an extraordinary Board meeting or Finance and Performance Committee meeting.

94/20 Health and Safety Update

The Director of Workforce and Organisational Development presented a report to update the Board on the progress made against the action plan previously approved by the Board at the meeting on 9 January 2020. The action plan is managed and monitored through the Trust's Health and Safety Committee, who report directly to the Audit and Risk Committee. The Audit and Risk committee received the updated action plan in July 2020. Key points to note were:

- Richard Hill has been appointed to the Head of Health and Safety role for CHFT.
- The report includes an update on the activities related to fire safety.

The Chief Operating Officer gave a brief update on the fire action plan which was provided to Board for assurance through the Review Room at the meeting on 2 July 2020. The main outstanding issue is the fire strategy. Mott MacDonald have carried out all of their onsite visits and a Fire Committee meeting is scheduled at which the fire strategy will be confirmed. As specified in the external report, the role of Fire Officer has been moved into CHFT from CHS. With support from the Director of Transformation and Partnerships and team from a reconfiguration perspective, succession planning has been considered for the Fire Officer which will help with working through some of the reconfiguration plans. The Chief Operating Officer confirmed that work has been ongoing while waiting for the fire strategy.

OUTCOME: The Board **APPROVED** the Health and Safety update and **NOTED** the progress against actions identified in the action plan at Appendix 1.

95/20 Board Assurance Framework (BAF)

The Chief Executive presented the Board Assurance Framework for 2020/21 for approval following review by the Audit and Risk Committee in July 2020. There are a total of 23 risks, reducing to 22 if risk 5/19, EPR benefits realisation, is approved for removal (some elements of which will be subsumed by the new risk 2/20, investment to fund the digital strategy); seven new risks have been added.

Details of a new streamlined process to review the risks were provided in the paper with Board committees to take a greater role in reviewing the risks on the BAF. Chairs of each

respective committee should be clear of this responsibility and will be asked to provide the scrutiny/assurance lens on how the risks will be addressed.

AG pointed out that some of the risks seem to be duplicated (for example risks 9/19, HRI Estate and equipment, and 14/19, capital funding). The Director of Finance advised that this is likely to be related to long and short term risks but will clarify this with AG outside of the meeting.

AN confirmed that the Non-Executive Directors were clear about the responsibilities of the respective Committees both in relation to the risks and the risk appetite. He asked that Committee chairs consider where there is a gap on the risk appetite and raise for discussion at Board if necessary.

The Board **AGREED** the addition of 7 new risks to the Board Assurance Framework, **AGREED** the removal of risk 5/19 EPR benefits realisation, **NOTED** the updates to risk and movement in risks scores for risks 4/19, 8/19, 9/19, **APPROVED** the revised wording of the risk appetite, **NOTED** the risk exposure identified in the paper, and noted that board committees are to undertake detailed review of those BAF risks for which it is responsible as noted in the paper.

96/20 Quality Report

The Director of Nursing presented the Quality Report for the period June-July 2020 to provide the Trust with ongoing oversight of the Quality agenda and the emerging issues that need to be considered. The Quality Report was discussed at the Quality Committee meeting on 2 September 2020. The following points were of note:

- The Trust's performance around complaints remains a concern and will be a key part of the stabilisation and reset workstreams. A new Assistant Director for Patient Experience has commenced in post and will focus on complaints responses.
- The Care Quality Commission (CQC) has been operating under an emergency support framework. The Trust has responded to this by reformatting the local ward accreditation process around the emergency support framework, which will strengthen the ability to prepare for any CQC scrutiny.
- Of the outstanding actions from the 2018 CQC inspection, the Trust has five actions to complete. The report included an update on the mitigation plan for each of the outstanding actions.
- There has been a deterioration in pressure ulcer development, some of which is attributable to Covid-19 and some to a slightly different reporting arrangement.
- Dementia screening remains a challenge.
- Assurance remains limited for nutrition and hydration – this is related to issues around clinical record keeping, which is being considered as a focus under the quality priorities.
- In Legal Services, there have been issues on turnaround times and responses to inquests, but an Interim Head of Legal Services has been employed following the departure of the Head of Legal Services at the end of July 2020.

RH asked for assurance that the issues raised in the report around nutrition and dementia screening were being addressed. The Director of Nursing explained the challenges related to clinical record keeping and advised that a very thorough action plan is in place which is regularly reviewed by the Quality Committee, and systems and processes are in place to look at the barriers and make the necessary improvements.

The Director of Nursing advised that just prior to the pandemic the medical division had been tasked with re-energising the approach to elderly care within the organisation. There is evidence of good practice in the Trust around frailty and the enhanced support services, but there are also opportunities to modernise the delivery of services for elderly care. The

Medical Director added that it is important to keep the focus on dementia screening; some of the issues are linked to the recording of data on the Electronic Patient Record system (EPR) and work continues to achieve a more reliable and ongoing approach to data entry.

The Chief Executive expressed his concerns over the lack of progress with completion of complaints. The Director of Nursing advised that the new Assistant Director for Patient Experience has identified that complaints will be her top priority. A detailed discussion followed on the need to make progress on complaint responses including ensuring that all areas of the organisation are engaged, within a specific timeframe. Further discussions will take place outside of the meeting to determine at what point consideration should be given to introducing external resources to improve complaint responses.

OUTCOME: The Board **NOTED** the Quality Report and activities across the Trust to improve the quality and safety of patient care.

97/20 Integrated Performance Report – July 2020

The Chief Operating Officer provided the Board with the performance position for the month of July which was very positive. She advised that the report had been discussed in detail by the Finance and Performance Committee. The report is to be revised over the next few months in order to become more outcome focussed and will also include data related to health inequalities. RH added that a great deal of progress has been made over the last couple of months in developing some of the performance indicators and this will continue over the next few months.

AN asked for an explanation on the increased numbers of delayed transfer of care. The Chief Operating Officer explained some improvements are still required and this remains an area of focus and has been identified as a risk going into the winter period.

AG also asked about the performance of stroke patients admitted directly to an acute stroke unit. The Chief Operating Officer advised that a deep dive is to be undertaken into this area as part of a decision to undertake deep dive exercises for areas that have remained in 'red' for a length of time. The results of the deep dive will be reported back to the Board.

AG further asked about the return to work interviews which are only at 60%, even though staff absence is good. The Director of Workforce and Organisational Development advised that there is always a time lag for recording the interviews. She explained that HR Business Partners are currently looking into this but she would welcome a deep dive into this area. The Chief Executive added that recent data on sickness absence for the Trust is encouraging, and the Director of Workforce and Organisational Development explained that CHFT looks positive compared to a number of other Trusts, partly due to careful tracking and monitoring of absence by HR administration colleagues and also managers across the organisation maintaining good practice generally. The Chief Executive asked if there was a possibility for a blended approach with the good work on tracking absence to include the return to work interviews. The Director of Workforce and Organisational Development agreed follow up on this, and suggested that it would be beneficial to share the methodology with the new Assistant Director of Patient Experience for complaint responses.

OUTCOME: The Board **NOTED** the Integrated Performance Report and current level of performance and **NOTED** the action of a deep dive in Stroke performance.

98/20 Annual/Bi-annual Reports

The Nursing and Midwifery Safer Staffing report was provided by the Director of Nursing for assurance.

OUTCOME: The Board **RECEIVED** the Nursing and Midwifery Safer Staffing Report.

The Director of Infection Prevention Control (DIPC) Report was provided by the Medical Director for assurance.
OUTCOME: The Board **RECEIVED** the Infection Prevention Control (DIPC) Report.

The Safeguarding Update Annual Report Adults and Children was provided by the Director of Nursing for assurance.
OUTCOME: The Board **RECEIVED** the Safeguarding Update Annual Report Adults and Children.

The Huddersfield Pharmacy Specials Annual Report was provided by the Director of Finance for assurance.
OUTCOME: The Board **RECEIVED** the Huddersfield Pharmacy Specials Annual report.

The Audit and Risk Committee Annual Report was provided by the Director of Finance for assurance.
OUTCOME: The Board **RECEIVED** the Audit and Risk Committee Annual Report.

The Finance and Performance Committee Annual Report was provided by the Director of Finance for assurance.
OUTCOME: The Board **RECEIVED** the Finance and Performance Committee Annual Report.

The Quality Committee Annual Report was provided by the Director of Nursing for assurance.
OUTCOME: The Board **RECEIVED** the Quality Committee Annual Report.

99/20 Governance Report

Terms of Reference
The Chair presented the Governance Report in the absence of the Company Secretary. The paper included revised terms of reference for the Audit and Risk Committee, the Quality Committee and the Finance and Performance Committee following their approval by the individual committees.

Non-Executive Director Tenures
An update was provided on Non-Executive Director tenures. There are two NEDs whose tenures expire in 2020: Andy Nelson whose tenure expires on 30 September 2020 and Alastair Graham whose tenure expires on 30 November 2020. For 2021 there is one tenure ending, with the Chair's first period of tenure due to end on 31 March 2021. A meeting of the Nominations and Remuneration Committee will be held on 8 September 2020 to consider whether the Trust is best served by ongoing continuity and the re-appointment of the present incumbents or whether the Trust requires a new/refreshed skill set.

Governance Business Better Than Usual
On 2 July 2020 the Board discussed and supported ways that it could improve and streamline governance arrangements, grouping these into 9 themes, building on the experience of revised working arrangements during Covid-19. The paper outlined progress to date and plans for monitoring progress with Governance Better Than Usual.

OUTCOME: The Board **APPROVED** the revised terms of reference for the Audit and Risk Committee, the Quality Committee and the Finance and Performance Committee, **NOTED** the upcoming tenures of two Non-Executive Directors ending in 2020 and the process for review of these, and **NOTED** progress to date and plans for monitoring progress with Governance Better Than Usual.

100/20 Receipt of Minutes of Meetings

The following Minutes of sub-committee meetings were provided for assurance:

- Finance and Performance Committee – minutes from meeting held 29.6.20 and 3.8.20
- Audit and Risk Committee – minutes from meeting held 22.7.20
- Quality Committee – minutes from meetings held 29.6.20 and 3.8.20
  DS advised that the Quality and Safety Strategy had been presented to the Quality Committee at the meeting on 2 September 2020. This will go back to the next Quality Committee meeting and will be shared with the Board at the Development session on 10 September 2020.
- Workforce Committee – minutes from meetings held 15.7.20 and 10.8.20
- Covid-19 Oversight Committee – minutes from meetings held 29.6.20 and 20.7.20
  DS advised that the Oversight Committee had agreed that as there were now fewer decisions to be reviewed, it would only meet as and when necessary.
- Organ Donation Committee – minutes from meeting held on 15.7.20
- Council of Governors – minutes from meeting held on 9.7.20.

No questions were raised.

OUTCOME: The Board **RECEIVED** the Minutes of the sub-committee meetings noted above**.**

101/20 Items for Board Assurance in the Review Room

Calderdale and Huddersfield Solutions Ltd – Managing Director Update August 2020

OUTCOME: The Board **RECEIVED** the Calderdale and Huddersfield Solutions Limited Managing Director Update.

Freedom to Speak Up Annual Report

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

Update from West Yorkshire & Harrogate Partnership's Chief Executive Lead

OUTCOME: The Board **RECEIVED** the Update from the West Yorkshire & Harrogate Partnership's Chief Executive Lead.

80/20 Any Other Business
There was no other business.

Date and time of next meeting
Date: Thursday 5 November 2020
Time: 9:00 – 12:30 pm
Venue: Microsoft Teams
The Chair closed the meeting at 12.30pm

5. Matters arising

To Note

Presented by Philip Lewer

6. Chair's Report

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

- Daily Covid-19 Update

To Note

Presented by Owen Williams

TRANSFORMING AND IMPROVING PATIENT CARE

8. Staff Story

‘Working with Covid’

To Note

9. 2020-21 Strategic Plan – Progress Report up to 31 October

To Note

Presented by Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	**5th November 2020**
Meeting:	**Public Meeting of the Trust Board**
Title of report:	**2020-21 Strategic Plan – Progress Report up to 31 October**
Author:	**Anna Basford**
Sponsor:	**Owen Williams**
Previous Forums:	**None**

Actions Requested: Note the assessment of progress against the 2020/21 strategic plan.

Purpose of the Report

Provide an update on progress made against the 2020/21 strategic plan as at 31st October 2020.:

Key Points to Note

This report highlights that of the 19 deliverables:

0	are rated red
2	are rated amber
17	are rated green
0	have been fully completed

EQIA – Equality Impact Assessment

For each objective described in the one year plan the accountable 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

Note the assessment of progress against the 2020/21 strategic plan.

compassionate care

Calderdale and Huddersfield NHS Foundation Trust
2020-21 Strategic Plan – Progress Report up to 31 October

Purpose of Report

The purpose of this report is to provide an update on progress made against the four goals described in the Trust's 1-year plan for 2020/21:

- Transforming and improving patient care;
- Keeping the base safe;
- A workforce fit for the future;
- Sustainability.

Structure of Report

The report is structured to provide an overview assessment of progress against key deliverables 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 area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 19 deliverables:

0	are rated red
2	are rated amber
17	are rated green
0	have been fully completed

Recommendation

Note the assessment of progress against the 2020/21 goals.

2020 / 21 One Year Strategy

Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	**Sustainability**
	Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual'. (AB)	Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleagues safety. (OW)	Develop and implement flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for Nurse staffing and specialist medical roles, thus retaining a turnover below 10%. (SD)	Deliver the 20/21 regulator approved financial plan. (GB)
	Trust Board approval of reconfiguration business cases for HRI and CRH. (AB)	Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating. (EA)	Develop an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions. (SD)	Demonstrate improved performance against Use of Resources key metrics. (GB)
	Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire. (DB)	Involve patients and the public to influence decisions about their personal care and improve patient experience by: • responding to the needs of people from protected characteristics groups • implementing "Time to Care". • achieving patient safety metrics (EA)	Roll out our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams. (SD)	Trust Board approval of a 10 year sustainability plan to support reduction in the Trust's carbon footprint. (SS)
	Trust Board approval of a 5 year digital strategy supported by an agreed programme of work and milestones. (MG)	Develop an outcome based performance framework and deliver against key metrics. (HB)	Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of the workforce. (SD)	Collaborate with partners across West Yorkshire and in place to deliver resilient system plans. (AB)
	Use population health data to inform actions to address health inequalities in the communities we serve. (OW)	Deliver the actions in the Trust's 2020/21 Health and Safety Plan. (SD)	Assign a wellbeing champion to each Ward/Department/Service to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey. (SD)	

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual'.	**GREEN** On track	CHFT has engaged colleagues, patients and partners across the Calderdale and Greater Huddersfield health and social care system to capture learning from experience of their responses to the COVID -19 pandemic. The findings from this were presented to the Trust Board on 2nd July 2020 and 12 key learning themes of transformational changes that should be sustained and amplified were agreed by the Board. Governance and management arrangements to provide assurance on the implementation of this have been agreed by the Trust Board in September and are being implemented.	**Lead: AB** Transformation Programme Board
Trust Board approval of reconfiguration business cases for HRI and CRH.	**GREEN** On track	Formal governance structures have been established and the Transformation Programme Board has oversight of the transformation and reconfiguration plans. The Trust has quarterly review meetings with NHSE and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). The Trust has procured the external professional and technical capacity and advice required. The Trust is working with the Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases and is on schedule to complete the CRH OBC and HRI FBC by June 2021	**Lead: AB** Transformation Programme Board NHSE/I
Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire.	**GREEN** On track	The clinical strategy describes the Trust position on service development across West Yorkshire. A refresh of the clinical strategy by service is underway led by clinical leads meeting with all services, completion is due in November 2020.	**Lead: DB** Weekly Executive Board Quality Committee Trust Board
Trust Board approval of a 5-year digital strategy supported by an agreed programme of work and milestones.	**GREEN** On track	The 5-year Digital strategy was approved by the Trust BOD on 2nd July 2020. Milestones that are under development/ in progress and will be signed off in October are within the • Scan4 safety Project • Digital Aspirant Programme	**Lead: MG** Divisional digital boards Data Quality Board Digital Executive Board.

		• Optimisation plan Others to be agreed • Infrastructure Strategy • Information strategy • Integration and interoperability roadmap including core clinical systems	Report to Board and Finance and Performance Committee by exception.
Use population health data to inform actions to address health inequalities in the communities we serve.	**AMBER** Off track – with plan	Board development session completed, and organisational lead identified as Deputy CEO/Chief Nurse. Work on exploring impact of HI on Cancer pathways and outcomes underway together with a cross organisational focus on the quality of care for learning disabled (neurodiverse) patients care during the pandemic. Also work underway with Calderdale Council in respect of the Covid BAME action, plan which they have co-produced with local communities. The Trust Board has endorsed the plan and agreed to respond to key actions. First meeting of the Health Inequalities Oversight Group for England held in September. Undertook a review of progress made against the 8 national actions to date and the next meeting is scheduled for November.	**Lead OW** Weekly Executive Board Board of Directors Learning Improvement Review Board Health Inequalities Oversight Group (England)
Goal: Keeping the base safe			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleague's safety.	**AMBER** Off track – with plan	After lengthy and highly commendable planning work from several clinical/managerial colleagues and external partners, reset and stabilisation plans have been submitted to NHSE/I. This is categorised as amber for two reasons: 1. The plan was produced to meet regulatory phase 3 expectations underpinned by a core assumption that R = 1.0. As of 25/9, North East and Yorkshire regional rates were 1.2 - 1.5 with a growth rate % per day of +4 to +8. 2. There is a need to further develop the impact of these plans in terms of health inequalities.	**Lead: OW** Weekly Executive Board Trust Board

Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating.	**GREEN** On track	While CQC have not been undertaking any onsite inspections as a result of Covid we have been subjected to the enhanced engagement model in place. A more formal assessment of IPC was undertaken by CQC albeit a self-assessment, that was undertaken independently. This was well received by CQC and offered good assurance to our regulator. We meet regularly with CQC in formal engagement meetings with generally very good feedback. We are recognised as being an open and transparent organisation which serves us well. The CQC preparation process formally known as Ward Accreditation has been reviewed and updated, now called Focussed Support Framework (FSF) and is much more closely aligned to the CQC KLOEs etc. We have piloted the FSF and was well received and provided a very clear plan for support to improve. The CQC will be starting their on site inspections largely based around IPC. Plan are in place to improve our assurance around IPC. Well-led preparations are in a good place. The quality priorities align more closely to CQC domains and we are developing a dashboard to monitor performance more consistently across the Trust.	**Lead: EA** Quality Committee Weekly Executive Board
Involve patients and the public to influence decisions about their personal care and improve patient experience by: • responding to the needs of people from protected characteristics groups • implementing "Time to Care". • achieving patient safety metrics	**GREEN** On track	We have now appointed to the AD for patient experience to provide leadership to the issue of responding to the needs of those from the protected characteristic groups. LD services continue to improve and offer an improved experience for service users and families. On the back of a coroners case I have commissioned an independent review of the case as a precursor to review the experiences of BAME communities in our Trust. We have started some positive work with Sickle Cell groups. Time To Care has been launched and implemented, pace has picked up on this now we are out of the first wave of the pandemic. Patient experience metrics have been developed and new metrics will soon be in place for reporting on this locally and publicly. The new quality priority dashboard will enable more granular reporting on all safety and quality metrics. Access to KP has been extended to all band 7's and we have in place a Heatmap for all areas aligned to CQC domains.	**Lead: EA** Quality Committee Weekly Executive Board

Develop an outcome-based performance framework and deliver against key metrics.	**GREEN** On track	Discussions with domain leads and initial outcome KPIs developed, shared with relevant Committees and included in IPR Learning from Covid helping to shape further KPIs for introduction in Q3 & 4 with work ongoing, in parallel, to deprioritise some KPIs and develop a triangulation narrative	**Lead: HB** Integrated Board Report Weekly Executive Board Audit and Risk Committee Finance and Performance Committee
Deliver the actions in the Trust's 2020/21 Health and Safety Plan.	**GREEN** On track	Good progress has been made against the Health and Safety Action plan following the external audit carried out by Quadriga. An interim Head of Health and Safety was appointed in July to review the outstanding actions, including creating sub groups for specialist safety concerns. A new Head of Health and Safety commenced in September 2020. The interim Head has been extended to February 2021 to assist the Head of Health and Safety with COVID risk assessments. An internal audit of Health and Safety is being planned to commence in December 2020.	**Lead: SD** Quality Committee Trust Board
Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**assurance route**
Develop and implement flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for Nurse staffing and specialist medical roles, thus retaining a turnover below 10%.	**Green (on track)**	The Trust has in place the following: - • a focus on recruitment and retention in our people strategy 'The Cupboard' • a 3-year recruitment strategy • a 3-year apprenticeship strategy • a 5-year equality, diversity and inclusion strategy • a Covid specific redeployment focus • a Business Better Than Usual focus on the development of new 'generic' and multi-disciplinary workforce models in the future The NHS People Plan has a focus on flexible working, equality and diversity and recruitment including the following: - • all clinical and non-clinical permanent roles being flexible • flexible working in standard induction conversations for new starters and in annual appraisals	**Lead: SD** Workforce Committee

		• whether in hours or location, colleagues should (as far as possible) be offered flexibility regardless of role, team, organisation or grade • monitoring flexible working take-up • continue the implementation and effective use of e-rostering systems • roll out the new working carers passport to support people with caring responsibilities • overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets The NHS people Plan is available here: - https://www.england.nhs.uk/publication/we-are-the-nhs-people-plan-for-2020-21-action-for-us-all/ Our response to the Plan was considered by the Board of Directors at its meeting on 3 September 2020 and is available here: -  We are the NHS - People Plan 2020-21	
Develop an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions.	**Green (on track)**	We have in place the following: - • a focus on Talent Management through The Cupboard • an Executive Board approved succession planning tool • Board level as well as divisional and directorate succession plan assessments • an agreed recruitment and selection policy • an agreed equality of opportunity policy • a recruitment statement about open competition • leadership development programme open to all • an emerging 'development for all' programme of learning activity	**Lead: SD** Workforce Committee
Roll out our Leading One Culture of Care and	**Green (on track)**	The Trust's on-line leadership development programme was launched on 31 July 2020. Bespoke modules for	**Lead: SD** Workforce Committee

Management Essentials programme to support managers to successfully lead their teams.		Consultants; nurses and midwives; and Allied Health Professionals were made available on 2 October 2020. The final module 'mental health - working well under pressure' for each bespoke group will be delivered by the end of December 2020.	
Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of the workforce. (SD)	**Green (on track)**	The NHS People Plan emphasises the importance of improvement work in relation to equality and diversity and recruitment and makes specific reference to an 'overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.' The Trust's arrangements currently provide: - • for a BAME colleague to sit on an appointment panel for all Agenda for Change pay band 6 and above posts • recruitment and selection training which includes unconscious bias • an inclusive mentoring programme for Black, Asian and Minority Ethnic (BAME) colleagues and white colleagues in mentee and mentor partnerships	**Lead: SD** Workforce Committee
Assign a wellbeing champion to each Ward/Department/Service to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey. (SD)	**Green (on track)**	25 ambassadors identified and signed up with a further 30 in the pipeline. Mapping exercise to identify teams without a designated ambassador with a plan to engage those areas to be completed by 17 October 2020.	**Lead: SD** Workforce Committee
Goal: Sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver the 20/21 regulator approved financial plan. (GB)	**GREEN** On track	For 20/21 the finance regime has been changed to support organisations deliver a financial balance during COVID. For the 1st 6 months the Trust has been supported with retrospective top up and has delivered a financial balance. All claims for additional funding have been verified and supported as reasonable. For the remainder of the year an	**Lead: GB** Reported to Finance & Performance Committee / Estates Sustainability Committee Monthly regulator discussions

		ICS level allocation has been proposed and this is being reviewed before agreement to accept.	
Demonstrate improved performance against Use of Resources key metrics.	**GREEN** On track	The finance use of resource metric that is presented monthly at Finance and Performance committee shows improvement which is largely due to the improved cash position and reduced levels of borrowing. Additionally, a proactive exercise is continuing to review our overall position and assessment on the wider use of resources key lines of enquiry.	**Lead: GB** Reported to Finance & Performance Committee Quality Committee Monthly regulator discussions
Trust Board approval of a 10-year sustainability plan to support reduction in the Trust's carbon footprint.	**GREEN** On track	An update report about our Green Plan went to CHS board in September and is going to the Trust board in November. This report updates the Board on the work already done and future plans to reduce the Trusts carbon footprint.	**Lead: SS** Transformation Programme Board Trust Board
Collaborate with partners across West Yorkshire and in place to deliver resilient system plans.	**GREEN** On track	The Trust continues to work with WYAAT and the West Yorkshire and Harrogate Integrated Care System (ICS) and with place-based leaders in Calderdale and Kirklees to deliver system plans. Examples of this includes partnership work on: • Phase 3 reset plans • ICS financial plans • Pathology – work to procure a managed services contract across Leeds, Mid-Yorkshire Hospitals and CHFT • Vascular reconfiguration of services • WY BAME network	**Lead: AB** Plans reviewed by Board and WYAAT Committee in Common System Leadership Meetings with NHSE and ICS

10. Reconfiguration Update

To Note

Presented by Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	**5th November 2020**
Meeting:	**Public Meeting of the Trust Board**
Title of report:	**Calderdale and Huddersfield Service Reconfiguration**
Author:	**Anna Basford**
Sponsor:	**Owen Williams & Peter Wilkinson**
Previous Forums:	Information included in this report has previously been presented at CHFT Transformation Programme Board, Calderdale and Kirklees Joint Health Scrutiny Committee, Calderdale Health and Wellbeing Board, Calderdale and Huddersfield CCGs and to NHS England during September and October.

Actions Requested: Note the update

Purpose of the Report

- Provide an update on the reconfiguration programme of work and timeline;
- Provide an update on the development of the estate design at CRH and HRI;
- Inform the Board of the next steps to continue to involve members of the public and colleagues in the development of the plans.

Key Points to Note

Following approval of the Strategic Outline Case in January 2020 work has continued on planning for the programme of service reconfiguration and estate development. There will be a continuous process of communication and involvement of patients, families, carers, colleagues and stakeholders in the planning process. The planned programme timeline is to submit an Outline Business Case (OBC) for Calderdale Royal Hospital and a Full Business Case (FBC) for Huddersfield Royal Infirmary to NHS England and the Department of Health and Social Care for approval in 2021.

EQIA – Equality Impact Assessment

Since 2016 there has been a continuous process of Equality and Health Inequality Impact Assessments undertaken in relation to the planned programme of service reconfiguration and estate development. This work has previously demonstrated that there are no differential discriminatory equality or health inequality impacts. The Trust will continue to ensure compliance with its Public Sector Equality Duty throughout the planning process over the coming months. The process to do this has been enhanced and the service and estate developments that will be described in the business cases will be assessed through a process of engagement with patients, colleagues and the public to identify all impacts and any actions required to mitigate potential negative impact on health inequalities.

Recommendation

Note the update.

Calderdale and Huddersfield Service Reconfiguration
Update Report for the Trust Board
November 2020

1. Background

In December 2018 the Department of Health and Social Care (DHSC) announced that £196.5m of public capital funding had been allocated for investment at Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH). In 2019 the Strategic Outline Case (SOC) describing the future service model this investment will enable was completed and NHS England (NHSE) and the Department of Health and Social Care (DHSC) confirmed approval of the SOC in January 2020.

At CRH the investment will enable the provision of additional wards, theatres and a new A&E including a dedicated paediatric emergency department. At HRI the investment will enable the build of a new A&E department and the improvement of existing buildings to address the most critical estate maintenance and safety requirements.

To progress the programme of service reconfiguration and estate development further detail of the service model and estate design at each site will be developed and described in an Outline Business Case (OBC) for CRH and a Full Business Case (FBC) for HRI that will be submitted to NHSE and DHSC for approval in 2021.

The Trust Board has established a Standing Formal Committee known as the Transformation Programme Board that includes Non-Executive and Executive Director membership and has responsibility for leading delivery of the Programme of reconfiguration.

2. Purpose

The purpose of this report is to:

- Provide a general update on the reconfiguration programme of work and timeline;
- Provide an update on the development of the estate design at CRH and HRI;
- Inform the Board of the next steps to continue to involve members of the public and colleagues in the development of the plans for service reconfiguration in Calderdale and Huddersfield;

3. Programme Update

Following approval of the SOC in January 2020, work has been undertaken to clarify the process of developing the next stage of business cases required by NHSE and DHSC. This has

taken account of the fact that the estate at HRI carries a high risk in relation to the condition and reliability of the existing buildings. It has therefore been agreed with NHSE and DHSC that to enable the commencement of estate improvement work as early as possible a Full Business Case for the investment at HRI will be developed and submitted for approval by NHSE and DHSC in 2021.

For the investment at CRH an Outline Business Case will developed and submitted in 2021 and subject to NHSE and DHSC approval a subsequent Full Business Case will be developed for approval by 2023.

The content of the OBC and FBC(s) will align with and take account of Her Majesty's Treasury (HMT) Green Book guidance on public investment business cases. The necessary external capacity and capability to deliver the business cases has been appointed and this includes specialist technical advisors such as architects, engineers and healthcare planners.

A detailed Programme plan and timescale was developed in March 2020 however it became clear the plan would need to be revised considering the Covid-19 pandemic impact. A review identified the work that it was possible to continue to progress during the COVID-19 crisis and those areas that have been delayed. The areas impacted by delay include for example: workstreams dependent on clinical and public involvement, and; workstreams that require on-site visits and surveys by external contractors. The revised provisional headline milestones are shown below. Where possible actions are being taken to improve on this timescale.

Huddersfield Royal Infirmary		**Calderdale Royal Hospital**	
Milestone Description	**Complete by:**	**Milestone Description**	**Complete by:**
Design completed and full planning application submitted to Kirklees Council	Jan 2021	Design developed and outline planning application submitted to Calderdale Council	Feb 2021
Submission of Full Business Case to NHSE and DHSC for approval	June 2021	Submission of Outline Business Case to NHSE and DHSC for approval	June 2021
Commence Construction Work	Dec 2021	Submission of Full Business Case to NHSE and DHSC for approval	2023
Complete Construction Work	2023	Complete Construction Work	2025

4. Development of the Estate Design at CRH and HRI

During 2019/20 architects worked with Calderdale and Huddersfield NHS Foundation Trust (CHFT) to develop a "Design Brief" to inform the future building design and construction schemes at HRI and CRH. The approach to this aimed to ensure a continuous process of public and colleague involvement and a focus on what's important from a patient, carer, family and colleague perspective in terms of healthcare building design. This included public involvement workshops and meetings held in November and December 2019

Through this process members of the public and colleagues identified the issues that mattered to them in relation to the future design of health care buildings and facilities and this was used to develop a design brief that was previously presented to the Trust Board in March 2020 and subsequently submitted to the Calderdale and Kirklees Joint Health Scrutiny Committee.

The public and colleague involvement reports and the Design Brief are available on CHFT website. The Design Brief describes the principles that will inform the detailed architectural design and construction schemes at both HRI and CRH and will be used to complete the next stage (OBC and FBC) business cases required by NHSE and DHSC.

Since the development of the design brief the COVID-19 crisis has necessitated many service changes. Despite these challenging circumstances positive learning is emerging. During May and June 2020 CHFT undertook further public and colleague engagement to listen and learn from people's reflections on the service changes implemented during the pandemic and their aspirations for future service delivery. The views and input from this were reported at the public meeting of the Trust Board held in September 2020 and copy of the report is available on the CHFT website. The findings from the pandemic will build on the design brief previously developed to incorporate opportunities for improvement and accelerated transformation in some areas. This will also ensure that further design elements that take account of best practice in building design regarding infection control and prevention are included. This includes for example ensuring provision of single rooms and flexibility in the design to enable segregation of areas.

Work is currently in progress to develop the detailed designs for HRI and CRH by January and February 2021 and this will form the basis of planning applications that will be submitted to Calderdale and Kirklees Councils.

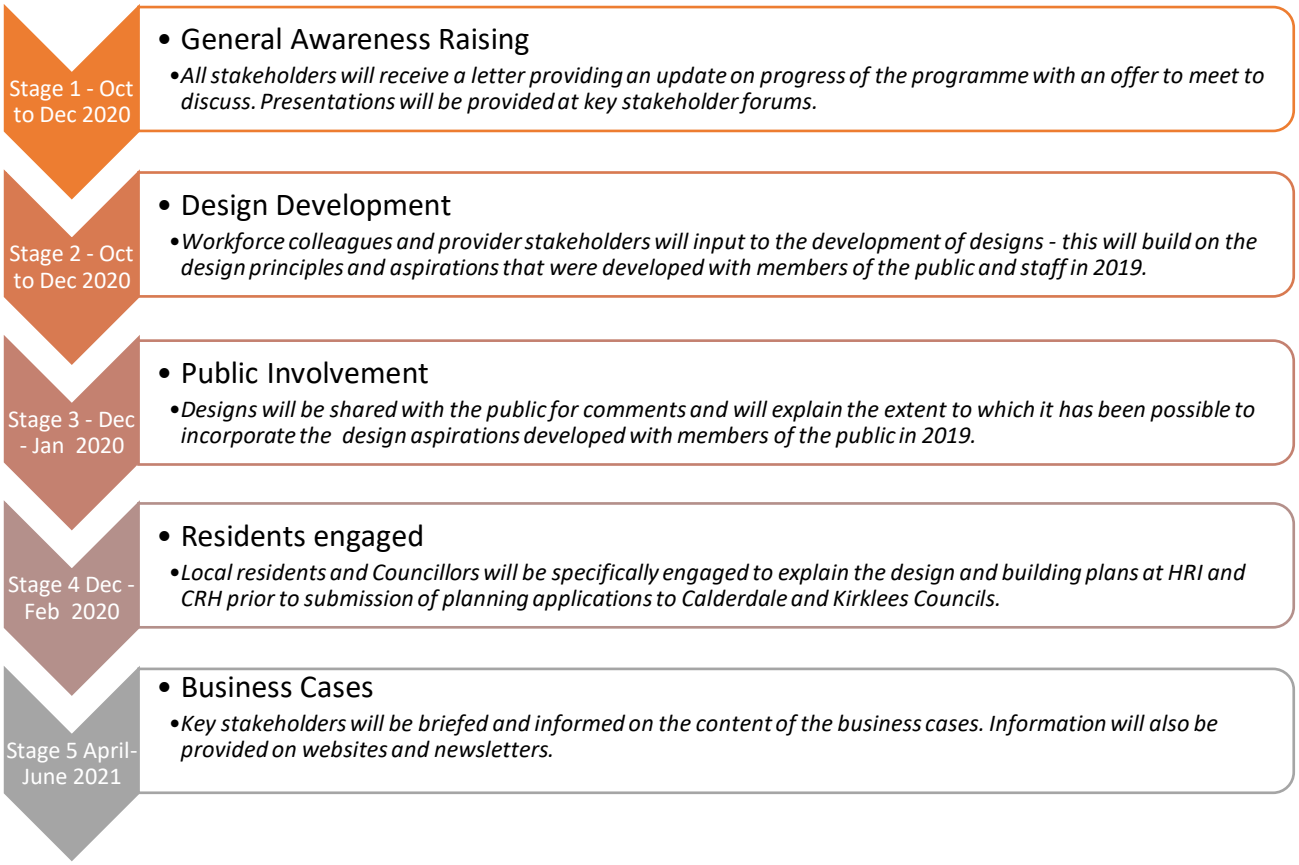
5. Next steps to involve members of the public and colleagues

There will be a continuous process of communication and involvement of patients, families, carers, colleagues and stakeholders in the planning process.

In the coming months further public involvement ahead of planning submissions will be undertaken to gain views from local people, colleagues and stakeholders about the design, appearance and other planning matters related to the estate development.

Reflecting the COVID-19 restrictions and the need for social distancing communication will include an online portal which will invite feedback together with mail-drops and written correspondence to ensure all sections of the community can become involved. We hope to gain a diverse range of views and we have invited comment from stakeholders of how we can amplify the reach of this project.

The headline next steps on communication and involvement activities over the next 12 months is shown below.



6. Recommendation

Members of the Trust Board are requested to:

- Note the programme timeline and general update.
- Note the process of involvement of public and colleagues that has been undertaken to develop the design brief and the next steps to involve members of the public and colleagues in the development of plans for service reconfiguration and estate development.

11. West Yorkshire Vascular Services Network - Implementation of Service Changes

To Note

Presented by Helen Barker

Date of Meeting:	Thursday 5th November 2020
Meeting:	Board of Directors
Title:	West Yorkshire Vascular Services Network - Implementation of Service Changes
Author:	Anna Basford Director of Transformation and Partnerships
Sponsor:	Helen Barker, Chief Operating Officer
Previous Forums:	This report – none. Background documents discussed at WYAAT, WYVAS, WY Joint Scrutiny Committee, NHS England

Actions Requested:
To note

Purpose of the Report

This briefing paper provides an update on implementation of the change to the number of hospitals in West Yorkshire providing complex vascular arterial surgery and inpatient vascular care.

Key Points to Note

In March 2020 following formal public consultation NHS England's Regional Commissioning Committee for North East and Yorkshire approved proposals to have two specialised vascular centres instead of three in West Yorkshire, one at Leeds General Infirmary and the other at Bradford Royal Infirmary.

Operational plans to enable implementation of the change in vascular service provision from the 16th November 2020 have been developed.

This will mean that Calderdale and Huddersfield NHS Foundation Trust will continue to provide vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services however complex arterial surgery and inpatient vascular beds currently provided at CHFT will move to Bradford Royal Infirmary (BRI) from 16th November.

This planned date for the service change will be kept under review in the coming weeks and could potentially be deferred subject to the impact of Covid-19 on hospital admissions across West Yorkshire.

EQIA – Equality Impact Assessment

An equality impact assessment in relation to the service change has been undertaken by the West Yorkshire Association of Acute Trusts. This determined that there were no differential negative impacts on people with protected characteristics as a result of the service change.

Consideration and analysis of the potential impact of proposals on those protected under the Equality Act, with specific regard given to the public sector equality duty will continue as the service changes are implemented and embedded. The findings of this will be reported with any necessary mitigation actions identified to reduce adverse impacts.

Recommendation

Members of the Trust Board are requested to note the planned implementation of changes to vascular service provision across West Yorkshire on the 16th November 2020.

West Yorkshire Vascular Services Network - Update Report

October 2020

1. Introduction and Background

This briefing paper provides an update on implementation of the change to the number of hospitals in West Yorkshire providing complex vascular arterial surgery and inpatient vascular care.

In March 2020 following formal public consultation NHS England's Regional Commissioning Committee for North East and Yorkshire approved proposals to have two specialised vascular centres instead of three in West Yorkshire, one at Leeds General Infirmary due to its status as a major trauma centre and the other at Bradford Royal Infirmary due to its co-location with renal care.

This means that Calderdale and Huddersfield NHS Foundation Trust will continue to provide vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services however complex arterial surgery and inpatient vascular beds currently provided at CHFT will move to Bradford Royal Infirmary (BRI).

Reports have previously been published providing detail of the background to this service change.

A link is provided below to the briefing document prepared earlier this year by NHS England for the West Yorkshire Joint Scrutiny Committee that provides additional detail and background information.

https://www.calderdale.gov.uk/nweb/COUNCIL.minutes_pkg.view_doc?p_Type=AR&p_ID=71712

2. Governance Arrangements for the Implementation of the West Yorkshire Service Changes

To implement the changes in vascular service provision the West Yorkshire Association of Acute Trusts (WYAAT) agreed to establish a West Yorkshire Vascular Service Network (WYVaS) comprising membership of Leeds Teaching Hospitals NHS Trust, Mid-Yorkshire Hospitals NHS Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust and Airedale NHS Foundation Trust.

The key principles agreed by WYVaS in relation to implementation of the vascular service changes are:

- To develop a West Yorkshire vascular network working as a West Yorkshire team with sub specialist team(s);
- To provide two strong arterial centres with inpatient beds which are well utilised;
- To ensure the case mix in the two centres reflect the specialist tertiary service provision and major trauma status of Leeds;
- To ensure that governance of the network is based on parity of esteem between partner organisations in WYVaS in relation to decision making, clinical model, workforce plan and operating principles; patient repatriation plans; estate plans.

The WYVaS Board (representing membership of all the Trusts listed above) has led work in recent months in relation to communications and engagement with colleagues; clinical governance; development of performance and financial management framework; patient repatriation plans; operational delivery models; workforce plans; and estate development plans.

3. Timeline for Delivery of the New Service Model

Operational plans have been developed to enable the change in vascular service provision across West Yorkshire to be implemented from the 16th November 2020. This will mean that from 16th November CHFT will continue to provide vascular day-case surgery, diagnostics, outpatient appointments and rehabilitation services however complex arterial

surgery and inpatient vascular beds currently provided at CHFT will move to Bradford Royal Infirmary (BRI). Patients that require these services will be directly referred or transported via ambulance to BRI.

The date for this service change is provisional dependent upon continued monitoring of the impact of Covid-19 on hospital admissions across West Yorkshire and service and workforce resilience to implement the service change during the pandemic. It should be noted that CHFT have assumed this moves takes place in the submission of their Phase 3 plan.

4. CHFT Workforce Impact of the Service Change

Over several years there has been a continuous process of involving and engaging CHFT colleagues in dialogue on the future plans for the provision of vascular services across West Yorkshire. Individual meetings and support has been provided to colleagues affected by this service change and to determine their eligibility for TUPE.

Not all colleagues affected by the creation of a Single Service will transfer to the employment of BTHFT on 16th November. Some colleagues affected by the change have transferred to other nursing and support roles at CHFT and some colleagues are still seeking new roles within CHFT.

Consultant medical colleagues will in future work as part of a West Yorkshire Vascular Service Network and this will mean that they will in-reach to BTHFT to provide complex arterial vascular surgery procedures. Consultant Job Plans have been agreed to enable this.

There are no colleague redundancies as a result of this service change.

5. CHFT Financial Impact of the Service Change

Across WY, vascular services have historically driven financial losses for provider organisations and under the revised clinical model the overall cost of delivering the service was always likely to increase, particularly in the short term. This is driven by the enhancements to deliver a higher service specification alongside challenges in releasing residual costs and overheads.

It was agreed that a gain share model was to be developed including all providers to support any additional costs incurred or further losses. The final agreement to a gain / loss share has not yet been made and is still to be agreed. At the time of writing the overall short-term cost increase is between £1.2m and £1.5m depending on the level of developments and enhancements being supported. These are currently going through a challenge process. The impact for 2020/21 is addressed in the phase 3 reset financial envelopes but agreement is needed from April 2021.

This agreement is key for CHFT in particular as under traditional commissioning, we will lose initial activity and income attributed to the whole pathway yet still incur post-operative and rehabilitation care costs. At WYAAT Directors of Finance forum on 16th October it was agreed that following further challenge, the residual increase in costs would not reside solely with CHFT and BTHFT. Commissioners are to be approached but ultimately any residual costs will be shared across WYAAT acute providers.

6. EQIA and QIA Impact Assessments

An equality impact assessment in relation the service change was undertaken by WYAAT in 2018. This determined that there were no differential negative impacts for people with protected characteristics as a result of the service change. This is attached as Appendix 1.

Consideration and analysis of the potential impact of proposals on those protected under the Equality Act, with specific regard given to the public sector equality duty will continue to be a focus of work of WYVaS as the service changes are implemented and embedded and the findings of this will be reported with necessary mitigation actions identified to reduce any adverse impact.

7. Recommendation

Members of the Trust Board are requested to note the planned implementation of changes to vascular service provision across West Yorkshire on the 16th November 2020.

Equality Impact Analysis – West Yorkshire Vascular Network: Options appraisal for recommendation of the preferred option for the location of the other arterial centre in West Yorkshire

Brief details of Project / Service Development/ Business Decision for reference:
Vascular services in West Yorkshire (WY) are currently based in three arterial centres at Leeds General Infirmary (LGI), Bradford Royal Infirmary (BRI) and Huddersfield Royal Infirmary (HRI). The Yorkshire & Humber Clinical Senate published their report on vascular services in January 2017. The report recommended that there should be two arterial centres in WY, one at LGI co-located with the Major Trauma Centre (MTC) and one at either BTHFT or CHFT. WYAAT agreed with NHS England that it would make a recommendation on its preferred option for the location of the other centre.

COMPLETED BY: Matt Graham, WYAAT Programme Director **DATE: 10 April 2018**

Protected characteristic	Does any aspect of this project actually or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this project	Can any action associated with this project be taken to enhance relations between people in this group and people not in this group?
AGE (any age groups, but particularly older or younger people and those in transition)	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population and specific "at risk" groups including over 65s	**Yes** Reducing from three to two arterial centres the centres will create a more resilient service. The future service model includes an aspiration for repatriation of patients to local services so they are closer to home and cared for in the most appropriate specialty. This has the potential to improve care for elderly patients by repatriating them to elderly medicine	**No**

Protected characteristic	Does any aspect of this project actually or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this project	Can any action associated with this project be taken to enhance relations between people in this group and people not in this group?
DISABILITY (including mental health, learning difficulties, sensory, physical impairment)	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population	**Yes** Reducing from three to two arterial centres the centres will create a more resilient service. The future service model includes an aspiration for repatriation of patients to local services so they are closer to home and cared for in the most appropriate specialty.	**No**
GENDER REASSIGNMENT (term to describe transitioning from one gender to the other)	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population	**Yes** Reducing from three to two arterial centres the centres will create a more resilient service. The future service model includes an aspiration for repatriation of patients to local services so they are closer to home and cared for in the most appropriate specialty.	**No**
PREGNANCY AND MATERNITY Pregnancy - condition of being pregnant or expecting a baby. And up to 26 weeks after birth.	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population	**Yes** Reducing from three to two arterial centres the centres will create a more resilient service. The future service model includes an aspiration for repatriation of patients to local services so they are closer to home and cared for in the most appropriate specialty.	**No**

Protected characteristic	Does any aspect of this project actually or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this project	Can any action associated with this project be taken to enhance relations between people in this group and people not in this group?
RACE Refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population and specific at risk groups, including white men and the Asian population.	**Yes** Reducing from three to two arterial centres the centres will create a more resilient service. The future service model includes an aspiration for repatriation of patients to local services so they are closer to home and cared for in the most appropriate specialty.	**No**
RELIGION OR BELIEF Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism).	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population. It has also looked at the impact on different religious groups.	**Yes** Reducing from three to two arterial centres the centres will create a more resilient service. The future service model includes an aspiration for repatriation of patients to local services so they are closer to home and cared for in the most appropriate specialty.	**No**

Protected characteristic	Does any aspect of this project actually or potentially discriminate against this group?	Can equality of opportunity for this group be improved through this project	Can any action associated with this project be taken to enhance relations between people in this group and people not in this group?
SEX A man or a woman.	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population and on specific at risk groups including men.	**Yes** Reducing from three to two arterial centres the centres will create a more resilient service. The future service model includes an aspiration for repatriation of patients to local services so they are closer to home and cared for in the most appropriate specialty.	**No**
SEXUAL ORIENTATION Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population	**Yes** Reducing from three to two arterial centres the centres will create a more resilient service. The future service model includes an aspiration for repatriation of patients to local services so they are closer to home and cared for in the most appropriate specialty.	**No**

Other considerations	Does any aspect of this project actually or potentially increase inequality?	Can equality of opportunity be improved through this project	Can any action associated with this project be taken to enhance equality
Potential Impact on tackling **HEALTH INEQUALITIES** (eg poverty, life expectancy, transport information, postcode)	**No** The future service model ensures that the majority of vascular activity will remain in its current locations. Only complex cases which need to be delivered in an arterial centre to deliver high quality care will be affected by the project. By reducing from three to two arterial centres the centres will be more resilient. Travel analysis has been undertaken to ensure the decision minimises the impact on the overall population. It has also looked at "at risk" groups including the most deprived 20% of the population (both overall deprivation and health deprivation)	**No**	**No**
Potential Impact on **human rights** using FREDA principles: **Principle** **Example** **F**airness fair processes **R**espect cultural diversity **E**quality not denied treatment **D**ignity degrading treatment **A**utonomy involved in decisions	**No**	**No**	**No**

ACTION PLAN

ISSUE	ACTION PROPOSED	LEAD	DEADLINE

Other Information for Reference– Optional

12. Calderdale Collaborative Community Partners Partnership Agreement

To Approve

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	**5th November 2020**
Meeting:	**Public Board of Directors**
Title of report:	**Calderdale Collaborative Community Partnership Agreement**
Author:	**Calderdale Collaborative Community Partnership Programme Board**
Sponsor:	**Anna Basford, Director of Transformation and Partnerships**
Previous Forums:	**Calderdale Collaborative Community Partnership Programme Board** **CHFT Weekly Executive Board**

Actions Requested:

- To approve the signing up by the Trust to the Collaborative Community Partnership Agreement.

Purpose of the Report

The purpose of this Agreement is to formalise and build on existing partnership working arrangements across the health and care system in Calderdale to enable a collaborative approach to the development and progression of community services.

The attached Partnership Agreement has been jointly developed and drafted by partner organisations. The purpose of this approach is to strengthen partnership work and streamline governance, making it effective and simple, enabling timely decisions to be made. The Agreement is based on, and consistent with, the governance arrangements that have been agreed by the West Yorkshire and Harrogate ICS Committee in Common.

All partners to the Agreement remain accountable for the services and the care provided by their respective organisations and existing contractual arrangements with commissioner will remain in place.

The partner organisations to this Agreement are CHFT, Calderdale PCNs, Calderdale Council, Calderdale CCG, Voluntary Action Calderdale, Locala Community Partnerships, South West Yorkshire Partnership Foundation Trust, Community Pharmacy West Yorkshire.

Key Points to Note

This a partnership agreement and not a legally binding contract. No legal obligations or rights shall arise between the partners as a result of this agreement.

EQIA – Equality Impact Assessment

The collaborative agreement confirms the commitment of health and social care partner organisations to work together to provide inclusive integrated and personalised care for people in Calderdale. The partnership aims to enable improved health and wellbeing outcomes for all of the Calderdale population. An Equality Impact Assessment has been completed and identified that the Partnership Agreement aims to enable integrated working of organisations to deliver a positive impact across all groups of people with protected characteristics. This work will also support and enable reduction in health inequalities.
Specific projects and programmes of work associated with service changes that may be developed through the partnership will have separate and specific EQIA and QIA assessments undertaken.

Recommendation
The Trust Board is asked to support the collaboration and **APPROVE** that CHFT will sign up as a partner to the Collaborative Community Partnership Agreement.

Calderdale Collaborative Community Partners Partnership Agreement

1. Partners to the Agreement

1.1 The members of the Calderdale Collaborative Community Partners and the parties to this agreement are in schedule 1:

1.2 As members of the Partnership all of these organisations subscribe to the vision and principles stated below and agree to participate in the governance and accountability arrangements set out in this Agreement. The organisations collectively will be referred to in this agreement as the 'Partners'

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2. Term of the Agreement

2.1 This Agreement will commence on the date of signature of the Partners. It will be reviewed within its first year of operation to ensure it remains consistent with the evolving requirements of the partnership and thereafter be subject to an annual review of the arrangements by the Calderdale Collaborative Community Programme Board.

3. Introduction and context

3.1 This Agreement is an understanding between the Calderdale Collaborative Community Partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the people who live in Calderdale, and to improve the quality of their health and care services.

3.2 Our partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. Commissioner and Provider organisations in Calderdale have come together to agree how we can improve people's health and improve the quality of their health and care services.

4. Purpose

4.1 The purpose of this Agreement is to formalise and build on existing partnership working arrangements. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. The purpose of this approach is to strengthen genuine partnership work and try and streamline the governance, making it effective and simple, enabling timely decisions to be made. This proposal does not set out to undermine the statutory responsibilities of the partners respective Boards and Governing Bodies. We remain accountable for the services and the care provided by our respective organisations.

4.2 The Agreement is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Agreement. It is a formal understanding between all of the Partners who have each entered into this Agreement intending to honour all their obligations under it. This Agreement does not replace or override the legal and regulatory frameworks that apply to statutory NHS organisations and the Council. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

4.3 Nothing in this Agreement is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the Agreement, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

5. Developing new collaborative relationships

5.1 Our partnership working and approach to collaboration will focus on the five Calderdale Cares neighbourhood localities to prevent ill health, support people to stay well, and provide them with high quality care and treatment when they need it. This will increasingly move away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment. The work of the partners will aim to deliver person-centred Health and Social Care against defined whole-population health outcomes, promoting people to start well: develop well; live well; and age well; across Calderdale.

5.2 We have recognised that there are clear benefits in working together across Calderdale to achieve better outcomes for people. The arrangements described in this Agreement set out how we will organise ourselves to provide the best health and social care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

6. Promoting alignment and Integration and Collaboration

6.1 The Partners acknowledge the statutory and regulatory requirements which apply in relation to competition, patient choice and collaboration. Within the constraints of these requirements we will aim to collaborate, and to seek greater alignment and integration of services, whenever it can be demonstrated that it is in the interests of patients and service users to do so.

6.2 The Partners are aware of their competition compliance obligations, both under competition law and, in particular (where applicable) under the NHSE&I Provider Licence for NHS Partners and shall take all necessary steps to ensure that they do not breach any of their obligations in this regard. Further, the Partners understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHSE&I and the Partners will keep this position under review accordingly. Public Contract Regulations 2015; NHS Procurement, Patient Choice and Competition Regulations (No2) 2013

6.3 The Partners understand that no decision shall be made to make changes to services in Calderdale or the way in which they are delivered without prior consultation where appropriate in accordance with the partners statutory and other obligations.

7. How we will work together in Calderdale

7.1 Our vision

Partners in Calderdale have all committed to support delivery of Calderdale Vision 2024.

7.1.1. The Calderdale Health and Wellbeing Board has set out a strategy and identified high level priorities based on the four life stages of:

- **Starting well (0-5)**
- **Developing Well (6-25)**
- **Living & working well**
- **Ageing well**

7.2 Partners to this Partnership Agreement will work together to deliver Care Closer to Home that will support achievement of the Calderdale Vision 2024 ambitions and the Calderdale Health Wellbeing Strategy.

7.2.1 Through the work of this Partnership Agreement, Partners aspire to achieve the following:

- People are empowered to take greater control over their lives and outcomes;
- Resources and assets are used to address the wider determinants of health and support well-being;
- The health and care system shifts towards prevention – changing the ways in which organisations and their staff work;
- Community services have a strong sense of local place;
- Care should be personal and based on what matters to each patient;
- The type and route of care delivery should suit the type and preferences of patients. This can mean different modalities for different types of patients;
- Professionals providing community-based care will deliver at the top end of their licence, enabling general practice to focus on population health management and acute teams to focus on specialist provision;
- Services are delivered in a way that constantly improves health outcomes of the population, by providing high quality care, efficiently and within the financial resources available

7.3 Calderdale Collaborative Community Partners will focus on three key interventions, which are:

- maintaining the health and well-being of people in their home through prevention and pro-active care;
- providing care and support to people that are in a crisis; and
- providing step down to home or to a new residence for people - ensuring they are supported in their care transition.

7.3.1 The Partnership will also aspire to:

- "transform the relationship between me and my health and wellbeing";
- "transform the relationship between me and the services which help me"; and
- "transform the relationship between the people who work together to help me, and their relationship with their work".

7.4 Our Objectives

7.4.1 The Partners to this Partnership Agreement have agreed to deliver sustainable, effective and efficient voluntary and community sector infrastructure services with significant improvements over the term of this Partnership agreement. In particular partners have agreed the following:

- to develop a partnership of Commissioners and Providers focused on the delivery of high-quality Calderdale Collaborative Community Partners - based on individual need;
- to focus on reducing health inequalities and delivering support closer to where people live;
- to provide safe services in partnership with other services, closer to home;
- to ensure that patients, colleagues and communities are fully involved in the development, design and delivery of service plans.

8. Overarching leadership principles for our partnership

8.1 We have agreed a set of guiding principles that will shape everything we do through our Partnership:

- We will be ambitious for the people we serve and colleagues;
- We will do the work once – duplication of systems, processes and work will be avoided as wasteful and potential source of conflict;
- We will undertake shared analysis of problems and issues as the basis of acting;
- We will apply subsidiarity principles in all that we do – with work taking place at the appropriate level.

8.2 We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation and of Calderdale Place;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to and adopt a culture of 'no fault, no blame' between the Partners and seek to resolve any disputes in an open, amicable and communicative manner;
- We assume good intentions;
- We implement our shared priorities and decisions, holding each other mutually accountable for delivery and assume collective responsibility and risks for ensuring achievement of the partnership aims and objectives;
- We make decisions on the basis of the needs of the population;
- We appoint and select key roles on a best person basis.

9. Partnership Governance

9.1 The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and the Council remains directly accountable to their electorate. The Partnership provides a mechanism for collaborative action and common decision-making.

Provision and delivery of services remain subject to the individual organisation's respective contractual / funding arrangements

9.2 Collaborative Partnership Board

9.2.1 Partnership Board will be established to provide the formal leadership for the Partnership.

9.2.2 The Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum. The Partnership Board has no formal delegated powers from the organisations in the Partnership.

9.2.3 The Partnership Board will be made up of 'duly authorised' senior representatives, typically at Executive Director level or equivalent, of all the organisations that are party to this agreement. The chair of the Partnership Board will be nominated from among the members and a vice-chair will be also be nominated. The chair and vice-chair roles will be reviewed annually with the aim that these roles will rotate across the organisations represented on partnership Board.

9.3 Roles and Responsibilities of Partnership Board Members

9.3.1 Through this Agreement the Partners agree to take a collaborative approach and collective responsibility for, managing performance, resources and the totality of population health. The partners will:

- agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our formal collaborative groups for decision making, engaging people and communities across Calderdale, and;
- identify good practice and innovation and ensure it is spread and adopted.

9.3.2 The following roles and responsibilities have been agreed:

The Commissioner Partners will:

- promote effective collaborative processes;
- clearly articulate:
    - performance and quality standards;
    - the scope of services and technical requirements;
    - known risks, escalation processes and triggers;
- have effective and streamlined works allocation processes;
- constructively negotiate and manage contracts.
- Advise of any procurement considerations in respect of services within the scope of the agreement.

The Provider Partners will:

- take responsibility for and manage the risks of delivering their services;
- provide on-going improvement in the delivery of their services;
- establish an environment to encourage collaboration;
- act in good faith in the best interests of service users;
- aspire to achieve high performance to generate enhanced quality, efficiency and value for money.

9.3.3 If a collaborative Partner wishes to admit a new person or organisation to join the partnership a proposal will be considered at the next Partnership Board meeting.

9.3.4 The proposal will set out the details of the proposed New Partner, reasons and rationale for the proposed admission and the likely impact on the services. The Partners intend that any organisation who is to be a partner to this Agreement (including themselves) shall commit to the Principles of this Agreement and ownership of the system success/failure as set out in this Agreement.

9.3.5 A New Partner shall only be admitted on the agreement of each member of the partnership, such agreement not to be unreasonably withheld or delayed. If this is confirmed the Partners will cooperate to enter into the necessary documentation and revisions to this Agreement if required.

9.4 Proceedings of the Partnership Board

9.4.1 The partnership Board will meet bi-monthly or more frequently as required.

9.4.2 The partnership Board will meet in private where appropriate to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the members.

9.4.3 The necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Partners respective organisations and the reporting arrangements.

9.5 Decision-Making and Resolving Disagreements

9.5.1 The approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with the Leadership Principles described in this Agreement. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

9.5.2 There are two levels of decision making:

- Decisions made by individual organisations - this Agreement does not affect the individual sovereignty of Partners or their statutory decision-making responsibilities.
- Partnership decisions - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum. Decision making will be based on all Partners unanimously agreeing to proposals. Such agreement not to be unreasonably withheld or delayed.

9.5.3 The Partnership Board has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for co-ordinating collaborative decisions that will progress achievement of the Care Closer to Home ambition and objectives described in this Agreement.

9.5.4 Partners to the Partnership Agreement will attempt to resolve in good faith any dispute between them in line with the Leadership Principles described in this Agreement.

9.5.5 The Partnership will apply a dispute resolution process to resolve any issues which cannot otherwise be agreed through these arrangements. This will involve escalation of the issue disputed (where it has not been possible to achieve a unanimous decision)

to the Calderdale Executive Leadership Group that includes Chief Officer representation from all members of this Agreement.

10 Financial Framework

10.1 All members of the Partnership Board are ready to work together, manage risk together, and support each other when required. The Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

10.2 The Partners to this Agreement will:

- aim to live within our means, i.e. the resources that we have available to provide services;
- develop a Calderdale system response to the financial challenges we face;
- develop payment and risk share models that support a system response;
- collectively manage our NHS resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to deliver financial sustainability.

10.3 The health Partners to this Agreement are committed to considering the adoption of payment models which are better suited to whole system collaborative working (such as Aligned Incentive Contracting). The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

10.4 Through this Agreement the Partners commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across Calderdale in the event of the emergence of financial risk outside plans.

11. Charges and liabilities

11.1 Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Agreement. By separate agreement, the Partners may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a "Contributions Schedule" to be developed by the Partnership and approved by the Partnership Board. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

12. **Information Sharing**

12.1 Provider partners will commit to work transparently and provide to each other all information that is reasonably required in order to achieve the partnership objectives and to design and implement changes to the ways in which services and new models of care are delivered (and where the services are delivered from).

12.2 Partners will agree and establish appropriate ethical walls between and within the Provider Participants so as to ensure that sensitive Information and confidential Information is only available to those members of the Provider Participants who need to see it for the purposes of the partnership and for no other purpose.

12.3 The Partners to this Agreement will provide to each other all information that is reasonably required in order to achieve the Objectives and take decisions on a Best

for Calderdale basis. The Partners have obligations to comply with procurement and competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

13. **Confidential Information**

13.1 Each Partner will keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Agreement. No Partner shall use any Confidential Information received under this Agreement for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

13.2 To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information, including but not limited to competition law.

14. Signatures

14.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same document.

14.2 The expression “counterpart” shall include any executed copy of this Memorandum transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

SIGNATURE PAGE

SIGNED by ....

for and on behalf of **Calderdale Clinical Commissioning Group** (Signature)

.....

(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **Calderdale Metropolitan Borough Council** (Signature)

.....

(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **Voluntary Action Calderdale** (Signature)

..... (Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **Calderdale and Huddersfield Foundation Trust** (Signature)

..... (Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **South West Yorkshire** (Signature)

Partnership NHS Foundation Trust .....

(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **Locala Community Partnership** (Signature)

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(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of **Community Pharmacy West Yorkshire**

(Signature)

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(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

for and on behalf of North **Primary Care Network**

(Signature)

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(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

Clinical Director on behalf of Upper Valley **Primary Care Network**

(Signature)

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(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

Clinical Director on behalf of Central **Primary Care Network**

(Signature)

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(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

Clinical Director on behalf of Lower Valley **Primary Care Network**

(Signature)

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(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

SIGNED by ....

Clinical Director on behalf of Calder and Ryburn (Signature)

Primary Care Network .....

(Date)

WITNESS:

Signature .....

Name .....

Address .....

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Occupation .....

(PLEASE COMPLETE IN CAPITALS)

The members of the Calderdale Collaborative Community Partners and the parties to this agreement are:

SCHEDULE 1 – CALDERDALE COLLABORATIVE COMMUNITY PARTNERS	
Calderdale Clinical Commissioning Group (CCG)	5th Floor, F Mill, Dean Clough Mills, Halifax, West Yorkshire, HX3 5AX
Calderdale Metropolitan Borough Council	Town Hall Crossley Street Halifax HX1 1TS
Voluntary Action Calderdale (VAC)	Resource Centre, Hall Street, Halifax, HX1 SAY
Calderdale and Huddersfield NHS Foundation Trust (CHFT)	Acre Street, Lindley. Huddersfield HD3 3EA
South West Yorkshire Partnership NHS Foundation Trust (SWYFT)	Fieldhead, Ouchthorpe Lane, Wakefield, WF1 3SP
Locala Community Partnerships CIC	Beckside Court 286 Bradford Road, Batley WF17 5PW
Calderdale Primary Care Networks (PCN) • Central Halifax • Calder & Ryburn • Lower Valley • North Halifax • Upper Calder Valley	
Community Pharmacy West Yorkshire	Brooklands Court, Tunstall Road, Leeds, LS11 5HL

13. CHFT Climate Change Update

To Approve

Presented by Stuart Sugarman

COVER SHEET

Date of Meeting:	5th November 2020
Meeting:	CHFT board
Title:	CHFT Climate Change/Sustainability update
Author:	Robert Dadzie, Environment Manager
Sponsoring Director:	Stuart Sugarman
Previous Forums:	CHS Board

Actions Requested:
The Board is asked to adopt national targets for Net Zero and to approve the proposed strategy for its delivery, including the adaptation plan (referenced on page 6 of the paper)

Purpose of the Report

Introduction
This document is an update to the report that went to CHFT Board in January 2020. It introduces a plan and set of initiatives for delivering carbon reduction across the CHFT. It is hoped that the successful implementation of these initiatives will allow the Trust to meet obligations relating to Climate Change and net zero. Across Calderdale and Kirklees, local authorities have pledged to achieve net zero carbon emissions by 2038, ahead of the national targets for delivery by 2050. Moreover, NHSE have recently announced a commitment to achieving carbon neutrality by 2040 (in relation to our direct emissions). With interim targets set for 2028-2032. Targets have also been set for reducing emissions relating to our supply chain.

The adaptation of health services to current and projected impacts of climate change is vital for ensuring future resilience across the NHS. It has a key role to play in supporting vulnerable groups during adverse weather events and increasing climate change impacts (SDU, 2014).

As a Trust CHFT has a significant role to play in leading and supporting action. The Trust is well positioned to realise the aligned benefits that can be achieved between public health and carbon reduction. As an anchor institution we are expected to demonstrate good practice. We already have a Sustainable Development Management Plan (SDMP) and a Sustainable Development Action Plan to implement this. Both documents are presently live, however need to be reviewed and transposed into a Trust-wide Green Plan, which is intended to be in place by March 2021.

This Green Plan will enable us to monitor and evaluate progress against our carbon reduction targets and on an annual basis. The proposals outlined will also enable us to demonstrate our efforts to patients, staff and the wider public.

Key Points to Note

This document builds upon the existing Sustainable Development Management Plan (SDMP) for the CHFT, which is due to be transposed into a Trust-wide Green Plan by March 2021.

What is a Green Plan? (NHSE, 2020)
A Green Plan is a Board approved, current live strategy document outlining the organisation's aims, objectives, and delivery plans for sustainable development. This should include implementation of the NHS Long Term plan deliverables.

Developing a Green Plan will help the CHFT to

1. Deliver on its Long-Term plan
2. Improve the health of the local community
3. Achieve its financial goals
4. Meet its legislative requirements

A Green Plan may be valid for 3 to 5 years and should be reviewed at least once in the interim period. To ensure a Green Plan has impact and that progress is made against the commitments set out, plans are expected to be reported to the Board or Governing Body on an annual basis. A Green Plan should be submitted to relevant partners and communicated to staff and the public via the intranet, newsletters and the organisation's website.

EQIA – Equality Impact Assessment

The resulting impact of rising global temperatures on the UK Healthcare sector is expected to be significant. Heat-related mortality is projected to increase steeply from around a 70% increase in the 2020s to around 540% in the 2080s. Ageing populations and those with underlying medical conditions are most likely to be adversely affected by increased temperatures.

Climate change is also likely to have more significant impacts on communities within poorer regions, who will be greater affected by increased fuel, energy, water and food costs. Deprived areas of our community, such as those highlighted in the Calderdale MBC report into the impact of COVID 19, are more likely to be negatively impacted by climate change. These include a high proportion of BAME communities.

However, the UK remains well-placed to benefit from a transition to net-zero emissions. Innovation and falling technology costs mean we now estimate that the UK's carbon reduction targets could be met at a lower cost than first estimated i.e. under 1% of GDP in 2050 (Committee on Climate Change, 2019). As the price of renewables continues to undercut fossil fuels and as technological innovation becomes more competitive the demand for green energy tariffs will increase along with access to carbon saving initiatives.

For instance, the cost of electric vehicle batteries is projected to fall by 32% between 2025 and 2030. Similar patterns are expected for renewable power generation, such as wind power which is expected to experience a 26% reduction in unit cost over the same period.

Nonetheless, climate actions with a positive intent to improve carbon reduction may impact some groups negatively. Plans to increase the number of electric cars and increase tax and fuel costs for petrol and diesel cars may disproportionately impact on economically disadvantaged groups. Electric cars are typically more expensive to buy second hand than diesel or petrol cars.

Deprived communities may also experience reduced accessibility to key services if laws to reduce carbon emissions from high polluting vehicles are introduced. This could be exacerbated by the reconfiguration of hospital services away from city centres which will also impact the ability of poorer communities to access health and care services. Ensuring our services are easy to access via frequent and affordable public transport is an important consideration.

Engagement plans for our climate change strategy will include specific engagement with staff and groups from each of the 9 protected characteristics, with an additional engagement focus for economically disadvantaged communities. All communications, plans and policies will be written in plain English, to support members of the community who are neuro diverse or who have learning disabilities. Consultation documents will also be available in different languages, audio and brail. A full EQIA will be conducted on our climate change activities and presented to Board.
Recommendation
The Board is asked to adopt national targets for Net Zero and to approve the proposed strategy for its delivery, including the adaptation plan (referenced on page 6 of the paper)

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

23/10/20 (Draft #2)

Climate Change Paper

A response to the growing threats posed by climate change, an event recognised as the century's biggest threat to public health. The NHS is ideally placed to address the health related impacts posed by climate change and as such its organisations are expected to respond to increased public concerns. The proposals outlined in the paper will ensure that the CHFT remains resilient and able to adapt to emerging targets for carbon reduction at both local and national levels.

1. EXECUTIVE SUMMARY

Currently the NHS is responsible for over 25% of total public sector emissions and 3.2% of total carbon emissions in England (NHSE / Sustainable Development Unit (SDU). Heating, ventilation, and air conditioning systems alone account for 15-35% of total operational electricity within hospitals.

In order to remain resilient all NHS organisations are expected to respond to the projected and current impacts posed by climate change (SDU, 2014). In respect of this NHS England recently stated that all NHS organisations should achieve Net Zero carbon standards in the development of new buildings and refurbishment projects.

Furthermore, NHS organisations are expected to outline how their resilience and emergency planning arrangements will:

1. Take part in local planning arrangements for adapting to climate change.
2. Understand risks to the organisation from climate change and develop appropriate action plans (as part of a Sustainable Development Management Plan or equivalent).
3. Report adaptation plan progress in the organisation's annual report.

The NHS Greenhouse Gas Protocol (GHGP) requires Trusts to deliver carbon savings across the following three scopes:

- **GHGP scope 1:** Direct emissions from owned or directly controlled sources, on site
- **GHGP scope 2:** Indirect emissions from the generation of purchased energy, mostly electricity
- **GHGP scope 3:** All other indirect emissions that occur in producing and transporting goods and services, including the full supply chain.

NHS Trusts are also expected to work towards net zero for a NHS Carbon Footprint Plus (illustrated in Figure 1). This addresses each scope outlined above, as well as the emissions from patient and visitor travel and the emissions from medicines used within the home.

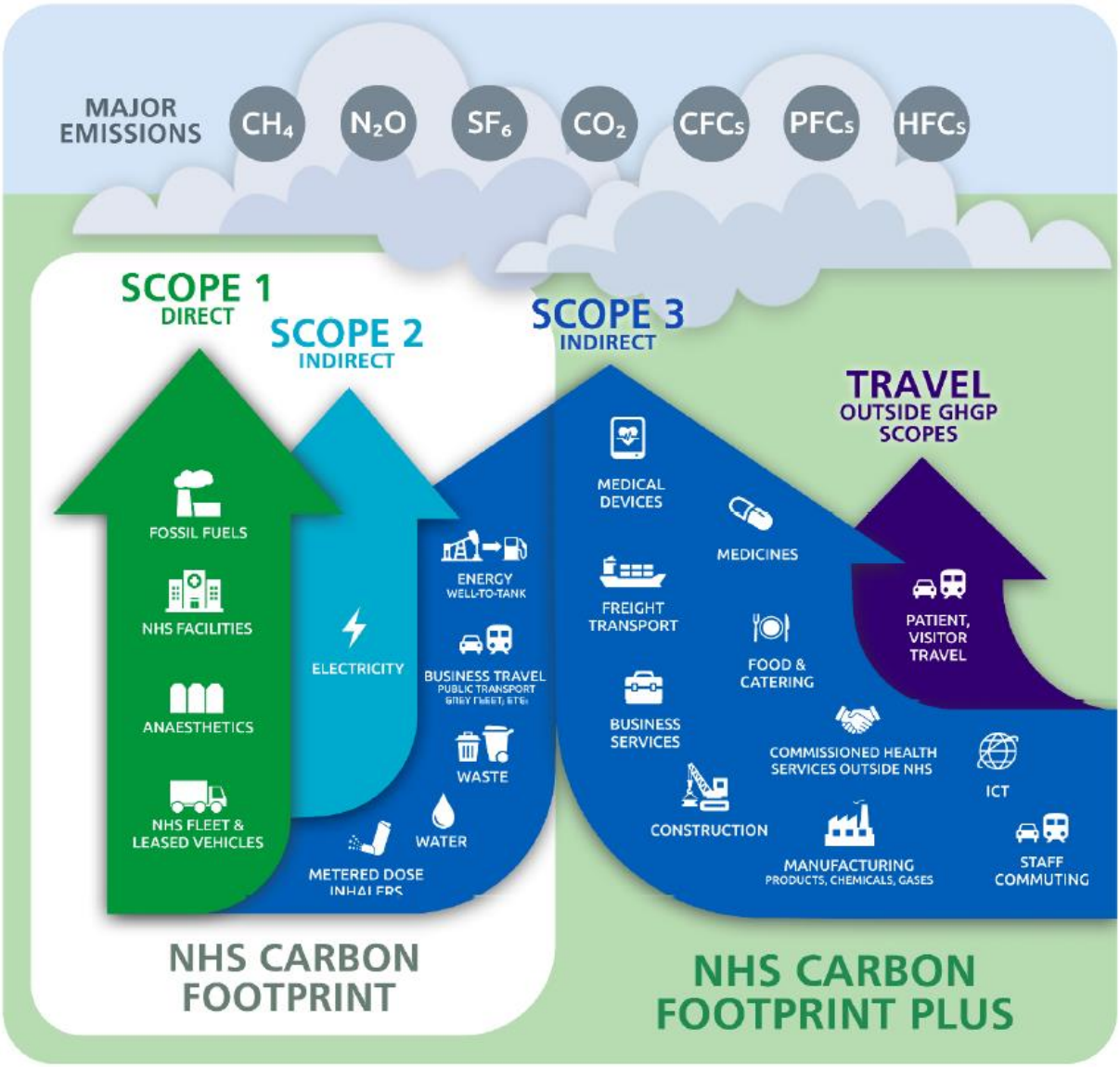
1.1. Emerging NHSE Targets

NHS England have announced two targets for delivering carbon neutrality. These are as follows:

1. Net zero for the NHS Carbon Footprint (scope 1&2 emissions).
    - 100% reduction of direct carbon emissions by 2040;
    - **Interim target -** 80% reduction achieved between 2028-2032.

2. Net zero for the NHS Carbons Footprint Plus (scope 3 incl. patient / visitor travel)
    - 100% reduction of indirect / supply chain emissions by 2045;
    - **Interim target -** 80% reduction achieved between 2036-2039.

FIGURE 1 - NHSE GREENHOUSE GAS PROTOCOL (GHGP) SCOPES 1-3



1.2.WHAT IS CARBON NEUTRALITY?

As a sector the NHS emits over 18 million tonnes of CO_2 each year, from heating, cooling, lighting, plant equipment, procurement, landfilled waste, and also through patient, staff and visitor travel.

Crucially, clinical decisions and procurement are also having an impact with a large proportion of greenhouse gas emissions arising from the manufacture and supply of drugs and equipment.

An organisation that is carbon neutral (i.e. which meets Net Zero targets) is one that avoids emitting greenhouse gases through its generation of energy. It is therefore 100% powered by renewable energy and achieves a level of operational energy performance in line with our national climate change targets (LETI, 2017). In circumstances where emissions cannot be fully reduced then carbon offsetting can be sought through investment into natural carbon sinks such as oceans and forests.

1.3.WHAT HAVE WE ALREADY DONE?

Our achievements so far include the following:

- Development of a Sustainable Development Management Plan (SDMP) and Action Plan;
- Establishment of a Sustainable Development Group and volunteer Green Champion network;
- Securement of funding to begin an LED lighting programme at HRI and CRH (replacing light fittings with energy efficient LED) to reduce consumption by more than 3 megawatts at both sites;
- CHFT now procures 100% of its energy from renewable energy tariffs through Opus Energy (HRI) and EDF (CRH);
- We have also identified Stuart Sugarman MD of CHS to be the climate and sustainability lead for the Trust;
- We are fully engaged in the climate/sustainability agenda attending groups through West Yorkshire and Harrogate Health & Care Partnership and the West Yorkshire Combined Authority;
- CHFT is also signed up to the WYATT sustainable procurement policy.

LED replacement update - The LED replacement project is expected to benefit the Trust by helping to reduce operational energy demands. Savings achieved to date through instalments across HRI have resulted in the following achievements:

Energy Saving

- Savings so far based on progress at HRI (FY19/20 and FY20/21 on-going):
  Cost saving: ~£11k (based on the lights being used 70% of the time)
  Energy Saving: 97,000 kWh. (70%)

- Expected savings once all LED Lights fitted across HRI (FY21-22):
  Cost saving: ~£178k (based on the lights being used 70% of the time)
  Energy Saving: 1,483,300 kWh. (70%)

- Expected savings at CRH
  Cost saving: ~£282k annually

2. WHAT IS THE PROPOSED PLAN

2.1.PROPOSED STRATEGY

We will transpose the existing SDMP into a trust-wide Green Plan. Alongside this and building on what we have already achieved, the set of opportunities that will be evaluated at the end of 2021 are as follows:

- Explore further avenues for project funding, including the emerging Public Sector Decarbonisation Fund – a grant offered by Salix. Invest funding into renewable energy generation (i.e. photovoltaics), insulation, heat pumps and efficient plant equipment.
- Pursue external consultation through the Low Skills Fund and to assist with developing the decarbonisation plan for the Trust.
- Ensure sustainability plans are fully aligned with and support the hospital reconfiguration plans. The Transformation Programme Board approved a Sustainability Design Brief at its meeting on 11/9/20
- Increased internal communication to facilitate behavioural change and to raise awareness of sustainability & our impact.

- Support and promote avenues of workforce engagement. For instance Carbon Literacy training and upcoming events.
- Integrate targets for carbon reduction and net zero into corporate objectives. Publically report ambitions and progress within annual publications.
- Support proposals for green travel planning, which promote active transport and seek to limit single-occupancy car journeys.
- Work alongside Calderdale & Kirklees local authorities and WYCA to promote a staff travel survey.
- Promote where possible local procurement policy to address Scope 3[1] supply chain emissions.
- Include sustainability as a requirement in Board papers and in business case applications (Update template documentation as soon as possible).
- Evaluate new fleet tender specifying electric or hybrid vehicles as a minimum and promote electric fleet vehicles where possible.
- Promote the use of Warp-it, an online platform for reuse of items within the Trust and with other organisations within the public and third sector (i.e. universities, hospitals, schools and charities).
- Continue with the installation of electric car charging points at HRI expanding depending on demand by fleet vehicles, staff and patients.
- Senior Trust and CHS staff to work with Calderdale and Kirklees council who have established a Climate Commission.
- Improve waste segregation, reducing reliance on financially and environmentally costly high temperature incineration.
- Identify and investigate viability of alternative solutions for specific clinical waste streams, e.g. reusable sharps containers, theatre waste and endoscopy waste.
- Work with our partners, such as Compass and ISS, to implement the NHS Plastic Pledge. To support this, investigate feasibility of offering staff and patient discounts for using reusable cups and food containers in our restaurants.
- Annual sustainability reporting (including carbon calculations) to publicise our achievements to date and future ambitions (coincide with CHFT annual report).
- Work alongside CHS Estates to limit onsite tree and vegetation loss.

Our long-term plans for 2021-2030 will include:

- Explore alternative solutions to Combined Heat and Power (CHP) systems, which support ambitions for Net Zero, for instance ground source or air source heat pumps.
- The design for a multi-storey car park at the CRH, should complement the proposed Green Travel plan for the Trust. The initial design must include charging points and it should also allow for future installations, with an overall target of around 10%.
- Promote carbon awareness and individual action through online platforms as seen for instance through Care Without Carbon initiative.
- Work with Workforce and Organisational Development (WOD) and Occupational Health to encourage sustainable (staff) travel through cycle schemes and public transport discounts.
- Target of recycling over 40% of non-clinical waste. Present numbers are closer to 10% at the CRH and 18% at the HRI.
- Work with Procurement to embed sustainable procurement through inclusion of sustainability specification and evaluation criteria in all procurement contracts.
- Work with WOD to increase agile working opportunities to reduce unnecessary travel to a specific place of work.
- Work with THIS to increase digital services to reduce the requirement for patients to travel to outpatient appointments. Communications strategy should reflect this.

[1] Greenhouse Gas Emissions are categorised as Scope 1, 2 or 3. Scope 1 refers to direct emissions i.e. through vehicles, combustion and fugitive releases. Scope 2 relates to our purchased electricity, heat & steam. Scope 3 relates to indirect emissions from our supply chain i.e. through investments, business travel, waste disposal and services / products.

- Embed BREEAM (building sustainability assessment) in reconfiguration plans for CRH and HRI (at initial design stage and during construction).
- Ensure that innovative, low carbon materials are embedded into the design of future builds and in order to reduce the embodied carbon associated with construction.
- Develop a strategy with Pharmacy to address scope 1 emissions by reducing the use of most harmful anaesthetic gases.
- Increase repair and reuse of equipment such as crutches and walking frames
- Investigate the opportunities to generate electricity onsite, e.g. via photovoltaic cells, to ensure resilience against future changes in global energy markets.
- Explore and adopt offsetting opportunities. For instance, funding to plant 6,000 trees (one for every staff member) on our estate, within the local authority and as part of the NHS National Forest to help mitigate the impacts of carbon in the atmosphere. Target of planting 1,200 annually.
- Work with Occupational Health to form a 'Green Gym' for staff to volunteer, e.g. tree planning, local clean-ups etc).
- Apply to the Combined Authority's Energy Accelerator scheme and associated European Local Energy Assistance (ELEA) fund. Consider requirements for CHFT reconfiguration – deadline for contractor tender process 31st July 2021.
- Facilitate behavioural change through staff engagement - work to increase workforce participation in sustainability events, training and online platforms.

2.2.Proposed Adaptation Plan

Adaptation planning is vital for ensuring future resilience across the NHS (SDU, 2014). The following criterion provides a checklist for ensuring resilience and adaptation is achieved by the Trust.

	Embedded in a Board approved Green Plan
	Approved annually by the Board
	Links to Emergency Preparedness Plans, Business Continuity Plans and vice versa
	Developed in partnership with Local Authority and other stakeholders, for example members of the Health and Wellbeing Boards, the third sector, service users
	Includes a mechanism for review and updating
	Scrutinised, or part of a mutual accountability process, e.g. by local resilience

2.3.Communications strategy

Internal communications will be an integral part of the Trust wide plan for carbon reduction. Message boards and intranet pages will support staff engagement & awareness; and also the uptake of emerging initiatives (i.e. carbon literacy training / car sharing opportunities / park and ride). A calendar of key dates should be published to promote participation with events for instance cycle/walk to work days; Earth Day and Veganuary. Internal communications will also be essential to communicate targets for carbon reduction alongside the achievement of significant milestones.

External communications will also be vital to the success of this plan. It is important that transparency is achieved in reporting. This can be realised through voluntary reporting enterprises such as Business in the Community (BiTC) or the Global Reporting Initiative (GRI). External channels will be a useful tool for updating patients and key stakeholders of our progress.

2.4.Travel Planning and Agile Working

The Green Travel Plan for the Trust will need to be further developed in order to address Scope 1 emissions from fleet vehicles and Scope 3 emissions from visitor travel and the supply chain. A travel survey will need to be published and completed by staff and visitors in order to calculate

the associated carbon footprint. The travel survey is to include questions relating to active transport, it will also need to determine the potential demand for car sharing, electric vehicles (EV) and salary sacrifice schemes. Present proposals aim to increase the availability of EV charging points within the design of multi storey car parking at the CRH - The results gathered from a travel survey will inform any future decisions regarding the installation and location of this supply.

COVID-19 has also increased opportunities to work from home. The travel plan should establish the potential for continued agile working, in an attempt to capitalise on the present trend in demand. Barriers to agile work should be identified through the survey, alongside opportunities to further encourage virtual communications (i.e. though platforms such as Microsoft Teams, Skype etc).

3. What will be the results?

The successful delivery of this Climate Change Plan will likely result in several localised benefits, which will be realised by the Trust, its patients, residents and employees. Carbon reduction measures remain intrinsically linked to conversations surrounding energy management, air quality, travel and transport and public health. Financially speaking, the proposed carbon reduction commitments should support efforts to increase efficiency throughout the Trust. Additionally, not only does carbon reduction help to lower our overall energy bills but by tackling transport related emissions we are also helping to improve air quality in around the CHFT. Table 2 in the appendices outlines financial benefits that can be achieved by the NHS through the implementation of carbon saving measures.

The Green Plan demonstrates how we will be PROACTIVE and lead by example.
By demonstrating commitment, we will work with staff and patient groups to ensure that by 2030 residents feel the health benefits of noticeably improved air quality and reduced road congestion. In addition to this patients and staff will benefit from the financial savings achieved through reduced operational energy demands.

3.1.Next steps

- **CHFT Board to officially adopt national targets for net zero and agree interim targets for monitoring carbon reduction (refer to page 2);**
- **CHS to communicate findings from annual carbon reporting to the CHFT Board;**
- **Transpose the current SDMP into a Trust wide Green Plan;**
- **Embed sustainability into emerging organisational strategies and reconfiguration plans;**
- **Update sustainability design brief for reconfiguration to reflect recently published targets for net zero. Seek external consultation to support with delivering the project's carbon plan;**
- **Ensure green agenda is included in travel planning and surveys;**
- **Begin discussions with procurement regarding Sustainable Procurement Policy & planning;**
- **Develop internal communications to promote staff, patient and visitor engagement.**

4. Appendices

The two tables below illustrate some of the carbon saving measures that NHS England aim to implement alongside their potential to achieve CO_2 and cost savings. It is important to note that whilst the cost benefits of Combined Heat and Power systems (CHP) are projected to increase over the next 10 years, the carbon savings obtained are projected to fall significantly over the same period. Whilst in 2010 an efficient CHP would have achieved around 30% less carbon emissions than gird electricity, as the supply of renewable energy increases then the carbon intensity of grid supply decreases. Meaning that the carbon benefits provided by CHPs also decreases in comparison to standard grid supply. The benefits decrease more significantly when the Trust's renewable energy tariffs are taken into account.

Emissions sector	Type of emissions reduction	Description	Impact
Building energy	Refurbish buildings	Refurbish all NHS buildings using Low or Zero Carbon Technologies (LZCT)	Reduces NHS building energy use by 25%.
Building energy	Replace buildings	Replace all NHS buildings with super-efficient stock	Reduces NHS building energy use by a further 25%.
Travel	Low carbon travel plans	Low carbon travel plans adopted across entire NHS	Reduces mileage and corresponding CO2 by 20%. Increasing vehicle efficiency reduces business travel emissions by a further 30%.
Building energy Procurement	40% renewable electricity procurement. (Superseded by 2050 Net Zero Targets)	40% renewable electricity from National Grid	Reduces NHS building energy emissions by 40%. Procurement related emissions will also drop by 5%. Superseded by Net Zero Targets which aim for 100% renewable procurement.
Procurement	Reduce pharmaceuticals wastage	Reduce pharmaceuticals wastage	Improvements in dispensing and packaging leads to 20% cut in pharmaceuticals purchased.
Procurement	Review procuring medical equipment	Review procuring medical equipment	Efficiencies reduce purchases by 20% in combination with sharing specialist equipment between Trusts.
Procurement	Maximise procurement efficiencies	Maximising procurement efficiencies	Minimising waste produces 20% savings in non-pharmaceutical and medical equipment
Travel Building energy	Model of care	Shifts to less intensive models of care	Reduce NHS emissions by an extra 10% above efficiencies already gained in transport and procurement.

Table 1 - NHS SDU GHG emission reduction measures

Table 2 - NHS Sustainable Development Unit (2010) - Carbon reduction measures and projected savings across the NHS.

Carbon Saving Measures	CO2 Savings (tCO2/yr)	£000 Savings (£000/yr)
1. Packaging of medical equipment	22,430	+81
2. Reduce drug wastage	6,827	+89,428
3. Teleconferencing to replace 5% of business miles	10,612	+13,913
4. Decentralisation of hot water boilers in non-acute/PCT	232,331	+2,547
5. Combined Heat and Power installed in acute trusts (referenced at the start of appendix)	5,508	+49,487
6. Variable Speed Drives	1,096	+925
7. Introduce hibernation system for ambulance stations	26,551	+148
8. Improve heating controls	29,686	+3,558
9. Improve lighting controls	30,140	+3,770
10. Energy efficient lighting	29,364	+2,743
11. Voltage optimisation	7,313	+2,202
12. Improve the efficiency of chillers	25,928	+519
13. Roof insulation	92,549	+1,685
14. Energy Awareness Campaign	20,610	+5,645
15. Building Management System optimisation	11,195	+1,154
16. Improve Insulation to pipework, and/in boiler house	2,999	+616
17. Install high efficiency lighting/controls - ambulance trusts	49,144	+165
18. 1 degree C reduction in thermostat temperature	8,933	+2,605
19. Improve the efficiency of steam plant or hot water boiler plant	214	+465
20. Upgrade garage and workshop heating	171	+10
21. Boiler replacement/optimisation for HQ/control centres	951	+2
22. Improve building insulation levels in ambulance trusts	25,928	+11
23. Wall insulation	7,957	+207
24. Office electrical equipment improvements	81,524	+32
25. Travel Planning	25,928	0
26. Insulation - window glazing and draught proofing	36,969	-156
27. Electric vehicles	245	-702
28. Wind Turbine	30,533	-6
29. Biomass Boiler	22,430	-1069

FINANCIAL SUSTAINABILITY

14. Month 6 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5th November 2020
Meeting:	Board of Directors
Title:	Month 6 Finance Report
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance
Previous Forums:	Finance and Performance Committee

Actions Requested:

To receive – to discuss in depth, noting the implications for the Board or Trust without formal approval

Purpose of the Report

To provide a summary of the financial position and forecast as reported at the end of Month 6 (September 2020)

Key Points to Note

Year to Date Summary

The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for the first six months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £14.03m of retrospective top up funding: £11.66m has been approved for M1-5, with a further £2.38m required for M6.

- Year to date the Trust has incurred costs of £16.28m in relation to Covid-19. M6 costs incurred were £2.33m, driven mainly by the expansion of the workforce, the segregation of patient pathways, increased Respiratory support capacity, backfill for increased sickness absence and PPE costs.
- The underlying position excluding Covid-19 costs is a year to date favourable variance of £2.25m, driven by the impact of lower levels of other activity on non-pay costs and staffing vacancies.
- The Trust is required by NHSI to report a balanced position, but this does not include the potential impact of the Elective Incentive Scheme which remains a financial risk. Based on Month 6 activity compared to National targets, the impact of this penalty is estimated to be £0.44m.
- Whilst there is no national expectation of CIP delivery, the Trust continues to deliver some savings as planned. CIP achieved year to date is £2.01m, £5.38m below plan
- Agency expenditure year to date is £1.95m, £0.94m below the planned level.

Key Variances (compared to NHSI derived plan)

- Clinical Contract income is in line with the NHSI Interim plan due to new fixed block and top up arrangements. The 'Retrospective Top Up' of £14.03m drives a favourable variance in overall Clinical Income, offset to some extent by lower than planned income from other sources including private patients, and the absorption of CCG Health Informatics contracts, (usually invoiced as non-clinical income), into the Block. The direct impact of Covid-19 on income generation is a £1.94m adverse variance, including a reduction in Private Patient, Car Parking and Catering income.
- Pay costs are £4.97m above the planned level year to date due to the impact of Covid-19 which is calculated to be £6.96m year to date. The costs attributed to Covid-19 were offset to some extent by underspends in some specialties due to reduced activity and a level of unfilled vacancies in unrelated non-Covid impacted areas.
- Non-pay operating expenditure is higher than planned by £3.70m. The costs directly attributable to the Covid-19 response were £9.32m, offset in part by lower than planned costs for specialties that have seen lower than planned activity particularly over the first 4 months of the year. This includes lower than planned consumables and drugs.

Forecast

The current Block and Top Up arrangements with access to retrospective funding to cover Covid costs have now ended. For Month 7 to 12 (Phase 3), the Trust will be required to manage within the ICS agreed financial envelope. The Trust has been allocated Covid and growth funding on a fair shares basis to cover the remainder of the year. Confirmed funding is insufficient to cover all forecast additional costs and the Trust is therefore planning a £24.92m deficit for the second half of the year. This position includes a £23m accounting adjustment that will not require cash funding leaving an underlying unfunded gap of £1.92m.

- Pay commitment for Phase 3 reset activity drives additional unfunded recurrent costs of £6.4m that will impact on 21/22.
- Wellbeing hour is assumed in the forecast at no additional cost.

Attachment: Month 6 Finance Report

EQIA – Equality Impact Assessment

The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an 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.

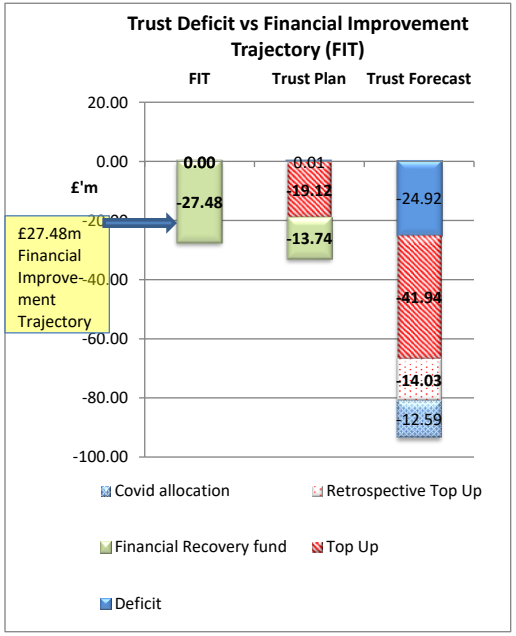
Recommendation

The Board is asked to receive the Month 6 Finance Report and note the financial position for the Trust as at 30 September 2020.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Sep 2020 - Month 6

KEY METRICS

	M6				YTD (SEP 2020)				Forecast 20/21			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£0.00)	(£0.00)	£0.00		(£0.01)	(£0.00)	£0.01		£0.47	(£24.92)	(£25.39)	
Agency Expenditure	(£0.48)	(£0.40)	£0.09		(£2.89)	(£1.95)	£0.94		(£6.52)	(£4.78)	£1.74	
Capital	£1.56	£0.99	£0.57		£8.42	£4.07	£4.35		£20.85	£23.52	(£2.67)	
Cash	£3.94	£58.71	£54.77		£3.94	£58.71	£54.77		£3.99	£28.03	£24.04	
Borrowing (Cumulative)	£20.98	£20.98	£0.00		£20.98	£20.98	£0.00		£19.88	£19.88	£0.00	
CIP	£1.23	£0.36	(£0.87)		£7.39	£2.01	(£5.38)		£14.77	£5.22	(£9.55)	
Use of Resource Metric	2	2			3	3			3	2		



Year to Date Summary

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- Pay commitment for Phase 3 reset activity drives additional unfunded recurrent costs of £6.4m that will impact on 21/22.
- Wellbeing hour is assumed in the forecast at no additional cost.

Total Group Financial Overview as at 30th Sep 2020 - Month 6

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M6

CLINICAL ACTIVITY

	M6 Plan	M6 Actual	Var
Elective	2,711	762	(1,949)
Non-Elective	29,620	22,466	(7,154)
Daycase	21,735	7,803	(13,932)
Outpatient	185,137	70,768	(114,369)
A&E	80,293	61,707	(18,586)
Other NHS Non-Tariff	915,220	533,219	(382,002)
Other NHS Tariff	65,966	38,743	(27,223)
Total	**1,300,682**	**735,467**	**(565,215)**

TOTAL GROUP: INCOME AND EXPENDITURE

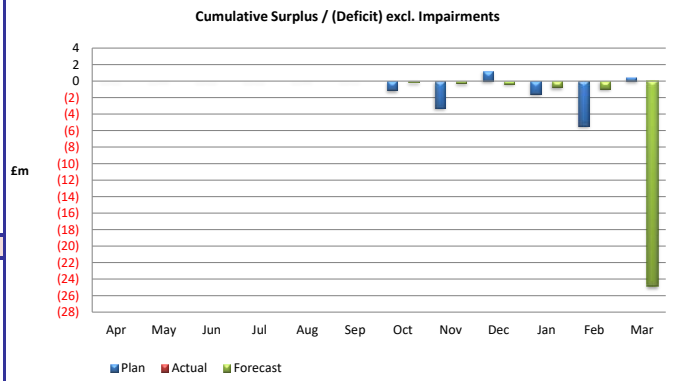
	M6 Plan	M6 Actual	Var
	£m	£m	£m
Elective	£8.50	£8.50	£0.00
Non Elective	£56.03	£56.03	£0.00
Daycase	£15.39	£15.39	£0.00
Outpatients	£23.13	£23.13	£0.00
A & E	£11.76	£11.76	£0.00
Other-NHS Clinical	£58.10	£60.03	£1.93
CQUIN	£1.89	£1.89	£0.00
Other Income	£27.78	£22.43	(£5.35)
Total Income	**£202.57**	**£199.15**	**(£3.42)**
Pay	(£133.52)	(£138.50)	(£4.97)
Drug Costs	(£21.25)	(£20.59)	£0.66
Clinical Support	(£13.16)	(£13.81)	(£0.66)
Other Costs	(£31.49)	(£35.19)	(£3.70)
PFI Costs	(£6.64)	(£6.64)	£0.00
Total Expenditure	**(£206.06)**	**(£214.73)**	**(£8.67)**
EBITDA	**(£3.49)**	**(£15.58)**	**(£12.09)**
Non Operating Expenditure	(£12.45)	(£12.01)	£0.45
Surplus / (Deficit) Adjusted*	**(£15.94)**	**(£27.59)**	**(£11.64)**
Conditional Funding (MRET/FRF/Top Up)	£15.93	£27.59	£11.66
Surplus / Deficit*	**(£0.01)**	**(£0.00)**	**£0.01**

* Adjusted to exclude items excluded for Financial Improvement Trajectory purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

	M6 Plan	M6 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£7.53	£11.66	£4.13
Medical	£21.26	£16.54	(£4.72)
Families & Specialist Services	(£3.94)	(£2.76)	£1.18
Community	(£0.92)	(£1.29)	(£0.37)
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£21.97)	(£22.96)	(£1.00)
THIS	£1.13	£0.75	(£0.39)
PMU	£1.77	£1.59	(£0.19)
CHS LTD	£0.30	£0.44	£0.14
Central Inc/Technical Accounts	(£7.52)	(£3.51)	£4.00
Reserves	(£1.29)	(£0.44)	£0.85
Unallocated CIP	£3.62	£0.00	(£3.62)
Surplus / (Deficit)	**(£0.01)**	**(£0.00)**	**£0.01**

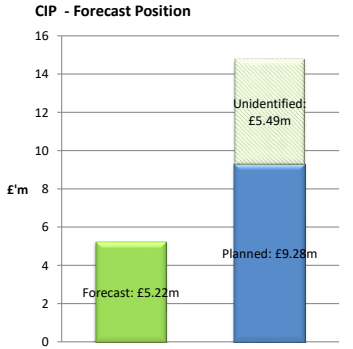
TOTAL GROUP SURPLUS / (DEFICIT)

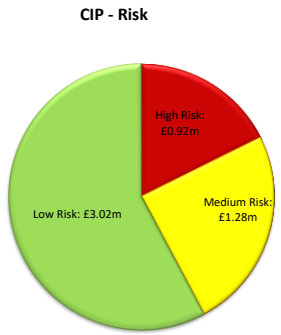


KEY METRICS

	Year To Date			Year End: Forecast		
	M6 Plan	M6 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£0.01)	(£0.00)	£0.01	£0.47	(£24.92)	(£25.39)
Capital	£8.42	£4.07	£4.35	£20.85	£23.52	(£2.67)
Cash	£3.94	£58.71	£54.77	£3.99	£28.03	£24.04
Loans	£20.98	£20.98	£0.00	£19.88	£19.88	£0.00
CIP	£7.39	£2.01	(£5.38)	£14.77	£5.22	(£9.55)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	3		3	2	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£14.77m**

Total Forecast **£5.22m**

YEAR END 20/21

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,574	2,278	(3,296)
Non-Elective	60,676	52,599	(8,076)
Daycase	43,418	22,181	(21,237)
Outpatient	368,867	160,143	(208,724)
A&E	158,149	133,379	(24,770)
Other NHS Non- Tariff	1,835,796	1,042,385	(793,411)
Other NHS Tariff	131,518	76,159	(55,359)
Total	**2,603,999**	**1,489,125**	**(1,114,873)**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£18.01	£18.01	(£0.00)
Non Elective	£114.89	£114.89	(£0.00)
Daycase	£30.72	£30.72	(£0.00)
Outpatients	£46.12	£46.12	(£0.00)
A & E	£23.16	£23.16	£0.00
Other-NHS Clinical	£112.00	£121.20	£9.20
CQUIN	£3.79	£3.79	(£0.00)
Other Income	£55.38	£45.73	(£9.65)
Total Income	**£404.07**	**£403.62**	**(£0.45)**
Pay	(£268.48)	(£286.54)	(£18.06)
Drug Costs	(£42.64)	(£41.90)	£0.73
Clinical Support	(£27.51)	(£31.01)	(£3.50)
Other Costs	(£59.54)	(£64.57)	(£5.04)
PFI Costs	(£13.21)	(£13.44)	(£0.22)
Total Expenditure	**(£411.38)**	**(£437.46)**	**(£26.08)**
EBITDA	**(£7.30)**	**(£33.83)**	**(£26.53)**
Non Operating Expenditure	(£25.08)	(£47.06)	(£21.98)
Surplus / (Deficit) Adjusted*	**(£32.38)**	**(£80.89)**	**(£48.51)**
Conditional Funding (MRET/FRF/Top Up)	£32.85	£55.98	£23.12
Surplus / Deficit*	**£0.47**	**(£24.92)**	**(£25.39)**

* Adjusted to exclude items excluded for Financial Improvement Trajectory: Donated Asset Income, Donated Asset Depreciation and Impairments.

DIVISIONS: INCOME AND EXPENDITURE

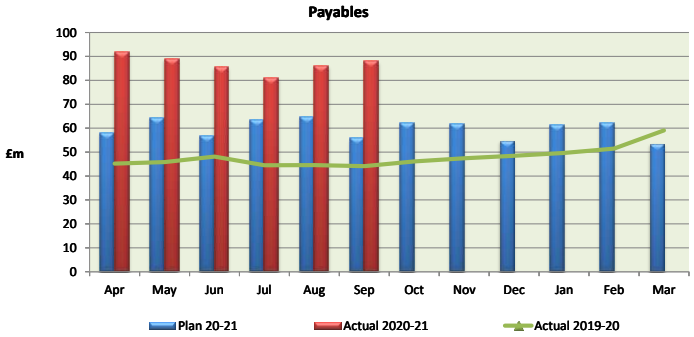
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£14.99	£17.51	£2.52
Medical	£44.01	£31.43	(£12.58)
Families & Specialist Services	(£7.10)	(£7.45)	(£0.35)
Community	(£1.89)	(£3.90)	(£2.01)
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£43.52)	(£46.03)	(£2.51)
THIS	£2.27	£1.49	(£0.78)
PMU	£3.55	£3.00	(£0.55)
CHS LTD	£0.75	£0.71	(£0.04)
Central Inc/Technical Accounts	(£15.39)	(£22.62)	(£7.22)
Reserves	(£3.81)	£0.94	£4.75
Unallocated CIP	£6.62	£0.00	(£6.62)
Surplus / (Deficit)	**£0.47**	**(£24.92)**	**(£25.39)**

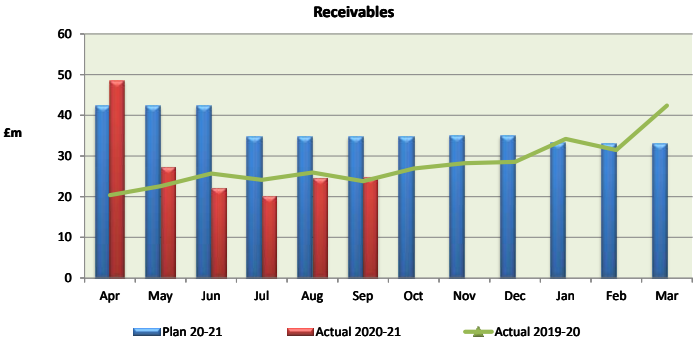
Total Group Financial Overview as at 30th Sep 2020 - Month 6

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

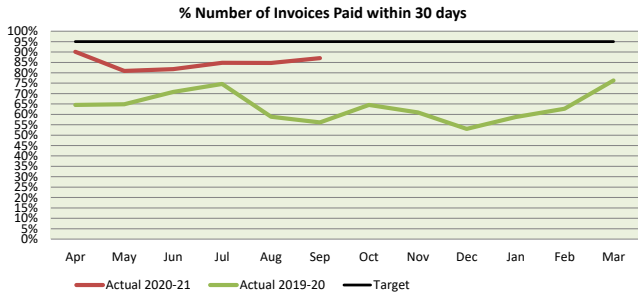
WORKING CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Payables (excl. Current Loans)	(£55.73)	(£87.94)	£32.21	
Receivables	£34.65	£24.88	£9.77	



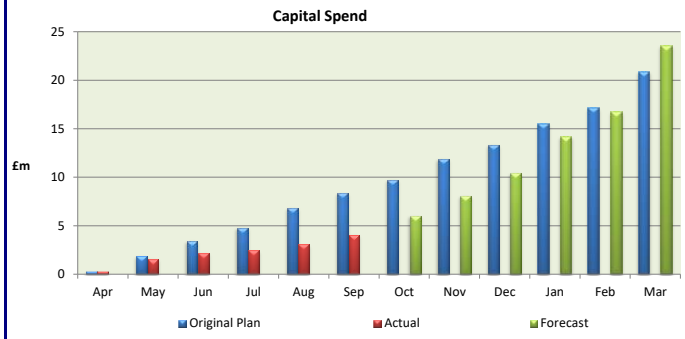


BETTER PAYMENT PRACTICE CODE



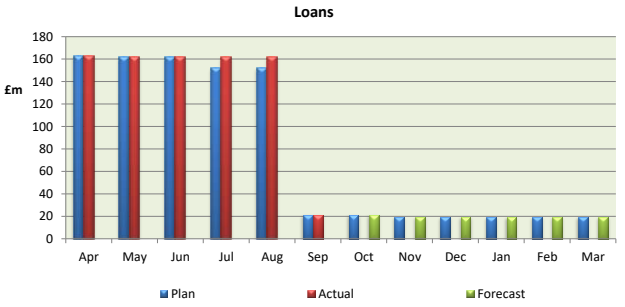
CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Capital	£8.42	£4.07	£4.35	

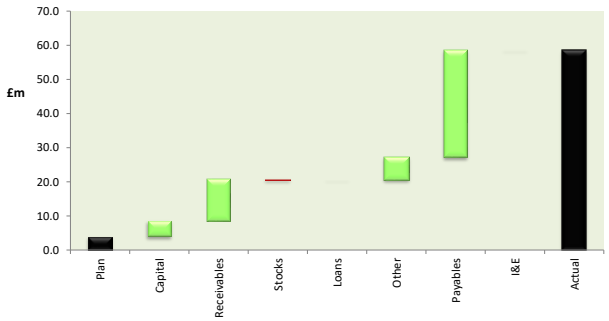


CASH

	M6 Plan £m	M6 Actual £m	Var £m	M6
Cash	£3.94	£58.71	£54.77	
Loans (Cumulative)	£20.98	£20.98	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for the first six months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £14.03m of retrospective top up funding (of which £11.66m has now been approved).
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- Whilst year to date activity is well below the original plan, it is increasing and Month 6 activity was overall higher than the Phase 3 plan / forecast.
- The Trust has incurred £16.28m in relation to Covid-19, of which £3.39m relates to gowns which were purchased by the Trust on behalf of the region.
- Year to date Capital expenditure was lower than planned at £4.07m against a planned £8.42m.
- Cash balance is £58.71m, £54.77m above plan: payments for October's Block and Top Up received in advance and £10m bonus Financial Recovery Funding (19/2
- No interim Revenue loans or PDC were required in month.
- Year to date CIP schemes have delivered £2.01m of savings, £5.38m lower than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3 against a planned level of 3. Liquidity is better than planned at level 3 due to the Trust's improved cash balance, all other metrics are as planned.

NOTES

- The Forecast shown is the Phase 3 plan submitted to NHSI on the 22nd of October. The current Block and Top Up arrangements with access to retrospective funding to cover Covid costs have now ended. For Month 7 to 12 (Phase 3), the Trust will be required to manage within the ICS agreed financial envelope. The Trust has been allocated Covid and growth funding on a fair shares basis to cover the remainder of the year. Confirmed funding is insufficient to cover all forecast additional costs and the Trust is therefore planning a £24.92m deficit for the second half of the year. This position includes a £23m accounting adjustment that will not require cash funding, leaving an underlying unfunded gap of £1.92m.
- The Trust is forecasting Agency expenditure of £4.78m, considerably below the NHSI ceiling of £8.82m, but offset by an increase in expenditure on Bank staff.
- The Trust is forecasting delivery of £5.22m savings against a Trust CIP plan for 20/21 of £14.77m.
- The Trust has not planned to borrow during this financial year due to changes in the cash regime, however should additional cash support be required due to the planned deficit position, the Trust should be able to access revenue support PDC.
- The total loan balance at year end is forecast to be £19.88m as planned. All Revenue and Interim Capital Loans (totalling £140.72m) were repaid and replaced by PDC funding during September.
- Capital expenditure is forecast at £23.52m, £2.67m more than the recently resubmitted 20/21 Capital Plan due to expected additional external funding for Urgent & Emergency Care, Endoscopy equipment, Critical Care and some additional Covid-19 related expenditure that is still waiting for approval, offset to some extent by a reduction in forecast expenditure for Reconfiguration.

RAG KEY: (Excl: UOR)

- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

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

RAG KEY: UOR

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

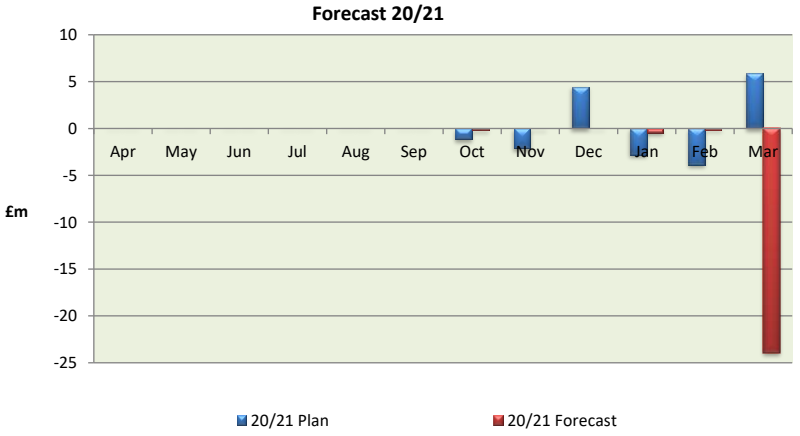
FORECAST

YEAR END 20/21

	Plan £m	Forecast £m	Var £m	
Elective	£18.01	£18.01	(£0.00)	
Non Elective	£114.89	£114.89	(£0.00)	
Daycase	£30.72	£30.72	(£0.00)	
Outpatients	£46.12	£46.12	(£0.00)	
A & E	£23.16	£23.16	£0.00	
Other-NHS Clinical	£112.00	£121.20	£9.20	
CQUIN	£3.79	£3.79	(£0.00)	
Other Income	£55.38	£45.73	(£9.65)	
Total Income	**£404.07**	**£403.62**	**(£0.45)**	
Pay	(£268.48)	(£286.54)	(£18.06)	
Drug Costs	(£42.64)	(£41.90)	£0.73	
Clinical Support	(£27.51)	(£31.01)	(£3.50)	
Other Costs	(£59.54)	(£64.57)	(£5.04)	
PFI Costs	(£13.21)	(£13.44)	(£0.22)	
Total Expenditure	**(£411.38)**	**(£437.46)**	**(£26.08)**	
EBITDA	**(£7.30)**	**(£33.83)**	**(£26.53)**	
Non Operating Expenditure	(£25.08)	(£47.06)	(£21.98)	
Surplus / (Deficit) Control Total basis*	**(£32.38)**	**(£80.89)**	**(£48.51)**	
Conditional Funding (MRET/PSF/FRF)	£32.85	£55.98	£23.12	
Surplus / Deficit*	**£0.47**	**(£24.92)**	**(£25.39)**	

*Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

Forecast



Month 7-12 (Phase 3) Financial Plan

The interim nationally agreed financial arrangements applied for the first 6 months of the year have now ended. The Trust will no longer have access to retrospective funding to cover Covid costs and instead from Month 7 the Trust will be required to manage within an ICS agreed financial envelope. The Trust has been allocated Covid and growth funding on a fair shares basis to cover the remainder of the year. Confirmed funding is insufficient to cover all forecast additional costs and the Trust is therefore planning a £24.92m deficit for the second half of the year. This position includes a £23m one off accounting adjustment that will not require cash funding, leaving an underlying unfunded gap of £1.92m as described below:

	£'m
Technical Accounting Adjustment:	£23.00
Loss of 'Other' Income:	£1.61
Annual Leave Accrual:	£0.50
Residual difference between funding and planned expenditure:	-£0.19
Total Planned Deficit	**£24.92**

This financial plan was submitted to NHSI on the 22nd Oct 20 and is an improved position compared to the draft plan sent to the ICS earlier in the month:

- £2.2m improvement following a review of Divisional forecasts and in particular workforce plans. Some posts were not agreed to progress and a level of likely slippage on recruitment has been recognised.
- The balance of £1.4m is the combined gap across Calderdale and Greater Huddersfield places and whilst included in the Trust's plan is recognised to be a system risk.
- The overall system risk absorbed within Provider plans is £9.2m and a collective decision was taken at the WY&H ICS Finance Forum that this level of risk should be manageable within a system financial envelope of £2.1bn.

Key Assumptions:

- Assumes the system is able to identify mitigation to cover the £1.4m planning gap.
- The forecast does not include any potential financial impact as a result of the Elective Incentive Scheme.
- Assumes that all future PPE requirements are provided through National Procurement.
- Does not include any additional costs that might be incurred as a result of supplying staff to NHS Nightingale.
- Assumes there will be no additional costs incurred as a result of introducing the Wellbeing Hour.
- Assumes a small increase in the amount of annual leave carried forward into the next financial year equating to 2 days for Nursing and AHP staff.
- Assumes that forecast efficiencies (CIP) of £5.22m are delivered as planned.

Risks and Opportunities:

- National funding for Covid Testing has been identified, but the mechanism for recovering costs is unclear and may be impacted by capped rates per test.
- The Trust has retained a small contingency of £0.79m to cover any unidentified winter or general pressures that emerge.
- CCG and some NHSE commissioned High Cost Drugs remain within block contracts which could drive either an over or underspend depending on activity levels.
- Whilst 2nd wave Covid costs have been included within plans, were students to be deployed for a protracted period as seen earlier in the year, costs might exceed forecast expenditure.
- Non pay expenditure assumes that the activity reset progresses as planned. If significant cancellations were required this could result in lower than planned expenditure.

Impact on 21/22 Planning

It should be noted that the pay commitment for Phase 3 reset activity drives additional unfunded recurrent cost of c.£6.4m that will impact on the 21/22 Business Plan.

COVID-19

Revenue Impact of Covid-19 - YTD SEP 2020					
Division	**Annual Leave Accrual**	**Covid-19 Direct Costs**	**Impact on activity**	**Loss of Income**	**Total**
	£	£	£	£	£
Central & Technical	0	7,621,875	42,208	0	7,664,083
Medicine	0	5,235,801	(409,789)	0	4,826,012
Families & Specialist Services	0	663,153	(152,550)	474,598	985,201
Calderdale & Huddersfield Solutions Ltd	0	730,446	(89,501)	73,000	713,945
Corporate Services	0	384,954	55,202	1,365,210	1,805,366
Community	0	627,862	0	30,346	658,208
Health Informatics	0	70,906	0	0	70,906
Surgery & Anaesthetics	0	942,780	(2,194,408)	0	(1,251,628)
NHS Nightingale (Hosted Costs)		3,264			3,264
Total costs identified	**-**	**16,281,040**	**- 2,748,837**	**1,943,154**	**15,475,357**
Retrospective Top Up requested					**14,031,213**

Capital Impact of Covid-19 - SEP 2020	
Details	**Covid-19 Costs**
	£
NPEX (PDC received)	330,000
Equipment	444,578
Asset Tracking	105,422
Total costs identified	**880,000**
PDC Confirmed	**330,000**

The Trust has incurred Covid-19 direct costs totalling £16.28m year to date as shown in the table and these have been reported to NHSI in support of the requested 'Retrospective Top Up'.

Key areas of spend are as follows:

Pay - £6.96m

Reported Covid-19 costs are the 'net cost' and represent the additional staffing costs incurred due to the Covid-19 response and do not include the cost of substantive staff that have been redeployed into expanded capacity areas. Pay costs relating to the Covid-19 response were primarily linked to the requirement for existing staff to work additional shifts, in particular over the Easter Bank Holiday weekend which coincided with a peak in the number of Covid-19 cases across the two hospitals. There were also significant additional costs incurred as a result of increased shifts in community services with most staff working the April bank holidays and additional shifts to support 7 day working which to some extent have continued into September. Almost 150 students (nursing, therapies and medical) had been added to the payroll up until mid August, many of whom were working in a supernumerary capacity. Changes to medical rotas also had a financial impact with additional enhancements paid to junior medical staff. Increased substantive costs were offset to some extent in earlier months by a reduction in agency and bank costs and lower than planned pay costs in some non Covid ward areas where bed occupancy was lower than usual. More recently the Trust has started to incur additional staffing costs related to Phase 3 plans to increase capacity in order to manage increasing levels of activity.

Non Pay - £9.32m

Clinical Supplies costs linked to Covid-19 are £2.40m, including costs related to increased ICU capacity of £0.44m, £1.09m on Covid testing and £0.4m on CT scanner hire.

Other non-pay costs attributable to Covid-19 total £6.92m includes the full cost incurred for the purchase of gowns (PPE) on behalf of the whole region (£3.39m) and other costs attributable to Covid-19 of £3.03m including other PPE costs of £1.55m (masks, gloves, eye protection, respirators etc), additional equipment, minor works for social distancing / segregation and patient transport.

The year to date position also includes £0.26m relating to additional costs incurred back in Month 3 due to the requirement to write off Drugs stock that had been manufactured by HPS (Pharmacy Manufacturing Unit). The Unit was commissioned back in March to produce large quantities of Noradrenaline (used in ICU patient Care) for use across the NHS. Demand was not as high as expected and subsequently the unit was asked to cease production, leaving a large quantity of unused drugs and raw materials to be written off.

Nightingale Hospital - £0.003m

The Trust has not accounted for any costs relating to the Nightingale hospital in Month 6.

Income Losses

In addition, the Trust has lost income totalling £1.94m including: loss of Car Parking Income, (£0.82m which is a combination of income from staff permits and income from patients and visitors), loss of catering income (£0.07m), loss of apprentice levy income (£0.08m from pausing of HCAs apprenticeships delivered internally) and loss of private patient income (in particular from Yorkshire Fertility).

These costs have been offset to some extent year to date by the indirect impact of lower than planned costs in non-Covid areas where activity has reduced as a result of the Covid-19 response.

Capital funding for Covid-19 costs has also been requested as shown. The Trust is still waiting for confirmation of PDC funding to cover most of this additional expenditure.

A WORKFORCE FOR THE FUTURE

15. Colleague Health and Well-being - VERBAL

To Note

Presented by Suzanne Dunkley

KEEPING THE BASE SAFE

16. Covid-19, Phase 3 Update - PRESENTATION

To Note

Presented by Helen Barker

17. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 5 November 2020
Meeting:	Trust Board
Title:	Board Assurance Framework – Update 2 2020/21
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee 21 October 2020 Review of individual risks by respective Board Committees
Actions Requested: To approve	

Purpose of the Report

The Board Assurance Framework is the key source of evidence that links the Trust's strategic objectives to risk and assurance. It is the main tool that the Board uses for discharging its overall responsibility for internal control.

This report presents the second update of the Board Assurance Framework (BAF) for 2020/21 since the last presentation of the Board Assurance Framework to the Board on 3 September 2020.

Key Points to Note

Board Committee review of Board Assurance Framework Risks
Good progress has been made with strengthening the role of Board Committees in reviewing and scrutinising assurances relating to those risks for which Committees are the responsible Committee. A report to the Audit and Risk Committee on 21 October 2020 confirmed that each Board Committee has endorsed this approach and is reviewing risks, with confirmation that risk reviews are scheduled into Committee workplans.

Risk 9/19 relates to the Trust's current and future estate and had two responsible Committees for risk oversight identified, the Quality Committee and the Joint Liaison Committee, which reports to the Finance and Performance Committee. It is a long standing risk on the BAF. Following discussion at the Joint Liaison Committee on 7 October 2020 and a further meeting with the Director of Nursing, Director of Finance, Managing Director for Calderdale Huddersfield Solutions and Company Secretary it has been agreed to:

- remove the Quality Committee as one of the two responsible Committees for risk 9/19, confirm that Finance and Performance Committee is the Board oversight Committee for the risk

- redefine the current estate risk for the Trust, with a view to removing risk 9/19 from the BAF and replacing it with a revised risk. The work will be led by the Managing Director for Calderdale Huddersfield Solutions with the new risk reported to the Board in March 2021.

The Audit and Risk Committee has reviewed the BAF and recommends it to the Board for approval. To note since the discussion by the Audit and Risk Committee there has been a change to risk 7/19 relating to compliance with NHS England / Improvement. This risk previously referenced both the CQC well-led framework and the Use of Resources

assessment. Aspects relating to the CQC well-led framework have been removed from risk 7/19 and added to risk 4/20 relating to the CQC ratings. Risk 7/19 now focuses on finance use of resources.

Risk Profile

Given the significant movement in the BAF in the report to the Board presented on 3 September 2020 there are no new risks and no changes to risk scores to report from this second update.

Updates to the risks are shown in red font on the enclosed full BAF document.

Risk Profile
The Trust has the following risk profile for its strategic risks as at the end of October 2020:

BAF Risks	Total Number of Risks
Red Risks	**11**
Amber Risks	**9**
Green Risks	**1**
Total	**21**

Key points to note:

- all risks have been updated by the lead Director during October 2020, with red font denoting updates
- total of 21 risks on the BAF
- six risks with risk exposure (see below)- three within the remit of the Finance and Performance Committee and three that of the Board.

Risk Appetite Exposure

The risk category and risk appetite is noted on the summary sheet of the BAF with five areas of risk exposure identified as noted below:

Strategic Goal (Responsible Committee in brackets)	Current Risk Score	Target Risk Score	Risk Appetite category	Risk Appetite
Transforming and Improving Patient Care				
07/20 Health Inequalities (Board)	16=	8	Harm and safety	Low
Keeping The Base Safe				
07/19 NHS I Compliance (Board)	15=	10	Regulation	Moderate
08/19 Performance targets (Finance and Performance Committee)	20=	12	Regulation	Moderate
05/20 Service capacity due to Covid-19 (Board)	20=	8	Harm and safety	Low

Strategic Goal: Sustainability				
14/19 capital funding (Finance and Performance Committee)	16=	12	Financial/Assets	Moderate
18/19 Long term financial sustainability (Finance and Performance Committee)	16=	16	Financial/Assets	Moderate

In considering risk exposure the Trust should consider:

- whether any further mitigating actions are needed to mitigate the risk
- alignment between the target risk score and the risk appetite

EQIA – Equality Impact Assessment

The BAF has a specific risk, risk 07/20, which relates to the Trust making slow progress addressing health inequalities in the 20% of the most deprived patients in our communities. Evidence shows that people from Black, Asian and minority ethnic (BAME) communities continue to face health inequalities, discrimination in the workplace and are more likely to develop Covid-19 and die as a result of it.

The Director of Public Health from Calderdale Council, together with a senior Public Health colleague, presented to the 3 September 2020 Board meeting a report on insight gathered through engagement with BAME communities regarding the impact of Covid-19. The Board supported the action plan and the key contributory actions which aim to address the impact of Covid-19 on BAME communities and health inequalities.

Effective partnership working is key to reducing health inequalities and the West Yorkshire and Harrogate Health and Care Partnership reported on 22 October 2020 on tackling health inequalities for Black, Asian and minority ethnic communities and colleagues. The Partnership Board recommended actions to reduce this impact, including monitoring of service access, uptake and outcomes by ethnicity to identify inequalities, with monitoring of progress by the Partnership Board. The report can accessed here:

https://www.wyhpartnership.co.uk/publications/tackling-health-inequalities-for-bame-communities-and-colleagues

In terms of other risks, should any of the Board Assurance Framework risks materialise and impact people from different protected characteristics the risk owner is accountable for assessing these and determining any proposed actions to mitigate any equality impact arising from the risk.

Recommendation

The Board is asked to:

- Approve the updated Board Assurance Framework
- Note the further work to be undertaken in relation to identification of the risk relating to the Trust estate
- support a focus on identification of gaps in control and actions to mitigate risks towards the target score by risk owners and Board Committees when next updating / reviewing each risk on the Board Assurance Framework

Appendices:

BAF

Update for 3 September 2020 Board v2 2020/21

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2020/21

Contents:

compassionate care

CHFT RISK APPETITE STATEMENT - revised August 2020

Risk Category	This means	Risk Appetite
Strategic / Organisational	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism and in taking big decisions to improve care appreciate this may attract scrutiny / interest.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, aiming to deliver our services within our financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commerical	We will always explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients 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 and promoting the well-being of our staff.	**LOW**
Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We maximise opportunities to work in partnership to support service transformation and operational delivery.	**SIGNIFICANT**

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020 for 5 NOVEMBER 2020 BOARD
FULL LIST

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming and improving patient care								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	15 =	10	AB	2827, 5806,7413,7414	Strategic/ Organisational	Significant
03/19	Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	15	6 =	4	DB	None	Regulation	Moderate
04/19	Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a a meaningful way to patient and service user feedback resulting in services not designing services using patient recommendations	12	12=	4	EA	None	Regulation	Moderate
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce	15	15 =	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	12	12 =	9	MG	7279, 7617	Innovation/ Technology	High
03/20	Risk the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation, resulting in the Trust not being able to stabilise the future delivery of services and missing opportunities for improvement in the quality, experience and efficency of service delivery.	12	12=	8	AB	None	Strategic/ Organisational	Significant
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete data, mismatch between service and deprivation, lack of quality priorites to advance health equity and health prevention, ineffective partnership working a resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	16=	8	EA	None	Harm and safety	Low
Keeping the base safe								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	12 =	10	EA	6345,7078, 5747 , 6715,	Regulation	Moderate
07/19	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement resulting in enforcement action	25	15 =	10	OW	None	Regulation	Moderate
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	20 =	12	HB	7615	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.	16	15 =	8	GB	5806	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage	9	9 =	4	SD	7413, 7414 , 7474	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation	12	12=	6	EA	None	Regulation	Moderate
05/20	Risk that services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand and non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is a potential for an adverse impact on health inequality.	20	20=	8	OW	7778, 7783, 7797, 7685, 7315, 7689, 3793, 7796. 7683,	Harm and safety	Low
A workforce fit for the future								
10a /19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	20 =	9	DB	2827,7078, 5747	Quality/Innovation & Improvement	Significant
10b /19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	20 =	9	EA	6345, 7557	Quality/Innovation & Improvement	Significant
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues	16	12 =	9	SD	7248	Quality/Innovation & Improvement	Significant
12/19	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to a lack of robust engagement mechanisms	12	9 =	4	SD	None	Quality/Innovation & Improvement	Significant
Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	16 =	12	GB	None	Financial/Assets	Moderate
15/19	Risk that the Trust will not deliver external growth for commercial ventures resulting in potential lost financial contrbution..	9 =	9 =	6	GB	None	Commercial	High
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	16=	16	GB	None	Financial/Assets	Moderate
06/20	Risk of climate action failure resulting in adverse impacts on public health, patients, natural environment and reputation	16	16 =	9	SS	None	Strategic/ Organisational	Significant

denotes risk with risk exposure

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly likely (5)					18/19 Long term financial sustainability =
Likely (4)			02/20 Digital Strategy = 04/20 CQC rating =	14/19 Capital = 06/20 Climate Action Failure = 07/20 Health Inequalities =	10.a /19 Staffing levels = 10b/19 Staffing levels = 8 /19 National and local performance targets = 05/20 Service Capacity due to Covid-19 response =
Possible (3)		3/19 Seven day services =	12/19 Staff engagement = 15/19 Commercial growth = 16/19 Health & Safety =	6/19 Compliance with quality standards= 11/19 Clinical leadership = 4/19 Public involvement = 03/20 Business Better Than Usual service transformation =	1/19 Approval of hospital reconfiguration strategic outline case, outline business case and full business case = 7/19 Compliance with NHS Improvement = 9/19 HRI Estate fit for purpose = 01/20 Clinical Strategy =
Unlikely (2)					
Rare (1)					

= no change to risk score

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
1.19	Board of Directors / Transformation Programme Board	Director of Transformation and Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE&I, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire & Harrogate Health & Care Partnership and commissioners to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and CCGs ability to provide formal letters of support for the business cases. A local system Partnership Transformation Board that has members from CCGs, ICS, YAS, and the Trust meets monthly to ensure system alignment and support for business case planning assumptions and development.	<u>First line</u> Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and NHSE/NHSI, DHSC <u>Second line</u> Trust Board approval of business cases (SOC approved, March 2019).OBC for CRH and FBC for HRI scheduled for approval by June 2021. <u>Third line</u> ICS and NHSE/NHSI review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019	• See below for further detail. 1. Clinical protocols to be agreed with Yorkshire Ambulance Services 2. Her Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 3. Agreement for development on the CRH site. 4. Provision of aditional car parking at CRH and a hospital travel plan is required.	The Trust is working with regulators to secure agreement that the early call down of capital to fund necessary professional and technical fees to produce the OBC will be agreed.	5x5 = 25	3x5 = 15	2x5 = 10

Gaps in Control	Timescales	Lead
1.Trust and CCGs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH and a hospital travel plan is required.	1. Discussions are taking place with YAS and activity modelling and clinical protocols will be agreed and confirmed in the OBC. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been drafted and is progressing to completion. 4. The Trust is finalising a business case for the development of a multi-storey car park facility for CRH. The Trust will then seek to progress this forward ahead of the reconfiguration.	AB for all actions

Links to risk register from current service configuration:
2827 - over reliance on middle grade doctors in A & E - workforce standards, A& E and critical care
5806 - urgent estate work not completed
7413 - fire compartmentation risk HRI
7414 - building safety risk, HRI

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
3.19	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Governance systems and performance indicators in place • Rosters focussed on managing Covid-19 providng extended cover • Early implementer to trial new NHSE methodology of Board assurance and sign off. Survey completed twice yearly (Spring/ Autumn) • Programme to extend 7 day working across medical specialities - now includes elderly medicine, respiratory, cardiology, gastro, stroke, haematology, acute medicine, diabetes with discussions progressing in palliative care • Reconfiguration of medical services: elderly medicine, cardiology, respiratory, gastroenterology has facilitated the introduction of speciality on-call rotas to expand provision of 7 day speciality cover	First line HSMR and SHMI within expected range. Audit to assess impact of expanded 7 day working on outcomes: HSMR and weekend vs weekday mortality trends over the last 2 years Second line Integrated Board report Benchmarked against four priority seven day standards - full compliance at most recent audit in May 2018. Bi-annual submission for compliance against the seven day standards to NHS England / Improvement approved at WEB (20/06/19, 12/12/19 confirmed compliance against all four NHSE priority standards) Single Oversight Framework. Quality Accounts 2019/20 confirmed compliance against standards 2018/19. Third line Positive feedback from NHSI/E, NHSE-led, WYAAT-wide implementation scheme Benchmarking exercise against remaining 6 non-priority standards to report to WEB	Radiology staffing pressures present risk of continued delivery of standards 5 and 6 - access to diagnostic tests and access to consultant -directed interventions Improved staffing in Accident and Emergency, however remains insufficient to deliver extended Consultant presence in accordance with National Guidance. Diagnsotic capacity in Radiology and Endoscopy limited by requirements of Covid-19.	• Scope for futher implementation limited without service reconfiguration or additional investment NHS I suspended collection of reports on seven day service standards due to Covid-19 in March 2020 - lack of clarity nationally on whether the sevem day service assurance process will continue. Action: Explore local audit measures Lead: Deputy Medical Director Future response to a second Covid-19 wave may impact delivery of 7 days services in some specialities as a result of changes to both medical and nursing rotas.	5x3 = 15	3x2= 6	2x2 = 4

Action	Timescales	Lead
Ongoing review of staffing pressures Radiology and A&E	Ongoing	DB/CP
Explore undertaking local audit of seven day standards	TBC	CP

Links to risk register:
No high level risks with score >15

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee	OWNER Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
4.19	Quality Committee	Executive Director of Nursing / Deputy Chief Executive	**Risk** Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a meaningful way to patient and service user feedback resulting in not designing services using patient recommendations **Impact** - poor patient experience Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group in place which mandates the workplan and oversees progress and audit activity for patient experience Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs • Patient engagement in Outpatient Transformation Programme • Pilots of changes to service models being tested with patients • Patient Engagement champions in clinical areas to support staff in engaging with patietns and service users • Public and patient engagement events re: business better than usual Strategic Outline Case • Nursing and Midwifery Strategy which enables staff time to care for patients	<u>First line</u> Public involvement and engagement included in Patient Experience Group, Areas of good practice with service users identified within the Trust, eg Youth Forum <u>Second line</u> Patient Story to Board meetings Governor attends Patient Experience Group Patient Experience Group reporting to Quality Committee add dates <u>Third line</u> Quality Account to NHS Improvement, CCGs and other stakeholders CQC rating of Good - report referenced positive examples of patient engagement Healthwatch reports (Outpatients post Electronic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and involvement data - lead Assistant Director for Patient Experience, March 2021 Lack of consistent approach when seeking patient input to re-designing services - plan for clinical attachments to Transformation porject support to consider impact of service change on patient experience. Senior Nurse has now been identified to work as part of the reconfiguration central team, November 2020 Lack of mechanism for systematic involvement of members of BAME communities. Action: To be considered within development of Patient and Service User Engagement Strategy , Assistant Director Patient Experience December 2020 Patient and service User Engagement Strategy to be developed by new Associate Director Patient Experience March 2021	Well-led developmental review identifies actions to improve patient involvement and Equality & Diversity - action delayed due to repsonse to Covid-19 pandemic. Action to pick up as Business Better Than Usuual, lead: Director of Nursing and Associate Director ofPatient Experience - timescale March 2021 due to current situation	3x4 = 12	3x4 = 12	1x4 = 4

		Lead
1. Develop central system of patient engagement	31/03/21	AD Patient Experience
2. Clinical attachments to Transformation project support	October 2020	Ellen Armistead
3. Mechanism for systematic invovlement of BAME communities	December 2020	AD Patient Experience
4. Patient and Service User Engagement Strategy	March 2021	AD Patient Experience

Links to risk register:
No risks on the risk register >15

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
01/20 July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to lack of collaboration across the West Yorkshire system to enhance the quality and resilience of clinical services due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk and 3/20 Business Better Than Usual risk .	Clinical Strategy - describes Trust position on service development across West Yorkshire Transformation Programme Board - clinical strategy informing decisions made to reconfigure services and ensure that the redesigned hospital model is fit for purpose Refresh of clinical strategy appendices by service underway led by clinical leads meeting with all services, completion November 2020 ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. Recently established Planned Care Alliance to co-ordinate and plan phased approach to reset, including redesign to planned care Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight.	**First Line** Clinical strategy developed and shared with WEB (23.5.19.) **Second Line (Board / Committee)** Clinical strategy - Board 4 July 2019 (private) Board Business Better Than Usual report to 2 July 2020 Board describing learning from Covid-19 will help to inform any necessary adaptation of the Clinical Strategy ICS clinical forum 7 July 2020 discussed Planned Preventative Care post Covid-19 Response to COVID-19 has by necessity driven enabling work for the strategy, including remote working, developments in community care, and virtual outpatients. **Third Line** None	Lack of agreed clinical strategy for West Yorkshire - action with WYAAT Chief Executives and Committee in Common / ICS (with exception of vascular and pathology services with established approaches) WYAAT and ICS beginning to develop system-wide approaches to reset, led by WYAAT clinical lead - 3 phases to March 2021, timescale and funding tbc. Consideration to be given to primacy of PLACE v system.	Review Trust clincial strategy in light of Covid19 / business better than usual programme of work - lead Medical Director with Director of Transformation & Partnerships by August 2020 Action: revised clinical strategy to WEB and Transformation Programme Board Timescale: January 2021, Lead David Birkenhead	3x5=15	3x5=15	2x5=10

1	Timescales	Lead
Ongoing monitoring and reiew via Transformation Programme Board, including future bed capacity CRH WYAAT - agreement of West Yorkshire Clinical Strategy	Ongoing TBC	David Birkenhead, Medical Director WYAAT Chief Executives

Links to risk register: None
See 1/19 reconfiguration BAF risk and 3/20 BBTU risk

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
02 /20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the 10 year digital strategy Digital Aspirant and Scan for Safety Funding for next 2 3 years and committed capital funding from the Trust Dedicated Digital Transformation Director co-ordinating digital programmes and providing leadership Governance via Digital Health Forum and Digital Operations Board. Digital Operations Board chaired by Managing Director Digital Health Monthly meetings with Managing Director Digital Health and Director of Finance reviewing progress with digital investment strategy - Divisonal digital Boards	**First Line:** Digital Health Forum meeting bi-monthly, programme of work and progress presenned at each meeting **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction **Third Line:** Digital Aspirant Trust Scan for Safety	Lack of consistent attendance at Digital Operational Board meetings - Action: Divisional Directors and Chief Operating Officer to ensure appropriate resource identified to attend divisional digital Board meetings Review terms of reference for Divisional Digital Boards to ensure clarity of purpose of group and consistent approach Action: Divisional Director of Operations Review Digital Operations Group terms of reference Lead: Managing Director Digital Health to become executive Sponsor Rviewing digital capital expenditure for 2021/22 Trust in November 2020	Managing Director Digital Health to launch Strategy at Divisonal Digital Boards Annual review Board 2021 July WEB review January 2021	**4x3 = 12**	**4x3 = 12**	**3x3=9**

Action	**Timescales**	**Lead**
Review terms of reference of Divisional Digital Boards (Divisional Directors) and Digital Operations Group (Managing Director - Digital Health) Ongoing monitoring via Finance and Performance Committeee 1/10 reconfiguration	November 2020 Ongoing	Divisional Directors for divisional digital Boards / COO /Mandy Griffin Gary Boothby

Links to risk register 7279 point of care testing / EPR interface, 7617 cyber risks , see linked 1/19 reconfiguration risk

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
03/20 July 2020	Transformation Programme Board	Director of Transformations and Partnerships	**Business Better Than Usual (BBTU)** There is a risk that the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation. As a result the Trust may not be able to stabilise the future delivery of services and will miss opportunities for improvement in the quality, experience and efficency of service delivery.	CHFT has engaged colleagues, patients and partners across the Calderdale and Greater Huddersfield health and social care system to capture learning from experience of their responses to the COVID -19 pandemic. The findings from this were presented to the Trust Board on 2nd July 2020 and 12 key learning themes of transformational changes that should be sustained and amplified were agreed by the Board. Governance and management arrangements to provide assurance on the implementation of this have been agreed by the Trust Board and are being implemented. This includes: - appointment of theme leads - establishment of BBTU Delivery Group - oversight by Transformation Programme Board	**First Line** - A BBTU Delivery Group chaired by the CEO has been established and includes membership of a named Lead for each learning theme. The Delivery Group will lead implementation and provide progress reports to the Transformation Programme Board. **Second Line** - the Transformation Programme Board will provide oversight of the BBTU programme of delivery and and provide reports on progress to the Trust Board. (16.10.20.) **Third Line**. External - the Trust will collaborate and work with external stakeholders (e.g.CCGs, acute and mental health Trusts, community providers, hospices, voluntary sector, social care, the West Yorkshire ICS, and NHSE) to progress and provide regular updates on actions to respond to learning from the pandemic.	Impact Assessments to be completed: Additional work is required to ensure and demonstrate that implementation of BBTU includes assurance of robust EQIA, QIA, digital impact assessment and patient involvement and to provide reports on this to the Workforce and Quality Committees. As the plans for implementation of each theme develops further work will be needed to assess the financial impacts of BBTU and provide reports on this to the Finance and Performance Committee. Lead: Anna Basford Timeframe: March 2021	The work to implement BBTU is at an early stage and key milestones need to be agreed to enable monitoring and reporting on progress.	3x4=12	3x4=12	2x4=8

Action	Timescales	Lead
Theme lead to develop blueprint of critical success factors -benefits, enablers, dependencies for each theme	Mid November 2020 with report to Transformation Programme Board December 2020	Theme leads

Links to risk register:None

TRUST GOAL:1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
07/20 July 2020	Trust Board	Director of Nursing / Deputy Chief Executive	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Director of Nursing named Board Executive providing accountable leadership for tackling health inequalities. Chief Executive expertise in health inequalities. Reset and stabilisation and winter plan EQIA Equality impact assessment (EQIA) process for service and policy changes. Equality Impact Assessment discussion at Board development session 6 August 2020, on Marmot Review Health Equity in Engalnd 10 Years and review A&E activity data by index of multiple deprivation and local super output area to increase knowledge of Board members on why addressing health inequalities is important and provide insight to local health inequality issues Diversity - 1 Executive and 1 Non-Executive BAME members of the Board brings lived experience to help tackle health inequalities. Trust Diversity and inclusion networks and 5 year plan for inclusion (Staff). West Yorkshire and Harrogate Healthcare Partnership (ICS) - Trust plays a full part in Health and Well-Being Boards and place-based partnerships, where where reducing inequality is an ICS goal and exemplified in the Professor Dame Donna Kinnair DBE review	**First Line** - developing data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring **Second Line** - Board development session 6.8.20. to increase knowledge and understanding re health inequalities locally and nationally EQIA referenced in all Board paper front sheets **Third Line**. External - none to date.	Action plan to be agreed with partners by 21 September 2020 of 8 urgent actions to address health inequalities in our service provision and outcomes. Lead: EA Leadership - Reflect our diverse community through a 5 year Board action plan for Board and senior staffing to match the BAME workforce by 2025: Action: Agree Board plan Lead: Director of Wokrforce and Organisational Development Timescale: November 2020	Restoration service activity performance monitoring to include deprivation data (index of multiple deprivation) for patients from 20% most deprived neighbourhoods and communitties: lead: EA/HB Timescale: December 2020	4x4=16	4x4=16	2x4=8
Action					**Timescales**			**Lead**		
Finalisation of action plan to address 8 urgent actions on health inequalities					21.9.20.			Ellen Armistead		
Links to risk register:None										

TRUST GOAL: 2 KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
6.19	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Review of quality governance arrangements • SI investigation process identifies recommendations to improve care with strong governance in place • Strengthened risk management arrangements at divisional level, including compliance registers • Programme of assurance visits in place • Consistent mandatory and essential training compliance • Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry/ Emergency Support Framework	First line Assessment of compliance with NICE guidance Ward accreditation - Performance against saferty must dos reviewed at ward / matron level Improvement in HSMR & SHMI Mandatory training compliance at July 2020 94.27% Improved real time assurance on impact of safety staffing and quality -Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed Bi-monthly Quality Report to Quality Committee and Board KPIs in Integrated Performance Report PSQB reports to Quality Committee Infection Prevention and Control report to Board IPC Board Assurance Framework approved at Board 2 July 2020, provided assurance on IPC activity Serious incident report to Quality Committee Safer Staffing Hard Truths report to Board 5.9.19. Third line CQC rating of Good Quality Account reviewed by External Auditors and stakeholder bodies Independent assurance on clinical audit strategy Feedback through ongoing relationship with arms length regulatory bodies Independent Service Reviews (ISR) and accreditations. ISR March 2019 assurance on process for responding	• Investigator capacity to support Si investigations and standard of serious incident investigations needs further improvement Alternative model for investigators to Quality Committee - September2020 • Safety "must do's" to be embedded on wards - Quality Governance - quality governance arrangements and structures to be reviewed Lead: Director of Nursing / Medical Director timescale September 2020 Further work required around Safe Care Live triggers	• CQC assessed the Trust as requires improvement for safe domain • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements - see 10a/19 (Allocate) New ward assurance visits being piloted ahead of roll out	3x5 = 15	3x4= 12	2x5 = 10

Action	**Timescales**	**Lead**
Develop alternative model for serious incident investigtaors and present to Quality Committee	November 2020	EA
Review of quality govenance arrangements	Ongoing	EA

Links to risk register:
Risk 6345 - nurse staffing risk, risk 7078 - Medical staffing risk , risk 7345 - Referrals to district nursing service, risk 5747 interventional radiology staffing, 6715 clinical documentation,

TRUST GOAL: 2. KEEPING THE BASE SAFE											
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
7.19	Board of Directors	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement (NHS E/I) **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• Board approved 10 Year Strategic Plan •Place based system meetings with NHS E/I(1 Kirklees, 1 Calderdale) • ICS system financial regime • Standing Financial Instructions and budget management • Review of monthly NHS E/I bulletins to assess any required actions • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Transformation project support in place • Use of Resources work steered by Finance and Performance Committee • Executive leads assigned for 5 Use of resources areas with working groups reporting to Executive leads • Post project evaluation reported at Capital Management Group for capital schemes and Commercial Investment Strategy group for revenue investment	First line Transformation project support Weekly monitoring of performance and Covid spend (incident Management Team and Finance) Minutes from Capital Management Group and commercial investment strategy group, reporting into Finance and Performance Committee. Second line Integrated Board report monitoring of key regulatory standards to every Board public meeting and Finance and Performance Committee, most recent F&P discussion 2.11.20.,Board 5.11.20. WEB Use of Resources report (9 July 2020) and Finance and Performance Committee (29 June 2020) describes preparatory approach to next assessment. Finance and Performance Committee (2.11.20.) updated on progress with 5 Use of Resource workgroups and approach to validation of assessment discussed. To month 6 the Trust has been supported and delivered a balanced financial position. (Finance and Performance Committee, Board 5 November 2020) All cash requests in support of Covid-19 have been fully supported. 5 November 2020). Third line Current use of resource score has been a 2 from April to August 2020 which was an improvement from 3. However due to loan repayments in September 2020 the capital service cover element of the score becomes a 4, and overall rating must default to a 3. This is a technical anomaly. Further autonomy granted from NHS E/I as result of performance and delivery of the 2019/20 control total from NHSE/I.	Financial envelopes have been issued at ICS level for the remainder of the year and plan submitted with recgonised gap have yet to be accepted by NHS E/I . Current use of resources methodology has not been adjusted to reflect government policy on loan repayments, action NHS E/I	• Performance against key targets • Use of Resources rating of requires improvement. Use of Resources score calculation Action: review reporting of use of resources score for capital service element given technical anomaly Lead: Director of Finance Use of Resources assessment validation to be undertaken via CHFT peer to peer internal review across 5 UoR groups (by end Q3 20/21), explore system/regional review to give independent scrutiny (Q4 20/21) Lead: Deputy Director of Finance Third Line Place based systems feedback from NHS E/I review meetings planned Q3 2020 /21, lead Helen Barker	**Initial**	**Current**	**Target**
								5x5 = 25	3x5 = 15	2x5 = 10

Action	**Timescales**	**Lead**
Review Use of Resources assessment testing and undertake audit Feedback from NHS E/I place based systems meeting	Q4 2020/21 Q3 2020/21	Kirsty Archer Helen Barker

Links to risk register: None

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
8.19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets due to a needs-based stabilisation and reset plan **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders	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 Current Covid-19 management and governance arrangements in place to oversee the delivery of needs-based care Daily escalation of performance issues from divisional hubs into Covid-19 tactical (daily meetings) and if required to Incident Management Team (IMT) for review Daily touchpoint meeting with IMT & Divisional teams for timely escalation, action and joint visibility Divisional PRMs recommenced September 2020 Thematic reviews commenced. Workforce and Respiratory service model underway	First line Daily Incident Management Team meetings including escalation of risks, incidents, complaints and staff concerns Weekly review of Covid-19 risk register Integrated Performance report focus of one WEB each month for detailed scrutiny with wider representation from divisions Second line Board sub committee detailed appraisals of position & actions Integrated Board Report discussed at each Board sub committee and Board of directors Third line Phase 3 assurance checklist completed and submitted to ICS Scenario table top exercises ongoing	Performance monitoring currently in divisional silos, Action: review current divisional performance review process and opportunity to undertake more thematic reviews: Lead: COO Timescale: commence September 2020, complete by March 2021 • System responsiveness dependent on formal escalation by CHFT when agreed triggers reached. Action: Awaiting system performance framework to be established . Lead: NHS England /Improvement Timescale: First place based meetings with NHS E/I arranged for Oct 2020	Developing outcome metrics however a recognised time lag for outcome to be evident. Action: Requires further investigation to establish real-time alert. Lead: Assistant Director of Performace Timescale: Q3 2020/21 No national triggers for cessation of phase 3 plans Action: Develop criteria and assessment process for local triggers for phase 3 Lead: COO with Incident Management Team and Divisional Leads	4x5 = 20	4x5 = 20	4 x 3 = 12
Actions					**Timescales**			**Lead**		
Establishment of local phase 3 triggers					October 2020			Helen Barker		
Links to risk register: 7615 4 hour Emergency Care standard										

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
9.19	Quality Committee (for quality aspects) with Joint Liaison Committee for CHFT /CHS risks	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders See risk 14/19 re capital funding	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Medical device and maintenance policies &procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts • Estates Strategy in place • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, * Capital Infrastructure Risk Allocation of £4.633m approved to reduce HRI backlog maintenance. Plans in place to demolish nurses home, Learning Centre, DATs building and Saville Court to reduce backlog maintenance.	First line • Close management of service contracts to ensure planned maintenance activity has been performed Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS Review of CHS SLAs (Quantitive KPIs & Qualitative Performance) carried out Q4 2020 Audits of routine checks, estates * Newly appointed Trust Health & Safety Manager with oversight of H&S across Trust & between partners Second line H&S Update to Board: Sept 2020, January 2020 Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports Assurance provided by HTM Compliance reports via external Authroised Engineers inspections against HTM standars. WEB reports on medical devices July 2019 H&S Training 95% target achieved, 97% as at 7.7.20. 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line PLACE assessments *1 CQC Compliance report Premises Assurance Model (PAMs) now available and illustratesto patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe. HSE review of water management Familiarisation visits by local operational Fire and Rescue teams External assurance from authorising engineers for high	Risk 9/19 to be replaced with revised estates risk Action: Re-write estates risk and present to relevant Board Committee, Audit & Risk Committee January 2021,Board March 2021 Lead: Stuart Sugarman (with input from Chris Davies and Robert Ross) Timescsale: mid-December 2020 Refresh of estates strategy - Action: Chris Davies for HRI, CRH lead tbc * HRI investment (£20M) full business case to be agreed by regulators, however current funding for early drawdown 2020/21, overseen by Transformation Programme Board * Develop Audit Programme on compliance carried out by Service Performance team for CHS/PFI services , lead Alison Wilson / Val Rigg • Funding for prioritised HRI work but does not cover all backlog maintenance. Discusssions ongoing with regulator and ICS on resolution to shortfall, lead Director of Finance • External review of estates to priorities expenditure to inform business case, with full capital funding subject to business case approval by NHS Improvement - submission business case Nov 2020.	• Issues identified with estate requiring urgent work 4 January 2021 next monthly update to Board on progress against annual action plan (delivered by S Dunkley & R Hill) *1 PLACE inspections will not take place in 2020 due to COVID-19	4x4 = 16	5x3= 15	2x4 = 8

Action	Timescales	Lead
Ongoing discussions regarding funding Audit programme to be developed Risk 9/19 to be replaced with revised estate risk	Ongoing Q3 2020 /21 December 2020	G Boothby Alison Wilson Stuart Sugarman

Links to risk register:
Risk 5806 - Urgent estate schemes not undertaken
Risk 7414 - Building safety risk, HRI
Risk 7413 - Fire compartmentation risk, HRI
Risk 7474 - Medical Devices

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
16.19 9/1/20	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage Internal audit review of H&S action plan underway	• SLA in place for CHS to provde Health and Safety Training for CHFT colleages. • Director and Non-Executive Director Health and Safety Champion identified Operational responsibility for H&S across sites sits with CHS for HRI and our partners at CRH - recently appointed interim technical advisor in CHS • Proactive Health & Safety Committee • Head of Health and Safety in post • Annual report on Health and Safety to Board • Health and Safety action plan • Training: 'Leading Safely' IOSH training for Board members February 2019 • Health and Safety mandatory training for staff (3 years) • Health and Safety training on staff induction • COSHH training • Risk assessment training	First line Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health and Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and securitry information . Second line Board joint responsibility for risk understood following the Board IOSH training in February 2019 WEB reports on mandatory training, health and safety training compliance currently at target levels 9 January 2020 external Health and Safety review presented to Board • 2019/20 Annual Health and Safety report and action plan to Board - 9 January 2020 • 2020/21 Annual Health and Safety action plan developed and presented to Audit & Risk Committtee in July 2020, Board 3 September 2020 H&S deep dive to ARC 22 July 2020 Updates to Board on H&S 3 September 2020 Third line External health and safety review (Quadriga) 2019 (reference also to fire safety)	• Health and Safety Policy to be revised to include statement of intent with supporting policy / procedural guidance and provide clarity on roles and responsibilities - lead Head of H&S once in post - Need for specific policies for Risk Assessment, Noise Policy and others (as detailed in Quadriga report) - CHS technical advisor to develop by end November 2020 The current health and safety measures for overseeing and assurance seeking to be reviewed and a paper prepared and shared with a view to seeking the introduction of a formal health and safety management system, specific to the NHS that will also help provide better oversight of compliance including that of our service providers and subsidary partners.	• Review RIDDOR reporting, Develop Risk Assessment Policy & matrix, ensure compliance with fire safety, share and discuss joint CHS & Trust risks & mitigation at Joint Liaison Committee meetings. lead CHS technical advisor Jan 2021 Board update on H&S, Lead: H&S Richard Hill / S Dunkley Day to day h&s activity is lead by CHS with ultimate responsibility through the Managing Director, CHS. CHFT needs to assure itself that these activities provide a health & safe environment for staff, patients and visitors. Lead: Stuart Sugarman / Suzanne Dunkley Review exisiting audit and inspections arrangements for monitoring health and safety compliance within the Trust and our partner organisations so that the audits and inspection content align comfortably into the needs and expectations of a formal health and safety management system.	3x3 = 9	3x3 = 9	2x2 = 4

Action	Timescales	Lead
Internal audit review of health and safety	Internal audit review being scoped October 2020	Audit Yorkshire

Links to risk register:
7413 fire compartmentation, 7414 building safety, 7474 medical devices

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
04/20 July 2020			Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply	CQC response group meets monthly, oversses divisional compliance with regulatory standards/ compliance registers and reports to Quality Committee	**First Line:** Reports to CQC Response Group from divisions	New CQC preparation assessments currently being prioritised Uncertainty of direction of future	Due to Covid-19 no latest view of performance - restart September 2020			

	Quality Committee	Director of Nursing / Deputy Chief Executive	rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	Regular engagement meetings with CQC - currently working within Emergency Support Framework Process for internal assessment against CQC standards Dedicated CQC lead Independent Well-led Governance development review, phase 2 completed Appointed to Assistant Director for Quality and Safety to increase capacity CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes aligned to CQC standards	**Second Line:** Quality Committee reports from CQC Group Quality update report to Board (2 July 2020) Review by Quality Committee and Board of progress with CQC action plan . Quality report to 2 July, 3 September and 5 November 2020 Board report describes monitoring of 5 actions to be completed from 2018 inspection. CQC well-led governance phase 2 report shared at Board workshop 10 September 2020 **Third Line:** Quarterly formal engagement meetings with CQC Current CQC rating of "good" including well-led governance	Uncertainty of direction of future CQC inspection and rating regime - currently Emergency Support Framework replaces earlier regime Developments identified from well-led governance review to be progressed Lead: Ellen Armistead/ Suzanne Dunkley	•5 CQC outstanding actions (2 must do and 3 should do) with limited assurance (MD8 critical care, SD9 Emergency Department). Action monitoring by CQC Response Group. Timescale: All actions to be closed by end of November 2020 CQC engagement underway on revised strategy for well -led governance framework and changed approach to regulation (Ends Nov 2020)	4x3=12 !	4x3=12	3x2=6

Action	Timescales	Lead
Roll out of new clincial division self assessments CQC Response Group monitoring 5 outstanding CQC actions with a view to closure	Q3 2020/21 End of November 2020	Divisional Nursing Ellen Armistead

Links to risk register:
None

TRUST GOAL:2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
05/20 July 2020	Trust Board	Chief Executive	Risk that: - services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand. - non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is a potential for an adverse impact on health inequality. See also BAF 08/19 re performance targets and BAF 7/20 health inequalities	All current Covid-19 plans (and revisions) submitted for Incident Management Team approval and cross reference with relevant reset and stabilisation plan workstream and have an EQUIA, These must be able to describe a rapid re-escalation prior to sign off. Checklist for stabilisation and re-set plans completion including PPE, testing, social distancing and IPC. Bed modelling in place as part of Phase 3 plan and safest bed model agreed. IPC pathways amended to reflect national guidance, cross checked with Board of Directors principles on patient and staff safety Key areas have retained additional staffing and estate capacity to support re-escalation. Utilising independent sector capacity for urgent diagnostics and treatment. Retained additonal diagnostic capacity to supplement reduced internal capcaity or provide additional capacity for backlog clearance All inpatient waiting lists clinically reviewed and priority status identified. Criteria for outpatients agreed and clinical review ongoing. Reviewing waiting lists and cross referencing with deprivation index. Working with system partners on referral pathways and winter plans Health & Well-Being risk assessment of staff	**First Line:** Records of daily meetings and decisions of IMT (Inner Core) Daily review of Covid-19 activity and weekly review of all other waiting list data Submission of national data sets Performance Review meetings reviewed reset plans **Second Line** Board sub committee detailed appraisals of position & actions (3 September 2020) Performance reports to relevant Board Sub-Committees **(**Finance and Performance, Quality Committee, Workforce Committee) **Third Line** Scenario testing	1. Reset plans have interdependency risks on workforce that will limit capacity and connected triggers not yet in place Action: IMT working with Divisions to agree triggers 2.Health inequalities deprivation data and how to assimilate with clinical data for holistic needs assessment	May need to reprioritise activity based on health inequality deprivation analayis as consequence of delayed understanding of the position. Lead: Chief Operating Officer, Q3, 2020/21 Clinical prioritsation - lack of process for out patient activity - action: escalated to Divisional Directors by Medical Director.	4 x 5 - 20 !	4 x 5= 20	2x4=8
Action:					**Timescales**			**Lead**		
1. Clinical review for out patient activity					Ongoing			Medical Director David Birkenhead		
Links to risk register: 7778 staff infection from Covid-19, 7783 social distancing, 7797 IPC compliance, 7685 PPE supply, 7796 staffing shortages due to covid-19 testing 7315 out patient appointment capacity, 7689 out patient waits, 3793, Opthalmology follow up appointments, 7683, isolation capacity, 7778, staff infections										

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE (Where are we failing to gain evidence about our system/ controls?)	RATING OCTOBER 2020		
								Initial	Current	Target
10a /19	Workforce Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Guardian of Safe Working in place which ensures safe working hours for junior doctors. • E -job planning ensures efficient use of medical staff workforce and visibility of Consultant workforce activity • Revisions to rotas for Consultants and registrars and trainees with clincians and medical HR to support training, staff and activity backlog • Use of CESR programme to increase Consultant workforce in appropriate specialties supports recruitment and retention • Medical workforce team portfolio includes recrutiment and retention workstream • Recruitment and retention has been successful through year, continue agency and bank use of medical staff for shortage specialties, medical bank well established, agency spend within control totals • Service improvement in cardiology, respiratory and frailty, with developmnent of acute floor and frailty service at HRI to aid recruitment • Impact of shortages in specialties nationally, Gastro, Radiology mitigated by network working, explore advanced pratitioner to support Consultant workforce, use external reporting for Radiology •Workforce Committee • WYAAT networking approach to pressured specialties, eg Vascular Surgery agreed network, Interventional Radiology and programme of work • ED business continuity plan in place; • Ongoing recruitment programme • Medical Workforce Programme Steering Group stood down for Covid-19 since March - usually meets bimonthly, focus on using current staff effectvely, retention and recuitment.(planning e-rostering and commencing job planning work) Segmentation approach and vacancy tracker in place to focus medical recruitment resource on clinically high risk and likelihood of appointment. Vacancy tracker maps medical workforce to medical establishment, tracks vacancies, pipeline and retention. Electronic job planning in place	First line Staffing levels, training & education compliance and development reported to WEB, Divisional business meetings and PSQBs consider staffing levels as part of standard agenda, IPR with key KPIs shows slight decrease in sickness levels, and reduction in agency spend Weekly meeting on agency spend and report to Turnaround Executive 6 additional PA posts recruited to Improvements in mortality (HSMR / SHMI). Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend - reduction in medical agency spend based on forecast. Vacancy tracker broadly shows improvement in some medical specialties. Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – from 46 Full Time Equivalent (FTE) in June 2019 to 23 FTE vacant posts in June 2020, recently appointed to Gastroenterology and Emergency Medicine, shortage specialties. Offers to Global Fellows in Radiology to mitigate risk created by Radiology the consultant vacancies. Medical Appraisal and revalidation report to Board, demonstrates high quality workforce. Guardian of Safe Working annual and quartetly report (2.7.20.) on working hours to Board - investing in improved facilities for trainees PSQB reports to Quality Committee Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship with arms-length bodies, GMC Report on Junior Doctor Experience	Medical E-rostering only partially implemented for doctors - rosters being progressed for junior doctors. Planning started on E-rostering project Pensions rules reduce willingness of medical staff to deliver additional work (national issue), alleviated to some degree by the increase in threshold for tapering. Regional procurement exercise for e rostering and job planning systems, led by WYAAT, with Trust leading on E-rosterirng), in process funded by NHS I monies - Commencing job planning process however completion date for WYAAT procurement for systems awaited Medical Workforce Groups continue to be stood down due to Covid-19	• Need to embed workforce plan	4 x 4 = 16	4 x5 = 20	3 x 3 = 9

Action	Timescales	Lead
E-rostering being rolled out to medics- timescale exteded from September 2020 to March 2021 to allow more information on Consultant activity to be populated on the system - review once regional procurement complete	March 2021 (may slip due to Covid-19 priorities) Lisa Cooper, Medical Workforce with Claire Wilson and Pauline North /procurement team	Associate Medical Director Medical Director Workforce

Links to risk register:
Risk 2827 - Over reliance on middle grade doctors in A&E
Risk 7078 - medical staffing risk
Risk 5747 - Vascular / interventional radiology staffing

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020		
								Initial	Current	Target
10b.19	Workforce Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Daily staffing meetings, Workforce meetings increased in areas of greatest need (can this go as the first bullet point) •Daily and weekly nurse staffing escalation reports • Nursing and Midwifery Strategy- implementation of "Time to Care" • Ongoing recruitment programme in place, including international recruitment • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes • Risk assessments in place • Nursing and Midwifery Group, monthly meeeting reviews operational issues, strategy and seeks assurance	First line Divisional business meetings and PSQBs consider staffing levels as part of standard agenda IPR shows slight decrease in sickness levels, and reduction in agency spend Bi-annual review of ward nursing levels 6 additional PA posts and nursing associate posts recruited to Medical : Improvements in mortality (HSMR / SHMI).Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend Agency spend reported weekly to Turnaround Executive Reduction in average hourly rate for nursing staff has not impacted on fill rate. Workforce meetings reviewed as part of reset. Second line Monthly performance meetings (PRM) review workforce reports Workforce Commitee receives updates on recruitment and retention issues., Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board Septemner 2019 KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee Third Line Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship wth arms-length bodies	Nursing Despite controls in place there will still be occasions where capacity does not meet demand, eg increasing staffing sickness **Nursing and Midwifery Strategy not yet embedded.** **Action:** To refocus nursing workforce on key deliverables of Time to Care **Lead:** Andrea Dauris **Timescale** November 2020	New ward accreditation process in pilot phase ahead of full roll-out	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
		EA

Links to risk register:
Risk 6345 - nurse staffing risk , 7557 ED staffing (nursing)

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
11.19	Workforce Committee	Director of Workforce and Organisation Dewvelopment Executive	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. -	• Organisational Development Strategy, The Cupboard recipe cards for Working Together to Improve (leadership and engagement), equality, diversity and inclusion and talent management recipe cards which set out key actions in these areas and measures for monitoring success. • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Performance appraisal based around behaviours with temperature check guide introduced to help colleagues to think about the four pillars and their contribution to one culture of care • Development of new roles across professional groups, eg physicians associates., development of five new career ladders for apprentices alongside new strategy for Apprenticeships • Development of Managers Essentials programme and compassionate leadership orgramme, CLIP, designed collaboratively with colleagues Leadership development programme launched 31 July 2020 inckudes 3 core modules - Working Together to Get Results, Management Essentials, Leading One Culture of Care plus bespoke modules for nursing and midwifery, consultant and AHP leaders • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. • Development of specific behavipours to support 4 pillars by BAME network	<u>First line</u> Clinicians leading of transformation programmes e.g. cardio /respiratory Recruitment to key Consultant roles across the Trust - report to Workforce Committee 5.11.19. New microwebsite for recruitment due last 1/4 2020. New appraisal documentation for 2020 appraisal season.Hot house- 19 October 2020 on new roles/skill mix <u>Second line</u> Integrated Performance Report and Workforce Committee reports show a rolling absence rate of 4.25% (as at July 2020) and rolling turnover score of 6.98% as at August 2020. Revalidation report to board Board approval of OD strategy - March 2019 and Board update on delivery of OD strategy - Jan 2020 Wokforce Committee approved Management Essentials & Leadership (Clip) Programme in December 2020, Board noted January 2020 Staff survey results 2019 and action plan presented to Board 2 July 2020 with Leadership Programme launch noted as priority <u>Third line</u> Investors in People (IIP)Silver Accreditation to 2021 based on assessment of the IIP principles of leading, improving and supporting. Very positive feedback from interim IIP annual review from October 2019. Armed Forces Silver status awarded June 2020. BMA referring to CHFT as an employer of choice for junior doctors due to level of support for trainees Feedback from Royal Colleges Junior doctor GMC questionnaire feedback Positive feedback from Junior doctors on medical training - Health Education England survey, July 2019, showed improved scores in Anaethesia, Paediatrics, Urology, Obstetrics and Gynaecology, Trust moved from 8th in region to 5th, with 100% response rate OFSTED Interim report has given reasonable progress on all actions relating to the clinical assessment team for Apprentices (August 2019)	None	None Response to Covid-19 has enabled us to further embed the meaning of one culture of care, which will be further embedded through the leadership progamme launched in July 2020 Improvements in future staff survey scores would enable reduction of risk score	4x4 = 16	3x4 =12	3x3 = 9

Actions	Action, Lead, Timescales	Lead
None		

Links to risk register:
Risk 7248 - essential safety training

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING OCTOBER 2020 Initial	Current	Target
12.19	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to lack of robust engagement mechanisms. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Colleague engagment is a key recipe card in The Cupboard which set out key actions in these areas over the next 3 - 5 years and measures for monitoring success. • Hot house events to ensure all strategic colleague policies and practices are developed collaboratively across the Trust • Appraisal process for 2020 revised to reflect and evidence one culture of care with all managers set an objective relating to their management of people in new appraisal documentation • Leadership visibility - back to the floor sessions and assurance visits ensure senior clinical and non clinical visibility and engagement based on themes • Quarterly staff FFT in place provides interim feedback on whether colleagues would like to receive treatment by the Trust • 'Ask Owen' and Freedom to Speak Up established as a communication channel for colleagues to use and raise issues/concerns • CHuFT portal for colleagues to congratulate and thank each other for a job well done • CHuFT celebrating success event programme reflecting feedback from colleagues about tone, style and logistics • Staff survey action plan with key principles and activities for 2020/21 approved by Board • Enhanced fo cus on health and wellbeing, self-care resources in The Cupboard, 24/7 wellbeing telephone access, listening and debriefing sessions and access to external counselling/psychology services • Wellbeing Champions roles established and rolled out • Inclusion Charter • New Equality Impact Assessment process • Equality group development - Colleague Disability Action Group, LGBTQ network and BAME network in place and well attended • Clear communication and branding one culture of care to colleagues • CHuFT app • Mindfulness events • Schwartz Rounds • Wellebing hour	First line CQC preparation for self assessment shows areas reporting GOOD in well led domain A total of 93 concerns were raised through Freedom to Speak Up between June 2019 and June 2020 reflecting better communication and engagement with the process Second line Integrated Board report shows a positive range of workforce metrics - attendance, trunover, vacanacies, appraisal compliance and essential safety training compliance Freedom to Speak Up annual report review by Workforce Committee following delegation by the Board of Directors on 2 July 2020 Hot House events held focusing on a range of topics including Health and Well Being, Equality and Diversity, Apprenticeships, Staff Survey demonstrating engagement and collaboration informing people management policices and processes Staff survey results 2019 to 2 July 2020 Board - position maintained and action plan approved Board development session 22June 2020 on leading one culture of care indicated full commitment from the Board to being role models for One Culture of Care Third line Staff FFT / staff survey provides some positive feedback, 2018 survey had highest respose rate of 51%,slight dip 2019 survey to 46% due to shorter survey period and early winter /operational pressures Investors in People accrediation - Silver award to 2021, which shows a more qualitiative review of Trust culture than the annual NHS staff survey CQC rating of Good	Hot House events have been postponed during the Covid pandemic and will restart on 19 October 2020		3x4 = 12	3x3 = 9	1x4 = 4

Action to address gap in control	Action and timescale	Lead

Links to risk register:
No high level risk register related risks scoring over 15.

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
FINANCIAL SUSTAINABILITY

HEADER										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
14.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Prioritised capital programme. Small contingency remains in place to cover any further changes. Transformation Programme Board established with oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience	<u>First line</u> Reporting through WEB on capital prioritisation 2019/20 Capital Plan delivered <u>Second line</u> Scrutiny at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes <u>Third line</u> Monthly return to NHS E/ I NHS E/I round table meeting to discuss reconfiguration Critical inrastructure funding of £4.6m granted in September 2020 to support £ for £ reduction in backlog maintenance. Urgent emergency care capital of £2.2m awarded September 2020. Business case for reconfiguration continues to progress through NHS E/I approval process	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Lead: Director of Finance	Ongoing discussions and clarity required relating to shortfall of capital monies. Lead: Director of Finance, awaiting national guidance on capital Backlog maintenance costs will remain in excess of planned capital spend.	4x5 = 20	4x4 = 16	3x4=12

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through Finance &Performance Committee and Board	Ongoing	GB

Links to risk register:

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
15.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Huddersfield Pharmacy Specials (HPS), Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place Health Informatics Service (THIS) contract income for all customers approved and monitotred via quarterly contract review meetings THIS Executive Board meeting with Non-Executive attendance Escalation process if THIS targets not met-Finance and Performance Committee and THIS Contract meeting. CHS Board chaired by Non-Executive Director. HPS Board attended by Non Executive Director	**First line** Individual boards (THIS, HPS, CHS) and report on performance against targets into Finance and Performance Committee **Third Line** Successful bid for digital aspirant funds to support both digital development and ongoing capital requirements.	HPS requires further capital investment to continue to grow. Exploring future commercial options - lead: Director of Finance THIS have been succesful in bidding for external work to close the gap and have been set a deliverable plan. additional risk has emerged due to project delays following COVID. The 2020/21 financial plan for both THIS and HPS is unlikely to be met due to reduced demand following COVID. HPS produce products used in elective surgery and demand for these products is reduced. For THIS many organisations have reduced in year developments that required THIS support. The financial plan for 2020/21 protects the Trust from this risk.	HPS requires capital investment to meet its ambitious growth plans. A proposal is being developed and is being discussed at HPS Board. The proposal is being finalised and will be discussed at CHFT Board during 2020/21.	**3x3 = 9**	**3x3 = 9**	**2x3= 6**

Action		**Lead**
Ongoing monitoring of financial position through F&P and Board Explore future commercial options	Ongoing ongoing	GB GB

Links to high level risk register:

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit –and reliance on cash suppport. Whilst the Trust is developing a business case that will bring it back to unsupported financial balance in the medium term. this plan is subject to approval and the release of capital funds **Impact** - financial sustainability - loss of financial recovery funding (FRF) - increased regulatory scrutiny - Impact - financial sustainability - insufficient cash to meet revenue obligation - inability to invest in patient care or estate - adverse impact on Use of Resources rating	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Project Management Office in place to support the identification and delivery of CIP Escalation forum to support CIP schemes off track Budgetary control process with increased profile and ownership Business better than usual forum being established to drive improved and more efficient pathways. Accurate activity, income and expenditure forecasting Development of: - 25 year financial plans in support of Business Case - 5 year Long Term Financial Plan forms part of ICS financial plan Standing Financial Instructions set authorisation limits Finance and Performance Committee in place to monitor performance and steer necessary actions	<u>First line</u> Reporting on financial position, cash and capital through divisional Boards and Performance Review meetings and WEB monthly Capital Management Group meeting receives capital plan update reports <u>Second line</u> Scrutiny at Finance and Performance Committee and Board Reports on progress with strategic capital to Transformation Programme Board (monthly) Board Finance reporting ICS delivered financial plan in 2019/20 <u>Third line</u> 2020/21 pre COVID planning - challenge and recovery trajectory would have been accepted. Monthly return to NHS E/ I‡ Strategic Outline Business Case submitted April 2019 and 5 year plan submitted October 2019.	Pre COVID plan required a CIP of £15m to be delivered and this had not been fully identified at 1.4.20 Pressures on capacity planning due to external factors. Competing ICS priorities for resources Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. Project Echo reliant upon external approval to progress. Limited additional revenue costs have been included for the development of the Reconfiguration Business Case	Additional COVID costs year to 31.8.20 have totalled £13.95m and reterospective top up has been provided and assumed of £11.86m. The Finance regime for the remainder of the year has now been issued to the ICS and work continues to assess if the phase 3 re-set plans can be delivered within the agreed funding envelope. Reliance on overall ICS acceptance and delivery of plan as the allocation is baed at ICS level and requires ICS agreement. Use of resources review being undertaken.	5x5 = 25	4x4 = 16	4x4 = 16

Action	**Timescales**	**Lead**
2020/21 Financial Plan	31/03/2020	G Boothby
Development of financial modelling for reconfiguration Outline Businss Case	31/12/2020	G Boothby

<u>First line</u>
Reporting on financial position, cash and capital through divisional Boards and Performance Review meetings and WEB monthly
Capital Management Group meeting receives capital plan update reports

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING OCTOBER 2020**		
								Initial	**Current**	**Target**
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	**Risk** Risk of climate action failure including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	Energy - 100% energy bought from green sources and installation of LED lighting to reduce energy consumption Signed up to NHS pledge to reduce plastic usage in hospital Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS Reconfiguration design and build principles led by a Sustainability design brief and overseen by Transformation Programme Board. Internal climate change group meets quarterly, focusing on idea generation and initiatives to reduce carbon emissions, eg re-usable items. External controls- Environment Manager and MD of CHS connected into a range of West Yorkshire sustainability groups involving the WYCA, WYATT, Kirkless & Calderdale Councils	First line monthly monitoring of the Trusts energy consumption Second line 1. monitor against our Sustainability Development Management Plan (SDMP) 2.annual Board paper on sustainability/climate change Climate change sustainability brief for the reconfiguration agreed and taken to Board Third line working towards ISO14001 accreditation as a means of assuring environmental management systems across the CHFT	A Sustainable Development Management Plan and Action Plan is already in place and this now needs to be transposed into a Green Plan Climate strategy is being developed for presentation to Board, lead Managing Director CHS Initially a lack of clarity as to which Board Committee has responsibility for sustainability / climate change -action confirm which Board Committee is responsible - current lead identified as Finance and Performance Committee	Baseline assessment of carbon emissionswill enable monitoring of progress in reduction in future years. Board report on climate change strategy to CHS Board in September and Trust Board in November 2020 Climate change group - consider reporting through to CHS Board - lead Managing Director CHS Annual report to Board on climate change and progress with actions.	4x4 = 16	4x4 = 16	3x3=9

Action	**Timescales**	**Lead**
Development and approval of climate change strategy Confirmation of which Board Committee leads on Climate Change	Ongoing	Stuart Sugarman

Links to risk register: No risks 15 or over on HLRR

BOARD ASSURANCE FRAMEWORK
OCTOBER 2020
KEY

ACRONYM LIST

BAF	Board Assurance Framework
BTHT	Bradford Teaching Hospitals NHS Foundation Trust
CCG	Clinical Commissioning Group
CIP	Cost Improvement Plan
CQC	Care Quality Commission
CQUIN	Commissioning for Quality indictor
CHS	Calderdale Huddersfield Solutions LTD
ED	Emergency Department
EPAU	Early Pregnancy Assessment Unit
EPR	Electronic Patient Record
F&P	Finance and Performance Committee
FBC	Full Business Case
FFT	Friends and Family Test
HSMR	Hospital Standardised Mortality Ratio
IBR	Integrated Board Report
ICS	Integrated Care System
IIP	Investor In People
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
NHS I	NHS Improvement
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PMU	Pharmacy manufacturing unit
PPI	Patient and public involvement
ITFF	Independent Trust Financing Facility
KPI	Key performance indicators
NHS E	NHS England
NHS I	NHS Improvement
OBC	Outline Business Care
OSC	Overview and Scrutiny Committee
PFI	Private Finance Initiative
PMO	Programme Management Office
PMU	Pharmacy manufacturing unit
PPI	Patient and public involvement
WEB	Weekly Executive Board
WYAAT	West Yorkshire Association of Acute Trusts
WYSTP	West Yorkshire Sustainability and Transformation Plan
ICS	Integrated Care System
DH	Department of Health
IPC	Infection Prevention Control

	New risk
	Breach of risk appetite

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
HB	Helen Barker, Chief Operating Officer
MG	Mandy Griffin, Managing Director of Digital Health
RM	Ruth Mason, Associate Director of Engagement and Inclusion
AM	Andrea McCourt, Company Secretary
CP	Cornelle Parker, Deputy Medical Director seven day service lead
SS	Stuart Sugarman, Managing Director CHS
OW	Owen Williams, Chief Executive
EA	Ellen Armistead, Director of Nursing / Deputy Chief Executive
ALL	All board members

18. High-Level Risk Register

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	October 2020
Meeting:	Board of Directors
Title:	High Level Risk Register
Author:	Maxine Travis, Senior Risk Manager
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing
Previous Forums:	Trust Risk Group 17.08.2020, 14.09.2020, 12.10.2020, Quality Committee 02.09.2020 Covid Incident Management Team – weekly

Actions Requested:
To approve.

Purpose of the Report

To provide the Trust Board with assurance as to the robust identification and management of risk and to present an update on risks on the High Level Risk Register.
To provide an update on the scope and Terms of Reference of the Risk Group (previously Risk and Compliance)

Key Points to Note

The Risk Group was re-established in August 2020 following a period where meetings were stood down due to the pandemic. The paper to Board in June 2020 described the governance arrangement for risk management during this time.

The Risk Group met in August, September and October 2020, and key changes to the HLRR are captured in the HLRR summary paper.

There has been a review of the Terms of Reference to re-focus the group on scrutiny and challenge of High Level risks with the remit for compliance being taken up by the CQC response
group. he revised TOR of Risk Group will be presented to the appropriate sub-committees of the Board for ratification during the next governance cycle.

A monthly deep dive of one High Level or longstanding Trustwide risk has been established which enables all divisions to contribute collectively to the discussion, considering barriers to mitigation, effectiveness of treatment plans to address gaps and risk scoring.

All divisions have been asked to review all risks on the risk registers and are expected to present these back to the Risk Group.

EQIA – Equality Impact Assessment
There are no equality impacts in respect of this paper. The equality impact of specific risks is articulated within the risk controls and gaps with mitigations put in place where indicated. The risk owner is accountable to determine any proposed actions to mitigate any equality impact arising from a risk.
Recommendation
The Board is asked to acknowledge that the established governance processes for the identification, scoping, management and oversight of risk in place and proposed changes to the remit of the Risk Group: The Board is asked to: i. consider, challenge and confirm that potential significant risks within the high level risk register are being appropriately managed ii. approve the current risks on the risk register iii. advise on any further risk treatment required

High Level Risk Register – October 2020

TOP RISKS

The following risks scored at 25 or 20 on the high level risk register remain the same as the previous month and are:

7454 (20): Radiology Staffing Risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
7689 (20): Waiting for diagnostics, operations and outpatients (COVID)
7683 (20): Lack of isolation capacity (COVID)

The Trust risk appetite is included below.

NEW RISKS

None

INCREASED RISKS

None

REDUCED RISKS

7223 THIS Mar-2018 (C4 x L3 = 12)
Risk of: Inability to access all clinical and corporate digital systems:
(EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc).

Due to:
Failure of CHFTs digital infrastructure
Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure).

Resulting in:
The inability to effectively treat patients and deliver compassionate care
Not achieving regulatory targets
Loss of income

August 2020 risk was scored at C4 x L4 = 16.
Likelihood reduced to 3: Significant improvements in awareness across the trust around the importance of BCPs along with tighter processes in place around patching key infrastructure in line with the new DSP Toolkit has helped to reduce the score slightly. Residual gaps in controls include password policy, further work around securing maintenence windows on systems and further work on server specific patching. Dark Trace has also been implemented to further assist against malicious activity. Score reduced to 12 (Target score still not met). Target score expected to be met alongside DSPT compliance in March 21.

7599 – Community Nursing November 2019 (C3 x L2) = 6

Risk of Community staff not being able to complete contemporaneous patient records due to existing IT equipment being at end of life.

Business case approved and new laptops acquired. Risk score reduced from 15 and removed from HLRR

7430 – FSS – Radiology (C3 x L4 = 12)

There is a risk of:
Being in breach of IRMER regulations

Due to:
The way roles are set up within EPR

Resulting in:
Non medical staff permitted to request Radiology exams as part of their role

September risk score at (C3 x L5 =15)
September 2020: EPR update has now taken place. Liaising with EPR team to re-start this piece of work and to fit it into their programme of works.
October 2020: Update as per September 2020. THIS have a long list of programs, therefore it is not possible to provide a timescale for completion of these works or where this ranks in terms of priority. Some monitoring is being undertaken by radiology when they get the requests through.

CLOSED RISKS
None

TRUST RISK PROFILE

KEY: = Same score as last period ↓ decreased score since last period
! New risk since last period ↑ increased score since last period

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	Minor	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6715 Poor quality / incomplete documentation =7315 Appointment =7615 Emergency Care Standard	= 6345 Nurse Staffing = 7078 Medical Staffing =7454 Radiology staffing =7689 Diagnostics,OPD, operations =7683 Isolation facilities	
Likely (4)				=7248 Essential Safety Training =6829 Pharmacy Aseptic Dispensing Service =3793 Opthalmology capacity =2830 ED Mental Health Breach =7617 Cyber risks =7557 Meeting RCPCH guidelines ED =6596 Delay in SI investigations =7778 Staff infected with Covid =7783 Social distancing restraints =7796 Track and trace isolation and team shortages =7797 Variable IPC guidelines =7685 PPE supply chain =7852 Reduced services for Pain Clinic =7527 Maxillofacial follow up appointment	= 2827 Over reliance on locum middle grade doctors in A&E
Possible (3)					= 5747 Vascular /interventional radiology service =7413 Fire compartmentation HRI =7414 Building safety =7474 Medical Devices
Unlikely (2)					
Rare (1)					

CHFT RISK APPETITE STATEMENT - August 2020

Risk Category	This means	Risk Appetite
Strategic / Organisational	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism and in taking big decisions to improve care appreciate this may attract scrutiny / interest.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, aiming to deliver our services within our financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commercial	We will always explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients 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 and promoting the well-being of our staff.	**LOW**

Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We maximise opportunities to work in partnership to support service transformation and operational delivery.	**SIGNIFICANT**

High Level Risk Register

NHS
The Health Informatics Service
Informing Healthcare

	Risk No	Div	Dir	Dep	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	Tolerate	RC	Exec Dir	Lead
Very High	2827	Medical	Emergency Care	Accident & Emergency CRH/HRI	Apr-2011	Active	Developing our workforce	Risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risk 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.	20 4 x 5	20 5 x 4	12 4 x 3	1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	Sept 2019 New rota's working well. To date there has been a reduced requirement for ad hoc locums. Nov 2019 New rota's working well. To date there has been a reduced requirement for ad hoc locums Feb 2020 There is no further progress to update April 2020 Focus on medical staffing rota's to respond to Covid-19 has seen significant changes to rota patterns, these remain compliant. See Covid risk 7678 May 2020 Clinical fellows recruited Continue to support and recruit ST3 & 4s July 2020 Clinical fellows have now started in the depatment Continue to support and recruit ST 3 & 4s	Oct-2020	Jan-2021		WEB	David Birkenhead	Dr Amjid Mohammed
Very High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Active	Keeping the base safe	There is a risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Establishment reviews/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least three times each 24 hour period using the Safer Care tool with formal escalation to Director of Nursing to agree mitigating actions. - staff redeployment where possible - nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream - Active recruitment activity, including international recruitment - Introduction of new roles eg Nurse associate	Low numbers of applications to nursing posts across grades and specialities National shortage of RGN's	16 4 x 4	20 4 x 5	9 3 x 3	• Local/domestic recruitment - monthly assessment centres • International recruitment project • Nursing associate role development and deployment of graduating cohorts • Workforce transformation (NA's, TNA's and ACP's) • Developing nursing retention strategy • Use of flexible workforce • Utilisation of nursing workforce using safe care live • Response to the NHS interim people plan - significantly grown the number of undergraduate Health students to improve the pipeline of nurses to recruit (See attached milestone plan/tracker in documents)	December 2019 Update: New graduates now in post and going into shift fill - on new preceptorship programme International recruits progressing well (35 in post - 5 going through the OSCE training programme) Next TNA programme due to start on the 6th of Jan 2020 January 2020: Full review of the risk completed New graduates now in shift fill Planning for the deployment of the first NA cohort in June 2020 International recruitment continues Planning for the next cohort of TNA's Hosting increased numbers of undergraduate students Risk 5937 merged to this risk (6345) February 2020: Local and domestic recruitment activity continues. International recruitment on-going Plans continue to deploy the next cohort of nursing associate graduates	Sep-2020	Oct-2020		WF	Ellen Armistead, Suzanne Dunkley	Michelle Bamforth

								Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077). Risk was also referenced in Risk 5937 - this has now been merged to Risk 6345.							into the workforce Work progressing to embed safe care live. March 2020: - Recruitment activity continues both locally and internationally - Continue to work with HEE to deliver on the national nursing associate expansion plans - Continue to progress action plan/work through the NHSi national retention plan - Progressing work around access to undergraduate nursing programmes via the apprenticeship route April 2020:: Focus on nurse redeployment to mitigate the impact on staffing and requirement for increased capacity in specific clinical areas has seen a significant impact on nursing rotas. See Coid risk 7676 July 2020: Local and domestic recruitment activity continues. International recruitment on-going Plans continue to deploy the next cohort of nursing associate graduates into the workforce Work progressing to embed safe care live Continue to focus on nurse redeployment as the Trust embeds reset plans August 2020: Focus on nurse redeployment to mitigate the impact on staffing and requirement for increased capacity in specific clinical areas has seen a significant impact on nursing rotas. See Coid risk 7676 Local and domestic recruitment activity continues. International recruitment on-going Plans continue to deploy the next cohort of nursing associate graduates into the workforce Work progressing to embed safe care live Continue to focus on nurse redeployment as the Trust embeds reset plans September 2020: Fully review of the risk compleated Local, domestic and international recruitment activity continues New greaduate recruitment plans progressing well, new recruites to join the Trust at the end of September. Next cohort or NA's to graduate in Jan 2021 and next training cohort to start in Dec 2020 Plan to continue to host increased numbers of undergraduate students						

Very High	7078	Corporate	Medical Director's Office	Operational	Oct-2017	Active	Keeping the base safe	Medical Staffing Risk (see also 6345 nurse staffing, 2827 A&E middle grade, 7454 radiology, 5747 interventional radiology) Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to difficult to recruit to Consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology, and dual site working which impacts on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives	Medical Staffing Job planning established which ensures visibility of Consultant activity. E-rostering roll out commenced to ensure efficient use of Consultant time Establishment of staff bank to ensure vacant posts filled WYAAT networked approach to pressured specialties Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) - HR resource to manage medical workforce issues. - Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Risk of pensions issue impacting on discretionary activity National shortage in certain medical specialties Regional re-organisation could potentially de-stabilise the workforce E-rostering partially implemented for doctors (expected by Sept 2020) - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	December 2019 A number of interviews have been arranged at Consultant level during December. There are strong applicants for substantive posts at Consultant level for Urology, Respiratory Medicine, Rheumatology, Care of the Elderly, Acute Medicine, Neurology, Ophthalmology and Renal Medicine. In addition interviews are scheduled for fixed term appointments at Consultant level in Anaesthetics Haematology and Radiology. Current Vacancy data shows that there are 21 consultant level vacancies so if these applicants are appointed then we will be able to reduce this vacancy rate further. A recent paper regarding consultant recruitment has been presented to the Workforce Committee. This showed that consultant level vacancies have reduced from 31 gaps in October 2018 to 20 in October 2019. The changes to the pay arrangements for doctors in training with regards to their weekend allowances have all been applied and updates completed. Further work will be required next year to introduce the new rota rules for doctors in training which were agreed over the summer by NHS Employers and the BMA. Invites for the Local Clinical Excellence Awards have been sent out and all applications are to be submitted by the end of December for consideration by the Awards Panel. Briefing sessions for the panel are being delivered throughout December so that scoring can commence in January without delay. The Awards panel are due to meet Wednesday 12 February 2020. February 2020 Preparation and pre-employment checks for new trainees that will join the Trust in February is almost complete, with no delays anticipated. Given the volume of new starters to CHFT the Medical Education department have planned a Medic specific induction for Wednesday 5 February 2020. A large number of trainee vacancies are a cause for concern within Paediatrics and Emergency Medicine. The Medical Director has highlighted the concerns to Health Education England with regards to Paediatrics which has been caused by vacant posts, maternity leave and a number of less than full time trainees. The national shortage of paediatric doctors is compounding the problem. The number	Jun-2020	Aug-2020		WF	David Birkenhead	Pauline North

														of gaps is creating pressure within the department as consultants are often required to 'act down' into registrar level roles to ensure safe patient care. Whilst post offers have been made for Paediatric Trust doctors, there will be a period of time before they are ready to commence in post as these are overseas candidates who will need to relocate to the UK. Two offers have been made for Trust doctor roles at ST3+ level in Emergency Medicine and whilst a large number of vacancies remain, these new appointments offer an opportunity for the trust to develop a skilled team that is not overly reliant on Agency workers. They are both very keen to progress through the CESR route to enhance skills and expand their experience. A number of overseas doctors attended the GMC Welcome to UK Practice session on 20 January 2020. This is a training session delivered by the GMC which gives a useful insight into the communication differences between different healthcare economies. All attendees felt it was useful and opportunities have been identified to improve the induction experience of Medical staff when joining the Trust from overseas. These suggestions will form part of the action plan for Medical HR to improve the recruitment experience. April 2020 Focus on medical staffing rota's to respond to Covid-19 has seen significant changes to rota patterns, these remain compliant. See Covid risk 7678						
Very High	7454	Family & Specialist Services	Radiology	Main X-Ray	Apr-2019	Active	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in Consultant capacity resulting in a reduction of cover in some specialist areas and overall general capacity with the potential for breaching national targets.	- Agency Sonographer cover. - NHS Locum cover. - Lung and chest: Additional reporting support from external providers and temporary change to job plan. Ad hoc support from WYAAT Trusts. - IR: Support from neighbouring organisation (1 day per week); Support, 1 day per week, through private agreement with private provider; working with WYVAS to plan cover until vascular service reconfiguration complete. - Additional reporting support from external providers. - Neuro: Additional reporting support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.	Vacancies in all areas, including: - Lung and chest: Gap during annual leave of one remaining Consultant. - IR: Gap when contracted NHS Locum is on annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave.	15 3 x 5	20 4 x 5	1 1 x 1	- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all required areas. - Actively seeking a second overseas fellow. - Existing consultants working through competencies to enable coverage of gaps. - Outsourcing increased to free up capacity where possible. - Locum support employed when available e.g. breast radiologists - Appointed a NHS Locum Chest Radiologist, due to commence August 2020. Feb update - this consultant has now given back word.	February 2020 Update: Risk reviewed and description and other fields updated to reflect the current position. August 2020 update: 2 additional overseas global fellows appointed, start date on hold due to Covid 19. One trainee due to commence placement in September 2020. Covid impact has temporarily reduced demand for routine reporting there the service is less reliant on outsourcing, although some outsourcing work continues.	Aug-2020	Aug-2020		PSQB	Stephen Shepley	Sarah Clenton

Very High	7683	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk of not having adequate isolation (Side room) facilities Due to an increase in demand and initiation of testing of asymptomatic patients Resulting in failure to safety isolate patients and further transmission of Covid-19 to vulnerable patients	Infection Control policies and procedures PHE guidance In-house testing of patients. Daily IMC VC meetings. SITREPS Monitored by Tactical with reporting and escalation into Covid re bed capacity and patient flow.	One platform for testing and if this goes down will need to revert for testing to Leeds with results taking longer to receive Aerosol generating respiratory interventions should be in single side rooms or require all in the area to wear PPE.	12 4 x 3	20 4 x 5	6 3 x 2	Establish in-house testing and turn-around of results to move negative out of isolation - in place Review anti-microbial protocols for antibiotic prescribing to reduce patient contact and move to early discharge Plan for commencement of testing of asymptomatic patients - in place Monitor patient flow	July 2020: 16th, increased pressure on blocked beds and side room availability, becoming challenging. June 2020 all patients are tested on admission, isolated until result is back. Negative are cohorted or in side rooms. PPE used in line with national guidance. Bed flow management integral to Tactical and escalated to IMT. Increasing non-elective activity. 01.05.2020 Planning for testing of asymptomatic patients who are admitted. Evidence currently indicates that 5% asymptomatic tests are positive. Need to segregate patients until results back. If non-positive are cohorted with asymptomatic positive case, then all will require cohorting. Commenced testing of all care home patients as higher prevalence. Potential for increased patient flow challenges. Tactical monitoring bed availability including side rooms, and beds blocked fully/empty. 30.3.2020 in-house testing providing results within 4 hours and enabling step down of patients not requiring isolation. Current capacity allowing for 4-bedded bays to be used as side rooms. IPC reviewing antimicrobial prescribing and antibiotic stewardship guidance	Aug-2020	Jan-2021		NA	David Birkenhead	Claire Speight, Bev Walker
Very High	7689	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk that patients may have to wait for outpatient appointments, diagnostic tests or routine operations Due to cancellations of routine surgery and rescheduling of clinics Resulting in their condition deteriorating, potential impact on treatment options available and a less positive outcome	EPR booking and validation processes Urgent fast-track processes in place Risk assessment for re-prioritisation of appointments Virtual appointments commenced in some prioritised areas	Unable to meet target KPI's for RTT and diagnostics, and that patients will wait longer than is best practice for outpatient appointments with an increase in the ASI list and holding list.	20 4 x 5	20 4 x 5	4 2 x 2	Clinical review and prioritisation of essential patients Medicine: risk assessment of booked and due, consider remote or delay 3-6 months. Working up CAS model and recovery plan. Incident reporting for identifying patient harm or impact on prognosis or outcome Complaints and PALS Team logging enquiries and concerns re waits for appointments, and patients not wishing to attend for appointments	July 2020: clinical validation and prioritisation in place, appointments including virtual, some diagnostics commenced, endoscopy. June 2020 Clinical validation and prioritisation of appointments has commenced. Clinic letter templates being amended to include additional instruction to patients who are required to attend face-to-face appointments. Virtual clinics running across specialties. Response to contacts from patients awaiting treatment from Yorkshire Fertility Clinic. 02.04.2020 Medicine: risk assessment of all patients with an appointment booked and who are due an appointment to identify whether they can have their appointment remotely or if it can be delayed 3-6 months. Planning to implement a CAS model for all specialties once routine elective work recommences, this will help reduce the waiting time for new patient appointments and therefore the time to first treatment. A review is taking place of all clinics to allow us to identify what can remain remote (VC or telephone) in the future, so this doesn't all revert to	Aug-2020	Aug-2020		NA	Anna Basford	T Strickland, S Shepley, A Ameen, L Willia

														routine face to face working. 30.3.2020 risk assessment in Divisions, essential patients are being identified. Medicine: Risk assessment, re-prioritisation and deferring 3-6 months for patients booked for April 2020 will be completed by end of March 2020. Work commenced on appointments for May and June 2020.						
High	7778	Trustwide	All Divisions	All Departments/Wards	May-2020	Active	Keeping the base safe	There is a risk of staff potentially becoming infected with Covid 19 Due to caring for patients with the virus Resulting in sickness and potentially death	Following PHE guidance PPE Identification and cohorting of patients Dissemination of safety messages Staff testing - asymptomatic testing of staff commenced. Evidence showing that frontline staff caring for Covid positive patients have infection rate 1%, which is higher than staff in non-frontline and non-covid work areas Social Distancing guidance Working from home - reduce infection and allow for greater social distancing	Inabililty to determine where the infection has been acquired - not able to account for staff movement and contacts out of the work environment - therefore clarity of application of RIDDOR in these cases Non-adherence to social distancing failure to properly wear, or remove PPE at appropriate times	15 5 x 3	16 4 x 4	5 5 x 1	Monitor staff sickness absence Provision of Occupational Health advice Staff testing for symptomatic, asymptomatic and those isolating due to family symptoms Provision of PPE appropriate to task WYAAT position on application of RIDDOR	3rd September 2020 - reviewed by PPE group - risk to sit with social distance group. PPE group will advise on PPE June 2020: Social Distancing workstream in place. Provision of surgical masks for public areas and offices with occupancy requiring PPE, and for patients. Work to encourage staff to adhere to social distancing guidance is ongoing with raising awareness, Greeter roles on main entrances, segretation of seating areas in restaurants, and prompting staff to consider behaviours. 18.05.2020 Social Distancing guidance and FAQs distributed 01.05.2020 recognition regionally, nationally and internationally that staff are catching Covid and some deaths of healthcare workers. Suggestion that BAME staff groups may be more affected. More community staff are testing positive. Planning for testing of all staff with recognition that 1-5% staff will have a positive result, impacting on workforce.		Oct-2020		NA	Helen Barker	Helen Barker
High	7783	Trustwide	All Divisions	All Departments/Wards	May-2020	Active	Keeping the base safe	There is a risk of being unable to achieve national standard of social distancing of 2 metres Due to constraints of the environment and estate, the buildings, corridors and room sizes, and configuration of spaces in their current form and how they were utilised pre-Covid and staff failure to adhere to guidance Resulting in potential for cross infection from patients to/from staff, and staff to staff staff, a lack of confidence of patients to attend for necessary care and reputational damage to the Trust	Covid IMT oversight of risk, incidents and workstream Covid IMT oversight of Stabilise and Reset including proposals for commencement of activity Outpatient activity is limited to emergency clinics for vascular patients at SOPD. Following PHE guidance to offer PPE to any patient attending clinics Chairs in waiting areas are distanced.	SOPD Estate- not in an ideal location to meet face-to-face Surgical Clinics for Vascular, plastics, colorectal, urology. narrow corridor (3 metres), SOPD entrance doorway (1 meter) and small waiting area (3 metres) which get congested with footfall from patients arriving for multiple surgical clinics, activity in pharmacy opposite SOPD and passing staff who are attending other services on subbasement (endoscopy, pharmacy, medical engineering, Haematology OPD). High risk patients (Vascular Hot clinics) coming to SOPD. Canteen/restaurant and kitchen facilities - staff queueing and failing to adhere to social distancing requirements Open plan office areas with	16 4 x 4	16 4 x 4	8 4 x 2	Plan for Stabilise and Reset (recovery) being conscious of requirements for social distancing Signage to support social distancing message in public spaces is ordered Signage for small meeting rooms ordered - one person/two person space Covid bulletin providing key messages regarding social distancing Top Tips for Managers and FAQs Social Distancing wardens in communal areas such as restaurant at busy times Monitor ED attendance and patient flow Workplace risk assessment for offices and shared environments	July 2020: 16th - ED waits, working on a trigger for escalation of inability to achieve social distancing. impact of minor injuries and ED presentations. July 2020 Covid IMT - workplace risk assessment for office environments. June 2020 Social distancing and environmental workstream in place. 19/5/2020- OPD and SAS meeting about clinics to discuss challenges for reinstating clinics safely. 15/05/2020 C-IMT Top Tips and FAQs formatted, Newsletter dissemination via line manager channel, bulletin route and Divisional Manager cascade. Signage 'walk on left and 'single person rooms' 14/5/2020 SOPD - outpatient activity is limited to emergency clinics for vascular patients.Patient attending for face-to-face clinic is asked to wear a face mask, gel hands and limited attendance. Chairs in waiting areas rearranged to limit to one patient waiting in clinic and 2 metre distancing in corridor. 2 patients can sit social	Aug-2020	Jan-2021		PSQB	Helen Barker	Rachel Roberts, Catherine Riley

									banks of desks Unable to achieve a one way system for entry and exit to clinics in outpatient settings due to the design of the estate. Small meeting rooms that do not allow for social distancing				distancing in waiting area and 5 can sit outside in corridor. Total that can be held using risk assessment is 7 at any one time. 13/5/202 SOPD is not fit for purpose to meet volume of patients and this must be factored in to reconfiguration of outpatients. 12/5/2020 SOPD Microsoft teams meeting to discuss and escalate to Divisional Director of FFS who has raised concerns at Incident Management Team (IMT) for COVID response.Outpatient Recovery Plan meeting scheduled.						
High	7796	Trustwide	All Divisions	All Departments/Wards	Jun-2020	Active	Keeping the base safe	There is a risk of staff or whole team shortages Due to the Government Track and Trace system advising self-isolation for contacts of Covid Resulting in potential for reduction in services and impact on patient care	Social Distancing guidance and Trust workstream PPE provision and guidance on wearing in the workplace	Some teams are unable to socially distance at the required 2 metres when working (eg. Pathology labs) Movement of staff outside of working hours	16 x 4	16 x 4	4 x 2	Social Distance workstream - identify opportunities to social distance and reduce risk Communications to staff when guidance is updated	June 2020: Social Distancing work commenced, focus on public and work areas and signage, PPE, space utilisation. Recognition that some teams work in a restricted space and not possible to socially distance. Not possible in some cases to reduce the size of the team without significantly impacting the volume of activity that they can deliver, creating a further risk. .	Sep-2020	Nov-2020		NA	Jason Eddleston	Jason Eddleston
High	7852	Surgery & Anaesthetics	Critical Care	Pain Clinic	Aug-2020	Proposed for Acceptance	Keeping the base safe	There is a risk of reduced service delivery in the Pain Clinic ,due to a reduced workforce model in response to staffing requirements in ICU, resulting in delay of treatment and potential risk to patient safety and increased length of stay	Currently service delivered by Band 7 0.8 WTE 0.64 WTE band 5 . Band 6 CNS to support service 1 day a week from week commencing 12 September	No onsite cover from a pain nurse specialist, wards and clinics normally supported 5 days a week 8.30-17.00 Band 7 due to shielding requirements working remotely only. No nurse specialist cover whilst Band 7 on AL (on leave now until 2nd September) risk rate would reduce to 12 when back Band 5 new to service	16 x 4	16 x 4	0 x 0	Review of staffing requirements daily on ICU over next week and release of CNS if acuity allows Band 6 CNS to support service 1 day a week from week commencing 12 September.		Nov-2020	Jan-2021		PSQB	Thomas Strickland	Fiona Kaye
High	7685	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	PPE SUPPLY CHAIN There is a risk of the supply chain for PPE not being maintained or responsive Due to increased demand and reduced capacity Resulting in failure or delays in provision of essential PPE to frontline staff	National control of distribution by MOD - 01.04.2020 (Clipper logistics) Strategic and tactical command National Supply Chain Disruption arrangements Materials Management Group CHFT PPE Group - decision-making and governance PHE guidance is accepted as the definitive guidance for PPE. Product recall process and Quality testing contract available Mutual Aid in place and experiences indicate effective and responsive	Reporting system with real-time stock position National distribution by MOD - no longer able to order our own stock: Range of PPE guidance being disseminated by professional bodies leading to confusion. National push deliveries that are recalled due to quality control issues	20 x 5	16 x 4	2 x 2	National Distribution model by MOD Respond to updated national guidance Establish centralised ordering process Region-wide (WYAAT) order for gowns Monitor use of masks in view of change to national guidance on useage in public areas for both staff and patients. Mutual aid and national escalation in place and triggered as required. Product recall process developed by PPE group	3rd September 2020 - Reviewd by PPE group. New IPC guidenace currently being worked through. FFP3 stratergy agreed option4 blended approach. 28th July 2020 - Reviewed by PPE Group - Product Recall established and implemented responsively and successfully, process disseminated to on-call distribution to support implementation out of hours. Additional supply of 5000 goggles received as part of the strategy for eye protection rolled out to clinical areas with decontamination SOP. Strengthened organisational postion with 90 hoods delivered, and deployed into clinical areas, supported with a tracking system. No "real" escalations due to deteriorating stock postions over the last month. July 2020 - new Head of Procurement in post, handover done. Continued monitoring of stock levels with reaching out for mutual aid where necessary and national escalation. Sml nitrile gloves	Sep-2020	Oct-2020		NA	Ellen Armistead	Kate Roberts / Andrea Dauris

from MYHT and supply anticipated from national push delivery. PPE group looking at mask dispensers for visitor stations.

June 2020 - monitoring of increased use of surgical masks due to requirement to use in office spaces, public spaces by staff and by patients/public attending hospital premises. Increased use of PPE due to recommencement of some clinical activity.

21..05.2020 PPE group - surgical masks - staff concerns/preferences regards fit of some, different types and fastenings; need to ensure that staff are comfortable but understand purpose of mask. Specification is appropriate for purpose.
Gowns - phased removal of yellow spanish gowns, had delivery 10,000 blue gowns that are level 3 and push delivery of level 4, white gowns. Blue gowns for swap out wards and depts first, then crash trolleys. Ensure stock for over w/e and BH period. MatMan Team working every morning.

22.04.2020 - Gowns CAS alert - national shortage: mitigations improve cohorting, ensure correct staffing levels in ICU, national planning for critical shortage. Progress procurements as ICS.
1500 theatre hats for covid areas hair protection - approved.

22.04.2020 PPE group
Gowns - bought 500 disposible lab coat style - delivered.
Fabric lab coats, reusable - being costed up, contract PAYG contract. Laundry can respond.
Need an advisory note for staff with different types of gowns via the daily update.
Spanish gowns - checking of batches for consistency of quality, but believe they meet the AAMI level 2 standard that we ordered. Some other Trusts have chosen to opt out of the contract.
Completing an organisational stock take on gowns - update position by later today.
Effective placement of patients/cohorting for AGPs will support best/sessional PPE use.
Need internal controls for distribution of right type of gowns to right areas. To strengthen process for donations, and what is being brought in by individual staff - follow approved governance routes.
Some ward-level stockpiling of coveralls, brought back into central store.
Procuring head gear for hair protection

- approved order.
Hoods - tracking (add a risk) asset tracking system being developed, should include hoods.
Request to Astra Zeneca to loan hoods - being progressed.

21.04.2020 Difficulty getting 'O' rings for hoods, can't buy them but have ordered the equipment to enable us to make them. Disposible mask 8833 (cone shaped) no planned delivery, escalate to NSDR - look at FIT testing to flat masks and prioritise distribution of cone shaped.
Gowns 5000 delivered on saturday, large order signed. PPE working on ICS footprint.
In a better position for gloves from big national delivery, long sleeved ok at present.

20.04.2020 - First delivery of gowns order across WYAAT arrived Saturday am, reviewed quality. Have 6 days disposible gown stock. Contingency plan for material gown, sending around technical guidance.

16.04.2020 long gloves same position as yest. 1000 coveralls instead of gowns, 5000 gowns due 17th.
CHFT leading regional arrangement 640,000 gowns delivered @ 80000/wk to Yorkshire - first delivery due, to evaluate the quality and proceed.
£3.4M with upfront payment £1.7M, working with NHSI for clearance, developing a contract.

15.04.2020 Long gloves - plea has located 6 boxes, other Trusts using normal gloves. Gowns - main concern, have days of coveralls, 5000 due on 17th.

15.04.2020 (PPE Group) bolstering stock of coveralls for gowns, need to be careful with mutual aid requests.
2 days of long gloves until out of our stock, ability to order has been taken away - push orders only. Manage double-gloving practice.

13.04.2020 Long gloves - looking at alternatives. Gowns supply resolved and contingency in place.
Scrubs - only received one batch, maintaining own stock and placing order with new supplier.

10.04.2020 4200 disposible gowns, use 1000/day - reduce through sessional use (PPE group)

09.04.2020 Sourcing contingency coveralls for gowns,

08.04.2020 gowns did not arive

															yesterday, critically short now. None in stores, just on wards, <24hrs left. Same in rest of yorkshire and manchester. Sessional use guidance, see PPE risk. 07.042020 Expect 4000 gowns will know today. 06.04.2020 Gowns and hoods are issues. Different FFP3 masks being supplied. 03.04.2020 PPE no delivery 2 days, no FFP3s for 3 days, not tested on all types in stock. National gown supply issue. 01.04.2020 nationally moved to a national distribution model by MOD, no longer able to order our own stock. Daily drop of PPE, informed at 11pm what we will receive. PPE received with national stock expiry assurance - message out in daily Covid update briefing regards expiry dates. Sourcing alternative gowns, visors. 30.3.2020 RAG position for PPE - areas of concern are gowns, visas Estates and facilities are developing an Analytics system for stock control to allow for reporting to Covid Incident Group. Developing a non-stock order list.To set up a Covid cost centre to track directly related bulk stock ordering. .						
High	6829	Family & Specialist Services	Pharmacy	Pharmacy	Aug-2016	Active	Keeping the base safe	The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispensing Service to provide the required number of aseptically prepared parenteral medicines. This is due to the CRH unit being temporarily closed for a refit and the HRI ADU having quality issues as highlighted in the May 2018 and January 19 EL (97) 52 external audit which reported 3 major deficiencies limiting its capacity to make parenteral products. Resulting in the unavailability of chemotherapy / parenteral treatments in a timely manner (i.e. delays in treatment for patients), increase in cost of buying in ready to use products and increase in staff time (and error risk) from nursing staff preparing parenteral products including syringe drivers on the wards.	A business case has been approved 2017/18 to provide update facilities on the CRH site. It is planned that the new unit will open ~ Feb 2020 and the HRI unit will close. An action plan has been produced (and agreed by the auditor) to remedy the major deficiencies at HRI unit which includes a capacity plan to limit products made on site. The action plan is monitored by the Pharmacy Board at monthly team meetings and FSS Divisional Board and PSQB with monitoring of non-compliance. Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. HRI ADU currently being re-audited every 6 months - re audit Jan 19 and July 19 In order to provide assurance regarding capacity during the interim period there are a number of strategies to be implemented before October 2019, including:	Until the strategies outlined above to improve capacity have been implemented we will not know that this workload is safe to deliver. other options to consider will be working hours of the unit - currently operational Mon-Fri 8.30-5pm . Potentially when CRH closes, will open HRI unit earlier at 7.30am to prepare those doses required at CRH and ensure timely transport. Delay in project- new unit not now due to open until Aug 20	15 3 x 5	16 4 x 4	3 3 x 1	Agreed Action Plan October 18 to reduce capacity at HRI ADU i - key points relate to process measures in department (being addressed) and the need to progress consolidation of the units leading to closure of the HRI unit. Delays in project have delayed the temporary closing of the CRH unit to November 2019. Syringe drivers are now made on wards and procurement of ready to use TPN bags is now being phased in .. Phasing in of ready to use chemo batches also underway.	April 19 update. HRI EL audit plan produced and submitted to auditor for review. Capacity tool now in use to review products made at HRI and monitor capacity. Capacity report submitted monthly for review at Pharmacy Board. Syringe drivers no longer made by unit. TPN outsourcing- Go See to Chesterfield March 26th. FS liaising with dieticians and nursing staff and must ensure any increase in nursing time is clearly highlighted (require understanding if extra lines required for additional electrolyte administration) Ready to use chemo- procurement plan agreed -to introduce more ready to use batch chemo over next 3 months . June 19 update. Aseptics progress reported at June Divisional PRM. Aseptic Staffing in new model reviewed to ensure meet the required QA standards. Financial costs have increased from original feasibility study. Project has been delayed due to procurement process issues initially and more recently due to extra estates works (air extractors/ planning permission). New target date for	Nov-2020	Apr-2021		DB	Ellen Armistead	Elisabeth Street

									buying in ready to administer injectable medicines (mainly chemo), reviewing products which are prepared in the units on both sites to reduce activity (to include: syringe drivers, adult parenteral nutrition), update the product catalogue, and from June 2020 - outsource radiopharmacy (buy in MDVs of radioisotopes from Bradford)						opening June 2020. Aseptics managers continue to work on EL audit action plan to ensure necessary quality standards are reached. August 19 update - units had an EL Audit on 30th July and are awaiting report from that. Use of bought-in bags of PN is at over 60% when stock is available -- there have been delays from the supplier on occasion which have necessitated in-house production. No firm timescale available for the start of the build at CRH Sept 19 update. Issues with purchase of ready to use TPN due to national supply issues causing increase in capacity at HR unitl. Enabling work tender has been awarded to separate company to that for aseptic build work (Bassaire). Bassaire are now stating that they will need to charge by the hour for the validation work now required for them to validate the enabling work. Estates / Engie and Pharmacy to meet as a matter of urgency to understand contracting and finical implications of this. October 2019 update. CRH unit due to close 29th November and enabling work to commence 2nd Dec(awaiting confirmation date from Engie). Further issues with vinyl in HRI unit (peeling off wall, increasing risk of micro contamination- estates booked in to repair on 9/10th Nov)Outstanding action from EL audit was to remove sink in HRI unit. Work to be completed 26th/27th October.Engie/ Bassaire reached agreement regarding validation work and responsibilities. This will be at no extra cost to the Trust. New CRH unit still planned to be open mid/ end June 2020 December 19 update. Delay due to Project Echo/ lease agreements with lenders solicitors being reviewed. CRH unit now due to close Jan 20 and enabling work start mid- Jan but awaiting confirmation from Associate Director of Finance re outcome of lease sign off debate. This is likely to delay opening of new unit to Aug 20 and reliance on HRI aseptic unit until that point. February 20 update- as Dec update- further delays in lease sign off / step in rights/ defect liability contract and therefore start of enabling work is further delayed. New unit at CRH unlikely to be open before Sept 2020. May 20 update- whilst Engie and Trust agreed to lease sign off, still awaiting lender sign off before Engie can be instructed to start enabling work. New unit unlikely to be open before Dec 20						

														June 20 update Building work of the new unit at CRH to start 26th June 20 (and due to finish Feb 20) Aug 20 update Building work continues. No major delays identified at this point and on track fro key milestones Sept update. Enabling work virtually finished. Delay in Bassaire starting next phase due to concerns raised following drilling tests about the volume of noise and vibration being generated which is affecting patient care on CCU. Plan now to temporarily relocate CCU but this moves requires installation of new telemetry equipment and the ordering of this equipment takes 4- 5 weeks. Hence Bassaire delayed next phase for at least 4 weeks which will delay the opening of the new unit to April 21						
High	7617	Corporate	THIS	THIS -Operational	Dec-2019	Active	Keeping the base safe	Risk of: being in breach of contractual obligations, reputational damage to the Trust and becoming an NHS England/Improvement (the Cyber Risks and Operations group) trust of concern. Due to: non- compliance with the Data Security protection toolkit Resulting in: inability to trade due to contractual obligations not being met, loss of income and reputational damage. In addition, as a HSCN consumer, we are responsible for maintaining compliance with relevant NHS Digital Information Governance and data security standards and accreditation including the Data Security and Protection Toolkit (DSPT) which is one of our obligations under the HSCN Connection Agreement. It is not necessary to complete a Data Security and Protection Toolkit (DSPT) assessment in order to gain access to HSCN. However, all organisations that have or require access to NHS patient data and systems must use this toolkit to provide assurance that they are practicing good data security and that personal information is handled correctly. Our current Trust status stands as 'Standards Not Met', If we are to publish a further DSPT with 'Standards Not Met', our Organisation may become a Trust of concern to NHS England/Improvement.	Control Group established – Governance Risk and Compliance (GRC) IT Workstreams in place to address areas of non-compliance Operational control by THIS Director Project management in place to steer progress Data Protection Officer oversight Digital Investment (Darktrace etc) Aug 2020 - Plan in place	Password Policy Delivery of planned work for March 21	16 4 x 4	16 4 x 4	4 4 x 1	3 workshops have taken place to understand the resource and capital investment needed to close the gaps and meet the required level of compliance. The output from these workshops is the compilation of a plan with timescales and deliverables. This plan will be complete in Dec 19 with the first actions commencing in January 2020 where funding allows for resource and infrastructure investment. Plan underway with positive outcome expected July/Aug 2020. Revised plan going to Divisional Board in Aug 2020.	Weekly meetings are being held to track progress and highlight any areas of concern. 3 initial workshops to understand the scale of the changes required have taken place during Nov/Dec 19 Raised at Divisional Board in both November and December 2019 with senior management engagement Feb 2020: There is a plan in place following the workshops however requests for supplementary funding (both capital and revenue pressures) has been rejected therefore THIS are working through the work plans that have been agreed over the next 6 months in order to complete a further DSPT self assessment in October 2020. No change in risk score. April 2020 - The DSPT submission has been moved to Sept 2020 due to C19. Investment in digital and implementation of the new password policy will mean that it is more probable that we will meet the standard. Alongside tested BCPs, the mitigation around some of the gaps in controls and an increased understanding of digital ways of working, the likelihood of this risk will reduce closer to the submission in Sept. Aug 2020 - Significant progress has been made for our submission in September 2020, however this will still be non-compliant as expected. DSPT progress reviews continue to be carried out, for both Information Security and Technical aspects. There is now a plan in place for delivery of the key elements ready to meet compliance in March 21. These actions with reduce the score once the plan has been signed off by Divisional Board in August.	Sep-2020	Mar-2021		DB	Mandy Griffin	Rob Birkett
Hig	752	Sur	and	- tme ort-	201	Acti ve	Kee	There is a risk that patients will develop a recurrent cancer or	A failsafe process has been implemented for the post cancer	EPR system (Lists) Lists of patients	15	16	4	Review outstanding validations- Completed	September 2019 51 patients validated as of 17th	Sep- 2020	Oct- 2020		PSQ -	Tho	Laur

								more invasive cancer if they are missed for their follow up appointments, this is due to patients not being booked back in for their require time frame of appointment for the surveillance check - resulting in patients / hospital cancelling the appointments and patients are not being seen at the designated timeframes.	patients , ? recurrent cancer / Surveillance through the cancer head and neck services. The validation team are prioritising the maxillofacial validation of 591 patients. Checks that all orders at placed following outpatients attendance Added onto careplans of review of follow ups dates required for all cancer diagnosed patients	Failsafe Escalation process to implemented within appointment centre, secretaries. Appropriate training within the department	5 x 3	4 x 4	2 x 2	Develop process with appointment centre (Validation team) Completed Develop escalation process with appointment centre , secretaries for cashing up of clinics, and process to add further requests if appointments are cancelled. Completed Communication plan within the head and neck services. Completed High level process to roll out within the division. - Ongoing , process map developed, awaiting sign off by division.	September 2019. Meeting arranged Friday 20th September 2019 with appointment centre Update to be given at red panel Friday 20th September 2019. Met with validation team 18th September to confirm 519 patients on the IO (Incomplete order list) - Actions: * To start validating Maxfax patients , approx. timescale for completion is 3 days . Appointment lead to update General manager (GM) daily of progress * Ensure 2017 patients have all been completed of any outstanding validations still in circulation * GM and Project manager to produce clinical validation SOP and share across the division team. * Division to discuss priority of specialities to be validated in high risk order and send to the validation team with rationale *GM exploring how to RAG rate surveillance patients with Information management. 4th October update - Validation almost complete. review and drill down to patients pathways that have been delayed. 12 December update - All validation for Maxfax completed and monitored weekly . Development of surveillance patients portal digitally is being worked by information management. Progressing well for all patients identified no commencing date as yet. To be sent to DMT to reduce risk January/February 2020 Update clinical validation process to be sent to DMT for sign off and circulate wider through the trust. ENT Validations - Being monitored through customer contact awaiting latest update following 2018 validations MArch 2020 update: Validation team redeployment for COVID-19. Therefore incident raised by one point (likelihood 4 x impact 5). April 2020 Update Impact - Capacity for seeing surveillance patients Portal to be signed , expected end of the month to go live , to ensure surveillance patients are kept on track and can be monitored as a RAG rating system . Mitigation - Fast track team are tracking patients with daily updates and escalations . Telephone consultations						

														also have been introduced to contact patients at check points and escalation process currently being developed. May 2020 Ongoing work to with trail of live portal July 2020 validations ongoing and trial still continuing , to present to collegues , clinicians in August 2020 August 2020 - Band 5 approved for 12 month secondment , to track patients and support with project work to improve booking of appropriate appointments. CNS team also implementing telephone reviews at specific check points of the surveillance pathway to ensure patients are not lost to follow up reviews.						
High	7557	Medical	Emergency Care	Accident & Emergency CRH/HRI	Oct-2019	Active	Keeping the base safe	There is a risk to patient safety and experience for children and families visiting the Emergency Departments at CHFT. Due to the current workforce model which does not support the RCEM and National guidelines (RCPCH) which recommend 2 x Qualified Registered Children's Nurses on a shift in an ED at any one time. Resulting in the inability to : Provide care appropriately for sick children Recognise the sick and deteriorating child Have staff trained in appropriate distraction techniques for children Lack of awareness of all safeguarding flags and signs to be aware of in children attending the department.	2 RSCN nurses employed at Calderdale 6 Nurses currently on the Child In ED course via the university RN's working in the department who have previously completed the child in ED course APNP's attending the HRI site to care for sick children Work on going to look at an interim model while awaiting reconfiguration	Unable to recruit RSCN's in current workforce model Risk of recruiting RSCN's leading to poor morale and leaving the trust Unable to send a large proportion of staff on the Child in ED course due to study leave	16 4 x 4	16 4 x 4	1 1 x 1	To subscribe to the child in ED course at every intake via the university. Create a business case to increase the work force model to achieve RSCNs on each shift	January 2020 - HLRR - Review of articulation of the Risk to be completed by Andrea Gillespie and Ellen Armistead January/February 2020: Task and finish group being set up to look at new ways of achieving cover with RSCN's in department. Visit to Frimley park planned Jan 2020. May 2020: Task and finish group currently suspended due to pandemic. Both areas segregated for COVID-19, therefore neither area is a sutable paediatrics currently. Continue to only have 2 qualified RSCNs at CRH site. Model worked up for converting both departments in paeds area when COVID pandemic over. June 2020: Work has re commenced re: a Paeds ED at CRH. Plans being drawn up for environment and staffing. Aw dates from University re: commencement of Care of sick child in ED course. July 2020 Currently looking at how to include paeds with a segregated ED assessing staffing numbers and RSCN numbers meeting on 9th July 2020 Recruited an Advanced Paediatric Practitioner starting this month Septemeber 2020: Aw decision re: paeds ED at CRH quotes obtained. Nurses identified to commence care of sick child course in Jan 2021.	Oct-2020	Apr-2021		NWG	Ellen Armistead	Louise Croxall/Jayne Robinson
High	7248	Corporate	Organisational Development	Workforce	Apr-2018	Active	Developing our	The risk: Not all colleagues will complete their designated core 'Essential Safety Training' (EST) subjects. In addition not all colleagues will complete their role specific training.	All electronic e-learning training programmes are automatically captured on ESR at the time of completion. WEB IPR monitoring of compliance data. Quality Committee assurance check	None	16 4 x 4	16 4 x 4	4 4 x 1	January 2019 Targeted emails to departments with an average compliance below 85% Weekly drop in sessions at CRH and HRI for staff to access ESR support.	June 2019 - The work identified above is continuing but the completion date has been put back to the end of July 2019. This is due to some technical issues identified in the process - the Workforce BI Team have raised these with the ESR Functional Advisor and	Mar-2020	Mar-2020		WF	Suzanne Dunkley	Charlotte North

								Resulting in: Colleagues practicing without the recorded required knowledge or understanding of core EST subjects. This could lead to unsafe practice, potentially leading to incidents involving colleagues and/or patients. EST consists of 10 'core' subjects which all colleagues must be consistently 100% compliant in. There are a further 35 subjects which are 'role specific' – subjects which are dependent on the role the colleague has. The Trust has a compliance target of 90%. Our core subjects have been consistently above this target since April 2019, with an average of 95.22%. The focus therefore is on the compliance of the 35 role specific subjects. Compliance for these subjects range from 97.60% to 50.04%. We expect all role specific training to be on target by August 2020.	Well Led oversight of compliance data identifying 'hot-spot' areas for action Divisional PRM meetings focus on performance and compliance. Human Resource Business Partners are working closely with divisional colleagues on a weekly basis to ensure compliance.					Additional training dates have been added for safeguarding and MCA/DoLS level 3.There are sufficient places to train ALL staff who are currently non-compliant. Plans are in place to ensure that the right staff are booked on and that the courses are full. Role Specific EST - SMEs of subjects with compliance below 90% will be contacted w/c 28.01.19 and asked to submit a plan of action for Q4 2018/19 and Q1 2019/20 to improve compliance. Registers will be marked 'live ' in ESR at the point of training which will show compliance in a much more timely manner.	IBM. Additional DSA classroom sessions have been attended to raise compliance in this subject. August 2019 - The 9 core subjects of EST have been 're-set' in the system and this has enabled colleagues to play the learning without difficulty. A 'deep-dive' into Infection Control Level 2 and all Resuscitation subjects has taken place to identify capacity. September 2019 - The core 9 subjects are consistently attaining a compliance of over 90%. Focussed activity is taking place on the role specific subjects where compliance is below 85%. This includes contacting SME's to ensure the target audiences are correct and working with HRBP's to share non-compliance with relevant departments. October 2019 - Activity remains focussed on the role specific subjects where compliance is below 85%. Specifically, Adult & Paediatric Basic Life Support where a capacity/demand issue has been identified. November 2019 - The core 9 subjects remain at over 90% compliance, with 5 subjects consistently over 95%. Fire Warden training has been assigned to all Band 6 Nurses which has seen a reduction in compliance, work is under way to review the target audience and increase capacity. December 2019 - Of the 34 role specific subjects, 19 are at below 85% compliance. Each of these is being scrutinised this month with a plan in place to increase compliance by end of March 2020. January 2020 - The core 9 subjects remain at over 90% compliance. Of the 34 role specific subjects, 18 are now below 85% compliance. An action plan is in development to address these and this will be shared with the Executive board this month. February 2020 - The core 9 subjects remain at over 90% compliance. A full deep-dive into the role specific subjects below 90% has taken place and the findings presented to Executive Board. For these subjects, details of non-compliant colleagues is being emailed to managers in February. An EST Line Manager Bulletin special is being sent to managers which explains where we are at and what we need to do to improve compliance. March 2020 - Moving and Handling compliance has dropped below 90% -						

														work is being carried out in divisions to address this. Both Safeguarding Adults/Children Level 3 and Infection Prevention Control Level 2 classroom sessions have been cancelled due to COVID-19. E-learning is available for IPC and is in development for Safeguarding.						
High	6596	Corporate	Corporate Quality	Governance and Risk Quality	Jan-2016	Active	Keeping the base safe	There is a risk of not complying with the national SI framework March 2015 due to not conducting timely investigations into serious incidents (SIs) resulting in delays to mitigate risk, to realise learning from incidents and share the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Scheduling of SI reports into orange divisional incident panels to ensure timely divisional review of actions. - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Investigator Training - to update investigator skills and align investigations with report requirements. - Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Risk Team support to investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning - Investigation Pack and plan for each SI investigation, with initial and midpoint meetings with Risk to monitor progress	1. Operational pressures and impact on capacity to undertake investigations in a timely way, further exacerbated by Covid 2. Sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation, particularly doctors. 4. Lack of access to documents on EPR to non clinical investigators. 5. Operational pressures impacting on time for conducting investigations 6. Requirement to undertake SI investigations is not in Consultant job plans 7. delivery of RCA training workshop suspended due to Covid	16	16	4	Increase number of trained investigators Be clear in delivering training there is a requirement to participate in SI investigations as part of the investigation team To add EPR document access for non clinical SI investigators Learning Group to develop approach on learning and a learning event - Quality Priority for 2020/21 Paper with options investigations	July 2020 current position 20 ongoing SIs, number of overdue investigations is reducing. Risk Team conducting a number of investigations including writing reports. Administrative support for Risk Team and SI process is significantly impacted by sickness absence. Recruited to Datix Manager and commenced in post. Risk Team also supporting Covid IMT by monitoring of covid-related incidents, complaints and concerns and leading development and maintaining of the Covid Risk register, further impacting on capacity to deliver SI investigations. One shielded member of nursing staf has been identifed to support the Risk Team with investigations, but as yet does not have a laptop. Continue to maintain relationship with commissioners and provide updates on progress of investigations. April 2020 continued pressure on delivery of SIs within timescales required by the framework. Majority of SIs now have at least one extension. Risk Team have taken over writing reports for most investigations, with specialist input sought to provide evidence base. Position escalated to AD Q&S and via senior management team meeting, additional investigator support requested within team but not forthcoming. February 2020 - Discussion with Director of Nursing regarding written communication to line managers of investigators regarding their involvement in serious incident investigation to reduce withdrawal rates. Dec 2019 - challenges with operational pressures and time for investigation teams to progress investigations. Risk Team supporting by requesting statements, collating information. Escalated status of SIs to SI panel. Consideration to be given to options for pool of trained investigators.	Sep-2020	Dec-2020		QC	Ellen Armistead	Maxine Travis
High	2830	Medical	Emergency Care	Emergency [illegible]	Apr-2011	Active	Keeping the	There is a risk to safety and experience for mental health patients who are at risk of harming themselves or others, and of absconding from the department. Due to excessive waits for Mental Health Act assessments and	Appropriate assessment from nursing team to identify high risk patients. (ReACT self-harm risk assessment at triage.) Nurse in visible areas use 1-1 nursing if deemed appropriate. Referral to Mental Heath Liaison	Delays in timely assessment from the CAMHS service. Mental health inpatient capacity limited locally and nationally. Absence of departmental guideline for rapid	3	16	9	Develop clear escalation process to support nurse staffing in the ED when demand exceeds capacity.	Nurse coordinator/Matron to be made aware and closely monitor. On-going multi-agency work with Missing Person Policy being reviewed by Nurse Consultant Absence of assessment room that meet Royal College of Psychiatrist	Nov-2020	Dec-2020		NA	Gemma Berriman	Louise [illegible]

								mental health in-patient bed availability. Resulting in a lack of supervision and care provided in the wrong place	Team, service available over 24 hours. Use of security service as necessary. Referral to CAMHS for children and adolescents. Missing Persons Policy for escalation if patients abscond	tranquilisation of mentally disturbed patients No clear pathway between SWYFT and the Local Authority in terms of the timeliness of Mental Health Assessments, Gatekeeping assessments and securing a bed in a MH facility Lack of additional resource availability to provide 1:1 when required.					standards. Development of rapid tranquilisation guideline March 2018 Met with partners in SWYFT and Social care to review the MH Assessment pathway Work in progress to present to the AED Board in March by the DOp in Medicine June 2018 Still awaiting update from meeting in March 2018 from AED board. Work still on going with SWYFT. October 2018: Ligature free rooms in the process of being completed. Work still on-going with SWYFT re: mental health response times and recent 12 hour breaches. January 2018: Ligature free rooms complete and SOP's disseminated to staff. Work on going with SWYFT and investigations still happening re: 12 hours breeches. Sept 2019 Patient awaiting MH bed absconded and took his own life last week. Gap in control: Lack of additional resource availability to provide 1:1 when required. Action plan: Develop clear escalation process to support nurse staffing in the ED when demand exceeds capacity. October 2019 Discussed at Risk and Compliance, and agreed for inclusion onto the high level risk register update to wording shared with Matron December 2019: Continuing to review all mental health long waits within the department and evaluate care in the department and appropriate escalation. January 2020: Work ongoing in the department SOP produced to standardise care in the ED for this patient group. Awaiting results from recent serious incidents. February 2020 Review of Risk with Sarina Beacher no changes required to the wording April 2020 - Serious incident inestigations with SWYPFT are signed off, actions agreed. May 2020: Working with mental health teams to establish better ways of working 1 st meeting held last week and feedback given to Mental Health. June 2020: Feedback to mental health						

														ops group on incident that have occurred month on month. Escalations to SWYFT on each extended wait. July 2020 Continue to feedback to mental health ops group regarding patients who have extended waits Ongoing work with SWYPT to look at delays Clear escalation process Assessment of care given whilst in ED for long waiters 13.7.2020 Three long wait MH patients with DTA awaiting beds September 2020: Care reviewed in teh departmetn continues to be excellent. Delays escalated to CCG and through Ops group. one 12 hour wait in month.						
High	3793	Surgery & Anaesthetics	Head and Neck	Ophthalmology	May-2017	Active	Keeping the base safe	Risk of delays for ophthalmology outpatients on the pending list requiring follow up appointments due to clinic capacity and consultant vacancies. This may result in clinical delays, possible deterioration of patient's condition, reputational damage and poor patient experience.	- Substantive consultants (Con A, Con B, Con C, Con D...) and a bank consultant (NA) are undertaking WLIs and Validations - Have 2 long term locum Consultants (Con E & Con F) in place (as of Nov 2018) - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract one-stops, cataract post ops, Ocular Hypertension follow-ups) - Daily overview of current pending list with escalation to clinicians by interim General Manager - Sub-specialty closed to out of area referrals to reduce impact on service (Cornea Services not on directory of services as of Sep 2018). - Centralisation of Ophthalmology admin to support additional validation and slot utilisation in Ophthalmology (happened in summer 2018)	- Lack of substantive consultants (currently 2 vacancies as of Nov 2018) - Reliance on locum and agency staff (potential loss of capacity with 2 weeks notice) - Need to optimise clinic templates to help prioritise patients based on their clinical needs and therefore reduce risk	6 3 x 2	16 4 x 4	3 1 x 3	- Corneal consultant advert out (shortlisting complete, interview date set April 2019) Appointment made, anticipated start date July 2019 - Glaucoma consultant advert due out (job description being re-written as of Nov 2018, VCF already approved by execs) - Release medical ophthalmic staff from MR/RVO intravitreal injection clinics by training non-medical injectors e.g. nurses and orthoptists (Mar 2019) Monitoring throughput in outpatients and increasing numbers (August 20)	24/10/19 - Raised at customer contact regarding utilisation and vacant slots across Ophthalmology, Orthoptics and Optometry - vacant slots could be filled by patients on the holding list however lack of resource within appointment centre booking to fill the slots. Now relying on failsafe co-ordinators to book in order to keep patients safe e.g retina sub-specialty 309 pts that are 0-12 wk overdues (no one has attempted to book their appt as they don't feature in the 'no capacity' section within the KP. This is resulting in the dept unsure of what additional capacity needs to be added to the sub-specialty due to wasted slots as a result of lack of boking resource. KP shows 188 vacant slots between April-Sept 19 within retina sub-specialty - not booked. Had these been attempted to be booked and 'no capacity' then this would have been raised to failsafe co-ordinator to find additional capacity and book leading to patients being seen on time. 25/11/19 - holding lists numbers reduced to 1434 (reduction of 753) since the appointment of 2 additional failsafe co-ordinators - effective implementation demonstrating results. 1 patient overdue between 27-38 and 29 overdue 13-26 weeks. 1404 overdue between 0-12 weeks, 253 retina, 184 general ophth f/up, 95 occuloplastic, 43, cornea. 513 are visual fields that continue to be a result of booking issues and end up being seen as extras on the day required. Discussed with risk dept - in view of still high numbers keep at current rating score - to re-review at DMT meeting 27/11/19. 3/12/19 - reviewed risk score with Pnt - in view of holding list numbers reducing from 2200 to 1300 and having only 28	Sep-2020	Oct-2020		DB	Will Ainslie	Pnt Laloe

														patients over 12 weeks overdue - to reduce the likelihood to 3 but continue with same impact = 12. Score to be confirmed 9/12/19 - discussed at risk and compliance - agreed reduction, which will be confirmed at SAS PSQB on 16th December 2019 To remain at 16 until a work together session with ophthalmologists in Jan 2020 January/February Update Holding list currently 1249, 500 are diagnostic visual fields due to EPR scheduling error rather than genuinely overdue, Orthoptic team validating and identifying those to book. Failsafe co-ordinators proving effective in identifying capacity and monitoring overdue requests. Requested for a weekly report of % no. of patients seen 'on time', seen within '25% of the scheduled request', within 25-50% overdue request and over 50% their scheduled request. Continue to work on recruitment to full vacancies with substantive, locum, agency and transformational work utilising non-medical workforce. April 2020 - Due to the impact of COVID-19 and the cancellation of non-essential out-patient appointments and operations, Ophthalmology, Orthoptics and Optometry have risk stratified patients based on Moorfields risk stratification guidance which has been implemented nationally. The department continues to see high risk patients face to face, moderate risk patients by phone and video and low risk postponed between 4-9 months as appropriate (all done by Consultants, Orthoptist, Optometrists). These delays could lead to delayed diagnosis, investigations and treatment and potential sight loss August 2020 - Implemented utilisation use of independent sectors (Spire and OPTEGRA). Consultant start dates - 4 consultants started July-August. To discuss in DMT to extend target date						
High	5747	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Mar-2013	Active	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant interventional radiologist posts resulting in an inability to deliver hot week vascular cover on alternate weeks in collaboration with Bradford Teaching Hospitals FT.	- 1 NHS Locum in post (on 12 month contract, due to be renewed in the Summer). - 1 NHS (Bank) Locum supporting thee service in tandem with the above. - 1 day per week support from a neighbouring organisation. - 1 day per week support under private agreement from a private provider (ended August 2020) - Working closely with WYVAS to plan and secure adequate cover.	- Uncertainty over date vascular reconfiguration will be complete. Aug 2020 update - date set for 16th Nov 2020 - Difficulty in securing cover long term whilst reconfiguration discussions are ongoing.	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post, advertising for joint post with Bradford Teaching TH. 2. Working with WYVAS to progress a regional approach.	February 2020 Update: Full review of risk and update to all section to reflect the current position. August 2020 update: Cover through NHS Locum and NHS bank consultant, supported by Leeds consultant one day per week working well. 3-4 months until on-call goes to Bradford, which will lessen need for vascular out of hours cover although non-vascular cover remains a concern.	Sep-2020	Sep-2020		DB	Stephen Shepley	Sarah Clenton

High	6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Active	Keeping the base safe	There is a risk to patient safety, outcome and experience Due to inconsistently completed documentation on EPR Resulting in a potential increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group.- lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment	20 4 x 5	15 3 x 5	6 3 x 2	Establishment of clinical documentation group	April 2019 - Work ongoing to in relation to Clinical Record Group with two main areas of interest - Digital Champions and devising an audit tool. Direct link now with a new project - Voice Recognition which requires streamlined EPR clinical documentation. May 2019 - Presentation to Digital Health Forum on 09.05.19 regarding Digital Champions and support from senior team. June 2019 - Further work required around Digital Champions requested by the Board - liaising with Leeds as they do use Digital Champions - arranging a go see. Through the Clinical Records Group and audit tool is being produced to look at the Clinical Record for data that cannot be extracted from the system to further reassure regarding the clinical record. July 2019 - Conference call with Leeds who are happy to facilitate a go see. Audit Tool being trialled in 2 ward areas as to usability and data extracted. Engaged with Acute Floor at CRH to look at record keeping in particular care plans and universal use. Sought assistance of training team in the first instance. Almost a trial of a Digital Champion Role as Ward Manager keen to support and train. August 2019 - To arrange a go see with Leeds in connection with Digital Champions. Do not have sign off from the Board as to whether this can be progressed. Met with Ellen Armistead to discuss Digital Champions - under review. Progressing with the engagement with the acute floor. Looking at reviewing care plans, encounters, saved not signed. All high risk items relating to record keeping within the Trust are being cascaded with greater emphasis as part of the induction of new staff. September 2019 - Dates to be confirmed for visit to Leeds in relation to Digital Champions in clinical areas. Engagement with the acute floor taking place currently looking at all aspects of record keeping. Digital Ward Assurance available through the Knowledge Portal for all ward managers to be able to monitor their own ward progress. Clinical Records Group formulating an E Cras Audit Tool - currently being trialled in 2 ward areas. December 2019 - Date arranged for	Oct-2020	Mar-2021		WEB	Ellen Armistead	Carol Gregson/Graham Walsh

														visit to Leeds - 17th December with engagement from ED, Acute Floor and Training. E Cras Audit Tool being audited on Ward 6 CRH. Engagement nationally with counterparts who use the same electronic system looking at alternatives to improving digital clinical record. Continue to support the Discharge Quality Group factoring in digital clinical record. February 2020 - Digital Champions - received the go ahead from Chief Nurse and Chief Medical Officer to progress Digital Champions. Business case to be submitted detailing what this would look like and the associated benefits. Go See at Leeds carried out in December regarding proof of concept. - Re-education being scoped through Outpatients Department. Plan to re-educate all members of staff who deliver care in this area and to then move to inpatient services. September 2020 Delay in implementation of the above due to onset of Coronavirus. Action Plan produced to progress this piece of work this includes 1. Optimisation Strategy that will support - Develpoment of Digital Champions - In depth analysis of what current working practices are around - benchmark where the trust is currently - define gold standard for record keeping 2. Working together get results completed with Nursing/Midwifery Managers to highlight issues and plan way forward 3. Task and Finish Group set up to target clinical area to test out how to progress and then roll out across other clinical areas - to inlcude review of Ward Assurance, at the elbow training and KP+ reporting						
High	7315	Trustwide	All Divisions	All Departments/Wards	Aug-2018	Active	Keeping the base safe	There is a risk of delay to patient care, diagnosis and treatment Due to insufficient outpatient appointment capacity to meet current demands Resulting in poor patient experience, damage to organizational reputation and increased concerns/complaints and possible claims. Please refer to following individual risks: 4050 6078 6079 7199	Monitoring of appointment backlog at Performance Meetings Validation of Holding List (follow up backlog) and Appointment Slot Issues List (new patient backlog) Clinical Assessment of follow up backlog (where exceeded 10 weeks beyond appointment due date) Regular review of backlogs at specialty level with specialty managers SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level	Insufficient appointments to meet current demands at specialty level. Consultant vacancy factor Non compliance of Clinical Assessment process Loss of functionality (EPR) for GPs to refer to named clinician and patients to use self check in on arrival at appointment.	15	15	6	Monitoring of appointment backlog at Performance Meetings Validation of Holding List and Appointment Slot Issues List SOPs and Data Collection Workbooks for management of backlogs Review of templates at consultant/specialty level	October 2019 There is still a lack of capacity for new and f/up patients. Total ASI's currently stand at 2,161 and f/ups overdue stands at 9,859. Discussions have taken place at WEB and agreed a focused piece of work needs to be done. OP Transformation is helping clinical divisions optimise technology to reduce waiting times. WTGR session outcome to revamp customer contact meeting to include higher accountability of capacity issues with clinical divisions. Recent audit of new patient ASI's showed inaccuracy between ERS and	Aug-2020	Aug-2020		PSQB	Helen Barker	Mel Addy, Asif Ameen and Stephen ?,

								7202	Transformational programme to improve outpatient efficiency and release capacity Delivery of 18 weeks RTT..						the APP. From November the new patient ASI's will be managed directly on ERS instead of the app to give greater accuracy and reduce admin work. Paper referrals and long waiters will still need to be managed via the app as there is no current alternative. December 2019 There is still a lack of capacity for new and f/up patients. Total ASI's currently stand at 2,368 and f/ups overdue stands at 8,478. Discussions around the action plan continue to take place at WEB. 2020/21 Planning discussions have detailed capacity and demand plans. OP Transformation is helping clinical divisions optimise technology to reduce waiting times. WTGR session outcome to revamp customer contact meeting to include higher accountability of capacity issues with clinical divisions. We have now switched off the ASI app for ERS refs and reporting is going through KP+ which gives greater accuracy and reduce admin work. Paper referrals and long waiters are still managed via the app as there is no alternative currently. February 2020 Significant prgress made see below - monitoring whether this is a sustained improvement prior to reviewing risk score. FSS Update: 1. Paediatrics perspective – ASI managed on a weekly basis additional clinics put in specialties where we have long waits eg Allergy and enuresis. Follow ups longest waiters cardiology working to find solution – increased local offer reviewing visiting consultant offer from Leeds 2. Gynaecology – management of ASI – managed on a weekly basis. Adding additional clinics to support from registrar level - Further work to be undertaken with follow ups to look for other solutions. Medicine Update: Medicine ASI's currently at 378, a significant reduction in the last month (13.1.20. the number was 696, February 2019 was 1587, August 2019 was 1227. Specialities with the biggest reductions are Gastro, Cardiology due to implementation of the CAS service and Neurology due to Nurse Led Services. The division is on trajectory to further reduce ASIs by March 2020 as requested as part of the RTT 4 point plan. Surgery Update: ASI position improved,						

														currently best position for 5 years, Opthalmoloyg remains a challenge due to Orthopaedic workforce, 2 fail safe pathways and triage of follow -ups. Specialty specific ASI risks to be developed. April 2020: appointment capacity impacted by cancellations due to covid-19. Develop recovery plan to assess and address the impact. (see Covid risk register entry) July 2020 see individual risks and the Covid Risk Register entry for stabilisation and reset. Clinical validation and prioritisation of outpatient waiting lists commenced. Virtual and face-to-face clinics being established, working with primary care on streaming and triage.						
High	7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Fire committee has been established in November 2019 where fire safety is discussed and any risks escalated. Chief Operating Officer, is the nominated executive lead for fire safety Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training continues throughout CHFT via CHS Fire Safety Office • Face to face • Fire marshal • Fire evacuation • Fire extinguisher	Number of areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 5 x 3	15 5 x 3	1 1 x 1	Feb 2018 The Trust has bid to NHSI for early release of capital monies to support further fire compartmentation work. However, in order for CHS to manage this in a prioritised risk based approached it is essential the Trust are able to decant areas to enable CHS to complete building works to a satisfactory standard. Feb 2019: Walk around on wards between CHS, CHS Fire Officer and Matrons with the aim of de-cluttering wards to ensure a safe and effective evacuation. May 2019: Delivery of fire training June 2019: Fire risk assessments, installation of sockets July 2019: NHSI capital bid for 19/20 Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trusts reconfiguration plans. Fire Committee to review fire risks.	SEPT 19 Independent Fire Engineer to provide fire risk assessments for CHS (Trust) CHS provided with “reasonableness” view on work carried out on fire safety infrastructure to date Fire Safety Committee established to understand current position / gaps / next steps CHS Fire Safety SLA to be reviewed to ensure suitable & sufficient for Trust purposes. Transfer of Fire Officer back into Trust Fire Safety Committee gathering all external / internal information to provide an overarching view of fire safety and provide an update of the risk October 2019 Update 60 minute fire compartmentation building works has commenced through CHS that will ensure that 60 minute compartmentation is in place across the HRI building by Spring 2020. The approach and management of fire risk has also been considered within the HRI Strategic Development Plan that will be presented to Trust Board in November. Furthermore, the Trust has commissioned a Fire Strategy review that will provide a position statement on the works completed to date along with identifying the key investments required over the future years. The strategy will also cover the Trust’s overall responsibilities e.g. Fire Risks Assessments, Evacuation Strategy and Training. This will be reported to Board once complete in early 2020. Nov/Dec 2019 CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short, medium and long term plan aligning with Trust’s reconfiguration	Jun-2020	Aug-2020		FIREC	Helen Barker	CHS / CHFT

														plans. FEBRUARY 2020 Fire Committee reviewing Fire Risk to ensure appropriate risks identified and sufficient controls are in place. Fire Committee meeting 26th Feb to review and submit the risks which will likely remove this risk. MARCH 2020 Fire Committee reviewing Fire Risk to ensure appropriate risks identified and sufficient controls are in place. Fire Committee meeting 8th April 2020 and will review / approve all Fire related risks. April 2020 additional fire risks due to impact of Covid-19, fire loading, increased use of oxygen, increased storage of supplies and equipment, movement of staffing, utilisation of theatres as critical care wards, fire evacuation routes altered. Full risk impact scoped and added to Covid risk register.						
High	7414	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in significant incident and harm to patients, visitors and staff. CHS RISK = 7318	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned Structural Engineers to repair the areas observed along the west side elevation of the building and carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis.	CHS and Trust received the full structural site survey which identified areas of high, medium and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 5 x 3	15 5 x 3	1 1 x 1	Feb 2019 - Structural Engineers requested to provide costings based on high risk, medium risk and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. Costs expected March 2019. Progress managed at monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 are escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan	October 2019 The approach to cladding is being determined as part of the HRI Strategic Development Plan (SDP) to be presented to Board in November. This SDP will propose an estates strategy for the site and provide the Trust with an investment strategy to address the cladding risk in the short and longer term. A design solution will be developed following approval of the SDP. Dec 2019 - CHS carrying out re-inspection 12 months on, any remedial works will be carried out from the re-inspection. CHS awaiting finalisation of the SDP but continue to explore over cladding option following an option appraisal. FEBRUARY 2020 CHS continue to monitor cladding following works completed on high risk areas. Option appraisal provided to CHS which will be considered as part of capital works. MARCH 2020 Survey recommended inspection carried out at 6 monthly intervals which now takes place.	Apr-2020	May-2020		FC	Gary Boothby	C Davies / A Wilson
High	7615	Medical	Directo	ments/	Dec-2019	Active	Keepin	There is a risk of not meeting the four hour emergency care standard	Operational procedures to improve patient experience and flow are in place and reviewed at 3 hourly bed	Partners not being able to deliver YAS - transport - escalation	15 3 x	15 3 x	1 1 x	Patient Flow action plan in place Governance - reported monthly at WEB	February 2020 Update Position remains challenging. Mitigation continues	Jun-	Aug-		WEB	Helen	Bev

								Due to increasing demand on Emergency Care (approximately 5% above plan) meaning significant workload above workforce model, inappropriate use of ED. ED team factors including medical and nurse staffing (Risk ID 2827 and 6044), not triaging, patient flow, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community Resulting in poor patient experience, potential risks to delivery of fundamental care standards and potential harm to the patients, increased scrutiny and reputational risk to the organisation	meetings Ambulance hand over time Time to triage Seen in 60 minutes by a medic Digital - manages time and RAG rates Clinical site commanders KPI - refer for inpatient bed before 3 hours Coordinators managing ED Matrons in place at both EDs Urgent care action cards direct staff Housekeepers providing fundamental care External support for dept in times of pressure - eg gynae, paeds Surge and Escalation plan - OPEL Training of on call managers and teams Skill mix- training for newly qualified nurses Streaming from the fron tdoor and admission avoidance services - frailty, streaming,	and response times and transfer to bed base Interruption of the Local Care Direct Service, GP closures for training Vacancy Non compliance with action cards and process without escalation Engagement and understanding of the risk at ward level and across teams	5	5	1	Patient Flow action plan owner – Deputy COO, Accountability- Directors	April 2020 Profile of patients attending ED has changed due to impact of Covid. Segregation of patients and managing covid risk is focus. Breaches are still being montiored. Link to MH bed waits risk - see action plan agreed for delivery of SI recommendations.						
High	7474	Trustwide	All Divisions	All Departments/Wards	May-2019	Active	Keeping the base safe	There is a risk to the organisation of out of service medical devices being in circulation and use across CHFT due to the lack of assurance of the Trust Asset Register being up to date including equipment which has been gifted or bought without CHS involvement resulting in potential patient harm. CHS Risk 7438	CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium and low risk category to provide an up to date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date. CHFT staff are aware of the need to report medical devices requiring repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives.	Failure to manage, maintain and service medical devices.	5 5 x 1	15 5 x 3	1 1 x 1	Schedule maintenance prioritising high risk devices	In the first week since this risk was identified, 10% have been identified and serviced, CHS have identified a number of other devices that have been done but are awaiting update and some that are due to be disposed of or have already been sent for repair. As CHS have moved into a new month the number has risen again as more equipment goes out of date. 2019/04/15-Update- Numbers are falling slowly • High risk (728 to 691), • Medium risk (2617 to 2621), • Low risk (1973 to 1918), a total of (5318 to 5230) Considering that the number increases daily as more equipment goes out of date CHS consider this as significant progress especially with respect to High risk devices. Locating devices has proven to be a problem in most areas. May 2019 Update Locating devices has proven to be a problem in most areas. 2019/05/09-Update-Numbers are falling slowly for High risk (691 to 643), Medium risk rising (2621 to 2635), Low risk rising (1918 to 1956), a total of (5230 to 5234) the number has risen slightly due to the time taken to complete high risk work taking longer as it is generally more complex equipment and the time put aside to investigate and locate equipment. There are another 324 maintenance events planned this month as well as the extra work to catch up we have recruited to a vacant post, which will aid	Mar-2020	Mar-2020		RC	Ellen Armistead	Robert Ross

in reducing the amount of high risk and employed a member of flexible workforce to assist with the low risk work.

2019/05/17-Update-High Risk numbers continue to fall High risk (643 to 592), Medium risk fell (2635 to 2612), Low risk rising (1956 to 1987), a total of (5234 to 5195)

2019/05/21-Update Contract meeting held with SLA provider Mid York's now in agreement with them to complete outstanding work, problem identified individuals within CHFT retaining un-serviceable medical devices within community(this will be stopping have instructed Mid York's to remove devices), a forecast of dates for servicing will be pushed out to community.

May 2019 – Score agreed at 15 by Jackie Murphy DoN and Gary Boothby, DoF

June 3rd 19 - Agreed at Risk and Compliance with changes to wording

2019/06/05-Update-High Risk numbers continue to fall High risk (592 to 574), Medium risk fell (2612 to 2488), Low risk fell (1987 to 1824), a total of (5195 to 4886). More High risk are to be tackled next week during theatre audit, SLA provide to tackle all out standing work and visits to be published to ensure greater attendance, however recently an in use anesthetic device was identified as faulty during maintenance programmed due to this risk. The device was overdue service by in excess of 3 years, this has now been rectified awaiting department to raise Datex.

20190612-Update-A number of devices have been identified as not managed on eQuip and not maintained these items include Beds, Hoists, Chairs and other devices, these are now being added to eQuip and service and maintenance are being arranged.

20190707-Update-High Risk numbers continue to fall High risk (574 to 561), Medium risk rose (2488 to 2505), Low risk rose (1824 to 1893), a total of (4886 to 4959). Another anesthetic machine has been removed from service for disposal, two more will not be supportable beyond the end of the month and will require replacement. Medical devices have been found that have had unauthorised repairs made by unqualified personnel, which have compromised the devices, their results, patient safety and IPC. Also a

previously decommissioned device that had not been seen for 9 years has been found, returned and withdrawn from service.

30th July 2019 Update
- numbers of hi, med, low devices maintained
- Increase in staffing levels (to be confirmed)
- Positive Awareness raising exercise (via screen savers etc)
- visits planned to matrons / sisters meetings

2019/08/02-Update-High Risk numbers continue to fall High risk (561 to 490), Medium fell greatly (2505 to 2244), Low fell (1893 to 1775), a total of (4959 to 4509). Both Draeger Fabius anesthetic machine have been removed from service for disposal, they have also been identified for replacement. Medical devices training team produced a poster and screen saver, which has been published this has increased the identification of devices that are out of date, therefore enabling the reduction of the number of devices at risk. We are finding more devices that are End of Life or end of support these are being added to CHS risk 7478.

2019/09/02-Update-High Risk numbers rose High risk (490 to 511), Medium fell (2244 to 2172), Low rose (1775 to 1825), a total of (4509 to 4508). We are finding more devices that are End of Life or end of support these are being added to CHS risk 7516 & CHFT 7478, these risks are being reduced due to allocation of funding to replace devices.

2019/10/01-Update-High Risk numbers rose High risk (511 to 524), Medium rose (2172 to 2184), Low rose (1825 to 1860), a total of (4508 to 4568). Impact has slowed this month, due to staff leave and training this should aid in decreasing the shortfall next month.

2019/12/02-Update-High Risk numbers fell High risk (524 to 408), Medium fell (2184 to 1722), Low fell (1860 to 1325), a total of (4568 to 3455). The audit carried out with community has greatly reduced the number of devices we are looking for this in conjunction with contracts management and training has had a positive impact on compliance.

February 2020 update
2020/02/04-High Risk numbers fell High risk (408 to 393), Medium fell (1722 to 1714), Low fell (1325 to 1283), a total of (3455 to 3390). Continuing efforts to reduce the number of devices

														at risk.					
Moderate	7430	Family & Specialist Services	Radiology	All Radiology	Mar-2019	Active	Keeping the base safe	There is a risk of being in breach of IRMER regulations due to the way roles are set up within EPR, as this allows non medical staff who are not permitted to request Radiology exams as part of their role. Under IRMER 17 regulations a non medical health care professional can refer for radiological examinations but only under a clearly defined agreed protocol and only after receiving the appropriate irmer training. therefore access to radiology requesting should be restricted to these groups only.	There is an approval process within radiology to allow access to non medical referring that require access to this for their role. A register of all non-medical referrers is accessible to all staff. It is fully up to date and updated daily. Radiology staff can check unknown referrers against this list. When requests from inappropriate staff are noticed they are taken up with the staff in question. All radiology requests are vetted for appropriateness and justified in accordance with IRMER 2017. Please note this also includes requests that do not involve ionising radiation e.g. ultrasound and MRI. A quarterly audit is done of request made, and any prolific requestors are contacted.	Despite this gatekeeping the volume of requests that come into radiology mean this manual checking is ineffective. These requests will come through into the Radiology systems and although the name of the referrer is present with the request unless each one is individually checked staff would be unsure if an unrecognised name is a new FY1 or non medical referrer, thus there is a good chance the exam will be done. The numbers of requests received mean the controls in place can never be 100% effective There is no way to stop the problem at source without the creation of extra EPR requesting groups which would add to an admin burden to the system or potentially affect other systems within EPR.	15 3 x 5	12 3 x 4	9 3 x 3	- To audit quarterly and contact referrers concerned - To continue to raise issue via digital board - To ensure Radiology record of approved requesters continues to be up to date - At last audit some 6707 (12% of total) requests were made by inappropriate referrers.	Jan 20: Meeting for pilot booked for 14 Jan. There is a freeze on EPR developments from 27th Jan till end of May where we will not be able to make any changes in any domain. This will halt work on this project while the EPR upgrade is done. Feb 20: A freeze is now in place on any EPR development work till the end of May. We will be unable to advance the pilot of this project till the EPR upgrade is completed. April 2020: as Feb 20 update - Freeze likely to be extended due to focus on Covid-related IT developments August 2020: The EPR upgrade is scheduled for August 19th. Once this is completed this work can be considered by the EPR team. September 2020: EPR update has now taken place. Liaising with EPR team to re-start this piece of work and to fit it into their programme of works. October 2020: Update as per September 2020. THIS have a long list of programs, therefore it is not possible to provide a timescale for completion of these works or where this ranks in terms of priority.	Jan-2021	Mar-2021		PSQB	Stephen Shepley	Mark Williams
Moderate	7223	Corporate	THIS	THIS -Operational	Mar-2018	Active	Keeping the base safe	Risk of: Inability to access all clinical and corporate digital systems: The lack of access to clinical patient systems (EPR, Athena, Bluespier), Clinical Diagnostic and Ordering (ICE, PACS, Ordercomms) as well as corporate systems (Email etc). Due to: Failure of CHFTs digital infrastructure Failure of the interconnecting components (Network, Servers, Active Directory) of the digital infrastructure through whatever cause (Cyber, Configuration, Component failure). Resulting in: The inability to effectively treat patients and deliver compassionate care Not achieving regulatory targets Loss of income	Resiliency: Network – Dual power (plus UPS) and fibre connections to all switch stacks - Automatic network reconfiguration should a network path be lost (OSPF etc) - Computer Rooms and Cabs on the trust back up power supply Servers - Dual power supplies to each rack - Computer Rooms and Cabs on the trust back up power supply - Mirrored/Replicated Servers across sites - Back up of all Data stored across sites Cyber Protection: - End point encryption on end user devices - Anti-Virus software (Sophos/Trend) on all services and end user devices - Activity Monitoring - Firewall and Port Control on Network Infrastructure Monitoring/Reporting: - Traffic Monitoring across the network	Maintenance windows for digital systems including resilience testing Patching process audit Password Policy	16 4 x 4	12 4 x 3	8 4 x 2	- All clinical areas to have documented and tested Business Continuity Plans (BCPs) - All corporate areas to have documented and tested Business Continuity Plans (BCPs) - Informatics to have documented Disaster Recovery (DR) plans in line with ISO - Routine testing of switch over plans for resilient systems - Project to roll out Trend (Anti-virus/End point encryption etc) completing April 2018 - IT Security Manager continually kept up to date with the most recent thinking around cyber security as well as training/certified to the relevant standard (almost complete). - Password Policy being progressed, rollout due Oct 2020 - Improvements in Patching process have been emdeded and picked up through the DSPT Plan	Nov 19 - As per Octobers update, the DSP Toolkit Plan is still being pulled together with resource being identified for a Jan 2020 start. There is a separate risk logged for potential non-compliance of the toolkit (7617)however the overlap with this risk is significant enough to maintain (and potentially increase) the score. February 2020 - There are a number of associated Cyber/DSPT/Reliance risks relating to the reliance of CHFT on its digital platforms. Work has been ongoing in Jan/Feb 2020 towards DSPT however not to the extent that would change the scoring of this risk at this point. No further update. April 2020 - The DSPT submission has been moved to Sept 2020 due to C19. Investment in digital and implementation of the new password policy will mean that it is more probable that we will meet the standard. Alongside tested BCPs, the mitigation around some of the gaps in controls and an increased understanding of digital ways of working, this risk will meet its target score late 2020. Aug 2020 - Significant improvements in awareness across the trust around the	Nov-2020	Mar-2021		RC	Mandy Griffin	Rob Birkett

									- Suspicious packet monitoring and reporting - Network capacity, broadcasting/multicasting and peak utilisation monitoring/alerts. - Server utilisation montoring/alerts Assurance/Governance: - Adhering to NHSD CareCert Programme - ISO27001 Information Security - Cyber Essentials Plus gained - IASME Gold Support/Maintenance: - Maintenance and support contracts for all key infrastructure components. - Mandatory training in Data and Cyber Security						importance of BCPs along with tighter processes in place around patching key infrastructure in line with the new DSP Toolkit has helped to reduce the score slightly. Residual gaps in controls include password policy, further work around securing maintenence windows on systems and further work on server specific patching. Dark Trace has also been implemented to further assist against malicious activity. Score reduced to 12 (Target score still not met). Target score expected to be met alongside DSPT compliance in March 21.						

Risks = 28

19. Guardian of Safe Working Hours Quarterly Report Q2 - Guardian of Safe Working Hours

To Note

COVER SHEET

Date of Meeting:	5th November 2020
Meeting:	Board of Directors
Title:	Quarter 2 report (23rd June-30th September 2020) from the Guardian of safe working hours, CHFT
Author:	Anu Rajgopal
Sponsoring Director:	David Birkenhead
Previous Forums:	none

Actions Requested:
To note

Purpose of the Report

To provide an overview and assurance of the Trust's compliance with safe working hours for junior doctors across the Trust and to highlight and detail any areas of concern

Key Points to Note

- All junior doctor rotas are compliant with the new rota rules
- The number of exception reports remain low and are mainly submitted from the medical division across a range of junior doctor grades. These are being completed and agreed in a timely manner which is an improvement from previous years.

EQIA – Equality Impact Assessment

The medical workforce is ethnically diverse and exception reports submitted by our junior doctors have been split by ethnicity and gender. The analysis shows that the exception reporting data is representative of the medical workforce in the Trust.

Recommendation

The Board is requested to:

1. Note the report
2. Acknowledge the input of our medical education team in successfully organising the second annual CHFT's got medical talent awards virtually and recognise the hard work of all our nominated junior doctors and winners.

Q2 report: (23rd June-30th September 2020)

Guardian of safe working hours (GOSWH), CHFT

Executive summary

This quarter, the exception reports are mainly from medical specialities and ophthalmology. These have been submitted as a result of increased workload, delayed ward rounds, missed breaks and over run clinics. All exceptions have been completed in a timely manner which is an improvement over previous years and compensation agreed with the trainees.

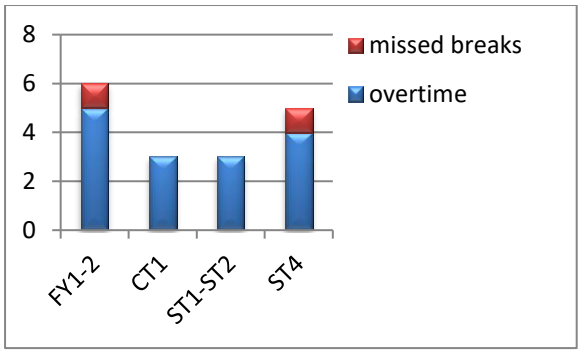
There has been reasonable engagement by the trainees in the Q2 Junior doctor's forum (JDF) and via the microsoft teams chat. The process around accessing post-shift rest facilities has been clarified and agreed. Additionally, the mechanism for payment as a result of exception report compensation has been made smoother and is working well. The junior doctor's mess on both sites have been refurbished and are now being accessed regularly.

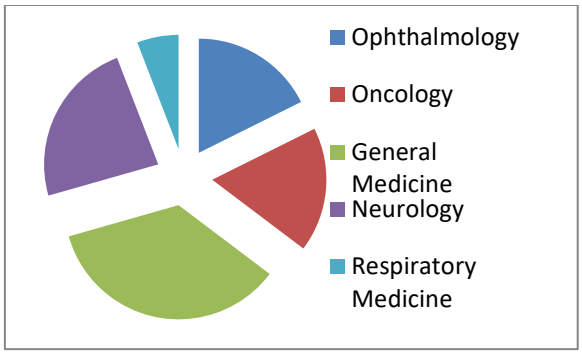
The CHFT Junior doctor awards 2020 were held virtually over the pandemic and received great feedback from trainees and supervisors with an improvement in the number of nominations received compared to last year.

In August, the GOSWH induction for the new junior doctor cohort was done virtually and there was good engagement from them in the Q and A session.

a) Exception reports and trends

This quarter there have been a total of 17 exception reports from 9 junior doctors. Majority of these have been submitted as a result of working overtime and two were for missed breaks. There is an even split between the grades of doctors including two senior trainees (ST4).





There were three ophthalmology ERs, all submitted due to exceptionally busy eye clinics which run overtime due to complicated patient presentations. In oncology, the three exceptions arose due to delayed ward rounds and the completion of jobs following these. This has been escalated by me to the clinical lead this month with a suggestion to explore the need for a work schedule review. The rest of the exceptions were from Medicine, all submitted due to a high workload and minimal staffing on the relevant dates.

Junior doctors in this new cohort have been allocated time within their work schedules to complete mandatory training. No further exception reports have been submitted regarding this.

There have been no exceptions from general surgery this quarter

b) Rota gaps, areas of concern and updates

There remain a high number of registrar gaps in Paediatrics and Accidents & Emergency medicine as reported previously. These vacancies continue to be covered by ACPs (advanced clinical practitioners) and locums when required. There are two trust-grade doctors in paediatrics on the junior rota as well.

In medicine, there are now two medical registrars added to the rota for nights and weekend shifts following discussions with the divisions, junior doctors and the rota teams.

In previous quarters, there were issues raised in the Trauma and orthopaedics registrar rota regarding overtime when attending the post night-shift trauma ward round. These work schedules have now been revised and a new compliant rota has been sent out to the new cohort starting in October. The division will be reviewing this rota 6 monthly to coincide with the registrar rotations.

c) Junior doctor awards

CHFT's Got Medical Talent 2020 awards were held virtually on 23rd July as part of the Medical Staff Forum weekly COVID-19 update. The medical education manager and deputy manager were instrumental in the organisation of this event with assistance from our executive leaders and senior staff who formed the judges panel and provided us with the technical support.
We received 85 nominations across six categories: Compassionate care, Research, audit & quality improvement, Medical Education, Clinical leadership, Going above & beyond (the call of duty) and the junior doctor's choice award for the best supervisor. Additionally, we also had 7 highly recommended nominations.
The awards were presented by our Medical Director and there were 5 junior doctor winners since the same person won two of the awards. All winners were given a trophy and all nominated doctors received certificates.
The event was a great success and I received extremely positive feedback from our trainees about working at CHFT and how valued they felt as a result of these awards.

d) Junior doctor forum (JDF)

The quarterly JDF was held remotely on 21st September with three new junior doctor representatives. Medical HR confirmed that the 18 junior doctor rotas have now been redesigned and are compliant with the new rota rules. All work schedules have also been updated to reflect these changes.
The process to access post-shift rest facilities at CHFT has been agreed and drafted. So far, two trainees have accessed these en-suite facilities this quarter.
Along with medical HR and payroll, I have agreed on a smoother process of payment to junior doctors following compensation as a result of exception reporting.
The junior doctor representatives will communicate the opening of the newly refurbished doctor's mess and the access to post-shift rest facilities for trainees.

A survey was conducted at the end of July by an ST3 in Medicine to get feedback from junior doctors at CHFT regarding the COVID-19 response and to review teaching during the pandemic. It was anonymous and sent out to all junior doctors.
Of the 45 responses received, majority (82%) felt that they had good support at work with adequate senior cover and enjoyed the team working. The catering services were praised. Areas for improvement were Trust communication in general and specifically around the PPE (personal protective equipment) which was rapidly changing and conflicting at times, lack of debriefing in most directorates except respiratory medicine and gastroenterology and a lack of rest facilities on night shifts.
Most responders were satisfied with remote and small group teaching though a paucity of laptops was highlighted.
Following the survey, a number of recommendations were made. A weekly Microsoft teams meeting for junior doctors where concerns could be escalated, highlight the new refurbished junior doctor's mess facilities at both hospital sites, access to laptops from the learning centre and support debriefing in all departments. All these have since been actioned.

The survey was circulated to the JDF members and the Trust COVID Incident management team (IMT)

e) Guardian presentation at the junior doctor's induction

I presented remotely at the new junior doctors induction in August. This was to highlight the exception reporting process, work schedule reviews, access to post-shift rest facilities, the junior doctor's forum and junior doctor awards. The recorded presentation has been circulated to the new starters in October as well.

Summary

Whilst there remain significant rota gaps in paediatrics and emergency medicine, minimal staffing is being managed by locums (mainly bank) and other staff grades like ACPs and Trust grade doctors. The number of exception reports remains low and these are being dealt with in a timely manner. As GOSWH I am keen to ensure that any feedback from our trainees from the initial COVID surge is taken into account in the phase 2 COVID planning. I will be reporting progress on this in my next quarterly report.
The Trust Board is asked to receive and note the Guardian of Safe Working Hour's report.

Anu Rajgopal
Guardian of safe working hours
October 2020

20. Learning from Deaths Quarterly Report Q1 and Q2

To Note

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5 November 2020
Meeting:	Board of Directors
Title:	Learning from Deaths Report (Quarters 1 & 2 2020/21)
Authors:	Cornelle Parker, Deputy Medical Director Gemma Pickup, Clinical Governance Support Manager
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	Quality Committee 26.10.20

Actions Requested:
To note.

Purpose of the Report

- To provide the Board of Directors with assurance of the Learning from Deaths (LFD) mortality review process and escalation to Divisions

Key Points to Note

- 21% of deaths have been reviewed using the initial screening tool (ISR). This falls short of the 50% target for mortality reviews as a result of the ISR process being suspended as part of the initial Covid response. This released Supporting Professional Activity (SPA) time for clinicians to increase capacity for clinical activity.
- 66 structured judgement reviews were complete over the 2 quarter. Key learning points from the reviews were:
    - Lack of senior clinical review to confirm, or modify management
    - Lack of consideration given to recent previous admissions with each case being treated seemingly in isolation
    - Lack of mental capacity assessments despite identified cognitive impairment
    - Lack of documentation to support involvement of family and or carers
    - Identification of frailty but no identification/articulation of appropriate goals of care
    - Overall poor documentation

EQIA – Equality Impact Assessment

The LFD annual report paper was submitted to board earlier in the year which examined the mortality for our local population in respect of gender, age and ethnicity.

Additional aspects of EQIA include:
Deaths of those with learning difficulties aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities will be 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 Structured Judgement Review (SJR). These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group (MSG).

Child deaths: Whilst all deaths are notified to the Child Death Overview Panel and a core data set collected, not all deaths will be reviewed in detail and are therefore considered for SJR review. Particular consideration is given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention.

Maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on Datix to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports are presented to the Mortality Surveillance Group.

Stillborn and perinatal deaths are reported to the National MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) to allow confidential review and wider learning dissemination. These cases are also reported on Datix to ensure local governance and risk management structures are followed. Stillbirths and neonatal deaths are reviewed by a multidisciplinary team and reported nationally via the Perinatal Mortality Review Tool.

Recommendation

The Board is asked to note the Learning from Deaths Quarter 1 and Quarter 2 report and the following recommendations:

1. 50% of all in-patient deaths to be subject to Initial Screening Review by June 2021
2. To work with the new Lead Medical Examiner team to align the Learning from Deaths processes
3. Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities

Calderdale and Huddersfield NHS Foundation Trust

Learning from Deaths Report
Quarters 1&2 2020/2021

The Learning from Deaths (LfD) team submitted the annual LFD report to the Board of Directors in July 2020 which included a focused review of all Covid and non-Covid inpatient deaths that occurred between 23rd March and 19th May 2020 i.e. the initial surge period of the pandemic. 126 of these deaths occurred in Quarter 1 of 2020/21 and were included in the review.

In Quarter 1 (April – June 2020), there were 449 adult inpatient deaths at CHFT.
In Quarter 2 (July – September 2020), there were 325 adult inpatient deaths at CHFT

Mortality metrics

The Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) trends were examined in the annual LFD report submitted to Board in July 2020.

HSMR compares how many patients die within 30 days of admission to hospital, with how many we would have predicted to die given their age, gender, area-level deprivation, diagnoses and co-morbidities. The rolling 12-month HSMR score (August 19 - July 2020) is 91.88. This is an improving position from 92.39 for the previous rolling 12-month period of July 19 - June 20.

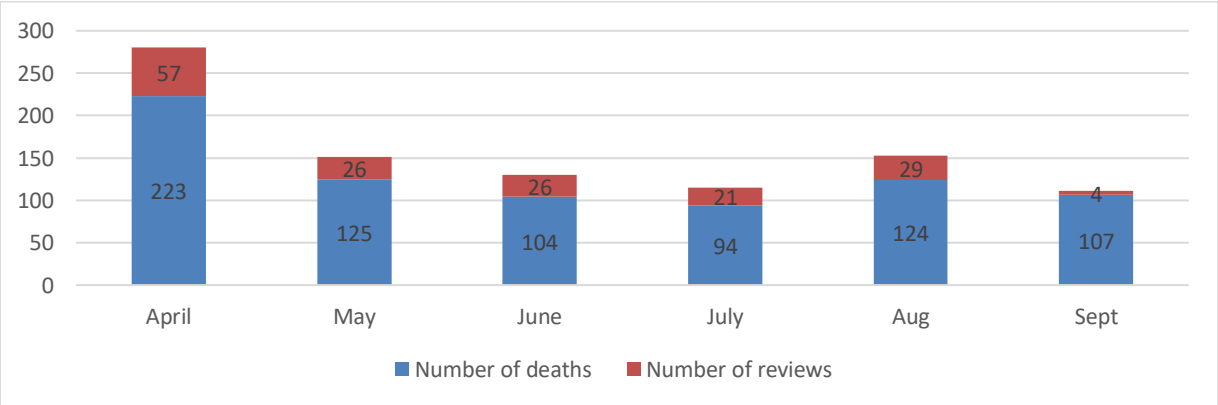
SHMI is for non-specialist acute trusts and is the ratio between the actual number of patients who die and the expected on the basis of average England figures. It includes deaths in hospital and in contrast to the HSMR, deaths which occurred outside hospital within 30 days of discharge. The rolling 12-month SHMI for July 2019 - June 2020 is 99.05. This has improved from the April 2020 position, and is below the 100 target.

Looking at the rolling 12 months figure (October 19 – September 20) crude mortality is 1.66% (1,601 deaths). This is similar to the previous rolling 12-month period (September 19 – August 20), 1.60% (1,587 deaths).
In terms of benchmarking, CHFT sits in the 2nd quartile at 38th position out of 132 trusts.

Initial Screening Reviews (ISR)

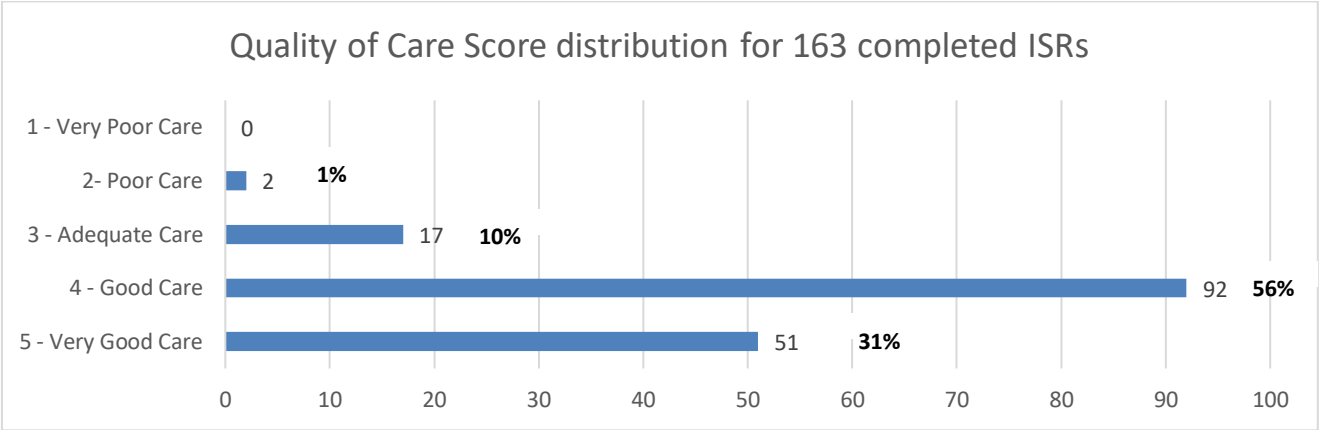
The online initial screening review tool focusses primarily on initial assessment, ongoing care and end of life. Reviewers are asked to provide their judgement on the overall quality of care as described above. Specialities have been given the opportunity to identify additional specific questions to 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 774 adult inpatient deaths in Quarters 1&2, 163 (21%) have been reviewed using the initial screening tool (ISR). This falls short of the 50% target for mortality reviews as a result of the ISR process being suspended as part of the initial Covid response. This released Supporting Professional Activity (SPA) time for clinicians to increase capacity for clinical activity.



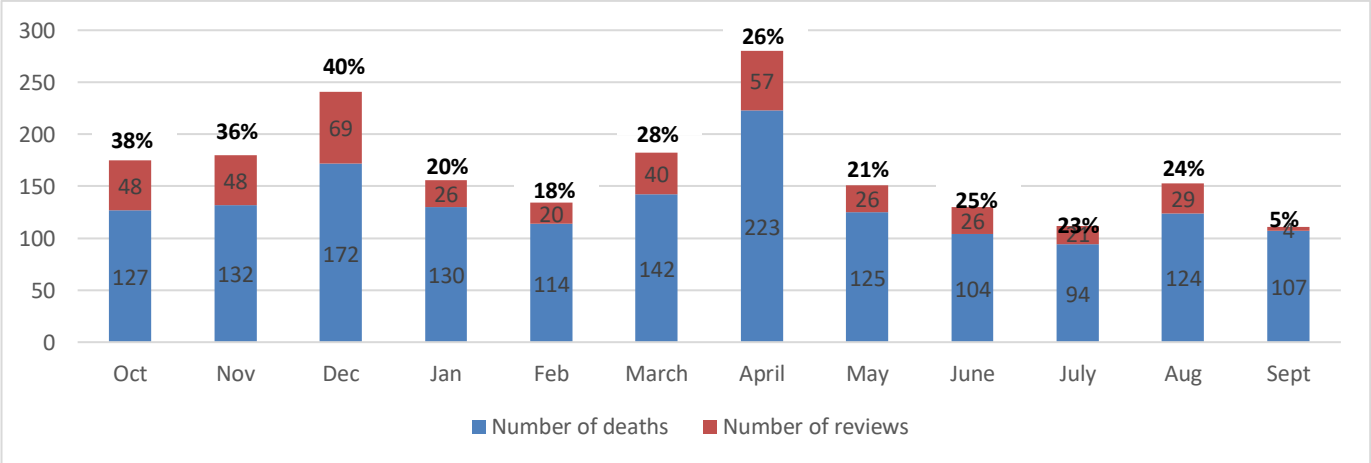
Dr Cornelle Parker, Deputy Medical Director & Gemma Pickup, Quality Governance Lead

The quality of care was assessed as follows:



Poor or very poor care triggers further investigation using the structured judgement review (SJR) process.

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



As previously stated, the significant dip in performance from January onwards can be attributed to the Covid pandemic as ISR activity was suspended however we expect these numbers to start to increase over the coming months as ISR's have now recommenced.

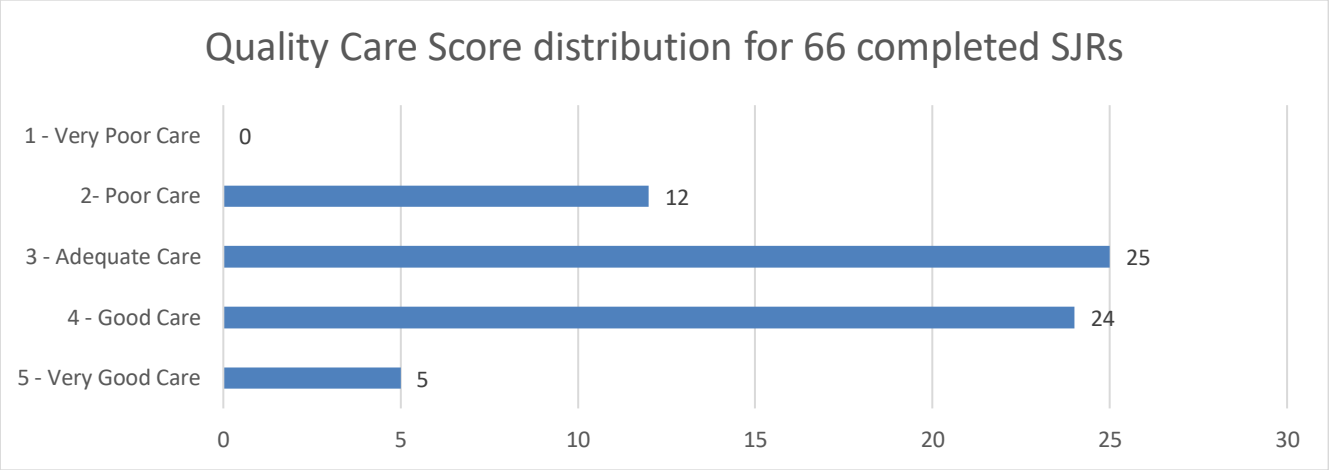
Structured Judgement Reviews

Structured Judgement Reviews (SJR's) have continued throughout the Covid pandemic response.

	Apr	May	Jun	Jul	Aug	Sept	Total
Escalated from ISR	0	0	0	1	0	3	**4**
Complaint	0	0	1	0	1	1	**3**
SI Panel	0	0	0	0	0	0	**0**
Elective	0	0	0	0	0	1	**1**
LD	0	2	1	0	1	1	**5**
2nd Opinion SJR	0	1	3	2	2	2	**10**
Coroner	0	0	0	1	1	2	**4**
Other	9	11	0	17	0	8	**45**
Total Requested	**9**	**14**	**5**	**21**	**5**	**18**	**72**

A total of 72 SJRs were requested across Quarters 1 and 2 of 2020/21 and 66 SJRs were completed across the 2 quarters. The findings from SJRs are shared with the speciality mortality lead and appropriate Clinical Director.

The quality care scores for these are below



From these SJRs the following learning themes were identified:

- Lack of senior clinical review to confirm, or modify management
- Lack of consideration given to recent previous admissions with each case being treated seemingly in isolation
- Lack of mental capacity assessments despite identified cognitive impairment
- Lack of documentation to support involvement of family and or carers
- Identification of frailty but no identification/articulation of appropriate goals of care
- Overall poor documentation

The following good practice was identified:

- Intra-specialty communication especially between acute medicine, cardiology and respiratory teams.
- The way nursing staff dealt with a patient's son who had mental health issues was really good; their response to family queries and management of difficult conversation was excellent
- Praise for the ITU consultant - the way they provided support to their team, regularly had conversations with family members. They took difficult decisions in a timely fashion; clinical documentation was meticulous, and they were exceptional in their clinical reasoning and approach.
- Excellent leadership by LD matron and Consultant in-charge. High standard of communication and empathy shown by staff to the patient, HCP and family
- Early recognition of complex medical background, frailty and learning disability. Appropriate goals of care and DNRCPR implemented. MDT involvement throughout patient's journey. Regular senior reviews with very good and clear management plans. Very good documentation of communication with NOK. Excellent End of Life Care
- Timely assessment and management; recognition that conservative management would be in the best interest of the patient; good communication with the family; recognition of deteriorating patient and starting the care of the dying pathway.

Recommendations in relation to LfD for 2020/21 proposed in annual report presented at July Board and approved

- 50% of all in-patient deaths to be reviewed by June 2021
- Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities
- To work alongside the new Medical Examiner team and align the LfD processes.

21. Quality Report

To Note

Presented by Ellen Armistead

Date of Meeting:	**Thursday 5 November 2020**
Meeting:	**Board of Directors**
Title:	**Quality Report (Reporting period Aug-Sept 2020)**
Author:	**Doriann Bailey, Assistant Director for Patient Safety**
Sponsoring Director:	**Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive**
Previous Forums:	**None**

Actions Requested:

- To note

Purpose of the Report

The purpose of this report is to provide the Trust with ongoing oversight of the Quality agenda and the emerging issues that need to be considered.

It is to ensure that the Board is provided with a level of assurance around key quality and patient experience outcomes and confirmation that during the ongoing response to the COVID pandemic, the processes and systems within the Trust to ensure quality and safety are fit for purpose.

To provide in some detail the Trust's preparedness for relevant regulatory scrutiny.

Key Points to Note

- There are some outstanding actions from the 2018 CQC inspection, the Trust still have five actions to complete. The expectation of the CQC response group is that these actions will be closed by the end of November.
- The Focused Support Framework piloting has been undertaken and plans for roll out are being enacted. Plans to develop this to become a more multi-professional process are underway.
- CHFT have been an outlier showing as "Much Worse" nationally on the Central Alert System (CAS) indicators. We remain an outlier in the September report as the improvement work is ongoing and will be reflected in future reports.
- The Trust position for Facing the Future Standards for Children in Emergency Care settings. CHFT Current Position with Recommendation 9 & 10. Work is ongoing to provide further assurance in relation to risk mitigations.
- That CHFT will undergo a CQC Patient FIRST for ED review, the meeting will take place in late October 2020.
- Pressure Ulcer – A reduction to 2 areas of limited assurance, noting an improving position with reasonable assurance across 6 areas.
- Nutrition and hydration – assurance remains limited

- Complaints: this remains a concern for the Trust and a service review is currently still underway.
- Venous Thromboembolism VTE – to note the achievement of the 95% target of patients being risk assessed for developing a VTE
- There are plans in place to improve reporting around quality indicators across the Trust.

EQIA – Equality Impact Assessment

In undertaking the Equality Impact Assessment this ensures that the Trust is sited on all aspect of our care delivery and the impact this can have on the diverse patient group. This in turn demonstrates that as a Trust we are considering the needs of all in our care and ensures that services we provide do not have a disproportionate impact on individuals or groups that share a protected characteristic under the **Equality Act 2010.**

It is also appropriate that we consider the impact on other groups not 'protected 'under the Equality Act including parents/carers and/or socio-economic groups.

It is not anticipated that the summary positions described within this report will have a detrimental impact on any of the protected characteristics but seeks to give the assurances that as a Trust we are doing everything in our power to reduce risk and ensure high quality and safe care for all.

The Equality Impact Assessment is an ongoing process and should be an integral part of service delivery and enable us to demonstrate that the Trust is offering a service that meets legislation, encourages equal access for all and reduces as many negative impacts identified as possible in terms of its overall delivery of high quality care.

In ensuring the above as a Trust we well be well placed to respond positively to external scrutiny from the Commission for Equality & Human Rights, the Care Quality Commission, and the Audit Commission.

Recommendation

The Board is asked to note the content of the report and the ongoing activities across the Trust to improve the quality and safety of patient care.

Contents

1. Introduction

The primary aim of Calderdale and Huddersfield Foundation NHS Trust is to treat and care for people in a safe and compassionate environment and to protect them from avoidable harm.

This report has been formatted to ask the question *'Are we assured'* as previous Board papers provided reassurance. As a Trust working towards the Outstanding CQC marker, the question for any Trust committee should be one of '*Am I assured and am I confident that we know where the risks lie'.*

The Quality Committee provides the scrutiny, monitoring and assurance on all the quality programmes that are in place within the Trust. Further assurance is provided by the Trust Council of Governors.

This report provides an update on assurance against several quality measures for the period August – September 2020.

2. Care Quality Commission (CQC)

2.1 CHFT Care Quality Commission (CQC) Workstreams - Summary

During quarter 2 the CQC workstreams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Mangers, Trusts recovery plan, national guidance and CQCs Emergency Support Framework.

The trust received commendable feedback from CQC for the Phase 1: Emergency Support Framework IPC Board Assurance Framework review. Assurance was gained that the Trust had undertaken a robust assessment of infection prevention and control (IPC) procedures across services since the onset of the pandemic and measures to mitigate IPC risks had been implemented

Extensive preparation has been ongoing during quarter 2 to launch the Focused Support Framework (FSF), which is in line with CQCs Phase 2: Engagement and Monitoring approach to regulation during the COVID-19 pressures. The process was piloted in August and has now been finalised and rolled out from October

2.2 2020/21 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions

Of the outstanding actions from the 2018 CQC inspection, the Trust still have five actions to complete. These have been defined as must do (MD) and should do (SD).

Following a lengthy period of review and continuous work within the Divisions, the status of the must do and should do actions has been set out below, the status remains the same as quarter 1.

In brief the two 'must do' and three 'should do' are not yet embedded in the Trust and have resulted as actions for specific focus for the CQC Response Group. Further the two 'must do' actions remain incomplete pending further consideration of the quality and financial impact of the CQC actions.

Action leads were asked to present a position statement and plans to further progress all remaining 2018 CQC actions at the August and September CQC Response Group.

The CQC response group will receive a report into its November meeting around closing down these outstanding actions with a very clear view on mitigation, ongoing monitoring and audit.

The exceptions plan below sets out, in detail, the present position:

Compliance	Quarter 1 20/21	Quarter 2 20/21	Plan for Quarter 3	Assurance
MD1 - The trust must improve its financial performance to ensure services are sustainable in the future	The Use of Resources Self-Assessment process is now well underway with a number of teams meeting regularly to gather evidence and address all key lines of enquiry. The Trust's submitted draft financial plan for 20/21 was in line with the required Financial Improvement Trajectory, but all financial planning is currently on hold due to Covid-19. The Q1 reported position was break-even, with a underlying position, (excluding Covid-19 costs), that was favourable to the NHSI plan.	The Trust has started a Use of Resources Self-Assessment process focusing on areas set out in the CQC Use Resources Criteria. This piece of work is now well underway with a number of teams meeting regularly to gather evidence and address all key lines of enquiry. The Trust's submitted draft financial plan for 20/21 was in line with the required five year Financial Improvement Trajectory, this plan was overridden subsequently due to Covid-19. The Month 5 reported position was break-even, based upon the temporary financial regime in place to support Covid pressures.	National guidance on the financial regime for the final half of 2020/21 is awaited. It is expected that the Trust will be allocated a financial target and that an element of the funding will be activity driven against national targets. Phase 3 planning submissions for activity, workforce and finance are currently being refined. Once these plans are finalised the underlying recurrent financial position will be established. This will inform 2021/22 planning and future reconfiguration business case financial modelling. It was agreed at the CQC Response Group that this action will be finalised long term and no further update is needed until April 2021.	**SUBSTANTIAL ASSURANCE**
MD8 – The Trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.	Q4 actions haven't been progressed, and no plans to reinstate at this time. Ross Kitson and the anaesthetic department has revisited the original options appraisal which was presented at WEB. Considering the recent COVID experience and the desire to increase the CRH bed-base to 8 critical care beds, which makes the CQC action even more essential. At this point, awaiting responses and input to a proposal describing service change options to facilitate the aforementioned.	During the escalation period, and during the re-set period it has become apparent that the concerns of the CQC, and indeed our own with regards the national guidance, are very relevant to the current workload. After departmental meetings we are progressing with a consultation process (mediated by the Critical Care re-set group going forward), to evaluate the consensus approach to altering the CRH OOH consultant cover, which will be presented to IMT. In the interim the CRH ICM consultants have remained as resident due to concerns with the on-going risk.	At the moment there isn't enough material to provide a full update detailing mitigating risks and monitoring. The next steps will be:- A options appraisal paper for clinical colleagues was produced by Ross Kitson. Staff across the board have been consulted on a number of occasions over the last 4 months the latest being Monday 28th September. There is agreement that changes need to be made to the rota but how those changes can be implemented has yet to be resolved. There is a significant amount of work to be done in respect of refining job plans and working out the finances.	**LIMITED ASSURANCE**

			In the interim the risk continues to be managed by the existing work force.	

SD3 - The trust should develop processes to measure the outcomes of mental health patients in order to identify opportunities to improve care	The operational group has now become a workstream of the reset and stabilisation at the trust and the TORs have been sent to the Quality Committee	TOR for workstream agreed and new attendees invited to meeting. Mental Health policy approved pending comments at QC. Additional clinical guidelines reviewed in relation to Joint working with SWYPFT. Children and Young People and Community services guidelines are progressing. CAMHS forum is embedded and in place. Meeting held to progress training strategy and Mental Health Dashboard. Ligature training to be reviewed alongside Policy development.	Dashboard currently under development. Task and finish group to collate and finalise MH data / training strategy to develop. Staff trained in Receipt and scrutiny training to be shared with site commanders. Position statement from ED to be presented at the October CQC Response Group, with recommendation to move action to Blue and close for ED.	**SUBSTANTIAL ASSURANCE**
SD6 - The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	Plans to introduce testing methods into the revised Ward Accreditation process. Meetings booked to discuss operational implications and plans to roll out with safeguarding team.	All levels of MCA DOLS training compliance currently above 90%. Level 2 and Level 3 training is currently on the intranet. 7 Minute briefings sent out during Covid -19. MCA DoLS questions are now included in the Focused Support Framework.	Level 2 training package to be finalised and uploaded onto ESR. Level 3 face to face training to be reviewed and planned for 2020-21. Further scoping with new Named Adult Safeguarding Professional for delivery of bespoke training. Policy being updated in preparation for LPS.	**SUBSTANTIAL ASSURANCE**
SD9 - The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.	Remains non-compliant. A further consultant has been recruited, but the service has lost some PAs to cover a maternity leave. The service continues to work towards recruitment of consultants into our vacant posts.	3Rs paper written to support current 14 hours per day 5 days a week with consultant overlap to support busy periods. Action plan developed Assessment of demand within our Emergency Departments 14 hours consultant cover 5 days a week, with extra cover at weekend on a WLI basis/some contracted PAs	Actively recruiting to consultant posts in the Emergency Departments. Continued work with reconfiguration plans Job planning is being examined but could take a few months to complete. The CQC Response Group have requested that ED show how the division is managing the risk mitigation with completed actions i.e. minutes of meetings, available to view. At this point the CQC Response Group maybe in a position to accept the risk and close the action once sufficient evidence is received.	**LIMITED ASSURANCE**

2.3 CQC Engagement Meetings

From 01st September 2020 CHFT was assigned a new Acute CQC Relationship Manager, Tim Franklin and new CQC Inspection Manager, Victoria Head.

The last full official engagement meeting between both parties took place on 16th September 2020 and was used as an informal introductory meeting.

Victoria Head asked for CQC's regards to be passed to all CHFT teams. CQC recognise how challenging it has been working with COVID-19 in some really difficult circumstances.

Regular catch up meetings have continued to take place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services Relationship Managers. These catch ups are scheduled to continue on a monthly basis with the next full engagement meeting scheduled for December 2020.

The engagement conversations have been structured in line with CQC Emergency Support Framework.

Moving forward the meetings will take a more structured approach focusing on:

- CQC update / arrangements during Covid-19
- CHFT community services: focus
- CHFT provider update: any changes to management structure, compliance Issues, finance, governance
- CQC inspection / action plan
- CHFT concerns: from clinical audit, clinical outcomes and unexpected deaths (including inquests)
- Risk Register: (any changes to current risk status with brief outline of mitigating actions taken)
- Specific data from safety systems: serious incidents/safeguarding/complaints
- Outcome of other external reviews or investigations

CHFT currently have 15 open enquiries with CQC; 3 of which are awaiting closure.

2.4 CQC Emergency Support Framework - Update

The Emergency Support Framework (ESF) has been CQCs regulatory approach during the coronavirus (COVID-19) pandemic.

It provided a structured framework for the regular conversations that inspectors were having with providers and covers the following four areas:

- Safe care and treatment
- Staffing arrangements
- Protection from abuse

- Assurance processes, monitoring, and risk management

For NHS Trusts this framework was split into 2 key workstreams as set out below:

Phase	Description	Requirements
Phase 1: IPC	A focus on IPC based around the NHSE/PHE IPC Board Assurance Framework. 11 question relating to IPC had to be answered and findings submitted back to CQC. 10 of the 11 questions mirrored the 10 Key lines of enquiry within the NHSE/PHE IPC Board Assurance Framework. Thus, making the review of IPC across the Trust mandatory.	• A review of IPC to be commissioned and undertaken across the Trust using the NHSE/PHS IPC Board Assurance Framework. • Final report of IPC Board Assurance Framework report to be submitted to CQC. • To provide assurance to the trust CHFT Board of Directors and submit evidence that confirmation that the BAF was discussed and agreed upon at Board level. • Provide evidence that any associated Risk with regards to IPC is documented and monitored via a Covid-19 Risk Register. • Submit Trust supporting statements and evidence to reinforce the findings within the report.
Phase 2: Engagement and Monitoring	Continued monitoring and engagement via intelligence and relationship meetings	• Having open and honest conversations about our current assurance and position via the CQC : CHFT Engagement meetings. • Taking action to keep people safe, by providing regular updates to any open enquiries with CQC and potential Serious Incidents of interest picked up via STEIS. Also, reporting and acting upon any intelligence within the CQC Insight Report. • Capturing and sharing what we do – sharing what has worked well and innovations with CQC such as our virtual visiting • Ensuring monitoring and assurance processes are in place to target support where it's needed most.

The trust was commended for their approach to Phase 1:IPC as CQC were assured that the Trust had undertaken a robust assessment of infection prevention and control (IPC) procedures across services since the onset of the pandemic and measures to mitigate IPC risks had been implemented.

CHFT continue to have regular engagement with CQC as outlined in section 3 to support Phase 2: Engagement and Monitoring. To further support this phase a 'Focused Support Framework' has been developed, piloted and rolled out across the Trust as a mechanism to be able to identify were support maybe needed across services.

2.5 Focused Support Framework

2.5.1 Purpose and Aim

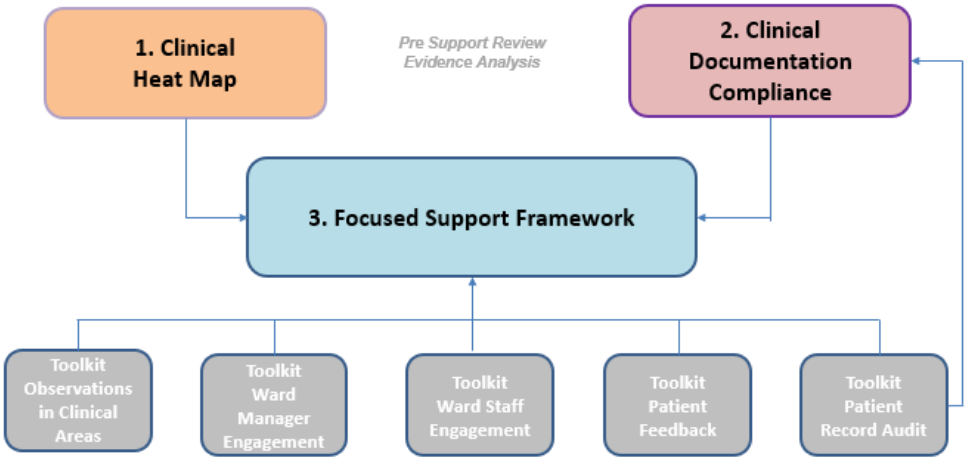
The newly devised framework has incorporated a new streamlined approach focused on collecting quality data while 'freeing up' frontline staff to focus on quality improvement projects with the aim of delivering excellent patient care.

Together the framework will aim to provide a 360-degree evaluation of the ward environment and workforce and has been streamlined to improve efficiency whilst providing nursing leaders with a temperature check of the ward culture and environment.

The FSF gives Ward Managers and their Teams the opportunity to showcase the Safe and Compassionate Care which is delivered to patients across the Trust on a daily basis. The review is also a mechanism used to identify where extra support may be needed within clinical areas. Support packages will be available where needed and implemented by our Trust subject experts.

2.5.2 The Framework Structure

The new review is comprised of three elements:



2.5.3 Clinical Heatmap

This is a live database which is available via Knowledge + and provides data on Nursing Quality Dashboards: Providing a summary of Workforce, Quality and Safety and Patient Experience data collated for each ward; assisting nursing and midwifery leaders with the ability to complete a monthly check. The results are shared with frontline staff, keeping them up to date with the quality of care they are providing and includes:

- Safe Staffing
- Workforce and Training
- Recruitment and Retention
- Audit
- NQI's
- Infection Control
- Patient Feedback

2.5.4 Clinical Documentation Compliance

This is audited monthly and provides standards of compliance in clinical documentation, this is also available on Knowledge +.

2.5.5 Focussed Support Framework Toolkit

A clinical based Toolkit comprising of an area visit alongside discussions with patients. Interviews with staff and the clinical lead of the area form part of this section but can be undertaken via teams. This reduces the number of reviewers to a clinical area at any one time.

The framework consists of a toolkit that will furnish assessors with the necessary tools to be able to undertake the review and will utilise the Trusts technology. This includes:

- Compliance Review via a digital Heat Map
- Observations at Ward Level
- Ward Manager Engagement
- Ward Staff Engagement
- Patient Feedback
- Patient Records Review

2.5.6 Review Methodology

The review focused on 6 key lines of enquiry as outlined in the Emergency Support Framework (ESF), as part of the CQC regulatory approach during the coronavirus pandemic, including:

- Safe Care & Treatment
- Staffing
- Protection from Abuse
- Nutrition and Hydration
- Compassionate Patient Care
- Staff Wellbeing

The review takes a focused approached looking at key areas of compliance and regulation from Nursing standards; CHFT key priorities of reducing patient harm; the Health and Social Care Act (2015); Nursing 6 C's; the '15' Steps approach and the CQC Key Lines of Enquiry.

This system has been adapted and developed from the Trusts Ward Accreditation process which was under review prior to the pandemic.

2.5.7 Focused Support Framework Pilot Review

The Focused Support Framework Pilot was run on Ward 6C at CRH in September.

Feedback of process was positive from both the Review team and Ward Manager. The process was run successfully over a 1-week period, with a hybrid of onsite observations, off site review i.e. patient record audit and staff engagement via Teams.

The framework and process identified where extra support was needed on the ward area and also highlighted areas of good practice.

A final report was shared with the Ward Management team and a feedback panel was set up to discuss the findings.

From the findings a support package has now been put in place by the subject experts to ensure the Ward has the extra support needed.
Further development needs of the process was also identified and highlighted the following, all of which will be progressed in Q3:

- Medical staff involvement in the tool and assessment should be enhanced and work is ongoing to ensure this is included.
- Review needs to take a more holistic approach and staff engagement to involve all disciplines with the ward area, domestic, AHP, HCAs.
- Safeguarding section to be tested in the next review by Vicky Thersby to ensure flow of questions and accuracy.
- The framework has been reviewed by paediatric and maternity services to ensure framework fits specialist areas – frameworks to be piloted.

2.5.8 FSF Review Next Steps

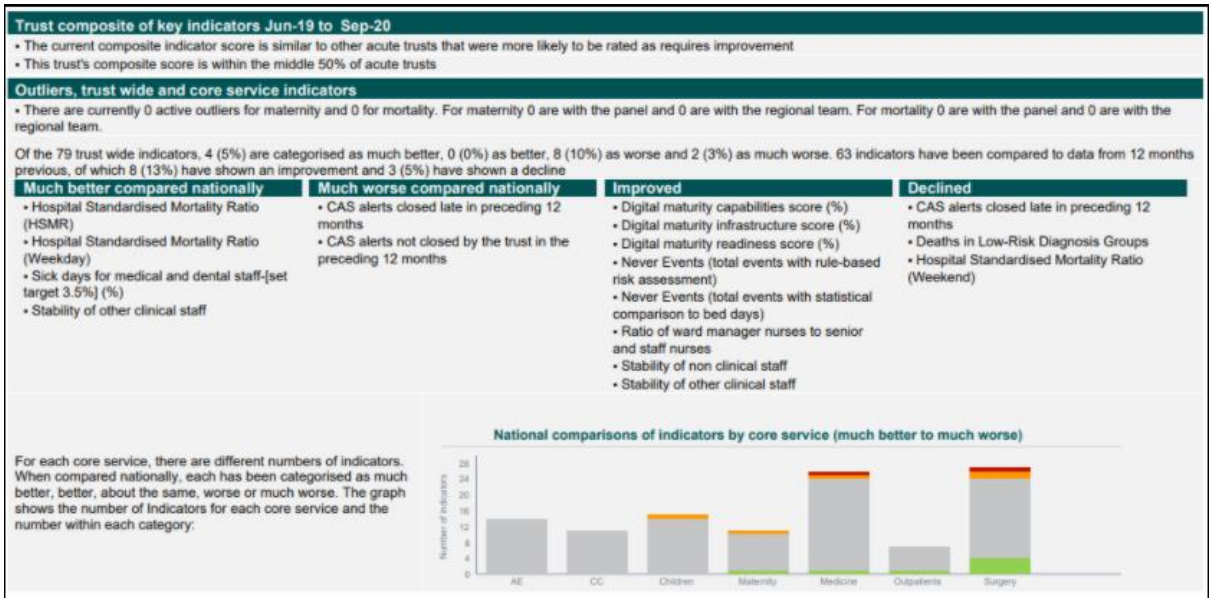
Next steps for quarter 3 include:

- SOP to be developed outlining the final process and agreed.
- Pool of staff to be involved in the reviews to be.
- Where support packages are put in place from subject expert teams these can be easily accessible for other areas if the same support is needed. “Support Package Portfolio”.
- Process to share the learning from each review to be developed.
- FSF Digital – plans have progressed to make recording the FSF findings digitalised utilising Microsoft Forms which can then pull through to KP+, therefore Heatmap and FSF review findings will be accessible via 1 programme.

2.6 CQC Insight Report

The most recent CQC Insight Report was published in September 2020 with the previous report been published in July 2020.

A summary of the report can be found below. After a review of both the July and September reports there has been no changes to CHFTs outlier status.



CHFT have been an outlier showing as Much Worse nationally on the Central Alert System (CAS) indictors. This was highlighted in quarter 1 and a Quality Improvement review has since been undertaken to look at the standard operating procedure and governance processes. We remain an outlier in the September report as the improvement work has not yet been updated and reflected in the report.

S6	**CAS alerts closed late in preceding 12 months** MHRA - CAS Alerts (26 Aug 2020)		< 25% of alerts closed late Aug 18 - Jul 19	>= 50% alerts closed late Aug 19 - Jul 20	↓	MW
S6	**CAS alerts not closed by the trust in the preceding 12 months** MHRA - CAS Alerts (26 Aug 2020)		NA	>=5 alerts still open Aug 19 - Jul 20	NA	MW

As of September, the current position re CAS alerts is as follows:

We have the following open:

- 4 PSA
- 1 MDA 2020/022 defibrillator paddles
- 2 Estates and Facilities (2020/01 allergens, 2019 05 door buffers)

Significant improvement activity is ongoing to develop improved systems, processes and reporting arrangements.

2.7 Facing the Future Standards for Children in Emergency Care settings

In June 2018 the Royal College of Paediatric and Child Health (RCPCH) published Facing the Future: Standards for children in emergency care settings, developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings. The guidance included 70 standards across a range of areas including: integrated emergency care systems, the environment, workforce and training, management of treatment and care, safeguarding, mental health, complex needs, safe transfers, death of a child, information systems and research.

Following this publication, the CQC published a briefing guide in recognition that two of the Workforce Recommendations (9 & 10) are particularly difficult to meet in DGHs where there is no separate Children's ED. The CQC guide outlines mitigation that should be in place should standards 9 &10 be less than fully compliant.

Recommendation 9: Every emergency department treating children must be staffed with a Paediatric Emergency Medicine (PEM) consultant with dedicated session time allocated to paediatrics.

Recommendation 10: Every emergency department treating children must be staffed by two registered children's nurses on each shift.

2.7.1 CHFT Current Position with Recommendation 9 & 10

It has been identified that the Trust is currently not compliant with standards 9 & 10, this was also previously highlighted in the 2018 CQC inspection.

SD10 HRI: *The trust should ensure that children are seen in an appropriate environment by staff that are suitably skilled, qualified and experienced.*

CRH: *The service did not have two registered paediatric nurses on shift over a 24-hour period. Paediatric nurses did not work overnight. However, adult nursing staff*

undertook two days of paediatric training on induction that was delivered by a dual registered nurse consultant and included basic paediatric life support.

HRI: *The service did not have registered paediatric nurses on shift despite seeing paediatric patients. However, staff undertook two days of paediatric training on induction that was delivered by a dual registered nurse consultant and included basic paediatric life support.*
A full review of the standards 9 & 10 and the required mitigation set out in the CQCs facing the futures briefing guide has been commissioned and undertaken by the Emergency Department. The final report is due to be presented at the October CQC Response Group.

2.8 Use of Resources

The Trust is still progressing with its Use of Resources Self-Assessment process focusing on areas set out in the CQC Use Resources Criteria. This piece of work is now well underway with several teams meeting regularly to gather evidence and address all key lines of enquiry.

2.9 CQC Provider Collaboration Review in ED

CHFT have been asked to partake in the Provider collaboration Review in ED. The meeting will take place mid October 2020 and will focus on the following:

The Provider Collaboration Review will focus on urgent and emergency care in eight systems. CQC will look at how providers are collaborating to develop urgent and emergency care services together in light of COVID-19 prior to potential further peaks, and ahead of this winter.

For each review CQC will interview a range of providers, including NHS 111, out of hours, urgent treatment centres, Accident & Emergency, and ambulance services. They will also speak to providers who are likely to experience urgent and emergency care services.

There operational activity will take place in October 2020. Following the review activity each system will receive a summary of findings and be asked to provide a response including planned actions.

The national external reporting will include a headline summary of themes and trends in our November 2020 COVID-19 Insight report, where systems will be named but not individual providers.

A full summary report for all eight provider collaboration reviews with all of the themes and trends found will be published in January 2021 on the CQC website.

2.10 CQC Patient FIRST for ED

CQC brought together a team of senior emergency department clinicians to develop ‘Patient FIRST’. The team included expertise from paediatrics. All the clinicians work in emergency departments rated as good or outstanding. And they are CQC specialist professional advisors.

Patient FIRST is a support tool designed by clinicians, for clinicians. It includes practical solutions that all emergency departments could consider. Implementing these

solutions supports good, efficient and safe patient care - for both adult and paediatric care. It also includes guidance for senior leaders at trust and system level.
FIRST stands for:

- Flow
- Infection control, including social distancing
- Reduced patients in emergency departments
- Staffing
- Treatment in the emergency department

Patient FIRST is for people directly or indirectly involved in delivering urgent and emergency care.

CQC have requested a meeting with CHFT executives and senior managers and clinicians responsible for urgent and emergency care to have a structured conversation to understand the level of executive level support to the emergency department and patient flow through the hospital. The inspector will focus on specific key lines of enquiry (KLOEs) from the Safe, Responsive and Well Led domains.

The meeting will take place in late October 2020.

2.11 CQC Regulating During the Next Phase of the Coronavirus Pandemic

CQC Chief Inspectors, and Deputy Chief Inspector and lead for mental health services, have issued a joint statement setting out how they will regulate during the next phase of the coronavirus (COVID-19) pandemic.

From 6 October, they will begin to roll out our transitional regulatory approach, starting with adult social care and dental services.

The transitional regulatory approach is flexible and builds on what was learnt during the height of the pandemic. The key components are:

- A strengthened approach to monitoring, with clear areas of focus based on existing Key Lines of Enquiry (KLOEs), to enable us to continually monitor risk in a service
- Use of technology and our local relationships to have better direct contact with people who are using services, their families and staff in services
- Inspection activity that is more targeted and focused on where we have concerns, without returning to a routine programme of planned inspections.

CQC will continue to adapt transitional regulatory approach and remain responsive as the situation changes. They will also be considering longer-term changes to regulation, which they will explore through engagement on the future strategy.

2.12 CQC Strategy

As part of how CQC are developing their next strategy, they have shared their latest thinking on a range of key areas. The draft strategy is built on four central and interdependent themes that determine the changes they want to make to how they regulate. Running throughout each theme is an ambition to improve people's care by looking at health and care systems, and how they're working together to reduce inequalities. Key areas below:

- **PEOPLE**: We want to be an advocate for change, ensuring our regulation is driven by what people expect and need from services, rather than how providers want to deliver them. We want to regulate to improve people's experience, so they move easily between different services.
- **SMART**: We want to be smarter in how we regulate, with an ambition to provide an up-to-date, consistent, and accurate picture of the quality of care in a service and in a local area.
- **SAFE**: We want all services to promote strong safety cultures. This includes transparency and openness that takes learning seriously – both when things go right and when things go wrong, with an overall vision and philosophy of achieving zero avoidable harm.
- **IMPROVE**: We want to play a much more active role to ensure services improve.

2.13 Plan for Quarter 2 2020/21

Below sets out the CQC Workstream priorities for Quarter 3.

Quarter 3 Priorities	Trust Leads
Continuous monitoring of outstanding MD & SD Actions from 2018 Inspection with the aim of closing.	CQC Response Group / Action Leads
Finalise the Focused Support Framework including a schedule of reviews across the Trust (as set out in section 5.8)	Shelley Rochford / Janette Cockroft
Partake in the CQC Provider Review Collaboration for ED	ED Senior Leadership Team
Partake in the CQC Patient FIRST interview	ED Senior Leadership Team
CAS Alert Improvement Journey	Andrea McCourt / Doriann Bailey
Facing the Futures Standards - Clear position and mitigating risks report completed.	ED Senior Leadership Team
Understanding the CQC Strategy and what this means for NHS Trusts	Doriann Bailey / Shelley Rochford

Key workstreams in Quarter 3 will also be guided by CQC engagement and Trust rest plans.

3. Venous Thromboembolism (VTE)

3.1 Venous Thromboembolism (VTE) is a collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE is a significant cause of mortality, long-term disability and chronic ill-health problems, many of which are avoidable. It has been estimated that the management of hospital associated VTE costs the NHS millions per year. This includes the costs of diagnostic testing, treatment, prolonged length of stay in hospital and long-term care. Long term complications that reduce the quality of life add to the human cost and overall burden of VTE.

3.2 VTE Prevention is supported by national standards that facilitate high quality care and NICE guidelines for reducing risk in patients admitted to hospital.

VTE Outcome	Quarter 3	June / July 2020	Aug / Sept 2020	Assurance
To meet the 95% target of patients being risk assessed for	KPI - 95%+ compliance achieved for all months in Quarter 1 2020 Regular VTE slot on induction for all new starters.	Achieved	August 96.1% achieved September 95.5%	**SUBSTANTIAL ASSURANCE**

developing a VTE	VTE committee liaised with Divisional Quality Governance Leads around areas of low compliance – due to covid crisis we have been behind in this work in first and second quarter in 2020. In November, the Patient Safety Group supported the committee's proposal that if areas under perform for three consecutive months, that an action plan is produced and is fed into the next committee meeting.		VTE committee will review the individual ward/clinical area level breakdown and liaise with appropriate divisional governance leads for feedback and to facilitate improvement measures	
Maintain the level of Hospital acquired VTE episodes, not more than 20% of all VTE episodes	Achieved	Achieved	Achieved – June to August 2020	**SUBSTANTIAL ASSURANCE**
No Avoidable hospital acquired VTE Deaths	Achieved	Achieved	Achieved – June to August 2020	**SUBSTANTIAL ASSURANCE**
Audit actions plan and schedule of re audit	Plan a re-audit this year of all action plans - ongoing Pharmacy led audit on VTE prevention and prescribing prophylaxis – ongoing Management of suspected PE in pregnant patients - awaiting approval in MMC	No change to Q3 position	Await pharmacy led audit on VTE later this year Await approval of VTE treatment guidance in MMC	**REASONABLE ASSURANCE**

4. Pressure Ulcers

4.1 Pressure ulcers are a key indicator of the quality and experience of patient care. Many pressure ulcers are preventable, so when they do occur, they can have a profound impact on the overall wellbeing of patients and can be both painful and debilitating. Preventing them will improve care for all vulnerable patients.

Pressure Ulcer Collaborative meetings are held on a monthly basis. Minutes and action logs for these evidence initiatives taking place. Pressure Ulcer Collaborative reports are submitted to the Patient Safety Group, Safeguarding Operational Group and the Nursing and Midwifery Committee. These evidence Trust wide quality improvement initiatives.

Objective	Quarter 1 2020/21	July 2020	Aug / Sept 2020	Assurance
Reduction in pressure ulcers	There was a significant increase in pressure ulcers in Q1 (134). This period coincided with the start of the COVID-19 pandemic.	There was a significant decrease in pressure ulcers in July 2020 (33).	There were 28 pressure ulcers in August and 42 in September. This represents a decrease	**LIMITED ASSURANCE** The Trust has been unable to evidence a

Objective	Quarter 1 2020/21	July 2020	Aug / Sept 2020	Assurance
			from Q1 (134) to Q2 (103) Reports from 1/4/20 include all pressure ulcers category 2 and above (inclusive of unstageable and deep tissue injury). This aligns with NHSI recommendations.	sustained reduction in pressure ulcers. The reports outlined above demonstrate the initiatives in place.
No Category 4 declared	1 category 4 pressure ulcer declared in Q1 (hospital acquired in Feb 2020)	No category 4 pressure ulcers were declared in July 2020.	No category 4 pressure ulcers were reported in August and September 2020.	**REASONABLE ASSURANCE**
Reduction in CHFT Acquired Medical Device Related Pressure Ulcers (MDRPU)	There was a significant increase in MDRPU in Q1 (24). This figure includes 2 staff/face mask related pressure ulcers. The overall increase in numbers coincides with the peak of the COVID-19 pandemic with a sudden increase in the number of acutely unwell patients in critical and respiratory care settings.	There was a significant decrease in MDRPU in July 2020 (2).	There were 4 MDRPU in August and 5 in September. This represents a decrease from Q1 (24) to Q2 (11)	**LIMITED ASSURANCE** The reduction is not sustained, and actions are in place to address MDRPU.
Reduction in Category 3 Pressure Ulcers	There was a reduction in category 3 pressure ulcers in Q1 (2).	Following validation there were no category 3 pressure ulcers declared in Q1.	There was 1 category 3 pressure ulcer in August and 0 in September. This represents a reduction from Q1 (2) to Q2 (1)	**REASONABLE ASSURANCE**
Education and Training- PUSH Tool / Safety Huddles	Virtual education programme commenced in June 2020 via Microsoft Teams. PU Collaborative now facilitated via Microsoft Teams resulting in improved attendance.	Virtual education programme continues. Programme extended to ward staff commencing in September 2020. Review commenced of all CHFT PU investigation templates Increased monitoring and follow up of DTI and unstageable pressure ulcers via newly appointed Tissue Viability Nursing Associates	78 attendees accessed virtual tissue viability training events in last 3 months Made Easy Guides in skin care added to Powerchart to support best practice	**REASONABLE ASSURANCE**
Documentation	Care plan for Skin care under POP written and awaiting confirmation from Bradford that they are happy to use on Powerchart. Patient advice leaflet completed and to be submitted for addition to the repository.	Review of EPR Powerchart documentation completed with recommendations identified for change and submitted. Systmone documentation review on going with community teams	Documentation change requests submitted to EPR teams.	**REASONABLE ASSURANCE**
Resources / Policies	Moisture Associated Skin Damage policy has been	Moisture Associated Skin Damage policy awaiting ratification	Non concordance policy drafted	**REASONABLE ASSURANCE**

Objective	Quarter 1 2020/21	July 2020	Aug / Sept 2020	Assurance
	devised and circulated for consultation. National PU resources disseminated to members of PU Collaborative via Microsoft Teams		Virtual tissue viability Nurse consultations being provided to patients in care homes are an additional resource which have been made available to care homes.	
Provision of appropriate pressure redistributing equipment	Mattress audit completed Conclusions: 261/357 (73%) mattresses in an acceptable condition 89 adult condemned mattresses were replaced immediately Paediatric mattresses to be ordered with immediate effect Trolley mattress audit: completed July 2020 and replacement plan in discussions with procurement. Repeat audit arranged for September 2020 70 new powered alternating pressure mattresses acquired for secondary care settings. These offer improved support surface provision for patients requiring constant low pressure such as those receiving palliative care.	New additional pressure redistributing non powered cushions ordered and made available to wards	Ward mattress audit repeated in Sept 2020. Conclusions: 277/333 (83%) mattresses in an acceptable condition. All condemned mattresses were replaced immediately.	**REASONABLE ASSURANCE**

5. Nutrition and Hydration

The Nutrition Operational Group continues to meet monthly and is currently being chaired by the Corporate matron with good representation from its members.

Below provides an update from the key workstreams:

Enteral feeding

Clinical areas of high/regular usage of NG tubes continue to be access the online self-directed, on-going management which is a theoretical module for existing practitioners. This is monitored monthly via a compliance dashboard(attached). New nursing staff to these clinical areas can access 1:1 initial training via the nutritional specialist nurses with competencies undertaken within the clinical environment.

There has been a recent dip in the compliance in ICU however this is being proactively managed.

Enteral PEG

Referral to the nutritional specialist nurses is now a more robust process on EPR promoting a prompt response

Work is progressing related to an integrated pathway post PEG insertion to provide further guidance after the initial insertion provided by the endoscopy department. A patient passport has been devised to provide information for continued care in community.

MUST training compliance.

MUST compliance (Nutritional screening for adults) online training remains compliant with all Divisions scoring 95% or above.

STAMP nutritional screening (for paediatrics) training has recently been devised which will provide an online training and link with ESR to ensure compliance is centrally monitored.

Allergen awareness training

Estates and Facilities Alert EFA-2020/001 Issued: 29 January 2020 Valid until 29 January 2022 Allergens Issues - Food Safety in the NHS .https://www.health-ni.gov.uk/sites/default/files/publications/health/EFA-2020-001-Allergens-Alert.pdf

Actions required to achieve compliance which were identified as predominantly relate to awareness of food allergens and intolerances by clinical ward-based staff.

Action 3
Ensure all staff involved in the preparing and serving of food have training to the appropriate levels in allergen management. Clinical staff at ward level do not routinely receive training or awareness on food sensitivities as a requirement to role specific training.
3.1 Utilise the Food Standard Agency online module related to allergies and the body which provides information on the 14 main allergens and food sensitivities and effects on the body. This would be undertaken by role specific ward-based staff, nutritional assistants, housekeepers and all nursing workforce groups at ward level.
https://allergytraining.food.gov.uk/english/
Staff will be provided with a booklet and asked to sign the booklet to register an increased awareness, a record of this is to be maintained at ward level. A communication launch will be undertaken week commencing 19 October 2020 and staff will be given asked to complete the booklet in the module by the end of Q4.
3.2. Raise awareness through a communication campaign running from mid-October with information regarding the 14 main food allergens and a YouTube video (FSA website) providing a brief overview of reactions to food sensitivities. A poster has been distributed to the ward for pictorial reference to the allergens.
3.3. Utilise the nutritional assistant network to raise awareness and promote the information already in the ward catering files on allergens.
3.4 5. Information re allergens is now available on the Nutrition and Hydration section of the intranet.

Action 5.

Ensure there is clear information available throughout the organisation advising those suffering from food allergies about who to inform and how.

5.1 Devise a flow chart to direct the actions to take if a patient is admitted with an allergy and involvement of catering and dietetics if required, will be circulated to the ward managers mid-October as part of the communication strategy.

5.2 There is no formalised patient information currently available to signpost who and how the patient is to inform regarding their allergy/intolerance. Existing medical clerking on EPR does identify allergen status and this would then require communication with the ward team. The patients nursing admission section of EPR identifies nutritional care requirements, this is the opportunity to gather the information and action dietary choices and dietary requirements, with escalation to the catering /dietetic department if required.

Currently the trust does not routinely monitor the compliance that food allergies are recorded in EPR. The newly devised Focused support framework does include a question on food allergies within the nutrition and hydration framework which could be utilised on a small scale to assess the wards compliance. Further discussion are ongoing as to the possibility that this information could be collated electronically.

Action 8

Review current policy on allergens and ensure it has guidance on controlling risks that may present at charity fundraising food events e.g. bake sales.

8.1 Review existing CHFT Nutrition and hydration Policy (2018) to include expanded section on allergen management and include advice re home produced buns and cakes sales. This policy is due a full review in Spring 2021.Key messages regarding allergen contents to be included in trust wide cake bakes i.e. Macmillan coffee morning. Also, this message to be emphasised in the ward-based allergen awareness booklet for staff.

Nutritional and Hydration Compliance

Compliance in all aspects of clinical documentation remains of concern with limited assurance provided in 4 out of 5 sections for nutrition and hydration. The Focused Support Framework will assist in supporting the monitoring of documentation, the tool has recently been piloted on the cardiology ward and will now process with rollout and work has commenced within the Clinical Records Digital Optimisation Strategy. The objective compliance is 95%.

Objective	Quarter 2	Quarter 3	June and July 2020 update	Aug / Sept 2020	Assurance
All patients (>LoS 8hrs) have a completed fluid balance chart?	10.1%	23.3%	19.4%	**15.7%**	LIMITED ASSURANCE
Nutritional support care plans will be evident for all adults' patients with MUST of 2 or above?	88.2%	85.5%	89.0%	**88.1%**	SUBSTANTIAL ASSURANCE
Patients with a MUST score of 2 or above will be referred to a dietician	2.7%	4.4%	4.6%	**7.8%**	LIMITED ASSURANCE
Food charts will be completed for patients with a MUST of 2 or above	31.9%	16.9%	13.5%	**14.9%**	LIMITED ASSURANCE

All adult patients will receive a MUST assessment within 24 hours admission/ transfer to the ward?	15.0%	16.6%	22.1%	**18.0%**	**LIMITED ASSURANCE**

6. Sepsis

6.1 The Sepsis Collaborative in June agreed the below measures would be reporting on going forward:

- Antibiotic administration within the hour from the earliest alert in both Emergency Departments (ED) – an improvement trajectory of 10%

- Sepsis Care Bundle compliance – improvement trajectory to 50%

Objective	Quarter 4	June to July 2020 update	Aug / Sept 2020	Assurance
EPR Sepsis bundle/PowerPoint presentation	WTGR action plan updated May 2020. This underpins the improvement work of the Sepsis Collaborative Group. The work in Q4 was about understanding the data quality and CHFT position. New sepsis power plan for doctors launched on the 21/3/20 after media drive. Provides improvements with ordering tests, antibiotics and use of the sepsis treatment bundle. Sepsis dashboard will provide compliance figures monthly. Improvement from 37.8% to 45.1% of bundle compliance noted. Sepsis presentations ongoing, sepsis nurse working on slides being set up and narrated on EPR so doctors and nurses can access and sign off learning. This has been actioned due to Covid 19 and significant reduction in face to face training. Sepsis nurse is delivering training on new starter induction. Recruitment of sepsis champions completed at HRI, CRH ongoing.	WTGR updated monthly prior to sepsis collaborative meeting. Further work to improve antibiotic administration compliance in ED continues. ED compliance improved to 80% in the month of June (May position 67.7%). Sepsis power form guidance added to junior doctors' induction. Sepsis 6 poster campaign commenced. Sepsis training progressing, lead nurse is being supported with training of surgical nurses by band 7 Sepsis champions recruited both sites and Train the Trainer commenced in front end areas.	Antibiotic administration compliance in ED August = 62.8% Sept = 56.8% ED consultant monitoring cat 2 patients being seen sooner; purchase of sepsis trollies both EDs; improving escalation of IV access issues; micro teachings in EDs; new ED clinical skills trainer for nurses now in place. Sepsis 6 poster drop and sepsis information boards Recording of all elements of the sepsis 6 care bundle August = 41.4% Sept = 42.4% showing an improvement of 2% Sepsis 6 CHFT screen saver arranged for month of October 2020 Sepsis training and train the trainer ongoing at both sites. Sepsis champion doctors now being recruited from Medicine	**REASONABLE ASSURANCE**

	Monthly sepsis newsletter commenced April 2020 and distributed. Sepsis Press education digital newspaper being built for quarterly release.		with support of Acute floor consultant. Newsletter continues to be distributed monthly	

7. Complaints

A service review is currently still underway, of which the draft report will go to the next Quality Committee meeting for sign-off, in advance of going to the 5 November 2020 Executive Board meeting.

Work is underway supported by Felicity Astin (Professor of Nursing) to develop an evidence-based framework to support the analysis of existing data sources, to develop constructed stories; the usability of this framework will translate across to other service areas.

Additionally, a proposal is currently being worked up which will be contained within the service review report. This proposal sets out a potential approach aimed at reframing people's perspectives and approach towards complaints (exploration of mind sets and unconscious bias).

It has been identified that currently the Trust is not where it should be at in terms of equality monitoring data at part of the complaints process, this matter is currently being addressed by additional data fields being included on Datix.

Following last years' service review, an action plan was progressed, the latest activity is as follows:

- The Complaints Team are in the process of devising some accessible module complaints investigator training on the intranet;
- In addition, work is underway to create a 'patient experience' video, following shared learning from Wrightington, Wigan and Leigh Trust, which will incorporate interviews from complainants discussing their experiences at our Trust.

During August to September 2020, the Patient Advice and Liaison Service (PALS) team had 603 contacts, an increase of 3% from 583 contacts in August to September 2019.

Aug/Sept 2020 - Complaints Summary:

End of Sept Complaints Summary	Aug	Sept
Live complaints	85	87
Breaching complaints	13	10
Complaints under investigation with PHSO	5	6
Complaints received	34	34
Complaints closed	11	33
Complaints reopened	4	3
PHSO complaints received	0	1
PHSO complaints closed	0	0
PALS contacts received	256	347

Objective	Quarter 2	Quarter 3	Quarter 4	June and July 2020 update	Aug/Sept 2020	Assurance
Senior divisional decision makers should receive all complaints and allocate accordingly	Implemented	Implemented; complaints weekly tracker shows allocation in a timely manner. Need audit to check embeddedness due to be undertake at the end of Q4.	No progress made	Audit spot check completed; Divisions are allocating complaints to investigation in a timely manner.	Audit spot check completed; Divisions are allocating complaints to investigation in a timely manner.	**SUBSTANTIAL ASSURANCE**
Database to be developed to provide an overview of colleagues with skills in more complex complaints and less experienced complaint handlers	Not implemented	No progress made.	No progress made.	No progress made during pandemic - Divisional update to be provided	No progress made during pandemic - Divisional update to be provided	**LIMITED ASSURANCE**
The Trust should review its complaints training offer to include training in communication skills, strategies to build confidence in having difficult conversations and duty of candour as well as process	Bespoke Training for areas within the Trust delivered as required	Bespoke training for areas within the Trust delivered as required.	Complaints Training currently under review.	Complaints Training currently under review and working with Divisions.	Complaints Training currently under review and working with Divisions.	**REASONABLE ASSURANCE**
Audit of learning from PHSO cases	In progress	Audit has not yet been undertaken due to focus on backlog of breaching responses; implementation was due end December 2019. Plan to be undertaken and presented with end of year complaints report.	Although no progress has been made specifically in relation to the PHSO, the Complaints Team have taken the view that all actions and learning require a review. Regular spot-checks are needed to ensure longevity that these are still being implemented and in addition to ensure stricter monitoring that actions as a	Spot checks of historic learning/actions still being implemented in areas on hold due to Covid-19 pandemic.	Spot checks of historic learning/actions still being implemented in areas on hold due to Covid-19 pandemic.	**REASONABLE ASSURANCE**

Objective	Quarter 2	Quarter 3	Quarter 4	June and July 2020 update	Aug/Sept 2020	Assurance
			result of a complaint have been completed.			

8. Legal

8.1 The Head of Legal Services and Complaints left the Trust at the end of July 2020. This has given the Trust the opportunity to reassess this role and look to split management of the legal and complaints functions. An Interim Head of Legal Services has been employed for a period of 3 months to review Legal Services and assist with recruitment of a permanent successor.

8.2 Clinical Negligence

- 188 active clinical negligence claims
- 14 new clinical negligence claims were received.
- 4 clinical negligence claims were concluded.
- Damages totalled £207,000

8.3 Employers' and Public Liability (EL/PL) Claims

- 20 active EL/PL claims
- 6 EL/PL claims were received
- 1 EL/PL claim was concluded
- Damages totalled £22,000

8.4 Lost Property

- 13 active lost property claims
- 2 lost property claims were received
- 1 lost property claim was concluded
- £0.00 paid in respect of lost property claims

8.5 Inquests

- 77 active inquests
- 13 inquests were opened
- 3 inquest files were closed

Objective	Quarter 2	Quarter 3	Quarter 4	June and July 2020	Assurance
System in place to ensure effective communication within the Legal Services Department	KPIs set and implemented	98% compliant with department KPIs	100% compliant with department KPIs	At the end of 2019/20 98% of KPI were met. During Covid-19 report on KPIs has ceased to all staff with the department to help support clinical colleagues; therefore, figures not available for this period. Reporting will be reviewed as part of wider review.	**LIMITED ASSURANCE**
Datix Module for Legal	Not implemented	Datix reviewed with Trust Datix	Legal Services Department	Not implemented	**LIMITED ASSURANCE**

Objective	Quarter 2	Quarter 3	Quarter 4	June and July 2020	Assurance
Services reviewed and updated		Lead, stages streamlined, and actions set up for Inquests. Further work required in Q4.	together with wider Governance Department moved offices and sites during Q4. Work on Datix module was paused during this time to focus on the move.		
Audit of Legal Services files on Datix	Not implemented	Not implemented	Not implemented	Audit of Legal services files continues to take place as part of quarterly reporting. At present audit feedback sheet has been designed and feedback is given to handlers on an individual basis. Quarterly basis has been deemed a reasonable period of time for audits to take place.	**REASONABLE ASSURANCE**
SOP for DP7 requests	SOP set up	In Q3 the role and responsibility for managing all DP7 requests was given to Legal Services. Currently no SOP in Trust for handling these.	Confirmed that DP7 requests from the Police that relate to Trust staff or incidents that have happen on Trust property. All other requests will be handled through Access to Data DP7 requests have been added to Datix as a type in claims module and managed under the SOP for legal disclosures.	Confirmed that DP7 requests from the Police that relate to Trust staff or incidents that have happened on Trust property should be referred to Legal Services.	**REASONABLE ASSURANCE.**
Disclaimers for personal property on EPR	Not implemented	Not implemented, discussions being undertaken with EPR Team in relation to this.	The Digital Health Team are looking into how disclaimers can be added to EPR. There has been little movement as claim handler for lost property is on sick leave.	The Digital Health Team are looking into how disclaimers can be added to EPR. There has been little movement as claim handler for lost property only returned to work in July 2020 and has had a phrased return to work	**LIMITED ASSURANCE**

Objective	Quarter 2	Quarter 3	Quarter 4	June and July 2020	Assurance

9. Incidents

9.1 Serious Incidents (SIs)

9.1.1 Summary of Patient safety Incidents and Incidents with Severe Harm or Death for the year April 2019 to September 2020 and number of SIs reported by month

Month reported	No of Patient Safety Incidents reported (all)	No of Patient Safety Incidents of severe harm or death	SIs By the month externally reported on StEIS
Apr 2019	1031	4	0
May 2019	1049	6	6
Jun 2019	929	3	3
Jul 2019	1053	2	2
Aug 2019	981	4	1
Sep 2019	964	3	7
Oct 2019	1141	5	3
Nov 2019	998	4	6
Dec 2019	976	4	3
Jan 2020	1068	4	2
Feb 2020	962	3	2
March 2020	876	4	0
April 2020	625	2	1
May 2020	790	4	1
June 2020	931	7	9
July 2020	994	5	2
Aug 2020	937	3	2
Sept 2020	954	7	4

9.1.2 Types of SI Declared in August and September by StEIS category and Division

STEIS	ID	Incident date	Division	Description	Level of harm	STEIS Ref	STEIS Category
AUGUST	183218	07/04/2020	MED	Delay in obtaining and commencement of CPAP in a covid positive patient.	Death	2020/14472	Treatment delay meeting SI criteria
	187197	08/08/2020	SAS	Prescribing and administration of Gentamicin in a patient with diagnosed Acute Kidney Injury. Also, IG incident, sharing logins. Urinary catheterisation incident causing harm.	Moderate harm	2020/15984	Medication incident meeting SI criteria
SEPTEMBER	187490	30/03/2020	SAS	Treating patient since March 2020 for Wet Macula degeneration. Missed diagnosis of Ocular tumour (eye) Having treatment at Sheffield oncology for melanoma to avoid body metastasis with very high chance of loosing the only eye.	Severe harm	2020/16448	Diagnostic incident including delay meeting SI criteria (including failure to act on test results)
	187609	20/08/2020	MED	Patient swallowed vernagel sachet from inside urinal bottle. Previous National Patient Safety Alert	Minor Harm	2020/16425	Medication incident meeting SI criteria

9.2 Never Events

9.2.1 In 2020/21, the Trust has reported the following Never Events:

April 2020 - Wrong site surgery - Moderate Harm
Dermatology wrong site wide local excision
A summary of the incident and immediate actions was provided to Quality Committee in May 2020.

June 2020 – Retained swab – Moderate Harm
Urology retained swab requiring further surgery for retrieval.
A summary of the incident and immediate actions was provided to Quality Committee in July 2020

9.3 Summary of Progress with SI Actions

9.3.1 In summary, as of 3rd October 2020, there are 80 open actions against serious incident investigations, of these 15 are over 6 months overdue. The Trust maintains a month-on-month improved position on delivery of actions and is collectively addressing actions to mitigate risks across both SIs and Divisional Orange investigations where there are common requirements.

9.4 Learning from Safety Incidents in Quarter 4

9.4.1 Serious incident reports submitted to the Clinical Commissioning Group (CCG) in August and September 2020 are as follows:

ID	Division	STEIS Ref	STEIS Category	Level of harm
176317	Medical Division	2019/24522	Slip, Trip, Fall	Severe
Lessons Learned: • Where you identify a risk and decide on an intervention, if that resource is not available (ie. one-to-one or enhanced care), then this should be escalated, and alternatives considered. • Comprehensive documentation in Safe Care Live is essential to managing risks associated with safe staffing levels across the organisation. • Where the family request an intervention and this is not appropriate, the reasons for this should be clearly explained and documented (in this case a falls alarm as the audible alarm can cause distress to an already confused patient)				
184526	Families and Specialist Services - Radiology	2020/10164	Diagnostic incident including delay meeting SI criteria (including failure to act on test results) Missed diagnosis of Ewing's Sarcoma on chest xray	Severe
Lessons Learned:				

ID	Division	STEIS Ref	STEIS Category	Level of harm
• Protocol for bony lump should include a tangential view as standard for all Plain Film examinations. At the time this was only performed as standard for suspected foreign bodies in extremities (i.e. hands and feet).				
177153	Medical	2020/10492	Apparent/actual/suspected self-inflicted harm meeting SI criteria	Severe
Lessons Learned: • The electronic referral and handover process is not appropriate for all patients; where the record does not give the full picture, a verbal handover should be delivered • Mental Health Liaison Team colleagues can support with advice and history even where the patient may not be medically fit for Mental Health referral or assessment • An environmental risk assessment of clinical area should be conducted prior to admission of patients with self-harm presentation to ensure safety of high-risk patients. • It is important that the appropriate staff group provides the escort on transfer from ED as identified in the CHFT Transfer policy to ensure appropriate level of supervision and handover. • A detached call bell cord that is awaiting re-fixing presents an opportunistic ligature risk; it must be stored safely in a secure area and not left in the bathroom				
185181	Families and Specialist Services – maternity	2020/12014	Diagnostic incident including delay meeting SI criteria (including failure to act on test results) Failure to recognise and diagnose syphilis during pregnancy	Moderate
Lessons Learned • Management of persistent vaginal discharge in obstetric patients should be escalated to senior review after three presentations with the same complaint.				

10. Medicine Safety

10.1 The Medication Safety and Compliance group continues to raise awareness of the importance of safe storage and handling of medication.

Objective	Quarter 2	Quarter 3	Quarter 4	July to Aug 2020	Aug and Sept 2020	Assurance
Non-compliance of the medicines management 'must do's	Requirement of clear escalation process for non-compliant areas. Senior nurses to be reminded of responsibilities	The Trust Medicines Code has been updated and includes a process for the escalation and management of the staff responsible in any non-compliant areas Presentation to senior nurses of responsibilities and process of escalation Letters issued from ADNs to senior nurses reminding staff of responsibilities Celebration of high performing areas	Pharmacy continue to complete spot checks and audits	Spot check audits have identified issues with ward medicines trolley's: not being secure when not in use and containing out of date medicines. Ward managers asked to include trolleys in meds safety spot checks.		**SUBSTANTIAL ASSURANCE**
Non-secure storage of medication cupboard keys in those areas not open 24/7	Review of medication key security and installation of digital key safes	Non-compliant areas identified. Business case for digital key safes / successful funding bid to Commercial Investment and Strategy Group. Procurement of key safes. Priority areas for installation highlighted.	Key safes and digilocks have been procured and installed.	Completed		**SUBSTANTIAL ASSURANCE**
Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100%	Require improvement in completion of medicines must do's/ compliance with fridge temp	Audit results disseminated to nursing and midwifery staff Issue highlighted in Safe Medicines newsletter	Spot checks continue and new monitoring sheet implemented. Business case finalised for WIFI	Funding approved. Active temperature monitoring software being installed w/c 10/8/20. SOP being finalised	Comms being issued to wards. Software to be calibrated. SOP to be finalised. Then training plan to be implemented.	**REASONABLE ASSURANCE**

Objective	Quarter 2	Quarter 3	Quarter 4	July to Aug 2020	Aug and Sept 2020	Assurance
compliant (audit completed July/ results shared September 19)	monitoring standards	Monitoring sheet revised to include colour code when temperature out of range Spot check of medicines management standards by pharmacy teams. Awaiting review of ward managers annual medicines management audit to identify if improvements to previous practices - Feb 20	based system for monitoring of ambient and fridge temperatures. Business case presented at Scan5safety project group to request funding.	prior to training roll out. Manuel monitoring to continue until active system live and embedded.		
To improve medical gas training to ensure compliant with HTM requirements				50 additional nursing staff to receive DNO training on 3/4th Aug. Unfortunately, this training needs to be rescheduled due to local Covid lock down resulting in BOC cancelling session	BOC DNO training completed. Michelle Bamforth's team to lead on ensure refresher training is completed every 3 years. Medical gas leaflet approved and shared with ward managers to cascade to staff.	**REASONABLE ASSURANCE**
Requirements for areas administering Entonox and nitrous oxide to complete annual occupational exposure checks				The following areas need to complete a COSSH risk assessment which includes the requirement for annual occupational exposure checks: ED, Endoscopy, maternity, children's, plaster room, radiology	Theatres, facilities and endoscopy have yet to nominate lead to complete COSSH risk assessment. New Health and Safety manager appointed and commenced in post on 21st Sept and he is aware of the issue and requested him to lead taking this forward.	**LIMITED ASSURANCE**

22. Integrated Performance Report – September 2020

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 5th November 2020
Meeting:	Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee, Quality Committee

Actions Requested:
To note

Purpose of the Report

To provide the Board of Directors with the performance position for the month of September 2020.

Key Points to Note

Trust performance for September 2020 was 72%, a much improved position on the previous 3 months.

SHMI is back below 100 (Covid patients have been excluded nationally), short-term sickness is back to green, return to work interviews improved plus within Finance borrowing has improved.

A number of indicators continue to be affected adversely by the COVID situation including Diagnostics 6 week waits, ASIs and 52 week waits.

In addition 3 of the stroke indicators are now below target.

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 contents of the report and the overall performance score for September.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

September 2020

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Contents

RAG Key	
Not achieving target or threshold	
Achieving target	
Between target and threshold	

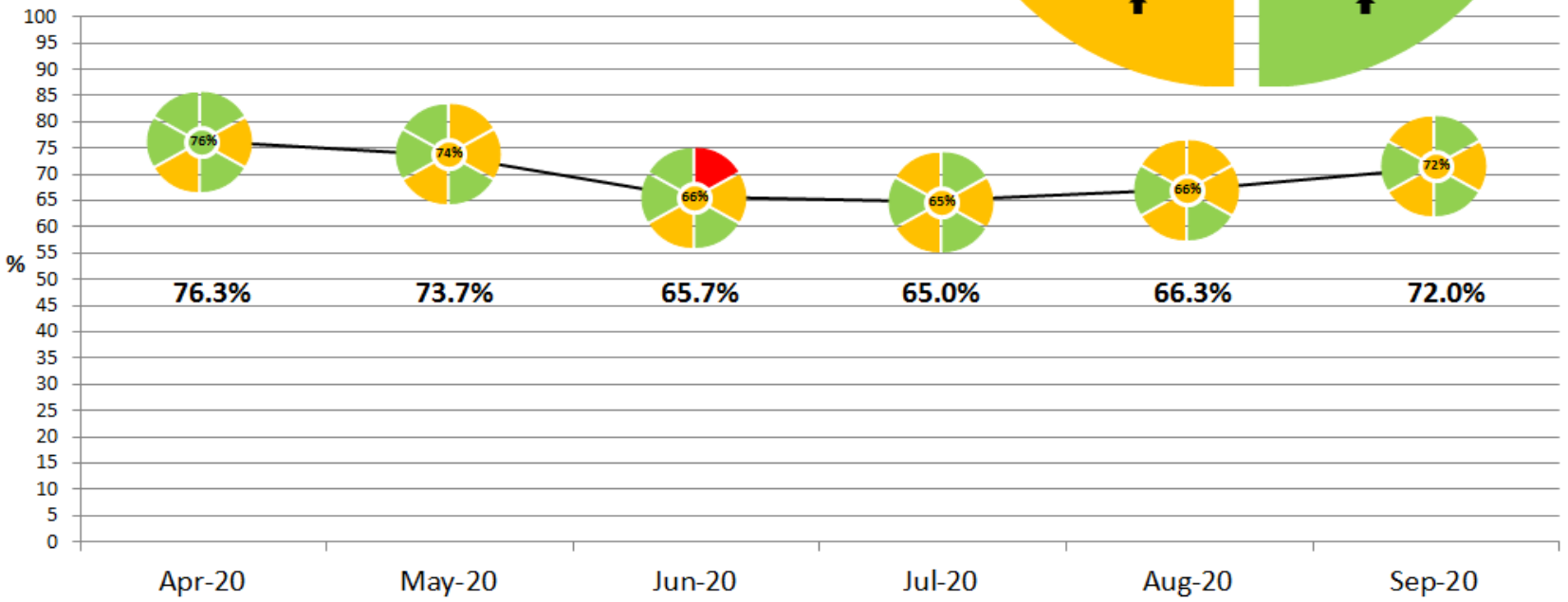
Performance Summary

September 2020

OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

RESPONSIVE	
Diagnostics 6 weeks	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover



Key Indicators

	19/20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Performance Range		
SAFE									Green	Amber	Red
Never Events	1	0	1	1	0	0	**0**	**2**	0		>=1
CARING									Green	Amber	Red
% Complaints closed within target timeframe	42.00%	94.0%	82.0%	80.0%	70.0%	71.0%	**62.0%**	**75.0%**	100%	86% - 99%	<=85%
EFFECTIVE									Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	1	0	0	0	0	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	5	1	1	1	0	0	**0**	**3**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.63	98.4	98.68	99.05				**99.05**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	88.6	91.32	91.56	92.39	91.88			**91.63**	<=100	101 - 109	>=111
RESPONSIVE									Green	Amber	Red
Emergency Care Standard 4 hours	87.48%	92.59%	95.24%	94.76%	93.72%	90.65%	**88.93%**	**92.49%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	51.21%	71.43%	71.93%	67.24%	54.41%	58.33%	**50.94%**	**64.96%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.59%	98.24%	99.02%	98.52%	98.92%	99.66%	**97.85%**	**98.70%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.66%	100.00%	100.00%	97.70%	95.87%	100.00%	**100.00%**	**98.68%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.64%	99.42%	97.37%	98.26%	97.83%	97.69%	**100.00%**	**98.54%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	98.96%	96.88%	96.00%	69.57%	86.84%	91.30%	**one to repo**	**88.65%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	97.87%	97.78%	100.00%	**100.00%**	**99.26%**	>=98%		<=97%
38 Day Referral to Tertiary	53.08%	76.00%	45.45%	40.00%	70.00%	60.00%	**58.82%**	**61.17%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.81%	93.61%	91.41%	85.59%	91.72%	91.16%	**93.81%**	**91.67%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	90.80%	72.22%	37.50%	0.00%	0.00%	33.33%	**0.00%**	**30.00%**	>=90%		<=89%
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	78.06%	70.98%	85.89%	73.94%	80.62%	84.34%	**83.31%**	**80.13%**	>=70%		<=74%
WORKFORCE									Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	3.93%	4.11%	4.22%	4.25%	4.25%	4.22%	*	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	2.50%	2.61%	2.69%	2.73%	2.74%	2.72%	*	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.43%	1.50%	1.52%	1.53%	1.51%	1.50%	*	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.81%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	97.63%							-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	84.10%							-	>=95%	>=90%	<90%
FINANCE									Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	9.76	(0.00)	0.00	0.00	0.00	0.00	**0.00**	**0.01**			

Safe - Key measures

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Performance Range		
Falls / Incidents and Harm Free Care																Green	Amber	Red
All Falls	1,815	134	164	165	163	169	154	161	93	117	141	155	132	**169**	**807**	Refer to SPC charts		
Inpatient Falls with Serious Harm	25	1	4	3	6	1	1	4	0	0	3	4	1	**3**	**11**	Refer to SPC charts		
Falls per 1000 bed days	7.7	6.9	7.3	8.3	7.7	8.0	7.9	9.4	8.6	9.8	10.5	10.5	8.5	**11.3**	**9.9**	Ongoing Monitoring		
Number of Serious Incidents	36	7	3	6	3	2	2	0	1	1	8	2	2	**4**	**18**	Refer to SPC charts		
Number of Incidents with Harm	2,236	166	215	176	153	180	166	145	128	146	174	198	149	**183**	**978**	Refer to SPC charts		
Percentage of Duty of Candour informed within 10 days of Incident	99%	100%	100%	100%	100%	100%	100%	91%	100%	100%	100%	93%	90%	**100%**	**94%**	100%	96 - 99%	<=95%
Never Events	1	0	0	0	1	0	0	0	0	1	1	0	0	**0**	**2**	0		>=1
Percentage of SIs investigations where reports submitted within timescale – 60 Days	50.00%	50.00%	none to report	0.00%	0.00%	none to report	0.00%	none to report	25.00%	0.00%	0.00%	0.00%	100.00%	**33.00%**	**15.00%**	Ongoing Monitoring		
% Emergency Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	75.00%	72.00%	72.00%	70.00%	74.00%	74.00%	72.00%	70.00%	78.00%	82.00%	88.00%	95.45%	82.14%	**in arrears**	**85.14%**	>=90%	86% - 89%	<=85%
% Inpatient Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	68.26%	76.00%	50.00%	64.29%	61.11%	71.43%	70.00%	68.75%	64.86%	60.00%	64.00%	86.36%	64.00%	**in arrears**	**65.76%**	>=90%	86% - 89%	<=85%
Maternity																		
Elective C-Section Rate	10.41%	9.29%	10.84%	8.29%	11.06%	8.96%	11.85%	11.89%	9.86%	9.30%	11.78%	13.03%	10.14%	**10.42%**	**10.80%**	<=10% Threshold		
Emergency C-Section Rate	15.77%	17.92%	17.59%	15.28%	14.75%	12.83%	14.88%	14.08%	14.25%	14.93%	15.18%	18.30%	14.52%	**15.14%**	**15.43%**	<=16% Threshold		
Total C-Section Rate	26.17%	27.21%	28.43%	23.58%	25.81%	21.79%	26.72%	25.97%	24.11%	24.23%	26.96%	31.33%	24.66%	**25.56%**	**26.22%**	<=27% Threshold		
% PPH ≥ 1500ml - all deliveries	3.06%	3.98%	3.13%	2.33%	1.61%	3.15%	2.75%	3.16%	3.01%	2.54%	4.19%	3.26%	4.11%	**2.98%**	**3.35%**	<= 3.0%	3.1% - 3.4%	>=3.5%
Antenatal Assessments < 13 weeks	92.13%	91.46%	93.71%	93.32%	91.55%	90.02%	91.79%	92.50%	92.93%	93.02%	92.84%	94.03%	94.74%	**90.62%**	**93.01%**	>90%	81% - 89%	<=80%
Maternal smoking at delivery	12.35%	11.30%	11.60%	14.50%	12.67%	9.69%	11.57%	13.11%	14.50%	11.80%	10.70%	9.00%	9.00%	**10.90%**	**10.97%**	<=12.9%		>=13%
Pressure Ulcers/VTE Assessments																		
Number of Trust Pressure Ulcers Acquired at CHFT	98	23	26	29	23	26	25	21	41	42	35	24	28	**under validation**	**170**	Refer to SPC charts		
Pressure Ulcers per 1000 bed days	1.38	1.18	1.15	1.46	1.09	1.23	1.28	1.22	3.80	3.52	2.61	1.63	1.81	**under validation**	**2.67**	Refer to SPC charts		
Number of Category 2 Pressure Ulcers Acquired at CHFT	291	22	26	26	20	23	23	20	19	25	23	11	12	**under validation**	**90**	Refer to SPC charts		
Number of Category 3 Pressure Ulcers Acquired at CHFT	33	1	0	3	3	3	1	1	2	2	0	1	1	**under validation**	**6**	Refer to SPC charts		
Number of Category 4 Pressure Ulcers Acquired at CHFT	0	0	0	0	0	0	1	0	0	0	0	0	0	**under validation**	**0**	0		>=1
Number of Deep Tissue Injuries	123	11	19	9	8	7	14	7	14	9	10	11	6	**under validation**	**50**	0		>=2
Number of Unstageable Pressure Ulcers	38	1	6	4	3	1	8	1	6	6	2	1	9	**under validation**	**24**	0		>=3
Number of patients with a Pressure ulcer	282	19	22	29	23	24	24	17	31	33	31	19	25	**under validation**	**139**	Refer to SPC charts		
% of leg ulcers healed within 12 weeks from diagnosis	92.07%	100.00%	100.00%	97.22%	100.00%	86.40%	80.00%	26.30%	40.00%	44.40%	12.50%	42.90%	50.00%	**38.50%**	**35.70%**	>=90%	86% - 89%	<=85%
Percentage of Completed VTE Risk Assessments	96.04%	95.72%	95.98%	96.60%	96.38%	95.97%	96.06%	95.46%	95.56%	96.05%	95.89%	96.26%	96.14%	**95.46%**	**95.90%**	>=95%	86% - 89%	<=85%
Safeguarding																		
Health & Safety Incidents	220	20	18	19	14	19	14	17	4	28	35	18	19	**17**	**121**	Ongoing Monitoring		
Health & Safety Incidents (RIDDOR)	4	0	0	1	0	1	0	0	2	2	1	0	1	**0**	**6**	0		>=1
Medical Reconciliation within 24 hours (excluding Children)	36.70%	36.80%	37.10%	37.60%	38.10%	38.80%	39.00%	39.60%	72.80%	57.60%	58.30%	61.20%	56.60%	**58.90%**	**60.40%**	>=68%		<=67%
Electronic Discharge																		
% Complete EDS	96.58%	97.36%	96.43%	96.99%	96.63%	95.15%	93.74%	93.58%	95.22%	94.96%	94.88%	93.86%	91.86%	**in arrears**	**94.08%**	>=95%	91% - 94%	<=90%

Caring - Key measures

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Performance Range		
Complaints																Green	Amber	Red
% Complaints closed within target timeframe	42.0%	47.0%	40.0%	41.0%	50.0%	51.0%	47.0%	64.0%	94.0%	82.0%	80.0%	70.0%	71.0%	**62.0%**	**75.0%**	100%	86% - 99%	<=85%
Total Complaints received in the month	494	49	53	40	32	43	31	27	10	14	29	17	30	**32**	**132**	no target		
Complaints re-opened	68	3	7	6	5	8	5	3	1	2	4	1	4	**3**	**15**	no target		
Inpatient Complaints per 1000 bed days	2.12	2.46	2.39	2.01	1.61	2.13	1.64	1.57	0.93	1.17	2.17	1.22	2.19	**2.13**	**1.63**	no target		
No of Complaints closed within Timeframe	222	24	29	20	24	19	18	13	15	18	16	16	5	**14**	**84**	Refer to SPC charts in Appendix		
Total Complaints Closed	545	51	73	55	53	36	40	21	16	22	20	23	7	**26**	**114**	no target		
Friends & Family Test																		
Friends & Family Test (IP Survey) - % would recommend the Service	96.88%	97.31%	97.63%	96.78%	97.06%	95.79%	96.44%	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=96.7%	93.8% - 96.6%	<=93.7%
Friends and Family Test Outpatients Survey - % would recommend the Service	91.98%	91.92%	91.70%	92.80%	92.68%	92.68%	92.08%	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=96.2%	93.4% - 96.1%	<=93.3%
Friends and Family Test A & E Survey - % would recommend the Service	84.54%	80.28%	85.86%	81.84%	85.78%	86.49%	86.25%	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=87.2%	82.8% - 87.1%	<=82.7%
Friends & Family Test (Maternity) - % would recommend the Service	99.20%	98.66%	99.60%	98.70%	98.73%	99.30%	99.50%	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=97.3%	94.3% - 97.2%	<=94.2%
Friends and Family Test Community Survey - % would recommend the Service	96.32%	97.07%	96.20%	94.66%	96.70%	97.46%	93.91%	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=96.7%	94.4% - 96.6%	<=94.3%
Caring																		
Number of Mixed Sex Accommodation Breaches	3	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=1
% Dementia patients screened following emergency admission aged 75 and over	46.23%	45.83%	46.50%	35.45%	39.50%	40.72%	42.89%	40.74%	35.28%	40.15%	40.09%	40.37%	42.49%	**34.23%**	**38.77%**	>=90%	88% - 89%	<=87%

Effectiveness - Key measures

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Performance Range		
																Green	Amber	Red
Infection Control																		
Number of MRSA Bacteraemias – Trust assigned	1	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Total Number of Clostridium Difficile Cases - Trust assigned	26	2	1	2	0	2	3	5	1	2	4	7	4	**2**	**20**	No target		
Preventable number of Clostridium Difficile Cases	5	0	0	0	0	1	0	0	1	1	1	0	0	**0**	**3**	<=4 & YTD <=40		
Number of MSSA Bacteraemias - Post 48 Hours	19	1	1	2	2	4	1	0	0	2	3	2	1	**2**	**10**	No target		
Number of E.coli - Post 48 Hours	29	4	2	0	1	3	1	5	2	5	4	2	1	**2**	**16**	No target		
MRSA Elective Screening – Percentage of Inpatients Matched	96.22%	96.00%	95.00%	96.70%	94.20%	95.20%	94.90%	95.80%	87.00%	69.00%	73.00%	68.40%	61.40%	**75.00%**	**72.60%**	>=95%	94% - 93%	<=92%
Mortality																		
Stillbirths Rate (including intrapartum & Other)	0.16%	0.00%	0.24%	0.00%	0.45%	**0.00%**	0.00%	0.24%	0.27%	0.00%	0.26%	0.50%	0.27%	**0.25%**	**0.26%**	<=0.47%		>=0.48%
Perinatal Deaths (0-7 days)	0.10%	0.00%	0.24%	0.00%	0.00%	0.24%	0.27%	0.00%	0.00%	0.00%	0.00%	0.25%	0.00%	**0.00%**	**0.04%**	<=0.1%		>=0.11%
Neonatal Deaths (8-28 days)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**	<=0.1%		>=0.11%
Local SHMI - Relative Risk (1 Yr Rolling Data)	99.94	96.97	97.35	97.42	98.99	98.89	98.84	99.94	98.4	98.68	99.05	Due Oct 20			**99.05**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	89.64	88.6	88.57	88.86	91.43	90.35	89.34	89.64	91.32	91.56	92.39	91.88	Due Oct 20		**91.63**	<=100	101 - 109	>=111
Crude Mortality Rate	1.25%	0.96%	1.22%	1.27%	1.73%	1.21%	1.14%	1.62%	4.66%	2.30%	1.69%	1.37%	1.87%	**1.50%**	**2.11%**	No target		
Coding and submissions to SUS																		
% Sign and Symptom as a Primary Diagnosis	8.11%	7.90%	8.10%	8.09%	7.39%	8.22%	8.05%	7.10%	5.34%	7.84%	7.82%	8.18%	8.16%	**7.84%**	**7.60%**	<=8.3%	8.4% - 9.4%	>=9.5%
Average co-morbidity score	5.52	5.08	5.41	5.10	5.58	5.55	5.65	6.38	7.00	6.66	6.62	6.44	6.90	**6.12**	**6.60**	>=5.08 / >=5.30 from April 20		<=4.7
Average Diagnosis per Coded Episode	6.06	5.69	6.05	5.91	6.11	6.03	6.24	6.64	7.86	7.97	7.74	7.61	7.92	**7.48**	**7.75**	>=6.14 / >=6.48 from April 20		<=5.8
Recruitment to Time and Target (Research)	83.33%	88.00%	86.30%	87.70%	82.10%	82.30%	83.50%	82.90%	83.34%	83.10%	73.68%	77.78%	79.98%	**80.49%**	**79.72%**	>=80%	76% - 79%	<=75%
Best Practice Guidance																		
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	75.96%	75.86%	77.55%	91.89%	72.41%	77.36%	67.57%	77.08%	56.10%	56.67%	66.67%	42.86%	51.06%	**74.36%**	**57.21%**	>=85%	84% - 83%	<=82%
IPMR - Breastfeeding Initiated rates	76.39%	76.30%	77.80%	76.20%	74.30%	75.50%	78.00%	76.40%	78.57%	77.70%	81.10%	76.30%	75.30%	**72.90%**	**76.92%**	>=70%	66% - 69%	<=65%
Readmissions																		
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Trust (excluding ambulatory)	8.80%	7.60%	9.09%	8.66%	9.56%	8.82%	8.81%	10.41%	14.62%	11.48%	11.41%	10.89%	11.65%	**10.03%**	**11.68%**	<=7.96% as per Model Hospital		>=8.99%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG (excluding ambulatory)	9.70%	8.79%	9.83%	9.42%	10.93%	9.15%	10.16%	11.85%	14.71%	11.47%	10.40%	11.18%	12.02%	**10.58%**	**11.73%**	<=7.96% as per Model Hospital		>=8.99%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG (excluding ambulatory)	9.62%	7.82%	9.94%	9.45%	10.15%	10.26%	9.19%	10.39%	15.06%	12.67%	13.13%	10.97%	12.33%	**10.02%**	**12.36%**	<=7.96% as per Model Hospital		>=8.99%
Community																		
% Readmitted back in to Hospital within 30 days for Intermediate Care Beds	5.78%	5.60%	10.00%	9.70%	7.00%	6.80%	5.10%	8.10%	17.50%	7.70%	2.00%	7.40%	6.30%	**2.00%**	**7.20%**	No target		
Hospital admissions avoided by Community Nursing Services	2,995	252	291	315	283	320	259	277	350	267	228	264	241	**240**	**1,590**	>=186		

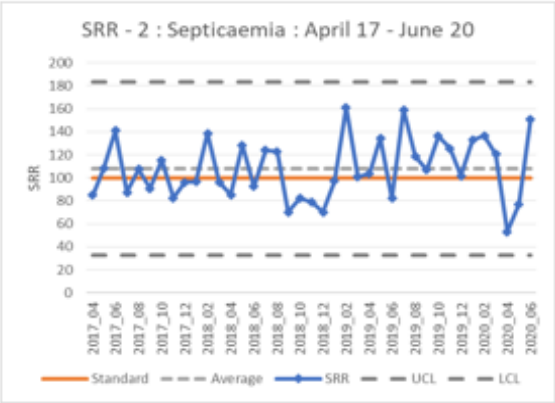
Summary for Integrated Performance Report

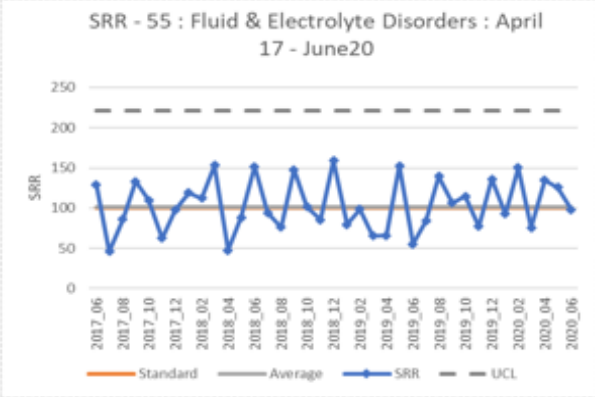
Outcome Indicators

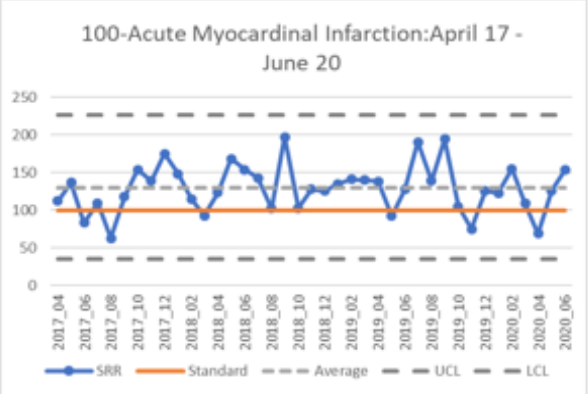
Approach taken - worked with our Benchmarking software providers Healthcare Evaluation Data (HED) to understand if they provided facility to monitor these areas as per Insight Report
Insight Report focuses on 10 Clinical Classification System (CCS) Diagnostis Groups - there are in total over 250, need to consider deep dive into all that are areas of potential concern.
HED advised that they do provide a facility within the Clinical Quality Module of their tool but it uses a marginally different methodology. The table below is used to illustrate how close the HED assessment is when balancing to the figures provided in the Insight report.
The latest 12 month figure from HED (March 19 to Feb 20) is also provided as is a graph for all 10 areas showing the trend over time going back to April 2017
In addition the number of additional readmissions than expected is provided as an attempt to illustrate the scale of any issue
All figures quoted in table are the relative risk score unless stated. A value greater than 100 means that the patient group being studied has a higher readmission level than NHS average performance

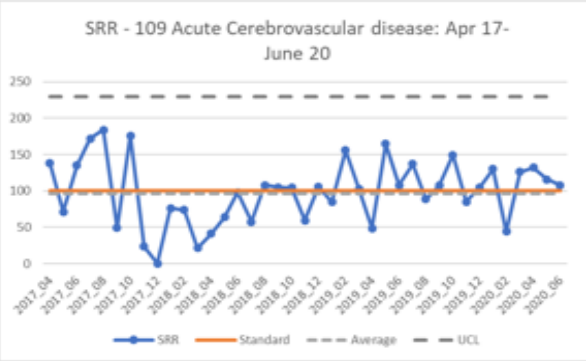
Insight Report Emergency Readmissions

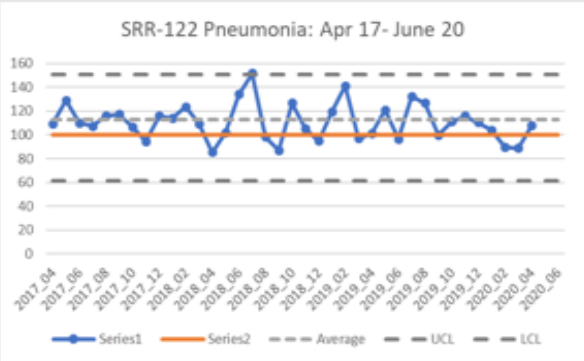
	Oct 17 - Sep 18		Oct 18 - Sep 19		Mar 19 - Jun 20			
CCS No & Diagnostic Group	Insight	HED	Insight	HED	HED	95% Confidence Interval	No of Discharges	No of Additional Readmissions
2 - Septicemia (except in labor)	101.5	102.2	112.7	107.2	119.3	(101.30, 139.50)	587	25.4
55 - Fluid and electrolyte disorders	110	105.8	106.9	97.1	103.6	(88.90, 120.10)	645	6.2
100 - Acute myocardial infarction	137.8	139.2	134.8	138.1	128.4	(109.30, 150.00)	798	35.4
109 - Acute cerebrovascular disease	114.4	72.4	131.1	105	111.7	(92.40, 133.70)	822	12.3
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)	117.6	105.8	114	107.7	106.9	(98.80, 115.50)	2830	41.6
125 - Acute bronchitis	113.1	98.6	112.2	99	98.6	(88.20, 109.80)	1956	-4.9
127 - Chronic obstructive pulmonary disease and bronchiectasis	117.9	119.7	106.9	111.8	107.8	(97.60, 118.80)	1361	29.8
157 - Acute and unspecified renal failure	122.5	121.9	108.3	108	107.5	(92.10, 124.80)	640	12.1
159 - Urinary tract infections	117.9	109.2	120.8	111.9	110.6	(101.40, 120.50)	2211	50.5
226 - Fracture of neck of femur (hip)	94	87.2	79.7	84.3	86.5	(68.10, 108.20)	568	-11.9

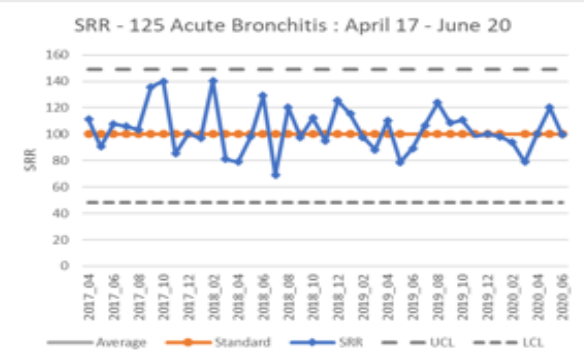


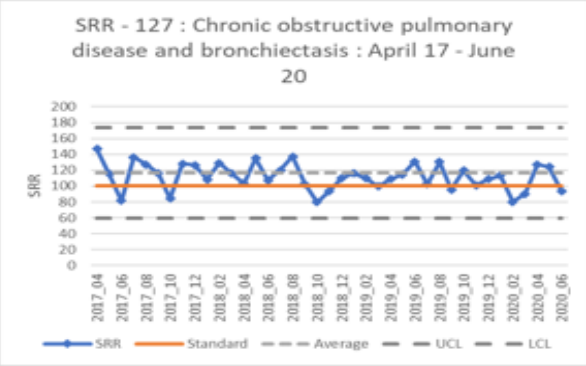


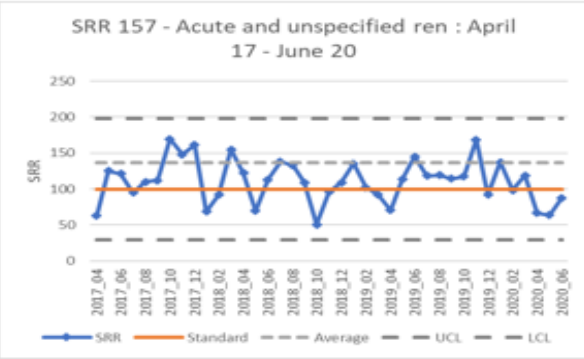


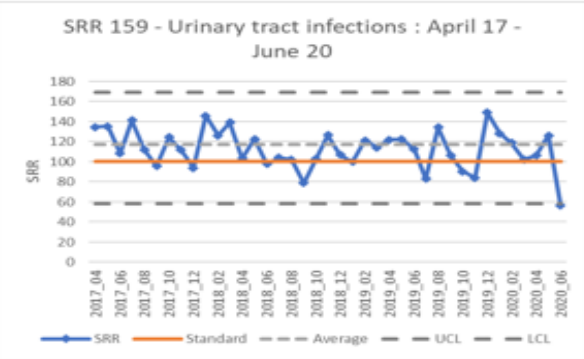

SRR - 109 Acute Cerebrovascular disease: Apr 17- June 20
SRR
Standard
Average
UCL

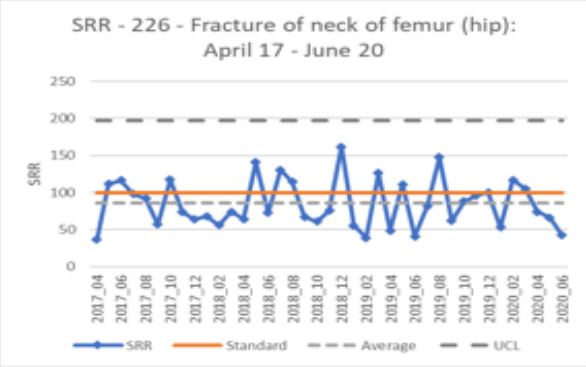

SRR-122 Pneumonia: Apr 17- June 20
Series1
Series2
Average
UCL
LCL


SRR - 125 Acute Bronchitis : April 17 - June 20
SRR
Average
Standard
SRR
UCL
LCL

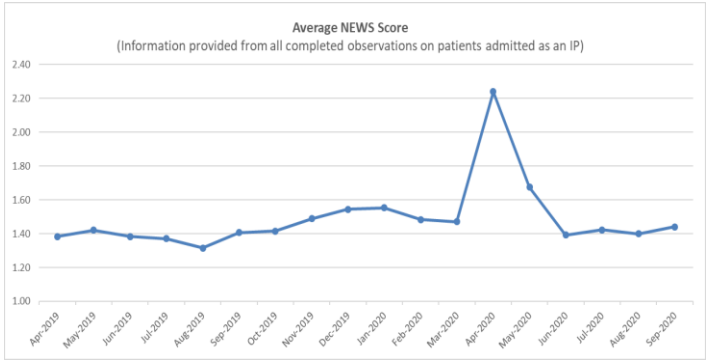

SRR - 127 : Chronic obstructive pulmonary disease and bronchiectasis : April 17 - June 20
SRR
SRR
Standard
Average
UCL
LCL

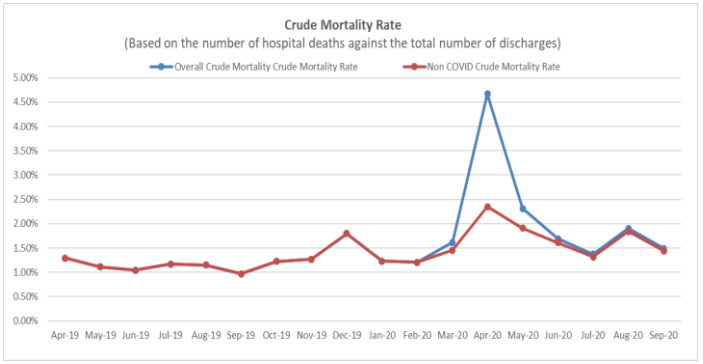

SRR 157 - Acute and unspecified ren : April 17 - June 20
SRR
SRR
Standard
Average
UCL
LCL

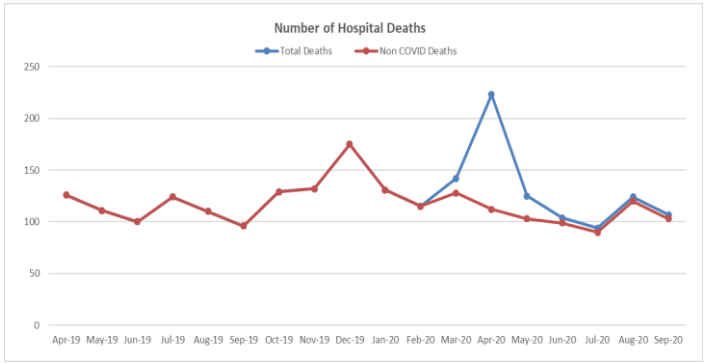

SRR 159 - Urinary tract infections : April 17 - June 20
SRR
SRR
Standard
Average
UCL
LCL

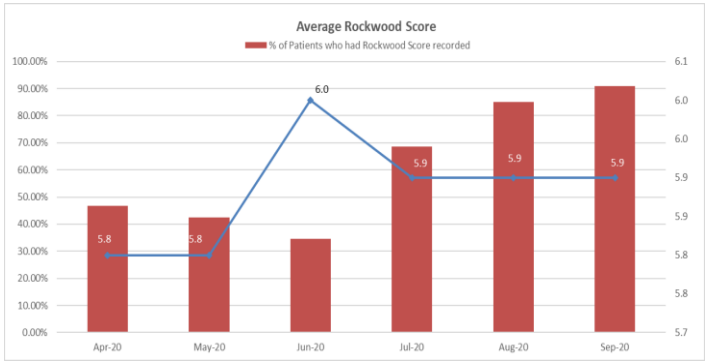

SRR - 226 - Fracture of neck of femur (hip): April 17 - June 20
SRR
SRR
Standard
Average
UCL

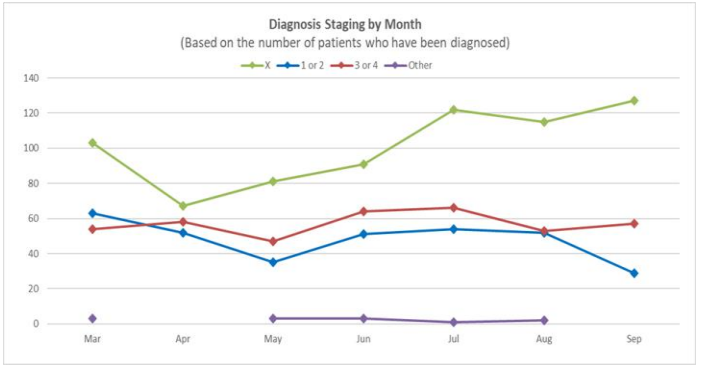
Outcome Measures

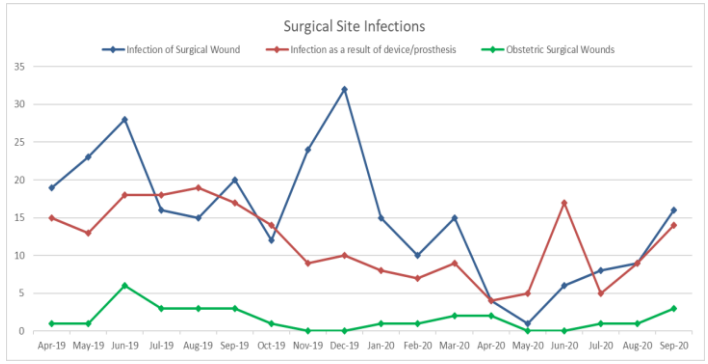












Responsive - Key measures

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Performance Range		
																Green	Amber	Red
Accident & Emergency																		
Emergency Care Standard 4 hours	87.48%	86.82%	84.19%	82.68%	81.97%	85.88%	85.55%	87.96%	92.59%	95.24%	94.76%	93.72%	90.65%	**88.93%**	**92.49%**	>=95%		<95%
Emergency Care Standard 4 hours inc Type 2 & Type 3	89.08%	88.44%	86.23%	85.06%	84.42%	87.70%	87.41%	89.26%	93.12%	95.52%	95.11%	94.10%	91.13%	**90.04%**	**93.01%**	>=95%		<95%
A&E Ambulance Handovers 15-30 mins (Validated)	9,469	821	859	840	941	802	632	641	255	254	253	395	411	**406**	**1,974**	0		>=1
A&E Ambulance Handovers 30-60 mins (Validated)	369	20	35	48	41	32	40	14	3	0	1	3	8	**7**	**22**	0		>=1
A&E Ambulance 60+ mins	20	3	4	0	2	1	5	0	0	0	0	0	3	**2**	**5**	0		>=1
A&E Trolley Waits (From decision to admission)	9	0	0	9	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=1
Patient Flow																		
Delayed Transfers of Care	3.30%	3.63%	4.06%	3.17%	3.93%	3.33%	3.65%	3.94%	0.15%	0.21%	0.17%	0.22%	0.47%	**0.21%**	**0.24%**	<=3.5%	3.6% - 4.9%	>=5%
Coronary Care Delayed Discharges	591		43	54	53	57	51	33	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**		No target	
Green Cross Patients (Snapshot at month end)	25	105	88	90	90	104	106	25	17	48	49	52	47	**51**	**51**	<=40	41 - 45	>=45
Advice & Guidance responded within 48 hours	82.03%	78.89%	77.52%	82.09%	79.53%	76.96%	83.90%	83.50%	79.00%	84.30%	81.40%	78.90%	77.40%	**82.30%**	**80.40%**	>=80%	71% - 79%	<=70%
Stroke																		
% Stroke patients spending 90% of their stay on a stroke unit	73.62%	77.50%	58.93%	67.24%	63.50%	83.02%	79.49%	86.76%	92.86%	91.23%	74.14%	81.16%	82.98%	**83.33%**	**83.79%**	>=90%	89% - 86%	<=85%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	51.21%	62.50%	41.82%	47.37%	40.40%	49.06%	58.97%	55.88%	71.43%	71.93%	67.24%	54.41%	58.33%	**50.94%**	**64.96%**	>=90%		<=85%
% Stroke patients Thrombolysed within 1 hour	77.78%	80.00%	81.82%	63.64%	85.70%	100.00%	25.00%	75.00%	62.50%	53.85%	83.33%	90.00%	85.71%	**75.00%**	**74.07%**	>=55%		<=50%
% Stroke patients scanned within 1 hour of hospital arrival	53.99%	59.52%	55.17%	50.79%	53.80%	50.94%	48.72%	45.71%	48.84%	50.88%	57.63%	40.85%	48.98%	**44.23%**	**48.34%**	>=48%		<=45%
Cancellations																		
% Last Minute Cancellations to Elective Surgery	0.92%	0.76%	1.31%	1.07%	0.92%	1.06%	0.79%	0.81%	0.32%	0.30%	0.00%	0.13%	0.36%	**0.38%**	**0.25%**	<=0.6%		>=0.8%
Breach of Patient Charter (Sitreps booked within 28 days of cancellation)	0	0	0	0	0	0	0	0	17	0	0	0	0	**0**	**17**	0		>=2
No of Urgent Operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=2
18 week Pathways (RTT)																		
18 weeks Pathways >=26 weeks open	1,396	1,447	1,489	1,472	1,680	1,730	1,305	1,396	2,306	3,542	4,531	6,264	8,133	**8,446**	**8,446**	0		>=1
RTT Waits over 52 weeks Threshold > zero	5	0	0	3	8	7	6	5	28	76	176	331	509	**777**	**777**	0		>=1
% Diagnostic Waiting List Within 6 Weeks	95.04%	91.18%	97.11%	98.80%	98.32%	98.62%	99.70%	95.04%	40.24%	34.60%	46.98%	51.96%	46.14%	**50.73%**	**50.73%**	>=99%		<=98%
Cancer																		
Two Week Wait From Referral to Date First Seen	98.59%	99.09%	99.15%	99.40%	99.20%	99.07%	99.59%	99.20%	98.24%	99.02%	98.52%	98.92%	99.66%	**97.85%**	**98.70%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.66%	99.27%	96.77%	97.92%	98.38%	99.41%	98.66%	99.24%	100.00%	100.00%	97.70%	95.87%	100.00%	**100.00%**	**98.68%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.64%	100.00%	98.51%	100.00%	100.00%	99.45%	100.00%	99.30%	99.42%	97.37%	98.26%	97.83%	97.69%	**100.00%**	**98.54%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	98.96%	96.00%	100.00%	100.00%	100.00%	100.00%	100.00%	92.86%	96.88%	96.00%	69.57%	86.84%	91.30%	**none to report**	**88.65%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	97.87%	97.78%	100.00%	**100.00%**	**99.26%**	>=98%		<=97%
38 Day Referral to Tertiary	53.08%	40.91%	59.09%	57.14%	54.17%	57.69%	63.16%	61.11%	76.00%	45.45%	40.00%	70.00%	60.00%	**58.82%**	**61.17%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.81%	91.76%	87.56%	91.85%	91.49%	87.08%	96.15%	91.44%	93.61%	91.41%	85.59%	91.72%	91.16%	**93.81%**	**91.67%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	90.80%	88.89%	77.50%	100.00%	92.86%	95.45%	80.00%	90.48%	72.22%	37.50%	0.00%	0.00%	33.33%	**0.00%**	**30.00%**	>=90%		<=89%
104 Referral to Treatment - Number of breaches - Patients Treated	29.0	0.5	4.5	3.5	3.5	3.5	1.5	2.5	0.0	2.0	3.0	1.5	0.5	**2.5**	**9.5**	0		>=1
104 Referral to Treatment - Number of breaches - Patients Still waiting	7	6	7	7	8	7	5	7	4	6	11	11	9	**10**	**51**	0		>=1
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	78.06%	82.34%	79.72%	71.34%	71.98%	71.54%	79.41%	79.81%	70.98%	85.89%	73.94%	80.62%	84.34%	**83.31%**	**80.13%**	>=70%		<=74%
Elective Access																		
Appointment Slot Issues on Choose & Book	28.15%	25.18%	22.97%	31.20%	23.50%	18.26%	25.39%	20.40%	130.03%	112.99%	105.12%	85.56%	in arrears	**in arrears**	**108.43%**	<=20%		>=21%
ASI (Appointment Slot Issues) > 22 Weeks	354	169	240	131	95	112	183	354	800	999	1585	2,244	2,012	**1,234**	**5,490**	0		>=1
Total Holding List	10,663	9,282	8,887	8,291	9,600	8,406	8,661	10,663	14,562	17,946	19,911	21,651	21,591	**20,286**	**20,286**		No target	
Holding List > 12 Weeks	1,832	1,115	1,326	1,244	1,501	1,090	1,513	1,832	3,081	4,314	5,497	6,757	9,195	**7,192**	**7,192**	0		>=1

Workforce - Key Metrics

	18/19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Target	Threshold/Monthly
Staff in Post																	
Staff in Post Headcount		5690	5712	5717	5694	5733	5733	5721	5858	5869	5876	5870	5724	5738	-	-	
Staff in Post (FTE)		4988.09	5010.90	5037.98	5015.81	5050.59	5044.89	5049.46	5168.35	5173.65	5184.72	5195.15	5064.84	5096.10	-	-	
Vacancies																	
Establishment (Position FTE)**		5221.81	5228.41	5248.77	5249.17	5248.92	5250.42	5219.02	5314.42	5312.37	5323.61	5373.84	5376.13	5381.86	-	-	
Vacancies (FTE)**		233.72	217.51	210.79	233.36	198.33	205.53	169.56	146.07	138.72	138.89	178.69	311.29	285.76	-	-	
Vacancy Rate (%)**		4.48%	4.16%	4.02%	4.45%	3.78%	3.91%	3.25%	2.75%	2.61%	2.61%	3.33%	5.79%	5.31%	-	-	
Staff Movements																	
Turnover rate (%) - in month		0.50%	0.54%	0.42%	0.59%	0.60%	0.41%	0.73%	0.48%	0.57%	0.40%	0.56%	0.74%	0.77%	-	-	
Executive Turnover (%)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-	-	
Turnover rate (%) - Rolling 12m		7.97%	7.87%	7.55%	7.43%	7.36%	7.35%	7.26%	7.09%	7.20%	6.86%	6.84%	6.98%	7.27%	-	**11.50%**	<=11.5% Green <=12.5 >11.5% >12.5% Red
Retention/Stability Rate (%) - rolling 12m		89.79%	89.91%	90.29%	90.11%	89.63%	89.55%	89.49%	90.38%	90.29%	90.53%	90.84%	90.70%	90.39%	-	-	
Sickness Absence - Rolling 12 month																	
Sickness Absence rate (%) - rolling		3.66%	3.71%	3.74%	3.84%	3.86%	3.86%	3.93%	4.11%	4.22%	4.25%	4.25%	4.22%	*	-	**4.00%**	=< 4.0% - Green 4.01% -4.5% Amber >4.5% Red
Long Term Sickness Absence rate (%) - rolling		2.39%	2.41%	2.42%	2.47%	2.48%	2.49%	2.50%	2.61%	2.69%	2.73%	2.74%	2.72%	*	-	**2.50%**	=< 2.5% Green 2.5% -2.75% Amber >2.75% Red
Short Term Sickness Absence rate (%) - rolling		1.27%	1.30%	1.33%	1.37%	1.37%	1.37%	1.43%	1.50%	1.52%	1.53%	1.51%	1.50%	*	-	**1.50%**	=< 1.5% - Green 1.5% -1.75% Amber >1.75% Red
Attendance rate (%) - rolling		96.34%	96.29%	96.26%	96.16%	96.14%	96.14%	96.07%	95.89%	95.78%	95.75%	95.75%	95.78%	*		**96.00%**	
Sickness Absence - Monthly																	
Sickness Absence rate (%) - in month		3.86%	3.95%	4.07%	4.34%	4.25%	3.89%	4.63%	5.47%	4.52%	3.75%	3.61%	3.67%	*	-	-	
Long Term Sickness Absence rate (%) - in month		2.75%	2.54%	2.51%	2.69%	2.58%	2.52%	2.72%	3.35%	3.19%	2.67%	2.55%	2.65%	*	-	-	
Short Term Sickness Absence rate (%) - in month		1.11%	1.41%	1.56%	1.65%	1.67%	1.37%	1.91%	2.12%	1.33%	1.08%	1.06%	1.02%	*	-	-	
Attendance rate (%) - in-month		96.14%	96.05%	95.93%	95.66%	95.75%	96.11%	95.37%	94.53%	95.48%	96.25%	96.39%	96.33%	*		**96.00%**	
Attendance Management																	
Sickness Absence FTE Days Lost -in month		5935.10	6245.80	6233.03	6728.98	6628.90	5687.70	7238.10	8363.71	7244.23	5818.30	5801.84	5839.32	*	-	-	
Average days lost (FTE) per FTE - Rolling 12 month		13.37	13.54	13.66	14.02	14.09	14.09	14.34	14.80	15.19	15.30	15.33	15.30	*	-	-	
Sickness Absence Estimated Cost (£) - month		£0.52M	£0.57M	£0.57M	£0.62M	£0.60M	£0.52M	£0.67M	£0.79M	£0.65M	£0.52M	£0.52M	£0.52M	*	-	-	
Return to work Interviews (%)		72.36%	85.22%	78.11%	76.43%	71.27%	69.43%	58.15%	51.54%	56.86%	60.32%	63.12%	65.03%	*	-	**90.00%**	90% Green 65%-89% Amber <65% Red
Spend																	
Substantive Spend (£)		£19.50M	£19.69M	£19.76M	£19.64M	£20.05M	£19.95M	£20.15M	£21.07M	£20.89M	£21.34M	£20.25M	£21.38M	£20.92M	-	-	
Bank Spend (£)		£1.44M	£1.34M	£1.46M	£1.55M	£1.40M	£1.71M	£1.93M	£1.68M	£1.52M	£1.64M	£1.79M	£1.64M	£2.14M	-	-	
Agency Spend (£)		£0.54M	£0.62M	£0.58M	£0.38M	£0.45M	£0.46M	£0.47M	£0.37M	£0.21M	£0.23M	£0.32M	£0.43M	£0.40M	-	-	
Proportion of Temporary (Agency) Staff		2.50%	2.85%	2.67%	1.74%	2.06%	2.08%	2.07%	1.59%	0.94%	1.00%	1.42%	1.82%	1.69%	-	-	
Essential Safety (12m rolling)																	
Overall Essential Safety Compliance		95.22%	95.30%	95.32%	95.13%	94.79%	94.88%	94.81%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Conflict Resolution (3 Year Refresher)		95.68%	96.17%	96.55%	96.39%	95.96%	96.26%	96.27%	94.73%	95.94%	96.04%	96.04%	96.10%	96.41%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Data Security Awareness (1 Year Refresher)		93.25%	92.24%	92.51%	92.95%	93.94%	94.14%	94.32%	92.73%	90.76%	90.36%	90.36%	90.77%	92.13%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Dementia Awareness (No Renewal)		99.38%	99.35%	99.31%	99.14%	99.13%	99.39%	99.34%	97.49%	97.73%	97.72%	97.16%	97.48%	97.25%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Equality and Diversity (3 Year Refresher)		96.99%	97.60%	97.94%	97.68%	97.10%	97.26%	97.54%	96.07%	96.93%	97.16%	91.04%	97.21%	97.58%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Fire Safety (1 Year Refresher)		95.77%	95.21%	95.03%	94.60%	94.31%	94.77%	93.42%	90.40%	90.27%	91.04%	97.07%	90.29%	92.86%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Health and Safety (3 Year Refresher)		98.56%	98.64%	98.46%	98.34%	98.21%	97.95%	97.98%	96.28%	96.96%	97.07%	92.09%	97.32%	97.78%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Infection Control (1 Year Refresher)		94.63%	94.19%	93.97%	93.51%	94.04%	93.99%	94.86%	92.89%	92.84%	92.09%	90.36%	91.86%	93.17%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Manual Handling (2 Year Refresher)		93.10%	93.87%	93.70%	93.01%	90.90%	89.77%	89.81%	89.30%	91.57%	91.67%	91.67%	92.57%	94.29%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Safeguarding (3 Year Refresher)		89.98%	90.29%	89.97%	90.32%	89.62%	89.96%	89.55%	91.03%	91.62%	92.48%	94.43%	93.64%	93.64%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Appraisal																	
Appraisal (1 Year Refresher) - Non-Medical Staff		96.11%	95.21%	94.65%	93.65%	92.75%	91.62%	90.12%	6.20%	20.85%	33.49%	47.31%	56.27%	68.29%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)		86.71%	83.81%	88.42%	83.23%	82.21%	78.61%	84.10%	80.76%	76.37%	72.83%	67.25%	63.07%	58.38%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red

*	Data one month behind
**	Vacancy information is updated monthly and is based on the funded establishment in ESR, this is fed by the establishment information stored in the Trust's financial systems.
-	Sickness absence data does not include self / household / shielding isolation due to COVID-19.
-	Data is based on substantive ESR primary assignment information which may not be refelctive of temporary COVID-19 redeployments
-	Staff in Post data, and therefore vacancy data, includes year 2 and 3 student nurses, recruited on a temporary basis to support the Trust during the COVID-19 crisis.
-	Due to the postponement of the Appraisal season, the monthly Metric is lower than would normally be expected

Workforce - Key Metrics

WORKFORCE	Current Month Score	Previous Month	Trend	Change	NHSi Submitted Position
Staff In Post (Headcount)	**5738**	5724	↑	14	-
Staff In Post (FTE)	**5096.1**	5064.8	↑	31.26	-
Establishment (FTE)	**5381.9**	5376.1	↑	5.73	-
Starters	**50.67**	30.73	↑	19.94	-
Leavers	**39.19**	20.89	↓	18.30	-
Vacancies (FTE)	**285.76**	311.29	↑	-25.53	-
Vacancies (%)	**5.31%**	5.79%	↑	-0.48%	-
Turnover Rate (rolling 12 month) (%)	**7.27%**	6.98%	↓	0.28%	*11.5%

ATTENDANCE MANAGEMENT	Current Month Score	Previous Month	Trend	Change	Target
Sickness Absence Rate (rolling) (%)	**4.22%**	4.25%	↑	-0.03%	4.0%
Long Term Sickness Absence Rate (rolling) (%)	**2.72%**	2.74%	↑	-0.02%	2.5%
Short Term Sickness Absence Rate (rolling) (%)	**1.50%**	1.51%	↑	-0.01%	1.5%
Sickness Absence Rate (month) (%)	**3.67%**	3.61%	↓	0.06%	4.0%
Long Term Sickness Absence Rate (month) (%)	**2.65%**	2.55%	↓	0.10%	2.5%
Short Term Sickness Absence Rate (month) (%)	**1.02%**	1.06%	↑	-0.04%	1.5%
Return to work interviews completed (%)	**65.0%**	63.1%	↑	1.91%	90.0%

APPRAISAL	Current Month Score	Previous Month	Trend	Change	Target
Appraisal (YTD)	**68.29%**	56.27%	↑	12.02%	-
Medical Appraisal (YTD)	**58.38%**	63.07%	↓	-4.69%	-

ESSENTIAL SAFETY TRAINING	Current Month Score	Previous Month	Trend	Change	Target
Data Security Awareness (1 Year Refresher)	**92.13%**	90.77%	↑	1.36%	90.00%
Infection Control (1 Year Refresher)	**93.17%**	91.86%	↑	1.31%	90.00%
Fire Safety (1 Year Refresher)	**92.86%**	90.29%	↑	2.57%	90.00%
Manual Handling (2 Year Refresher)	**94.29%**	92.57%	↑	1.72%	90.00%
Safeguarding (3 Year Refresher)	**93.64%**	93.64%	↔	0.00%	90.00%
Conflict Resolution (3 Year Refresher)	**96.41%**	96.10%	↑	0.31%	90.00%
Equality & Diversity (3 Year Refresher)	**97.58%**	97.21%	↑	0.38%	90.00%
Health, Safety & Wellbeing (3 Year Refresher)	**97.78%**	97.32%	↑	0.47%	90.00%
Dementia Awareness (No Renewal)	**97.25%**	97.48%	↓	-0.23%	90.00%

Key

↔	No movement from previous month	*	Internal target rather than NHSi Submitted Position
↑	Improvement from previous month		Not achieving target
↓	Deterioration from previous month		Achieving target

* The recruitment data has been realigned to take into account the National Streamlining agenda and targets set locally. Data shows agenda for change (AFC) recruitment and Medical and Dental (M&D) only and excludes recruitment activity relating to deanery doctors, retirement, volunteers and rolling adverts.

	AfC		Medical		All				
RECRUITMENT	Current Month Avg Days	Previous Month	Current Month Avg Days	Previous Month	Current Month Avg Days	Previous Month	Trend	Change	Target (Days)
Vacancy approval to advert placement	4.7	8.9	4.0	9.5	**4.7**	8.9	↑	-4.2	8
Shortlisting to interview	3.7	4.9	7.0	11.3	**3.9**	5.2	↑	-1.3	12
Interview to conditional offer	2.1	1.4	0.1	0.9	**1.8**	1.4	↓	0.4	6
Pre employment to unconditional offer	31.3	18.3	93	52.5	**33.2**	20.9	↓	12.3	18
Unconditional Offer to Acceptance	5.9	10.7	83	0.0	**15.5**	10.7	↓	4.8	3

Vacancy approval to advert placement-The average number of days between a vacancybeing submitted for approved and the advert being placed.

Shortlisting to interview- The average number of days between date vacancy closed and date invited to interview

Interview to conditional offer- The average number of days between the interview date and the date of informing of a decision.

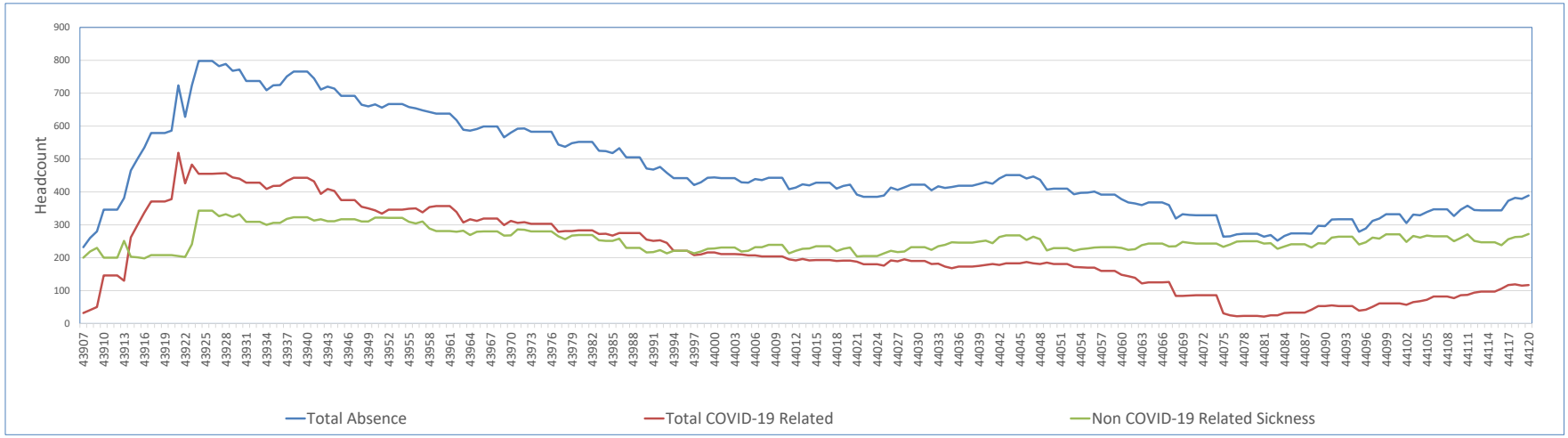
Pre employment to unconditional offer -The average number of days between the date Conditional Offer letter sent & the date Unconditional Offer letter sent

Unconditional Offer to Acceptance - The average number of days for Unconditional Offer to Acceptance

PAY	Current Month Spend	Previous Month	Trend	Change	Target (Budget)
Substantive Expenditure	**£20.92M**	£21.38M	↑	-£0.45M	£19.92M
Agency Expenditure	**£0.40M**	£0.43M	↑	-£0.03M	£0.81M
Bank Expenditure	**£2.14M**	£1.64M	↑	£0.50M	£1.05M

COVID-19 - Key Metrics

ABSENCE



The data above is taken from the Trust daily situation report. 17-18 March represents ESR absence data only. 19 March to 1 April 20 represents combined ESR absence data and Occupational Health call log data. 2 April 20 includes Roster isolation information. 3 April 20 onwards represents the full absence picture, combining ESR absence data, Roster absence data, and isolations recorded via the Occupational Health call log.

Workforce Absence @ 16 October 2020

	Headcount	% of workforce
Absence - COVID-19 Related	117	1.9%
Absence - Sickness (Non COVID-19 Related)	272	4.4%
Total Absence	389	6.3%

Testing

Location	Number Tested
CHFT	1839
Locala	6
Home	57
External	37
Total	1939

Results *		
Negative	1648	86.8%
Positive	247	13%
Awaiting	4	0.2%

* Excludes inconclusive tests

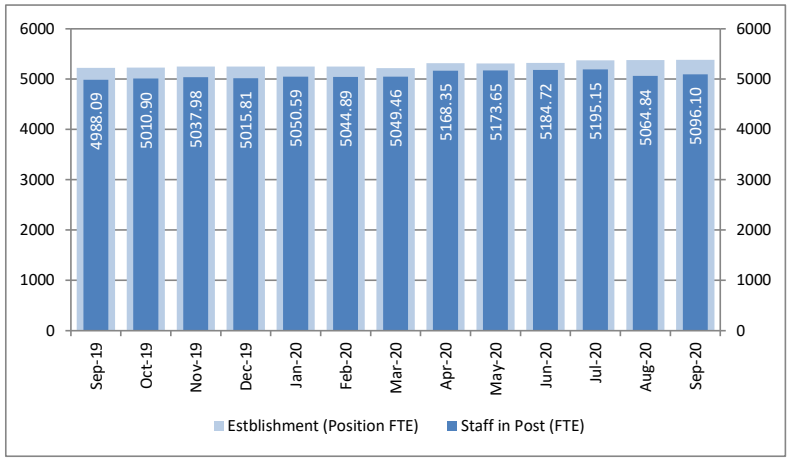
Self Isolation (Staff Presenting Symptoms) Testing

	Number Tested	Negative	Positive	Awaiting
BAME (incl mixed and other)	229	80%	20%	0%
White	819	86%	13%	0%
Not Stated	62	90%	10%	0%

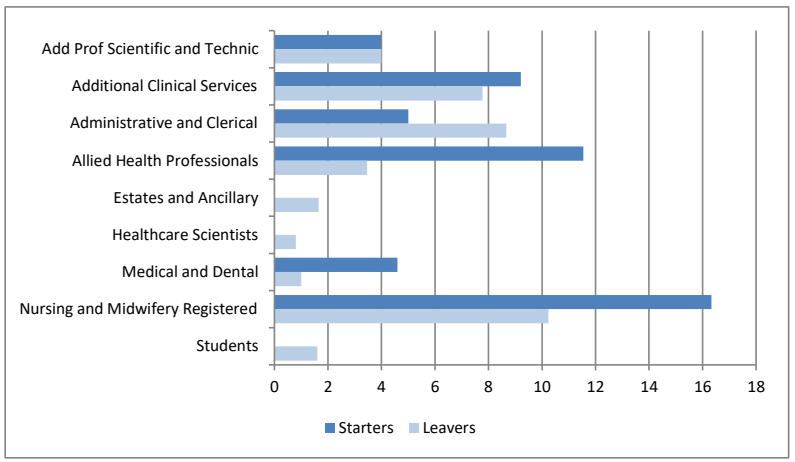
Covid Related Key Metrics

Reality

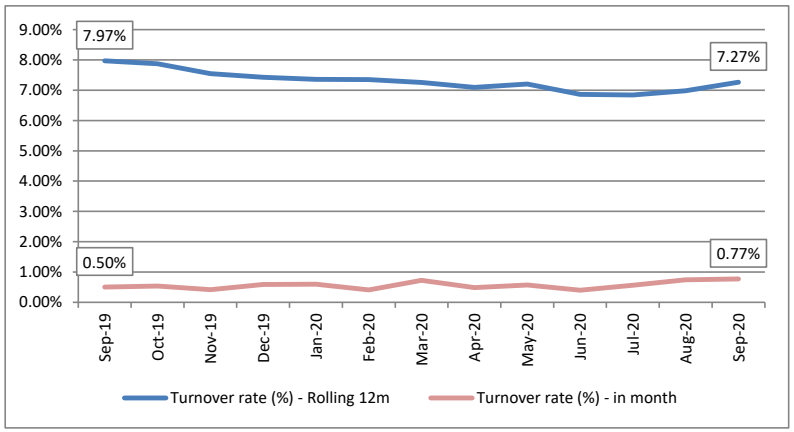
Staff in Post (FTE) v Establishment (FTE)



Starters & Leavers (FTE) by Staff Group - September 2020



Turnover



Turnover by Staff Group

Staff Group	In-Month	Rolling
Add Prof Scientific and Technic	1.91%	9.35%
Additional Clinical Services	0.70%	7.03%
Administrative and Clerical	0.87%	6.53%
Allied Health Professionals	0.87%	11.69%
Estates and Ancillary	3.42%	5.47%
Healthcare Scientists	0.70%	11.43%
Medical and Dental	0.27%	8.67%
Nursing and Midwifery Registered	0.64%	5.81%

Result

Have a Retention Strategy with interventions aimed at key staff groups which currently have a high turnover.

Response

The increase in staff in post seen in April 20 on the adjacent Staff in Post graph is due to the temporary recruitment of year 2 and 3 nursing students

Retention

The Trust has developed its People Strategy, which includes a focus on Recruitment and Retention. Specific initiatives have included:-

- More streamlined recruitment
- Improved induction
- Health and wellbeing
- Colleague engagement
- Recognition and Reward
- Career development

Further work is being developed to enhance our People Strategy in 'The Cupboard'.

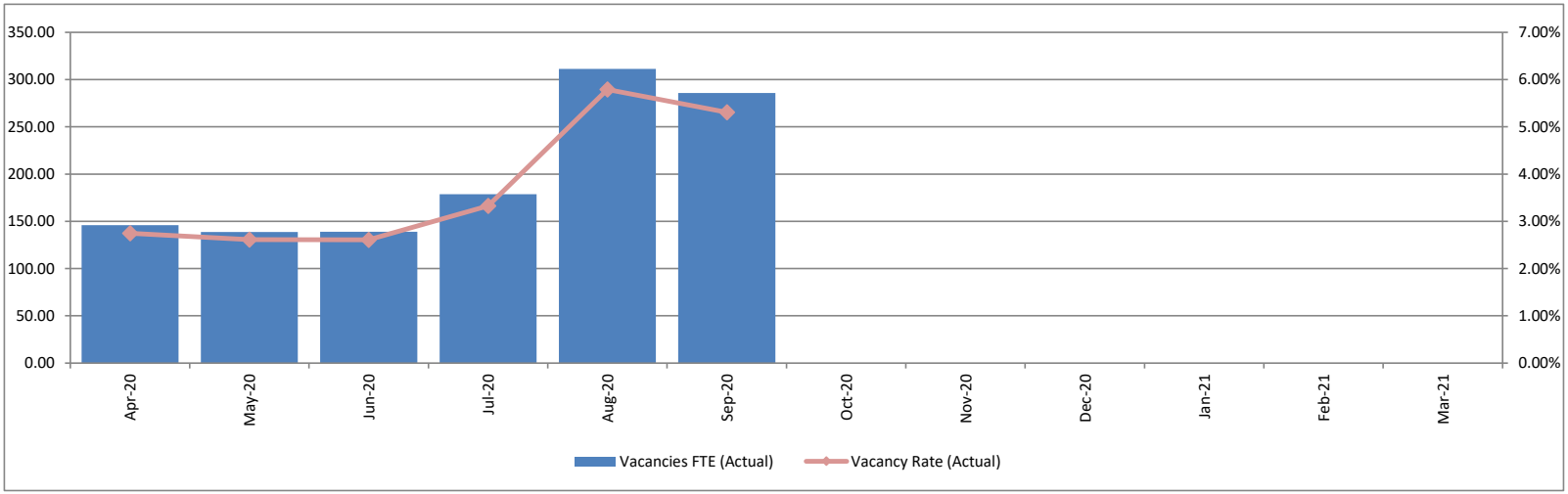
To support the retention of the Nursing workforce, the Trust offers a comprehensive induction and all new starters are enrolled on a year long graduate programme which is supported by the preceptorship programme.

The Trust is part of cohort 4 of NHSI Retention Direct Support Programme which is a clinically led programme aimed at supporting Trusts to improve their Nursing retention rates. The programme is currently on hold due to COVID-19 pressures.

Staff in Post / Starters & Leavers / Turnover

Reality

Vacancies



Vacancies by Staff Group

Staff Group	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Add Prof Scientific and Technic	222.54	209.78	12.76
Additional Clinical Services	1106.67	1071.57	35.10
Administrative and Clerical	1073.13	1002.35	70.78
Allied Health Professionals	392.45	406.90	-14.45
Estates and Ancillary	56.07	47.39	8.68
Healthcare Scientists	125.84	114.05	11.79
Medical and Dental	650.18	626.81	23.37
Nursing and Midwifery Registered	1754.98	1611.85	143.13
Students	0.00	5.40	-5.40
Total	**5381.86**	**5096.10**	**285.76**

Additional Clinical Services Breakdown

Role	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Asst./Associate Practitioner Nursing	29.23	26.67	2.56
Health Care Support Worker	81.24	74.25	6.99
Healthcare Assistant	712.75	622.99	89.76
Nursery Nurse	1.83	1.03	0.80
Nursing Associate	10.91	21.40	-10.49
Trainee Nursing Associate	2.00	53.00	-51.00
Total (Unregistered Nursing)	**837.96**	**799.34**	**38.62**
Other Additional Clinical Service	268.71	272.23	-3.52

Result

CHFT to be the employer of choice in a competitive environment through a recruitment strategy which includes candidate attraction to the Trust.

Achieve and maintain a vacancy rate below 5.4%.

Response

The Trust is participating in the regional streamlining agenda focused on enabling staff movement. Due to the work the Trust has already completed through the Stepchange reviews and the implementation of Trac, the focus is on internal efficiencies through the utilisation of ESR, further use of Trac and the revision of the Recruitment and Selection line managers training course

Recruitment

The Trust is continuing to progress the application for the 67 undergraduate student nurses and midwives who graduated in September 2020. The Trust is completing its recruitment activity for the next cohort of TNA's who will begin on programme in December 2020. We have also successfully graduated 15 TNA's from cohort 1 who are now in receipt of their Pin numbers and then will be deployed into the workforce as registered nursing associates. Cohort 2 TNA's will complete studies in December 2020 and join the nursing workforce

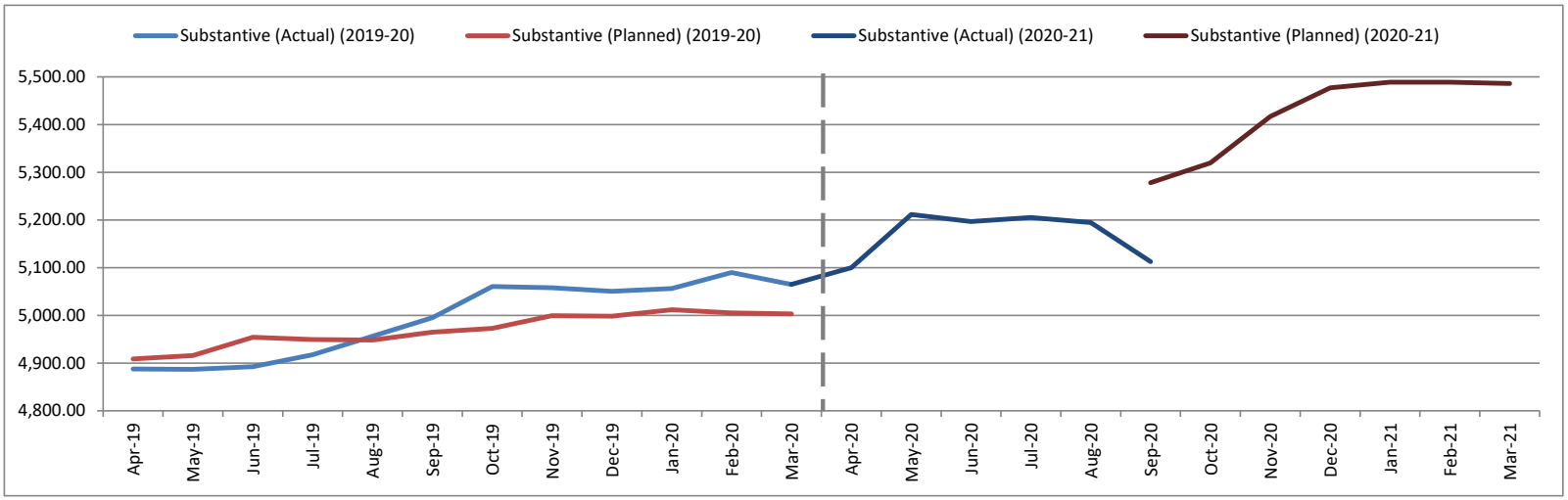
Medical Recruitment

GMC Session, known as 'Welcome to UK Practice' was hosted in October 2020 for our overseas doctors that have commenced in post over the last six months. The session gave these new starters the opportunity to meet each other in addition to highlighting some of the cultural differences between the NHS and the health care system that was in operation in their country of origin. Work is underway with divisional colleagues to develop escalation rotas that may be implemented in response to increasing numbers of Covid patients. It is not possible to use the rotas that were in place in April and May due to a number of factors. The BMA have not agreed to any variations to the rota rules for doctors in training, Health Education England have confirmed that GP and Psychiatry trainees will not be released from their current training placement to join acute rotas, and specialties that released trainees to join a shared rota earlier in the year must keep them within specialty to ensure they receive the training opportunities they have been placed with us to receive. Consequently, the numbers of colleagues available to join the emergency rotas have been affected and therefore new rotas are being designed and tested for compliance.

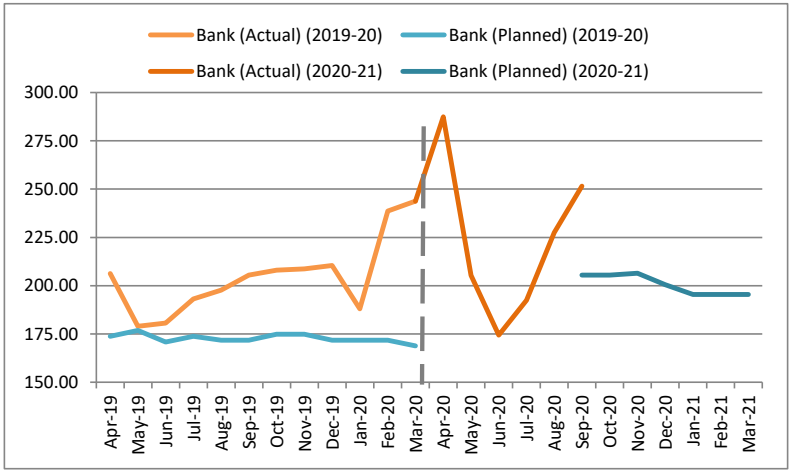
Vacancies

Reality

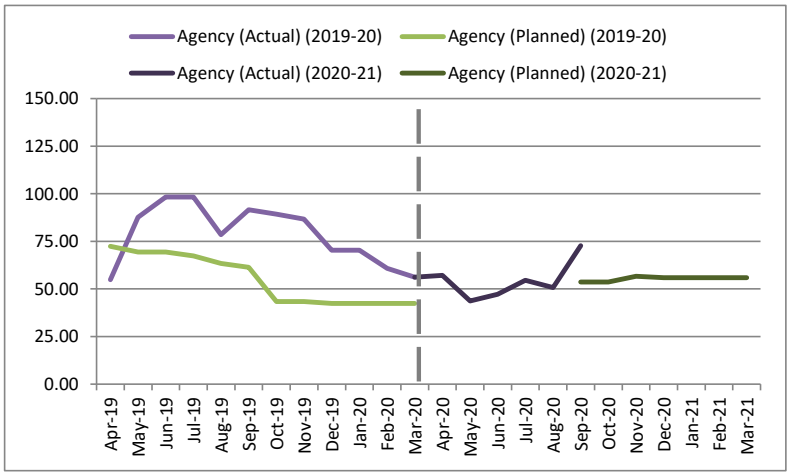
Substantive



Bank



Agency



Result

Increasing the substantive workforce whilst reducing the reliance on bank and agency usage.

These graphs show the FTE worked in-month for substantive, bank and agency workers, against the planned figures submitted to NHSi at the start of the

Response

These graphs show the hours worked in-month converted into FTE for substantive, bank and agency workers, against the planned figures submitted to NHSI at the start of the service year. In 2019/20 whilst the Trust reduced agency usage within the Medical & Dental staff group in particular, usage remained high in Nursing and Midwifery and The Health Informatics Service (THIS). This resulted in agency FTE being above plan.

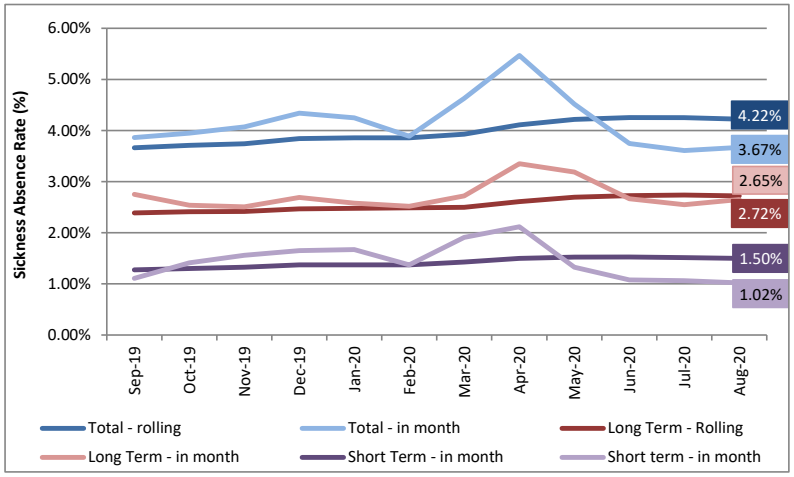
Operational planning was suspended by NHSi for an initial period of 1 April 2020 to 31 July 2020.

Final phase 3 workforce plans for the period September 20 to March 21 have been submitted to NHSI in September 2020.

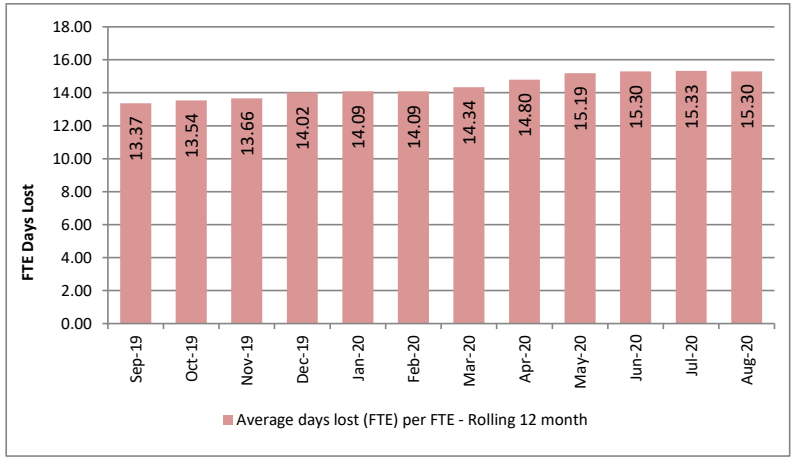
Workforce Plan

Reality

Sickness Absence



Average Days Lost Per FTE - rolling 12 month



Sickness Absence Reasons - August 20

Reason	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	2294.77	39.28%
S25 Gastrointestinal problems	499.01	8.54%
S12 Other musculoskeletal problems	491.93	8.42%
S28 Injury, fracture	459.87	7.87%
S15 Chest & respiratory problems	284.65	4.87%
S19 Heart, cardiac & circulatory problems	226.67	3.88%
S13 Cold, Cough, Flu - Influenza	203.45	3.48%
All Other Reasons	1381.98	23.65%

Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

Sickness absence data does not include self / household / shielding isolation.

The Trust has a robust attendance management approach agreed with staff side partners, which is supported by in-house occupational health provision and effective support to line managers.

The OH Service have responded to over 160 health and wellbeing assessments for Covid Age with letters of recommendations to managers where required. Staff swabbing continues, and the OH service is actively supporting track and trace activity for staff contacts within the workplace.
There has been an increased demand for staff swabbing in connection with the return of children to school, and a sense of a slight increase in the number of positive cases being identified.
The Seasonal Flu campaign plans are finalised with the ambition to immunise as near to 100% of colleagues as possible and using Covid safe methods of administration.
The campaign launched from 28 September with further details published on the intranet from 21 September.
As of 16 October 1500 colleagues (25.1%) have received the flu immunisation. With 29% of front-line staff being immunised.

The wellbeing questionnaire remains live for any colleague who wishes to undertake a personal risk assessment of their health and wellbeing

Sickness Absence

Reality

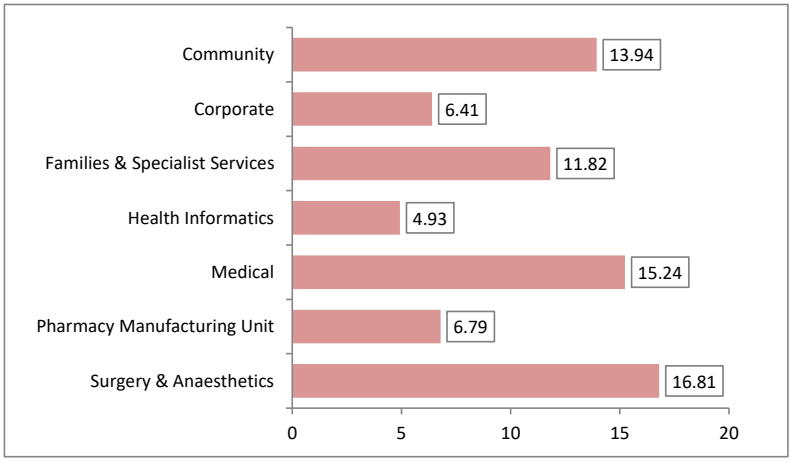
Sickness Absence - in-month

Division	Jul-20	Aug-20
Community	4.07%	3.82%
Corporate	2.03%	1.76%
Families & Specialist Services	3.14%	3.24%
Health Informatics	0.98%	1.35%
Medical	4.12%	4.18%
Pharmacy Manufacturing Unit	0.84%	1.86%
Surgery & Anaesthetics	4.43%	4.60%

Sickness Absence by Staff Group - rolling 12 month

Staff Group	Short Term	Long Term	Total
Add Prof Scientific and Technic	1.51%	2.07%	3.58%
Additional Clinical Services	2.20%	4.38%	6.58%
Administrative and Clerical	1.09%	2.20%	3.30%
Allied Health Professionals	1.21%	1.78%	2.99%
Estates and Ancillary	2.07%	2.89%	4.96%
Healthcare Scientists	1.10%	1.33%	2.43%
Medical and Dental	0.84%	0.72%	1.56%
Nursing and Midwifery	1.62%	3.16%	4.79%
Students	1.67%	0.49%	2.16%

Average Days Lost Per FTE - rolling 12 month



Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

In **Surgery & Anaesthetics**, absence has seen a slight increase in month. Short term absence is below target. Data is shared with the Directorates, with specific focus on individual breaches. Deep dives are taking place monthly.

In **Medicine** absence improved in August in line with the Trust positions and continues to do so as Covid-19 prevalence reduces. Deep dives are scheduled for 5 areas within Medicine.

In **FSS** Absence rates have seen a slight increase in month but is still below the overall Trust Target. Long Term absence has seen a slight increase but short term has improved again. there are a number of Long Term absence cases that are being prepared to be taken to formal panels in the next 4 weeks.

In **Community**, management of sickness absence continues. HR Adviser continues to support line managers with the management of Long term sickness Absence. Additional support has been provided to line managers in hot spot areas.

HR Adviser contacts all line mangers who have not completed a Return to work interview.

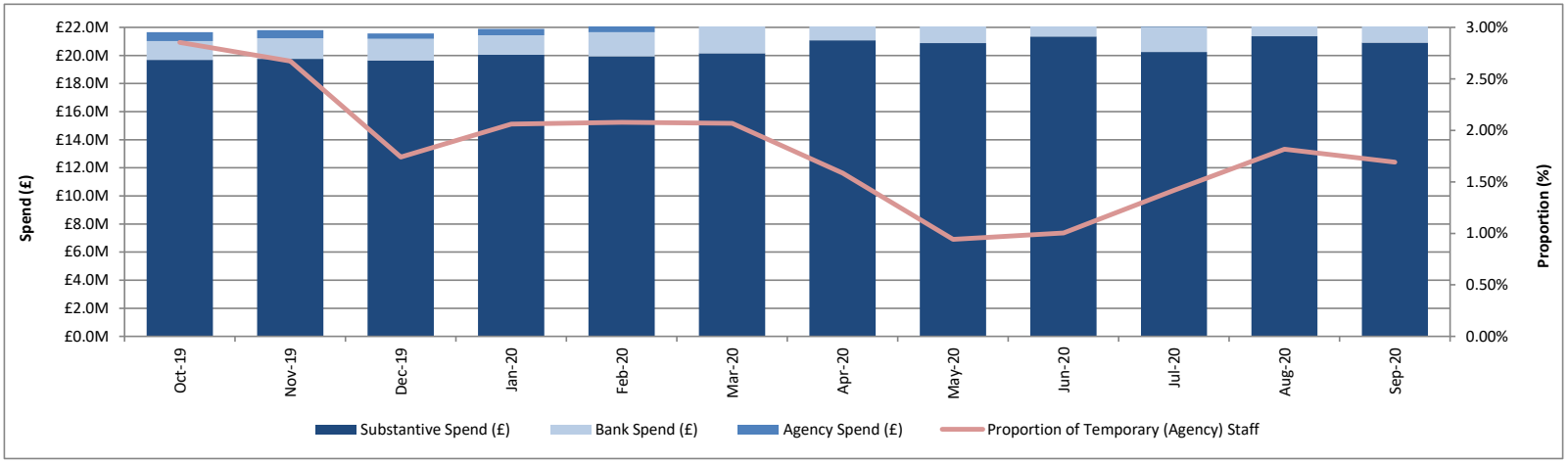
In **Corporate, PMU & THIS** HR Adviser continues to support line managers with the management of Long term sickness Absence. Additional support has been provided to line managers in hot spot areas.

HR Adviser contacts all line mangers who have not completed a Return to work interview.

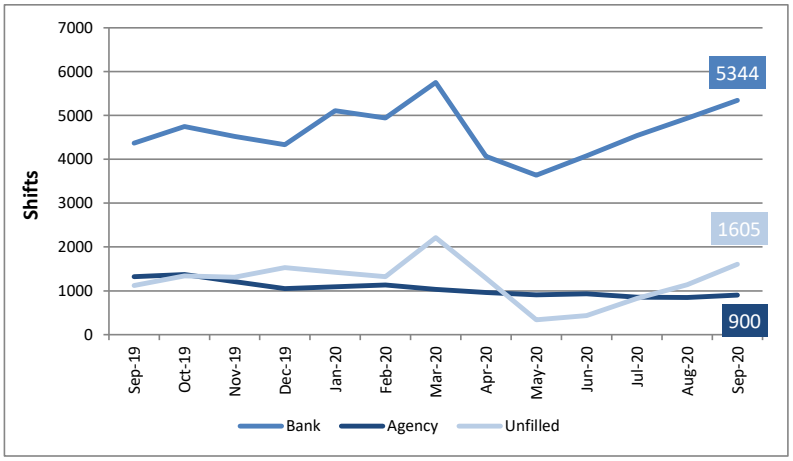
Sickness Absence - Divisional/Staff Group

Reality

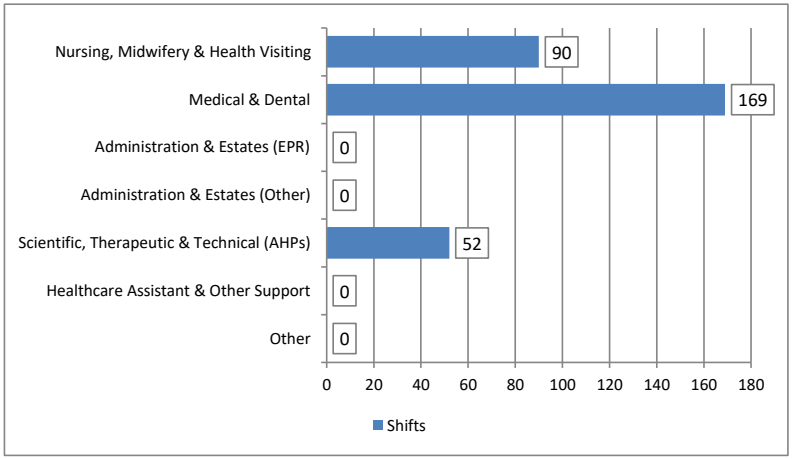
Workforce Spend



Agency, Bank and Unfilled Shifts



Number of shifts that broke the agency cap - August 2020



Result

Continue to reduce the use of agency colleagues and reduce the bank paybill in 2019/2020.

Response

A total of 311 shifts broke the agency cap in September 2020, this is an increase on 298 in August 2020

From 6 April 2020 the Trust removed usage of short notice, high cost Tier 3 agency shifts for Nursing and migrated Tier 2 agencies to Tier 1.

Whilst agencies that supplied at Tier 2 and Tier 3 were framework providers, the shifts still represented a significant cost to the Trust when in comparison to Registered Nursing Staff through Bank and Tier 1.

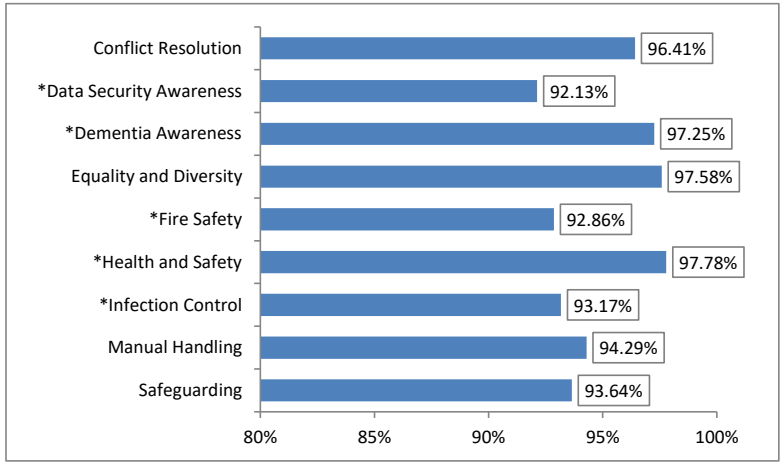
Removing these two Tiers has helped to achieve lower average hourly rates, from £34.01 to £31.17 per hour.

Agency usage remains low with 59% of Nursing shifts and 79% of Medical shifts filled by Bank.

Workforce Spend / Agency Usage

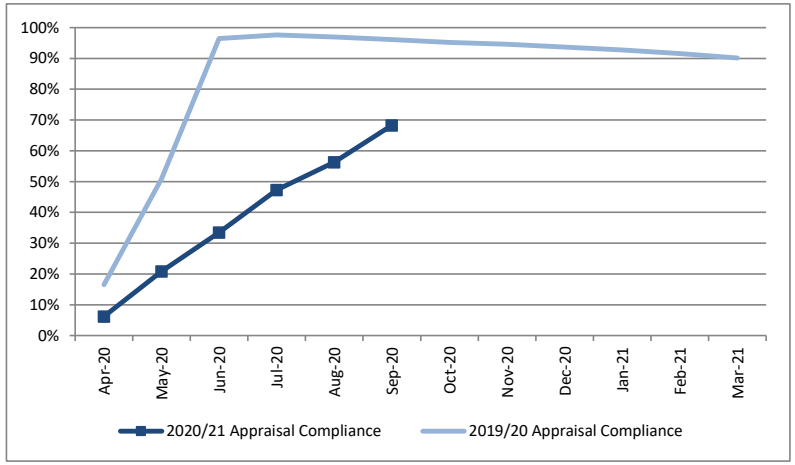
Reality

Essential Safety Training

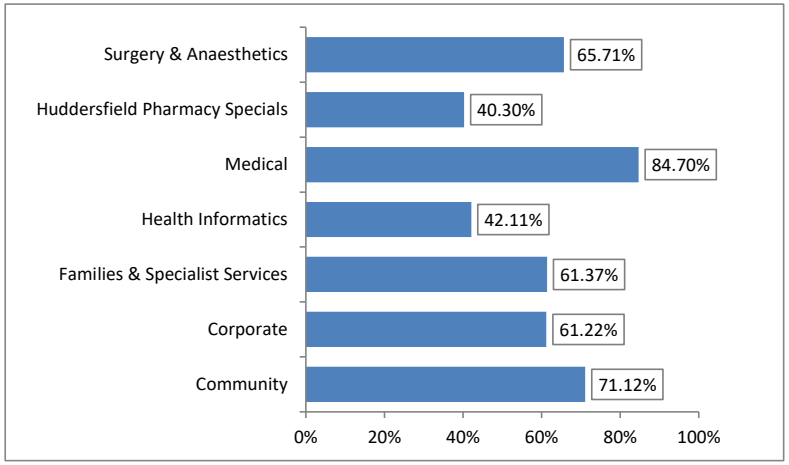


* Essential Safety Training elements that are covered at Corporate Induction.

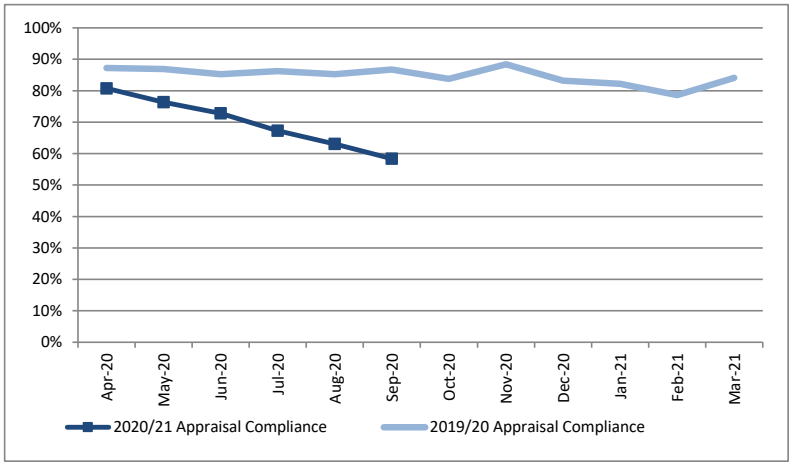
Non-Medical Appraisal Compliance



Non-Medical Appraisal Compliance by Division



Medical Appraisal Compliance



Result

Appraisal compliance is consistently above 95%.

Essential safety training compliance is consistently above 90% stretching to 95%.

Response

Essential Safety Training
A paper is presented weekly to Executive Board highlighting the compliance figures for all EST including role specific training.

The focus remains on improving role specific subjects with less than 85% compliance.

Appraisal
The Trust now adopts an appraisal season approach. The appraisal season runs from 1 April to 30 June every year. The final position for the 2019/20 appraisal season was 97.63%.

The appraisal season and Medical appraisals for 2020/21 have been postponed due to the ongoing COVID-19 situation. The appraisal season for AfC staff in 2020/21 will now run from 1 July to 31 October 2020.

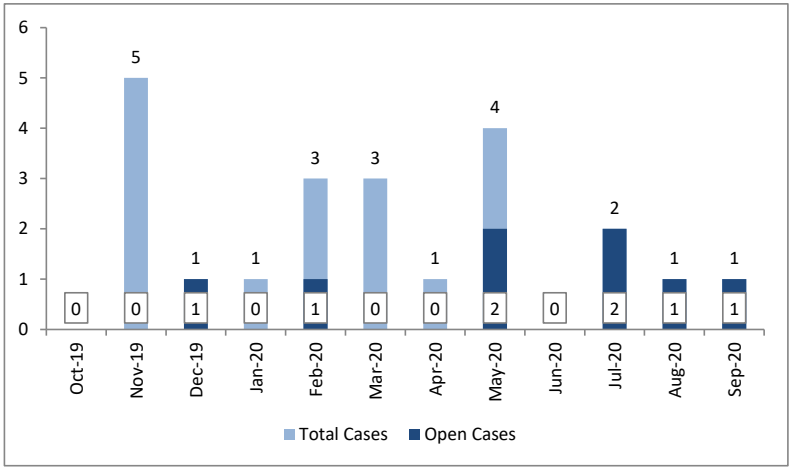
A shortage of Medical Appraisers has now been resolved through recruitment and training existing colleagues.

Oral Surgeons have now been excluded from the denominator in the medical appraisal compliance as the General Dental Council undertake the appraisal.

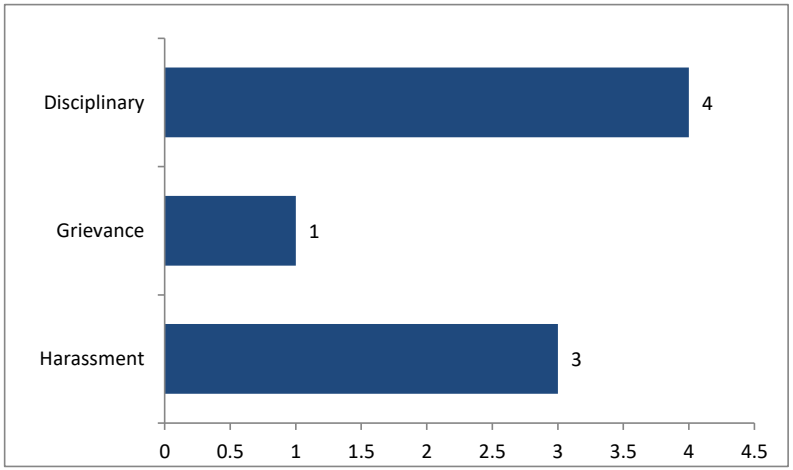
Essential Safety Training / Appraisals

Reality

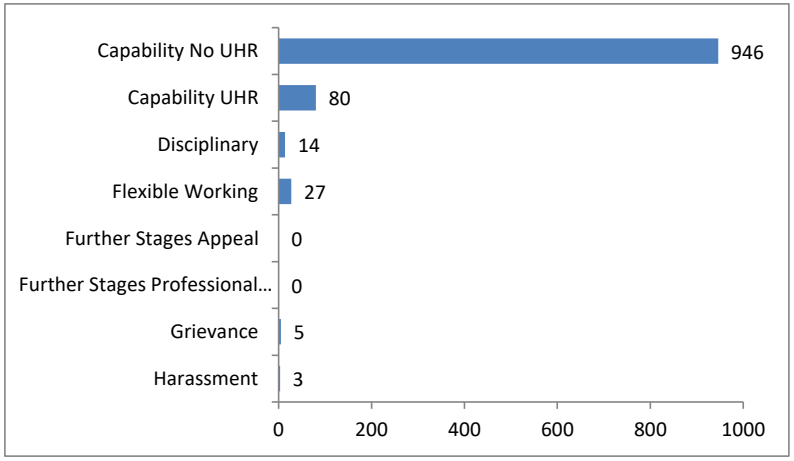
Disciplinary, Grievance, Harassment cases opened last 12 months



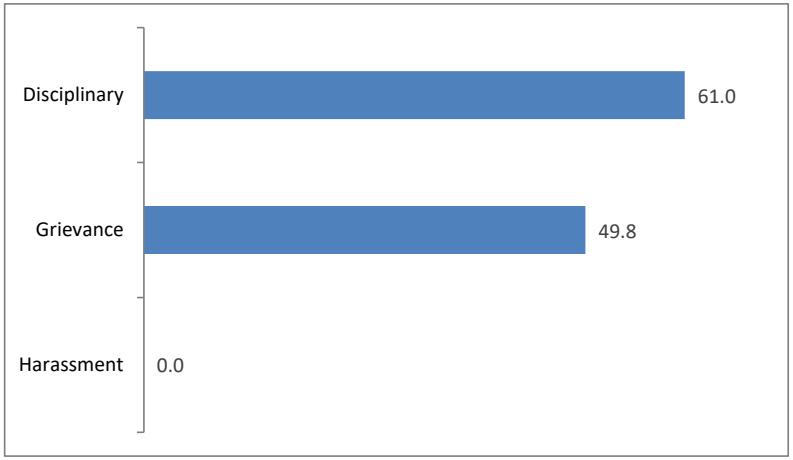
Open Disciplinary, Grievance, Harassment cases by type



All cases opened in the last 12 months by case type



Average number of days to close cases



Result

Maintain a robust capturing process.

Response

Following a deep dive into employee relations cases, the HR Team reviewed the way in which employee relations cases were been recorded and updated. This has resulted in a number of changes which will ensure consistency and enable automated reporting of case management.

- ESR will now be the sole recording system for employee relations cases. Previously the HR Team had been trying to maintain two different systems which led to discrepancies.

- If the employee has a registered disability, absence management cases will now be recorded under 'Capability UHR'. All other absence management cases will be recorded under 'Capability No UHR'.

- Long term sickness absence will now be captured on ESR.

- Unsatisfactory performance during a probationary period will now be captured on ESR.

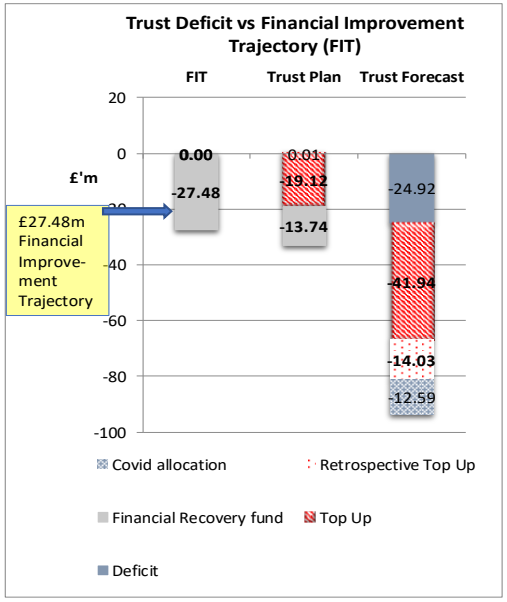
* The average no. of days to close Harassment cases is zero due to the cases still remaining open.

Employee Relations

EXECUTIVE SUMMARY: Total Group Financial Overview as at 30th Sep 2020 - Month 6

KEY METRICS

	M6				YTD (SEP 2020)				Forecast 20/21			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£0.00)	(£0.00)	£0.00		(£0.01)	(£0.00)	£0.01		£0.47	(£24.92)	(£25.39)	
Agency Expenditure	(£0.48)	(£0.40)	£0.09		(£2.89)	(£1.95)	£0.94		(£6.52)	(£4.78)	£1.74	
Capital	£1.56	£0.99	£0.57		£8.42	£4.07	£4.35		£20.85	£23.52	(£2.67)	
Cash	£3.94	£58.71	£54.77		£3.94	£58.71	£54.77		£3.99	£28.03	£24.04	
Borrowing (Cumulative)	£20.98	£20.98	£0.00		£20.98	£20.98	£0.00		£19.88	£19.88	£0.00	
CIP	£1.23	£0.36	(£0.87)		£7.39	£2.01	(£5.38)		£14.77	£5.22	(£9.55)	
Use of Resource Metric	2	2			3	3			3	2		



Year to Date Summary

The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for the first six months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £14.03m of retrospective top up funding: £11.66m has been approved for M1-5, with a further £2.38m required for M6.

- Year to date the Trust has incurred costs of £16.28m in relation to Covid-19. M6 costs incurred were £2.33m, driven mainly by the expansion of the workforce, the segregation of patient pathways, increased Respiratory support capacity, backfill for increased sickness absence and PPE costs.
- The underlying position excluding Covid-19 costs is a year to date favourable variance of £2.25m, driven by the impact of lower levels of other activity on non-pay costs and staffing vacancies.
- The Trust is required by NHSI to report a balanced position, but this does not include the potential impact of the Elective Incentive Scheme which remains a financial risk. Based on Month 6 activity compared to National targets, the impact of this penalty is estimated to be £0.44m.
- Whilst there is no national expectation of CIP delivery, the Trust continues to deliver some savings as planned. CIP achieved year to date is £2.01m, £5.38m below plan.
- Agency expenditure year to date is £1.95m, £0.94m below the planned level.

Key Variances (compared to NHSI derived plan)

- Clinical Contract income is in line with the NHSI Interim plan due to new fixed block and top up arrangements. The 'Retrospective Top Up' of £14.03m drives a favourable variance in overall Clinical Income, offset to some extent by lower than planned income from other sources including private patients, and the absorption of CCG Health Informatics contracts, (usually invoiced as non-clinical income), into the Block. The direct impact of Covid-19 on income generation is a £1.94m adverse variance, including a reduction in Private Patient, Car Parking and Catering income.
- Pay costs are £4.97m above the planned level year to date due to the impact of Covid-19 which is calculated to be £6.96m year to date. The costs attributed to Covid-19 were offset to some extent by underspends in some specialties due to reduced activity and a level of unfilled vacancies in unrelated non-Covid impacted areas.
- Non-pay operating expenditure is higher than planned by £3.70m. The costs directly attributable to the Covid-19 response were £9.32m, offset in part by lower than planned costs for specialties that have seen lower than planned activity particularly over the first 4 months of the year. This includes lower than planned consumables and drugs.

Forecast

The current Block and Top Up arrangements with access to retrospective funding to cover Covid costs have now ended. For Month 7 to 12 (Phase 3), the Trust will be required to manage within the ICS agreed financial envelope. The Trust has been allocated Covid and growth funding on a fair shares basis to cover the remainder of the year. Confirmed funding is insufficient to cover all forecast additional costs and the Trust is therefore planning a £24.92m deficit for the second half of the year. This position includes a £23m accounting adjustment that will not require cash funding leaving an underlying unfunded gap of £1.92m.

- Pay commitment for Phase 3 reset activity drives additional unfunded recurrent costs of £6.4m that will impact on 21/22.
- Wellbeing hour is assumed in the forecast at no additional cost.

Total Group Financial Overview as at 30th Sep 2020 - Month 6

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M6

CLINICAL ACTIVITY

	M6 Plan	M6 Actual	Var
Elective	2,711	762	(1,949)
Non-Elective	29,620	22,466	(7,154)
Daycase	21,735	7,803	(13,932)
Outpatient	185,137	70,768	(114,369)
A&E	80,293	61,707	(18,586)
Other NHS Non-Tariff	915,220	533,219	(382,002)
Other NHS Tariff	65,966	38,743	(27,223)
Total	**1,300,682**	**735,467**	**(565,215)**

TOTAL GROUP: INCOME AND EXPENDITURE

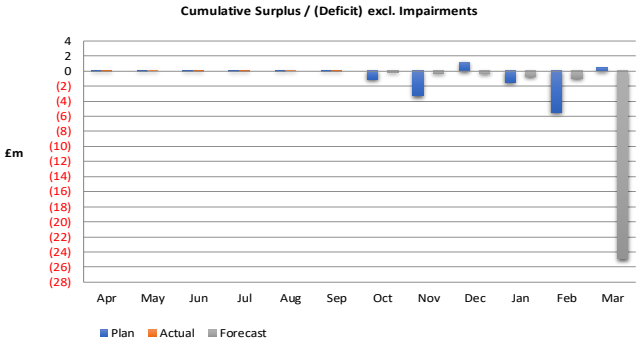
	M6 Plan £m	M6 Actual £m	Var £m
Elective	£8.50	£8.50	£0.00
Non Elective	£56.03	£56.03	£0.00
Daycase	£15.39	£15.39	£0.00
Outpatients	£23.13	£23.13	£0.00
A & E	£11.76	£11.76	£0.00
Other-NHS Clinical	£58.10	£60.03	£1.93
CQUIN	£1.89	£1.89	£0.00
Other Income	£27.78	£22.43	(£5.35)
Total Income	**£202.57**	**£199.15**	**(£3.42)**
Pay	(£133.52)	(£138.50)	(£4.97)
Drug Costs	(£21.25)	(£20.59)	£0.66
Clinical Support	(£13.16)	(£13.81)	(£0.66)
Other Costs	(£31.49)	(£35.19)	(£3.70)
PFI Costs	(£6.64)	(£6.64)	£0.00
Total Expenditure	**(£206.06)**	**(£214.73)**	**(£8.67)**
EBITDA	**(£3.49)**	**(£15.58)**	**(£12.09)**
Non Operating Expenditure	(£12.45)	(£12.01)	£0.45
Surplus / (Deficit) Adjusted*	**(£15.94)**	**(£27.59)**	**(£11.64)**
Conditional Funding (MRET/FRF/Top Up)	£15.93	£27.59	£11.66
Surplus / Deficit*	**(£0.01)**	**(£0.00)**	**£0.01**

* Adjusted to exclude items excluded for Financial Improvement Trajectory purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

	M6 Plan £m	M6 Actual £m	Var £m
Surgery & Anaesthetics	£7.53	£11.66	£4.13
Medical	£21.26	£16.54	(£4.72)
Families & Specialist Services	(£3.94)	(£2.76)	£1.18
Community	(£0.92)	(£1.29)	(£0.37)
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£21.97)	(£22.96)	(£1.00)
THIS	£1.13	£0.75	(£0.39)
PMU	£1.77	£1.59	(£0.19)
CHS LTD	£0.30	£0.44	£0.14
Central Inc/Technical Accounts	(£7.52)	(£3.51)	£4.00
Reserves	(£1.29)	(£0.44)	£0.85
Unallocated CIP	£3.62	£0.00	(£3.62)
Surplus / (Deficit)	**(£0.01)**	**(£0.00)**	**£0.01**

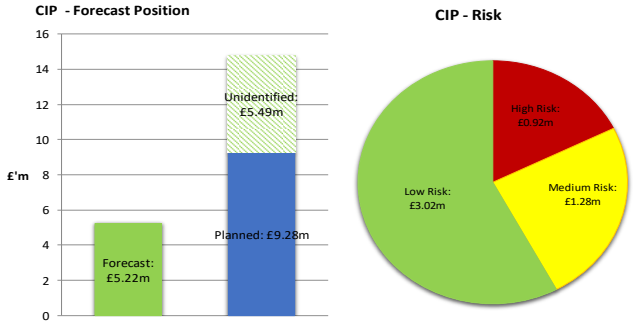
TOTAL GROUP SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date M6 Plan £m	Year To Date M6 Actual £m	Year To Date Var £m	Year End: Forecast Plan £m	Year End: Forecast Forecast £m	Year End: Forecast Var £m
I&E: Surplus / (Deficit)	(£0.01)	(£0.00)	£0.01	£0.47	(£24.92)	(£25.39)
Capital	£8.42	£4.07	£4.35	£20.85	£23.52	(£2.67)
Cash	£3.94	£58.71	£54.77	£3.99	£28.03	£24.04
Loans	£20.98	£20.98	£0.00	£19.88	£19.88	£0.00
CIP	£7.39	£2.01	(£5.38)	£14.77	£5.22	(£9.55)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	3		3	2	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14.77m **Total Forecast £5.22m**

YEAR END 20/21

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,574	2,278	(3,296)
Non-Elective	60,676	52,599	(8,076)
Daycase	43,418	22,181	(21,237)
Outpatient	368,867	160,143	(208,724)
A&E	158,149	133,379	(24,770)
Other NHS Non- Tariff	1,835,796	1,042,385	(793,411)
Other NHS Tariff	131,518	76,159	(55,359)
Total	**2,603,999**	**1,489,125**	**(1,114,873)**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan £m	Actual £m	Var £m
Elective	£18.01	£18.01	(£0.00)
Non Elective	£114.89	£114.89	(£0.00)
Daycase	£30.72	£30.72	(£0.00)
Outpatients	£46.12	£46.12	(£0.00)
A & E	£23.16	£23.16	£0.00
Other-NHS Clinical	£112.00	£121.20	£9.20
CQUIN	£3.79	£3.79	(£0.00)
Other Income	£55.38	£45.73	(£9.65)
Total Income	**£404.07**	**£403.62**	**(£0.45)**
Pay	(£268.48)	(£286.54)	(£18.06)
Drug Costs	(£42.64)	(£41.90)	£0.73
Clinical Support	(£27.51)	(£31.01)	(£3.50)
Other Costs	(£59.54)	(£64.57)	(£5.04)
PFI Costs	(£13.21)	(£13.44)	(£0.22)
Total Expenditure	**(£411.38)**	**(£437.46)**	**(£26.08)**
EBITDA	**(£7.30)**	**(£33.83)**	**(£26.53)**
Non Operating Expenditure	(£25.08)	(£47.06)	(£21.98)
Surplus / (Deficit) Adjusted*	**(£32.38)**	**(£80.89)**	**(£48.51)**
Conditional Funding (MRET/FRF/Top Up)	£32.85	£55.98	£23.12
Surplus / Deficit*	**£0.47**	**(£24.92)**	**(£25.39)**

* Adjusted to exclude items excluded for Financial Improvement Trajectory: Donated Asset Income, Donated Asset Depreciation and Impairments.

DIVISIONS: INCOME AND EXPENDITURE

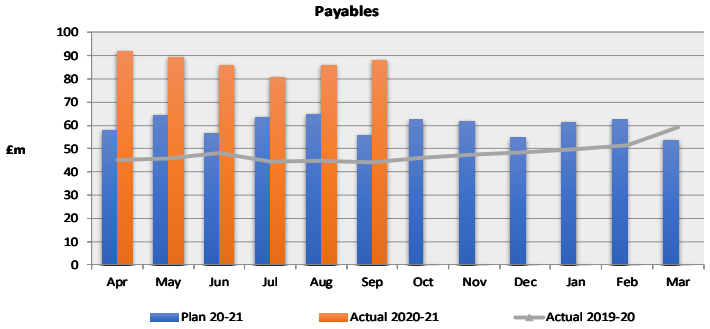
	Plan £m	Forecast £m	Var £m
Surgery & Anaesthetics	£14.99	£17.51	£2.52
Medical	£44.01	£31.43	(£12.58)
Families & Specialist Services	(£7.10)	(£7.45)	(£0.35)
Community	(£1.89)	(£3.90)	(£2.01)
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£43.52)	(£46.03)	(£2.51)
THIS	£2.27	£1.49	(£0.78)
PMU	£3.55	£3.00	(£0.55)
CHS LTD	£0.75	£0.71	(£0.04)
Central Inc/Technical Accounts	(£15.39)	(£22.62)	(£7.22)
Reserves	(£3.81)	£0.94	£4.75
Unallocated CIP	£6.62	£0.00	(£6.62)
Surplus / (Deficit)	**£0.47**	**(£24.92)**	**(£25.39)**

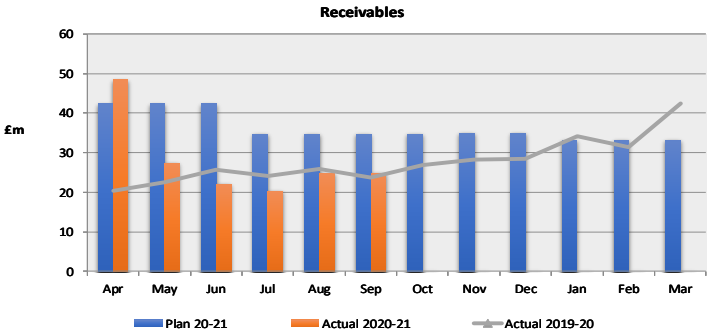
Total Group Financial Overview as at 30th Sep 2020 - Month 6

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

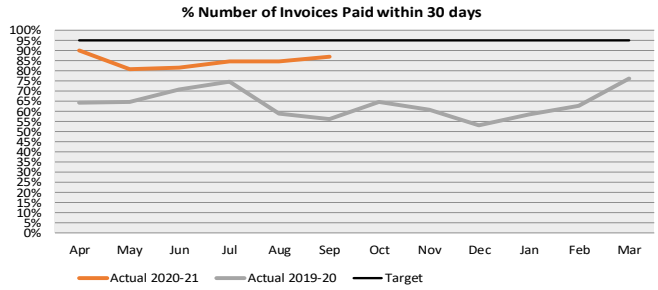
WORKING CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Payables (excl. Current Loans)	(£55.73)	(£87.94)	£32.21	
Receivables	£34.65	£24.88	£9.77	



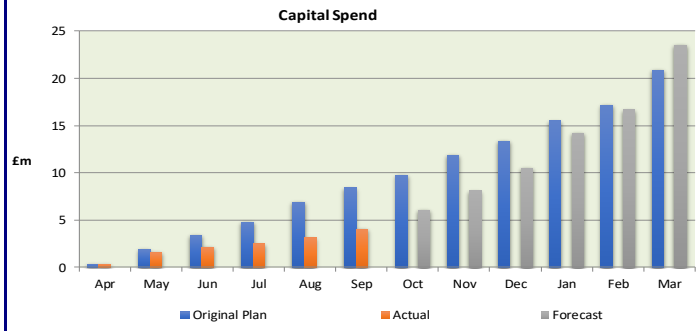


BETTER PAYMENT PRACTICE CODE



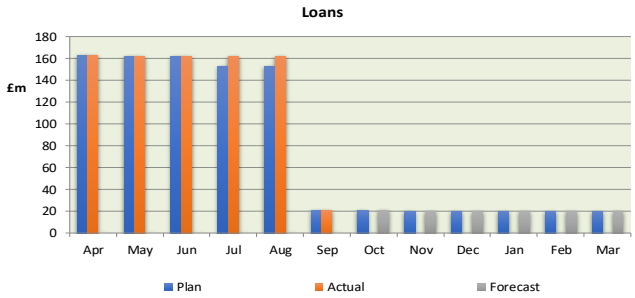
CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Capital	£8.42	£4.07	£4.35	

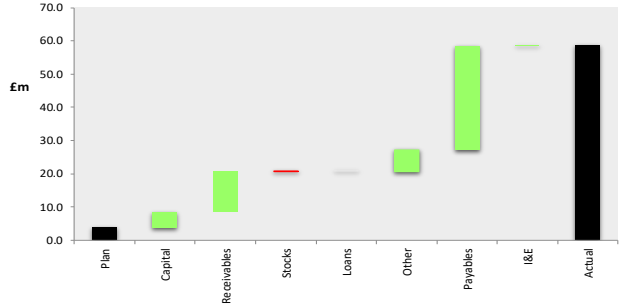


CASH

	M6 Plan £m	M6 Actual £m	Var £m	M6
Cash	£3.94	£58.71	£54.77	
Loans (Cumulative)	£20.98	£20.98	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for the first six months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £14.03m of retrospective top up funding (of which £11.66m has now been approved).
- Clinical Contract income is in line with the NHSI Interim plan due to new fixed block and top up arrangements. The assumed 'Retrospective Top Up' of £14.03m drives a favourable variance in overall Clinical Income, offset to some extent by lower than planned income from other sources including private patients and the absorption of CCG Health Informatics contracts, (usually invoiced as non-clinical income), into CCG block contracts.
- Whilst year to date activity is well below the original plan, it is increasing and Month 6 activity was overall higher than the Phase 3 plan / forecast.
- The Trust has incurred £16.28m in relation to Covid-19, of which £3.39m relates to gowns which were purchased by the Trust on behalf of the region.
- Year to date Capital expenditure was lower than planned at £4.07m against a planned £8.42m.
- Cash balance is £58.71m, £54.77m above plan: payments for October's Block and Top Up received in advance and £10m bonus Financial Recovery Funding (19/20
- No interim Revenue loans or PDC were required in month.
- Year to date CIP schemes have delivered £2.01m of savings, £5.38m lower than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3 against a planned level of 3. Liquidity is better than planned at level 3 due to the Trust's improved cash balance, all other metrics are as planned.

NOTES

- The Forecast shown is the Phase 3 plan submitted to NHSI on the 22nd of October. The current Block and Top Up arrangements with access to retrospective funding to cover Covid costs have now ended. For Month 7 to 12 (Phase 3), the Trust will be required to manage within the ICS agreed financial envelope. The Trust has been allocated Covid and growth funding on a fair shares basis to cover the remainder of the year. Confirmed funding is insufficient to cover all forecast additional costs and the Trust is therefore planning a £24.92m deficit for the second half of the year. This position includes a £23m accounting adjustment that will not require cash funding, leaving an underlying unfunded gap of £1.92m.
- The Trust is forecasting Agency expenditure of £4.78m, considerably below the NHSI ceiling of £8.82m, but offset by an increase in expenditure on Bank staff.
- The Trust is forecasting delivery of £5.22m savings against a Trust CIP plan for 20/21 of £14.77m.
- The Trust has not planned to borrow during this financial year due to changes in the cash regime, however should additional cash support be required due to the planned deficit position, the Trust should be able to access revenue support PDC.
- The total loan balance at year end is forecast to be £19.88m as planned. All Revenue and Interim Capital Loans (totalling £140.72m) were repaid and replaced by PDC funding during September.
- Capital expenditure is forecast at £23.52m, £2.67m more than the recently resubmitted 20/21 Capital Plan due to expected additional external funding for Urgent & Emergency Care, Endoscopy equipment, Critical Care and some additional Covid-19 related expenditure that is still waiting for approval, offset to some extent by a reduction in forecast expenditure for Reconfiguration.

RAG KEY: (Excl: UOR)

- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

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

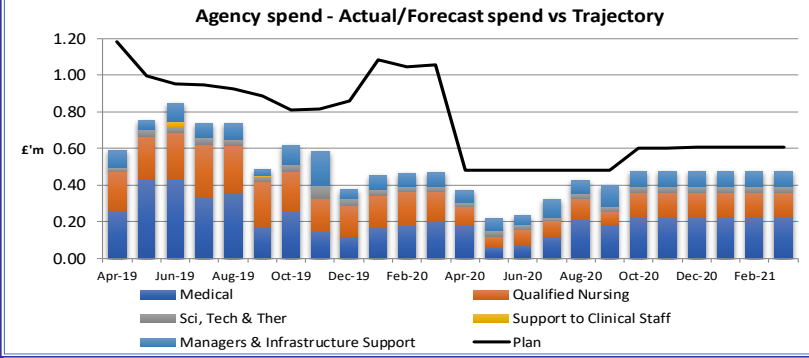
RAG KEY: UOR

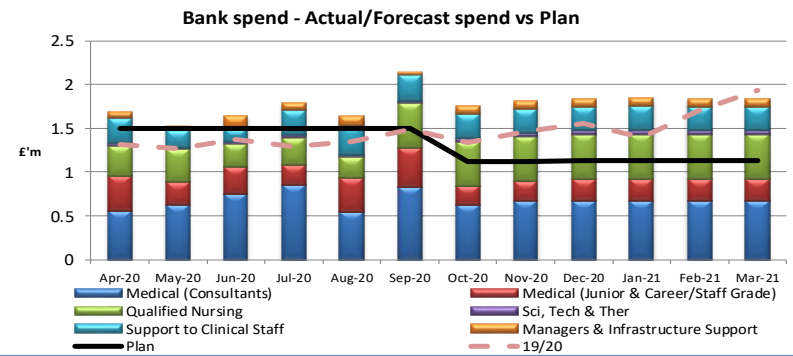
- All UOR metrics are at the planned level
- Overall UOR as planned, but one or more component metrics are worse than planned
- Overall UOR worse than planned

WORKFORCE

Vacancies

	Sci, Tech & Ther	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	7	102	23	146	27	304
Staff in post (WTE)	734	1,395	627	1,610	1,080	5,445
% Vacancies	1%	7%	4%	8%	2%	5%





Cumulative Agency and Bank Spend	Plan £'m	Actual £'m	Var £'m	
Agency Year to Date	(£2.89)	(£1.95)	£0.94	
Agency Forecast	(£6.52)	(£4.78)	£1.74	
Bank Year to Date	(£8.97)	(£10.40)	(£1.43)	
Bank Forecast	(£15.73)	(£21.30)	(£5.56)	

Vacancies
At the end of Month 6 the Trust was carrying 304 vacancies, 5% of the total establishment and a reduction compared to Month 5 of 38. Medical vacancies remained static at 4%. Nursing vacancies reduced from 9% to 8%, as did Sci & Tech vacancies, reducing from 3% to just 1%. Admin & Estates vacancies increased slightly to 7%.

Agency rate cap
Overall Cap breaches reduced slightly in Month 6, but remain higher than average for the year to date. The first four months of the year had seen a significant reduction in both Nursing and Medical breaches, but cap breaches for both staff groups have increased since Month 5.

Agency ceiling
Total reported agency expenditure year to date is £1.95m; £0.94m below the planned value, and lower than those seen in Month 5. The year to date underspend on agency costs is offset by an increase in the use of internal Bank staff, with expenditure on Bank £1.43m higher than planned year to date, increasing significantly in month for both Nursing and Medical staff groups.

The planned agency trajectory for 20/21 is £6.52m, which is lower than the £8.82m NHS Improvement ceiling and currently the Trust is forecasting agency expenditure for the full year of only £4.78m, £1.74m below plan.

Nursing agency costs reduced by £0.05m in month to £0.07m, and remained well below the planned level due to a reduction in both hours and average hourly rate. Overall this is a year to date favourable variance to plan of £0.56m reflecting the progression of plans to reduce reliance on agency staff, particularly higher Tier agencies and replace with an increase in the use of bank nurses, but also reduced activity and the influx of additional student nurses up to mid August that temporarily bolstered staffing numbers and reduced reliance on other forms of temporary staffing.

Medical Agency costs also reduced in month (£0.03m) to £0.18m, above the planned level in month, but year to date costs remain below plan with a year to date favourable variance of £0.04m. In earlier months, additional staffing costs due to Covid-19 were offset by a reduction in planned activity that would usually be supported by a level of agency expenditure.

Bank usage
Expenditure on internal Bank staff is £10.40m, £1.43m higher than planned year to date. £2.77m of these costs relate to the Covid-19 response including: additional medical costs of £1.77m due to changes to rotas and segregation of patient pathways; and nursing costs of £0.89m due to backfill for higher sickness absence and plans to release bed capacity.

FORECAST

YEAR END 20/21

	Plan £m	Forecast £m	Var £m	
Elective	£18.01	£18.01	(£0.00)	
Non Elective	£114.89	£114.89	(£0.00)	
Daycase	£30.72	£30.72	(£0.00)	
Outpatients	£46.12	£46.12	(£0.00)	
A & E	£23.16	£23.16	£0.00	
Other-NHS Clinical	£112.00	£121.20	£9.20	
CQUIN	£3.79	£3.79	(£0.00)	
Other Income	£55.38	£45.73	(£9.65)	
Total Income	**£404.07**	**£403.62**	**(£0.45)**	
Pay	(£268.48)	(£286.54)	(£18.06)	
Drug Costs	(£42.64)	(£41.90)	£0.73	
Clinical Support	(£27.51)	(£31.01)	(£3.50)	
Other Costs	(£59.54)	(£64.57)	(£5.04)	
PFI Costs	(£13.21)	(£13.44)	(£0.22)	
Total Expenditure	**(£411.38)**	**(£437.46)**	**(£26.08)**	
EBITDA	**(£7.30)**	**(£33.83)**	**(£26.53)**	
Non Operating Expenditure	(£25.08)	(£47.06)	(£21.98)	
Surplus / (Deficit) Control Total basis*	**(£32.38)**	**(£80.89)**	**(£48.51)**	
Conditional Funding (MRET/PSF/FRF)	£32.85	£55.98	£23.12	
Surplus / Deficit*	**£0.47**	**(£24.92)**	**(£25.39)**	

*Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

Forecast

Month 7-12 (Phase 3) Financial Plan

The interim nationally agreed financial arrangements applied for the first 6 months of the year have now ended. The Trust will no longer have access to retrospective funding to cover Covid costs and instead from Month 7 the Trust will be required to manage within an ICS agreed financial envelope. The Trust has been allocated Covid and growth funding on a fair shares basis to cover the remainder of the year. Confirmed funding is insufficient to cover all forecast additional costs and the Trust is therefore planning a £24.92m deficit for the second half of the year. This position includes a £23m one off accounting adjustment that will not require cash funding, leaving an underlying unfunded gap of £1.92m as described below:

	£'m
Technical Accounting Adjustment:	£23.00
Loss of 'Other' Income:	£1.61
Annual Leave Accrual:	£0.50
Residual difference between funding and planned expenditure:	-£0.19
Total Planned Deficit	**£24.92**

This financial plan was submitted to NHSI on the 22nd Oct 20 and is an improved position compared to the draft plan sent to the ICS earlier in the month:

- £2.2m improvement following a review of Divisional forecasts and in particular workforce plans. Some posts were not agreed to progress and a level of likely slippage on recruitment has been recognised.
- The balance of £1.4m is the combined gap across Calderdale and Greater Huddersfield places and whilst included in the Trust's plan is recognised to be a system risk.
- The overall system risk absorbed within Provider plans is £9.2m and a collective decision was taken at the WY&H ICS Finance Forum that this level of risk should be manageable within a system financial envelope of £2.1bn.

Key Assumptions:

- Assumes the system is able to identify mitigation to cover the £1.4m planning gap.
- The forecast does not include any potential financial impact as a result of the Elective Incentive Scheme.
- Assumes that all future PPE requirements are provided through National Procurement.
- Does not include any additional costs that might be incurred as a result of supplying staff to NHS Nightingale.
- Assumes there will be no additional costs incurred as a result of introducing the Wellbeing Hour.
- Assumes a small increase in the amount of annual leave carried forward into the next financial year equating to 2 days for Nursing and AHP staff.
- Assumes that forecast efficiencies (CIP) of £5.22m are delivered as planned.

Risks and Opportunities:

- National funding for Covid Testing has been identified, but the mechanism for recovering costs is unclear and may be impacted by capped rates per test.
- The Trust has retained a small contingency of £0.79m to cover any unidentified winter or general pressures that emerge.
- CCG and some NHSE commissioned High Cost Drugs remain within block contracts which could drive either an over or underspend depending on activity levels.
- Whilst 2nd wave Covid costs have been included within plans, were students to be deployed for a protracted period as seen earlier in the year, costs might exceed forecast expenditure.
- Non pay expenditure assumes that the activity reset progresses as planned. If significant cancellations were required this could result in lower than planned expenditure.

Impact on 21/22 Planning

It should be noted that the pay commitment for Phase 3 reset activity drives additional unfunded recurrent cost of c.£6.4m that will impact on the 21/22 Business Plan.

COVID-19

Revenue Impact of Covid-19 - YTD SEP 2020					
Division	**Annual Leave Accrual**	**Covid-19 Direct Costs**	**Impact on activity**	**Loss of Income**	**Total**
	£	£	£	£	£
Central & Technical	0	7,621,875	42,208	0	7,664,083
Medicine	0	5,235,801	(409,789)	0	4,826,012
Families & Specialist Services	0	663,153	(152,550)	474,598	985,201
Calderdale & Huddersfield Solutions Ltd	0	730,446	(89,501)	73,000	713,945
Corporate Services	0	384,954	55,202	1,365,210	1,805,366
Community	0	627,862	0	30,346	658,208
Health Informatics	0	70,906	0	0	70,906
Surgery & Anaesthetics	0	942,780	(2,194,408)	0	(1,251,628)
NHS Nightingale (Hosted Costs)		3,264			3,264
Total costs identified	-	**16,281,040**	**- 2,748,837**	**1,943,154**	**15,475,357**
Retrospective Top Up requested					**14,031,213**

Capital Impact of Covid-19 - SEP 2020	
Details	**Covid-19 Costs**
	£
NPEX (PDC received)	330,000
Equipment	444,578
Asset Tracking	105,422
Total costs identified	**880,000**
PDC Confirmed	**330,000**

The Trust has incurred Covid-19 direct costs totalling £16.28m year to date as shown in the table and these have been reported to NHSI in support of the requested 'Retrospective Top Up'.

Key areas of spend are as follows:

Pay - £6.96m

Reported Covid-19 costs are the 'net cost' and represent the additional staffing costs incurred due to the Covid-19 response and do not include the cost of substantive staff that have been redeployed into expanded capacity areas. Pay costs relating to the Covid-19 response were primarily linked to the requirement for existing staff to work additional shifts, in particular over the Easter Bank Holiday weekend which coincided with a peak in the number of Covid-19 cases across the two hospitals. There were also significant additional costs incurred as a result of increased shifts in community services with most staff working the April bank holidays and additional shifts to support 7 day working which to some extent have continued into September. Almost 150 students (nursing, therapies and medical) had been added to the payroll up until mid August, many of whom were working in a supernumerary capacity. Changes to medical rotas also had a financial impact with additional enhancements paid to junior medical staff. Increased substantive costs were offset to some extent in earlier months by a reduction in agency and bank costs and lower than planned pay costs in some non Covid ward areas where bed occupancy was lower than usual. More recently the Trust has started to incur additional staffing costs related to Phase 3 plans to increase capacity in order to manage increasing levels of activity.

Non Pay - £9.32m

Clinical Supplies costs linked to Covid-19 are £2.40m, including costs related to increased ICU capacity of £0.44m, £1.09m on Covid testing and £0.4m on CT scanner hire.

Other non-pay costs attributable to Covid-19 total £6.92m includes the full cost incurred for the purchase of gowns (PPE) on behalf of the whole region (£3.39m) and other costs attributable to Covid-19 of £3.03m including other PPE costs of £1.55m (masks, gloves, eye protection, respirators etc), additional equipment, minor works for social distancing / segregation and patient transport.

The year to date position also includes £0.26m relating to additional costs incurred back in Month 3 due to the requirement to write off Drugs stock that had been manufactured by HPS (Pharmacy Manufacturing Unit). The Unit was commissioned back in March to produce large quantities of Noradrenaline (used in ICU patient Care) for use across the NHS. Demand was not as high as expected and subsequently the unit was asked to cease production, leaving a large quantity of unused drugs and raw materials to be written off.

Nightingale Hospital - £0.003m

The Trust has not accounted for any costs relating to the Nightingale hospital in Month 6.

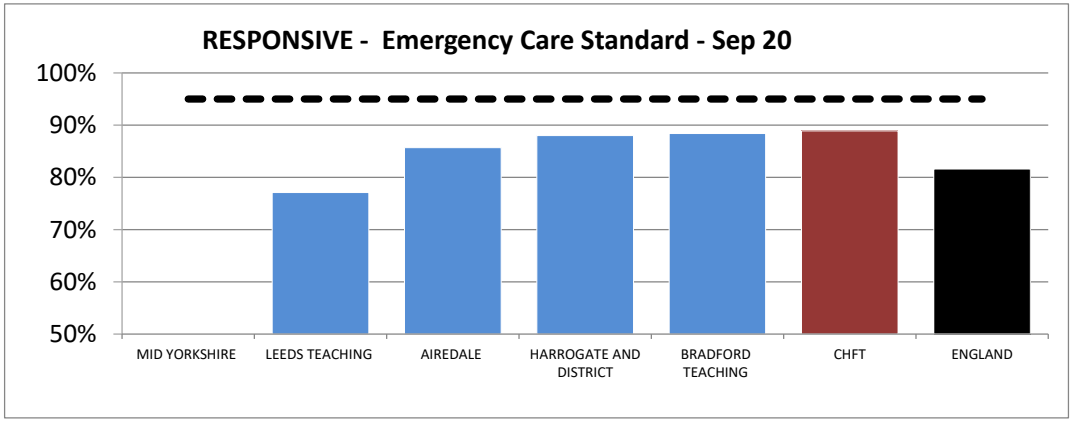
Income Losses

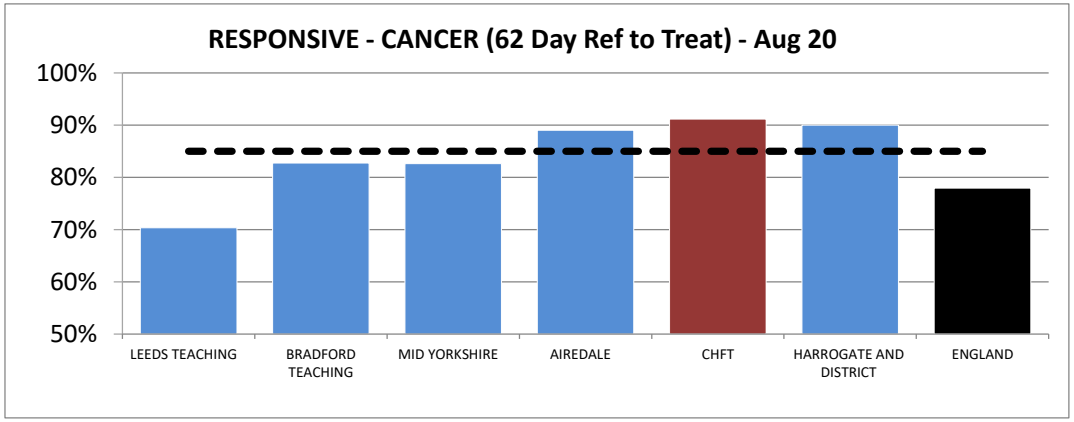
In addition, the Trust has lost income totalling £1.94m including: loss of Car Parking Income, (£0.82m which is a combination of income from staff permits and income from patients and visitors), loss of catering income (£0.07m), loss of apprentice levy income (£0.08m from pausing of HCAs apprenticeships delivered internally) and loss of private patient income (in particular from Yorkshire Fertility).

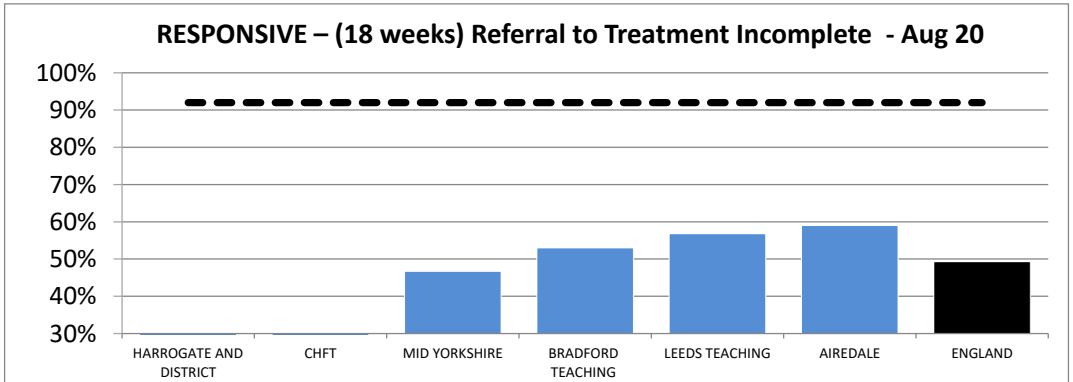
These costs have been offset to some extent year to date by the indirect impact of lower than planned costs in non-Covid areas where activity has reduced as a result of the Covid-19 response.

Capital funding for Covid-19 costs has also been requested as shown. The Trust is still waiting for confirmation of PDC funding to cover most of this additional expenditure.

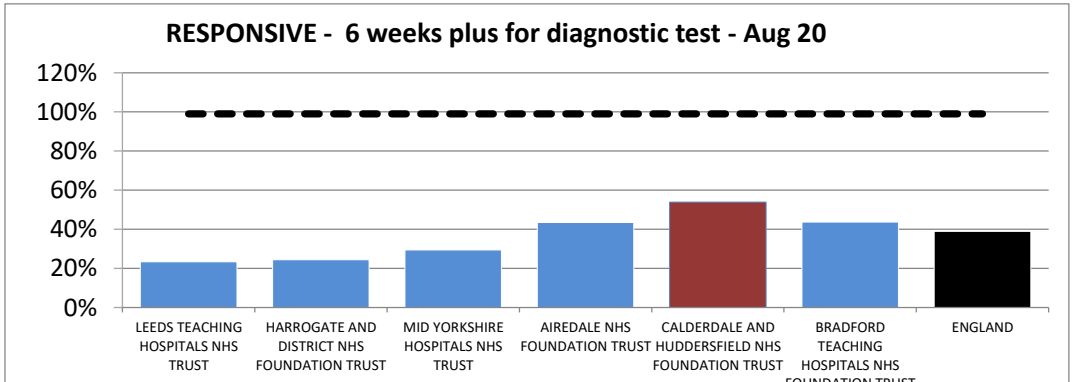
Benchmarking - Selected Measures

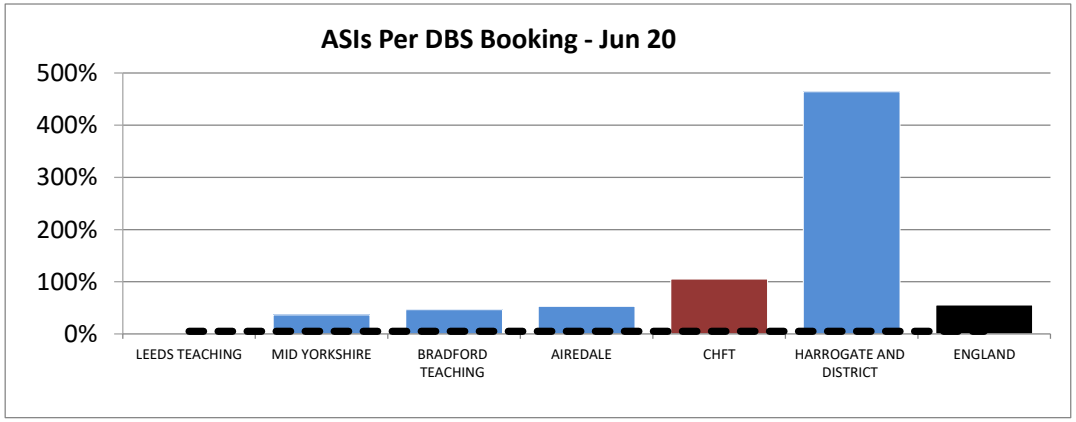






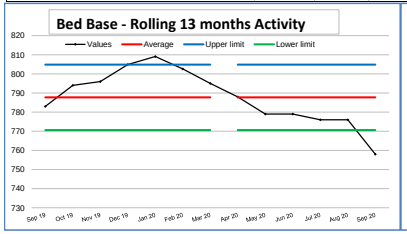
CHFT and Harrogate not included as trialling new Elective Care Standard

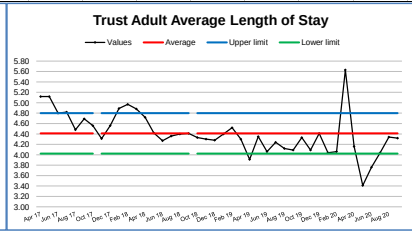


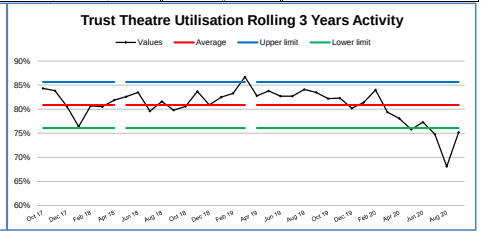


Efficiency & Finance - Key measures

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Performance Range		
																Green	Amber	Red
Did Not Attend Rates																		
First DNA	7.70%	8.29%	6.92%	7.25%	7.44%	6.94%	7.20%	8.02%	4.40%	3.76%	2.68%	2.78%	2.89%	**3.58%**	**3.29%**	<=7%	7.1% - 7.9%	>=8%
Follow up DNA	6.67%	6.51%	6.18%	6.50%	6.43%	6.21%	6.06%	6.72%	5.57%	4.55%	4.98%	4.61%	5.15%	**5.20%**	**5.04%**	<=7%	7.1% - 7.9%	>=8%
Average length of stay																		
Average Length of Stay - Overall	4.26	4.09	4.33	4.09	4.41	4.04	4.06	5.63	4.16	3.41	3.76	4.04	4.34	**4.32**	**4.01**	<=5.19 / <=4.25 from April 20		>=5.30
Average Length of Stay - Elective	2.27	2.00	2.01	2.32	2.39	1.94	2.60	2.30	1.44	1.54	2.03	3.69	2.90	**2.97**	**2.65**	<=2.49 / <=2.30 from April 20		>=2.60
Average Length of Stay - Non Elective	4.50	4.36	4.62	4.31	4.63	4.26	4.25	6.03	4.26	3.45	3.81	4.06	4.41	**4.4**	**4.07**	<=4.62 / <=4.40 from April 20		>=5.50
Average Length of Stay - Non Elective - Excluding Ambulatory	5.64	5.57	5.80	5.50	5.72	5.36	5.42	7.28	4.88	4.16	4.54	4.81	5.3	**5.35**	**4.85**	<=5.56		
Average Length of Stay - Overall - Excluding Ambulatory	5.20	5.06	5.28	5.06	5.34	4.96	5.03	6.66	4.75	4.08	4.51	4.77	5.14	**5.17**	**4.75**	<=5.15 / <=5.10 from April 20		>=5.25
Pre-Op Length of Stay - Elective Patients	0.05	0.06	0.03	0.05	0.12	0.04	0.04	0.05	0.07	0.04	0.14	0.24	0.11	**0.17**	**0.14**	<= 0.02 as per Model Hospital		>0.04
Pre-Op Length of Stay - Non Elective Patients	0.64	0.64	0.66	0.57	0.58	0.57	0.59	0.85	0.52	0.48	0.56	0.72	0.68	**0.72**	**0.62**	<=0.73 as per Model Hospital		
Non Elective with zero LOS (not ambulatory)	8,055	624	663	709	670	694	640	620	439	581	528	554	501	**532**	**3,135**	Not applicable		
Elective Inpatients with zero LOS	907	91	102	91	66	88	68	73	27	11	16	9	19	**25**	**107**	<=75	YTD <=900	>=80
Day Cases																		
Day Case Rate	89.66%	89.33%	89.37%	89.45%	89.90%	90.53%	89.42%	89.43%	91.94%	94.55%	94.62%	93.56%	92.84%	**92.17%**	**93.21%**	>=89.25%	80.1% -89.24%	<=80%
Failed Day Cases	1,483	119	111	134	113	123	149	116	31	23	30	77	64	**80**	**305**	<=120	YTD <=1440	>=125
Beds																		
Beds Open in Month - Plan	801	778	778	778	778	801	801	801	785	770	770	770	770	**770**	**770**	Not applicable		
Beds Open in Month - Actual	795.00	783.00	794.00	796.00	804.88	809.10	802.60	795.00	788.00	779.00	779.00	776.00	776.00	**758**	**758**	Not applicable		
Hospital Bed Days per 1000 population - Adults	40.44	45.78	48.7	46.89	48.26	48.65	45.27	40.44	25.05	30.18	32.79	36.42	38.27	**38.55**	**24.97**	18/19 Baseline		
Emergency Hospital Admissions per 1000 population - Adults	0.08	0.09	0.10	0.10	0.10	0.11	0.09	0.08	0.06	0.08	0.08	0.09	0.08	**0.08**	**0.06**	18/19 Baseline		
Occupied Bed Days							17,829	16,007	9,269	11,578	12,604	14,178	14,714	**14,834**	**77,177**	Not applicable		
Cancellations																		
Clinical Slots not Utilised	8.70%	not available	not available	not available	not available	not available	not available	10.00%	32.30%	32.80%	24.10%	14.30%	11.60%	**0.08**	**20.60%**	Not applicable		
Endoscopy Utilisations - Trust level	98.30%	98.51%	97.88%	98.61%	98.36%	97.20%	99.30%	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Endoscopy Utilisations - CRH	99.69%	99.74%	99.56%	99.84%	99.54%	99.65%	99.64%	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Endoscopy Utilisations - HRI	97.22%	97.70%	96.73%	97.49%	97.18%	95.39%	98.73%	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Hospital Cancellations within 6 Weeks	11,704	not available	not available	not available	not available	not available	not available	8,273	17,022	7,545	3,822	4,368	3,253	**3,638**	**3,638**	0		>=1
Theatre Utilisation																		
Theatre Utilisation (TT) - Main Theatre - CRH	83.60%	85.40%	82.00%	83.80%	81.30%	82.10%	84.00%	79.90%	89.16%	82.80%	80.30%	86.50%	80.00%	**71.00%**	**80.10%**	>=90%	86% - 89%	<=85%
Theatre Utilisation (TT) - Main Theatre -HRI	87.80%	86.70%	88.90%	89.20%	84.60%	88.20%	89.30%	82.70%	63.15%	72.30%	90.90%	64.60%	57.00%	**63.00%**	**66.40%**	>=90%	86% - 89%	<=85%
Theatre Utilisation (TT) - HRI DSU	73.80%	76.00%	74.80%	70.80%	72.80%	72.30%	78.50%	73.30%	57.62%	58.70%	62.50%	75.40%	70.00%	**82.20%**	**74.40%**	>=88%	85% - 87%	<=84%
Theatre Utilisation (TT) - Trust	82.40%	83.50%	82.20%	82.30%	80.20%	81.40%	84.00%	79.40%	78.09%	75.80%	77.30%	74.80%	68.10%	**75.20%**	**74.20%**	>=90%	84% - 89%	<=83%
% Theatre Scheduled Late Starts > 15 mins - Trust	37.29%	37.23%	37.29%	37.35%	39.05%	32.71%	36.50%	44.93%	56.76%	55.10%	45.45%	50.98%	65.17%	**53.61%**	**55.27%**	Not applicable		
Total Fallow lists - Trust	705	39	53	40	84	58	52	30	ocation due	**No Reallocation due to COVID**						To be confirmed		
Flow																		
No. of Ambulatory patients	12,405	1,042	1,071	1,131	1,011	1,195	1,076	787	434	653	699	655	662	**669**	**3,772**	To be confirmed		
Emergency Hospital Discharges	51483	4130	4500	4551	4449	4729	4033	3732	2,620	3,095	3,277	3,440	3,279	**3,433**	**19,144**	<=4200	YTD <=50400	>=4201
Stranded 7 Days	48.07%	48.32%	48.90%	46.64%	47.45%	47.88%	48.22%	50.70%	37.50%	37.49%	39.58%	42.10%	44.40%	**43.68%**	**41.17%**	<=30%	31% - 99%	>=40%
Super Stranded 21 Days	97	90	102	100	93	104	106	97	24	22	31	40	49	**55**	**37**	<= 95	96 - 97	>=98
Average time to start of reablement (days)	6.94	8.20	6.00	5.80	6.10	4.60	4.20	4.20	2.00	2.50	2.80	3.10	4.20	**4.50**	**3.20**	<=5 days	6 - 8 days	>= 9 days
% Catheter Lab Utilisation	89.00%	not available	not available	not available	not available	not available	not available	not available	not available	not available	not available	not available	not available	**not available**	**not available**	No target		







Efficiency & Finance Frailty- Key measures

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Performance Range
Acute Admissions - Aged 75+ Years																Green / Amber / Red
Acute Admissions aged 75+	9,851	744	852	822	936	947	784	757	581	635	692	741	739	**745**	**4,133**	not applicable
Frail* patients admitted aged 75+	3927	286	323	316	433	437	307	295	188	203	236	226	271	**271**	**1,395**	
% patients admitted aged 75+ who are frail**	39%	38%	38%	38%	46%	46%	39%	39%	32%	32%	34%	31%	37%	**36%**	**32%**	
Frailty Admissions with LOS < 3 days																
Patients 75+ with a LOS < 3 days	5060	374	434	451	446	503	408	320	260	327	340	377	362	**367**	**2,033**	not applicable
Frail* patients with a LOS < 3 days	1595	105	141	140	167	184	130	91	81	83	105	83	108	**93**	**553**	
% of patients with a LOS < 3 days who are frail**	32%	28%	32%	31%	37%	37%	32%	28%	31%	25%	31%	22%	30%	**25%**	**32%**	
Patients 75+ occupied bed days	69085	5215	5827	5372	6533	6267	4940	7011	3,409	3,005	3,781	4,561	4,594	**4,545**	**23,895**	
Frail* occupied bed days	32362	2433	2254	2405	3414	3536	2358	2926	1,074	1,170	1,425	1,886	1,975	**2,175**	**9,705**	
Average frail* non-elec IP LOS	42.0	8.51	6.98	7.61	7.88	8.09	7.68	9.92	5.71	5.76	6.0	8.4	7.3	**8.0**	**5.7**	
Average Frailty Rockwood Score		not available							5.80	5.80	6.00	5.90	5.90	**5.99**	**5.99**	
Re-admitted back to the Frailty Team within 30 days	1035	59	**87**	107	113	124	98	93	84	112	72	100	107	**97**	**572**	
% Re-admitted back to the Frailty Team within 30 days	20%	11%	**14%**	18%	17%	18%	17%	18%	17%	20%	14%	17%	18%	**17%**	**not available**	

* Data is based on the following Treatment Functions: General Medicine; Endocrinology; Hepatology; Diabetic Medicine; Respiratory; Nephrology; Neurology; Rheumatology; Geriatric Medicine

** The frailty team at Calderdale and Huddersfield Foundation Trust have defined frail patients as being a patient over and including the age of 75 with one of the ICD 10 diagnosis codes described by the Acute Frailty Network (AFN).

Activity - Key measures

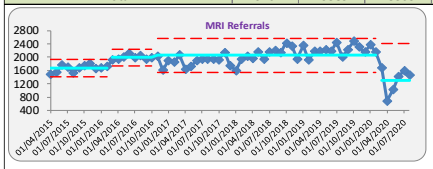
	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	YTD % Change
GP referrals to all outpatients																
02T - NHS CALDERDALE CCG	35,430	3,360	3,606	2,937	2,447	2,993	2,421	1,885	673	1,174	1,842	1,966	1,813	**2,129**	**9,597**	**-51.99%**
03A - NHS GREATER HUDDERSFIELD CCG	32,540	2,999	3,245	2,726	2,199	2,721	2,461	1,873	722	1,241	1,875	2,057	1,934	**2,120**	**9,949**	**-42.96%**
Other	6724	657	609	550	426	555	470	325	96	113	168	200	202	**193**	**972**	**-73.11%**
Trust	74,694	7,016	7,460	6,213	5,072	6,269	5,352	4,083	1,491	2,528	3,885	4,223	3,949	**4,442**	**20,518**	**-49.83%**
Trust - % Change on Previous year	0.09%	21.13%	12.61%	7.91%	-6.54%	-4.62%	-2.22%	-37.31%	-76.93%	-63.22%	-37.66%	-41.33%	-38.98%	**-36.94%**	**-49.83%**	
03J - NHS NORTH KIRKLEES CCG	2,533	274	239	211	155	198	190	119	38	46	78	98	110	**90**	**460**	**-67.40%**
02R - NHS BRADFORD DISTRICTS CCG	0	0	0	0	0	0	0	0	40	29	46	58	65	**51**	**289**	**-73.12%**
03R - NHS WAKEFIELD CCG	912	88	87	64	67	68	58	49	6	10	8	3	5	**5**	**37**	**-91.67%**
02W - NHS BRADFORD CITY CCG	0	0	0	0	0	0	0	0	5	4	4	0	0	**0**	**13**	**-95.22%**
01D - NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	75	8	10	6	1	7	7	2	0	0	1	1	1	**1**	**4**	**-90.00%**
03C - NHS LEEDS WEST CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
02N - NHS AIREDALE, WHARFEDALE AND CRAVEN CCG	0	**0**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
03G - NHS LEEDS SOUTH AND EAST CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
02V - NHS LEEDS NORTH CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0.00%**
15F - NHS LEEDS CCG	83	9	8	5	8	7	3	5	0	0	0	5	1	**1**	**7**	**-88.71%**
ACTIVITY VARIANCE AGAINST CONTRACT																
Day Case Variance against Contract	-284	49	-123	92	162	-12	121	-760	-2,796	-2,470	-2,578	-2,353	-1,717	**-1,917**	**-13,932**	
% Day Case Variance against Contract	-0.74%	1.40%	-3.20%	2.62%	5.42%	-0.33%	3.62%	-20.68%	-80.27%	-77.63%	-74.20%	-70.41%	-50.79%	**-64.10%**	**-50.44%**	
Elective Variance against Contract	-53	14	-21	11	-5	-37	39	-76	-364	-365	-406	-346	-225	**-237**	**-1,949**	
% Elective Variance against Contract	-1.06%	3.11%	-4.05%	2.28%	-1.17%	-8.10%	9.18%	-16.08%	-79.12%	-81.36%	-81.09%	-78.47%	-58.72%	**-71.89%**	**-54.15%**	
Non-elective Variance against Contract	-962	-166	54	65	-81	367	-94	-823	-1,959	-1,201	-997	-1,062	-826	**-1,002**	**-7,154**	
% Non-elective Variance against Contract	-1.75%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-3.42%	-38.67%	-31.67%	-28.17%	-26.35%	-17.66%	**-24.15%**	**-20.07%**	
Outpatient Variance against Contract	162	-289	-296	-347	1,232	-70	-1,066	-6,806	-18,441	-16,695	-15,365	-13,995	-11,147	**-37,538**	**-113,047**	
% Outpatient Variance against Contract	0.07%	-0.96%	-1.03%	-1.13%	5.09%	-0.30%	-3.62%	-21.48%	-61.92%	-61.13%	-56.22%	-52.76%	-39.29%	**-61.78%**	**-117.41%**	
Accident and Emergency Variance against Contract	3,199	256	103	614	346	647	538	-2,310	-6,037	-4,326	-3,153	-2,512	-902	**-1,655**	**-18,586**	
% Accident and Emergency Variance against Contract	0.58%	1.99%	0.78%	4.92%	2.66%	5.19%	4.68%	-18.02%	-46.70%	-38.81%	-33.85%	-29.69%	-6.92%	**-23.15%**	**-12.47%**	

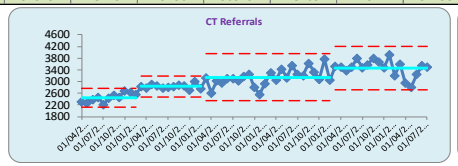
Please note further details on the referral position including commentary is available within the appendix.

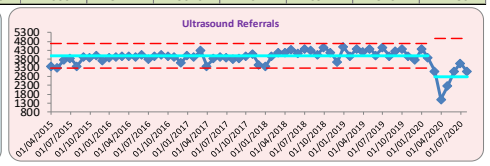
Radiology Summary of Activity of Key Modalities - August 2020

Referrals into Service

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	YTD 20/21	YTD 19/20	Increase	%
MRI	2188	2230	2173	2444	2004	2228	2479	2303	2154	2374	2153	1671	689	1026	1418	1595	1469	6197	11039	-4842	-44%
CT	3497	3380	3498	3785	3481	3572	3790	3683	3482	3911	3212	3599	2949	2807	3249	3545	3489	16039	17641	-1602	-9%
Obstetrics	2288	2481	2247	2581	2400	2329	2480	2276	2287	2394	2175	2301	1909	1951	2235	2244	2076	10415	11997	-1582	-13%
General Radiology	16923	17116	16434	18090	16876	16765	17406	16472	15653	18242	15665	12489	6629	8962	10935	12812	12348	51686	85439	-33753	-40%
Ultrasound	4205	4382	4011	4445	3962	4256	4364	3975	3741	4375	3861	3112	1500	2266	3107	3568	3098	13539	21005	-7466	-36%
Total	29101	29589	28363	31345	28723	29150	30519	28709	27317	31296	27066	23172	13676	17012	20944	23764	22480	97876	147121	-49245	-33%





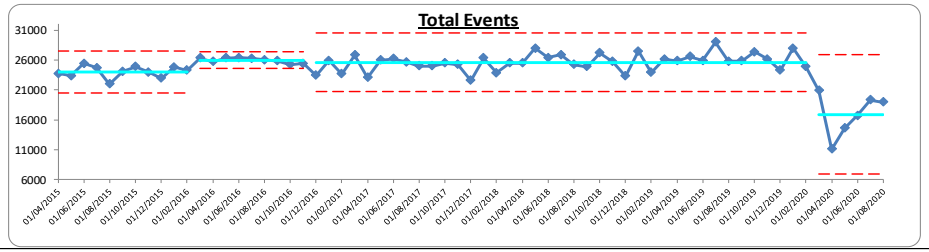


How does this compare to Trust activity Trend?

A&E Activity ha s decreased by 24%, Outpatients decreased by 27% and Inpatients (excluding Maternity) decreased by 40%

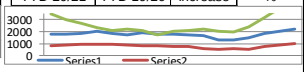
Activity

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	YTD 20/21	YTD 19/20	Increase	%
Total Events	25,856	26,555	25,921	29,002	25,777	25,871	27,344	26,191	24,262	27,950	24,917	20,906	11,080	14,583	16,696	19,353	18,936	80,648	133,111	-52,463	-39%
MRI	1900	1778	1905	2041	1874	1992	1990	2132	1849	2068	1974	1832	502	698	822	1190	1201	4413	9498	-5085	-54%
HRI -MRI	675	629	647	682	637	658	698	701	677	690	703	643	221	261	266	329	372	1449	3270	-1821	-56%
CRH - MRI	463	500	498	558	479	492	582	551	446	533	473	455	160	164	197	226	161	908	2498	-1590	-64%
Mobile	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
New Scanner - HRI	626	561	643	703	675	752	606	735	621	744	679	579	118	151	232	240	226	967	3208	-2241	-70%
CRVAN	127	76	108	90	78	84	92	134	98	92	112	143	0	0	0	0	0	0	479	-479	-
Other/Unknown	9	12	9	8	5	6	12	11	7	9	7	12	3	122	127	395	442	1089	43	1046	2433%
CT	3,053	2,925	3,072	3,302	3,009	3,206	3,331	3,132	3,024	3,389	3,187	2,718	1,755	2,576	2,579	2,836	2,911	12,657	15,361	-2,704	-18%
General Radiology	15,364	15,664	15,003	17,202	15,071	15,031	15,911	15,148	14,361	16,532	14,381	11,438	5,865	7,941	9,284	10,986	10,914	44,990	78,304	-33,314	-43%
Obstetrics	2,098	2,367	2,131	2,392	2,257	2,196	2,316	2,144	2,112	2,242	2,071	2,123	1,786	1,853	2,110	2,067	1,959	9,775	11,245	-1,470	-13%
Ultrasound	3,441	3,821	3,810	4,065	3,566	3,446	3,796	3,635	2,916	3,719	3,304	2,795	1,172	1,515	1,901	2,274	1,951	8,813	18,703	-9,890	-53%
Total Exams	28,260	29,008	28,480	32,306	28,619	28,405	29,930	28,739	26,521	30,743	27,471	23,073	12,387	16,402	18,715	21,526	21,122	90,152	146,673	-56,521	-39%
MRI	1964	1845	1985	2134	1956	2069	2058	2215	1934	2151	2046	1908	515	712	839	1210	1230	4506	9884	-5378	-54%
HRI -MRI	698	654	663	707	667	680	711	729	708	700	719	670	223	273	270	340	380	1486	3389	-1903	-56%
CRH - MRI	471	513	524	575	495	512	598	572	456	556	486	462	168	168	205	239	169	949	2578	-1629	-63%
Mobile	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-
New Scanner - HRI	653	587	681	751	706	783	643	766	663	790	721	618	121	149	235	251	235	991	3378	-2387	-71%
CRVAN	133	78	108	93	81	87	94	137	99	96	113	145	0	0	0	0	0	0	493	-493	-
Other/Unknown	9	13	9	8	7	7	12	11	8	9	7	13	3	122	129	380	446	1080	46	1034	2248%
CT	4,439	4,253	4,498	4,979	4,366	4,719	4,826	4,586	4,363	4,999	4,741	4,167	2,825	4,056	4,108	4,354	4,441	19,784	22,535	-2,751	-12%
General Radiology	15,971	16,342	15,657	18,318	16,062	15,647	16,560	15,785	14,885	17,253	14,974	11,820	5,948	8,068	9,492	11,312	11,293	46,113	82,350	-36,237	-44%
Obstetrics	2,107	2,372	2,134	2,398	2,264	2,200	2,320	2,153	2,119	2,248	2,079	2,125	1,791	1,856	2,115	2,072	1,962	9,796	11,275	-1,479	-13%
Ultrasound	3,779	4,196	4,206	4,477	3,971	3,770	4,166	4,000	3,220	4,092	3,631	3,053	1,308	1,710	2,161	2,578	2,196	9,953	20,629	-10,676	-52%



Waiting List at Month End

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	YTD 20/21	YTD 19/20	Increase	%
Total number on MRI Waiting List	1774	1803	1878	2044	1845	1761	1913	1779	1780	1755	1671	1295	1335	1527	1867	2042	2192				
Total number on CT Waiting List	856	873	931	945	973	925	855	845	757	770	614	562	581	553	748	909	1017				
Total number on US Waiting List	3454	3025	2727	2353	2085	2226	2111	1766	2024	2106	2231	2042	2008	2409	3173	3950	4625				



Number of Exams reported

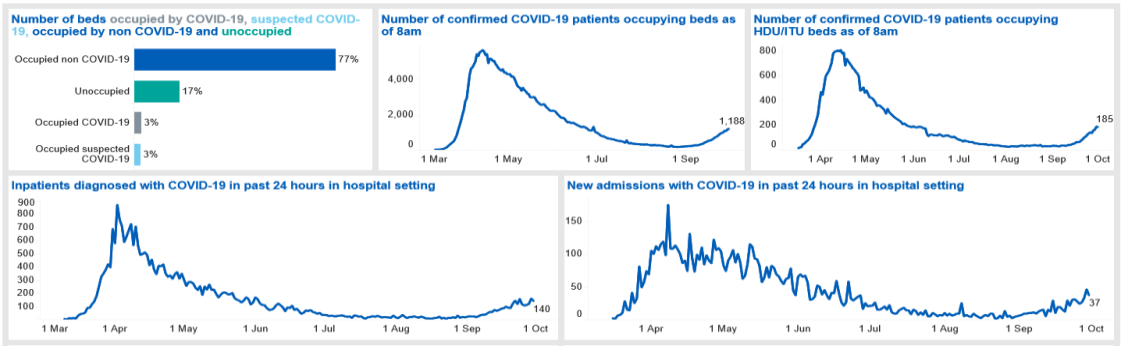
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	YTD 20/21	YTD 19/20	Increase	%
Internal (Planned)	13589	13823	12320	15530	13995	12592	13511	12221	12550	13959	12956	15532	9098	11411	12777	14472	14221	61979	69257	-7278	-11%
Insourced (Extras)	253	152	102	283	17	0	0	0	0	0	46	23	0	0	0	0	92	92	807	-715	-
Locum Radiologist/Sonagropher	288	392	690	1114	217	1161	502	454	512	783	581	479	727	409	579	683	468	2866	2701	165	6%
Auto Reported	4216	2861	2476	2372	2126	3042	3266	3128	3458	4694	3355	2869	562	1042	2063	3008	1911	8586	14051	-5465	-39%
Outsourced	3278	7511	7279	8759	7481	7409	8055	8310	10180	11003	10037	5418	707	1059	995	1298	1507	5566	34308	-28742	-84%
Total	21624	24739	22867	28058	23836	24204	25334	24113	26700	30439	26975	24321	11094	13921	16414	19461	18199	79089	121124	-42035	-35%
% Outsourced	15%	30%	32%	31%	31%	31%	32%	34%	38%	36%	37%	22%	6%	8%	6%	7%	8%	7%	28%	-21%	
% Insourced/Outsourced	16%	31%	32%	32%	31%	31%	32%	34%	38%	36%	37%	22%	6%	8%	6%	7%	9%	7%	29%	-22%	

Appendices

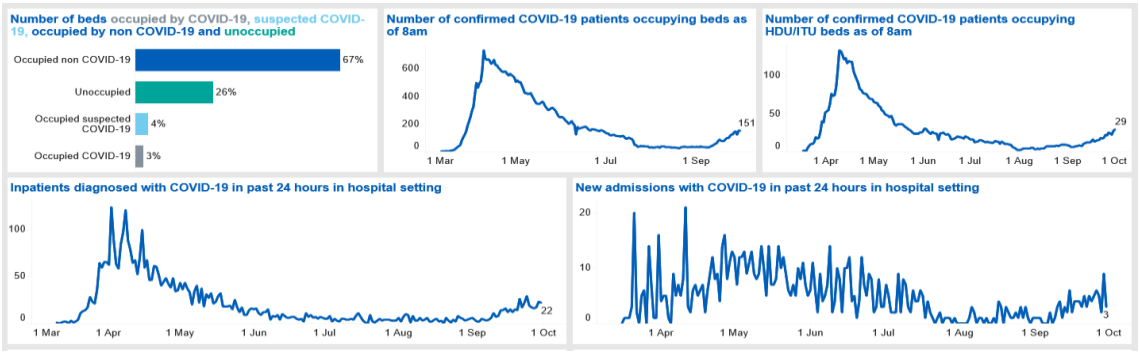
COVID-19 IPR APPENDIX

COVID Metrics across the Region:

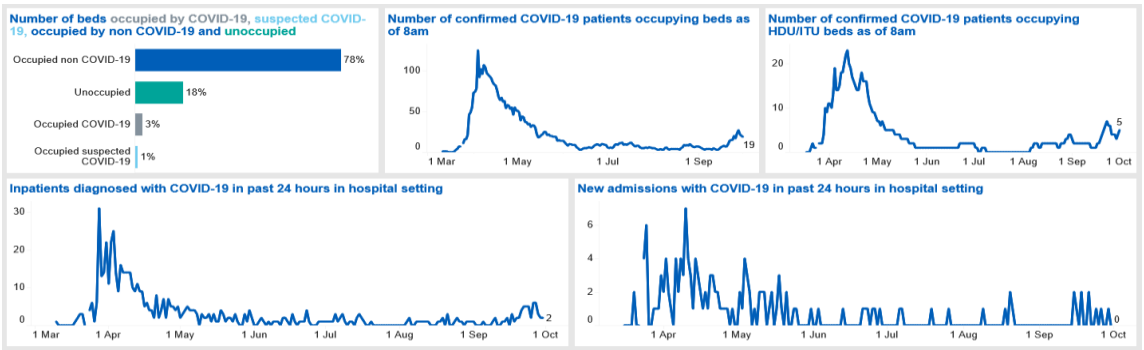
North East and Yorkshire and North West: Peak of Covid19+ inpatients in early April followed by reduction until early September when a second wave looks to be having an impact. Covid19 admissions are now increasing week on week. Occupied beds for Covid19 and suspected Covid19 are both at 3% compared to 2% and 1% respectively last month.



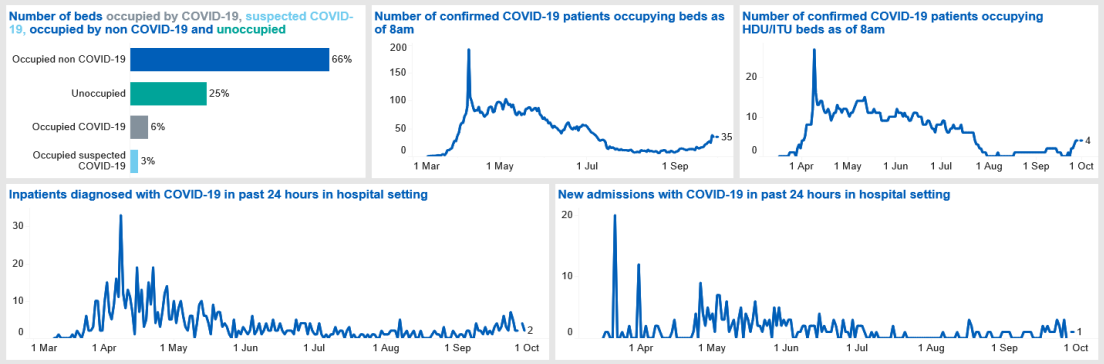
WYAAT: Same pattern as Region above. Occupied beds for Covid19 patients are 3% compared to 1% last month.



CHFT: Same pattern as WYAAT with occupied beds for Covid19 patients at 3% compared to 1% last month.



BTHFT: Bradford reduction in Covid cases was flatter since April than the areas above. Early September also shows signs of the second wave with Covid19 admissions increasing week on week. Occupied beds for Covid19 and suspected Covid19 are 6% and 3% respectively compared to 2% and 0% respectively last month – a much more significant increase than that seen in other areas above.



Beds Occupied Position as at 1st October across WYAAT – 1 day snapshot

Number of beds (confirmed COVID-19, suspected COVID-19, **other patients and unoccupied**) **reported as of 8am**

Bed type:

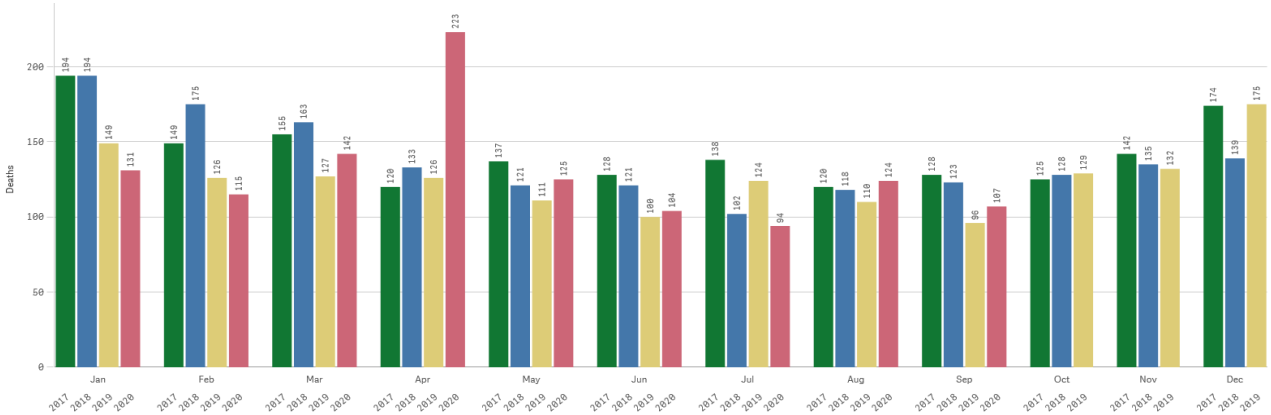
Click on +/- sign to drill-down/roll-up. Top filters are not applied on this chart.

Region	Organisation			
North East and Yorkshire	Airedale NHS Foundation..	9 (3%)	3 (1%)	261 (75%)	74 (21%)
	Bradford Teaching Hospit..	35 (6%)	16 (3%)	383 (66%)	148 (25%)
	Calderdale and Huddersfi..	19 (3%)	8 (1%)	486 (78%)	114 (18%)
	Harrogate and District N..	1 (0%)	6 (2%)	202 (65%)	103 (33%)
	Leeds Teaching Hospital..	53 (2%)	161 (7%)	1,359 (62%)	635 (29%)
	Mid Yorkshire Hospitals ..	34 (3%)	31 (3%)	720 (71%)	227 (22%)

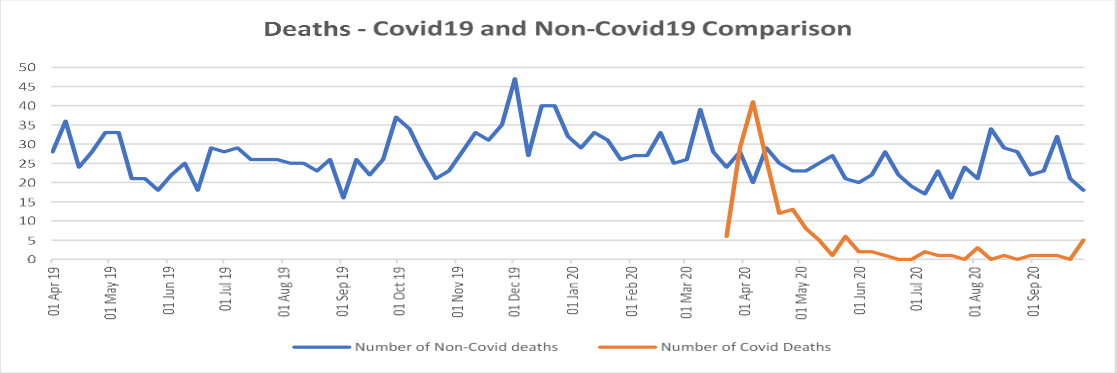
Except for Harrogate all Trusts have seen an increase in the percentage of beds occupied by confirmed Covid19 patients. Bradford have the highest bed occupancy of confirmed Covid19 patients at 6% whereas Leeds have the highest bed occupancy of suspected Covid19 patients at 7%. All Trusts except CHFT within WYAAT have had a decreased % bed occupancy of non-Covid19 patients from the September snapshot.

CHFT Mortality:

Historical Comparison

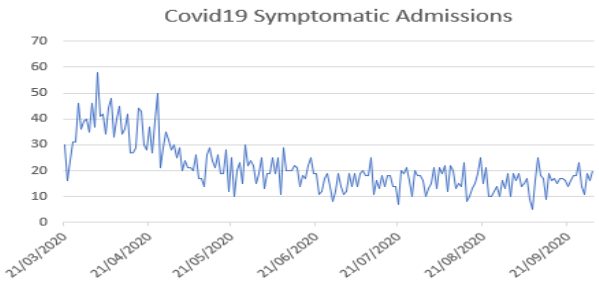


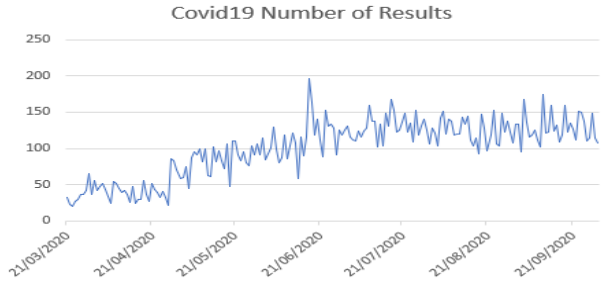
Impact of Covid19 deaths on historical trends seen particularly in April and then less so since May with the lowest number of deaths in July in the last 4 years. Deaths in September were higher than same month in 2019 but lower than 2017 and 2018.



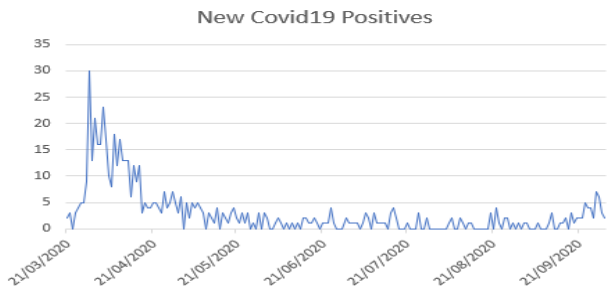
Peak number of Covid19+ deaths in early April with a sustained reduction since then to mid/end September. Week commencing 28th September there were 5 Covid+ deaths; this is the highest number of Covid deaths since the end of May.

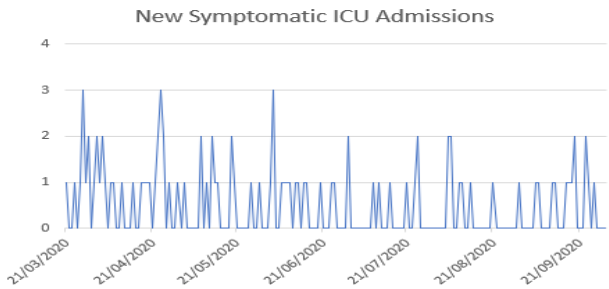
Covid19 Hospitalisation in England Surveillance System (CHESS) was developed by Public Health England (PHE) for monitoring hospitalised COVID-19. The scheme is based on the existing UK Severe Influenza Surveillance Scheme (USISS) that was created following the 2009 influenza pandemic. Objectives of CHESS are to monitor and estimate the impact of Covid19 on the population.



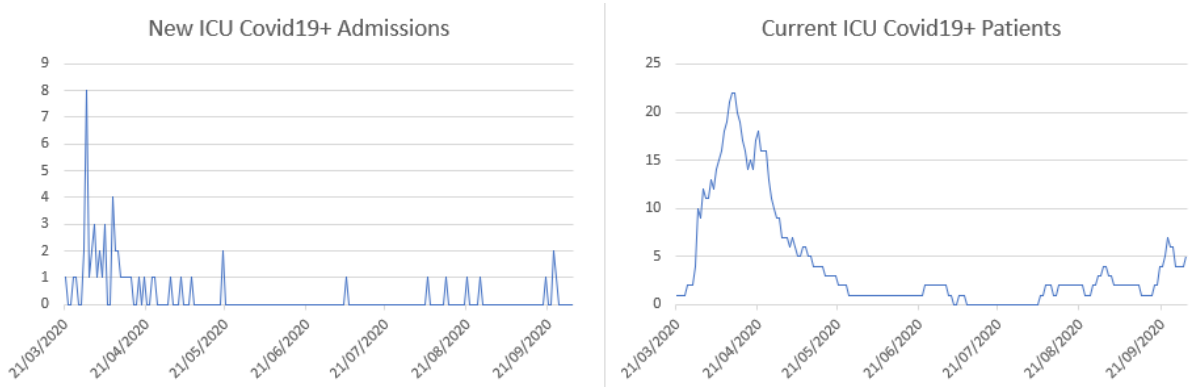


Since a peak in late March/early April there has been an overall reduction in symptomatic admissions to CHFT to a steady state with some daily variation since mid-June. The increase in number of Covid19 results from start of May relates to a change in testing policy to include asymptomatic admissions.





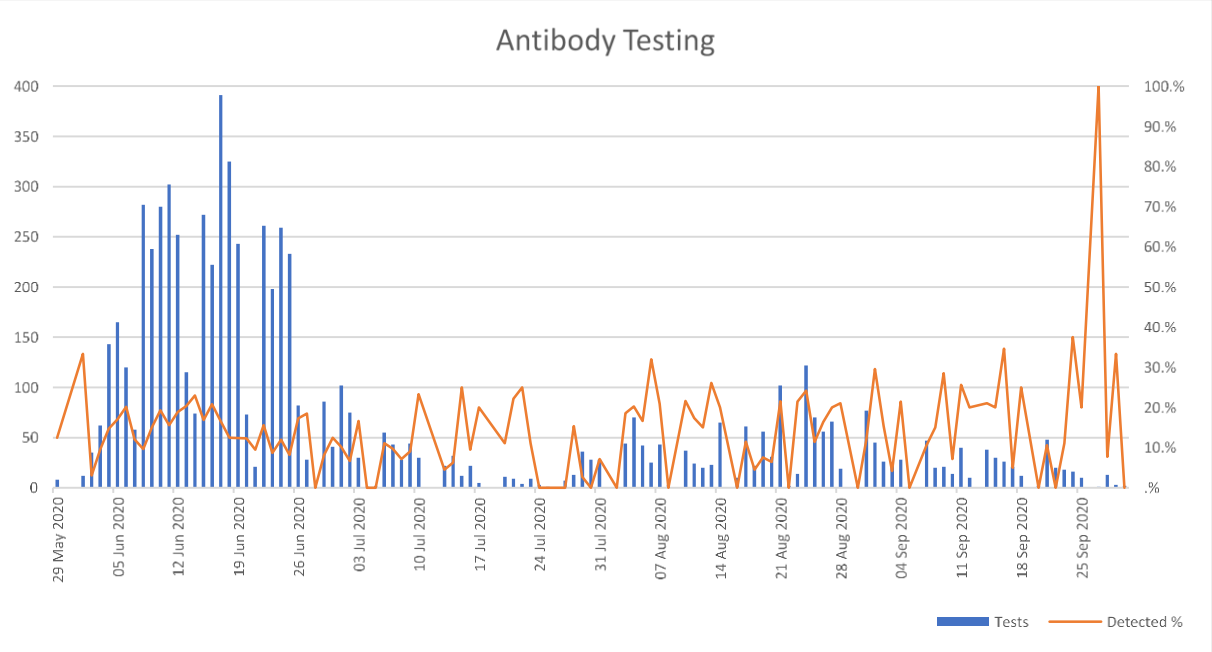
Since 29th March the trend was a gradual and sustained decrease in new Covid19+ inpatients however there has been an upward trend since mid-September.



There was a peak of Covid19+ patients in ICU's 10th - 12th April and other than a small increase around 22nd April there had been a continual decrease in patients in ICU until a small increase during August which continued into September. The September ICU maximum was 7 on 23rd September.

Antibody Testing:

Graph below shows the number of staff who have had the blood test for presence of Covid19 antibodies and the percentage where presence was detected. Numbers being tested has reduced since the end of June and completion of testing campaign. On average detection of Covid19 antibodies is 15%.



Appendix - Appointment Slot Issues

ASIs

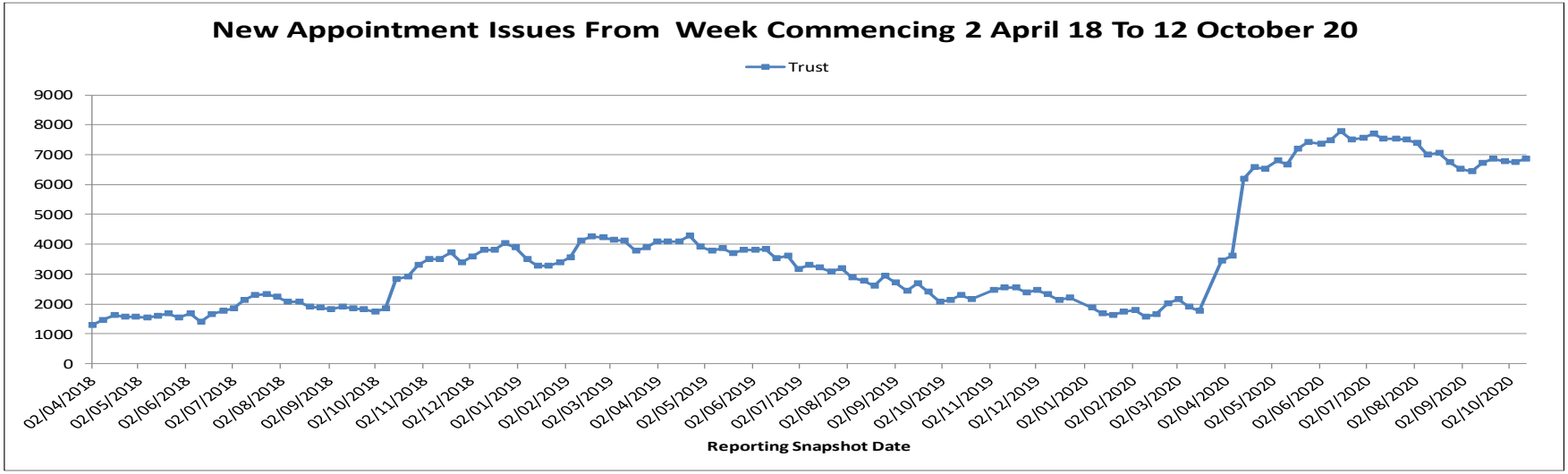
As at 12th October there were 6,863 referrals awaiting appointments.

The top specialties for ASIs backlog are:

ENT	1307
Ophthalmology	933
Trauma and Orthopaedics	795
Paediatric ENT	668
Total	570
MSK	559
Total	411
Neurology	405
Cardiology	304
Yorkshire Fertility	224
Gastroenterology	211
Pain Management	175
Orthoptics	173
Gynaecology	147
Paediatric Urology	138
Paediatric Trauma and Orthopaedics	136

642 patients have been waiting over 6 months, (this was 1,431 on the last report)

Specialty	Weeks Waitng							
	Total	0-13	14-17	18-21	22-25	26-29	30-51	52+
Total	411	397	1	3	0	0	10	0
Chemical Pathology	4	4	0	0	0	0	0	0
Paediatric Epilepsy	0	0	0	0	0	0	0	0
Paediatrics	36	32	0	2	0	0	2	0
Yorkshire Fertility	224	224	0	0	0	0	0	0
Gynaecology	147	137	1	1	0	0	8	0
Total	1092	850	82	63	3	11	80	3
Cardiology	304	247	30	25	0	1	1	0
Endocrinology	22	18	1	0	0	0	3	0
Gastroenterology	211	198	1	0	1	1	7	3
Diabetic Medicine	14	13	0	0	0	0	1	0
General Medicine	8	4	1	0	0	0	3	0
Geriatric Medicine	58	27	14	4	0	3	10	0
Clinical Haematology	4	4	0	0	0	0	0	0
Medical Oncology	0	0	0	0	0	0	0	0
Nephrology	15	14	0	0	0	0	1	0
Rheumatology	29	23	1	1	0	1	3	0
Neurology	405	281	34	32	2	5	51	0
Respiratory Medicine	22	21	0	1	0	0	0	0
Total	4785	3328	487	401	40	99	403	27
Colorectal Surgery	90	85	2	0	0	3	0	0
Breast Surgery	20	18	0	0	0	0	2	0
General surgery	70	67	1	0	0	0	2	0
Ophthalmology	933	838	58	13	1	6	17	0
Paediatric Ophthalmology	86	61	5	5	0	5	10	0
Orthoptics	173	129	14	10	0	5	15	0
Pain Management	175	92	24	10	3	5	41	0
Urology	95	94	1	0	0	0	0	0
Paediatric Urology	138	81	11	5	0	3	38	0
Audiology	26	22	0	2	0	0	1	1
ENT	1307	875	205	181	6	4	36	0
Paediatric ENT	668	343	60	58	9	23	167	8
Maxillo-Facial Surgery	4	4	0	0	0	0	0	0
Plastic Surgery	11	11	0	0	0	0	0	0
Paediatric Plastic Surgery	3	3	0	0	0	0	0	0
Paediatric Surgery	16	11	0	0	0	0	5	0
Trauma and Orthopaedics	795	461	96	95	17	44	64	18
Paediatric Trauma and Orthopaedics	136	96	9	21	4	1	5	0
Vascular Surgery	39	37	1	1	0	0	0	0
Total	570	520	37	4	0	7	1	1
Podiatry	11	10	0	0	0	0	1	0
MSK	559	510	37	4	0	7	0	1
Total	5	5	0	0	0	0	0	0
Not CHFT	0	0	0	0	0	0	0	0
Other CHFT	0	0	0	0	0	0	0	0
-	5	5	0	0	0	0	0	0
Total	6863	5100	607	471	43	117	494	31



Appendix - Referrals

September 2020 Referrals

•GP Referrals down 53% financial YTD September 2020 compared with September 2019. This is completely understandable following the ceasing of all routine referrals for during the Covid19 pandemic.
•From April to September 2020, there were 126 working days, compared with 124 for the corresponding period 2019.
•These two additional working day could indicate an anticipated 1.6 % increase of GP referrals. Clearly the impact of Covid19 on referral demand has been far more dramatic.

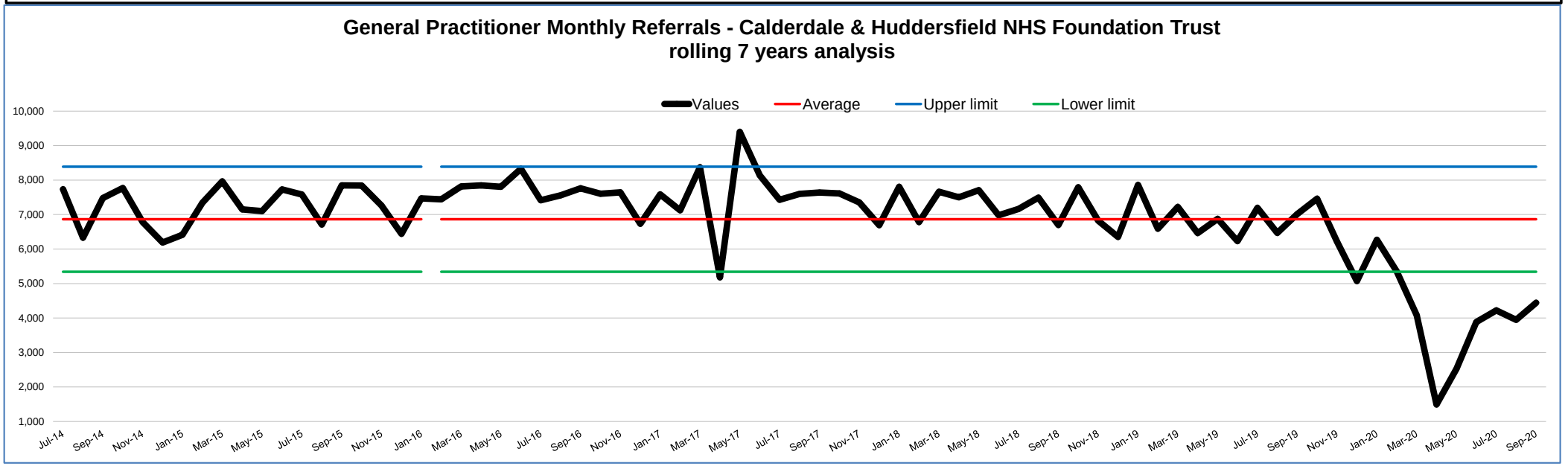
•NHS Calderdale GP referrals have seen a decrease of 50.8% (9,926) for the year to date and NHS Greater Huddersfield has had a large decrease overall of 43% (7,576).

Detailed Investigation of movement at specialty level has not been considered as a result of the large overall decrease.

Other CCGs with contracts with CHFT have all had similar marked reduction in referral volumes

A brief summary is as follows

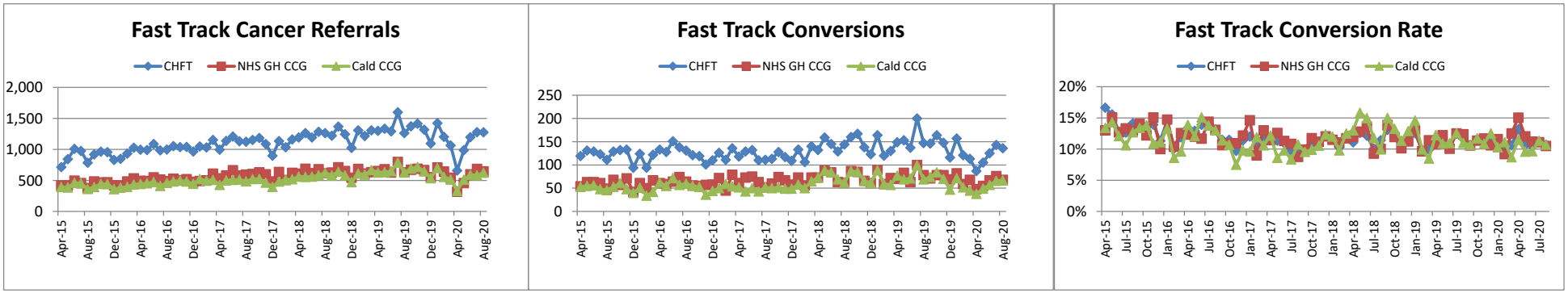
	19/20 YTD	20/21 YTD	Var	% Var
NHS Calderdale	19,523	9,597	-9926	-51%
NHS Greater Huddersfield	17,525	9,949	-7576	-43%
NHS North Kirklees	1,378	460	-918	-67%
NHS Bradford District	1,087	289	-798	-73%
NHS Bradford City	266	13	-253	-95%
NHS Wakefield	473	37	-436	-92%
NHS Heywood	42	4	-38	-90%



Activity - Key measures

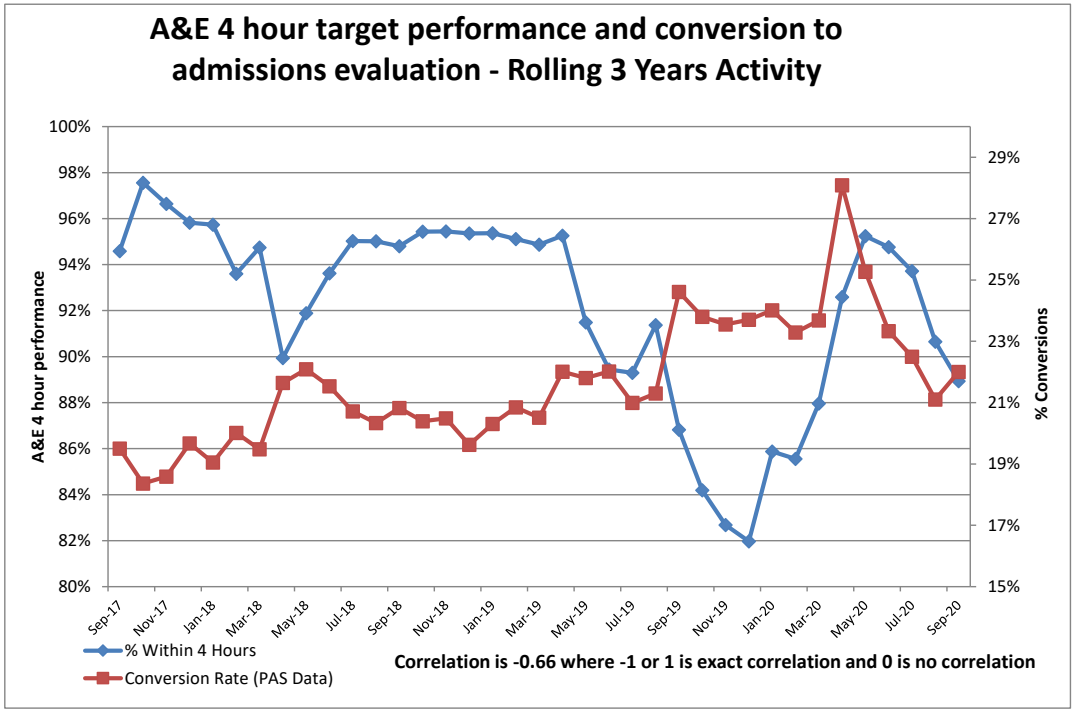
	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	YTD % Change
Fast Track Cancer referrals in month and of those referrals numbers that diagnosed with cancer (conversions)																
NHS CALDERDALE CCG Referrals	7,664	691	712	644	531	702	558	515	330	512	590	579	624	in arrears	in arrears	
NHS CALDERDALE CCG Conversions	874	75	85	78	53	82	62	45	39	49	57	70	67	in arrears	in arrears	
NHS CALDERDALE CCG Conversion Rate	11.4%	10.9%	11.9%	12.1%	10.0%	11.7%	11.1%	8.7%	11.8%	9.6%	9.7%	12.1%	10.7%	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Referrals	7,836	666	686	662	551	707	643	543	320	458	598	684	647	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Conversions	929	71	84	81	76	91	59	68	51	55	67	87	68	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Conversion Rate	11.9%	10.7%	12.2%	12.2%	13.8%	12.9%	9.2%	12.5%	15.9%	12.0%	11.2%	12.7%	10.5%	in arrears	in arrears	
Other CCG Referrals	159	14	15	8	8	12	2	6	9	17	10	15	4	in arrears	in arrears	
Other CCG Conversions	16	3	2	1	0	3	0	0	0	1	1	1	1	in arrears	in arrears	
Other CCG Conversion Rate	10.1%	21.4%	13.3%	12.5%	0.0%	25.0%	0.0%	0.0%	0.0%	5.9%	10.0%	6.7%	25.0%	in arrears	in arrears	
CHFT Fast Track Referrals	15,659	1,371	1,413	1,314	1,090	1,421	1,203	1,064	659	987	1,198	1,278	1,275	in arrears	in arrears	
CHFT Fast Track Conversions	1,819	149	171	160	129	176	121	113	90	105	125	158	136	in arrears	in arrears	
CHFT Fast Track Conversion Rate	11.6%	10.9%	12.1%	12.2%	11.8%	12.4%	10.1%	10.6%	13.7%	10.6%	10.4%	12.4%	10.7%	in arrears	in arrears	
% Change on Previous year																

Note YTD Change for conversions is a month in arrears as latest month will still have conversions to feed through.



Appendix - A and E Conversion rates and Delayed Transfers

	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	YTD % Change
Analysis of A and E activity including conversions to admission																
A and E Attendances	154,445	13,153	13,311	13,091	13,336	13,105	12,017	10,511	6,895	9,445	10,087	11,544	12,129	**11,620**	**61,720**	-21.9%
A and E 4 hour Breaches	19,339	1,734	2,105	2,267	2,404	1,851	1,736	1,266	511	450	529	725	1,134	**1,286**	**4,635**	-39.9%
Emergency Care Standard 4 hours	87.48%	86.82%	84.19%	82.68%	81.97%	85.88%	85.55%	87.96%	92.59%	95.24%	94.76%	93.72%	90.65%	**88.93%**	**92.49%**	6.5%
Admissions via Accident and Emergency	34,851	2,864	2,949	3,083	3,160	3,146	2,799	2,489	1,937	2,387	2,353	2,597	2,559	**2,556**	**14,389**	-16.5%
% A and E Attendances that convert to admissions	22.57%	21.77%	22.15%	23.55%	23.70%	24.01%	23.29%	23.68%	28.09%	25.27%	23.33%	22.50%	21.10%	**22.00%**	**23.31%**	-5.3%



Delayed Transfers of Care (Reportable & Not reportable) Snapshot on 15th October 2020	Calderdale	Kirklees	Other	Total
Total number of patients on TOC Pathway	30	24	1	55
Awaiting Completion of Assessment	24	3	1	28
Awaiting Care package in own home	5	10		15
Awaiting Residential home placement	1	8		9
Awaiting public funding				0
Awaiting further non-acute NHS Care		1		1
Awaiting community equipment and adaptations				0
Awaiting nursing home placement		2		2
Disputes				0
Patient or Family choice				0
Housing - Patients not covered by Care Act				0

Appendix - Cancer - By Tumour Group

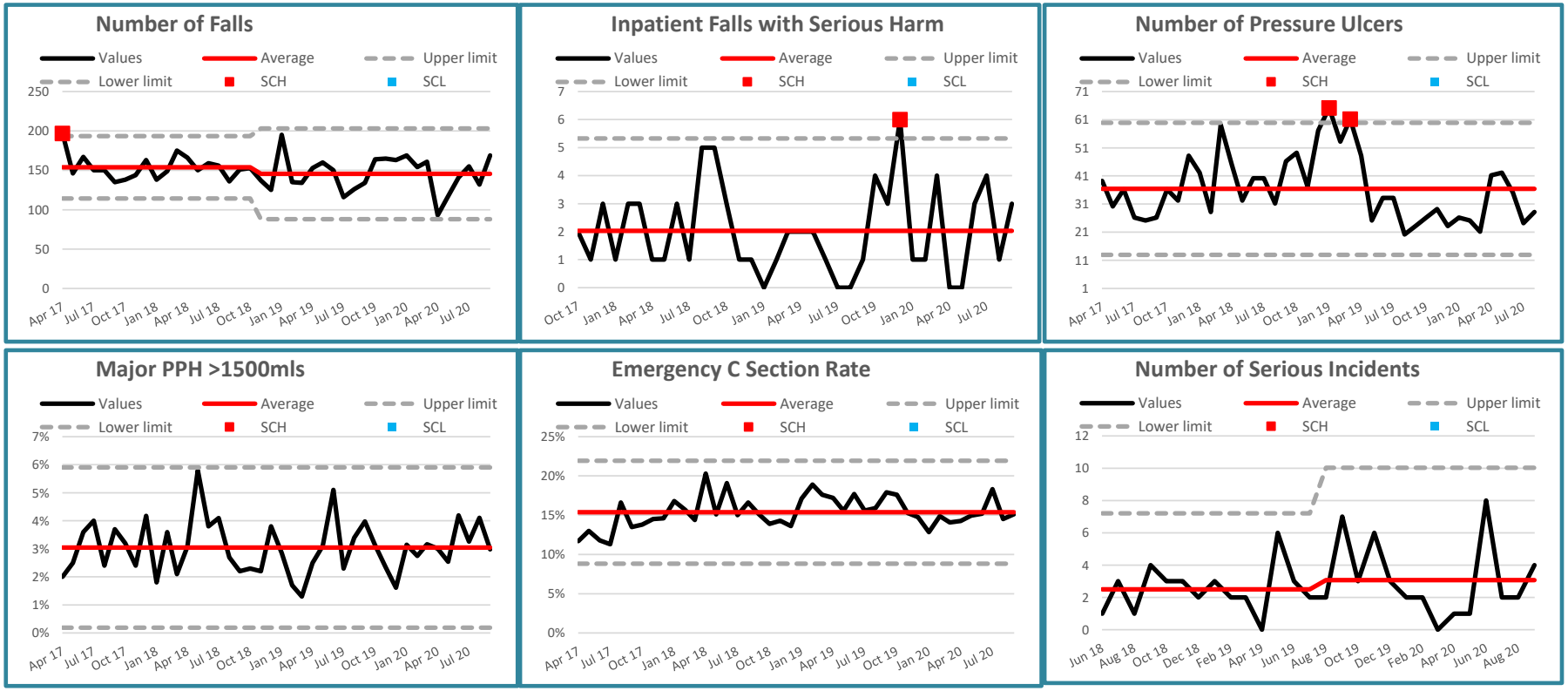
	19/20	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	YTD	Performance Range		
62 Day GP Referral to Treatment																Green	Amber	Red
Breast	99.19%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	88.89%	**100.00%**	**97.75%**	>=85%	81% - 84%	<=80%
Gynaecology	91.67%	78.95%	100.00%	100.00%	90.00%	80.00%	100.00%	100.00%	90.00%	93.33%	100.00%	80.00%	100.00%	**66.67%**	**87.93%**	>=85%	81% - 84%	<=80%
Haematology	87.40%	100.00%	80.00%	76.92%	60.00%	66.67%	100.00%	90.91%	100.00%	100.00%	100.00%	100.00%	91.67%	**77.78%**	**90.91%**	>=85%	81% - 84%	<=80%
Head & Neck	56.72%	40.00%	57.14%	none to report	33.33%	36.36%	100.00%	60.00%	53.85%	0.00%	45.45%	60.00%	66.67%	**0.00%**	**47.50%**	>=85%	81% - 84%	<=80%
Lower GI	83.08%	80.00%	61.11%	100.00%	91.67%	78.95%	88.89%	100.00%	90.91%	66.67%	46.15%	62.50%	80.00%	**100.00%**	**76.77%**	>=85%	81% - 84%	<=80%
Lung	82.26%	87.50%	78.95%	81.82%	88.00%	91.67%	84.62%	73.08%	100.00%	100.00%	100.00%	85.71%	100.00%	**93.33%**	**96.30%**	>=85%	81% - 84%	<=80%
Sarcoma	87.50%	none to report	none to report	100.00%	100.00%	100.00%	none to report	0.00%	none to report	100.00%	none to report	100.00%	none to report	**none to report**	**100.00%**	>=85%	81% - 84%	<=80%
Skin	99.76%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=85%	81% - 84%	<=80%
Upper GI	84.81%	100.00%	92.31%	82.61%	66.67%	75.00%	100.00%	100.00%	75.00%	91.67%	33.33%	100.00%	80.00%	**76.47%**	**81.48%**	>=85%	81% - 84%	<=80%
Urology	89.96%	88.89%	82.50%	88.00%	95.74%	91.53%	93.18%	91.11%	96.30%	80.00%	100.00%	93.75%	94.12%	**100.00%**	**95.70%**	>=85%	81% - 84%	<=80%
Others	100.00%	100.00%	100.00%	none to report	none to report	100.00%	100.00%	100.00%	100.00%	100.00%	none to report	100.00%	100.00%	**none to report**	**100.00%**	>=85%	81% - 84%	<=80%
Two Week Wait From Referral to Date First Seen																		
Brain	94.70%	100.00%	92.31%	100.00%	100.00%	100.00%	100.00%	100.00%	80.00%	100.00%	77.78%	100.00%	100.00%	**100.00%**	**93.62%**	>=93%	86% - 92%	<=85%
Breast	98.43%	98.42%	99.07%	99.04%	98.25%	99.50%	100.00%	99.01%	100.00%	100.00%	96.10%	97.81%	99.05%	**99.56%**	**98.56%**	>=93%	86% - 92%	<=85%
Childrens	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**0.00%**	**94.74%**	>=93%	86% - 92%	<=85%
Gynaecology	98.48%	98.53%	98.40%	98.18%	99.20%	97.30%	100.00%	100.00%	100.00%	97.73%	98.13%	97.64%	100.00%	**98.75%**	**98.63%**	>=93%	86% - 92%	<=85%
Haematology	98.59%	100.00%	100.00%	100.00%	100.00%	90.48%	95.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Head & Neck	99.16%	100.00%	98.29%	99.21%	100.00%	100.00%	99.17%	97.56%	94.34%	95.93%	96.46%	99.22%	99.13%	**92.48%**	**96.39%**	>=93%	86% - 92%	<=85%
Lower GI	99.26%	99.34%	100.00%	100.00%	100.00%	99.60%	99.63%	100.00%	100.00%	100.00%	100.00%	99.63%	100.00%	**99.68%**	**99.85%**	>=93%	86% - 92%	<=85%
Lung	98.67%	97.37%	96.43%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Sarcoma	96.48%	90.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	88.89%	100.00%	**100.00%**	**97.44%**	>=93%	86% - 92%	<=85%
Skin	98.42%	99.36%	99.69%	99.61%	99.02%	99.62%	99.53%	98.76%	98.18%	99.50%	100.00%	100.00%	99.60%	**96.27%**	**98.93%**	>=93%	86% - 92%	<=85%
Testicular	97.47%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Upper GI	96.87%	98.37%	97.30%	97.98%	96.84%	96.46%	99.04%	98.18%	89.80%	100.00%	100.00%	100.00%	100.00%	**96.58%**	**98.39%**	>=93%	86% - 92%	<=85%
Urology	99.34%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	98.39%	100.00%	96.88%	100.00%	**99.13%**	**98.97%**	>=93%	86% - 92%	<=85%

Appendix 1 - ESR Staff Groups - Roles

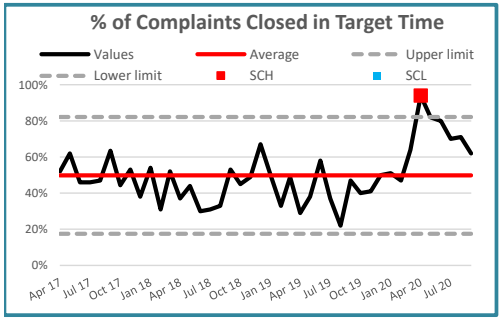
Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals
Chaplain	Assistant	Accountant	Advanced Practitioner
Clinical Director	Assistant Practitioner Nursing	Adviser	Chiropodist/Podiatrist
Manager	Assistant/Associate Practitioner	Analyst	Chiropodist/Podiatrist Manager
Operating Department Practitioner	Counsellor	Architect	Dietitian
Optometrist	Health Care Support Worker	Board Level Director	Dietitian Manager
Pharmacist	Healthcare Assistant	Chair	Dietitian Specialist Practitioner
Physician Associate	Healthcare Science Assistant	Chief Executive	Multi Therapist
Practitioner	Healthcare Science Associate	Clerical Worker	Occupational Therapist
Psychotherapist	Nursery Nurse	Finance Director	Occupational Therapist Manager
Technician	Nursing Associate	Librarian	Orthoptist
	Phlebotomist	Manager	Orthoptist Manager
	Technical Instructor	Medical Secretary	Physiotherapist
	Technician	Non Executive Director	Physiotherapist Manager
	Trainee Healthcare Science Practitioner	Officer	Physiotherapist Specialist Practitioner
	Trainee Healthcare Scientist	Other Executive Director	Radiographer - Diagnostic
	Trainee Nursing Associate	Personal Assistant	Radiographer - Diagnostic, Manager
		Receptionist	Radiographer - Diagnostic, Specialist Practitioner
		Researcher	Speech and Language Therapist
		Secretary	Speech and Language Therapist Manager
		Senior Manager	
		Technician	

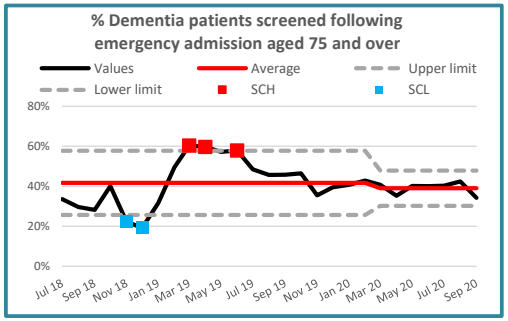
Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Assistant	Healthcare Science Practitioner	Consultant	Advanced Practitioner
Cook	Healthcare Scientist	Foundation Year 1	Community Nurse
Driver	Manager	Foundation Year 2	Community Practitioner
Engineer	Specialist Healthcare Science Practitioner	Specialty Doctor	Director of Nursing
Gardener/Groundsperson	Specialist Healthcare Scientist	Specialty Registrar	Midwife
Housekeeper		Staff Grade	Midwife - Manager
Maintenance Craftsperson		Trust Grade Doctor - Foundation Level	Midwife - Specialist Practitioner
Porter		Trust Grade Doctor - Specialty Registrar	Modern Matron
Supervisor			Nurse Consultant
Support Worker			Nurse Manager
Technician			Sister/Charge Nurse
Telephonist			Specialist Nurse Practitioner
			Staff Nurse

Safe - SPC Charts

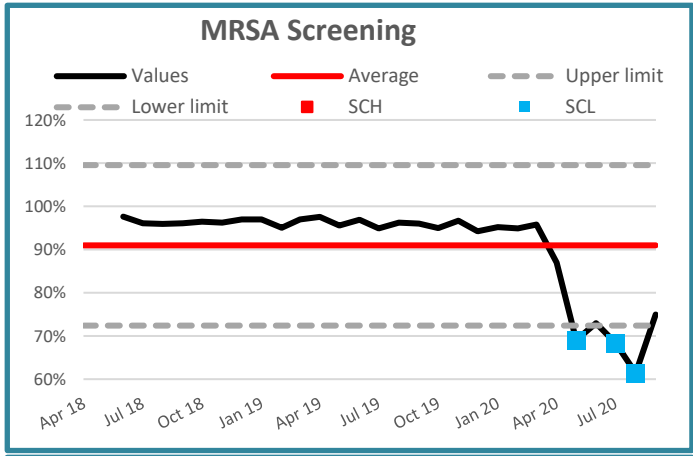


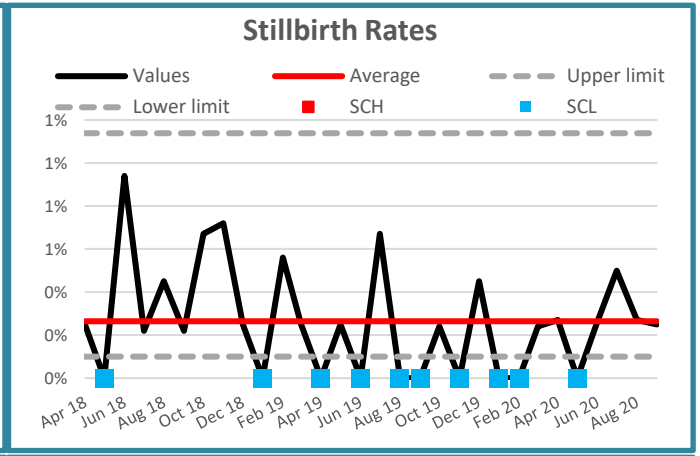
Caring - SPC Charts

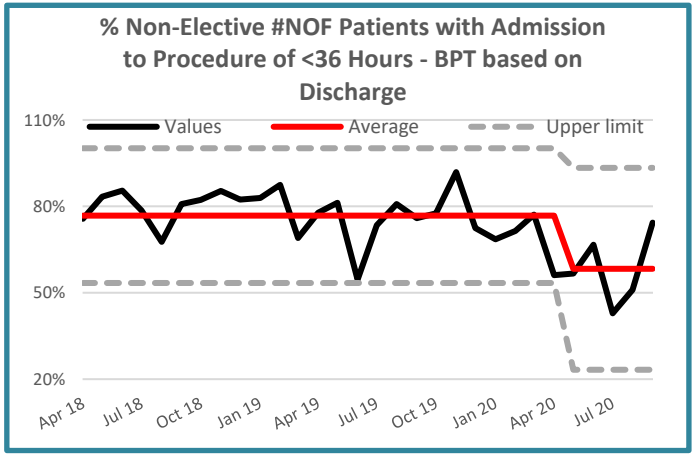


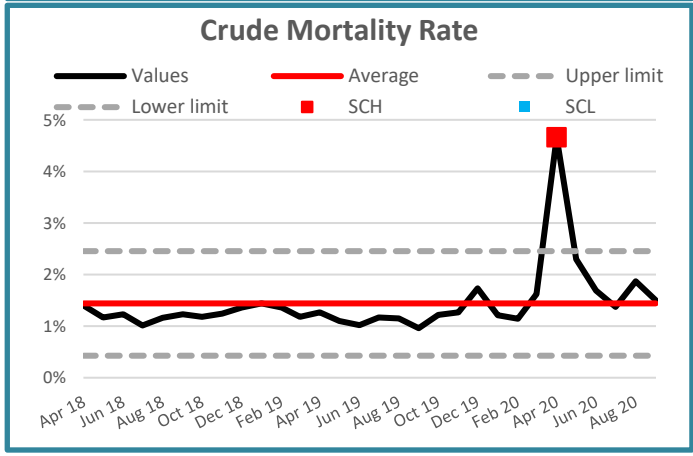


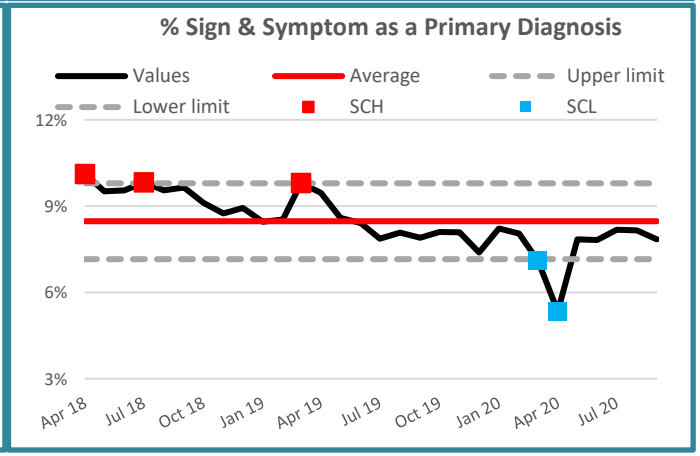
Effective - SPC Charts

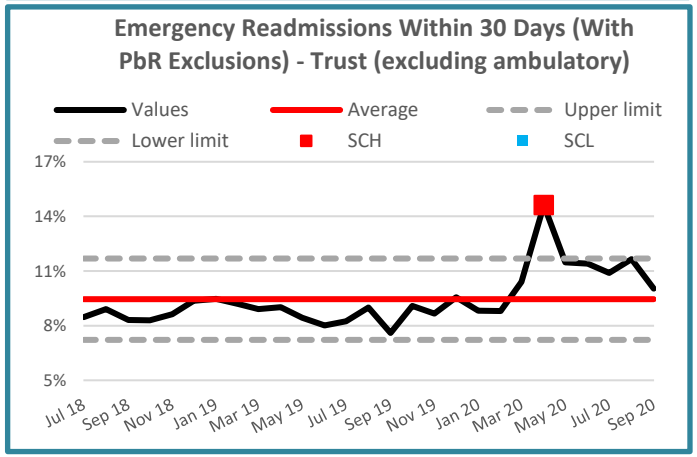




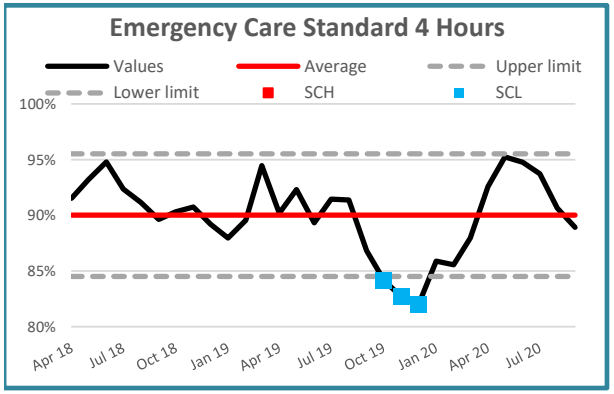


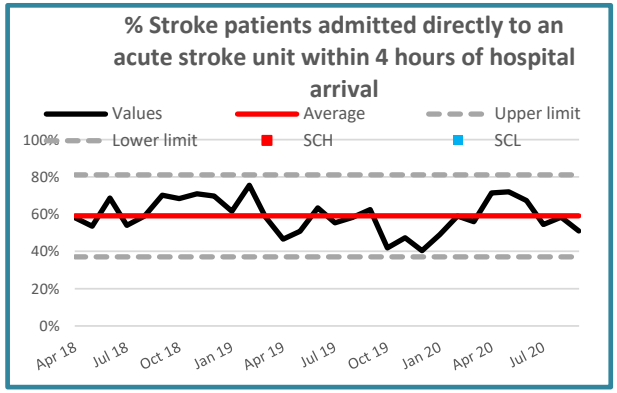


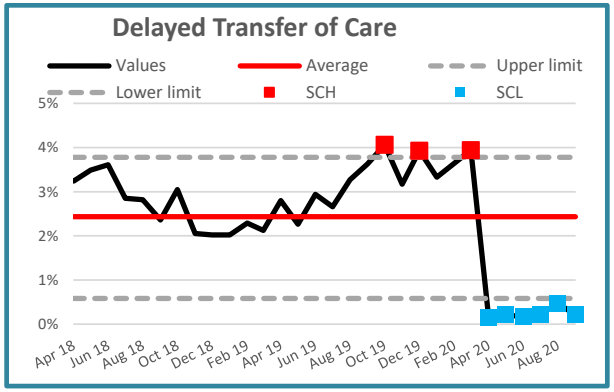


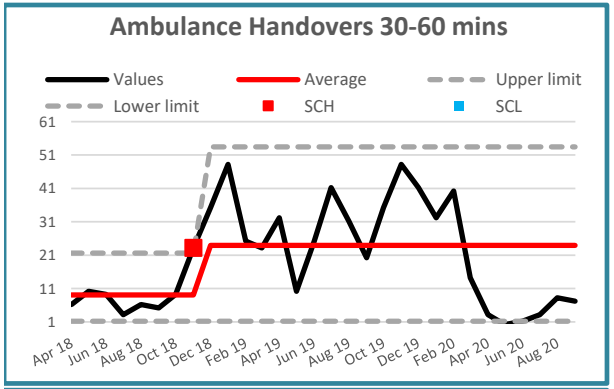


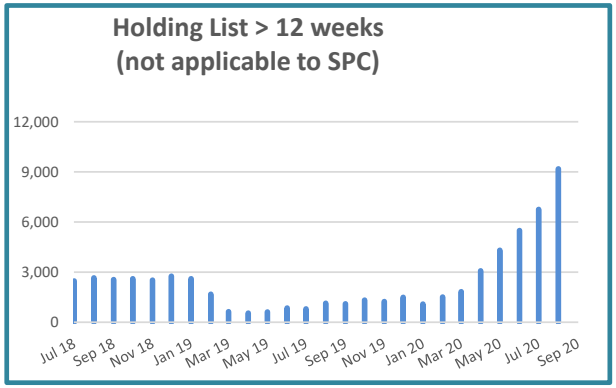
Responsive - SPC Charts

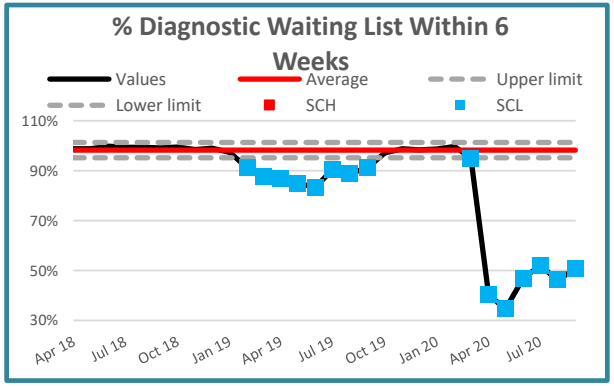


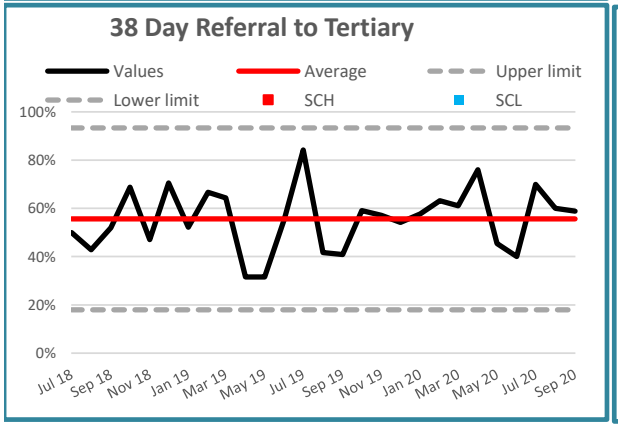


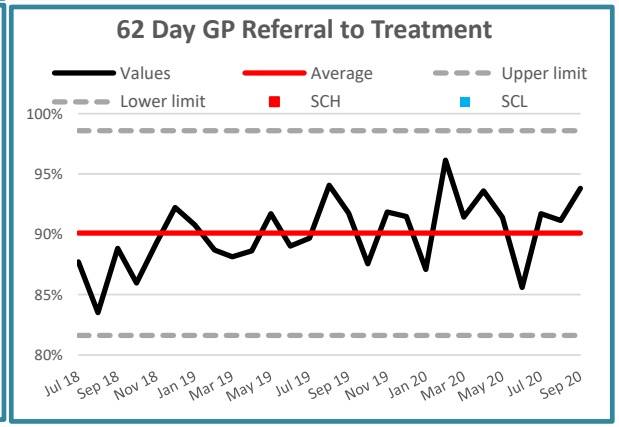












Methodology for calculating the performance score

The "key" targets are all measures included in NHS Improvement's Single Oversight Framework or measures on which the Trust is particularly focussing and are deemed more important.

Standard KPIs and "Key" targets

- Each RAG rating has a score - **red** 0 points; **amber** 2 points; **green** 4 points
- For "Key" targets, scores are weighted more heavily and are multiplied by a factor of 3 - **red** 0 points; **amber** 6 points; **green** 12 points

Calculating Domain Scores

- Add up the scores for each KPI per domain; divide by the maximum total score possible for that domain to get a percentage score.
- Apply the thresholds for the overall domain to get a RAG rating for each domain.
- Thresholds: < 50% is **red**, 50% to < 75% is **amber** and 75% and above is **green.**

Calculating Trust Performance Scores

- Calculate the overall performance score by adding up the scores for all domains; dividing by the maximum total score possible for all domains to get a percentage
- Apply the same thresholds as above to RAG rate the overall score

Glossary of acronyms and abbreviations

- **A&E** - Accident & Emergency
- **ADN** - Associate Director of Nursing
- **AED** - Accident & Emergency Department
- **ASI** - Appointment Slot Issue
- **ASU** - Acute Stroke Unit
- **BPT** - Best Practice Tariff
- **CCG** - Clinical Commissioning Group
- **CCU** - Critical Care Unit
- **CD** - Clinical Director
- **CDiff** - Clostridium Difficile
- **CDS** - Commissioning Data Set
- **CDU** - Clinical Decision Unit
- **CEPOD** - National Confidential Enquiry into Patient Outcome and Death
- **CHPPD** - Care hours per patient day
- **CIP** - Cost Improvement Programme
- **CQC** - Care Quality Commission
- **CQUIN** - Commissioning for Quality and Innovation
- **CRH** - Calderdale Royal Hospital
- **CT** – Computerised tomography
- **DH** - Department of Health
- **DNA** - did not attend
- **DSU** - Decision Support Unit
- **DTOC** - Delayed Transfer of Care
- **EBITDA** - Earnings before interest, tax, depreciation and amortisation
- **ECS** - Emergency Care Standard
- **EEA** - European Economic Area
- **EPR** - Electronic Patient Record
- **ESR** - Electronic Staff Record
- **FFT** - Friends and Family Test
- **FSRR** - Financial Sustainability Risk Rating
- **FSS** - Families and Specialist Services
- **GM** - General Manager
- **GP** - General Practitioner
- **GH** - Greater Huddersfield
- **HAI** - Hospital Acquired Infection
- **HCA** - Healthcare Assistant
- **HDU** - High Dependency Unit
- **HOM** - Head of Maternity
- **HRG** - Healthcare Resource Group
- **HR** - Human Resources
- **HRI** - Huddersfield Royal Infirmary
- **HSMR** - Hospital Standardised Mortality Rate
- **I&E** - Income and Expenditure
- **ICU** - Intensive care unit
- **IT** - Information Technology
- **KPI** - Key Performance Indicator
- **LOS** - Length of Stay
- **LTC** - Long Term Condition
- **MAU** - medical admission unit
- **MRI** - Magnetic resonance imaging
- **MRSA** - Methicillin-Resistant Staphylococcus Aureus
- **MSK** - Musculo-Skeletal
- **MSSA** - Methicillin Susceptible Staphylococcus Aureus
- **NHSE** - NHS England
- **NHSI** - NHS Improvement
- **NICU** - Neonatal Intensive Care Unit
- **NoF** - Neck of Femur
- **OD** - Organisational Development
- **PAS** - Patient Administration System
- **PbR** - Payment by Results
- **PHE** - Public Health England
- **PHSO** - Parliamentary and Health Service Ombudsman
- **PPH** - Postpartum Haemorrhage
- **PRM** - Performance Review Meeting
- **PTL** - Patient Tracking List
- **PU** – Pressure Ulcer
- **QIPP** - Quality, Innovation, Productivity and Prevention
- **RAG** - Red Amber Green
- **RCA** - Root Cause Analysis
- **RN** - Registered Nurse
- **RTT** - Referral to Treatment
- **SACT** - Systemic Anti-Cancer Treatment
- **SAU** - Surgical Admission Unit
- **SH** - Safety Huddle
- **SHMI** - Summary Hospital-level Mortality Indicator
- **SI** - Serious Incident
- **SITREPs** - Situation reports
- **SSNAP** - Sentinel Stroke National Audit Programme
- **SOP** - Standard Operating Protocol
- **SRG** - Systems Resilience Group
- **SUS** - Secondary Uses Service
- **UCLAN** - University of Central Lancashire
- **UTI** - Urinary Tract Infection
- **UoR** – Use of Resources
- **Var** - Variance
- **VTE** - Venous Thromboembolism
- **WLI** - Waiting List Initiative
- **WTE** - Whole Time Equivalent
- **YAS** - Yorkshire Ambulance Service

23. Governance Report

a) Use of Trust Seal

b) Confirmation of Non-Executive Director appointments

c) NED visibility/Assurance Quality Visits

To Note

Presented by Andrea McCourt

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 5 November 2020
Meeting:	Board of Directors
Title of report:	Governance Report
Author:	Jackie Ryden, Corporate Governance Manager
Sponsor:	Andrea McCourt, Company Secretary
Previous Forums:	None

Actions Requested:

- To note:
  - the use of the Trust Seal
  - the confirmation of Non-Executive Director re-appointments
  - the involvement of Non-Executive Directors in Trust meetings with staff

Purpose of the Report

To inform the Board on the use of the Trust Seal since 6 July 2020 and inform the Board of the reappointment of two Non-Executive Directors and the involvement of Non-Executive Directors in Trust meetings with staff.

Key Points to Note

a) Use of the Trust Seal

The Trust Seal has been used twice since the last report to the Board on 6 July 2020 as detailed below, with the register of each sealing enclosed detailing further information at appendix 1.

The Board is asked to **NOTE** the use of the Trust Seal for the following items:

2020/21
08/20 Lease agreement for Ainleys Industrial Estate, Elland
09/20 Sale of freehold land Acre House

b) Reappointment of Non-Executive Directors

The Nominations and Remuneration Committee of the Council of Governors at its meeting on 8 September 2020 agreed that Andy Nelson and Alastair Graham would be re-appointed as Non-Executive Directors for a further term of three years until 30 September 2023 and 30 November 2023 respectively. This decision was ratified at the Council of Governors meeting on 22 October 2020.

c) Non-Executive Director Engagement with Staff

With remote working by Non-Executive Directors (NEDs) in response to Covid-19 there has been previous discussion with Board members about how NEDs can engage with a range of Trust staff whilst unable to visit staff on site.

A programme of visits of NEDs to existing Trust meetings has been agreed which include virtual visits to the following meetings during October, November and December: weekly leadership meetings with managers, weekly meetings with Directors of Operations, Nursing Huddle, Business Better than Usual, bi-weekly meetings with doctors and Friday nursing briefings.

EQIA – Equality Impact Assessment
The Board 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 **NOTE** the use of the Trust Seal detailed in the paper, **NOTE** the reappointment of two Non-Executive Directors and the involvement of NEDs, **NOTE** the actions of Non-Executive Directors to increase their engagement with staff.

compassionate care

APPENDIX 1

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS July 2020 – October 2020

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
08-20	14 July 2020	14 July 2020	Lease agreement for Ainleys Industrial Estate, Elland New offices for THIS and Equipment Loan Store The enclosed lease and license to alter are in relation the new property in Elland which collocates The Health Informatics Service and CHS Equipment Loan Store. The project has been through WEB and a number of other forums. The main leaseholder is Calderdale & Huddersfield Solutions Ltd with CHFT being a guarantor. An agreement to lease has already been signed by The Trust in January 2020. The new building replaces Oak House, Woodvale and Salterhebble Loan Stores. Capsticks have acted for the Trust in the drafting of the lease and negotiation with the landlord.	NAME: Ellen Armistead TITLE: Executive Director of Nursing NAME: David Birkenhead TITLE: Executive Medical Director

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
09-20	29 September 2020	29 September 2020	Sale of Freehold Land Acre House The documents are requiring Trust signature for the sale of Acre House. The documents include a contract, and transfer of registered title. The sale has been agreed previously at WEB and sale values agreed with Gary Boothby. Documents and plan to be signed. The transfer is due to complete before the end of September 2020	NAME: Owen Williams TITLE: Chief Executive NAME: Helen Barker TITLE: Chief Operating Officer

24. Annual / Bi-Annual Reports:

a) Winter Plan

b) Emergency Planning Annual Report

c) Medical Revalidation and Appraisal Annual Report

d) Annual Self Assessment Report for Health Education England

For Assurance

Presented by Helen Barker and David Birkenhead

25. Update from sub-committees and receipt of minutes & papers

- Finance and Performance Committee meetings held 1.9.20 and 28.9.20
- Quality Committee meetings held 2.9.20 and 28.9.20
- Workforce Committee meetings held 19.10.20
- CHFT Annual General Meeting 7.10.20
- Charitable Funds Committee meeting held 26.8.2020
- Audit and Risk Committee held 21.10.20
- Council of Governors meeting held 22.10.20

For Assurance

26. Items for Review Room

- CHS MD Update October 2020
- WYAAT Collaborative Programme Report September 2020
- WY&H Healthcare Partnership Report September 2020
- WY&H Healthcare Partnership Monthly Update

For Assurance

Date and time of next meeting

Thursday 14 January 2021, 9:00 am

Venue: Microsoft Teams tbc