Public Board of Directors

Schedule	Thursday 2 September 2021, 9:00 — 12:00 BST
Venue	Microsoft Teams
Organiser	Jacqueline Ryden

Agenda

9:00	1. Welcome and Introductions: - Emma Catterall, Head of PALS and Complaints (Observing) - Kirsty Archer, Acting Director of Finance - Nikki Hosty, Assistant Director of Human Resources / Freedom to Speak Up Guardian - Devina Gogi, Guardian of Safe Working Hours To Note - Presented by Philip Lewer	1
	2. Apologies for absence: - Gary Boothby, Director of Finance - Andy Nelson, Non-Executive Director To Note - Presented by Philip Lewer	2
9:01	3. Declaration of Interests To Receive	3
9:02	4. Minutes of the previous meeting held on 1 July 2021 To Approve - Presented by Philip Lewer	4
	APP A - Draft Minutes of the Public Board of Directors 01.07.21 v3.docx	5
9:04	5. Action Log and Matters Arising For Review - Presented by Philip Lewer	21
	APP B - Action Log 01.07.21 (Public Board of Directors).docx	22
9:06	6. Chair's Report To Note - Presented by Philip Lewer	23
9:09	7. Chief Executive's Report	24

11:44	26.	Review of Sub-Committee Terms of Reference • Audit and Risk Committee To Approve - Presented by Andrea McCourt	326
		APP T - Audit and Risk Committee Terms of Reference 21 July 2021.docx	327
11:49	27.	Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room) • Finance and Performance Committee – Minutes 01.06.21 & 28.06.21 • Quality Committee – Minutes 21.06.21 & 12.07.21 • Audit and Risk Committee – Minutes 21.07.21 • Workforce Committee – Minutes 09.08.21 To Note - Presented by Richard Hopkin, Denise Sterling, Andrea McCourt and Karen Heaton	334
		APP U1 - Finance and Performance Committee - Chair Highlight Report - 020821.doc	335
		APP U2 - Chair Quality Committee highlight report 190721.doc	336
		APP U3 - ARC Chair Highlight Report - 210721.doc	337
		APP U4 - Workforce Committee Chair Highlight Report - 090821.doc	338
11:59	28.	Date and time of next meeting Thursday 4 November 2021, 9:00 am Venue: Microsoft Teams To Note - Presented by Philip Lewer	339

1. Welcome and Introductions:

- Emma Catterall, Head of PALS and Complaints (Observing)
- Kirsty Archer, Acting Director of Finance
- Nikki Hosty, Assistant Director of Human Resources / Freedom to Speak Up Guardian
- Devina Gogi, Guardian of Safe Working Hours

To Note

Presented by Philip Lewer

2. Apologies for absence:

- Gary Boothby, Director of Finance
- Andy Nelson, Non-Executive Director

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Receive

4. Minutes of the previous meeting held on 1 July 2021

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 1 July 2021 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	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
Karen Heaton **(KH)**	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
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager
Jayne Duffy	Community Matron, District Nursing **(for item 86/21 patient/staff story)**
Nicola Hosty	Assistant Director of Human Resources
Jean Robinson	Senior Infection Control Nurse **(for item 94/21)**
Richard Hill	Head of Health and Safety **(for item 99/21)**

OBSERVERS

Christine Mills	Public Elected Governor
Stephen Baines	Public Elected Governor / Lead Governor
John Gledhill	Public Elected Governor

79/21 Welcome and Introductions

The Chair welcomed everyone to the public Board of Directors meeting and in particular Jayne Duffy, Community Matron, presenting the patient story.

In light of the Government restrictions to groups of people meeting, this Board meeting took place virtually and was not open to members of the public. The meeting was recorded, and the recording will be published on our website after the meeting. The agenda and papers were made available on our website.

80/21 Apologies for absence

Apologies were received from Jude Goddard, public elected Governor.

81/21 Declaration of Interests

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

82/21 Minutes of the previous meeting held on 6 May 2021

The minutes of the previous meeting held on 6 May 2021 were approved as a correct record subject to the following amendments:

- Andy Nelson agreed to reflect his changes to the minutes under Green Plan (carbon literacy training) and Performance Management Framework (performance review report, rather than the framework)
- The Director of Finance highlighted a typo on page 7 – 05% should say 95%

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 6 May 2021 subject to the amendments above.

83/21 Action log and matters arising

The action log was reviewed and updated accordingly.

84/21 Chair's Report

The Chair reported he attends the Chairs and Leaders advice group for the development of the Integrated Care System (ICS). He reported Rob Webster is the interim Chief Executive of the ICS. The job description for the Chair of the ICS is currently being developed and is expected to go out to advert imminently, the push being collaboration and cooperation across West Yorkshire. The Chair reported he is the current Chair of WYAAT (West Yorkshire Association of Acute Trusts) and thanked the Non-Executives for their support.

OUTCOME: The Board **NOTED** the update from the Chair.

85/21 Chief Executive's Report

The Chief Executive shared feedback on a recent opportunity to act as an external Chief Executive assessor for Chief Executive recruitment for another Trust. He explained these are fantastic 'Go See' opportunities and a few ideas have been shared with the Chief Operating Officer. He added that the one area of commonality from the Chief Executive applicants was their attention to health inequalities. He re-iterated how important it is to recognise the embracement of doctors, nurses, and therapists in trying to address health inequalities, including our partners and senior Executive colleagues. The Chief Executive stated CHFT's strong commitment and activity in reducing health inequalities in the communities we serve is influencing not just our locality and West Yorkshire and highlighted the Trust should be proud of this.

OUTCOME: The Board **NOTED** the update from the Chief Executive.

86/21 Staff / Patient Story – Gathering Place

Jayne Duffy, Community Matron shared a presentation of a patient and staff story in relation to the homeless shelter 'Gathering Place' in Halifax and the service offered. Two patient stories were shared where there had been improvement in pressure ulcers after receiving treatment from the service.

AN thanked Jayne for sharing this story and asked how the service is advertised. Jayne explained it is usually by word of mouth on the street; however, there are posters up at the Gathering Place and A&E sites and roughly 60-70 people attend the banqueting table which can help promote the service. Jayne explained she has also presented at Ward Managers meetings to make the wards aware. AN asked if Jayne feels they need to advertise more widely and Jayne confirmed it is currently working for the service; however, they are open to further advertising.

The Director of Nursing formally thanked Jayne Duffy for her presentation and said it really demonstrates a blend of clinical excellence, expertise in wound care as well as real compassion responding to an incredibly vulnerable group. She added the presentation touched on the health reality for homeless people and shows how committed the Trust are to caring for vulnerable groups. The Director of Nursing expressed how extremely proud she is of the team for reaching out to these vulnerable groups.

AG stated it was a powerful presentation and a great example of how the Trust are tackling health inequalities. AG asked if this is already replicated elsewhere such as Huddersfield or Todmorden and if other services are offered here such as housing and welfare advice. Jayne confirmed the aim is to roll this service out to places like Brighouse, Todmorden etc. She confirmed the team have good relationships with the housing officers and the Basement project come into the service quite often.

The Medical Director asked if the service engages with mental health practitioners for support. Jayne confirmed most of the clients are under SWYPFT for mental health care and generally attend with a case worker. Jayne acknowledged that the challenge is more due to accessibility to different clinical information systems and the Medical Director agreed a holistic approach is needed which would be of great benefit.

DS added it is great to see this service developed for the hard to reach communities.

The Managing Director for Digital Health congratulated the team on this work, stating it is a great example having a gathering place to engage with these patients who could be affected by digital exclusion.

John Gledhill, public elected governor for Lindley and the Valleys said it was a powerful presentation and asked if additional resources would become an issue when developing this further. Jayne explained she is currently clinical two afternoons a week and is hoping to get some funding for additional nursing clinical time and is expecting this to be successful.

The Chief Executive stated this was a great example of looking to reduce inequality in action. He reminded colleagues that the definition of 'vulnerable' arises from the services that are available to meet the patient's needs, rather than the individual's themselves.

The Chair, with a background in social care, said it is a fantastic turnaround in the service in just two weeks which shows patients are treated with dignity and respect. The Chair thanked Jayne and the team on behalf of the Board for their fantastic services.

OUTCOME: The Board **NOTED** the staff and patient story on Gathering Place.

87/21 Health Inequalities Progress Report

The Director of Nursing presented the Health Inequalities progress report to update the Board of Directors on activity and progress in relation to the workstreams.

The Covid-19 pandemic exposed and exacerbated long standing inequalities particularly among the BAME communities. The NHS commissioned a review of the impact of Covid-19. Reporting in July 2020 the report made clear there are 8 urgent actions requiring a response from service providers. The Trust are actively addressing the 8 urgent actions as set out in the NHS review.

The key updates on the four workstreams were as follows:

- External environment: how we connect with our communities – refreshed assessment of our equality impact assessment (EQIA) and quality impact assessment (QIA) around all service changes, particular in relation to the

reconfiguration, working with partners on the Calderdale action plan in response to the impact on Covid-19 on BAME communities. Recent Board session on anchor institutions.

- The lived experience, initial focus on maternity services – At the end of May, 51% of women from a BAME background have been booked onto a care pathway. We commenced a process of discovery interviews for the low index of multiple deprivation (IMD) groups to understand how they feel being cared for. Anonymous staff survey developed to go out all maternity staff to understand the complexities and challenges for caring for service users from different backgrounds which will inform developing culturally competent care.
- Using our data to inform stabilisation and reset – 76% of adult patients with a learning disability have received treatment or have an individual treatment plan. This will extend out to children. All surgical lists remain compliant for 100% clinical prioritisation.
- Diverse and Inclusive Workforce – there have been a number of initiatives including appointment of a BAME community engagement role, Board development session to discuss the Trust's ambitions to become an anchor institution and the steps towards achieving this.

In response to the expectation around strengthening leadership and accountability the issue has been discussed in a number of forums. A Health Inequalities Working Group has been established to oversee progress and activity, chaired by Peter Wilkinson.

AN asked if there is a national definition of learning disabilities. The Director of Nursing confirmed there is a definition and Amanda McKie, Matron for Learning Disabilities, leads on this work. There are two or three dedicated vaccination clinics for people who are living with a learning disability. The Chief Operating Officer added 81% of adult patients with a learning disability have now had their treatment; however, new patients are being identified who are already on the list. She added it is harder to differentiate a child with complex needs or a learning disability and Amanda has undertaken some work with the Paediatric consultants to create criteria and a checklist which the Trust are looking to implement with the GPs.

AN asked if there is a corporate requirement to formally report this data. The Director of Nursing responded that there is no formal reporting at the moment; however, this may well become a requirement as the ICS will be asking for assurance on this. The Chief Executive confirmed the Trust have been reporting both organisationally and at PLACE level. The Trust have completed a return to the ICS and have been part of the Calderdale and Kirklees PLACE response. This has been reviewed at ICS level which is driven by working towards the 10 biggest ambitions of the ICS.

RH highlighted the good progress which is aided by the excellent data. He acknowledged there is still challenge in some areas and asked if the Trust is confident that they are tracking not only the BAME group and those with a learning disability, but other members in the lower IMD categories. The Chief Operating Officer responded the Trust are not actively tracking all groups but are tracking the whole IMD piece. She suggested the homeless population might be the next group; however, this is currently a full time piece of work focusing on learning disability and the infrastructure will need to be there. The Chief Executive clarified the focus on IMD 1 and 2 is linked largely to the white population.

PW chairs the monthly Health Inequalities working group sessions and stated there is real focus and enthusiasm across the four workstreams with great attendance. He suggested there needs to be enough space and time, highlighting the importance of giving the workstreams time to look at the data, undertake discovery interviews and reach some solid conclusions.

OUTCOME: The Board **NOTED** the progress in relation to CHFT's response to NHS

expectations of providers in tackling health inequalities.

88/21 2020/21 Strategic Objectives Progress Report

The Director of Transformation and Partnerships presented an update on progress made against the 2020/21 strategic plan for the period ending June 2021. Of the 19 deliverables, 2 have been fully completed, 12 are rated green and 5 are rated amber.

AN suggested the completed 10 year sustainability plan goal should be added as evidence to the approved Green Plan to strengthen the progress made.

AN asked if any headlines came out of the hot houses that have taken place focused on skills and attributes required in our leaders post pandemic. The Director of Workforce and OD stated what prevailed was the ability for leaders to be kind and compassionate to patients all the way through to their teams. Another prevailing theme that came out was the importance of wellbeing strategies and the health and wellbeing of colleagues.

DS provided feedback that there is a level of frustration from BAME colleagues attending inclusive recruitment panels having to explain why they are there each time. The Director of Workforce and OD recognised this as a significant issue and confirmed there is still more work to do on inclusive recruitment. The Chief Operating Officer linked this back to health inequalities and confirmed there is still work to do on the BAME and health inequalities agenda in the Trust and a long way to go to make this a core value.

RH pointed out the completed objective to develop an outcome based performance framework and key metrics and stated if the objective is to deliver against key metrics he is not confident the Trust are achieving blue in all metrics. The Chief Operating Officer responded that the wording will be updated to make this clearer.

RH highlighted the deliverable to stabilise the delivery of services in response to the Covid-19 pandemic is off track and asked why the Trust believe this is still off track. The Medical Director responded that due to the new delta variants there are still a number of patients with Covid-19 in the Trust, although this is significantly lower than in the past, the infection control measures are still in place which impacts on flow. The Chief Executive added this may be rated as off track due to a degree of caution by the Trust as the hospital and community experience has substantially changed from previously. There is currently no indication on the July roadmap as to what will happen in hospital environments. The Chief Executive stated the rating of amber seems reasonable and a further update on this will be expected at the November Board. RH agreed with this rating but felt the progress update did not necessarily lead to this conclusion.

OUTCOME: The Board **NOTED** the assessment of progress against the 2020/21 strategic plan.

89/21 Clinical Services Strategy

The Medical Director presented the refresh of the Clinical Services Strategy that was agreed in 2019 to incorporate key learning over the past two years. This has been informed by significant engagement with colleagues and partner organisations during 2020-21.

The key points to note were:

- Covid-19 has made some changes to the approach of which some will be carried forward in the Strategy including the remote working of colleagues and remote consultations with patients and need to provide isolation facilities and social distancing in the organisation

- Developed with broad engagement within CHFT, system partners, including third sector partners and the public
- Focus is on 'Putting the patient first' and the aim of the Strategy is to strengthen patient care in our population within PLACE and the ICS
- The Strategy aligns with the 2019 NHS long term plan to improve out of hospital care
- Focus on reducing health inequalities, noting the 7 year difference in life expectancy from the least most deprived deciles
- Looks to reduce pressures in A&E and focus on patient centred care and develop digital ambitions and interoperability between different systems
- Aligns to Trust visions and values
- Strategy will take us through to reconfiguration of services in 2025
- The aim of the Strategy is to maintain performance moving forward with an goal to move to a CQC rating of 'outstanding'
- Advances digital health for CHFT and improve efficiency in the use of theatres, Trust estate and using staff most efficiently
- Deterioration – use of nervecentre and other metrics to allow for rapid identification
- The Strategy commits the Trust to work with local system partners to deliver seamless care across PLACE and the ICS
- Key themes are described on page 8 of the Strategy
- Over the last year, there has been a successful approach to research and development which the Trust intend to build on moving forwards
- Includes the ambitions and views of the future of each clinical directorate

AG highlighted the research success through the Covid-19 period and the exciting development for the research hub. AG asked if there is more specific data underneath the Strategy which explains how improved outcomes are measured i.e. better outcome in 5 or 10 years time than another part of the country. The Medical Director explained there are a number of quality metrics in the Integrated Performance Report (IPR) i.e. stroke, SSNAP (stroke care) data and stated output measures are harder to measure. He added there are a number of measures across the different clinical services and the Trust continue to meet regulatory targets. In terms of the strategy, the aim is to deliver better outcomes across the ICS which includes how the Trust will contribute to better health outcomes across West Yorkshire.

AN confirmed the 'Getting it Right First Time' (GIRFT) Programme provides information on outcomes for each specialty. The Medical Director confirmed this active programme involving clinical colleagues continues to develop and look at individual metrics.

AN asked if there will need to be a further refresh of this in terms of the ICS. The Medical Director explained the ambitions of the ICS over the next 4-5 years have been captured in the Strategy.

AN highlighted in the digitally enabled section of the Strategy that there are patients who are not comfortable in using technology and the Strategy should include how we continue to support these patients. The Medical Director agreed that not all patients will be able to access computers and there needs to be alternatives to this, he agreed it would be sensible to reference this within the Strategy.
Action: Medical Director to reference how the Trust supports patients who don't use technology in the Strategy

DS asked where Allied Healthcare Professionals (AHPs) and other services within the multi-disciplinary team fit in and contribute to the delivery of the strategy. The Medical Director confirmed the Clinical Services Strategy includes everyone that delivers clinical care i.e. AHPs with the expectation that they will be fully contributing to the strategy.

DS asked where the oversight and management of the delivery plan sits. The Medical Director explained the metrics around the estate will be reported at Transformation Board and the performance metrics will be reviewed at weekly Executive Board. The Strategy will go to the Workforce Committee. There is no single over-arching group for the management of the Strategy. The Medical Director confirmed once the Strategy has been approved, the next steps will be to socialise the Strategy more widely in the organisation. This will be a public document and will be shared across the ICS.

The Chief Executive highlighted the level of maturity in the document, stating there is a sense of ambition with community services mentioned as a centre of excellence opportunity. This is a key building block to developing the WYAAT Clinical Strategy. He highlighted the recent developments in non-surgical oncology, vascular and stroke. The Strategy references CHFT's ambition and the Chief Executive re-iterated the Strategy will be seen in different governance routes such as the GIRFT clinically led process.

The Chief Operating Officer highlighted the Trust needs to use this proactively to drive decision making and use it for prioritisation. The Medical Director supported this approach and agreed it should be used in a proactive way, rather than it being a reference document.

KH agreed that it was a live document and highlighted the real success over the past few years in research and development (R&D) with aspirations to improve this further. KH asked where the dedicated research hub would be located. The Medical Director said this space is to be identified, there are a few rooms in Huddersfield Royal Infirmary which are too far away from normal clinic activity; however, acknowledged lots can be done virtually. KH acknowledged seeking and obtaining research funding is a highly competitive area in which the Trust has been successful and said it would be good to see how many Principal investigators and co-investigators (CIs) the Trust have in the next reports on R&D over the next 2-3 years.

OUTCOME: The Board **APPROVED** the refreshed Clinical Services Strategy 2021-2025.

90/21 5 Year Digital Strategy Annual Review

The Managing Director for Digital Health presented the first annual review of the 5 year Digital Strategy. The key points to note were:

- Principles within the strategy have been maintained throughout, which focuses on delivering outstanding care for our communities and aligns with the workforce strategy under one culture of care
- Covid-19 has enabled the Trust to access data and accelerate our digital programmes and has been an important part of our response in managing the hospital successfully
- Health Informatics Services enabled 160 labs to be connected for Covid-19 testing
- Interoperability progress - SWYPFT can now see the Trust's Electronic Patient Record which is good progress
- Biggest challenge has been integration – now looking at integrating Ascribe (Pharmacy) system which is nearly there. Integrated Medisoft (Ophthalmology) and started conversations to integrate the maternity K2 Athena system
- Invested £4.6m into a number of projects which included Digital Aspirant and Scan for Safety funding, progress on the voice recognition project struggled due to not being on site to support staff adopting this, progress is now being made
- Rolled out Windows 10 and Office365, not only in CHFT but across all of the customers THIS support in West Yorkshire
- All hardware has been refreshed in the Community Division to ensure they can access what they need 24/7
- £4.2m further investments for next year

- Divisional Digital Boards are really embedded now
- Infrastructure Strategy will be completed the end of this month with a business case
- Optimisation Plan is being developed which has been delayed, an external agency has been commissioned to undertake internal in-depth analysis
- ICS collaborations around digital will continue

A video was shared on the CHFT Digital Health Strategy and vision:-
https://vimeo.com/569283665/9125293aad

KH congratulated the Managing Director for Digital Health and stated the importance of this agenda has increased over the last 12 months. KH asked how the Trust are bridging any gaps in the workforce around digital capability to understand how digitally savvy the workforce are. The Managing Director for Digital Health confirmed part of the report talks about the optimisation plan which confirms an ongoing need for 'at the elbow support'. Additional time is needed on the shop floor to look at how staff are using technology and to find ways of improving this, understanding where workarounds are being used.

AN said it shows a great story on what has been achieved and explained there was a recent debate at Executive Board that more resource is required. AN added it will be useful to be more explicit in future updates about the next 12 months and setting out the next period and a summary table setting out the updates in the Digital Strategy. The Managing Director for Digital Health confirmed the Digital Operational Board includes an update on all the programmes and the Digital Health Forums are used for deep dives in certain areas or to show progress on projects and programmes across the Trust and beyond; therefore, this can be included in future.

AG said the video shows an impressive list of achievements and the Trust is going from strength to strength. He asked if the Trust are integrated with social care partners and asked for assurance in the area of telephony (switchboard) to be on the agenda going forward. The Managing Director for Digital Health confirmed social care for Calderdale can see the Trust's electronic patient record (EPR) and discussions have started with Kirklees. The delay at Kirklees is mainly due to them buying an off the shelf system whereas Calderdale built their own and the Trust had direct relationships with those that built this system; however, this it took almost 15 months to get to this point. She added telephony was raised at the Transformation Programme Board around reconfiguration and Catherine Riley is leading on this work. This is with regards to connecting inside and outside of the hospital and is on the agenda and will go through the reconfiguration programme. The Chair added he is also conducting some interviews on telephony following a conversation with Catherine Riley.

The Chief Executive stated the Digital Strategy is broader than the EPR and the Trust have worked hard getting the workforce using technology and feeling comfortable. He added that Community colleagues are keen to explore and expand the functionality of Systm1 and the Managing Director for Digital Health confirmed a meeting is taking place next week.

OUTCOME: The Board **NOTED** the good progress that has been made against the commitments laid out in the Trust 5 year Digital Strategy for 2020/21.

91/21 2021/22 Budget Book

The Director of Finance presented the formal record of the budget for 2021/22. The key points to note were:

- Delays to sign off the budget were due to delays in guidance
- Figures presented are in line with what was described last month
- Plan to breakeven after 6 months in H1 (half 1)
- Plan to deliver £3m of savings

- The funding framework for H2 (half 2) is yet to be confirmed and this may provide additional funding compared to the current planning assumptions
- For H2, the efficiency requirement based on current assumptions suggests £14.2m which is a challenge

RH confirmed he is satisfied with the numbers and principles agreed at the last Board and Finance and Performance Committee. He stated the position regarding H2 (months 7 -12) could change when we know the funding regime as £14m presents a significant efficiency challenge. He acknowledged it is unusual to approve the budget in July and not know the position for the second half of the financial year.

OUTCOME: The Board **APPROVED** the Budget Book for 2021/22.

92/21 Month 2 Financial Summary

The Director of Finance presented the month 2 financial summary and highlighted the key points below:

- To date the Trust has delivered a £3.28m surplus, a favourable variance of £2.94m
- This favourable variance is driven by a slippage on developments, vacancies, lower than planned recovery costs and higher than planned Elective Recovery Funding (ERF) with just over £2.5k of this funding received
- Payment of elective recovery funding monies is based on the whole of the Integrated Care System (ICS) and the whole of the ICS need to deliver the activity against the trajectory to receive this funding
- Forecasting a balanced position
- The Trust are still monitoring efficiency savings and £1m have been identified, largely on a non-recurrent basis

OUTCOME: The Board **NOTED** the Month 2 Finance Report and **NOTED** the financial position for the Trust as at 31 May 2021.

93/21 Staff Survey Progress against actions

Nikki Hosty, Assistant Director of Human Resources introduced the actions arising from the National Staff Survey 2020 and assured the Board that these are being progressed and clear next steps have been identified.

RH recognised the improvements in the staff survey results, particularly around health and wellbeing. He noticed the scores in relation to involvement and team effectiveness had declined and asked if there were any reasons behind this and if it was Covid related and what the Trust are doing to address this. The Assistant Director of Human Resources explained the team believe this is Covid related; however, digital platforms have enabled the continuation of meetings, managers are not as visible as they once were. The aim is to get back on track and be more visible.

The Managing Director for Digital Health asked why the corporate areas aren't included in the results, stating she is proud of the Health Informatics Service results which are not shown here. She felt the report and presentation was more Divisionally focused and there are corporate areas that are equally important. The Assistant Director of Human Resources agreed the corporate work was not included and has been progressing in terms of all the action plans. She agreed the Corporate areas will be included going forward.

PW asked how the response rate of 50% compares to the national average. The Assistant Director of Human Resources confirmed the Trust are slightly above the national average.

AN asked when the results will be received from the Pulse survey. The Assistant Director of Human Resource confirmed this will be run by NHS England/ Improvement with 17

questions, 9 are linked to the annual staff survey. The results will be received on 9th August 2021 providing an organisation wide output from the survey broken down by different demographics e.g. gender. The results will tie into key priorities i.e. wellbeing, feeling valued etc.

KH re-assured the Board that progress on the staff survey actions is being monitored through the Workforce Committee. She highlighted there is little time to progress work in between national surveys and, with the addition of the Pulse survey, expressed concern about over-surveying staff.

OUTCOME: The Board **NOTED** the progress made against the 5 key themes identified from the results of the National Staff Survey 2020.

94/21 Director of Infection Prevention Control (DIPC) Annual Report

The Medical Director presented an annual report of the position of performance and of Healthcare Associated Infections (HCAIs) for 2020-21.

The key points to note were:

- "A year like no other" for infection control
- Additional staffing was put in place to manage the Covid-19 pandemic which included supporting the fit testing of FFP3 masks and use and training of PPE
- Infection Control Performance Board reported through to Quality Committee and the Board, in addition to this, policies and guidance were taken through the Incident Management Team for discussion and approval
- Overall performance has been good with some concern in Clostridium difficile toxin which has shown an increase in cases
- Reporting requirements changed from previous years and now includes patients who acquired c.diff following their admission to hospital 30 days post discharge which could relate to a longer length of stay
- MRSA – 3 babies acquired MRSA which was brought under control quickly with no harm
- Guidance around Covid-19 developed rapidly at the start of the pandemic which required significant effort from the team with lots of work to supply PPE to the organisation, review entry and exists for patients and staff, ventilation of the organisation with support from estates and provide advice and guidance to Occupational Health in identifying symptomatic staff in the organisation
- 35 outbreaks of Covid-19 were reported in total which have now been closed (involving 89 patients and 79 staff)
- Number of hospital onset Covid infections was 225 – majority occurred during the peak of the pandemic October – January
- Successfully established Covid Vaccination Programme provided almost 50k vaccines to people in the health care economy
- Increase in antibiotics use largely related to Covid or respiratory tract infections, number of quality improvement projects being taken forward
- Ward 18 development was completed this year which supplied additional capacity

The Medical Director acknowledged the work of Infection Control team and massive contribution from Anu Rajgopal, Consultant Microbiologist and Jean Robinson, Senior Infection Control Nurse, who guided the Trust safely through the pandemic. Anu Rajgopal has now stepped down as the Infection Control Doctor and Jean Robinson is retiring imminently.

AG highlighted hand hygiene compliance is down from 89% the previous year to 78% and asked if this was due to the extra pressures of Covid-19. The Medical Director responded this is a key factor of infection control and compliance is more down to the recording of hand hygiene rather than deterioration. He added that real hand hygiene compliance is

60% at best in organisations for best efforts and anything above this is good. He added there have been additional challenges that Covid presented such as the additional use of PPE and use of gloves. Jean Robinson added the bare below the elbow audit looks at compliance on this and hand hygiene looks at opportunities at point of care.

Jean Robinson formally thanked the Board for their support over the last 18 months.

OUTCOME: The Board **NOTED** the assurances in the 2020/21 Annual Infection Prevention Control report that there were effective systems in place for infection prevention control (IPC) during the year; the performance against key IPC targets in 2020/21 and areas for improvement for 2021/22 and the IPC team response to the Covid-19 pandemic.

95/21 Learning from Deaths Annual Report

The Medical Director presented the Learning from Deaths Annual Report for 2020/21. The key points to note were:

- 1,789 inpatient deaths, of these 486 related to Covid-19
- Increase in mortality associated with Covid from September through to March
- Hospital Standardised Mortality (HSMR) remains a positive outlier with CHFT performing in the top 5% of Trusts
- Summary Hospital-level Mortality (SHMI) has been increasing over last 18 months and is a focus of concern – out of hospital deaths is significantly worse, a further external review of SHMI by Professor Mohammed, an expert at Bradford University, is being recommissioned
- Improving the alerting systems for early intervention which had an impact the first time round
- Scrutiny of deaths – Medical Examiner's Office has now been established with deputies to support this work and all hospital deaths and death certificates are being scrutinised, liaising with families and coroners as required, if any concerns on quality of care is raised it will move into a mortality review process
- Key themes from mortality reviews are included in the report

DS asked if there was a timeframe for the medical examiner service being rolled out to community and the need to double the staffing. The Medical Director confirmed the expectation is to have this established by the end of April 2022 and further updates will be provided to the Quality Committee.

OUTCOME: The Board **APPROVED** the Learning from Deaths Annual Report and the recommendations.

96/21 Fire Safety Annual Report 2020/21

The Chief Operating Officer presented the Fire Safety Annual Report for 2020/21. The key points to note were:

- Positive progress made on fire safety measures whilst also responding to the pandemic and the fire team provided input in terms of the increased PPE and use of oxygen
- There have been lots of redeployed staff and additional fire safety training required
- Successfully signed off the fire strategy and updated the fire policy
- An external audit helped shape capital programme and priorities for fire team over next 12 months
- Completed estate work in terms of fire, which included the introduction of Dry Risers at HRI, the Trust's interim mitigation for further compartmentation which remains limited due to estate occupancy
- Training moved to an online platform – very good e-learning package
- Appointed a further fire officer which will help support the reconfiguration and have more than 1 fire officer at CHFT

AN asked if there is an issue to ever complete the compartmentation at HRI. The Chief Operating Officer explained from an interim perspective, this work would take the Trust to reconfiguration in which there will be ward space at that point.

The Chief Executive asked for assurance on personal evacuation plans and PEEPs i.e. personal emergency evacuation plan where assistance is needed in terms of disabled, young children, elderly or frail.
Action: Chief Operating Officer to provide assurance on personal evacuation plans and PEEPs i.e. personal evacuation plan where assistance is needed

OUTCOME: The Board **NOTED** the Fire Safety Annual Report for 2020/21 update.

97/21 Quality Report (inc. Maternity Services Update)

The Director of Nursing presented the Quality Report which provides the Trust with ongoing oversight of the Quality agenda and the emerging issues that need to be considered. The following points were highlighted:

- CQC improved position for the 'Must Do' action related to financial performance and closure of the remaining 'should do' actions
- CQC have now published their new strategy 'A New Strategy for the Changing World of Health and Social Care'
- Engagement meetings continue with CQC
- 360° review of quality and safety includes observe and act
- Central Alert Systems – 3 overdue alerts and 1 will be closed fairly quickly
- Compliance for dementia screening training has a good result, there is still work to do to increase compliance with screening which remains the target
- Increase in complaints and contact to the PALs service – some of this relates to concerns in waiting times and access and visiting restrictions also seen at other Trusts
- GIRFT opportunity for a 'Go See' and NHS E/I have undertaken a review around litigation in which a gap analysis will take place
- Delayed never event has been reported and is currently under investigation which related to a retained foreign object post procedure
- Maternity – about to make the third submission in response to the Ockenden review
- To note that the first Perinatal Quality Surveillance meeting was held on 25 May 2021 and that the meeting gives the assurances required by the Board Commissioners and Local Maternity System
- Maternity staffing – achieving 1-1 ratio in labour wards which is a key safety metric
- Significant challenges around meeting continuity of carer expectations
- 3 quality account priorities and 7 focussed quality priorities with limited assurance for nutrition and hydration, the steering group has been revamped with a clinical lead
- Quality priorities are now embedded at Divisional level

AG stated dementia screening has been an issue for some time and asked if the new Dementia lead will be undertaking a deep dive on this. The Director of Nursing confirmed the Dementia Lead has been asked to lead on this.

AN stated it is good to see improvement in complaints and asked if this means the backlog has been cleared. The Director of Nursing confirmed there is still a handful of legacy complaints in the backlog which has largely cleared. The Divisions have worked hard to implement and embed actions.

AN asked if the continuity of care in maternity is a challenge widely seen. The Director of Nursing confirmed this is a challenge widely seen and the target is around 35%. She

added discussions have taken place at WYAAT Chief Nurses meetings with LMS. There are challenges with vacancies in midwifery nationally.

DS asked if a decision has been made on the national bid for an additional 20 roles for staffing. The Director of Nursing confirmed a decision has not yet been made. KH added it is hard to know if CHFT, who are still struggling with a shortage of midwives will get a proportion of this.

The Chief Executive sought assurance from Non-Executive Directors that they had visibility of maternity issues and this was confirmed.

The Chief Executive highlighted the missed opportunities of other system partners to provide peer reviews and suggested this needs to be pushed further with Chief Nursing colleagues. The Director of Nursing re-assured the Board this is being discussed with Chief Nursing colleagues.

OUTCOME: The Board **NOTED** the Quality Report and ongoing activities across the Trust to improve the quality and safety of patient care and **APPROVED** for the Board to receive the monthly Maternity report which has been presented at the Quality Committee.

98/21 Integrated Performance Report (IPR) – May 2021

The Chief Operating Officer presented the performance position for the month of May 2021 highlighting the key points which were:

- Variation to the framework now includes a narrative with the aim to triangulate the IPR
- Main area of concern is in the responsive domain around backlogs – detailed conversation took place at Finance and Performance Committee this week with a request to provide more assurance that the Trust are doing all they can, the challenge is the availability of staff on the backlog clearance
- Reviewing waiting list initiative programme – the Director of Workforce and OD is leading the engagement on this
- Discussions are taking place with companies who will provide theatre staff
- Piece of work ongoing making sure no clinical harm comes to patients who are on the waiting list

AN asked if there was a trajectory for the plan. The Chief Operating Officer explained at the moment more patients are being added onto the waiting list than are being taken off. To cover this piece of work, the Trust will need to be working at 125%. The demand is a challenge.

AN asked if emergency department (ED) pressure is adding to the backlog clearance. The Chief Operating Officer responded that the ED pressure is not directly adding to this; however, it is taking a lot of time and attention. A piece of work is taking place with the CCG to put a slightly different model in ED which will help with minor demand. The Chief Operating Officer confirmed there have been no cancellations due to ED pressures.

The Chief Executive asked the Chief Operating Officer to report on the potential overlapping of ongoing support for non-surgical oncology, in particularly the backlog recovery, decision making and prioritisation.

The Chief Operating Officer explained CHFT made a choice to concentrate on patients with cancer and have maintained this performance and managed patients that presented with cancer in the timeline which provides the best outcomes. The Trust also made a decision to stick to P2 (priority 2) categorisation which allowed staff to be re-deployed to critical care. As a result of this, CHFT have more patients on the waiting list. As RTT (referral to treatment) has always been managed positively in the Trust, there was no need

for a qualified provider for routine activity; however, other organisations have been able to capitalise on this. The Trust are actively supporting Mid Yorkshire Trust in terms of non-surgical oncology.

OUTCOME: The Board **NOTED** the Integrated Performance Report and current level of performance for May 2021.

99/21 Health and Safety Update and Strategy

The Head of Health and Safety presented the health and safety update and strategy. The key points to note were:

- The Strategy covers the next 5 years to 2026 and sits alongside the health and safety policy and aligns to the 4 pillars
- The aim of our Health and Safety strategy is to identify, communicate and embed the overarching principles and activities that will create a safe environment in which to work, receive care and visit
- Actions and priorities will be planned, monitored and delivered
- Datix submissions will be monitored in relation to any emerging health and safety inequalities
- NHS workplace safety standards will be used as a framework for the next 5 years
- Training, communications and 'must-dos' will be accessible through effective channels and platforms
- Relaunch the health and safety training and refresh the 'Must Dos'
- Put the Patient First– the environmental conditions for patients and colleagues alike will continue to be a significant part of future discussion. A patient advocate and Staff Governor will be appointed to champion health and safety
- We will assess and review all Health and safety data by protected characteristic. All RIDDOR reportable incidents, slips trips and falls, sharps injuries and training data will be presented with a full breakdown of data
- We will also review patient and colleague Health and Safety data by IMD, identifying patterns and rectifying inequality
- A full EQIA of Health and Safety policy, activity and progress will be completed annually
- The impact of the Covid-19 pandemic has changed the way colleagues deliver care to patients, with new and innovative ways of working to protect both colleagues and patients, including a closer focus on PPE, social distancing, and hygiene
- We will ensure that Health and Safety activity adapts to our new ways of working, beginning with new requirements for working from home/more flexible working and virtual clinics
- Key activities for next 5 years were shared

The Director of Workforce and OD added the Health and Safety Strategy sticks to core principles and NHSE/I have workplace safety standards of 30 actions which are being followed, incorporating the Trust's 4 pillars. She explained the Health and Safety policy remains and does not change and the action plan will continue to be updated.

OUTCOME: The Board **APPROVED** the content of the Health and Safety 5 year Strategy and **NOTED** the progress made against the action plan presented and the Health and Safety Update.

100/21 Board Assurance Framework

The Company Secretary presented the first Board Assurance Framework (BAF) update for this financial year, 2021/22 which summarised movements in scoring and rationale for this. The full BAF will also be reviewed by the Audit and Risk Committee on 21 July 2021, with specific risks reviewed by Board Committees at agreed timeframes.

There have been no new risks added to the Board Assurance Framework (BAF) since the last report presented to the Board on 4 March 2021.

All BAF risks have been reviewed and updated by the lead Director with updates shown in red font for ease of reference in the enclosed full BAF document.

OUTCOME: The Board **APPROVED** the updated Board Assurance Framework as at 22 June 2021, noting the movement in risk scores and areas of risk exposure.

101/21 Governance Report

The Company Secretary presented the governance items for approval and two items for noting in July 2021.

OUTCOME: The Board **APPROVED** the Board of Directors meeting dates and Board Development Sessions for 2022/23, **NOTED** the Board workplan for 2020/21, the use of the Trust seal during Q2 and **RATIFIED** the urgent decision 01/21 regarding delegation of approval of the 2020/21 Quality Accounts.

102/21 Review of Sub-Committee Terms of Reference

The following terms of reference were reviewed as part of an annual review and approved by the Board:

- Workforce Committee Terms of Reference

OUTCOME: The Board **APPROVED** the terms of reference for the Workforce Committee.

103/21 Board Sub-Committee Chair Highlight Reports

The following Chair Highlight reports were received for the following sub-committees:

- Finance and Performance Committee
- Workforce Committee
- Quality Committee
- Audit and Risk Committee

The Director of Finance reported since the last Board meeting the 2020/21 annual accounts have been approved. The final position reported on a control total basis delivered a surplus position for the second year in a row in the current regime. The Chief Executive asked if this is common for two years in a row. The Director of Finance confirmed it was common last year and despite the underlying deficit it has been positively affected by the additional funding made available and has influenced the value for money opinion which has improved on previous years.

OUTCOME: The Board **NOTED** the Chair Highlight Reports for the above sub-committees of the Board.

104/21 Committee Review Annual Reports 2020/2021

The following Committee Review Annual Reports for 2020/21 were received:

- Finance and Performance Committee
- Workforce Committee

OUTCOME: The Board **RECEIVED** the Committee Review Annual Reports for the Finance and Performance Committee and Workforce Committee.

105/21 Items for Review Room

- Calderdale and Huddersfield Solutions Ltd – Managing Director Update June 2021

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

- Finance and Performance Committee meetings held 11.01.21., 1.02.21 and 1.03.21.
- Quality Committee meeting held 25.01.21., 22.02.21. and 22.03.21.
- Workforce Committee meeting held 8.2.21. and 8.03.21.
- Covid-19 Oversight Committee meeting held 26.03.21.
- Audit and Risk Committee meeting held 12.04.21
- Charitable Funds Committee held 23.02.21

OUTCOME: The Board **RECEIVED** the Calderdale and Huddersfield Solutions Limited (CHS) Managing Director Update for June 2021 and the minutes of the above sub-committees.

78/21 Any Other Business

There was no other business.

The Chair thanked the governors for their attendance and closed the meeting at approximately 12:30 pm.

Date and time of next meeting

Date: Thursday 2 September 2021
Time: 9:00 – 12:30 pm
Venue: Microsoft Teams

5. Action Log and Matters Arising

For Review

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 01.07.21

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
01/07/21 96/21	<u>Fire Safety Annual Report 2020/21</u> Chief Operating Officer to provide assurance on personal evacuation plans and PEEPs i.e. personal evacuation plan where assistance is needed in terms of disabled, young children, elderly or frail	HB		02.09.21		
01/07/21 89/21	<u>Clinical Services Strategy</u> Medical Director to reference how the Trust supports patients who don't use technology in the Strategy	DB		02.09.21		
06.05.21 64/21	Environment Manager to update the target of new builds in the Green Plan to 'very good' at a minimum with an aspiration of 'excellent' Environment Manager to review the recycling target of the Trust set at the minimum of 40% which has already been achieved and set a more ambitious target MD, CHS to inform the Company Secretary when the sustainability training is available for the Board to incorporate the change into Board papers	SS/RD	SS confirmed targets of new builds have been updated to 'very good' with an aspiration of excellent. SS explained recycling targets are being worked on to break these down over the next few years and put in stretch targets. Sustainability training – SS is working with Nikki Hosty in WOD before rolling out this training. In addition, CHS will be rolling out carbon literacy training for CHS colleagues and 'train the trainer' will be available to the Trust if interested later this year.	01.07.21		01.07.21

6. Chair’s Report

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

- Non-Surgical Oncology

To Note

Presented by Owen Williams

Transforming and Improving Patient Care

8. Staff / Patient Story – Health Inequalities Video

To Note

Presented by Ellen Armistead

9. Health Inequalities Update

To Note

Presented by Ellen Armistead, Helen Barker and Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title:	Health Inequalities Progress Report
Authors:	Ellen Armistead, Director of Nursing / Deputy CEO Anna Basford, Director of Transformation and Partnerships Helen Barker, Chief Operating Officer Suzanne Dunkley, Director of Workforce and OD Luke Stockdale, Director of Digital Transformation and Innovation
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy CEO
Previous Forums:	Health Inequalities Group

Purpose of the Report

The purpose of the report is to update the Board of Directors on activity and progress in relation to the current workstreams that support the Trust's ambitions to tackle health inequalities and noting key achievements to date.

Key Points to Note

The Covid 19 pandemic exposed and exacerbated long standing inequalities particularly amo ng the BAME communities. The NHS commissioned a review of the impact of Covid 19, report ing in July 2020 the report made clear there are 8 urgent actions requiring a response from se rvice providers. In response to this CHFT has set up a Health Inequalities Working Group to o versee progress and activity around the following workstreams:

- External environment: how we connect with our communities. Lead: Anna Basford, Director of Transformation & Partnerships. (Urgent Actions: 1,3,4,6,8)
- The lived experience, initial focus on maternity services. Lead: Ellen Armistead, Executive Director of Nursing/Deputy Chief Executive. (Urgent Actions: 1,2,5,6,8)
- Using our data to inform stabilisation and reset. Lead: Helen Barker, Chief Operating Officer. (Urgent Actions: 1,2,5,6,7,8)
- Diverse and Inclusive Workforce. Lead: Suzanne Dunkley, Director of workforce and OD. (Urgent Actions: 1,5,6,7,8)

External environment: how we connect with our communities: Working with our partners continues. A project has commenced on the development of a Directory of Services for ED st aff to enable them to help people who are homeless or asylum seekers by improving the signp osting into support services. The EQIA/QIA for the reconfiguration has been considered and c oncluded there was no differential discrimination to any protected characteristic groups.

The lived experience, initial focus on maternity services: At the end of July 53% of women from a BAME background have been booked onto a Continuity of Carer pathway. Early feedback from the discovery interviews has shown overall experience to be positive and has highlighted areas for improvement around communication in relation to services on offer. Staff have completed an anonymous survey in relation to perceptions of levels of culturally competent care delivery. The survey is due to conclude at the end of August and will report into Quality Committee.

Using our data to inform stabilisation and reset: Prioritisation of people with a learning disability is now embedded in wating list management with strong support from clinical colleagues. A project manager is being recruited to oversee the LD workplan and lead the development of the care navigator roles.

Diverse and Inclusive workforce: A "Say No to Racism" strategy has been developed. There is a more targeted approach to ensuring recruitment campaigns reach all sectors of the community. More BAME reps for interview panels have been recruited. The re-launch of the Leadership programme will include a focus on inclusive leadership.

Digital Inclusion: CHFT has reps on LA Digital Inclusion boards. There is strong partnership working with both public and third sector bodies to ensure our strategies are aligned and work in mutual support.

EQIA – Equality Impact Assessment

The purpose of the paper is to demonstrate the work currently underway to develop knowledge and facilitate a more informed EQIA process with the ability to utilise data and experience in decision making and prioritisation as well as monitor impacts.

The Trust has already reviewed and strengthened its processes for undertaking Equality Impact Assessment of proposed service changes. This has provided tools and training for colleagues to use and also includes processes for involving patients and carers in the assessments. Materials and information for this are available on the Trust intranet**.**

The aim of the lived experience workstream supports the triangulation of data to assess whether CHFT could be unintentionally disadvantaging service users.

Recommendation

The Board is asked to **NOTE** the progress in relation to CHFT's response to NHS expectations of providers in tackling health inequalities.

HEALTH INEQUALITIES PROGRESS REPORT

September 2021

1. Introduction

Health Inequalities are defined as:

Unfair and avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health and wellbeing.

The purpose of the paper is to update the Board of Directors on activity and progress in relation to the current workstreams that support the Trust's ambitions to tackle health inequalities.

2. Background and Context

The link between poor health outcomes and social deprivation has long been established and has been the subject of a number of significant independent reviews and research studies over many years. The Covid 19 pandemic exposed and exacerbated long standing inequalities particularly among the BAME communities.

The NHS commissioned a review of the impact of Covid 19, reporting in July 2020 the report made clear there are 8 urgent actions that needed to be progressed namely:

1. Protect the most vulnerable from COVID-19
2. Restore NHS services inclusively
3. Develop digitally enabled care pathways in ways which increase inclusion
4. Accelerate preventative programmes which proactively engage those at risk of poor health outcomes
5. Particularly support those who suffer mental ill-health
6. Strengthen leadership and accountability
7. Ensure datasets are complete and timely
8. Collaborate locally in planning and delivering action

In response to this CHFT has set up a Health Inequalities Working Group to oversee progress and activity around the following workstreams:

- External environment: how we connect with our communities. Lead: Anna Basford, Director of Transformation & Partnerships. (Urgent Actions: 1,3,4,6,8)
- The lived experience, initial focus on maternity services. Lead: Ellen Armistead, Executive Director of Nursing/Deputy Chief Executive. (Urgent Actions: 1,2,5,6,8)
- Using our data to inform stabilisation and reset. Lead: Helen Barker, Chief Operating Officer. (Urgent Actions: 1,2,5,6,7,8)
- Diverse and Inclusive Workforce. Lead: Suzanne Dunkley, Director of workforce and OD. (Urgent Actions: 1,5,6,7,8)

3 Strengthening Leadership and Accountability

The Health Inequalities Working Group is chaired by a Non-Executive Director and the group acts as an oversight group providing assurance that workstreams are delivering the ambitions as set out in the plan on a page (see appendix1).

A variety of development sessions have been held with the Board and the Council of Governors outlining the reality of the widening health gap nationally and locally as well as an update on the main workstreams. Health Inequalities work was a key focus at the Trust Annual General Meeting in July 2021.

Health Inequalities continues to be a regular agenda item on a number of trust wide leadership forums.

4 Workstream Updates

External environment: how we connect with our communities.

Partnership Working: The Trust has continued to work with system partners and communities to understand and develop actions that could support a reduction in inequalities experienced by people that are frequent attenders at A&E, homeless, asylum seekers or refugees. A possible way forward identified is to create a directory of services for A&E colleagues that could support them and help to signpost people to support that is available in the community. To inform this, work is being undertaken to conduct an internal audit to review A&E attendances and admissions for individuals in this group and also meetings with service users to learn about their experience has been facilitated by the St Augustine's Centre. The audit and service user experience stories will inform the development of a directory.

Work has continued with the Greenwood PCN who have an aim to reduce emergency respiratory admissions. Data exploration within CHFT confirmed an elevated admission rate compared to the wider CCG, with potential inequalities in IMD, age, ethnicity and potentially, gender. There was a suggestion of a BAME inequality in paediatric readmissions. Further meeting with the PCN refined the project further to asthma specifically and it was agreed to undertake a joint review of asthma attendances at CHFT. Following confirmation of a data sharing agreement, CHFT will provide data related to asthma attendances for Greenwood PCN. Internally we are linking with the Clinical Directors and General Managers in the Respiratory and Paediatric Services to support this.

Trust colleagues have continued to work with partners in relation to the Calderdale Action Plan to reduce the impact of Covid 19 impact on our BAME communities. Two meetings of a steering group with system partner representation have been held and an update on progress will be provided to the Calderdale Health and Wellbeing Board in October 2021.

Social Value: The Trust asked the Social Value Portal (SVP) to support the Trust in measuring and reporting the delivery of social value. The SVP has now developed an action plan that uses a nationally approved methodology for measuring social value in terms of economic, social and environmental impact of the Trust's £196m planned estate investment at CRH and HRI. This has quantified the expected social return that will be generated by contractors and their supply chain for example in relation to new jobs, apprenticeship weeks undertaken, hours of community engagement, tonnes of embodied carbon reduced etc. The Social Value assessment is based on a local needs analysis and targeted actions to support a reduction in health inequalities experienced by our local communities. The output from this will inform our implementation plans for the estate developments.

Reconfiguration EQIA / QIA: As part of the process of continuous assessment in relation to the Trust's Public Sector Equality Duty a refreshed assessment of the EQIA and QIA impact of the proposed service changes and estate developments at CRH and HRI has been undertaken. This has used the new and strengthened process to assess the EQIA and QIA impact and included meetings with groups of people that have protected characteristics to directly inform, advise and confirm the assessment and any mitigations required. The refreshed assessment has been reviewed by the Trust's Quality Committee and Transformation Programme Board in June. The conclusion of this work is that the overall impact in relation to EQIA and QIA is positive, there is no differential discriminatory impact, and appropriate mitigating actions have been identified.

<u>The lived experience, initial focus on maternity services.</u>

A key element of the Health Inequalities Group workplan over the next 12 months is to gain an insight into the lived experiences of women and their families when using maternity services. There is a well-established evidence base that demonstrates women from disadvantaged communities are at increased risk of poor perinatal outcomes. There is also a direct relationship between higher levels of socio-economic deprivation and higher stillbirth and neonatal mortality rates

There have been some studies that have concluded there is a high level of mistrust between mothers from BAME communities and healthcare resulting in a lower level of engagement with providers. Given the link between poor perinatal outcomes and the level of engagement with services how women are made to feel may have a direct impact of safety for both mother and baby.

Continuity of Carer: Work continues to achieve the targets for continuity of carer. While this is a very challenging target to achieve at the end of July 2021 53% of women from a BAME background have been booked onto a pathway.

Service User Experience: As part of the Trusts response to improving the service for women and families from BAME and vulnerable groups the service has commenced a series of discovery interviews to gain an insight into how it feels to be cared for by CHFT. Interviews are currently being undertaken, early feedback from service users describes an overall positive experience with some areas for improvement around information to explain services on offer. A more in depth report will be submitted to the Quality Committee in due course.

Culturally Competent Care: Given the link with clinical outcomes and service user engagement the service is undertaking some anonymous interviews with staff to gain insight into the challenges of caring for service users from vulnerable groups and different ethnic backgrounds. Early feedback has highlighted some gaps in understanding the extent of health inequalities within the lower IMD groups. The survey has also shown staff would be welcoming of further training and education.

Smoking Cessation: A local research project is underway to understand the barriers to smoking cessation in pregnancy. The aim will be to have the results of this published in relevant professional journals.

<u>Using our data to inform stabilisation and reset</u>

We continue to connect with other Trusts and ICS systems nationally, sharing our work and experience in the delivery of a Health Inequalities guided recovery framework. Particular interest is evident around Learning disabilities with CHFT increasingly viewed as a thought leader.

Learning Disability: The process for prioritisation of adult patients with a Learning Disability on surgical waiting lists has been embedded into surgical practice with new patients identified and dated as a priority. Dates for children on the waiting list who also have a learning disability continues to be rolled out however general capacity constraints in ENT mean this is slightly slower progress. We are currently working with other providers to explore other options for increasing capacity.

An operational project manager post has been advertised to support Health Inequalities with initial focus being on completing the action plan for Learning Disabilities by developing the individual prioritisation pathway from referral to treatment and to secure funding for the associated care navigator roles.

Waiting Times: In relation to ensuring equitable waiting times across the wider Health Inequality agenda significant progress has been made in the management of patients in the Priority 2 category where treatment should take place within 30days of prioritisation. There is minimal variation by ethnicity however there remains a waiting time difference by IMD group and initial feedback from the patient review highlighted higher levels of deferment from lower IMD groups; this is now being explored

Initial discussions have taken place on the potential development of a health inequalities matrix for waiting list prioritisation however the priorities agreed in the recovery framework will remain in place until this work is concluded and a formal recommendation agreed.

Data Quality: The quality of our data in relation to ethnicity has been reviewed with an initial position of 92% data capture. Virtual Go See's were enacted with Trusts where there was better capture along with an internal review of processes and procedures via a task & finish group. Data capture has increased to 97% as a result of 3 key areas of focus:

AED reception (1:1 training provided by the corporate Data quality team)

Inpatient admissions (report run every morning to show admissions with no ethnicity captured, call to the ward to highlight and input)

Outpatient registration (upgrade to InTouch screen for face to face that uploads directly into EPR and simple 'how to' guide for clinicians for virtual appointment registration

<u>Diverse and Inclusive Workforce.</u>

Progress and activity includes:

- Wrapping One Culture of Care around all our employees supporting their wellbeing, their time at work and their development in the future.
- The BAME Community Engagement Advisor is supporting members of our community and internal colleagues.
- Developed a 'Say No to Racism' strategy.
- We are building relationships within our communities through widening participation, offering application form and interview skills (also available for colleagues) advice and support and ensure our roles will be advertised in hard to reach areas. Working with conscious youth to support their employability skills and have 8 project search interns starting in September 21
- Leadership Development relaunch focussing on inclusive leadership, lived experience series of videos developed from equality group representatives.
- Inclusive Talent programme Empower has received great feedback and 24 colleagues have participated in the 20/21 scheme.

- Equality networks have been formed, have a chair and have a well established voice in the organisation, with additional health networks focussing on menopause, long covid and mental health
- We are expanding Inclusive Recruitment Representatives to participate on recruitment panels, developed pre sift values based recruitment questions plus a pool of EDI interview questions, the representatives will play a key role in the decision making process.

Digital Inclusion

Throughout the Trust Digital Inclusion is important as it gives the patient a choice of care where digital is appropriate, it is essential and meets the demands of those that class digital as a standard requirement in society today. The hospital, as a physical place of care, is changing with the increased capability and accessibility of digital within our communities. When designing solutions, the internal processes namely the EQIA/QIA within the Trust ensure the barriers that are connected to digital inclusion are considered. There are specific projects targeting certain pathways, where additional one-to-one training is provided, ensuring that all patients, regardless of their digital ability, are able to participate. This is evidenced by the TytoCare Pilot Project, a remote monitoring solution, where the project team has gone to great lengths of supporting patients in the use of this technology within the home. The use of technologies will increase the quality of patient care, supporting the work to help reduce health inequalities. The general benefits of digital will help with access to data and less reliance on the need to travel to the hospital. Simple tactics of providing "how-to guides/videos", albeit simple in nature, help builds people's confidence in engaging with the trust digitally.

As an anchor organisation within both Kirklees and Calderdale, the Trust is represented at both the Digital Inclusion forums in each Local Authority, respectively. Being part of these conversations and working together enables the organisation to work strategically with partners to ensure a level of consistency for our communities. More importantly, working with the Local Authority, partnership agencies and making use of established networks/forums will be advantageous for the Trust and will enable the Trust to reach into our communities to have the most impact. Digital Inclusion has been discussed at an executive level focusing in on the barriers our patient/communities face the output of this resulted in more focused work on developing our website and how best to inform our patients how they can engage digitally.

We have taken action to ensure that digital access includes translation and interpreters in the top 6 languages spoken across our area and also includes British Sign Language. We know that some people do not have access to digital technology either the equipment or WIFI and /or may not have the skills to use technology. We are working with Council colleagues and partner organisations to understand how we can support people and develop digital inclusion strategies and action plans. For example, by providing digital skills training, providing local support hubs, working with local communities and champions. The solutions to this will require all partners and broader interventions such as provision of free WIFI. In Kirklees the Huddersfield Methodist Mission, the Jo Cox Foundation and Age UK have offered to provided facilities that could offer community hubs for where people can access and be supported to use technology. We have also made links with the Kirklees employment and skills team and are exploring whether we can include training on using technology to access appointments as part of their adult learning programme. We will be taking all these ideas forward to develop a joint action plan with partners that will support reducing the risk of digital exclusion.

5 Summary

CHFT is actively addressing the 8 urgent actions as set out by the NHS. While this is a significantly challenging area the Trust can demonstrate significant progress and are becoming increasingly recognised as a leader in this arena. While the Trust has made good progress there is an acknowledgment there remains much to do and we are at the start of the journey to outstanding in tackling health inequalities.

Ellen Armistead,
Executive Director of Nursing/Deputy CEO
September 2021

Sustainability

10. Month 4 Financial Summary

To Note

Presented by Kirsty Archer

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title:	Month 4 Finance Report
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance
Previous Forums:	Finance and Performance Committee

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 4 (July 2021)

Key Points to Note

Year to Date Summary

Year to date the Trust has delivered a surplus of £3.07m, a favourable variance of £3.00m compared to plan. This favourable variance is driven by a combination of: slippage on developments, vacancies, lower than planned recovery costs and higher than planned Elective Recovery Funding (ERF). The in-month position is a £0.50m deficit, an adverse variance of £0.22m, with no ERF allocated in month 4 and increasing costs linked to both Covid and Recovery.

- Planning for the financial year ending 31st March 22 has once again been split into two halves, H1 (Half 1) and H2 (Half 2). For H1 the Trust plans to deliver a break-even position. H2 remains uncertain as confirmation of the funding envelope for the second half of the year is not expected until September but is expected to be more challenging.
- Funding for H1 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H1, the Trust has been allocated £22.19m of System Top Up funding, £11.27m of System Covid funding and £1.74m of Growth funding, a total Top Up of £35.20m to be received equally across the first 6 months of the year.
- In addition the Trust will have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and year to date has accounted for £2.97m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing, 3rd Year Student Nurse contracts and Isolation Hotels for overseas recruits. This remains subject to approval.
- In total the Trust has incurred costs relating to Covid-19 of £7.06m. Costs were driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the segregation of patient pathways (particularly within the Emergency Department), ICU staffing models and remote management of patients.
- These costs have been offset to some extent by an underspend on activity reset, slippage on new developments and lower than planned recovery costs.
- For H1 the Trust has an efficiency savings target of £3m, which is expected to be delivered but largely on a non-recurrent basis.

- Agency expenditure year to date is £1.88m, £1.06m lower than the NHS Improvement Agency expenditure ceiling.
- Clinical activity is higher than planned year to date across Elective and Outpatients points of delivery, with Daycase very slightly below plan. Activity was above the required threshold to secure Elective Recovery Funding (ERF) for Quarter 1. The Trust has assumed £3.19m of additional ERF in support of recovery as advised by the Integrated Care System (ICS). No ERF has been assumed for Month 4 due to an increase in the threshold from a planned 85% to 95% of 19/20 activity.

Key Variances

- Income is £1.86m higher than planned year to date. ERF is now included in the plan, but still drives a favourable variance of £0.36m. £2.97m of additional income has been accounted for to offset Covid-19 costs, funding for which has been requested from NHS Improvement. This is offset to some extent by lower than planned commercial income.
- Pay costs are £0.05m below the planned level year to date, although this includes £0.72m of Covid-19 costs that are outside of envelope and therefore offset by additional income. Recovery costs are £0.17m lower than planned. There remain some higher than expected pay pressures, particularly in Medical Division, where Emergency Department segregation and some enhanced staffing models on Wards and in Critical Care continue to drive higher costs. These costs have been offset by slippage on new developments, activity related underspends in Surgical Division and vacancies in Outpatients and Community Division.
- Non-pay operating expenditure was lower than planned by £0.83m. Recovery costs were as planned, but the position also includes Covid-19 related expenditure of £2.26m for vaccination costs and Covid-19 testing that are outside of envelope. The underlying position was a £3.09m underspend, including a non recurrent benefit in month of £0.62m for higher than expected VAT recovery, with the remaining underspend linked to lower than planned drugs and consumables costs.

H1 (Apr-Sep) Forecast

The Trust is forecasting a break-even position as planned at the end of this reporting period (H1). The underspend in the year to date position is not expected to continue into future months. Recovery costs will continue to increase over the next 2 months, and no associated ERF funding has been assumed due to the increased threshold requirements.

Attachment: Month 4 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 **NOTE** and receive the Month 4 Finance Report and note the financial position for the Trust as at 31 July 2021.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jul 2021 - Month 4

KEY METRICS

	M4				YTD (JUL 2021)				Forecast 21/22			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	(£0.27)	(£0.50)	(£0.22)		£0.07	£3.07	£3.00		£0.00	£0.00	£0.00	
Agency Expenditure (vs Ceiling)	(£0.74)	(£0.40)	£0.34		(£2.94)	(£1.88)	£1.06		(£8.82)	(£5.52)	£3.31	
Capital	£0.74	£1.03	(£0.29)		£4.59	£1.67	£2.92		£18.99	£14.63	£4.36	
Cash	£40.75	£40.69	(£0.06)		£40.75	£40.69	(£0.06)		£37.07	£36.03	(£1.04)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95%	96%	1%		95%	94%	-1%					
CIP	£0.49	£0.25	(£0.24)		£2.01	£2.17	£0.16		£17.23	£17.22	(£0.00)	
Use of Resource Metric	2	3			2	2			2	2		

Year to Date Summary

Year to date the Trust has delivered a surplus of £3.07m, a favourable variance of £3.00m compared to plan. This favourable variance is driven by a combination of: slippage on developments, vacancies, lower than planned recovery costs and higher than planned Elective Recovery Funding (ERF). The in-month position is a £0.50m deficit, an adverse variance of £0.22m, with no ERF allocated in month 4 and increasing costs linked to both Covid and Recovery.

• Planning for the financial year ending 31st March 22 has once again been split into two halves, H1 (Half 1) and H2 (Half 2). For H1 the Trust plans to deliver a break-even position. H2 remains uncertain as confirmation of the funding envelope for the second half of the year is not expected until September, but is expected to be more challenging.
• Funding for H1 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure.
For H1, the Trust has been allocated £22.19m of System Top Up funding, £11.27m of System Covid funding and £1.74m of Growth funding, a total Top Up of £35.20m to be received equally across the first 6 months of the year.
• In addition the Trust will have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and year to date has accounted for £2.97m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing, 3rd Year Student Nurse contracts and Isolation Hotels for overseas recruits. This remains subject to approval.
• In total the Trust has incurred costs relating to Covid-19 of £7.06m. Costs were driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the segregation of patient pathways (particularly within the Emergency Department), ICU staffing models and remote management of patients.
• These costs have been offset to some extent by an underspend on activity reset, slippage on new developments and lower than planned recovery costs.
• For H1 the Trust has an efficiency savings target of £3m, which is expected to be delivered but largely on a non-recurrent basis.
• Agency expenditure year to date is £1.88m, £1.06m lower than the NHS Improvement Agency expenditure ceiling.
• Clinical activity is higher than planned year to date across Elective and Outpatients points of delivery, with Daycase very slightly below plan. Activity was above the required threshold to secure Elective Recovery Funding (ERF) for Quarter 1. The Trust has assumed £3.19m of additional ERF in support of recovery as advised by the Integrated Care System (ICS). No ERF has been assumed for Month 4 due to an increase in the threshold from a planned 85% to 95% of 19/20 activity.

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• Income is £1.86m higher than planned year to date. ERF is now included in the plan, but still drives a favourable variance of £0.36m. £2.97m of additional income has been accounted for to offset Covid-19 costs, funding for which has been requested from NHS Improvement. This is offset to some extent by lower than planned commercial income.
• Pay costs are £0.05m below the planned level year to date, although this includes £0.72m of Covid-19 costs that are outside of envelope and therefore offset by additional income. Recovery costs are £0.17m lower than planned. There remain some higher than expected pay pressures, particularly in Medical Division, where Emergency Department segregation and some enhanced staffing models on Wards and in Critical Care continue to drive higher costs. These costs have been offset by slippage on new developments, activity related underspends in Surgical Division and vacancies in Outpatients and Community Division.
• Non-pay operating expenditure was lower than planned by £0.83m. Recovery costs were as planned, but the position also includes Covid-19 related expenditure of £2.26m for vaccination costs and Covid-19 testing that are outside of envelope. The underlying position was a £3.09m underspend, including a non recurrent benefit in month of £0.62m for higher than expected VAT recovery, with the remaining underspend linked to lower than planned drugs and consumables costs.

H1 (Apr-Sep) Forecast

The Trust is forecasting a break-even position as planned at the end of this reporting period (H1). The underspend in the year to date position is not expected to continue into future months. Recovery costs will continue to increase over the next 2 months, and no associated ERF funding has been assumed due to the increased threshold requirements.

Total Group Financial Overview as at 31st Jul 2021 - Month 4

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M4

CLINICAL ACTIVITY

	M4 Plan	M4 Actual	Var
Elective	1,225	1,379	154
Non-Elective	19,768	18,340	(1,428)
Daycase	15,218	15,079	(139)
Outpatient	129,483	132,532	3,048
A&E	53,285	59,301	6,016
Other NHS Non-Tariff	537,537	576,178	38,641
Other NHS Tariff	30,896	30,818	(79)
Total	**787,413**	**833,627**	**46,214**

TOTAL GROUP: INCOME AND EXPENDITURE

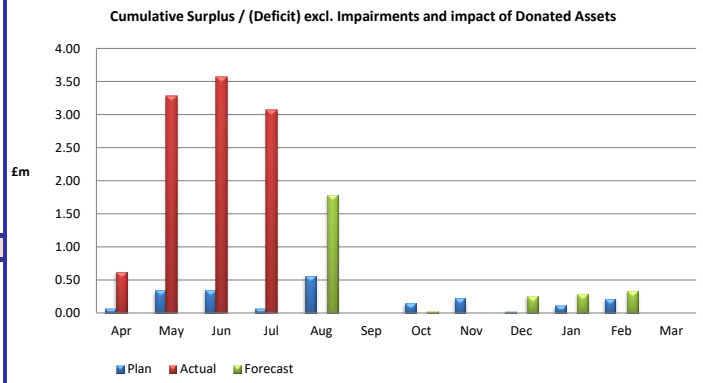
	M4 Plan	M4 Actual	Var
	£m	£m	£m
Elective	£3.71	£3.71	£0.00
Non Elective	£38.53	£38.53	£0.00
Daycase	£8.53	£8.53	£0.00
Outpatients	£10.95	£10.95	£0.00
A & E	£8.09	£8.09	£0.00
Other-NHS Clinical	£54.86	£58.76	£3.90
CQUIN	£1.13	£1.13	£0.00
Other Income	£16.87	£14.85	(£2.02)
Total Income	**£142.68**	**£144.56**	**£1.88**
Pay	(£96.77)	(£96.72)	£0.05
Drug Costs	(£13.97)	(£13.05)	£0.92
Clinical Support	(£11.16)	(£10.90)	£0.26
Other Costs	(£21.54)	(£21.89)	(£0.34)
PFI Costs	(£4.34)	(£4.34)	£0.00
Total Expenditure	**(£147.78)**	**(£146.90)**	**£0.88**
EBITDA	**(£5.10)**	**(£2.34)**	**£2.77**
Non Operating Expenditure	(£9.61)	(£9.38)	£0.23
Surplus / (Deficit) Adjusted*	**(£14.72)**	**(£11.72)**	**£3.00**
Conditional Funding (MRET/FRF/Top Up)	£14.79	£14.79	£0.00
Surplus / Deficit*	**£0.07**	**£3.07**	**£3.00**

* Adjusted to exclude items excluded for Financial Improvement Trajectory purposes: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE) and Impairments

DIVISIONS: INCOME AND EXPENDITURE

	M4 Plan	M4 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£27.74)	(£28.61)	(£0.88)
Medical	(£33.23)	(£36.57)	(£3.34)
Families & Specialist Services	(£27.70)	(£26.90)	£0.80
Community	(£8.30)	(£8.35)	(£0.05)
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£17.03)	(£17.62)	(£0.59)
THIS	£0.69	£0.74	£0.05
PMU	£1.01	£0.72	(£0.29)
CHS LTD	£0.29	£0.32	£0.03
Central Inc/Technical Accounts	£116.84	£116.50	(£0.34)
Reserves	(£4.76)	£2.84	£7.61
Surplus / (Deficit)	**£0.07**	**£3.07**	**£3.00**

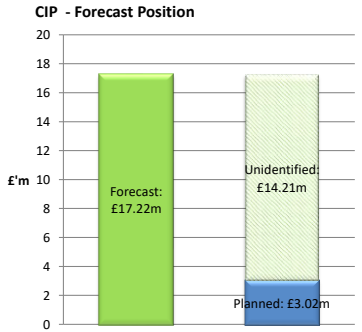
TOTAL GROUP SURPLUS / (DEFICIT)

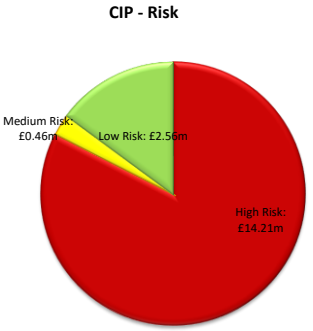


KEY METRICS

	Year To Date			Year End: Forecast			
	M4 Plan	M4 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	£0.07	£3.07	£3.00	£0.00	£0.00	£0.00	
Capital	£4.59	£1.67	£2.92	£18.99	£14.63	£4.36	
Cash	£40.75	£40.69	(£0.06)	£37.07	£36.03	(£1.04)	
Invoices Paid within 30 days (BPPC)	95%	94%	-1%				
CIP	£2.01	£2.17	£0.16	£17.23	£17.22	(£0.00)	
	Plan	Actual		Plan	Forecast		
Use of Resource Metric	2	2		2	2		

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£17.23m[1]**

Total Forecast **£17.22m**

[1] Estimated target based on internal planning assumptions. The scale of the efficiency requirement for H2 will not be confirmed until September 21.

YEAR END 21/22

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	3,790	4,308	518
Non-Elective	58,196	55,531	(2,665)
Daycase	46,367	47,947	1,580
Outpatient	402,979	423,725	20,745
A&E	154,885	172,540	17,655
Other NHS Non- Tariff	1,637,434	1,761,488	124,054
Other NHS Tariff	94,178	96,367	2,189
Total	**2,397,829**	**2,561,905**	**164,076**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£11.44	£11.44	£0.00
Non Elective	£113.53	£113.53	£0.00
Daycase	£25.34	£25.34	£0.00
Outpatients	£34.99	£34.99	£0.00
A & E	£23.42	£23.42	£0.00
Other-NHS Clinical	£156.69	£176.43	£19.74
CQUIN	£3.39	£3.39	£0.00
Other Income	£51.18	£45.05	(£6.14)
Total Income	**£419.98**	**£433.58**	**£13.60**
Pay	(£285.06)	(£286.91)	(£1.86)
Drug Costs	(£42.06)	(£41.44)	£0.61
Clinical Support	(£32.35)	(£38.50)	(£6.16)
Other Costs	(£55.88)	(£62.95)	(£7.07)
PFI Costs	(£13.03)	(£13.46)	(£0.43)
Total Expenditure	**(£428.37)**	**(£443.26)**	**(£14.89)**
EBITDA	**(£8.39)**	**(£9.68)**	**(£1.29)**
Non Operating Expenditure	(£29.05)	(£28.08)	£0.97
Surplus / (Deficit) Adjusted*	**(£37.45)**	**(£37.77)**	**(£0.32)**
Conditional Funding (MRET/FRF/Top Up)	£37.45	£37.77	£0.32
Surplus / Deficit*	**£0.00**	**£0.00**	**£0.00**

* Adjusted to exclude items excluded for Financial Improvement Trajectory: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE) and Impairments

DIVISIONS: INCOME AND EXPENDITURE

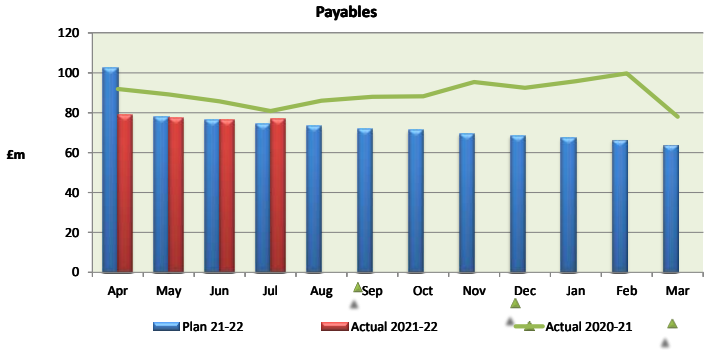
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£83.47)	(£93.13)	(£9.66)
Medical	(£100.62)	(£112.60)	(£11.98)
Families & Specialist Services	(£82.99)	(£82.82)	£0.17
Community	(£24.96)	(£25.99)	(£1.03)
Estates & Facilities	£0.00	£0.00	£0.00
Corporate	(£51.23)	(£52.46)	(£1.23)
THIS	£2.16	£1.92	(£0.24)
PMU	£3.02	£2.00	(£1.02)
CHS LTD	£0.88	£0.88	(£0.00)
Central Inc/Technical Accounts	£334.76	£342.32	£7.57
Reserves	£2.45	£19.87	£17.42
Surplus / (Deficit)	**£0.00**	**£0.00**	**£0.00**

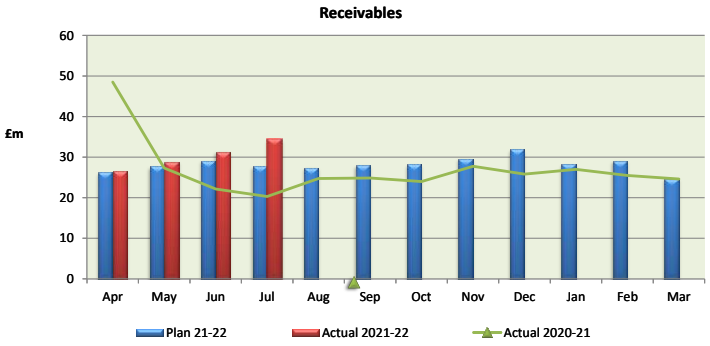
Total Group Financial Overview as at 31st Jul 2021 - Month 4

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

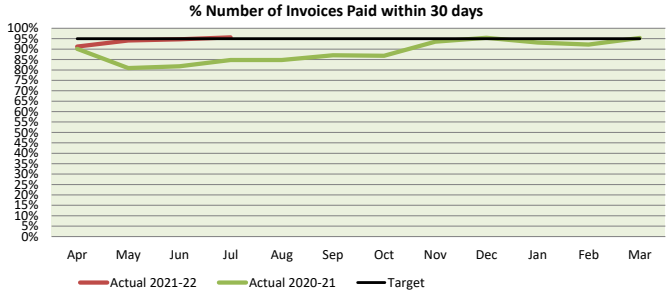
WORKING CAPITAL

	M4 Plan £m	M4 Actual £m	Var £m	M4
Payables (excl. Current Loans)	(£74.21)	(£76.85)	£2.64	
Receivables	£27.78	£34.37	(£6.59)	



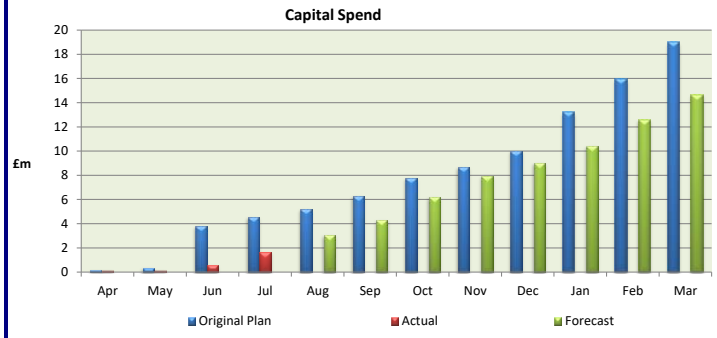


BETTER PAYMENT PRACTICE CODE



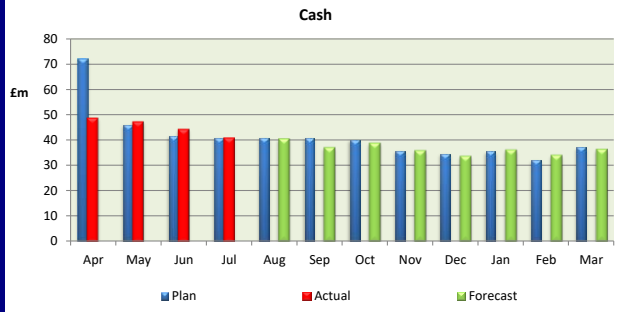
CAPITAL

	M4 Plan £m	M4 Actual £m	Var £m	M4
Capital	£4.59	£1.67	£2.92	

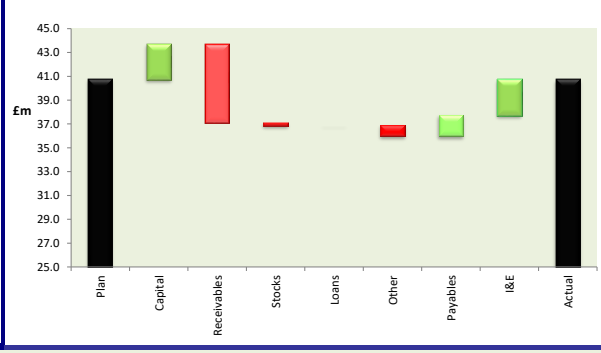


CASH

	M4 Plan £m	M4 Actual £m	Var £m	M4
Cash	£40.75	£40.69	(£0.06)	
Loans (Cumulative)	£18.77	£18.77	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date, the Trust has delivered a surplus of £3.07m, a favourable variance of £3.00m compared to plan. This favourable variance is driven by a combination of slippage on developments, vacancies , lower than planned recovery costs and higher than planned Elective Recovery Funding (ERF).
- Funding for H1 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H1, the Trust has been allocated £22.19m of System Top Up funding, £11.27m of System Covid funding and £1.74m of Growth funding, a total Top Up of £35.20m to be received equally across the first 6 months of the year.
- With the exception of Non-Elective and Daycase, all activity points of delivery are above the planned level year to date. Activity was above the required threshold to secure Elective Recovery Funding (ERF) for Quarter 1. The Trust has assumed £3.19m of additional ERF in support of recovery as advised by Integrated Care System (ICS). No ERF has been assumed for Month 4 due an increase in the threshold from a planned 85% to 95% of 19/20 activity.
- The Trust has incurred costs relating to Covid-19 of £7.06m, of which £2.97m are considered as 'outside of system envelope' and for which additional funding is available.
- Capital expenditure is lower than planned at £1.67m against a planned £4.59m.
- CIP delivered year to date is £2.17m, £0.16m above the planned level.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 2.

NOTES

- The Trust is forecasting to deliver a break-even position at both H1 (Apr-Sep) and for the full financial year.
- Planning for the financial year ending 31st March 22 has once again been split into two halves, H1 (Half 1) and H2 (Half 2). For H1 to Trust plans to deliver a break-even position. H2 remains uncertain as confirmation of the funding envelope for the second half of the year is not expected until September.
- No further Elective Recovery Funding (ERF) is assumed in the forecast as agreed with the ICS. This reflects the changes to the ERF threshold that were announced on the 9th of July.
- The Trust has a cash balance of £40.69m, £0.06m lower than planned.
- The estimated efficiency target for the year is £17.23m of which only £3m is required to be found in H1. This target is an estimate due to the uncertainly regarding H2 funding and is likely to change when funding arrangements are confirmed in September.
- The total loan balance is £18.77m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £14.63m on Capital programmes in this financial year, a reduction of £4.36m compared to the planned value.

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

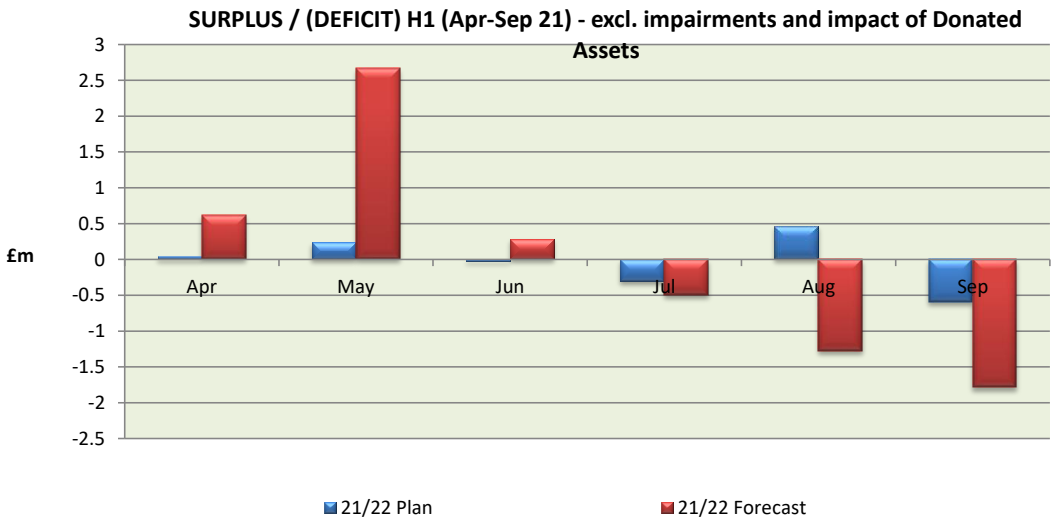
H1 (Apr-Sep) FORECAST POSITION 21/22

H1 Forecast (30 Sep 21)

Statement of Comprehensive Income	Plan £m	Actual £m	Var £m	
Income	£267.90	£272.92	£5.02	
Pay expenditure	(£145.27)	(£146.22)	(£0.96)	
Non Pay Expenditure	(£108.53)	(£112.64)	(£4.11)	
Non Operating Costs	(£14.27)	(£14.27)	(£0.00)	
Total Trust Surplus / (Deficit)	**(£0.17)**	**(£0.21)**	**(£0.04)**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	£0.00	£0.00	
Donated Asset depreciation	£0.21	£0.21	(£0.00)	
Donated Asset income (including Covid equipment)	(£0.04)	£0.00	£0.04	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**£0.00**	**£0.00**	**(£0.00)**	

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

MONTHLY SURPLUS / (DEFICIT)



Forecast for H1 (Apr-Sep 21)

- The Trust is forecasting a break-even position as planned at the end of this reporting period (H1). The underspend in the year to date position is not expected to continue into future months. Recovery costs will continue to increase over the next 2 months, and no associated ERF funding has been assumed due to the the increased threshold requirements, as advised by the ICS. ERF funding will be much harder to achieve as the threshold for delivery has increased to 95% of 19/20 baseline activity.

Forecast Assumptions:

- The forecast assumes £4.55m of recovery costs, (£0.86m lower than the £5.4m planned).
- The forecast assumes that Bank pay enhancements of 50% will cease after the agreed 4 week trial period.
- Elective Recovery Funding (ERF) of £3.19m is assumed in the forecast as agreed with the ICS. Whilst internal forecasts suggest that the Trust will exceed the revised 95% threshold in months 5 & 6 no further allocation has been assumed for H1.
- Covid-19 costs of £10.40m are forecast of which £6.27m is to be managed within the agreed system envelope, with the remainder assumed to be funded by additional funding.

Risks and Potential Benefits:

- Changes to the threshold have resulted in a reduction in ERF income of circa £1.11m compared to plan. Forecast activity suggests that there may still be some opportunity to earn ERF in Months 5 & 6, dependant on overall ICS performance.
- High Covid-19 cases and the impact on both capacity and staff availability.
- Risk of continued high A&E attendances and operational pressure driving additional cost.
- Continuation of Bank enhanced rates of 50%, beyond 4 week trial period, would drive significant additional cost, not currently reflected in the H1 forecast.
- Scope for further efficiencies to be identified.

COVID-19 & Recovery

Covid-19 Expenditure YTD JUL 2021	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	64	0	64
Remote management of patients	153	114	268
Support for stay at home models	18	0	18
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	317	60	377
Segregation of patient pathways	2,330	278	2,608
Existing workforce additional shifts	188	67	255
Decontamination	0	78	78
Backfill for higher sickness absence	99	2	101
Remote working for non patient activities	0	0	0
PPE - other associated costs	0	1	1
Sick pay at full pay (all staff types)	2	0	2
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	205	14	219
Enhanced PTS	0	91	91
COVID-19 virus testing - rt-PCR virus testing	50	1,112	1,162
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	470	1	471
COVID-19 - Vaccination Programme - Vaccine centres	0	1,124	1,124
COVID-19 - Vaccination Programme - Local vaccination service	4	0	4
NIHR SIREN testing - antibody testing only	9	1	10
COVID-19 - International quarantine costs	0	16	16
COVID-19 - Deployment of final year student nurses	182	0	182
Total Reported to NHSI	**4,092**	**2,961**	**7,052**
PPE - locally procured	0	3	3
Internal and external communication costs	0	1	1
Grand Total	**4,092**	**2,964**	**7,056**

Recovery Costs YTD JUL 2021	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	0	1,336	1,336
Additional Staffing - Medical	67	0	67
Additional Staffing - Nursing	91	0	91
Additional Staffing - Other	72	0	72
Non Pay	0	284	284
Enhanced Payment Model - Medical	158	0	158
Enhanced Payment Model - Nursing	182	0	182
Total	**570**	**1,620**	**2,190**

Covid-19 Costs

Year to date the Trust has incurred £7.06m of expenditure relating to Covid-19. Planned Covid costs year to date were £2.97m, but this plan does not include Covid-19 costs that are outside of System envelope and for which funding can be claimed retrospectively. These costs are highlighted in the table to the left and total £2.97m year to date **The underlying overspend on Covid was therefore £1.12m** and was driven by the continuation of some enhanced workforce models on wards and in ICU and a continuation of Emergency Department segregation. However, in the first few months of the year, this pressure has been offset by vacancies in Outpatients and underspends on consumables and drugs linked to elective and daycase activity were lower than historic levels, but are now rising.

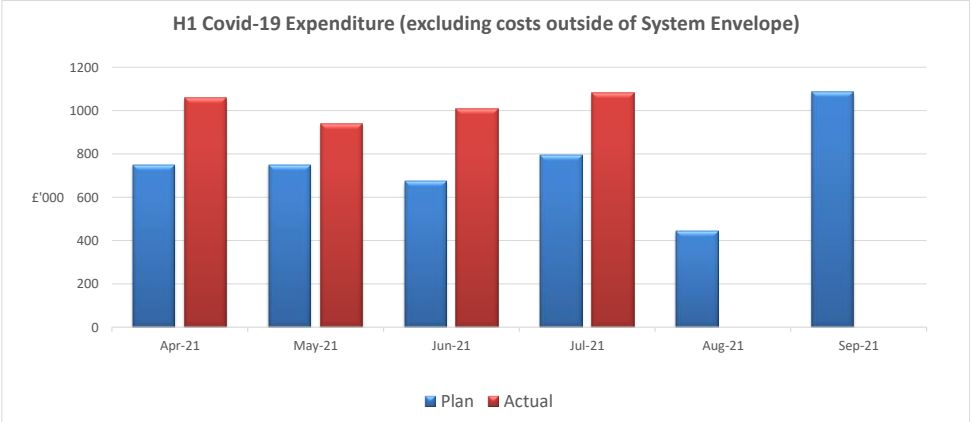
Covid-19 Funding

The Trust has been allocated block funding by the ICS to cover any Covid-19 costs totalling £7.52m year to date. In addition the Trust will be requesting retrospective Covid-19 funding of £2.97m to cover costs relating to Vaccinations, Covid-19 Testing, 3rd year student nurses and Isolation Hotels for overseas recruits.

Recovery

Recovery costs totalling £5.4m for H1 have been approved in conjunction with the Trust's activity plan. These costs were to be funded by a combination of Elective Recovery Funding planned to be circa £4.3m and Trust Reserves set aside to cover Covid-19 and excess Recovery costs.

- Year to date Recovery costs are £2.19m.
- The majority of the costs incurred related to use of the Independent Sector for outsourcing. The Trust has agreed contracts with Optegra, BMI and Spire.
- Elective Recovery Fund (ERF) Funding is allocated at System level and will only be paid if the Integrated Care System (ICS) as a whole exceeds activity thresholds.
- The ICS has confirmed that the Trust is eligible to receive additional funding via the Elective Recovery Fund as the thresholds agreed for April, May and June activity have been exceeded. £3.19m of income has been assumed in the year to date position, £0.36m more than planned.
- The recent anouncement by NHS Improvement that the threshold for ERF has been increased to 95% from Month 4 has resulted in a significant reduction in forecast ERF for the Trust. The ICS has advised the Trust to assume that no further ERF will be allocated in H1, and although internal forecasts suggest that the Trust will exceed the 95% threshold in months 5 & 6 no further allocation has been assumed for H1.



A Workforce for the Future

11. Health and Wellbeing Update Presentation

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	2 September 2021
Meeting:	Public Board of Directors
Title of report:	Ensuring the Wellbeing Hour is rolled out across the Trust
Author:	Gary Boothby, Executive Finance Director Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Sponsor:	Gary Boothby, Executive Finance Director Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee February 2020 Board of Directors July 2020 and September 2020 Executive Board December 2020, March 2021, July 2021 Board Development Session August 2021

Purpose of the Report

This report shares with the Board a plan to roll out the Wellbeing Hour across all teams and departments at CHFT. It shares examples from teams who have successfully rolled out the Wellbeing Hour and examples of teams who have not and the barriers preventing them from doing so.
The plan to roll out the Wellbeing Hour is centred on peer to peer support and positive role modelling and leadership from the Board and Divisional Senior Management teams.

Key Points to Note

- Our approach to One Culture of Care means that we care for ourselves and each other in the same way that we care for our patients. Keeping our colleagues safe and well is vital to positive patient experience and care
- There has already been a significant physical and mental health impact on colleagues over the last 18 months due to the COVID pandemic
- The volume of patients now requiring our care added to the Recovery programme means that there are continuing significant and conflicting demands on colleagues time
- The Wellbeing Hour is just one element of our COVID Health and Wellbeing Strategy, but is the clearest symbol to colleagues that their health and wellbeing is important
- The Wellbeing Hour is well received by some colleagues but not all Managers are able to incorporate it into their team's rosters or diaries. Some see it as an additional burden to planning rosters and service provision
- There has been continuous support to the Wellbeing Hour from the Board of Directors since it was first presented to Workforce Committee in February 2020. At the Board Development Session in August 2021, the Board continued their support for the Wellbeing Hour but wanted assurance that the Wellbeing Hour was being offered and facilitated to ALL teams across the Trust
- The Wellbeing Hour is not currently offered to Doctors in Training or Medical colleagues. This decision was previously taken based on the time built into PAs for development. However, there is growing support amongst these staffing groups (who are typically more reluctant to discuss their health and wellbeing) for the Wellbeing Hour. The paper therefore recommends a Task and Finish group with these staffing groups to better understand their health and wellbeing support requirements and to consider if and how implementation could be achieved
- The plan presented to Board to roll out the Wellbeing Hour focuses on peer to peer support, with those colleagues who have successfully rolled out the Wellbeing Hour supporting those that have as yet been unable to do so

EQIA – Equality Impact Assessment

Mental ill health affects 1 in 4 people in their lifetime. Under the Equality Act 2010, an individual is considered to be disabled if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

In England, women are more likely than men to have a common mental health problem and are almost twice as likely to be diagnosed with anxiety disorders. 80.4%+ of our workforce is female, and an appropriate strategy to assist in the prevention of anxiety stress and depression is therefore required.

In 2019, 5,961 suicides were recorded in England and Wales with three quarters of registered suicides being men. This is the highest rate since 2000. Whilst there are no official figures, it is widely recognised by research through organisations such as Samaritans that the COVID pandemic is increasing the risk factors that are known to lead to suicide.

The mental health of BAME colleagues is important because people from these communities already face individual and societal challenges that can affect access to healthcare and overall mental and physical health.

Evidence suggests people identifying as LGBT are at higher risk of experiencing poor mental health. Members of the LGBT community are more likely to experience a range of mental health problems such as depression, suicidal thoughts, self-harm and alcohol and substance misuse.

The wellbeing hour is a clear signal that we support the wellbeing of its workforce and may therefore encourage colleagues to speak up if they are struggling.

Analysis in relation to the uptake of the Wellbeing Hour by protected characteristic and IMD (index of multiple deprivation) is underway.

Source: www.ONS.gov.uk/ www.mentalhealth.org.uk

Recommendation

1. To **NOTE** the plan to roll out the Wellbeing Hour to all teams across CHFT
2. To **NOTE** that not all services are rolling out the Wellbeing Hour in the same way and that services value flexibility
3. To **NOTE** the task and finish group reviewing the application of the roll out of the Wellbeing Hour to Doctors in Training and the Medical workforce.

12. Improving People Practices

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	2 September 2021
Meeting:	Board of Directors
Title of report:	Improving People Practices
Author:	Azizen Khan, Assistant Director of Human Resources Jason Eddleston, Deputy Director of Workforce and Organisational Development
Sponsor:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee 5 November 2019, 9 December 2020 and 10 May 2021

Actions Requested

- To note

Purpose of the Report

NHS England/NHS Improvement (NHSE/I) set a requirement for NHS organisations to review people practices and disciplinary policies and procedures following guidance issued based primarily on learning from a critical incident at Imperial College Healthcare NHS Trust.

The paper describes the Trust's response. Consideration of the response satisfies an NHSE/I requirement that the Trust's disciplinary policy and procedure is reviewed and discussed at a Public Board of Directors meeting.

Key Points to Note

- Following the death of an NHS employee who was subject to formal action within conduct procedures in 2016 Imperial College Healthcare NHS Trust commissioned an independent inquiry led by Verita Consulting
- The report concluded that in addition to serious procedural errors throughout the investigation and disciplinary process the employee was treated poorly
- NHSI established a task and finish Advisory Group to consider to what extent the failings identified in the case were either unique to that NHS organisation or more widespread across the NHS, and what learning could be applied
- The Advisory Group reviewed several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements
- The Advisory Group made a series of recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS acknowledging there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing in formal processes
- The recommendations have been tested against our existing practice and actions identified to incorporate the learning from into our processes
- The actions are consistent with our commitment to 'One Culture of Care'.
- The actions have been implemented

- An assessment of the Trust's Disciplinary Policy and Procedure against a revised policy produced by Imperial College Healthcare NHS Trust has been undertaken and revisions to our local policy/procedural arrangements have been agreed with staff side partners and incorporated in a refreshed policy document.

EQIA – Equality Impact Assessment

It is essential we treat our people fairly and protect their wellbeing. Implementing the approach within formal processes that has been adopted following the review activity will contribute to this.

Recommendation

The Board is asked to note the content of the paper.

compassionate care

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

2 SEPTEMBER 2021

IMPROVING PEOPLE PRACTICES

1. PURPOSE

NHS England/NHS Improvement (NHSE/I) set a requirement for NHS organisations to review people practices and disciplinary policies and procedures following guidance issued based primarily on learning from a critical incident at Imperial College Healthcare NHS Trust.

The paper describes the Trust's response.

Consideration of the response satisfies an NHSE/I requirement that the Trust's disciplinary policy and procedure is reviewed and discussed at a Public Board of Directors meeting.

2. BACKGROUND

Following the death of an NHS employee who was subject to formal action within conduct procedures in 2016, Imperial College Healthcare NHS Trust commissioned an independent inquiry led by Verita Consulting. The investigation report can be found at https://www.verita.net/wp-content/uploads/2018/08/Imperial-Final-report-9-August-18.pdf.

The findings were reported to the Imperial College Healthcare NHS Trust Board and to NHS Improvement (NHSI) in August 2018. The report concluded that in addition to serious procedural errors throughout the investigation and disciplinary process the employee was treated poorly, to the extent that their mental health was severely impacted. The report recommendations were accepted by Imperial College Healthcare NHS Trust in full.

Subsequently, NHSI established a task and finish Advisory Group to consider to what extent the failings identified in the specific London case were either unique to that NHS organisation or more widespread across the NHS, and what learning could be applied.

The Advisory Group comprised multi-professional stakeholders and subject matter experts from the NHS and external bodies. The Group conducted an analysis of Verita findings and reviewed several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements.

3. NHSI RECOMMEDATIONS

The Advisory Group analysis highlighted key themes associated with the Verita inquiry which were common to the other historical cases considered. Principal among these were:-

- poor framing of concerns and allegations
- inconsistency in the fair and effective application of local policies and procedures
- lack of adherence to best practice guidance
- variation in the quality of investigations
- shortcomings in the management of conflicts of interest
- insufficient consideration and support of the health and wellbeing of individuals
- an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHSE/I People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees acknowledged the need for greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances.

The NHSI Chair wrote to NHS employers in May 2019. The letter is at Appendix 1. The letter provides additional guidance relating to the management and oversight of local investigation and disciplinary procedures and is based on the Advisory Group recommendations. The guidance represents actions characteristic of responsible and caring employers which reflect NHS values.

NHS organisations were asked to review the recommendations and assess current procedures and processes in comparison and, most importantly, make adjustments where required to ensure best practice. In addition, with respect to the management of cases it was recommended the following questions should be addressed within decision making processes to determine the best possible management actions:-

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?
- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?
- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?
- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.
- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?
-

The recommendations and best practice are consistent with our own 'One Culture of Care' and endorse an employee centric approach to the way we manage our processes.

Subsequent to publication of the NHSI recommendations and guidance, NHSE/I directed NHS organisations to review a revised disciplinary policy introduced by Imperial College Healthcare NHS Trust as part of remedial work to improve its people processes and to consider changes to local disciplinary policies and procedures.

In order to evidence organisational commitment to improving people practices NHS organisations have been asked to consider work undertaken locally in response to the recommendations by the NHS Chief People Officer. The letter is at Appendix 2.

4. TRUST ASSESSMENT

An assessment of the NHSI recommendations set out in the May 2019 letter has been completed with actions identified and implemented to enhance practice within the Trust. The full assessment is at Appendix 3.

An assessment of the Trust's Disciplinary Policy and Procedure has been undertaken with changes subsequently agreed with staff side partners and ratified at Executive Board. The assessment is at Appendix 4 and the revised policy is at Appendix 5.

5. CONCLUSION

The Board is asked to note the content of the paper.

Azizen Khan
Assistant Director of Human Resources

Jason Eddleston
Deputy Director of Workforce and Organisational Development

19 August 2021

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trusts and NHS foundation trusts chairs and chief executives

23 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's recommendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Appendix 2

NHS Improvement & NHS England

Prerana Issar
NHS Chief People Officer
Skipton House
80 London Road
London SE1 6LH
Prerana.issar@nhs.net
www.england.nhs.uk
www.improvement.nhs.uk

1 April 2021

Dear Colleagues

I hope you are keeping well during this very challenging time.

In December 2020 I wrote to ask that by the end of March 2021 you should have reviewed all disciplinary policies and procedures against the recommendations issued in May 2019 (in a letter from the Chair of NHSI about improving our people practices). Specifically, I asked that:

- your disciplinary policy is reviewed and discussed at a public Board or equivalent and
- your updated policy is made available on your organisation's public website.

I also cited as a good practice reference point the policy Imperial College Hospitals NHS Trust has published on its website

Since I wrote in December, the pandemic reached unprecedented levels and I know that you have been busy ensuring your organisations are fully focused on responding to Covid-19. Thank you so much for your continued efforts, which is making a massive difference to patients, our people and our NHS overall.

I appreciate, therefore, that the pandemic may well have delayed your intentions to review your disciplinary policies by the end of March. However, as we think about staff recovery and prioritising their health and wellbeing, it's important we ensure that HR policies and processes are compassionate, supportive and inclusive.

Therefore, could you please update your Regional Director of Workforce and OD with your progress by the end of April, and confirm to them your status on completing the stated actions by end of June 2021.

I hope you all manage to take some leave in the next few months to ensure you are looking after yourself. My heartfelt thanks for all your efforts.

Yours Sincerely,

Prerana Issar

Prerana Issar
NHS Chief People Officer

Calderdale and Huddersfield NHS Foundation Trust

NHSI GUIDANCE RELATING TO THE MANAGEMENT AND OVERSIGHT OF LOCAL INVESTIGATION AND DISCIPLINARY PROCEDURES

COMPLIANCE ASSESSMENT

OCTOBER 2019

Recommendations/guidance	Current practice	Assessment of practice	Next steps	Responsibility	Progress
1. Adhering to best practice **a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published)** **b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).**	CHFT conforms to ACAS guidance and best practice on investigations and hearings derived from developing caselaw. Established policies are in place and are reviewed in partnership with staff side representatives. Guidance notes are produced as and when required. Training and briefing sessions are scheduled on an irregular basis. The training includes up to date best practice and caselaw. A 'case manager' framework (with Board oversight cases involving senior doctors) operates for all investigations with clarity about the roles of case investigators and decision makers. There is separation between decision making for investigation next steps including referral to a formal panel and decision making by panels. Operational case management oversight across the full range of cases in play at any one time operates through the Workforce and OD Directorate.	We are good at separation of roles and responsibilities to produce independence and objectivity. This is established through ET decisions. In some cases investigations take too long to complete as a consequence of other operational demands. There is variability in the quality of investigation reports. Training support to case investigators and decision makers is not regular and systematic. There is no automatic case review programme. There are no systematic conflict of interest questions asked of decision makers. Instead we rely on individuals to recognise and declare actual or potential conflicts after the issue has been covered in training. There is also a check from the staff side representatives who will raise perceived conflicts. This has worked well in practice. Policy review is not always evidence based.	Establish a systematic approach to the creation of investigation terms of reference and the identification of associated timeframes for investigation completion with robust Case Manager oversight. Consider the design, operational framework and resourcing requirements for a dedicated case investigation team. Re-set the format of the investigation report template and brief case investigators on its use and thereafter assess compliance. Create a programme and schedule of training for those involved in cases as case investigators and decision makers. Consider case review mechanisms. Introduce a mechanism where decision makers are required to consider and declare any conflict of interest. Ensure policy reviews are evidence based with robust data/information available so as to facilitate the 'testing' of content.	Azizen Khan, Assistant Director of Human Resources Jason Eddleston, Deputy Director of Workforce and OD/Azizen Khan, Assistant Director of Human Resources Azizen Khan, Assistant Director of Human Resources Operational HR team Jason Eddleston, Deputy Director of Workforce and OD Azizen Khan, Assistant Director of Human Resources Barry Mortimer, Senior HR Adviser	Completed. Operational from November 2019 with further work on Case Manager engagement and oversight of investigation. Business case submitted, not being progressed. Completed on 29 February 2020. Completed with training provided from September 2020 with rolling programme into 2021. Use post-case debriefs to share learning. Judgement on the scale of involvement on a case by case basis with a focus on process and root cause. Completed. Added to terms of reference document. Completed. Process designed for more evidence based policy review.

Recommendations/guidance	Current practice	Assessment of practice	Next steps	Responsibility	Progress
	External and/or independent involvement, advice and expertise has been commissioned by the Trust. On completion of formal procedures case reviews to consider practice and to identify learning points are held though only on an ad hoc basis. Conflicts of interest when identified are dealt with and accommodated within procedures.				
2. Applying a rigorous decision-making methodology **a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.** **b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.**	There is always consideration of whether formal process is required. Doctor cases are dealt with rigorously in accordance with MHPS and caselaw. The Trust has adapted a slimmed down MHPS model for all other investigations and hearings so that the principles of separation of roles generate independence and objectivity in activity and decision making. Decisions about exclusions are taken at Director level (mainly Chief Executive, Director of Workforce and OD, Director of Nursing and Medical Director)	We are good at separation of roles and responsibilities to produce independence and objectivity. This is established through ET decisions. In some cases investigations take too long to complete as a consequence of other operational demands. There is variability in the quality of investigation reports. Training support to case investigators and decision makers is not regular and systematic. There is no automatic case review programme. There are no systematic conflict of interest questions asked of decision makers. Instead we rely on individuals to recognise and declare actual or potential conflicts after the issue has been covered in training. There is also a check from the staff side representatives who will raise perceived conflicts. This has worked well in practice. Decision making may not be always be recorded demonstrating that	See 1. Ensure that all decisions and their rationale are recorded in full and retained as part of the overall case management record. Consider ways to ensure 'one culture of care' is at the forefront of our thinking and decision making and that we treat individuals entering formal processes with care, dignity and respect. Consider the use, appropriateness and impact of alternative mechanisms to avoid entering formal processes (for example, mediation)	See 1. Azizen Khan, Assistant Director of Human Resources Jason Eddleston, Deputy Director of Workforce and OD/Azizen Khan, Assistant Director of Human Resources/Nikki Hosty, ED&I Lead/FTSU Guardian Barry Mortimer, Senior HR Adviser	Completed. All significant decisions are recorded in Case Managers letters and case conference notes for retention on case management folders. 'Say it, say it and say it again'. Completed. Template correspondence letters all reviewed now and in individual cases as they progress. Utilise nationally suggested triage questions to filter and make decisions Informal resolution to include discussion, acceptance of responsibility, apology, agreement to further training and re-training, agreements between colleagues, acceptance of sanction without a formal hearing (record keeping is essential to all these options). Build options into triage questions.

Recommendations/guidance	Current practice	Assessment of practice	Next steps	Responsibility	Progress
		consideration of context and prevailing factors have been considered.			
3. Ensuring people are fully trained and competent to carry out their role **Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles**	Training and briefing sessions are scheduled on an irregular basis. The training includes up to date best practice and caselaw.	Current delivery is by presentation. It is difficult to assess whether they are competent to carry out their role within formal procedures.	Create a programme and schedule of training for those involved in cases as case investigators and decision makers and monitor activity such that only trained colleagues are deployed in such roles. Create role specific narratives that describe activity and responsibility. Develop core competencies that are assessed. Decision makers participate in unconscious bias training ('Step in their shoes' programme to be developed Q1 2020) Design and implement a robust mechanism for feedback to case investigators and decision makers.	Jason Eddleston, Deputy Director of Workforce and OD/Azizen Khan, Assistant Director of Human Resources/Frank Sutcliffe, Legal Adviser Azizen Khan, Assistant Director of Human Resources/Frank Sutcliffe, Legal Adviser Jason Eddleston, Deputy Director of Workforce and OD/Azizen Khan, Assistant Director of Human Resources/Nikki Hosty, ED&I Lead/FTSU Guardian Nikki Hosty, ED&I Lead/FTSU Guardian Jason Eddleston, Deputy Director of Workforce and OD/Azizen Khan, Assistant Director of Human Resources	See earlier action in 1. Completed. Establish a list of trained case managers, case investigators and panel members. Completed. Capture in Case Manager letter and separate role description document. Completed. Learning outcomes identified in 'Stepping in their shoes' and case manager et al training programmes:- • Awareness of relevant aspects of best practice • Understand the principles of natural justice • Appreciation of race and cultural considerations • Explore the unconscious and hidden biases that we all have and minimise the influence that those biases have on our decision making • Understanding one culture of care and applying it every stage of the process Completed. Programme developed and rolled out as part of Leading One Culture of Care programme. Completed. For every case, Case Manager and Case Investigator will receive feedback including One Culture

Recommendations/guidance	Current practice	Assessment of practice	Next steps	Responsibility	Progress
					of Care. Debrief sessions take place.
4. Assigning sufficient resources **Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.**	The Trust gives consideration to the workload of individuals when assigning roles in formal processes and allows time and resources for case investigators and decision makers to carry out their roles. HR practitioners provide support and advice. In-house legal advice is also available. External and/or independent involvement, advice and expertise has been commissioned by the Trust.	Activity in relation to Investigations and panels has to live alongside the day job and therefore priority conflicts do arise.	Consider the design, operational framework and resourcing requirements for a dedicated case investigation team. Establish a systematic approach to the creation of investigation terms of reference, the identification of individuals to be assigned to roles in the process and consideration of other work commitments and the identification of associated timeframes for investigation completion.	Jason Eddleston, Deputy Director of Workforce and OD/Azizen Khan, Assistant Director of Human Resources Azizen Khan. Assistant Director of Human Resources	Business case submitted, not being progressed Completed.
5. Decisions relating to the implementation of suspensions/exclusions **Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.**	Decisions about exclusions are taken at Director level (mainly Chief Executive, Director of Workforce and OD, Director of Nursing and Medical Director)	Our practice in doctor cases is good. Last resort, it is never a one person decision, proper review, lifted when appropriate. Conscious of conflicts of interest. Proper oversight arrangements in place. Non-doctor cases may not be so rigorous. Recording of decision making in doctor cases may not be fully documented.	Create decision trees for exclusions. Ensure that all decisions are recorded in full and retained as part of the overall case management record. Provide guidance for action for on-call Directors and managers See 1. in respect of training provision, 2. in respect of 'one culture of care and 3. in relation to core competencies.	Barry Mortimer, Senior HR Adviser Azizen Khan, Assistant Director of Human Resources Jason Eddleston, Deputy Director of Workforce and OD. See 1., 2. and 3	To be actioned as part of policy review. Completed. Case management folders/tracker/case conference notes. Completed. A 'send them home' approach but with a clear one culture of care message (what support will be available?). Produce a script and information leaflet (our 'blue sheet').
6. Safeguarding people's health and wellbeing **a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be**	The Trust's occupational health service is referenced in correspondence although referral	This is an area where the Trust should provide clarity in its	Consider routine OH referral as part of case management process.	Christine Bouckley, Head of Occupational Health and Wellbeing	Completed. Wellbeing team to give every person entering the process a call. They will then

Recommendations/guidance	Current practice	Assessment of practice	Next steps	Responsibility	Progress
paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support. **b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.** **c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.**	for assessment is not actioned routinely.	approach generally and specifically on a case by case basis.	Identify and document in material to be shared with the employee entering the formal process the range of accessible support services available including access to support networks (BAME, Disability and LGBT+) Design and regulate the use of a communication plan template between the Trust and the employee entering the formal process that is to be agreed and incorporated into case management arrangements (ie terms of reference) and that identifies a designated 'support' contact who is unconnected with the case in any way and the basis and regularity for contact whilst the case progresses. Consider support for witnesses and immediate work colleagues in some cases.	Christine Bouckley, Head of Occupational Health and Wellbeing/Prasadu, Occupational Clinical Psychologist/Nikki Hosty, ED&I Lead/FTSU Guardian Azizen Khan, Assistant Director of Human Resources Operational HR team	refer to further support if necessary (ie Socrates, counselling, OH) Completed. Refreshed case manager letter and terms of reference (make sure the contact/communication is agreed with the employee). Completed. Make more consistent the support available, provide an information leaflet available to people in these 2 groups.
7. Board-level oversight **Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.**	The Workforce Committee, a main-Board sub-committee, chaired by a Non-Executive Director receives an annual deep dive paper. Exclusion reports are submitted on a case by case basis to the Board.	The integrity of formal processes must be preserved at all times and oversight should not mean interference. However, more detailed reporting to the Workforce Committee may be appropriate.	Review the design and content of the Workforce Committee deep dive report and consider a more regular reporting timeline.	Azizen Khan, Assistant Director of Human Resources/Adam Matthews, BI Analyst	Completed. Use ESR as our identified reporting tool.

Disciplinary procedures important questions to ask at triage stage:-

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

DISCIPLINARY POLICY AND PROCEDURE

In May 2019, NHS Improvement issued recommendations and guidance to NHS employing organisations to improve people practices based primarily on learning from a critical incident involving a London NHS Trust, Imperial College Healthcare. An assessment of existing Trust practice against the NHSI recommendations was completed with actions identified and subsequently implemented. The Workforce Committee received a final report at its 9 December 2020 meeting.

Imperial College Healthcare NHS Trust has revised its disciplinary procedure based on the learning from the critical incident. The procedure has been shared by NHS England/Improvement with NHS employing organisations asked to review their existing disciplinary policy and procedural arrangements against it.

This assessment of our current disciplinary policy and procedure should be read in conjunction with the Trust's Improving People Practices assessment.

Imperial College NHS Trust disciplinary policy	**Calderdale and Huddersfield NHS Foundation Trust disciplinary policy and procedure**	**Assessment and decision**	**Improving People Practices Compliance Assessment cross reference**
Includes foreword from CEO acknowledging shortcomings	No Chief Executive foreword	This is specific to Imperial Healthcare NHS Trust.	
Statement that all cases are to be thoroughly assessed to ensure sufficient understanding of issues to justify action	No specific reference to this	Add to Case Manager responsibilities	Recommendation/guidance no. 3 ensuring people are fully trained and competent to carry out their duties
References to training key individuals	Covered under Managers responsibilities only	Include the training offered to Case Managers, Case Investigators and Panel members	Recommendation/guidance no. 3 ensuring people are fully trained and competent to carry out their duties

Separate section on the role of TU representatives	No reference	Include a new paragraph detailing staff side representative responsibility	
Separate section on Confidentiality and reference to the Data Protection Act	Reference made. No standalone statement	Consolidate all existing references into one statement	
Describes a list of issues that could lead to disciplinary action and identifies separately, gross misconduct offences	Minor misconduct and gross misconduct offences are set out	Review gross misconduct offences and minor misconduct offences	
Separate paragraph on who can accompany an employee in formal meetings	Various references in the policy	Consolidate all references into one paragraph. Retain existing approach	Recommendation/guidance no. 6 safeguarding people's health and wellbeing
Separate paragraph on referral to professional bodies and other agencies	Separate references in the policy	Consolidate all references into one statement. Retain our current approach	
Employer reserves the right to take action independently of legal proceedings	Reference to conduct outside of work and the application of the procedure in such circumstances	Retain our current approach.	
Independent oversight by a manager at Agenda for Change 8c or above	Oversight provided by Case Manager	Retain our current approach. Do not specify level of seniority by pay band	Recommendation/guidance no.2 applying a rigorous decision-making methodology
Role of witnesses	Various references in the policy	Consolidate into one paragraph	

Reasons for exclusion and alternatives in more detail	Limited reasons for exclusion and alternatives to exclusion	Review reasons for and alternatives to exclusion	Recommendation/guidance no.5 decisions relating to the implementation of suspensions/exclusions
Defines who carries out employee exclusion	Only reference is to enacting exclusions out of office hours	Define who is responsible for enacting exclusion in normal office hours.	Recommendation/guidance no.5 decisions relating to the implementation of suspensions/exclusions
Exclusion reviewed every 5 days	Exclusion limited to and reviewed every 4 weeks	Retain existing approach. 4 weeks is reasonable and operationally appropriate. A designated support person to offer wellbeing support is made available to the excluded colleague. Additionally, the Case Investigators have a touchpoint every week with the excluded colleague to provide an update on progress in the investigation	Recommendation/guidance no.5 decisions relating to the implementation of suspensions/exclusions Recommendation/guidance no. 6 safeguarding people's health and wellbeing
Exclusion template letters included as policy appendices	Template letters are not provided with the policy	Retain our current approach. Important to retain version control as people could use template letters outside of formal process and procedure	Recommendation/guidance no. 1 adhering to best practice
Exclusion decision confirmed in writing within 3 working days	No reference in the Policy	Amend Policy to include specific reference to confirming a decision in writing within 3 calendar days	Recommendation/guidance no. 1 adhering to best practice
Excluding manager requires excluded employee where	No reference	Retain current approach to require the individual to return Trust items relevant to the	Recommendation/guidance no. 5 decisions relating to the implementation of

appropriate to return Trust property e.g. ID card		circumstances of the case, for example, a drug cabinet key	suspensions/exclusions
No pay if employee loses entitlement to work under the Immigration and Asylum Act	No reference	Not required to reference in the policy as this is not a conduct matter	
Excluded employee must not undertake paid work elsewhere and where they hold another job outside the Trust the employer will be informed if in the public interest	No reference	Replicate the terms of the exclusion in the policy as currently these are included in the exclusion letter only	Recommendation/guidance no.5 decisions relating to the implementation of suspensions/exclusions
7 calendar days notification of a hearing in writing	5 days though does not state working or calendar days	Adopt 7 calendar days to reflect the 7-day services we provide	
Requirement for diversity in panel membership	No reference	Programme currently provided includes equality and diversity and unconscious bias training. Continue to review composition of panels and wherever possible ensure panel diversity	Recommendation/guidance no. 3 ensuring people are fully trained and competent to carry out their duties
Employee able to raise concerns about diversity or possible panel bias	No reference	Review current narrative and amend to allow concerns to be raised being explicit that this must be prior to any hearing and not on the day of the hearing	Recommendation/guidance no. 1 adhering to best practice
Where dismissal is a possible outcome panel includes a member external to the Trust	No provision is made for this	Retain our current approach. When identifying panel members consideration is given to the profession of employee and panel members will	

who has knowledge skills and experience that reflects background or specialty of employee		reflect this particularly where concerns relate to clinical practice	
Audio recording of hearings that may result in dismissal and appeal hearings	HR representative acts as note taker	Retain existing arrangements. Consider use of voice recognition technology	
Outcome of hearings notified in writing within 7 calendar days	5 working days	To move to 7 calendar days as this reflects the 7-day services we provide	
No annual pay increase if first or final warning issued	No reference	Retain existing position. This will form part of the Pay Progression Policy from April 2021 for all staff who have a live warning. Include reference to Pay Progression Policy and vice versa	
Written warning remains on record for 6 months	12 months	Retain our current practice.	
Final written warning 12 months up to 24 months where it is an alternative to dismissal	18 months	Retain current arrangements	
Appeal panels are appropriately diverse, experienced and trained	No reference	Programme currently provided includes equality and diversity and unconscious bias training. Continue to review composition of panels and wherever possible ensure panel diversity	Recommendation/guidance no. 3 ensuring people are fully trained and competent to carry out their duties

Challenge by employee in relation to diversity or bias of panel	No reference	Review current narrative and amend to allow concerns to be raised being explicit that this must be prior to any hearing and not on the day of the hearing	Recommendation/guidance no. 1 adhering to best practice
For appeals against dismissal Chair will be an Executive Director. Panel to include external member and Senior HR representative. CEO will hear appeals from Executive Directors and the Chairman for an appeal from CEO	Reference is made to the Trust's appeal panel composition	Retain current arrangements but remove reference to Independent Member Include reference to a senior HR representative to act as Secretary to the panel	Recommendation/guidance no. 1 adhering to best practice

UNIQUE IDENTIFIER NO: P-16-2012
Review Date: April 2024
Review Lead: Director of Workforce and Organisational Development

DISCIPLINARY GROUP POLICY & PROCEDURE

VERSION 4

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

UNIQUE IDENTIFIER NO: P-16-2012
Review Date: April 2024
Review Lead: Director of Workforce and Organisational Development

Document Summary Table			
Reference Number	P-16-2012		
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Sponsor	Director of Workforce and Organisational Development		
Author	Assistant Director of Workforce and OD		
Where available	Trust Intranet, Workforce and Organisational Development Section		
Target Audience	All staff		
Ratifying Committee			
Executive Board			5 August 2021
Consultation Committees			
Committee Name		**Committee Chair**	**Date**
Staff Management Partnership Forum		Staff Side Chair	28 July 2021
Local Negotiating Committee		LNC Chair	18 July 2021
SMPF Policy Sub Group		Senior HR Adviser	6 May 2021
Other Stakeholders Consulted			
Ad hoc multi-disciplinary Group including Staff Side Chair			
Does this document map to other Regulator requirements?			
N/A			

Document Version Control	
Version No.	*Brief details of revisions or rationale of new Trust-wide policy*
1	Agreed Version
2	Redraft to include case management approach used in organisation. Includes clarified responsibilities, paragraph on conduct outside work, clearer guidance on hearings, general update and reformatting Addition of further clarification of process, replacement of reference to “suspension” with “exclusion”.
3	Update on gross misconduct categories, clarification of exclusion on full pay, general review.
4	Review of Disciplinary Policy and Procedure in line with “One Culture of Care” together with inclusion of support for employees subject to exclusion/disciplinary action. Review also considers key points in Imperial College NHSFT Disciplinary Procedure

UNIQUE IDENTIFIER NO: P-16-2012
Review Date: April 2024
Review Lead: Director of Workforce and Organisational Development

DISCIPLINARY POLICY AND PROCEDURE

POLICY STATEMENT

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

1. Introduction

This policy sets out the standard Disciplinary Procedure of the Trust and has been drafted to comply with statutory requirements and the ACAS Code of Practice. It should be read, where appropriate, together with the Trust's policies and procedures listed in paragraph 18 of the Supporting Procedure, local ward/departmental rules, and, where relevant, professional codes of conduct. Conduct relating to Medical and Dental staff is referenced in paragraph 2 of the Supporting Procedure.

The Trust's values are underpinned by a set of rules which enable staff to know what is expected of them. These rules are referenced in paragraph 3 below and are explained in more detail in the Supporting Procedure. The Trust wants staff to achieve the required standards of work and behaviour and where this does not happen every effort will be made to resolve issues informally and help employees improve without the need for formal procedures. All employees, but particularly Line Managers, have a responsibility to model good behaviour and set a clear example for their colleagues to emulate. Managers must be able to communicate their expectations so that they can set and maintain standards of behaviour.

2. The Trust's values

Within CHFT the aim is to have a talented, happy and productive workforce which is passionate about the care provided for patients and which takes full responsibility for its own behaviours. The Trust has adopted a "One Culture of Care" approach which means it looks after staff the same way it looks after patients. This workforce policy has been developed to facilitate this aim and to support the Trust's values. The Trust's values, as set out in the Four Pillars, (4 Pillars.JPG) underpin One Culture of Care and outline the Trust's expectations regarding the behaviour of staff in their work, towards their colleagues and to patients.

3. Rules

Rules are necessary for any organisation because they set standards and ensure that people know what is expected of them. Rules ensure that people are treated fairly and in accordance with the procedures set out in this policy. They must be taken seriously and respected by all staff. The Trust and its staff are required to comply with many rules and procedures because of the nature of healthcare work

and the requirement to put the patient first. All these rules and procedures must be adhered to. Breach of any of them could amount to misconduct or even gross misconduct depending on the circumstances. The rules are set out in more detail in the Supporting Procedure.

4. Trust Equalities Statement

The Trust aims to eliminate discrimination, harassment and victimisation and advance equality of opportunity through fostering good relationships, promoting inclusivity and embedding the One Culture of Care approach throughout the Organisation. Stakeholder engagement is vital to analyse the equalities impact of this policy and ensure where there are any negative impacts, mitigation has been discussed and acted on

5. Support for Staff

The Trust has put in place the following measures to support the health and welfare of any employee involved in a Disciplinary matter and to ensure they are treated with care, dignity and respect (see section 10, Supporting Procedure, for further details):

- A comprehensive communications plan overseen by the Case Manager which will keep the employee informed
- Assurance that all matters will be dealt with confidentially
- Continuous review of any exclusion/alternative action including regular communication with the employee
- Continuous assessment of any ongoing Disciplinary case to ensure there are no unnecessary delays
- Access to Occupational Health support including counselling
- Access to support from Trade Unions/Professional Organisations as appropriate including representation at formal meetings/hearings
- Access to a designated Trust employee unconnected to the case who can act as a support contact
- Access to Mental Health First Aiders
- Consideration of alternatives to Disciplinary Action such as mediation

6. Key Points Summary

The Supporting Procedure attached to this Policy Statement sets out the following key points:

- Conduct relating to Medical and Dental Staff is referenced in Section 2
- Section 3 sets out roles and responsibilities of employees, line managers, and everyone else involved in dealing with a Disciplinary matter
- Section 4 sets out the Trust's Disciplinary Rules, including minor misconduct, gross misconduct, and conduct outside work
- Section 5 outlines how conduct matters may first be reported
- Section 6 deals with the requirements for confidentiality
- Section 7 deals with the investigation including fact finding, formal investigation and Case Management

- Section 8 deals with referral to Professional bodies and other agencies
- Section 9 deals with exclusion from work
- Section 10 sets out a range of support measures for staff
- Section 11 sets out the process for formal meetings
- Section 12 sets out the right of representation at formal meetings/hearings
- Section 13 sets out the process for conducting hearings
- Section 14 sets out the procedure for dealing with appeals
- Section 15 deals with training and implementation
- Section 16 deals with Monitoring and Compliance
- Section 17 sets out the process for dealing with complaints that the Procedure has not been complied with

7. Supporting Procedure

The Supporting Procedure attached to this Policy Statement is an integral part of the Trust's Disciplinary Procedure and provides the necessary detail to support the implementation of the policy. In each instance the principles of fairness, equity and consistency are considered to be of the utmost importance, and managers must apply this policy in an equitable manner.

UNIQUE IDENTIFIER NO: P-16-2012
Review Date: April 2024
Review Lead: Director of Workforce and Organisational Development

DISCIPLINARY PROCEDURE

Contents

UNIQUE IDENTIFIER NO: P-16-2012
Review Date: April 2024
Review Lead: Director of Workforce and Organisational Development

1. Introduction

The Trust's intention is to encourage employees to achieve the required standards of behaviour so that the need for formal action is reduced. This Supporting Procedure is primarily to be used to secure improvement, but it has to be recognised that there may be cases where this is not possible, for example where an employee has not responded positively to encouragement to meet the required standards of conduct and behaviour.

When dealing with disciplinary matters the Trust will ensure that allegations are appropriately investigated, that employees under investigation are treated fairly, have the opportunity to be accompanied and have their say and that if a hearing is necessary it is fair. Being involved in a formal process is a stressful experience and support will be offered to the employee under paragraph 8 of this Supporting Procedure. Alternative processes such as mediation will be considered where appropriate to avoid entering the Disciplinary Procedure.

2. Conduct relating to Medical and Dental Staff

It should be noted that conduct issues relating to Medical and Dental staff are managed under the Procedure for Handling Concerns Regarding Medical and Dental staff Conduct and Capability (P-28-2007 - Procedure for Handling Concerns Regarding Medical and Dental Staff Conduct and Capability.pdf). However, where it is determined under that Procedure an issue will proceed to a disciplinary hearing, it will be handled in line with the Procedure defined in this document.

3. Roles and Responsibilities

Director of Workforce and Organisational Development

The Director of Workforce and Organisational Development has overall responsibility for this Policy and Procedure together with the following responsibilities:

- In conjunction with the Executive Director for the function concerned deciding whether exclusion is appropriate under paragraph 9 of this Procedure
- Participating as an appeals panel member as required
- Ensuring that training, including refresher training, is provided for all those who serve as Panel Members, Case Managers and Case Investigators

Executive Directors

- In conjunction with the Director of Workforce and Organisational Development deciding whether an employee within his/her function should be excluded from work under paragraph 9 of this Procedure

- Participating as an appeals panel member as required

- In conjunction with the appropriate Head of Service deciding whether an employee should be referred to his/her Professional Body

Heads of Service

- Responsibility for providing advice to Executive Directors regarding referrals to Professional Bodies in accordance with section 8 of this Procedure

Managers

All staff with management responsibilities are required to manage and to act fairly and in line with the Code of Conduct for NHS Managers.(Code_of_conduct_for_NHS_managers_2002.pdf)

Managers are responsible for:

- Modelling the values of the Trust
- Ensuring they are trained to deal with Disciplinary issues including conducting investigations and, where necessary, hearings
- Ensuring their staff understand and uphold the values of the Trust
- Ensuring that the Disciplinary rules are observed by all employees,
- Dealing with breaches where they occur ensuring, where appropriate, that the emphasis is on improvement rather than sanction.
- Seeking advice from their HR Business Partner on dealing with any breaches
- Providing appropriate support for staff subject to the Disciplinary Procedure ensuring that any staff entering these processes are treated with care, dignity and respect
- Providing support for witnesses ensuring they understand their role
- Keeping adequate records
- Ensuring any issues raised are dealt with confidentially
- Ensuring that alternative processes for resolving any issues are considered (eg mediation)

HR Business Partners

- Provide advice to managers, including the Case Manager on the implementation of the Disciplinary Procedure
- Support the investigation process acting as a Case Investigator where required
- Act as a Panel Member at Disciplinary Hearings and Adviser/Secretary to the panel at Appeal Hearings as appropriate
- Provide advice and support to witnesses as required
- Support the training of line managers on the implementation of the Disciplinary Procedure including conducting investigations

Employees

All employees must:

- Familiarise themselves with the Trust's values and expected behaviours in accordance with the appraisal process
- Ensure they practice and promote good behaviour, including the use of social media (social media - CHFT Intranet)
- Be familiar with the Disciplinary rules of the Trust and of their professional codes of practice (where applicable) and comply with them
- Maintain professional registration where this is a requirement of the job and the Professional Governing Body
- Ensure, where necessary, they have the appropriate "Right to Work" documentation
- Co-operate with the Trust in any disciplinary process, for example, by attending for interview, replying to questions, providing information, making formal statements and attending as witnesses if necessary
- Speak Up if they witness behaviour which could be harmful to patients or staff(G-113-2016 - Freedom to Speak Up - Raising Concerns (Whistleblowing) policy.pdf
- Seek guidance from their line manager or HR if they have any questions or concerns

Case Manager

- Oversight of any investigation conducted under this Procedure
- Ensuring they are appropriately trained to fulfil the Case Manager role
- Ensuring each case is thoroughly assessed to ensure sufficient understanding of the issues in order to justify any disciplinary action
- Determining the terms of reference for the investigation to include a communications plan in accordance with paragraph 7.3 of this Procedure
- Taking specialist advice where appropriate
- Appointing two case investigators in accordance with the circumstances of each case. One will normally be a HR representative
- Considering the Case Investigators report to determine whether there is a case to be considered by a disciplinary panel
- Where the case does not merit consideration by a disciplinary panel writing to the employee with any outcomes short of disciplinary action
- Confirming the terms of any exclusion in writing under paragraph 9 of this Procedure, ensuring that exclusions are subject to regular reviews under paragraph 9 of this Procedure
- Maintaining confidentiality throughout the process

Case Investigators

- Ensuring they are appropriately trained to fulfil the Case Investigator role
- Establishing and recording the facts of the case in an objective manner
- Gathering evidence, taking statements and interviewing witnesses

- Interviewing the employee concerned ensuring that he/she has the opportunity to give their point of view
- Sharing interview notes with the employee and any witnesses to ensure they are an accurate record
- Ensuring they have a regular touchpoint with the excluded employee to provide an update on progress
- Maintaining confidentiality throughout the process
- Producing a report for the Case Manager setting out the issues of concern and details of the investigation

Trade Union representatives

- Providing advice and support to their members during any Disciplinary process
- Working with the appropriate manager and HR to ensure the employee is properly supported

Witnesses

- Ensuring they report any issues personally to their line manager
- Ensuring careful notes are kept of issues witnessed
- Preparing a witness statement as required and agreeing it with the Case Investigator
- Attending hearings as required to give personal testimony in addition to answering questions on their witness statement

4. Disciplinary Standards

4.1 Minor Misconduct

Managers can often deal with minor conduct issues outside formal processes by means of advice and guidance. This is most appropriate where the minor breach appears to be accidental, or a rare lapse and the employee accepts the error and is receptive to advice. This is good practice and early intervention may mean that there is no need to go into a formal process. Some examples of minor misconduct could include initial episodes of:-

- Poor standard of work
- Poor timekeeping
- Unauthorised absence from work
- Failure to comply with the Trust's Uniform Policy
- Failure to follow Departmental rules/procedures/protocols
- Failure to uphold the values of the Trust

Advice and guidance is not a disciplinary sanction and so how it is given is left to the discretion of managers. The manager may for example identify a need for training or may be satisfied that nothing more than a discussion is required. In addition, the manager may also consider whether mediation

might be appropriate, particularly if the issue involves problems with workplace relationships.

If the manager decides, after discussion, that there is no need for further action then the employee should be informed of this immediately. A note should be kept of the discussion on the employees personal file and any action/review confirmed in writing. Where conduct issues cannot be dealt with by advice or guidance because, for example, they are too serious, or because there have been repeated incidents, more formal procedures will be used.

Incidents may occur, or facts might come to light which require a preliminary fact-finding exercise so as to establish the full picture. (see paragraph 6.1. on fact finding). This is not a disciplinary investigation and employees are required to co-operate in this preliminary assessment fully.

If, during any informal discussion or preliminary assessment the manager forms a belief, based on available evidence, that the issue is potentially a disciplinary matter then they may wish to adjourn the meeting and seek further advice from the Workforce and Organisational Development Directorate.

Should it be determined by the manager following HR advice that the matter is serious enough to potentially lead to disciplinary action the manager should inform the employee verbally that a formal investigatory meeting will be convened at which they will have the right of representation. The Case Manager will then write to the employee.

4.2 Gross Misconduct

Some forms of behaviour are so unacceptable that they are regarded as gross misconduct. If an employee commits a gross misconduct offence the Trust will follow a thorough investigation and hearing (see also Section 9- Exclusion from Work), to summarily dismiss from employment without notice or pay in lieu of notice even for a first offence. Any such dismissal will, where relevant, require the employees Professional Head of Service to notify the Professional Body concerned.

Some examples of gross misconduct are as follows (refer to the appropriate Trust Policy for further information):

1. Theft, fraud, falsification of records, dishonesty, bribery, impropriety (ie behaviour or actions that are dishonest, morally wrong or inappropriate for a person in a position of responsibility).
2. Violence or threat of violence
3. Bullying, harassment, intentional unlawful discrimination or sexual misconduct
4. Compromising patient trust, care or safety
5. Breach of any statutory or regulatory requirement concerning patient trust, care or safety
6. Damage to property or misuse of property
7. Conduct likely to bring the Trust into disrepute (ie behaviour which

could have a negative impact on the Trust's reputation)
8. Inappropriate use of social media
9. Attendance at work under the influence of alcohol or other drugs
10. Misuse of drugs or breach of any drug handling requirements
11. Breach of health and safety requirements including serious lack of care in respect of duties and/or towards other people which could result in serious loss, damage or injury
12. Breach of confidentiality including misuse, mishandling and/or loss of sensitive personal data
13. Misuse of Trust equipment including computers, internet or e-mail facilities
14. Any failure of integrity or probity in research.
15. Serious, deliberate or continued breach of Trust policy
16. Breach of contract.
17. Any conduct likely to undermine mutual trust and confidence for example making secret recordings of colleagues or the covert recording of formal meetings.
18. Working elsewhere whilst on sick leave that is unapproved and unauthorised

This is not an exhaustive list of examples. Other behaviour of a similar nature could be regarded as gross misconduct.

4.3 Conduct Outside Work

In order to safeguard the interests of the service and its users, the Trust needs to be aware of any conduct by its employees that may adversely affect the Trust's reputation or integrity, or its ability to deliver services to the public, even if that conduct occurs outside of working hours or away from Trust premises.

Employees are contractually required to notify their line manager of any conviction or caution given, or if they are notified of any pending prosecution, or if they are arrested, detained or placed on police bail. Failure to do so may result in disciplinary action being taken which may include summary dismissal for gross misconduct where appropriate following a thorough investigation and hearing.

In some circumstances, conduct outside work (e.g. offences of violence, dishonesty, theft, fraud etc) may call into question an employee's suitability to hold their position of employment by the Trust and may, in some cases affect their professional registration. The employee's Head of Service should be consulted in such cases and he/she will advise the Executive Director concerned as to whether it is necessary to contact the Professional Body for guidance in accordance with paragraph 8 of this Procedure. When such circumstances arise, they will be dealt with in accordance with this Procedure.

5. Concerns, Complaints and Reports

Conduct issues may come to light in a number of ways. A manager or colleague might report concerns or there may be a complaint from inside or outside the organisation. Employees are encouraged to raise with their manager any concerns they might have. They can also report matters through the Trust's Freedom to Speak Up Guardian Freedom to Speak Up - CHFT

There are times when a failure to raise concerns could be a disciplinary offence in itself, for example, when an individual becomes aware of a threat to patient safety posed by another employee and does not report it. If an employee is genuinely worried about the consequences of reporting an issue, particularly where there is a risk to patients or other employees, or evidence of malpractice or wrongdoing, he/she should seek advice from the Freedom to Speak Up Guardian, a trade union representative or HR to ensure that the matter can be raised safely. It should be noted that concerns can also be raised anonymously through the Trust's Raising Concerns (Freedom to Speak Up) Policy

6. Confidentiality

Disciplinary cases will be treated sensitively and confidentially. Information will only be shared with those who have a legitimate right to be informed in accordance with the Data Protection Act and the Common Law Duty of Confidentiality. Breaches of confidentiality could result in disciplinary action.

7. Investigation

7.1 Fact Finding

Where a concern has been raised and the facts are not clear the appropriate manager, supported by HR, should quickly conduct an informal fact finding exercise to assess whether there is sufficient substance to the concern to warrant a formal investigation. Where necessary the employee should be asked for his/her views. This is not part of the formal disciplinary process but the employee can be accompanied by a colleague or trade union representative to the fact-finding meeting provided this does not unduly delay the process.

7.2 Formal investigation

Concerns raised will be formally investigated where the facts are clear. The nature of the investigation will depend on the seriousness or complexity of the matter and whether the facts are agreed or disputed. The investigation should be prompt and reasonable in all the circumstances of the case in accordance with paragraph 7.3 below. Regular communication must be maintained with the employee throughout the investigative process and support offered in accordance with paragraph 10 below. Employees must co-operate with the

investigation. There may be issues where it is not clear at the outset of the investigation whether it is a conduct or capability issue, but the employee should be warned that disciplinary action is a potential outcome. If the concerns involve controlled drugs, safeguarding, fraud or data protection the relevant lead must be informed at the earliest opportunity regardless of whether the concerns are substantiated.

7.3 Case Management

A Case Manager will be identified to oversee any investigation under this Procedure and clear terms of reference for the investigation will be agreed together with timescales for completion.

The Case Manager will determine the terms of reference for the investigation. These will include a communications plan between the Trust and the employee which will ensure that all communications are:

- Timely
- Comprehensive
- Unambiguous
- Sensitive
- Compassionate

The Case Manager may wish to take specialist advice, for instance in cases of fraud or professional misconduct.

The Case Manager will confirm the terms of any exclusion in accordance with section 9 of this Procedure.

The Case Manager will consider at this stage whether referral of the employee to Occupational Health should be undertaken.

The Case Manager will be responsible for the appointment of Case Investigators. The Case Investigators will be identified in accordance with the circumstances of the investigation. The Case Investigators may also co-opt specialist support to aid the investigation. The Case Investigators do not make the decision on what action should be taken or whether the employee should be excluded from work and may not be a member of any disciplinary or appeal panel relating to the case.

The employee must be advised in writing of the names of the Case Investigators and made aware of the concerns that have been raised, including the terms of reference for the investigation. The employee will be asked to attend an investigative interview to put their view of events to the Case Investigators and be given the opportunity to be accompanied by a trade union representative or work colleague. The employee will be given as much information as possible at the investigation stage and details of the interview including any relevant additional information will be given in writing to the employee ensuring that he/she has sufficient notice to obtain representation The Case Investigators are responsible for establishing and recording the

facts of the case in an objective manner. The Case Investigators will gather evidence, take statements and interview witnesses. It is the responsibility of the Case Investigator to judge what information needs to be gathered and how that information should be gathered.

Where witnesses are interviewed a statement will be produced and shared with them to ensure it is an accurate record. Any comments/amendments made by the employee will be retained on file. Witnesses must be advised that they may be required to appear as a witness at a disciplinary hearing. Witnesses do not have a right to be accompanied if they are not subject to disciplinary action themselves.

The Case Investigators will ensure confidentiality is maintained during the investigation. Managers and individuals involved in the investigation will be informed they must not discuss the issue outside of the formal meeting, with workplace colleagues or third parties other than the employee's representative.

The Case Investigators will produce a report setting out the issues of concern, the details of the investigation, the facts of the case and the employee's response. It is important this is done impartially and must include all relevant evidence, whether it supports or refutes the concerns that are subject to investigation.

The Case Manager will consider the report and determine whether there is a potential breach of conduct that should be considered by a disciplinary panel.

At this stage the employee will be notified in writing of the decision to proceed to a formal disciplinary hearing if the Case Manager reaches that decision. The Case Manager will also write to the employee where a decision has been made not to proceed to a disciplinary hearing. A copy of the investigation report together with any other relevant information will be included with the letter to the employee.

The Case Manager will not be a part of any disciplinary panel or appeal panel but will ensure that appropriate checks are undertaken so that there is no potential conflict of interest for any panel member

The Case Manager may request information and interim reports from the Case Investigators at any time during the investigation to facilitate management of the investigation process in a timely and effective manner.

Where the facts are not in dispute and where it is determined that the case does not merit referral to a disciplinary panel the Case Manager may choose to put in writing to the employee any outcomes short of disciplinary action, for example training requirements or the expectations around improvements in conduct. The Case Manager and HR representative will still meet with the employee to review the case even where no further action is necessary.

8. Referral to Professional bodies and other agencies

8.1 Depending on the allegations, where an employee is registered with a Professional body, the appropriate Regulatory Body (General Medical Council, Nursing and Midwifery Council, Health and Care Professions Council) may be notified. This will be undertaken following consultation with the appropriate Executive Director.

8.2 Where allegations concern the safeguarding of children or vulnerable adults the Trust's Safeguarding lead must be informed without delay

8.3 Where cases include serious personal data breaches likely to result in a risk to the rights and freedoms of data subjects, the Trust has a legal duty to report such cases to the Information Commissioners office within 72 hours via the Trust's Data Protection Office

8.4 Where appropriate, investigations by the counter fraud team and other agencies such as the Police or Social Services may be carried out separately from investigations under this Procedure. The Trust will co-operate fully with any external investigations. Internal investigations under this Procedure will only be delayed where absolutely necessary

8.5 Where action short of dismissal is taken a referral to the Regulatory Body may occur**.**

8.6 Where an employee is dismissed for gross misconduct the appropriate Regulatory Body will be notified

9. Exclusion from Work

Exclusion of a doctor will be dealt with in accordance with the Procedure for Handling Concerns regarding Medical and Dental Staff Conduct and Capability. Exclusion of non-medical staff will be dealt with in accordance with this Procedure.

The phrase "exclusion from work" replaces the phrase "suspension from work" to avoid confusion with action taken by professional bodies to suspend members from their registers pending the outcome of a case.

Exclusion from the workplace is a temporary expedient and a precautionary measure. It is not a disciplinary sanction, and will only be used:

- To protect the interests of patients or staff and/or
- To assist the investigative process where there is a clear risk that the employee's presence at work would impede the investigative process

The need for exclusion may arise for one or more of the following reasons:

- An incident where serious allegations have been made
- A serious breakdown in workplace relationships
- There is a risk of the employee tampering with evidence or influencing witnesses and the investigation
- There is a risk to the employee themselves, other employees, patients or property
- The employee is the subject of criminal proceedings which may affect whether they can do their job

Exclusion from work must not be misused or seen as the only course of action that could be taken. The degree of action taken will depend on the nature and seriousness of the concerns and the need to protect patients and/or staff.

Alternatives to exclusion, should always be considered as follows:

- Transfer to other duties
- Restricting the employee to defined responsibilities including reduced access to Trust systems where appropriate
- Working under supervision
- Working from home
- Carrying out other activities such as audits, research or teaching

Any consideration of alternatives must be formally recorded.

The Executive Director for the function concerned together with the Director of Workforce and Organisational Development will determine whether it is necessary to exclude the employee(s).

For exclusions during normal office hours the act of exclusion will be carried out by the most appropriate Senior Manager supported by a HR representative.

In normal circumstances exclusions do not occur out of office hours although it may be necessary for the on-call manager in discussion with the on-call Director when notified of a conduct matter to speak with the employee concerned and if appropriate, notify them that they are not required to complete their shift and return home. In such circumstances this decision will be confirmed with the Executive Director and HR at the earliest opportunity.

Any decision to exclude will be managed and reviewed regularly by the Case Manager, at intervals of a maximum of four weeks in order to decide whether it is necessary to continue the exclusion. A decision to exclude must be confirmed in writing by the Case Manager within three calendar days as follows:

- The effective date and time of the exclusion
- The duration of the exclusion where this can reasonably be determined
- The content of the allegations
- The terms of the exclusion on full pay, including the need to be available

for work
- Confirmation that the excluded employee must not undertake paid work elsewhere for the period of the exclusion
- Where the employee holds a contract with another NHS Employer, confirmation that the other employer will be notified of the exclusion
- Confirmation that the matter will be subject to a formal investigation
- The communication channels between the employee and the Trust, including those open to the excluded employee
- The support measures available to the employee (see paragraph 8 below)
- Whether it is necessary for the employee to be instructed not to enter Trust premises, or where this can be allowed, the circumstances where this can be arranged
- Whether any items of Trust property relevant to the circumstances need to be returned to the Trust whilst the investigation is progressing

Exclusion will be on full pay (i.e., normal pay) including any additional enhancements based on an average of the last 12 weeks' pay. The Workforce and Organisational Development Directorate will notify the payroll department when an employee has been excluded. Whilst excluded, employees are expected to be available for work, for example to attend interviews. Exclusion will be superseded by annual leave or sickness if this means the individual is unavailable for work. Employees who make themselves unavailable for work are not excluded and will not be paid, for example a failure to maintain professional registration or absence without authorisation.

10. Support for staff

The manager in the Department concerned should seek guidance from their HR Business Partner as to the level of support which can be offered. This should be discussed with the employee and wherever possible a package of support agreed. This will include the following:

- Clarity on communication between the Trust and the employee during any process, to be set out by the Case Manager including the sharing of information.
- Continuous review of any exclusion/alternative duties
- Continuous assessment of any ongoing disciplinary case to mitigate any delays
- Referral to the Occupational Health Department for support, including counselling
- Access to the Trust's Freedom to Speak Up Ambassadors
- Identification of a designated "support" contact who is unconnected to the case. Wherever possible the support contact will be mutually agreed. The level of support to be provided will be subject to agreement between the employee and the designated support contact
- Access to Mental Health First Aiders (contact Occupational Health for further information)

In all cases employees should be treated with dignity. In addition, the manager should ensure that witnesses are properly supported and given advice on their role. In some cases, the manager may need to speak to the colleagues of the affected employee to deal with any rumours.

11. Formal Meetings

Employees subject to a disciplinary investigation will be given at least five working days' notice and longer where possible in writing of any interview or hearing unless they agree to waive the notice period.

The purpose of the meeting or hearing will be confirmed to the individual in writing. This includes the nature of any concerns to be discussed at a meeting or the nature of any allegations to be discussed at a formal hearing against them.

The employee will be given as much detail as possible at the investigation stage.

The employee has the right to be accompanied by a trade union representative or work colleague in any investigatory meeting, disciplinary hearing or appeal hearing. The representative should not be directly connected to the investigation, for example, a witness in proceedings.

The role of the representative is to assist and support the employee and to speak on the employee's behalf within the Procedure although the panel prefer to hear directly from the employee.

The employee is responsible for arranging his/her own representation for disciplinary investigation interviews, hearings and appeals. Making such arrangements should not cause undue delay to the process as it is in the interests of everybody to deal with disciplinary matters promptly. The unavailability of a particular representative should not be a reason for delaying matters for more than a few days.

The Trust is responsible for ensuring a record is kept of formal hearings and appeals. The record will usually be in the form of notes rather than a verbatim record.

12. Representation at formal meetings/hearings

12.1 Employees are required to attend formal meetings/hearings accompanied by an accredited trade union representative or work colleague. It is the employee's responsibility to arrange representation and to inform his/her manager of the details so that mutually convenient dates for meetings/hearings can be agreed.

12.2 Where the employee concerned is an accredited trade union representative the appropriate Full Time Officer will be notified before any action is taken.

12.3 Employees and their representatives must make every effort to attend

meetings/hearings and must notify their manager if they are unable to attend. In such cases an alternative date must be mutually agreed so that the meeting/hearing can take place within five working days of the original date. If the employee is unable to attend the re-scheduled meeting/hearing arrangements will be made for it to proceed in their absence.

13. Hearings

13.1 Preparation

If the Case Manager recommends that the case should progress to a disciplinary hearing the Case Investigators acting as Management Presenters will prepare the information for the hearing ('the Bundle'). The Bundle typically includes statements of witnesses or records of interviews, including those of the employee subject to investigation, and copies of any relevant documents. Any relevant material produced by the employee should be included in the Bundle. It is good practice to paginate the Bundle.

The HR Business Partner acting as Adviser/Secretary to the Panel will arrange for a letter setting out the allegations, arrangements for the hearing, contact details for the employee to raise queries and possible outcomes to be sent to the employee at least 7 calendar days before the hearing takes place and longer for a more complex case. In addition to the letter one copy of the Bundle will be sent to the employee together with a copy to his/her representative (if known). A copy of the letter and the bundle will be sent to each panel member at least 5 days before the disciplinary hearing takes place. The Case Manager does not have involvement in the process at this point.

The composition of the panel for a disciplinary hearing depends on the seriousness of the allegations and possible outcome. When identifying panel members consideration will be given to the employee's profession and the panel will reflect this particularly where concerns relate to clinical practice. The composition of panels will be reviewed wherever possible to ensure panel diversity:

- where dismissal is not a possible outcome, the panel will consist of a manager and a representative from the Workforce and Organisational Development Directorate

- Where dismissal is a possible outcome, the panel will consist of two managers and a representative from the Workforce and Organisational Development Directorate. The Chair of the Panel must have delegated authority to dismiss. In all cases the authority for dismissal rests with the appropriate Director/Director of Operations

13.2 Procedure

Disciplinary hearings must be objective. The panel will identify a Chair. The

hearing will normally follow the procedure below but there is nothing to prevent this being adapted if it best serves the interests of establishing the facts and/or allowing the employee to have a fair hearing and is agreed by the parties.

• The Chair will introduce those present
• The allegations will be set out by the Case Investigators, who will then present the investigatory report
• The Case Investigators may call witnesses and present evidence
• The Panel may permit questioning of the witnesses by the employee or their representative
• The Panel may ask questions
• The Panel may permit further questions of the witnesses by the Case Investigators
• The employee or their representative will outline whether the employee accepts or denies the allegations
• The employee will give his/her account of the matter
• The Panel may permit questions of the employee by the Case Investigators
• The Panel may ask questions
• The employee or their representative may call further witnesses and present other evidence
• The Panel may permit questions by the Case Investigators
• The Panel may ask questions
• The Panel may permit further questions by the employee or their representative
• The employee or their representative will sum up
• The Case Investigators will sum up
• The meeting will be adjourned to allow the panel to consider the case
• The Panel informs the parties of the decision by letter, normally within 7 calendar days of the hearing

If an employee fails to attend without good reason a hearing (or any meeting under this policy) the Trust has the right to consider the facts and make a reasonable decision as to how to proceed. This could be to hold a meeting in the employee's absence and make a decision on the basis of the information available. The employee must have been made aware that this is a potential outcome and given a chance to send a representative or make a statement.

Where statements are relied upon by either party at a disciplinary hearing the individual who made the statement should normally be available to be questioned where the statement is not accepted by all parties as fact. If this is not possible the panel shall attach a lesser weight to the evidence presented recognising the inability of the parties to explore the evidence.
The outcome of the hearing is to be confirmed in writing within 7 calendar days except in exceptional circumstances. In such circumstances, a likely timescale will be given to the employee.

The outcome letter will confirm the findings of the panel against the specific allegations: any admissions, accounts or mitigation presented; the evidence accepted or rejected, the rationale behind the panel decision and the disciplinary sanction to be applied (if any). It will also confirm the arrangements for submitting any appeal.

13.3 Making the Decision

The Panel will make a decision on the evidence presented to it. The decision and its rationale will be recorded in full and retained as part of the Case Management Record. The Panel will decide:

- whether there has been a reasonable investigation
- what they believed happened (on the balance of probability)
- whether they believe that the employee is guilty of the misconduct

What is the appropriate sanction taking into account:

- the nature and seriousness of the conduct
- what has been said by, or on behalf of the employee by way of explanation
- any mitigation submitted in support of an admission
- the employee's previous employment record

13.4 Sanctions

The sanctions available to a Panel are:

- a written warning which will remain on the employee's disciplinary record for 12 months
- a final written warning which will remain on the employee's disciplinary record for 18 months
- dismissal with notice. This may be appropriate where there has been a failure to improve after previous warnings, or, where a single instance of misconduct is so serious as to warrant dismissal, but is not so serious as to warrant dismissal without notice
- dismissal without notice. This is appropriate where the employee's behaviour amounts to gross misconduct

The Disciplinary sanction will impact pay progression as determined by the Trust's Pay Progression Policy.

Where the employee's conduct is deemed, after due consideration of all the evidence, to fall under the sanction 'dismissal with notice' but does not constitute gross misconduct the panel may recommend alternative action short of dismissal for example, demotion or disciplinary transfer without pay protection. Should the individual refuse the alternative action the sanction of dismissal will stand.

Warnings will be disregarded for disciplinary purposes once they expire i.e.,

they will not be 'live' for the purposes of being built on by subsequent warnings. However, the Panel should consider the employees overall employment record when considering a disciplinary sanction. The whole disciplinary record should be available to the panel after the decision on liability has been made but before the decision on sanction. The expired warning cannot be used to push the sanction over the line to dismissal, but it can be taken into account when considering whether to exercise leniency in a case in which dismissal is justified. Such cases are expected to be rare and will be considered in accordance with the principles set out in the case of Airbus UK Ltd v Webb [2008] EWCA CIV 49.

14. Appeals

14.1 Preparation

The employee should set out in writing the basis of the appeal within 14 days of the date of the letter confirming the decision by a disciplinary panel. If the appeal is against the disciplinary sanction the employee must explain why it is challenged. If the appeal is in respect of an alleged breach of procedure the employee must explain the nature of the breach and why it is said that it renders the decision or sanction unfair.

If the appeal is because of new evidence the employee must produce the evidence in advance of the appeal and explain why it was not produced at the original hearing.

The date for the appeal hearing will be agreed between both parties and the arrangements will be confirmed in writing by the Workforce and Organisational Development Directorate. A bundle of documents will be prepared consisting of:

- the bundle used at the disciplinary hearing
- the basis of the employee appeal
- a brief supporting statement of case from the management presenters

The papers will be sent to the Panel and both parties no less than 5 working days before the appeal hearing.

14.2 Procedure

Appeals will be heard by an appeal panel. The composition of the appeal panel depends on the nature of the appeal. Anyone previously involved in the case cannot participate as a panel member. The composition of appeal panels will be reviewed to ensure wherever possible diversity of the panel
Appeals against sanctions short of dismissal are heard by a Panel of two senior managers, one of which will be a representative from the Workforce and Organisational Development Directorate.

Appeals against dismissal will be heard by a panel of three, consisting of two Executive Directors and a Non-Executive Director of the Trust. A senior HR representative will act as Adviser/Secretary to the panel

The usual procedure of the appeal is:

• the employee or their representative sets out the reason for the appeal and explains the case
• a member (usually the Chair) of the disciplinary panel explains the reasons for the decision and comments on the appeal case
• the appeal panel may ask questions of either party or of the employee
• The meeting will be adjourned to allow the panel to consider the case
• The Panel informs the parties of the decision by letter, normally within 7 calendar days of the hearing

It may sometimes be necessary to hold an appeal by way of a re-hearing, for instance where there is significant new evidence to be presented. In a re-hearing, the procedure set out for the disciplinary hearing above will be followed except that the appeal panel will be in place of the disciplinary panel. A member of the disciplinary panel will explain the original decision as a witness at the appeal. The need for a re-hearing will normally be determined by the panel in advance and may require different arrangements to be made.

14.2 Deciding the Appeal

The appeal panel will decide if the appeal succeeds on the basis of:

- Sanction too severe
- Breach of procedure
- new evidence

In addition, in the case of a re-hearing the panel can also increase the sanction if it finds that the original sanction was insufficient for the circumstances of the case.

14.4 Appeal Outcomes

The Panel will determine what to do if the appeal succeeds. Possible outcomes could be:

- revoke the sanction
- substitute another sanction

15. Training and Implementation

Training for managers on the application of the policy is delivered by the Workforce and Organisational Development Directorate.

16. Monitoring Compliance with this Procedural Document

The implementation of this policy will be monitored and reviewed by the Director of Workforce and Organisational Development on an on-going basis and will be formally reviewed 3 years after adoption. The review will be data driven through ESR in order to ensure that any revisions necessary are evidence based.

17. Complaint that the Procedure has not been complied with

Where an individual is subject to an investigation or action under this Procedure, they would not normally be allowed to make a separate complaint under the Grievance Policy relating to it. Depending on the circumstances any grievance arising from the application of the Procedure will be addressed under this Procedure as part of the investigation or through the appeals process. Any complaints about panel diversity or possible panel member conflict of interest must be made prior to the hearing and not on the day of the hearing itself

18. Associated Documents/Further Reading

This Procedure should be read in accordance with the following Trust policies, procedures and guidance:

- Absence - Attendance Management
- Timekeeping
- Holiday arrangements
- Health and Safety
- Use of Equipment
- Discrimination
- Harassment and Bullying
- Bribery and Standards of Business Conduct
- Use of social media (CHFT intranet)
- Internet Use
- Uniform Policy
- NHS Managers' Code of Conduct
- Improving People Practices

19. Communication Plan

The Procedure is available on the Trust intranet.

13. Freedom to Speak Up Annual Report presented by Nikki Hosty

To Note

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	2 September 2021
Meeting:	Public Board of Directors
Title of report:	Freedom to Speak Up Board Annual Report
Author:	Nikki Hosty, Assistant Director of Human Resources
Sponsor:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee June 2021

Purpose of the Report

- This paper provides details of Freedom to Speak Up (FTSU) activity in the Trust since the FTSU Annual Board report in June 2020
- It is a statutory requirement that the Board receives and reviews FTSU activity on an annual basis. This Board paper covers the period 30 June 2020 to 29 June 2021
- The report is presented in a format that ensures compliance with the 'Guidance for Boards on FTSU in NHS trusts and NHS foundation trusts' published by the National Guardian's Office (NGO) and NHS Improvement (NHSI) in May 2018.

Key Points to Note

- Effective speaking up arrangements help protect patients and improve the experience of our colleagues. The opportunity to speak up is a measure of a Trust's openness and transparency and is a feature of well-led NHS organisations. Since the last report there has been a healthy indication that colleagues are more aware of the FTSU team and that colleagues are using a range of channels to speak up.

EQIA – Equality Impact Assessment

The equality impact for specific actions arising following consideration of the report to the Board assessment will be assessed, considered and mitigated as appropriate.

Recommendation

The Board is asked to **NOTE** and consider the content of the paper.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

2 SEPTEMBER 2021

FREEDOM TO SPEAK UP ANNUAL REPORT

1. PURPOSE

This paper provides information regarding Freedom to Speak Up' (FTSU) activity in the Trust since the last annual Freedom to Speak up Annual Board report in June 2020.

It is a statutory requirement that the Board is required to receive and review FTSU activity on an annual basis. This board paper covers the period 30 June 2020 to 29 June 2021.

The report is presented in a format that ensures compliance with the 'Guidance for Boards on FTSU in NHS trusts and NHS foundation trusts' published by the National Guardian's Office (NGO) and NHS Improvement (NHSI) in May 2018.

2. INTRODUCTION

The intent of the FTSU model is that in time it will be acknowledged, respected and embraced by all at the Trust. The aim of this report is to provide assurance to the Board that the FTSU channels in the Trust are robust, fair, healthy, responsive and that any learning points are acted on, shared and focused on continual improvement.

In 2018 the NGO and NHSI published guidance for Boards. To ensure we comply with'best practice the guidance is adhered to. This report has been structured to provide information concerning the following:-

Section 1 The assessment of issues

Section 2 Potential patient safety or workers experience issues

Section 3 Action taken to improve FTSU culture

Section 4 Learning and improvement

Section 5 Recommendations

3. CONCERNS REPORTED IN 2018/2019/2020/2021

Section 1 The Assessment of Issues

The table below shows the number and types of cases being dealt with by the FTSU Guardian and the FTSU Ambassador volunteers since 2018.

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
April to June 2018	2	0	2	1
July to September 2018	3	0	1	2

October to December 2018	4	3	1	2
2018 Total	9	3	4	5

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
January to March 2019	9	7	2	0
April to June 2019	18	5	4	4
July to September 2019	22	6	6	1
October to December 2019	18	10	6	1
2019 Total	67	28	18	6

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
January to March 2020	26	14	12	3
April to June 2020	26	10	4	5
July to September 2020	22	16	5	3
October to December 2020	14	6	8	2
2020 to date	88	46	29	13

Last 12 months data

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
30 June 2020 to 29 June 2021	67	41	24	14

Concerns received are very diverse in nature mostly linked to colleague experience rather than patient care, quality and safety.

The main theme over the course of the last 12 months is colleague attitudes and behaviours followed by policies and procedures. The key themes have not changed over the last three years.

On review of the data it is apparent that the increase in concerns in 2020 is linked to the pandemic and we are now seeing levels numbers coming through the FTSU portal equivalent to pre-pandemic.

Since the last report there has been:-

- A healthy indication that colleagues are more aware of the FTSU team
- Colleagues are using a range of channels to speak up
- Increased emphasis and promotion of 'One Culture of Care' (where we care for each other the same way we care for our patients)
- Enhanced focus on equality groups and how they can encourage and support speaking up
- A strong connection between wellbeing and where the root cause is a management issue, FTSU links are offered as a supportive channel.

Each year the speak up culture develops and supports our compassionate approach. Although the brand is vital we promote a range of channels and links to speaking up.

We now have six equality groups (Women's Voices, LGBTQ, BAME, Colleague Disability Action Group, Overseas Colleagues Network and Armed Forces Network). There are 142 local Wellbeing Ambassadors. The terms of reference for the groups encourage colleagues to share their views and actively listen and support one another.

Section 2 Potential patient safety or workers experience issues

Each concern raised has been treated with respect and care, with regular confidential communication with the colleague who has raised their concern and confidential discussions with the leaders responsible for the particular service where the concern has been highlighted. Some investigations have found that there are necessary actions that need to be undertaken to improve patient, care, quality or safety. The FTSU Guardian will ensure these concerns are followed up to ensure those lessons learned are implemented and embedded. In addition, the FTSU Guardian will triangulate learning and data through relevant management meetings, to identify opportunities to learn and improve.

Section 3 Action taken to improve FTSU culture

FTSU is discussed at each corporate induction, promoted during wellbeing conversations and at the equality group meetings.

FTSU Ambassadors remain positive and enthusiastic. This year has been difficult to engage with colleagues due to the pandemic however MS Teams has been really helpful to sustain the network connectivity.

The FTSU Guardian hosts regular sessions with the FTSU Ambassadors where we support and wrap 'One Culture of Care' around each other. Supervision for the Guardian comes from the West Yorkshire and Harrogate regional FTSU network which has continued virtually throughout the pandemic.

The growth of the speak up culture in the Trust is supported by a range of channels:_

- Ask Owen 'you can ask the Chief Executive anything'
  101 questions in the past 12 months compared to 105 in 2019/20 and 100 2018/19. Themes include colleague care (46) primarily Covid related with wellbeing identified as the biggest area of interest; policies (16) with the main issues related to Healthcare Assistant pay, and uniforms; and patient care (13) including remote working and restarting services.

- Staff Survey
  2799 colleagues completed the 2020 survey (50% of the Trust's workforce).

There were two questions relating to FTSU:-

The Trust has a Freedom To Speak Up Guardian and a network of FSUG ambassadors. Are you aware of this?		
Yes	1842 responses	72%
No	732 response	28%
The Trust has a FTSU portal for colleagues to raise their concerns. Are you aware of this?		
Yes	1544 responses	60%
No	1031 response	40%

The results in the 2019 staff survey were as follows:-

The Trust has a Freedom to Speak Up Guardian and a network of FSUG ambassadors. Are you aware of this?		
Yes	1560 responses	66.5%

Q96: The Trust has a FSUG portal for colleagues to raise their concerns. Are you aware of this?		
Yes	1187 responses	50.8%

It is pleasing to see the responses from the survey highlight an increased awareness of the FTSU Guardian, the FTSU network and the FTSU portal. There is still further work required to increase communications and engagement. This will be a main area of focus for the FTSU team in the next 12 months.

- Datix incident reporting over the 12-month reporting period in 2020 and compared to 2019.

2020/2021 data (1 June 2020 to 26 May 2021)

	Total
Pressure Ulcers/Moisture Associated Skin Damage (MASD)	3271
Slips, trips and falls	2027
Appointment/Admission/Transfer/Discharge	1659
Medication	1049

Assessment/Treatment/Diagnosis	854
Maternity Incidents	808
Infection Control	581
Health and Safety/Sharps/Security	579
Confidentiality/Communication/Consent/IG	467
Abuse/Self-Harm	414
Infrastructure/Resources/Staffing	391
Investigations (Scans/Tests/Results)	354
Safeguarding Adults	234
Blood Transfusion Related Issues	193
Medical Device	193
Safeguarding Children	11
Total	13085

2019 data

Pressure Ulcers/Moisture Associated Skin Damage (MASD)	
Slips, trips and falls	1999
Appointment/Admission/Transfer/Discharge	1862
Assessment/Treatment/Diagnosis	970
Medication	969
Maternity Incidents	779
Health and Safety/Sharps/Security	622
Infrastructure/Resources/Staffing	589
Confidentiality/Communication/Consent/IG	526
Abuse/Self-Harm	453
Total Datix incidents recorded (1 June 2019 to 31 May 2020)	**11715**

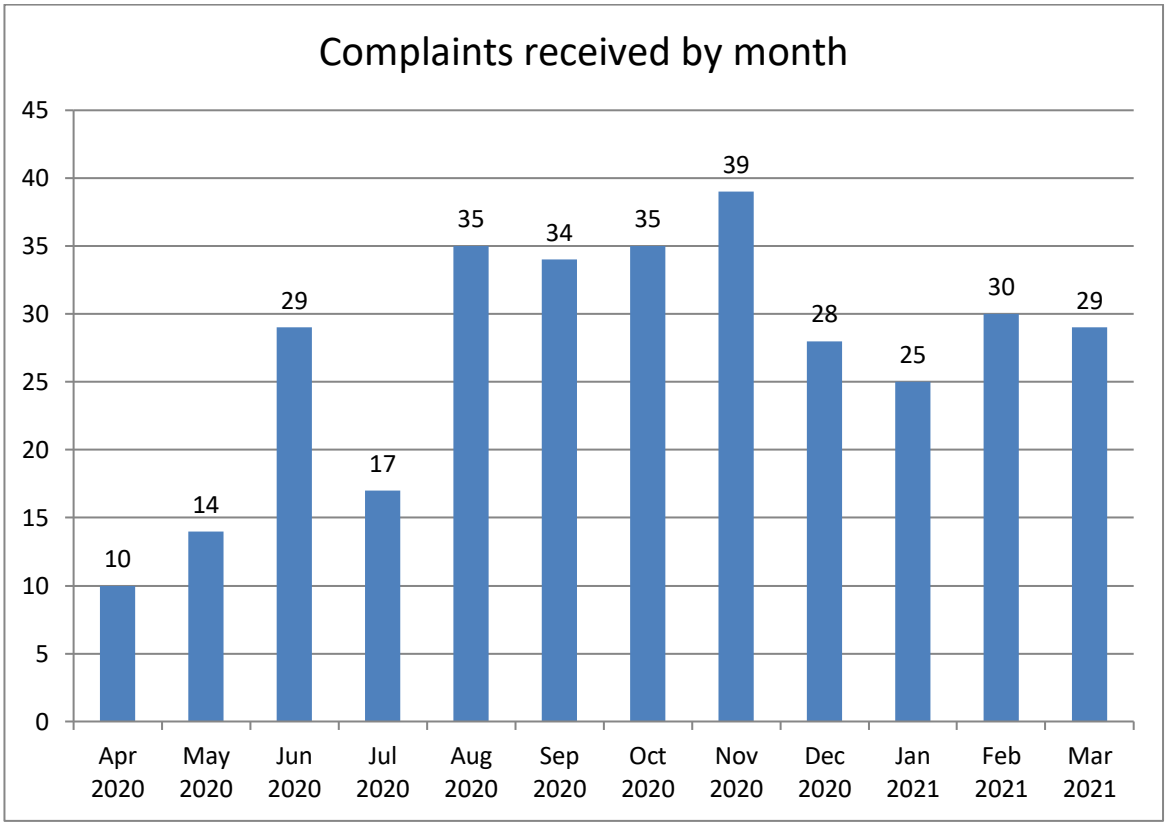
The Datix information is a strong indication that a speaking up culture is growing.

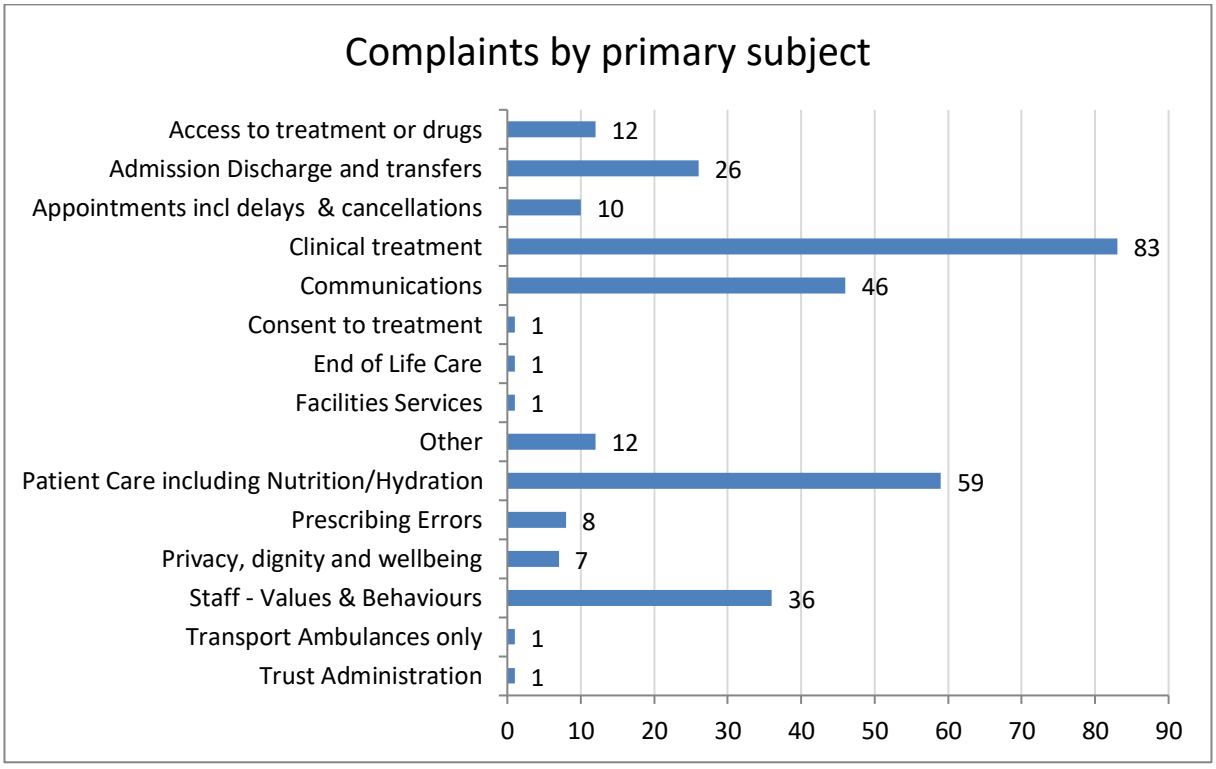
- Patient Experience

Information related to Patient Experience/Complaints have not been included in earlier annual reports, however, it is a helpful addition to indicate how we are triangulating the data we collect between Datix/Speak Up Channels and Patient Experience.

During 2020/21 the Trust received 325 complaints. This is a significant decline from 2019/20 (505). This is likely attributable to an enhanced emphasis on addressing concerns quickly and effectively via PALS and changing patterns of contact as a result of the Covid-19 pandemic.

The profile of complaints received in 2020/2021 is shown below. On average, the Trust received 27 complaints per month. April and May 2020 were significant outliers in this respect, which may have been related to the national Covid-19 situation at that time.





The aim in 2021 is to undertake deeper dives to understand what issues are raised through these channels, how we are reacting to this information and what we can learn from this information to enhance our speak up culture.

Section 4 Learning and Improvement

The Regional FTSU network is a significant source of learning and support. The FTSU Guardian finds this network invaluable for their learning and development. There is a national FTSU e-learning package and the Guardian proposes this is introduced as part of our core Essential Safety Training (EST).

Section 5 Recommendations

In the next 12 months the focus for the FTSU Guardian and FTSU Ambassador network will be to:-

- Develop a digital 'your voice matters' magazine which will share case studies, promote the equality networks and wellbeing channels
- Undertake a 'deep dive' into the available data to support our colleague and patient experience approaches
- Continue to increase the visibility of the speaking up channels and the FTSU Ambassador team
- Add the FTSU e-learning to the core EST programme.

Please note, future FTSU Guardian annual reports will cover the period 1 April to 31 March. The production and submission of an Annual Report to the Board is supported by the provision of an in-year 6-month report to the Workforce Committee.

4. CONCLUSION

The Board of Directors is asked to note the content of this report.

Nikki Hosty
Freedom to Speak Up Guardian

20 August 2020

Keeping the Base Safe

14. Winter Plan

To Approve

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	2 September 2021
Meeting:	Board of Directors
Title:	Winter Plan
Author:	Bev Walker, Deputy Chief Operating Officer
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	

Actions Requested:

To approve – To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action.

Assurance – to assure the Board that effective systems of internal control are in place.

Purpose of the Report

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

2021 has brought continued challenges to the NHS due to the worldwide pandemic outbreak of COVID-19. Preparedness for this winter in particular is imperative to ensure we keep our patients and staff safe and we remain resilient as an organisation.

The purpose of the plan is:

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

NHS England has reiterated that trusts are expected to respond appropriately to the demands of winter through attention to the following areas:

- Creating capacity through plans to address increasing numbers of patients without a reason to reside.
- Reducing variation in best practice (Improving patient flow and effective discharge planning)
- Demand and capacity planning using new NHSE bed modelling
- Planning for Peaks in demand over weekends and Bank Holidays, resurgence in COVID-19 and other winter illnesses.
- Assurance the plan supports the recovery plans.
- IPC guidance
- Staff workforce resilience- staff wellbeing and vaccination programme

Key Points to Note

The winter plan is based on the following strategic aims;

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs
- To work collaboratively with other health and social care providers to effectively manage capacity
- To assess risks to continued service provision and put plans in place to mitigate those risks
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels over the winter period to minimise the risk of harm
- To ensure patients do not wait in any part of the system unless clinically appropriate
- To ensure learning from Winter 2020/21, the COVID-19 pandemic and WY&H ICS Resilience Workshops is incorporated into 2021/22 Winter Plan.

In 2021 the Trust's internal Urgent Care Board with membership of all Clinical Director's, contributed to winter planning by developing new innovative schemes providing increased resilience and clinical effectiveness for the winter period:

Daily support for patient flow from the Clinical Divisions is already in place, additional senior support is provided by the Director of Operations, Associate Directors of Nursing and deputies as point of escalation and will chair of the critical 12.30pm Tactical Command Meeting. Strategic Command will be triggered at OPEL 3 to ensure any surge in activity above expected levels are acted upon immediately and provide additional assurance that good control and command is in place and learning is quickly acted upon.

The Deputy Chief Operating Officer and Divisional Director of Operations in collaboration with key service winter leads are responsible for the successful implementation and monitoring of the winter plan. The plan and its effectiveness will be reviewed throughout the winter period as a live document and learning shared and acted upon on a monthly basis. The Urgent Care Board membership will also play a key role in the review process.

EQIA – Equality Impact Assessment

The Winter plan aims to design and implement service policies and measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

Recommendation

The Board is asked to **APPROVE** the plan

Calderdale and Huddersfield
NHS Foundation Trust

Winter Plan 2021/22

Version 2

Document Summary Table			
Status	Draft		
Version	2		
Implementation Date	October 2021		
Current/Last Review Dates	October 2020		
Next Formal Review	June 2022		
Author	Deputy Chief Operating Officer		
Where available	Emergency Preparedness, Resilience and Response Section of the Trust Intranet		
Target audience	Executive Directors, On-call General Managers, Directors, General Managers, Senior Nursing Colleagues, Matrons, Senior Ward & Department staff, on call teams and CHS.		
Executive Sponsor	Chief Operating Officer		
Ratifying Committee			
Board of Directors			
Consultation Committees			
Committee Name		**Committee Chair**	**Date**
Urgent & Emergency Care Delivery Board		Chief Officer, Calderdale CCG	September 2021

Does this document map to other Regulator requirements?	
Care Quality Commission	Outcomes 4B, 6D, 10E and 14A

Document Version Control	
V1	Draft
V2	Updated with Divisional Winter Plans and Winter schemes
V3	

Contents

1. Introduction

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

The winter period is normally defined as being from early November to late March with specific emphasis on the 'Critical Period' early December to the end of January. However, NHS England expectations of Trusts to implement improvements as described below do not and cannot be achieved if just focused on planning through the winter but must be the focus throughout the year.

2. Purpose

The objectives of the Plan are as follows:

- To support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the winter and COVID response through Winter 2021/22
- To provide a framework for the development of other plans
- To provide the basis for agreement and working with other partners & organisations
- To provide reference material for use in the Trust
- To set out the information systems to be used to manage the response.

NHS England has reiterated that trusts are expected to respond appropriately to the demands of winter through attention to the following areas:

- Reducing Delayed Transfer of Care
- Reducing variation in best practice (Improving patient flow and effective discharge planning)
- Demand and capacity planning
- Planning/modelling for Peaks in demand over weekends and Bank Holidays and through anticipating impact of winter pressures which will include COVID-19.

3. Definitions

Import - the monthly report on take up of influenza vaccination in staff.

Organisational resilience - the ability to adapt and respond to disruptions to deliver organisationally agreed critical activities.

Sitrep - a daily report to NHSE which highlights pressures in Trust's capacity. Sign off will be required by 11:00, Monday-Sunday from the beginning of November 2019 until the end of March 2020.

THIS will support the reporting of the Sitrep on a daily basis and the Deputy Chief Operating Officer or deputy will complete the sign off, a rota has been created.

4. Duties (roles and responsibilities)

Chief Operating Officer

- Accountable officer at Executive level for Winter Planning

Deputy Chief Operating Officer

- Chair the Winter Planning Group
- Represent the Trust on the Joint Surge and Escalation Teleconferences
- Compile a situation report for the Joint Surge and Escalation Teleconferences
- Cascade the situation report from the Joint Surge and Escalation Teleconferences / Update the winter planning group and divisional leads of the situation across the local healthcare system
- Respond to requests for assurance from the CCG and NHS England
- Benchmark and share good practice from partner organisations
- Ensure that winter plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period
- Ensure that contingency plans that are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases including COVID-19 are appropriate and will deliver safe patient care and experience and organisational resilience.
- Ensure that the Trust Winter Plan aligns with those across the local health & social care system.
- Lead in 'keeping the base safe in partnership' with the Deputy Chief Nurse and Directors of Operations.

Divisional Directors

- Ensure each Division takes responsibility for securing sufficient capacity to meet out of hours demands on a daily basis
- Ensure collaboration across Divisions to ensure compliance with Patient First principles
- Ensure each Division has robust arrangements for escalation and any associate operational and tactical meetings

Deputy Chief Nurse

- Lead in 'keeping the base safe' in partnership with the Deputy Chief Operating Officer and the Directors of Operations.
- Ensure the daily staffing meeting are effective and any risk are escalated to tactical command.

Divisional Director of Operations

- Ensure that appropriate plans are in place to manage an increase in activity through the winter period within the division
- Ensure that divisional plans are joined up across the organisation

- Ensure that contingency plans are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases and COVID-19.
- Ensure that key staff groups are aware of the risks and response arrangements for winter
- Attend Urgent and Emergency Care Board (U&EC Board)

CHS, Clinical Site Commanders and Night Matrons

- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements
- Contact alternative transport providers if required

CHS

- Ensure that there are sufficient supplies of salt/grit for clearing car parks, pathways and roads on site and in community buildings where CHFT staff and patients are working/attending
- Liaise with contractors to arrange access to 4X4 vehicles for transport services if required
- Ensure that additional staff accommodation is available if required
- Cascade weather updates throughout the year including winter.

5. The Trust's Winter Strategy

The winter plan is based on the following strategic aims;

- To continue to provide high quality health and social care to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment at the time most beneficial to their needs
- To work collaboratively with other health and social care providers to effectively manage capacity
- To assess risks to continued service provision and put plans in place to mitigate those risks
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- To ensure optimum occupancy and staffing levels over the winter period to minimise the risk of harm
- To ensure patients do not wait in any part of the system unless clinically appropriate
- To ensure learning from Winter 2020/21 is incorporated into 2021/22 Winter Plan.

6. Winter planning arrangements

The Trust Operational Lead for winter planning is the Deputy Chief Operating Officer in collaboration with the Divisional Senior Management Teams.

The local UA&E Delivery Board has overall responsibility for ensuring that the health and social care service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity and acuity over the winter period. The CHFT

Winter Planning Group reports to the U&EC Board and, in addition to internal escalation arrangements, is responsible for ensuring that the Trust has plans in place for severe winter weather, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

The Trust's internal Urgent Care Board with membership of all Clinical Director's, has contributed to winter planning by developing new innovative schemes providing increased resilience and clinical effectiveness for the winter period. All innovations are being monitored against clear aims and KPIs:

Innovation Schemes 2021			
Work Stream	Project Number	Description	Implementation Date
Community Services	1	Out of Hours District Nursing/Palliative Care referral handler	October 2021
Paediatric Services	2	A 2nd Paediatric night registrar across Ward 3 (CRH), Ward 4 (HRI), NICU (CRH), postnatal emergencies, labour suite emergencies, CRH ED, HRI ED calls, and resus.	4th October 2021
Community Services- Pharmacy Support	3	Clinical Pharmacist (Band 6) -Community Based Winter Support	November 2021 *Dependent on recruitment timescales
Medical Division	4	Virtual Frailty Service & Frailty SDEC Expansion - Business case submitted	TBC
Surgical Division	5	Surgical SDEC- Medical Staffing for 'Hot Clinics'	September 2021
Surgical Division	6	Expansion of Surgical SDEC 24/7	September 2021
Medical Division	7	Virtual consultant service with Tytocare	ASAP
Family and Specialist Services	8	Medication – get it right from the start	Expected Nov 2021 for 6-month pilot *Dependent on recruitment
Family and Specialist Services	9	Safari Pharmacy Led Discharge	Expected Nov 2021 for 6-month pilot *Dependent on recruitment
Medical Division	10	ACP Weekend Cover for Medical SDEC	TBC

7. Command, control, and co-ordination

During the period 1 November – 29 February, a daily SitRep (Mon-Fri) will be completed for submitting to NHS England by the Health Informatics Service. The Monday SitRep will include details from the preceding weekend. SitReps will be signed off by the Deputy Chief Operating Officer/Director of Operations/Deputy Chief Nurse after high level validation with fully validated data submitted daily. Arrangements have been confirmed to ensure that there is adequate cover in case of absence.

Tactical Command will continue to be in place daily, this provides a more robust coordination of the command and control of the operational sites, escalation and actions needed to provide assurance of increased resilience during surge and escalation.

8. The National Escalation Framework

4 Hour Emergency Care Standard Performance is one measure of a whole health and social care system experiencing pressure, but it is not the only one. An Emergency Department (ED) could be experiencing isolated difficulties, but the rest of the system is coping well for example there are sufficient beds available and there is good flow through the system. Alternatively, an ED could be managing well whilst the rest of the hospital, and the wider system, community beds, community services and social care are experiencing high pressures due to a lack of capacity.

Escalation Triggers at Each Level

Local U&EC Boards have aligned their existing systems to the escalation triggers and terminology used below and adds to the triggers listed as appropriate. The escalation criteria detailed over the following pages are not an exhaustive list of triggers, nor do they constitute a rigid system where criteria must be met sequentially for escalation to take place. **Not all parts of the system need to meet all triggers to escalate – escalation can be service specific if agreed locally.**

Local U&EC Boards are able to demonstrate that appropriate triggers have been met to warrant escalation. NHS England and NHS Improvement sub-regional and regional teams will also use the framework to moderate and challenge in discussions with local systems.

National terminology (OPEL) has now been adopted and has been used within the Trust throughout 2018.

To ascertain the OPEL status of acute hospitals within Yorkshire, YAS contacts each acute trust. CHFT's Clinical Site Commanders will be contacted by Yorkshire Ambulance Service twice daily either by phone or email firstly at 09:00 each morning and secondly in the afternoon for the new national escalation level (OPEL) status for inpatient capacity and any associated comments noted by hospitals on the Daily Bed Alert Status Report.

Operational Pressures Escalation Levels	
OPEL 1	The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The Local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided. Additional support is not anticipated.
OPEL 2	The local health and social care system is starting to show signs of pressure. The Local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible. Local systems will keep NHS E and NHS I colleagues at sub-regional level informed of any pressures, with detail and frequency to be agreed locally. Any additional support requirements should also be agreed locally if needed.
OPEL 3	The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in OPEL 2 have not succeeded in returning the system to OPEL 1. Further urgent actions are now required across the system by all A&E Delivery Board partners, and increased external support may be required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally. National team will also be informed by DCO/Sub-regional teams through internal reporting mechanisms
OPEL 4	Pressure in the local health and social care system continues to escalate leaving organisations unable to deliver comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the Local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions taken, external extensive support and intervention required. Regional teams in NHS E and NHS I will be aware of rising system pressure, providing additional support as deemed appropriate and agreed locally, and will be actively involved in conversations with the system. Where multiple systems in different parts of the country are declaring OPEL 4 for sustained periods of time and there is an impact across local and regional boundaries, national action may be considered.

Figure 1

OPEL-Winter command and control arrangements (internal)

Operational Pressures Escalation Level (OPEL) 1 when operating within normal parameters. At OPEL 1 and 2, we would anticipate operations and escalation to be delegated to the relevant named individuals in each organisation across the A&E Delivery Board. At OPEL 3 and 4 however, it would be expected that there would be more executive level involvement across the U&EC Board, as agreed locally.

A second assessment of capacity alerts will be made at 16:00 and the capacity status for each hospital again reported.

Each division and department is responsible for the successful implementation of their escalation plans. In the event that significant pressures are identified the Deputy Chief Operating Officer or the Divisional Directors of Operations will decide to implement the Trust Emergency Management Arrangements Strategic (Gold) and Tactical (Silver) and Operational (Bronze).

The three-hourly Patient Flow Hospital Meetings chaired by the Clinical Site Commanders involving the patient Flow Team and Divisional Managers of the day, Matrons and on call managers/Matron of the day will monitor activity on each site and determine operational actions using a standard operating procedure and escalation policy to manage capacity issues. Tactical command has been in place throughout the COVID Pandemic and will remain in place through the winter period. The level (OPEL) at which the hospitals are working within will be determined at these

meetings. The Deputy Chief Operating Officer will report direct into the partner organisations involved in the Joint Surge and Escalation Plan.

OPEL Escalation Impact

<table>
<tr><th colspan="3">Overview</th></tr>
<tr><td colspan="3">Impact</td></tr>
<tr><td colspan="3">• Unpredicted increase activity in EDs, SAUs and Acute medical units- follow triggers described in the EDs escalation plan
• Increase in bed occupancy across the Trust
• Increased pressure on community healthcare services to support discharges above predicted
• Potential of the need to outlie patients into another speciality.
• Greater potential for inpatient outbreaks of infection and outbreaks in nursing homes preventing discharges

Impact 1 2 3 4 5
Likelihood
1
2
3 x
4
5</td></tr>
<tr><td colspan="3">Proactive strategy- Actioned by the Director of Operations</td></tr>
<tr><td colspan="3">• Identify flexible beds that can be opened in the short term to support increased admissions and staffing requirements
• Trigger escalation- OPEL</td></tr>
<tr><td colspan="3">Reactive strategy</td></tr>
<tr><td colspan="3">• Use of winter strategy & plan-
• Implement the joint surge and escalation plan- Strategic and Tactical and operational
• Activate business continuity plans and escalation plans
• Increase inpatient capacity by opening flexible beds as described in divisional plans</td></tr>
<tr><th>Trigger</th><th>Received by</th><th>Immediate action</th></tr>
<tr><td>ED reporting of increased activity</td><td>Emergency department matron/manager</td><td rowspan="2">• Reallocate junior medical/nursing staff to support the Emergency Department
• Establish additional trauma lists as required
• Review the availability of trauma surgery equipment
• Move from elective beds to trauma as demand dictates
• Use of flexible capacity- short term
• Surge & Escalation plan actions to be followed
• Monitor impact via Winter Room
• Review actions and impact from the twice weekly MADE</td></tr>
<tr><td>YAS reporting of increased activity</td><td>Emergency department. Patient flow team</td></tr>
<tr><td>Low temperatures Met Office - proactive</td><td>Emergency Planning Officer</td><td>• Prepare for increased attendance by patients in the at-risk groups</td></tr>
<tr><td>Community nursing workload</td><td>General Manager – Adult Community Nursing</td><td>• Review community case load to prioritise at risk patients
• Trigger business continuity plans</td></tr>
<tr><td>Assess bed capacity issues in line with regional plan</td><td>Director Of Operations</td><td>• Implement the escalation policy.
• Implement joint partner surge & escalation plan
• If required initiate System Tactical Call.</td></tr>
<tr><td>Requirement to expedite discharge</td><td>Clinical Site Commander

Discharge Matron/Discharge Team.</td><td>• Liaise with YAS to agree priority order for patient movement.
• Initiate spot purchasing agreements via LAs
• Start discharges with medicines to follow. (Use of taxis of transportation of medicines post discharge.)
• Use of day rooms and discharge lounges to facilitate expedite discharge.
• Discharge thresholds to be challenged.</td></tr>
</table>

9. Workforce

Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services over the 7-day period. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover an arrangement especially over the Xmas and New Year period and to ensure annual leave is managed appropriately over this period. Staffing gaps should be identified and mitigated by Divisional teams in hours, only last-minute absences will be actioned by on-call, out of hours teams

For Xmas & New Year a further review will be completed weekly from the beginning of December with a final sign off and escalation of any risks with mitigation plans by the 6th December 2021.

Health & Well Being

Colleague health and wellbeing support is to remain a priority, and a dedicated winter plan health and wellbeing strategy will be developed

Health & Well Being as part of the Recovery Framework – Key principles that have adopted.

- One Culture of Care - health and wellbeing of colleagues and the link to patient care made explicit
- Colleagues must be safe to practice
- Focus on staff mental AND physical health – adopt the basics of health and wellbeing: hydration, nutrition, sleep, facilities, breaks
- Compassionate leadership behaviours
- Concise, clear compassionate communication via a variety of channels
- Any additionality will be voluntary with regular wellbeing assessment of those regularly undertaking additional work.
- We will widen access to recruitment to ensure that we fill as many vacancies as possible, including reviewing clinical workforce models to maximise skill of AHPs, HCSWs and PAs
- Our communication strategy will focus on honest, transparent, and clear messaging through a variety of different channels

Vaccination

The target for Trust staff to have had the ‘flu vaccine for this year for Calderdale and Huddersfield the ambition is to achieve 100%of frontline staff. The emphasis will be on staff in clinical and clinical support roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, ‘myth busting’ and league tables of performance have been advertised on the intranet. The vaccine will include a booster vaccination against

COVID-19. Additional groups of staff have been trained to administer the vaccine so that it can be more accessible to staff.

Personal Winter Plan/Engagement Plans

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

10. Strengthened Operational Management

Daily support for patient flow from the Clinical Divisions is already in place, additional senior support is provided by the Director of Operations as point of escalation and will chair of the critical 12.30pm Tactical/Patient Flow Meeting if OPEL 3 is triggered.

Throughout the New Year period and for the full month of January the on-call manager will remain on site until 10pm each evening and there will be an additional support (buddy Manager) on site into the OOHs period. The buddy support manager will commence in November 2021.

If OPEL 3 is determined through the daily Tactical/Patient Flow Meetings, escalation will be sent out via a digital platform to Clinical colleagues to ensure greater awareness of the escalating position.

Urgent Care Action Cards and a revised surge and escalation plan will be relaunched in October to prevent exit block within ED, improve daily flow and operational management in a more consistent way and prevent and any patient waiting on hospital corridors. It will also aid continued delivery of CHFT recovery plans where dependant on OPEL level set out in the framework will ensure actions taken early will prevent cessation of planned activity.

Operational and Senior Leadership 7/7
There is on site presence 7 days a week from an operational lead at Director level and Senior Nurse lead at a minimum of Associate Director level to support the OOHs period at weekends. The operational lead will chair tactical command.

Lead Nurse-Patient Flow

Each hospital site will have increased presence of the lead nurses for Patient Flow through the winter period. They will ensure the patient flow meetings will be coordinated in a SMART way, are action focused and ensure the revised Urgent

Care Actions Cards are being operationalised daily in collaboration with the divisional clinical and management teams.

Clinical Site Commander

The Clinical Site Commander will effectively manage the Trusts bed capacity, ensuring the patient's journey is safe and their experience is good. They will be the point of escalation if surge is being experienced. They will hold a register of registered and appropriate volunteers that have access to 4x4 vehicles and who can provide assistance with transporting staff to work and home during times when roads are impassable due to adverse weather conditions.

Divisional Operational Winter Teams

There will be a Divisional manager and Matron who will be the leads for winter to support the patient's journey, ensuring safe effective admissions, transfers and discharge.

"On call/site manager of the day" & Support Manager

There is an on-call manager designated on site daily and an additional support (buddy) manager working on the opposite acute site.

Duty Matron

There will be a duty matron on site daily. Over the winter period a buddy matron will also be on site.

Reducing Admissions

Ambulatory Care in medicine and Medical Admission avoidance will be available on each hospital site to prevent avoidable medical admissions. Surgical Ambulatory will be available on the HRI site over the 24-hour period 7/7.

Reducing Delayed Discharges

SAFER Patient Flow Transformational Programme was relaunched in July 2021, the programme is supporting initiatives throughout 2021/22 to improve flow, prevent avoidable admissions, reduce LOS and improve timely discharges.

The weekly SAFER meetings will continue to consist of senior members of CHFT to ensure processes to improve flow across the wards for eg effective board rounds. Weekly Executive Discharge Meetings are also held with partner organisations with the aim is to reduce the number of patients who are medically fit for discharge remaining in hospital, support the reduction in those patients with the longest length of stay and manage those complex discharge pathways.

11. Divisional Winter Plans

CHFT's Divisional teams have prepared their winter plans through analysing their expected demand, modelling expected winter related pressures, tracking assumptions against their business plans and understanding the impact transformational work is having.

Central Operations (COT)

Discharge Team

- A daily huddle will be introduced to focus resource of the team when triggers on any specific pending delays occur this must be without reducing the robust management of the complex discharges.
- Working hours will be reviewed daily as part of the huddle and extended as required. Staff will work flexibly to support the service
- Case reviews of all patients daily with a manager of the discharge team

Discharge Planning

- Daily Transfer of Care (TOC) is now in place with Director level attendance from partner organisations at OPEL 3
- SAFER Transformation Programme implementing improvements to discharge planning reporting through the to the Quality Committee.
- Discharge Executive Meetings – 'Place Based' to support improvements in discharge for TOC patients.

Patient Flow Team

- There is a Digital Operations centre on each acute hospital site and is the hub for all Patient Flow Meetings and as required for escalation meetings using TEAMs
- Tactical Command will remain in place through the winter period and Strategic Command will be initiated through OPEL escalation and Tactical Chair in discussion with the Chief Operating Officer
- An additional transport service will continue to be available managed through the Clinical Site Commanders to support discharge and inter-hospital transfers
- Increased task management will be in place 'in hours' through H2.

Medical Division Winter Planning

The medical division will endeavour to maintain its usually bed base during winter pressures by:

- Using the SAFER programme to bring together divisional quality improvement workstreams supported by all Divisions, the Patient Flow team and the General Manager for Corporate Operations. Initially the focus will be developing a plan for every patient, through effective board rounds which will

be rolled out first to our Elderly Care wards and will use supporting information available on Knowledge Portal+.

- Opening an isolation facility on each hospital site (CRH ward 4D and HRI ward 18) to meet extra demand for patients with infections that require isolation and maintain flow. Ward 15 will continue to provide additional capacity on the HRI site.

Medical Directorate specific plans

Acute Directorate

- Consultant input into Frailty Same Day Emergency Care (SDEC) will be strengthened to improve admission avoidance - 4 days per week 13.00-21.00. Also, an additional band 6 nurse to support the increasing demand will be available 10.00-22.00 Mon-Fri.

- Enhanced Virtual Frailty Service – dedicated phoneline directly to the frailty nurse 08.00-22.00 7 days per week with access to a dedicated Geriatrician 4 days per week 13.00-21.00.

- Plans are being developed to reconfigure our current wards to allow morning medical SDEC cover at HRI.

- Continue with the relocation of Medical Ambulatory to ward 3 alongside Frailty SDEC, both services to provide resilience to each other in terms of staffing and skills. Maximise the use of ambulatory areas focussing on direct admissions to avoid ED attendance, building on the recent increased use of the SDECs. Develop direct streaming pathways from ED supporting the requirements of the new ED standards.

- Medical SDEC Advanced Care Practitioners (ACP), weekend cover will now be available 09.00-17.00 both acute hospital sites. ACP presence will mean more patients can be taken earlier in the day and should contribute to reduce the need for patients to be admitted into the bed base.

- If the bed base permits flexibility with the acute consultant rota there will be admission avoidance Mon-Fri afternoons in the Emergency Department (ED) at HRI.

- We will seek to cover with an extra Acute Consultant for ED admission avoidance twilight 5pm – 8pm 7 days through bank for the HRI site.

Emergency Care Directorate

- Streaming/Navigation –
  8am-8pm 7 days per week delivered by a ‘Front door’ streaming band 7 sisters at front door steaming to other services, GPs, ambulatory, specific pathways.

- Admission avoidance 10am-6pm Monday to Friday in ED at CRH.

- Tytocare scheme – using the Tytocare devices we are trialling remote video consultations with a clinician based in another location. Initially this will be run internally to CHFT but there is potential to expand this into care homes to prevent ED attendance and hospital admission. This will be reviewed prior to Winter.

- Continue with the pilot of the Urgent Care Hubs on both sites between 08.00-1800 Monday - Friday, reverting back to Local Care Direct outside of these hours. The initial phase will run until September and beyond this will either continue in the same format or the service will be brought in house.

Medical Specialities Directorate

- Respiratory Floor will remain on 4 pods, flexing between 47-54 beds and also flexing across pods 5A, B, C, D in response to demand for Covid positive capacity, non-Covid and influenza. So all Pods can be converted to admit covid positive patients.

- Management of CPAP patients across the Respiratory Floor and the Intensive Treatment Units will be as per the Standard Operating Procedure and the daily Respiratory/ITU meetings.

- Actively recruit to the staffing model for an Acute Respiratory Care Unit (ARCU) to increase resilience to manage CPAP patients on the Respiratory Floor.

- Direct pathway being developed to enable COVID positive patients to go directly to the respiratory floor from the Emergency Department.

- Respiratory Hot Clinics will continue for Calderdale patients only. Referrals will be via GPs to support admission avoidance. Plan in place to utilise this resource to aid discharge with patients returning to clinic within 24-48 hours post discharge if required. Starting negotiations with locala to replicate this model for Kirklees patients.

<u>Surgical Divisional Plans</u>

The Surgical Division has developed plans to be able to respond to increased non-elective demand.

Critical Care

- An escalation plan and standard operating procedure for the demand for critical care exceeding capacity in ICU has been developed (Appendix 1).

SAFER Programme

- The surgical division is supporting the initiatives to improve flow/discharge.

Trauma & Orthopaedics (T&O)

- In addition to current planned trauma lists, additional increases in demand will be delivered by following the Trauma Surge Pathway (Appendix 6)
- 4 additional Trauma lists will be available which in turn can be flipped to a 2nd acute theatre supporting all specialities.
- Acute fracture clinic referrals direct from ED for Consultant led treatment for patients with confirmed fractures are in place maximising virtual fracture clinics.
- Improved access to theatre will reduce pre-operative bed days and overall length of stay for some minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre
- An additional plaster room and adjoining clinic room capacity for fracture patients will be advantageous to T&O and this is now being sought.
- From October 2020 Surgical Ambulatory Care was relocated to Cedarwood creating extra capacity with the longer-term capacity to incorporate further surgical services i.e. T & O, urology and ENT.
- The elective inpatient orthopaedic surgery at CRH will continue as per the Phase 3 planning.
- Elective recovery plans are in place and will continue unless the organisation has escalated to OPEL 4.
  (Trauma surge plan appendix 6)

Family & Specialist Services (FSS)

There will be daily attendance in the Patient Flow meetings of Operational management from FSS to support patient flow, support prioritisation of diagnostics during increased demand.

FSS Directorate Manager of the day role (DMoD)

The Directorate Manager of the day role in FSS is a different role from other Divisions with a named Directorate being identified for each day Monday-Friday. The Directorate manager can be either the General Manager, Operational Manager, Matron/Senior nurse, or equivalent. With the same Directorate member being available for the whole day to ensure efficient follow through of any actions / updates.

The role is to take any escalations with mitigation plans from Division/ Directorates e.g., rota gaps, essential equipment being out of use, departmental on the day backlogs/waits (list not exhaustive) at the appropriate tactical meetings (9am, 12.30pm 3pm and 5pm if situation indicates a need) to ensure optimum flow locally and within the wider organisation.

The Directorate manager of the day's role is to continue to provide a progress update at subsequent tactical meetings and to feedback information to the Division or Directorate from Tactical using either email or team's chat
The FSS Directorate rep from FSS will only attend the 5pm tactical/bed meeting if the situation indicated or tactical requested.

Monday – Children's Directorate
Tuesday – Radiology Directorate
Wednesday – Women's Directorate
Thursday – Pathology Directorate
Friday – OPD/Pharmacy Directorate

Paediatrics

Based on modelling from Australia, from late August 2021 paediatric teams are expecting to see a 20-50% increase in RSV admissions. Whilst RSV is increasing, the ward is also seeing an increase in COVID-19 inpatients. In addition, the number of patients requiring CAMHS, and Social Care input has increased since COVID-19. There are national delays in securing beds/placements for these patients, adding further to existing bed and staffing pressures.

The Children's Directorate team have revised the escalation (OPEL) plan in line with COVID-19 and the expected RSV surge (Appendix 2)

Operational support

- During the winter period the Matron for the service continues to undertake a daily situation report during the week and will risk assess situations regarding staffing and activity on the Paediatric ward. To support the situation report process, there is an escalation plan in place (shared with this document)
- The safety huddle process on the ward is being refined and a 'safety checklist' will be established to support with flow and reporting staffing levels
- The paediatric team will be completing a twice daily status on a regional DOS

Nursing

- The paediatric ward operates on a workforce model that accounts for surge during the winter period. This strengthens nurse staffing and leadership during the winter period with the plan to have a Band 6 or 7 Nurse working clinically across all shifts
- It must be highlighted (as per risk 7539) the Nursing team are below on required establishment due to a number of vacancies.

PNP

- An APNP will be available 24/7 on the HRI site. Any gaps in the APNP rota are escalated to ED colleagues to ensure APLS cover is available in ED at the HRI site

Medical

- The weekly rapid access clinic will continue, supporting reviewing some patients who would have previously been seen in ED or referred to PAU by their GP. The capacity of this clinic will be reviewed regularly, with scope to increase these if and when required
- From September 2021, the Registrar rota will change to ensure a Twilight Registrar is available Monday - Friday. This will ensure greater medical presence during the hours with expected highest demand
- Where required, the paediatric medical team will support ED at peak times. At HRI, this is an APNP
- The Consultant scheduled to cover Ward 4, HRI, will undertake a virtual ward round if appropriate. This will enable them to support Ward 3, CRH, improving flow and timely discharge at peak times of activity

Neonates

Neonatal services work in partnership with Maternity services as part of a wider network that is managed by the transport service, Embrace.

The Deputy Head of Midwifery supports NICU from a nursing and maternity perspective. Working with the Clinical Nurse Manager for NICU, the Maternity bleep holder takes any capacity escalations.

From a medical perspective, any rota gaps are managed by the Rota Coordinator, with escalation to the College Tutor, Clinical Director and General Manager as required.

The unit has an escalation plan in place (Appendix 3)

Gynaecology

During the winter period the activity theatre plan has been planned to ensure the surge in medical winter emergency activity is supported.
In addition, prior to transferring to ward 8C the patient must be assessed against essential criteria as outlined below

CRITERIA FOR MEDICAL TRANSFERS TO: - THE GYNAECOLOGY AREAS

Prior to transferring to ward 8C the patient must be assessed against essential criteria as outlined in appendix 5

Maternity

Maternity will need to continue to provide essential services in line with NICE/RCOG guidance.

- During the winter period the Clinical Managers / Matrons for the inpatient and Birth Centre services continue to risk assess situations daily regarding staffing and activity throughout the Maternity Unit.
- The Clinical Managers / Matron for community will also review staffing/acuity on a daily or more regular basis as the need requires.
- If weather does not permit home visiting (particularly for postnatal care), the midwife is to contact the woman by telephone / virtual appointment to conduct a review of maternal and baby wellbeing.
- If an essential visit is required, the midwife / manager must undertake a full risk assessment and utilise the 4x4 service if all other options have been explored (i.e., staff members with 4x4's undertaking visit or transporting another member of staff – to go in 2's)
- On call midwifery staff should ensure their vehicle is in a place where easier access is enabled.
- On call midwifery staff should follow the loan worker policy and alert the LDRP Coordinator of being called out and ascertain if safe to do so.

There is an Escalation Plan in place – see appendix 4 that provides information for steps to take dependant on staffing and acuity levels which winter may affect.

Pharmacy

Pharmacy staff will work with medical and nursing staff to prioritise supply of medicines for discharge.

Wards should identify patients due for discharge on all ward areas as soon as possible and notify their ward pharmacy team accordingly. An e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Where possible, discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge.

Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines in their POD box or at home before a request is made to supply additional medications, which will enable pharmacy to dispense items which are genuinely required more quickly.

The weekend pharmacy service includes a dispensary service, available on both sites, and also a clinical pharmacy service to support medical admissions areas. This clinical team includes a prescribing pharmacist who will assist in prescribing medicines for TTOs. Pharmacy technicians will also be available each acute medical floor to improve reconciliation of medicines and also dispense any medications required for TTOs and counselling patients on their new medicines.

Out of hours an on-call pharmacist is available for urgent medication advice

Radiology

There is be a central contact point for in-hours escalation of specific issues – contact details are available to flow teams.

A second on-call system for the Emergency Department X-ray will enable extra capacity OOH during periods of exceptional demand throughout the winter period (November to March); triggers will be agreed with the ED team.
An innovation scheme supporting a new way of daily coordination is being introduced through winter to prevent delays and improve clinician access to radiologists.

Pathology

There will be a central contact point in each department for in-hours escalation of specific issues – contact details will be made available to flow teams in advance of the winter period

In the circumstances of increased demand for Pathology, Phlebotomy and Point of Care Testing services due to COVID or any other outbreak the service will be flexible to support demand.

Community Division

CHFT Community Healthcare Division staff accesses on-call support via the Trust on-call rota.

Priority 1 Clinical Services

The following services have been deemed as **Priority 1 Clinical Services:**

- District Nursing priority 1 patients (complex wound care, blocked catheters, administration of medications, OPAT and palliative care)
- Administration of medications including IV therapy and syringe drivers
- Support for discharge out of hospital
- Palliative Care
- Crisis Response Team
- Intermediate Care bed base
- IV Therapy priority one patients
- Palliative care priority one patients
- Gateway to Care
- Quest Matron support to Care Homes
- Community Respiratory Service
- Community Heart Failure Service
- Home Enteral Feeding
- Community Matrons
- Community Rehabilitation Team
- Podiatry- priority 1 patients (complex wound care)

Community Services Available

Gateway to Care

The service supports the co-ordination of intermediate care services and prevention of hospital admissions. The service accepts patient referrals from GPs, community clinicians, Social Workers and patients.
Referral should be made to Gateway to Care for the following services:

- Crisis Response Team
- Community Rehabilitation Team including Stroke early Supported Discharge Team, Falls Prevention Team
- Intermediate Care Beds
- Heatherstones

Hours of Operation	8.45am-5.30pm Monday to Thursday and 8.45am-5.00pm Friday
Contact Details	01422 393000

Intermediate Care

The intermediate care service is delivered by an integrated partnership of health and independent care home provider, ensuring a multi-disciplinary approach to care. Care is provided in one of our bed bases i.e.:

Bracken bed View (32 beds) and Heatherstones (12 apartments)

The Service Aims to:

- Promote a faster recovery from illness
- Prevent unnecessary presentation and admission to an acute hospital bed
- Prevent premature and unnecessary admission to long term care
- Maintain independence as long as possible

Service Criteria:

- Service user/patient must be over 18 years of age
- Medically stable
- A resident of Calderdale or Registered with a Calderdale GP
- Consent to rehabilitation

Hours of Operation	24 hours a day, 7 days a week
Referrals Accepted	Via Gateway to Care (in-hours) and via Crisis Intervention Team (weekends)
Lead Manager	Dave Nuttall
Contact Details	07785456582 (for IMC Beds)

Heatherstones provides temporary accommodation for adults for up to 6 weeks and facilitates early discharge, or prevents the need for admission to hospital, residential or respite care. The service is most appropriate for people who want to live independently but need short-term alternative accommodation or short-term help and support to achieve this.

The service aims to reduce individuals' dependency and reliance on direct services and prevent their level of need from increasing with people returning to their own home with the confidence and level of care required to enable them to cope long-term. Residents are expected to cook their own meals and do their own shopping and laundry. Reablement assistants provide support where needed.

Hours of Operation	Monday to Sunday 8.00am – 9.45pm 7 day service
Lead Manager	Nicola Gayle
Contact Details	01422 392229

Reablement

The Reablement service provides therapeutic care and support; with therapy care plans provided by CHFT community therapy team and then delivered by social care reablement staff. Access to reablement is via Gateway to Care following an assessment by a social worker.

Reablement is offered for up to 4 visits a day for a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned and a means test assessment will be undertaken to determine what financial contribution will be required by the individual.

Hours of Operation	8.00am-9.00pm, 7-day service
Lead Manager	Tracey Proctor
Contact Details	07748 797896

Reablement Team	Allocator	Contact number
Lower Valley	Julia Green	01484 728943
Upper Valley	Karen Willows	01422 264640
Central	Jo-Anne Rice	01422 383584

Enhanced Reablement

The Enhanced Reablement service provides early supported discharge for patients requiring a period of rehabilitation supported by therapists but who could manage in their own home

Reablement is offered for up to 4 visits a day for up to a period of 6 weeks with the aim to increase function and reduce dependence. If care is required following a period of reablement, a care package will be commissioned, and a means test

assessment will be undertaken to determine what financial contribution will be required by the individual

Hours of Operation	8am – 4pm
Lead Manager	Clare Folan
Contact Details	07879447218

Crisis Response Team

Crisis Response Team will provide support to someone in crisis in their own home for up to 72 hours. For example, if someone is struggling in their own home after a fall, or discharge from hospital where packages of care cannot start immediately. They also assess suitability for intermediate care beds. They are a responsive service and will assess within 2 hours for urgent referrals and 24-48 hours for routine referrals.

The team consists of nurses and a physiotherapist who undertakes assessments and set care plans. Rehabilitation assistants in the team offer up to 4 visits a day for a period of 72 hours with the aim to increase function and reduce dependence. If further reablement is required after 72 hours, the locality reablement teams continue the care.

Hours of Operation Assessors	8.00am–7.00pm 7 days a week
Reablement Service Work	8.00am-9.00pm 7 days a week
Lead Nurse	Susan Johnson
Contact Details	01422 307333/07917 106263

Specialist Palliative Care Out-of-Hours Team

This is collaboration between Overgate Hospice, Marie Curie and CHFT. This small team provide crisis support to people out of hours who are near the end of their life. The Specialist Palliative Nurse supports the person with symptom control, physical and emotional support and works with a Marie Curie Support Worker. They provide support to the person, carers and families.

Hours of Operation	7 day service
Lead Nurse	Abbie Thompson
Contact Details (9am-5pm Mon-Fri)	01422 310874
Contact Details (Out-of-Hours)	07917 106263

OPAT/ IV Therapy

This team provides antibiotic intravenous therapy to patients in their own homes. Patients remain under the care of their Physician or Consultant. This prevents some admissions and certainly reduces the LOS for many more.

- Patients have to be medically stable. Need to be under consultant referrals
- Commissioned for 12 administrations a day
- Compatible drugs need to be administered within 30 minutes

Hours of Operation	7 day/24-hour service
Lead Nurse	Jayne Woodhead
Contact Details	07795 825106

Community Nursing Services

District Nurses visit housebound patients that have complex health care needs. Patients that are able to be transported are expected to attend treatment rooms.

Hours of Operation	7 day/24-hour service
Contact Details Core Hours (8am-6pm)	07917 106263
Contact Details Evening/Night (6pm-8am)	07917 106263

Only **priority 1/urgent patients** are seen at night i.e. palliative care requiring symptom management, blocked catheters and patients requiring prescribed medication at agreed intervals.

Quest for Quality Service

CHFT has established a multi-disciplinary team consisting of community matrons, pharmacist, therapist and consultant geriatrician who caseload residents in all residential and nursing homes in Calderdale. This scheme's main role is to reduce the number of calls made to general practitioners to prevent avoidable admissions. They use Telecare and Tunstall Telehealth to promote health and wellbeing to the residents within the care homes.

The team have a responsive function to the care homes dealing with calls that would have been received by a GP and managing the residents. They also provide support to the care home staff to better manage their residents through training and education.

The pharmacist role has greatly helped with reviewing patient medication, reduction in polypharmacy and education and training of care home staff.

Hours of Operation	9am-6pm, 7 days a week
Lead	Susan Scriven
Contact Details	07770542879

Community Matron Service

Community Matrons provide a service to people with Long Term Conditions (LTC) who have complex health and social care needs which without effective case management are likely to result in the individual having repeated and avoidable hospital admissions and increased lengths of stay in hospital and frequent contact with primary care services.

They are based in localities with District Nursing Teams.

Hours of Operation	8.30am-4.30pm, Mon-Fri
Lead	Caroline Lane

Locality	Base	Matron	Contact Details
Upper Valley	Todmorden Health	Kim Scarlett	07833531624

	Centre	Sarah Howden	07901 518171
Lower Valley	Church Lane Surgery Rastrick	Sheila Kalanovic Mandy Kazmieski	07795825084 07795 825084
South Halifax	Stainland	Rachel Jackson	07768207663
North Halifax	Beechwood	Julie Norris	07770 734748
Halifax Central	Lister Lane	Louise Pedley/ Victoria Leah Jenny Dyson	07554110035 07795252396

Specialist Nursing

There are a range of specialist nursing services that support people in community settings.

Service Area	Hours of Operation	Lead Nurse	Contact Details
Bladder and Bowel	7.00am-4.30pm Mon-Fri	Joanne Hoyle	01422 252086
Respiratory	8.30am-4.30pm 7 days/Week	Sue Scriven	01422 307328
Heart Failure Cardiac Rehab	9.30am-5.30pm Mon-Fri 7.30am-4.30pm Mon-Fri	Clair Jones	01422 224260/ 07713 739144
Parkinson's	9.00am-5.00pm Mon-Fri	Sheryl McGin	01484 712515
TB	9.00am-5.00pm Mon-Fri	Mary Hardcastle Dale Richardson	07824 343770 07795 825070 01422 307307
Lymphoedema	9.00am-5.00pm Mon-Fri	Sarah Wilson	07557157096

Respiratory Team

During the winter period the Respiratory team will increase their working hours until 8pm and double capacity at the weekend to have two members of staff instead of one. This will enable the team to provide further focus upon key services offered to reduce pressures on the hospital:

- ESD – facilitating patients going home as soon as possible with support from the respiratory team 7 days a week
- Admission avoidance from ED 7 days a week, 9am-8pm
- Crisis management for community patients via the SPA. Direct telephone access for patients 7 days a week
- Admission avoidance from the community 7 days a week

Hours of Operation	8.30am-4.30pm 7 days a week
Lead Nurse	Gareth McMahon

Contact Details	01422 835195/07770542879

Cardiac Rehabilitation Services

Cardiac rehabilitation aims to support people to improve their physical health and quality of life, also to equip and support people to develop the necessary skills to successfully manage their condition.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Clair Jones
Contact Details	07825 054 496

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Early Supported Discharge for Stroke

This team provides support to enable patients who have had a stroke to be supported at home to reduce length of stay and increase function by facilitating people to be as active as possible. An enhanced service will be in place from November as part of the innovation scheme plans.

Hours of Operation	8.30am-5.00pm Mon-Fri
Lead Therapist	Sally Grose
Contact Details	01422 358146

Therapy Services

Therapy services provide interventions across in-patient, intermediate care and Community Services and will work flexibly across all areas to provide support where pressures manifest during the winter period.

Lead Manager	Debbie Wolfe 07825902363

Community Falls Service

The Falls Prevention Team is part of the Support and Independence Team who assess and advise people over the age of 50 who have had a fall or who are worried about their balance and frightened of falling. The team raise public awareness of falls and how to prevent them, identify older people who are at risk of falling using a simple five question screening tool, undertake detailed falls risk screening and refer patients to appropriate services to help, manage the risk of falling, provide education and advice to older people including advice on physical activity, diet, footwear and

environmental hazards. The team provide strength and balance groups in local settings and /or tailored exercises in older people's homes.

Hours of Operation	8.30am-5.00pm, 5 day service
Lead Therapist	Claire Folan
Contact Details	07879 447218

Senior Managers in Community Healthcare Division

Senior Managers on-call rota contact Calderdale Royal Switchboard on **01422 357171.**

Senior managers contact details are as follows:

Name	Role	Work mobile
Michael Folan	Director of Operations	07785416708
Liz Morley	Associate Director of Nursing	07747630989
Debbie Wolfe	Head of Therapy Professions	07825902363
Caroline Lane	Head Nurse	07713739144
Claire Folan	Community Therapy Service Manager	07879447218
Karen Turkington	Inpatient Therapy Services Manager	07468798613
Sarah Wilson	Matron for Community Nursing	07557157096
Susan Scriven	Matron for Specialist Nursing	07770542879
Abbie Thompson	Matron for Community End of Life Care	07747472125

Transportation and 4X4 Vehicles in Severe Weather

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. The Estates Department have access to a 4X4 vehicle. The Hospital Transport Service can also arrange to hire 4X4 vehicles through their vehicle contractor, Arrow.

The following voluntary organisations in Yorkshire and the Humber have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather.

The adult community nursing teams also work closely with Calderdale Council Adult Social Care to make best use of resources.

Equipment Ordering and Provision

Patients in the community may require equipment to keep them safe, assist daily living skills and improve mobility/function in their own home.

Physiotherapists, Occupational Therapists, Nursing Teams and the Crisis Intervention Team are regular referrers to access equipment. Equipment is arranged via the Loan Stores for Calderdale Royal Hospital patients based at the Community Support Centre, Salterhebble.

Loan Stores Hours of Operation	8.00am-4.30pm Monday-Friday 8.00am-12.00pm Saturday
Lead Manager	Andrew Mould
Contact Details	01422 261399

Escalation plans and business continuity plans

There are escalation plans that have been developed to support operations across all divisions. All escalation plans are found on the intranet, the ED and Paediatric escalation plan will be included in the On Call Manager's Pack.

Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services.

Cancer Pathway and Elective Pathway

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously and this will continue to be the standard we adhere too. Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of Consultants that are off at any one time over this period.

12. Severe Winter Weather- Impact on Service Delivery/Actions

Overview

Business Impact

- Absence of staff because they cannot get to work
- Difficulty for staff and patients to travel around and between sites
- Difficulty for community staff to access patients homes
- Increase in minor injuries from slips, trips and falls
- Reduced patient transport service
- Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities
- Difficulty for suppliers to get supplies to hospital

Likelihood \ Impact	1	2	3	4	5
1					
2				X	
3					
4					
5					

Proactive strategy

- Adverse winter weather plan in place and reviewed.
- Weather forecasts and gritting information published on the local authority websites.
- Stockpile of salt/grit for car parks and access ways to Hospital sites.
- Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes.
- Yorkshire Ambulance Service winter plan.
- Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work.
- Community staff advised to work to nearest location to their homes

Reactive strategy

- Implement flexible working arrangements where possible (adult community nursing)
- Implement the joint surge and escalation plan
- Contact Local Council Highways to request roads are gritted for essential appointments and discharges (this will not always be possible).
- Provide accommodation for essential staff who cannot get home from work
- Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible)

Trigger	Received by	Immediate action
Met Office Cold Weather Alert	Estates/Associate Director of Urgent Care	• Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments. • Clinical Site Commanders will assess the consequences for discharges • The Calderdale & Huddersfield Solutions have a planned process for maintaining the Hospital grounds. • Review by the outpatients and surgical management teams of impact on performance.
YAS PTS notification that journeys are affected or have been stopped	Clinical Site Commander	
Significant number of out-patient DNA	Outpatient manager	
Staff absence reporting	Department managers	• All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty. • Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager • All service areas will maintain up-to-date contact lists for all their staff • Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence. • Staff will be reallocated according to service need.

Cold Weather Alerts

Alert trigger	Trust Actions
OPEL 1 Winter Preparedness	• Work with partner agencies to co-ordinate cold weather plans • Work with partners and staff on risk reduction awareness • Plan for a winter surge in demand for services • Identify those at risk on your caseload
OPEL 2 Alert and readiness (60% risk of severe weather)	• Communicate public media messages • Communicate alerts to staff and make sure that they are aware of winter plans • Implement business continuity plans • Identify those most at risk • Check client's room temperature when visiting
OPEL 3 Severe Weather Action	• Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that staff can help and advise clients • Signpost clients to appropriate benefits • Maintain business continuity
OPEL 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days	• Activate emergency management arrangements • Communicate public media messages • Activate plans to deal with a surge in demand for services • Communicate with those at risk regularly • Ensure that the hospital sites are kept clear and accessible • Maintain business continuity

Road Clearance

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at:

http://www2.kirklees.gov.uk/winterUpdates/default.aspx
http://www.calderdale.gov.uk/transport/highways/winter-service/index.html

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations, the Local Councils may assist with road clearance where possible.

Kirklees Council will be operating "gritter twitter" this winter which gives real time information on the council's response to the winter forecast. This information can be used to plan journeys and has been used by schools to assess whether or not to

open. The link to twitter is can be found at the Kirklees Council weblink above. Calderdale Council regularly update their website with information about planned gritting routes during periods of severe weather.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the patient flow team who will be responsible for liaising with Kirklees Council Highways.

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

Managing absence

The Trust's Adverse Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

In the event that essential staff have difficulty getting to work and there are no alternate travel options, including car sharing or public transport, it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

Useful contact information

Organisation	Contact Name	Telephone / Email
4X4 Response	24hr call out number	Available in patient flow office
British Red Cross		
Calderdale Council Highways		01422 288002
		OOH 01422 288000
Calderdale Council Emergency Planning Team		01422 393134

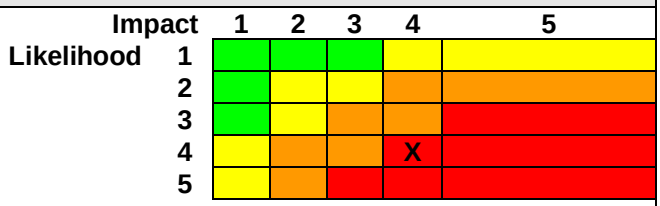
CHFT Accommodation		Via General Office
CHFT Hospital Transport Service		Via help desk
Kirklees Council Emergency Planning Team		01484 221000
Kirklees Council Highways		01484 414818
St John's Ambulance	24hr pager	Via switchboard

13. Seasonal influenza

Overview

Business Impact

- Absence of staff due to influenza illness
- Spread of the virus to staff due to ineffective use of personal protective equipment
- Lack of available supplies of personal protective equipment
- Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas
- Lack of available side rooms to isolate infectious patients
- Lack of available capacity on intensive care units to treat flu patients with serious illness
- Closure of ward areas and loss of bed days due to outbreaks of infection
- Increased monitoring and reporting requirements for flu-related activity



Proactive strategy

- Immunise staff for seasonal flu
- Community staff continue support people to stay at home
- Restate the risks and infection control requirements for managing flu patients
- Key messages reinforced by community staff
- Purchase additional supplies of face masks, gowns and goggles
- Create and manage a stockpile of FFP3 masks
- Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in A&E, ICU, Respiratory and MAU)
- Near patient testing in A&E for patients with suspected seasonal flu

Reactive strategy

- Promote key flu messages for patients (if you've got flu, stay at home)
- Follow standard infection control precautions for managing flu patients
- Reassign or redeploy staff in high-risk groups as appropriate
- Implement the joint surge and escalation plan
- Implement the escalation plan for critical care if required

Trigger	Received by	Immediate action
DH reporting - proactive	DIPC	• Alert forwarded by email rule to Director of Operations, Chief Nurse, Director of Infection Prevention and Control. • Staff in the Emergency Departments and out patient departments will remind relevant patients to have their flu jabs if they have not already done so. • Implement management of flu arrangements.
Surge in flu related activity	ED matron/CD	
Surge in flu admissions	Infection control team	

Infection Control

There is an expected surge of patients with respiratory illness e.g. Covid/Influenza in 2021/22. Guidance through public health and CHFT internal IPC team including the lead clinician will be managed through the Trust Tactical/Gold Meetings with all key partners within CHFT.

There will be near patient testing provided in the Emergency Department (ED) for patients with suspected seasonal flu and Covid. Patients that require admission with suspected or confirmed influenza/covid should be nursed in a side room with the door closed. A respiratory isolation sign should be displayed (further information on isolation of patients is available in the Isolation policy section K). All staff must wear personal protective clothing (PPE) as per latest guidance which is available on the trust intranet via the following link:- https://intranet.cht.nhs.uk/clinical-information/infection-prevention-control/coronavirus.

When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum.

If there are number of admissions with confirmed or suspected influenza/covid it may become appropriate to cohort patients in a single bed bay or ward area.
Some members of staff will be at greater risk from influenza/covid because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols

Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons and surgical masks.

A central stockpile of surgical masks, thumb in loop gowns and eye protection is established on each site. The stockpile is managed by the materials management team and accessible to the relevant wards and departments.

FFP3 masks or the positive pressure hood are required for specific infectious diseases (MERS and by staff performing cough inducing procedures for patients with suspected or confirmed infectious condition spread via respiratory secretions. FFP3 masks must be worn when performing the following procedures:

Defined Aerosol Generating Procedures (AGPs)	**PLEASE ENSURE WINDOWS ARE OPEN IF POSSIBLE, DURING AN AGP AS THIS WILL IMPROVE VENTILATION IN THE ROOM.** • Respiratory tract suctioning (excludes Oral/Oropharyngeal/Nasopharyngeal suction unless related to intubation/extubation) • Bronchoscopy • Tracheal intubation and extubation • Manual Ventilation • Tracheotomy or tracheostomy procedures (insertion or removal) • Upper ENT airway procedures that involve suctioning • Upper Gastro-intestinal Endoscopy where there is open suctioning of the upper respiratory tract • High-speed cutting in surgery/post-mortem procedures if involves the respiratory tract or paranasal sinuses • Dental procedures using high speed devices such as ultrasonic scalers and high-speed drills • Non-invasive ventilation (NIV) such as Bi-level Positive Airway Pressure ventilation (BiPAP) and Continuous Positive Airway Pressure ventilation (CPAP) • High-Frequency Oscillating Ventilation (HFOV) / High Flow Vapotherm & high flow Nasal Oxygen, AIRVO, • Induction of sputum using nebulised saline • Resuscitation including chest compressions • Cough assist devices (mask or vest)	All staff

Staff performing these types of procedures will include staff in ED, theatre, respiratory ward, ICU, and the acute floors in addition to staff groups such as Anaesthetists, Intensivists, endoscopists and physiotherapists (chest). Many wards and departments stock these masks, and the following wards are 'top up' areas:

HRI = PPE store on sub-basement

CRH = Side room on ward 4D

Fit Testing for FFP3 Masks

Prior to using an FFP3 mask the make/model and size of mask **MUST** be fit tested to the user to ensure a seal can be attained and the member of staff will be safe. Face masks come in various shape sizes so users can determine the most effective.

There are competent 'fit testers' in most clinical areas within the Trust who can carry out the assessment (register held on the intranet). Fit test kits are available from the IPC team for competent fit testers to use. It is the responsibility of the fit testers in each area to fit test their staff and to record the make model and size of mask that they require. Staff who have been fit tested are adding onto the equipment training database by the fit tester or the staff members manager.

Where a member or staff does not successfully fit test with the FFP3 mask used by the Trust, each management team must put in place appropriate risk mitigation measures to protect the member of staff from being exposed to a respiratory infection at work. This may involve:

- Training to use the positive pressure hood

- Reassigning to an alternative task

Positive pressure hood systems have been purchased for use in the emergency departments on both sites. Training is required prior to use by a competent user.

14. Christmas and New Year Bank Holidays

Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays over the Christmas, New Year period and the during this period when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period.

Reduced services

The Christmas and Bank Holiday arrangements for different services will be shared in the on-call pack which will be available in each Patient Flow office. Copies of the operational arrangements for theatres and clinical support services over the Christmas and Bank Holiday period will be again available for the on-call teams over the Christmas and New Year period.

Partner organisations

The Christmas and New Year cover arrangements for primary care, social care and safeguarding will be shared with the on-call teams for the Christmas and New Year period and stored in the patient flow offices on both CRH and HRI sites.

Communications

The Communications Team will issue media statements during winter to reinforce key health messages.
When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

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

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

Training and Implementation of the Winter Plan

The Divisional Director of Operations and identified leads for winter planning have overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by;

- Involvement of leads from each division in winter planning
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news
- Publication of related documents on the Preparing for Emergencies section of the staff intranet
- Publication of the plan on the Trust intranet
- Winter Plan briefings for Managers, Directors, Matrons, Ward/department sisters from October 2021
- To improve capability and resilience in CHFT senior management/clinical teams there will be a Table top exercise to test surge and escalation, the winter plan and major incident plans

Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement service policies and measures that meet the diverse needs of our service, population and workforce ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

Monitoring Compliance with this procedural document

The Deputy Chief Operating Officer and Divisional Director of Operations in collaboration with key service winter leads are responsible for the successful implementation and monitoring of the winter plan. The plan and its effectiveness will be reviewed throughout the winter period and learning shared and acted upon. The Urgent Care Board membership will also play a key role in the review process.

Associated Documents/Further Reading - Intranet

The Trust has a number of policies and plans that would be used in dealing with problems caused by winter conditions. They are both clinical and non-clinical and some are season-specific and others are for general use:
All can be found on the intranet- link
https://intranet.cht.nhs.uk/non-clinical-information/emergency-preparedness-resilience-response-local-secuirty-management-specialist/

a. Adverse weather policy
b. Pandemic influenza
c. Major Outbreak of Infection Policy
d. Emergency Management Arrangements
e. Escalation guidelines for the maternity units

f. Discharge Policy/Transfer of Care Policy

There are also some whole system plans that will be implemented as appropriate:
g. Joint Surge and Escalation & Winter Plan (2019/20 plan still in development)

APPENDICES

1: Criteria and SOP for open and referral to flexible capacity


Checklist on opening additional beds.docm

Paediatric Escalation Plan, Advanced Paediatric Nurse Practitioner Escalation Plan and Maternity Escalation Policy

APPENDICES 2, 3, 4, 5

2


20210805 Paediatric OPEL and Suspensic

3


20210805 NICU Surge and Escalatio


NICU Coordinator Escalation Guidance

4


C-84-2014 - Maternity Escalation F

5

Gynaecology Criteria

If the criteria to outlie are not met please escalate to the Matron for Gynaecology, On Call Duty Matron or Night Matron as appropriate.

- No acute delirium, confusion, disorientation
- Patient is not on the End-of-Life Care Pathway
- Minimal risk of falling

- For patients requiring re-ablement, intermediate or 24-hour care section 2 physio and OT referrals must have been completed
- NEWS within expected limits
- Patient does not require specialist nursing skills i.e., NIV, peg feeds, unstable cardiac symptoms, unstable diabetic, active seizures, probable CVA
- Patient with a known ongoing complaint/ grievance must have Senior review to assure that a move is in the best interest of the patient

Patient has not been admitted with a diagnosis of long term substance misuse (eg alcohol or drugs

6

HRI trauma surge pathway.docx

15. Director of Infection Prevention and Control Q1 Report

To Approve

Presented by David Birkenhead

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title:	Quarterly Director of Infection Prevention and Control (DIPC) report – 1st April 2021 to 30th June 2021
Authors:	Gillian Manojlovic - Senior IPC Nurse Lindsay Rudge - Deputy Director of Nursing / Assistant DIPC
Sponsoring Director:	David Birkenhead, Medical Director
Previous Forums:	None

Purpose of the Report

To provide the Board a report on the position of Healthcare Associated Infections (HCAIs) in Q1 from 1st April to 30 June 2021.

Key Points to Note

The Infection Prevention and Control (IPC) Board Assurance Framework (BAF) was updated on 30 June 2021, but some discrepancies were noted by the North East & Yorkshire IPC Lead Nurses and feedback via NHSE/I – a revised version is awaiting publication.

EQIA – Equality Impact Assessment

This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. Information on flu uptake has been analysed by ethnic group and reportedly separately.

Recommendation

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

IPC Report
1st April to 30th June 2021

1. Introduction

This report covers the period from 1st April – 30th June 2021 unless otherwise noted. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators. HCAI objectives not currently published for 21-22.

2. Performance targets

Indicator	End of year ceiling 2021/2022	Year to date performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	0	
C.difficile (trust assigned)	Objective expected to be minus 1 on 19/20 = **39**	10	7 HOHA = 1 preventable, 6 unpreventable *(1 further preventable case in July)* 3 COHA = 3 unpreventable
MSSA bacteraemia (post admission)	None set	0	
E. coli bacteraemia (post admission)	Objective awaited	8	8 post admission cases 13 COHA cases.
MRSA screening (electives)	95%	Not reported	Data accuracy issues remain. This will hopefully be resolved for the next report.
ANTT Competency assessments (doctors)	90%	79.24% (July data)	10% improvement seen since the last report. Divisions continue to be tasked to ensure medical staff complete ANTT assessment.
ANTT Competency assessments (nursing and AHP)	90%	91.35% (July data)	
Hand hygiene	95%	99.9% (July data)	
Level 2 IPC training	90%	92.4% (July data)	This continues as an e-learning package

COHA = community onset, healthcare associated
HOHA = hospital onset, healthcare associated

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	94.6%	
Isolation breaches	Non set	Not recorded this quarter	COVID-19 patients continue to take priority for side room isolation
Cleanliness	Non set	96.4%	

4. MRSA bacteraemia:

No cases to report during the current reporting period.

5. MSSA bacteraemia:

There have been no post-admission MSSA bacteraemia cases during the current reporting period. 2 cases have been reported to date in July. The IPC team will continue to review cases monthly.

6. Clostridium difficile:

The Trust awaits notification of the ceiling for cases in 2021/22. It is expected to be minus 1 case on the 19/20 objective, therefore 39 cases. The current number of cases is 10: (7 HOHA and 3 COHA).

All cases are subject to an investigation of which:

- 1 has been deemed as preventable,
- 9 unpreventable
- 0 pending.

A focused deep dive of last year's cases has been completed highlighting a number of key learning points with antimicrobial prescribing as a key issue in the increased incidence as well as timely sampling and isolation as areas for improvement. Divisions have been tasked with actioning the recommendations from the review.

7. E. coli bacteraemia:

There have been 8 post-admission *E. coli* bacteraemia cases during the reporting period, which is less than 20/21 when we had 12 cases. In addition, COHA cases are now recorded with 13 cases reported to date.

8. Outbreaks & Incidents:

8.1 Outbreaks

There have been 2 COVID19 outbreaks during the reporting period both of which are now closed (H17, C4D). All outbreaks are managed in line with COVID19 outbreak management guidelines and are monitored for 28 days. Issues identified included:

- Environmental issues especially difficult with maintaining social distancing for both patients and staff
- Mobile patients with cognitive impairment
- Staff attending work with symptoms

8.2 Healthcare associated COVID19 Infections (HOCI's)

All probable and definite HOCIs are investigated at CHFT following a process agreed with the divisions and the risk team. Any immediate learning is also discussed at the IPC gold meeting and communicated where relevant.

For this reporting period there have been 5 HOCI cases (4 definite, 1 probable). One issue highlighted as a possible source of infection that had not been noted as an issue previously was the socialising of patients with family and friends within the grounds of the hospitals.

8.3 Staff Covid test and trace

New guidance is being implemented to manage staff who are deemed essential to safe service delivery but would otherwise need to isolate. Staff testing and vaccine update is outlined in the Occupational Health report.

9. FFP3 FIT testing

The National programme to build resilience in the supply chain and reduce reliance on 3M as a manufacturer requires staff to be fit tested to at least 2 masks. In addition, further changes have been proposed by DH including repeat fit testing every 2 years and recording of fit testing in ESR. These changes are under discussion at IPC Gold.

The external fit testers should have finished in September, but it has been confirmed that this will be extended though no clarity as to how long.

10. Audits

COVID Assurance audits

Included in this is the following:

- IPC BAF framework self assessment – new framework is awaited
- Daily must do compliance by ward managers
- Weekly leadership walkround every Wednesday
- Weekly IPC Covid 19 assurance – completed by the Matrons
- 2 weekly FLO audits
- Night matron's assurance audit to monitor compliance OOHs to IPC and social distancing recommendations
- 7 day on site Senior Leadership rota

Quality Improvement Audits

The programme was put on hold during the reporting period, this has been reviewed and recommenced in May 2021.

Quality Priorities

The focussed Quality Priorities identified in 21/22 for reducing Hospital Acquired Infections including COVID 19. Our focus for this quality priority and actions to date are:

- **Implement patient testing strategies aligned to national guidance.** Elective testing pre-admission process in place; regular in-patient testing protocol implemented.
- **Support a system wide approach to the vaccination programme.** No update

- **Review and implement the CPE screening toolkit**: policy under review against the toolkit and feasibility of implementation of each element under discussion.
- **Reduce the number of preventable Clostridium Difficile infections**: deep dive completed, antimicrobial prescribing noted as the key issue in the increased incidence as well as timely sampling and isolation as areas for improvement. Divisions have been tasked with actioning the recommendations from the review.
- **Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection:** patient placement protocols and social distancing additional measures in place including masks for patients; regular in-patient testing protocol implemented; compliance monitoring in place.

FLO (Front Line Ownership) audits: These are carried out by clinical areas to confirm compliance with set elements of staff and patient safety indicators, teams identify where good practice and areas where standards need improving.

Quarterly FLO audits: These are completed by the IPCNs on acute areas, again these were put on hold during the reporting period, these will recommence in April and will be undertaken along the Matron and Senior nurse for the area.

11. Recommendations

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

16. Learning from Deaths Q1 Report

To Note

Presented by David Birkenhead

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title:	Learning from Deaths Q1 Report
Authors:	Cornelle Parker, Deputy Medical Director Mandy Hurley, Clinical Governance Support Manager
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	Quality Committee

Purpose of the Report

- To provide the Board of Directors with assurance of the Learning from Deaths (LFD) mortality review process
- To provide an update against agreed recommendations in relation to LfD approved in the annual report July 2021

Key Points to Note

1. In Quarter 1 (April – June 2021), there were 351 adult inpatient deaths. 12 of those deaths occurred in Covid+ patients
2. 18% of all in-hospital deaths have been reviewed using the initial screening tool (ISR) in Q1. This falls short of the 50% target for mortality reviews
3. Recovery plans are being agreed with the Respiratory and Elderly Mortality Leads, the specialities with the largest number of deaths, to achieve the 50% standard

EQIA – Equality Impact Assessment

Equality impact in relation to the impact of mortality on our local population in respect of gender, age and ethnicity is examined in detail in the Learning from Deaths Annual Report.

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 SJR. These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group.

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 of Directors is asked to **NOTE** the Learning from Deaths Q1 Report.

17. Guardian of Safe Working Hours Q1 Report presented by Devina Gogi, Guardian of Safe Working Hours

To Approve

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title:	Quarter 1 report (1st April 2021- 30th June 2021) from the Guardian of Safe Working Hours
Authors:	Devina Gogi, Guardian of Safe Working
Sponsoring Director:	Dr David Birkenhead, Medical Director
Previous Forums:	None

Purpose of the Report

The purpose of the report is to provide an overview and assurance of the Trust's compliance with safe working hours for Junior Doctors across the Trust for Quarter 1 2021/22 and to highlight and detail any areas of concern.

Key Points to Note

1. Overall decrease in exception reports in quarter 1 2021/22 compared to the previous quarter reflecting the return to a near normal working pattern
2. Efficiently filling the rota gaps in quarter 1 2021/22.
3. Successful hosting of Junior Doctors awards which was a recognition of the hard work and compassionate care delivered by junior doctors during the pandemic.

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 data is representative of the junior doctor population in the Trust.

Recommendation

The Board is asked to:

1. **NOTE** the Guardian of Safe Working Hour's Report for quarter 1, 2021/22.
2. **Acknowledge** the need for extra support and flexibility with training and rota for junior doctors in the next quarter as we enter the training recovery phase post pandemic

GUARDIAN OF SAFE WORKING HOURS REPORT (GOSWH)

Quarter 1 2021/22 Report (1st April 2021 to 30th June 2021)

1. Executive Summary

Quarter 1, 2021/22 included recovery towards a more normal work pattern/ rota in all specialities in CHFT. The COVID rota was changed to the pre COVID rota from Mid-March 2021.The number of exception reports have fallen significantly during this quarter compared to previous quarter.

The majority of exception reports were related to extra hours of working and were closed by overtime payments.

One work schedule review was done as 2 Exception Reports were submitted by the same doctor on 2 consecutive days highlighting a problem with Oncology helpline and staffing issues.

There were no immediate safety concerns noted in this quarter.

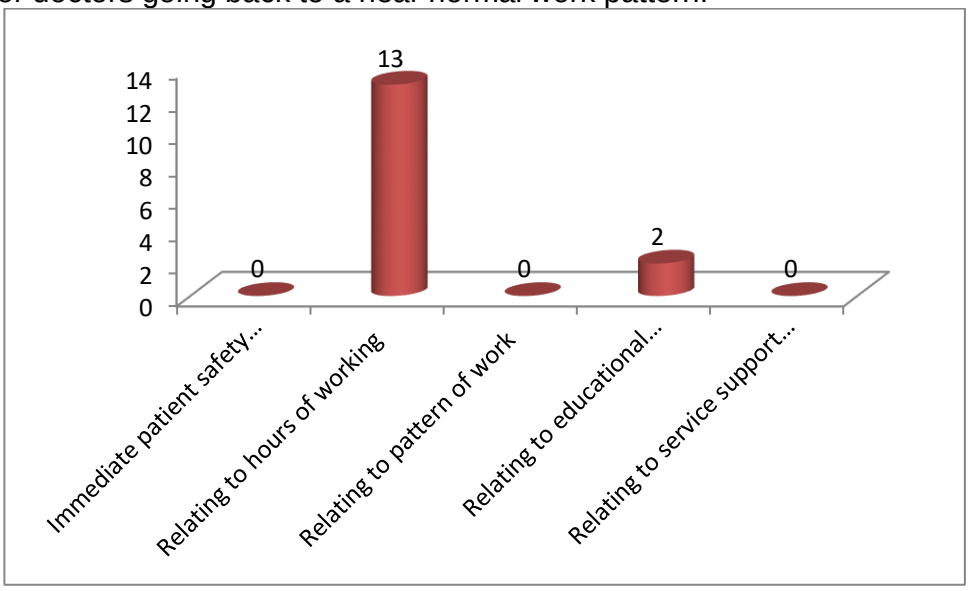
The gaps in the rota were filled efficiently by agency and bank locum and only 5% of the junior doctor's posts were unfulfilled across the trust.

The CHFT Junior Doctors awards were conducted virtually in May 2021 and were a great platform to applaud the hard work of the junior doctors during COVID pandemic.

2. Quarter 1 Report, 2021/22

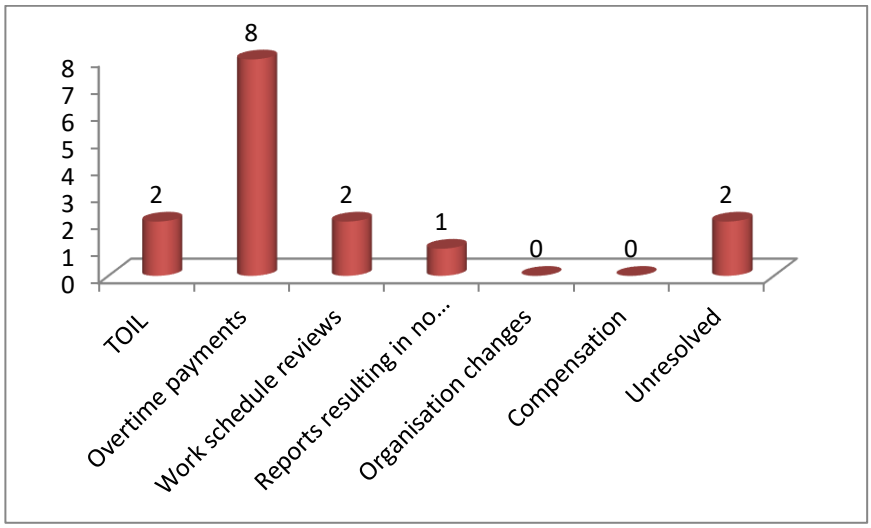
2 a) Exception reports and trends Quarter 1, 2021/22

There have been 15 Exception Reports (ERs) this quarter. This is significantly lower than the previous quarter. This coincides with returning to Pre COVID Rota and junior doctors going back to a near normal work pattern.



13 ER were related to hours of working while 2 were due to educational issues.

The two educational issues were related to loss of self development time for one Foundation Year 1 (FY1) and booking of clinic during protected academic meeting time for specialty trainee 4 in Neurology. Both these cases were highlighted to the management and administration team and resolved appropriately



The majority of the ERs were closed by overtime payments, two had TOIL (time off in lieu) and two were unresolved due to no response to the agreed outcome by the concerned doctor.

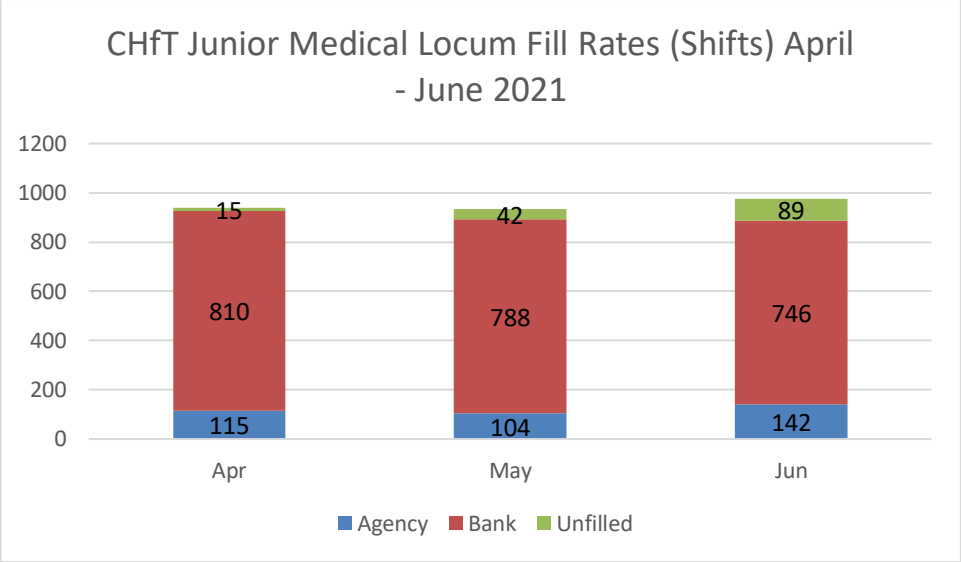
A work schedule review was related to two ERs on two consecutive days by FY1 in General Medicine which led to discussing the Oncology helpline and the staffing rota. This highlighted no presence of a twilight doctor, so regular issue of patients arriving at end of day and no specific person to handover to. This led to changes looking at the staffing at the end of the day or not accepting patients via helpline after certain time.

No guardian fines have been levied this quarter.

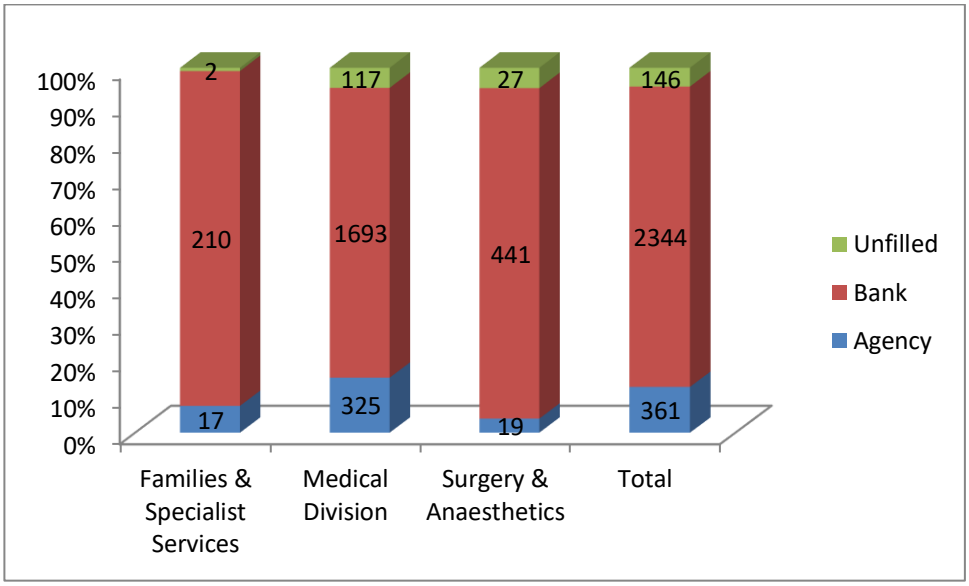
It is expected that there will be an increase in ERs in quarter 2 as currently training recovery issues are being highlighted.

2b) Rota Gaps between April to June 2021

The rota was changed to pre COVID ROTA from mid-March 2021. There were some rota gaps from April to June 2021 but they were filled by agency and bank locum.



The gaps were maximum in medical division but using the bank & agency locum the total unfulfilled posts were around 5%



2c) Junior doctor forum (JDF)

The JDF on 24th May 2021 was cancelled due to bereavement. There is one scheduled for September which will be reported on in the quarter 2 report.

2d) Junior Doctor awards 2020

In May 2021 we hosted the third 'CHFTs Got Medical Talent Awards ceremony". Due to COVID-19 the ceremony was held on line and the attendance rate was excellent.

All doctors employed by the Trust and working at a junior level could be nominated, as could teams of junior doctors, anyone could make a nomination. Approximately 280 doctors were eligible and we received 80 nominations. The categories were:

- Rewarding excellence in compassionate care
- Rewarding excellence in clinical leadership
- Rewarding excellence in medical education
- Rewarding excellence in research, audit and quality improvement
- Going above and beyond the call of duty.

We were not surprised that after a very challenging 12 months the 'compassionate care' and 'going above and beyond' categories received the highest number of nominations and the judges commented on how apparent it was that they juniors had really stepped up to the mark. What was also impressive was that despite the necessary focus on clinical work there were still excellent nominations for those who had established education programmes, supported medical students and become involved in research.

The junior doctors were really pleased that despite everything which was happening, he Trust had taken the time to organise and hold the awards

3. Recommendation.

At CHFT, the trainees returned to pre COVID rota after mid-March 2021. The return to near normal working pattern showed a decrease in ER in this quarter. However, it seems likely that there may be an increase in ER with regards to Educational opportunities in this next quarter as a number of training recovery issues are being highlighted.

Extra support and flexibility with training and rota to access educational facilities should be provided by the trust.

The Trust Board is asked to receive and note the Guardian of Safe Working Hour's Report for quarter 1, 2021/22.

Devina Gogi
Guardian of Safe Working Hours
September 2021

18. Safeguarding Annual Report

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	2 September 2021
Meeting:	Public Board of Directors
Title:	Safeguarding Adults and Children Annual Report
Author:	Andrea Dauris (Associate Director of Nursing – Corporate Services) Karen Burke (Named Professional Safeguarding Adults) Alison Pollock (Named Safeguarding Midwife)
Sponsoring Director:	Ellen Armistead (Executive Director of Nursing/Deputy Chief Executive)
Previous Forums:	Safeguarding Committee Meeting 3rd August 2021 Quality Committee Meeting 16th August 2021

Purpose of the Report

This report provides an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust for the reporting period April 2020 March 2021.

The report provides assurance to the Board of Directors highlighting key performance activity and information of how its statutory responsibilities are being met, and of any significant issues or risks, and how these are mitigated.

The report provides a focus on the work and commitment to safeguarding children and adults provided by the Safeguarding Team making reference to: -

- Prevent
- Safeguarding and Covid
- Hidden Harms
- Mental Capacity Act and Deprivation of Liberty Safeguards/ Liberty Protection Safeguards
- Training
- Adult Safeguarding
- Children's Safeguarding
- Mental Health
- Children Looked After Calderdale
- Domestic Abuse
- Safeguarding supervision

Key Points to Note

- During the Pandemic our focus has been to keep the base safe and in doing so we
- have achieved over 90% compliance in levels of Safeguarding Adults and Children,

FGM and Prevent competencies.

- For MCA DoLS training compliance level 1 has reduced to between 83.3 – 91.2% during the reporting period. This is possibly due to the training which was adapted for
- the Covid pandemic response with a self-declaration which has not yet been recorded.
- Safeguarding supervision is reported at 64.5% in March 2021 and improvement work continues in partnership across all divisions.
- We have maintained a business as usual functionality throughout the pandemic, conti nuing with day-to-day operations and attendance at multi-agency virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Calderdale and Kirkle es and their sub-groups
- Discharge quality improvement work with partner agencies (under the SAFER service improvement agenda) continues to work towards the improvement of the quality of hos pital discharges.
- The service level agreement with SWYPFT was updated to ensure that mental health services provided to CHFT continue effectively.
- CHFT ward staff have continued to make Deprivation of Liberty Applications throughout the pandemic ensuring the rights of our patients are safeguarded. These have continued to increase in 2020-2021 showing a maintained awareness amongst staff to ensure the Human Rights of patients are protected.
- From July 2020 Review Health Assessments carried out by the Children Looked After Team in Calderdale have been carried out virtually. Initial Health Assessments have a chieved 100% compliance with the exception of November 2020 achieving 74%. Revi ew Health Assessments achieved >95% compliance.

EQIA – Equality Impact Assessment

Equality impact assessment forms the basis of much of the work of the Safeguarding Team. The role of the team is to ensure that those in the most vulnerable groups are protected from harm.

Recommendation

The Board is asked to **NOTE** the key highlights of the report and activity of the Safeguarding Team for the reporting period April 2020-March 2021.

1. INTRODUCTION

This report is the Safeguarding Adults and Children annual report for the Trust Board, for the reporting period April 2020 – March 2021.

The report provides an overview of activity and outlines key achievements and developments on both the progress of the annual report priorities and our safeguarding strategy for 2020-22.

The report will focus upon our safeguarding response to the Covid-19 pandemic and the challenges it has posed, whilst providing assurance that Calderdale and Huddersfield Foundation Trust (CHFT) has fulfilled its statutory safeguarding responsibilities.

2. PREVENT

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

CHFT Safeguarding Team undertake regular patient searches and share information regarding potentially high-risk patients with Prevent partner agencies. We also attend Channel panel meetings to discuss individual cases to understand their vulnerability to being drawn into terrorism activities and engage with the person and partner agencies (e.g., CAMHS, housing, Social Serves) to make positive changes in the person's life.

CHFT had developed a small number of Prevent Champions to deliver Prevent training but this is now delivered by Government approved e-learning. Face to face training for apprentices will recommence after the pandemic restrictions are fully lifted. Some further work is required to determine if the Safeguarding Champions are confident in their Prevent counter-terrorism responsibilities.

CHFT have met its statutory responsibilities with the key achievements set out below: -

Key Achievements

- All staff receive Prevent Wrap training.
- Our training compliance has remained consistently above 90% throughout the year.
- Prevent activity and information is shared quarterly with NHSE and our Designated Safeguarding Nurses in the CCG.
- CHFT Safeguarding Team attend Channel panel meetings where partner agencies discuss individuals in the pre-radicalisation phase to prevent them being drawn into terrorism.

Priorities 2021-2022 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Explore the role of Prevent Champions and increase numbers if required.

3. SAFEGUARDING AND COVID

The Coronavirus Act 2020 did not suspend professionals' duties to safeguard children and adults or their responsibility to comply with the Mental Capacity Act/ Deprivation of Liberty Safeguards during this challenging time.

The Safeguarding team have maintained the safeguarding service consistently throughout the pandemic, ensuring our key statutory roles were maintained. There have been several changes to the team with the recruitment of a new Head of Safeguarding, Named Midwife for Safeguarding, Named Professional for Adult Safeguarding and a Safeguarding Adults Practitioner. The 1.0 WTE Named Nurse for Safeguarding Children has now been successfully recruited to. A further vacancy in the 0.8WTE Named Nurse for Safeguarding Children, due to a member of staff retiring provided an opportunity to develop a band 6 Specialist Advisor in Children's Safeguarding and Maternity which has also been recruited to.

Given the gap in cover arrangements the team have prioritised essential safeguarding work and informed key partners of the staffing position.

Feedback regarding Adult Safeguarding initial investigations to the Local Authority, is not meeting the multi-agency agreed timeframes which are defined in the multi-agency safeguarding adult's policy. This is due to a variety of reasons including:

- Outstanding investigations were inherited by the current team.
- Ward staff are on sickness leave or self-isolating and so incidents are unable to be concluded.
- The Datix system does not smoothly reflect the requirements of the adult safeguarding team
- Immediate actions were taken to address this issue. It was placed on the safeguarding risk register and options were discussed with the Kirklees Local Authority (LA). It was agreed with Kirklees that some low-risk quality issues would not be investigated under Section 42 of the Care Act (2014) but would be raised internally at CHFT through the Discharge Improvement Group. Additionally, in recognition of the operational pressures that staff are under, Kirklees LA agreed that there could be an informal "pause" on the timescales (as they are not a statutory requirement). The adult safeguarding team also worked closely with the Datix team to explore the use of a safeguarding module on the Datix system to make the process more efficient and easier to manage for hospital staff.

CHFT saw a significant reduction of children and adults attending the emergency departments in April and May 2020 resulting in a reduction in the number of safeguarding referrals CHFT made to both children and adult social care. Since then there has been a steady increase of children and adults attending the emergency departments.

The Safeguarding Boards and Partnerships were kept fully briefed and updated throughout this period. The Safeguarding Team have fulfilled all partnership requests for information and have contributed towards several safeguarding reviews during this period. Significantly, in Burnt Bridges, a SAR report, the health issues of people with multiple and complex needs, including those leading street-based lives were identified. The multi-agency work streams arising from this report, along with the Making Every Adult atter (MEAM) and trauma

informed practice approaches, should improve the health outcomes of patients with such complex needs and may address some local health inequalities.

Self-neglect has been a significant theme in SARS during this period and the self-neglect pathways and risk escalation conferences are in regular use. Other SAR reports have identified the use of the Mental Capacity Act (MCA) with patients who may have difficulties with their executive functioning (such as those with substance misuse problems, head injuries and phobias etc). We have updated the MCA policy to reflect this area and have inputted into various groups (such as the High Intensity User group) to ensure that recent case law is drawn to the attention of staff working with people with complex needs. The bespoke face to face training programme also includes this area.

We have seen several complex mental health patients (adults and children) over the last year and continued to be involved pro-actively with Divisions. The team have prioritised essential safeguarding work and maintained the key health practitioner role in the Domestic Abuse Hub. In line with the national trend during the pandemic there has been an increase in children admitted with non-accidental injury, particularly in the under 1's. In response to this CHFT has been involved in the roll out of the ICON programme (I-Infant crying is normal; C-Comforting methods can help; I- It's ok to walk away; N- Never shake a baby).

Key Achievements

- We have carried out business as usual within the team and continued to maintain our operational service throughout.
- Due to the pandemic restrictions, our level 3 training has not been delivered face to face this year with our packages and videos being placed on the intranet for staff to complete. We have developed an updated level 2 Safeguarding Children's and Adults combined E-learning package which includes MCA and DoLS level 1. A national E-learning package for MCA DoLS has been identified and with additional bespoke sessions it was agreed via the safeguarding committee that some staff groups will need to complete this further training, to ensure they are adequately equipped with the foundation for the effective implementation of the Liberty Protection Safeguards in April 2022.
- We have sent our Kirklees and Calderdale partners assurances regarding our business continuity arrangements.
- We have continued to attend virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Kirklees, and their safeguarding subgroups.
- Met regularly with our CCG Designated Nurses for Adults and Children.
- We have seen benefits to the virtual approach to training allowing staff to attend mandatory and bespoke training via Microsoft teams, improving Divisional and Trust compliance.
- During Q1 we reduced the frequency of the Safeguarding Committee and Operational Group in response to the pandemic. This has now returned to business as usual.
- Maintained our mandatory FGM and Prevent reporting responsibilities and submissions to NHSE.
- Held a virtual Safeguarding Week in the Trust in September 2020 to continue to raise awareness with staff regarding their safeguarding responsibilities.
- We have supported operational frontline staff in paediatrics, PPE, and the vaccination programme.

- Through our 'think family' approach we have distributed 7-minute briefings throughout the year on safe sleeping, MHA/MCA and Children/ Lived experience of the child/ adverse childhood experiences/ Dependent baby protocol/ conducting virtual contacts/ Young carers and safeguarding supervision.
- We presented at Friday morning briefings to senior staff on the MCA, DoLS, Domestic Abuse and Making Safeguarding Personal
- We successfully bid for a Ministry of Justice grant of approximately £62,000 to fund a Health IDVA to be based at HRI for two years.
- Developed a Safeguarding / Covid 19 intranet page resource for staff.
- Increased awareness of the ICON programme amongst CHFT workforce (ED, Maternity, Paediatrics and band 7 weekly meetings) and the public via social media and poster campaigns
- Collaboratively our Mental Health Liaison Team (SWYPFT) have worked in partnership with CHFT to reduce prolonged waits in the Emergency Department during this unprecedented time.
- We shared 'top tips' in carrying out virtual assessments to senior staff and circulated briefings and reminders to ensure safeguarding continued to be a priority and contributed to training being delivered.
- Safeguarding supervision is being delivered remotely as are our internal and multi-agency meetings.
- Worked collaboratively with Joint Security Operations Group, the security teams and the Resilience & Security Management Specialist to consider issues such as restraint of vulnerable patients, manging patients with behaviours that challenge others and to consider the Violence Protection Standards.
- Worked with colleagues to contribute to updating policies and procedures in line with the Mental Capacity Act (e.g. the Consent policy, Community Dysphagia policy, the Non-Concordance procedures, Management of Patients Not Brought to Medical Appointments and the Discharge Against Medical Advice document).
- Provided the CCG with Safeguarding Provider Assurance through position statement mechanism
- Supported completion for a multi-agency health audit reviewing communication between health agencies when a case has been referred to the DA Hub

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan

- Continue to work with Divisions ensuring that safeguarding adults and children and domestic abuse is part of all considerations when managing the re-introduction of services
- Review the recommendations from the Domestic Abuse Bill (April 2021) which will include training,
  staff updates and policies and procedures that may impact on practice
- Review the Domestic Abuse Policy
- Continue to learn about the impact of the Covid 19 pandemic in relation to safeguarding children and adults at risk and how this is influencing safeguarding practice

3.1 Hidden Harms

Crimes such as child abuse, child sexual exploitation, domestic abuse (including "honour"-based abuse), sexual violence and modern-day slavery, typically take place behind closed doors, hidden away from view. The Coronavirus measures risk making these crimes more prevalent and less visible.

Following the Hidden Harms summit hosted by the Prime Minister in May 2020 several national changes were proposed and recognised by the Safeguarding Partnership Board as priority areas. A summary of the national changes are reflected below: -

- Victims will be able to signal to staff in participating outlets, such as supermarkets and pharmacies, by using a code word for Domestic Abuse that they need immediate support.
- The National Crime Agency to improve its ability to tackle perpetrators seeking to offend against children via the Dark Web.
- A whole systems approach to co-ordinate data, intelligence, and tasking to tackle overlapping forms of exploitation.
- Improving intelligence gathering and analytical capability of the Regional Organised Crime Units and using that intelligence to deliver a Prevention Programme to target local activity on exploitation.
- Improve the quality of support available for victims and survivors of child sexual abuse and encourage collaboration between commissioners, providers, and communities over the next two years.
- Local authority-led projects in 11 areas in England working with adolescents at risk of sexual and criminal exploitation and peer-on-peer abuse.
- Increase prosecutions for modern slavery offenders and to mobilise forces to crackdown on organised immigration crime

Key Achievements

- We work in partnerships with our safeguarding adults board and children partnerships to share information and collaborate.
- Promoted the use of the Partnership Intelligence Portal for staff to feed in soft intelligence to the police in relation to gangs/County Lines and Modern Day Slavery. The Police use this information which prompts targeted work within our Districts.
- Attendance at local partnership meetings for children and young people at risk of exploitation
- We flag hospital records of children/ young people at risk of exploitation
- We have successfully used the under 18 and adults at risk CHFT bespoke proforma that has key questions in place in relation to vulnerability in gynaecology, sexual health and midwifery. This has now been built into EPR.
- Linked in with National Safeguarding Children Professional meetings to benchmark other regional trends in safeguarding children.
- We have monitored our safeguarding data closely throughout the year and noted

increases in children on a child protection plans and those coming into care in the autumn.

Whilst noting these increases we have continued to carry out safeguarding children medicals, initial and review health assessments by our Children Looked After team or our safeguarding team.

- Continued to deliver bespoke training to ED staff regarding Contextual Safeguarding.

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Provide updates to staff post Domestic Abuse Bill (April 2021)
- Review the impact that the Covid 19 Pandemic has had upon the emotional wellbeing of pregnant women, there is a planned audit due in quarter 2 reviewing perinatal mental health
- Continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multiagency meetings to share intelligence around this
- Develop awareness and training regarding the under 18's and adults at risk safeguarding proforma.
- Raising awareness of the Making Every Adult Matter (MEAM) agenda in conjunction with partner agencies.

4. MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Department of Health and Social Care issued guidance in April 2020 emphasising that the principle of the MCA and the safeguards provided by DoLS still apply.

All CHFT DoLS applications are quality assured by the adult safeguarding team providing evidence that the restrictions on the patient, that amount to a deprivation of liberty, are the least restrictive and in the patient's best interests, in addition to meeting the statutory requirement for an urgent DoLS authorisation and an application for a Standard Authorisation. Once the Standard Authorisation has been granted, the team ensure that any conditions on CHFT are complied with and that the Relevant Persons Representative (RPR) or Paid RPR is identified in the patient's records. We continue to work closely with the Independent Mental Capacity Advocate (IMCA) service.

4.1 DoLS Data in Q1, Q2, Q3 and Q4

	Number of Urgent DoLS Authorisations	Number of Standard Authorisations	Average p/month
2018-19	145	5	12
2020-21	191	0	16

The number of Urgent Authorisations reflects CHFT staff commitment to protecting the Human Rights of their patients. Patients have not usually been assessed for a Standard

Authorisations (by the Supervisory Body) as either the patient has been discharged, successfully treated or have regained the mental capacity to consent to their care and treatment arrangements. In some situations, staff have been able to use less restrictive care practices to prevent the patient being deprived of their liberty.

4.2 The Mental Capacity (Amendment) Bill

The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The purpose of the Bill is to provide a simplified legal framework and authorisation process which is accessible, clear, delivers improved outcomes for people deprived of their liberty and place the person at the heart of decision making. Because of the Covid-19 pandemic, the Minister for Care has deferred the implementation of the LPS to April 2022.

Implications for CHFT

This is a significant piece of statutory work which will include several departments to ensure the implementation is effective. There will be a transition period during which existing Authorisations will remain valid.

Hospitals (the responsible body) will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager).

- Referral pathways and authorisation process will need to be considered.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
    - The person lacks capacity to consent to the care arrangements
    - The person is of unsound mind
    - The arrangements are necessary and proportionate

  All 3 of the above criteria must be met
- The Authorisation can be used in a variety of settings (i.e.) those who live at home and have respite care and a day centre.
- Staff will need to be trained and aware of what the new Liberty Protection Safeguards (LPS) constitute as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP) – when the patient is objecting to the arrangements. The role of the AMCP is to carry out a pre-authorisation review and to determine whether to approve the arrangements.
- From final publication of the Code of Practice there will be approximately 6 months for successful implementation.
- The LPS will apply to children aged 16 and 17

CHFT are ensuring that the implementation of the LPS is a smooth process for staff, patients and their families. The local implementation network (LIN) is being re-established and there are regular meetings with the CCG lead and an internal draft action plan has been developed.

Key Achievements

- Referrals during the period April 2020-March 2021 have increased showing an awareness with staff to ensure the Human Rights of our patients are maintained
- Quality assured all referrals made by ward staff
- Developed a digital mental capacity assessment form which has been placed on

EPR.

- Updated the MCA DoLS Policy
- Bespoke training sessions have been developed

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Provide detailed report to the Executive Board regarding the Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- Develop a strategic implementation plan and implement LPS with digitized documentation.
- Review Trust Safeguarding Team resources to implement the new LPS scheme including staff recruitment, training across the Trust, new processes and expertise.
- Continue to ensure that all staff are trained in the Mental Capacity Act according to their role.
- Continue to work with our local networks and partners to ensure successful implementation.
- Audit the use of the MCA in relation to DoLS.
- Deliver bespoke MCA training to those who work with children to ensure a foundation for LPS implementation.

5. TRAINING

The Covid-19 pandemic infection control changes meant that CHFT stopped face to face training. To ensure we maintained safeguarding training for staff, it was moved to an e-package, available on the Safeguarding intranet pages enabling staff to complete these and self-declare their compliance. We supplemented this training through regular updates and briefings though divisional Patient Safety and Quality Board meetings, supervision sessions, and bespoke training. During this period, we have developed and worked on an alternative approach that will ensure our compliance with both Intercollegiate documents for adults and children. This has now been approved at the Safeguarding Committee.

As part of our re-stabilisation of training it was proposed and accepted at the Safeguarding Committee that CHFT safeguarding and MCA DoLS training is delivered via an eLearning package and bespoke training to ensure that staff are confident in their role requirements to undertake mental capacity assessments and correctly follow the Best Interests decision-making process. MCA and DoLS training packages at level 2 and level 3 will be separate to ensure staff meet the MCA training requirements and prepare the Trust for the implementation of the new Liberty Protection Safeguards.

Figure 1 indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee. As of March 2021, overall compliance was at 92.84%.

	31.03.2020					31.03.21					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	5842	21938	20155	1783	91.87%	6063	23284	21618	1666	92.84%	0.97%
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %						
NHS|MAND|Mental Capacity Act - 3 Years|	285	285	277	8	97.19%	237	237	208	29	87.76%	-9.43%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3254	3254	2960	294	90.96%	3312	3312	3081	231	93.03%	2.07%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	639	639	582	57	91.08%	648	648	592	56	91.36%	0.28%
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NHS|MAND|Safeguarding Children Level 3 - 3 Years|	545	545	437	108	80.18%	561	561	538	23	95.90%	15.72%
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	81	81	47	34	58.02%	86	86	56	30	65.12%	7.10%
372|LOCAL|Safeguarding Supervision|	595	595	358	237	60.17%	631	631	407	224	64.50%	4.33%
Grand Total	5842	21938	20155	1783	91.87%	6063	23284	21618	1666	92.84%	0.97%

Key

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

(Figure 1)

5.1 Exception reporting: Receipt and Scrutiny Training and Safeguarding Children Supervision.

Mental Health Act Receipt and Scrutiny training is delivered virtually over Microsoft teams by SWYPFT MHA administrators to CHFT senior nurses who would accept MHA section papers on behalf of the Trust.

The levels of Receipt and Scrutiny (of statutory Mental Health Act documentation) training has gradually increased from an average of Trust staff of 58% in April 2020 to 65.1% in March 2021 and recent data is more encouraging. Issues regarding staff completing a post training questionnaire have impacted upon training figures, however this has now been rectified.

Further training dates have been planned for 2021-2022.

Safeguarding Childrens Supervision is delivered virtually though Microsoft teams and compliance has increased by 5% since April 2020. The Committee has sent out Divisional reports to review and action to increase this compliance. Additional staff have been trained in providing safeguarding supervision with the intention of improving current levels of compliance.

Work has been completed with Maternity to ensure that all Community Midwives have an allocated supervisor. A reflective case study has been introduced into the Midwives day 2 training to capture safeguarding supervision. Compliance continues to be monitored.

Key Achievements

- We continue to engage and share training compliance with Divisions bi-monthly
- Maintained high levels of MCA DoLS and safeguarding training levels throughout the year
- Delivered bespoke training sessions to teams though virtual technology in relation to the MHA and MCA.
- Reviewed delivery and content of the Level 2 and 3 Safeguarding Training/ MCA/ DoLS training

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Implementation of Safeguarding Training to ensure ongoing compliance with the Intercollegiate documents.
- Continue to share compliance reports with Divisions.
- Update of the Supervision Policy to include Adult Supervision and develop local supervision models for staff who work primarily with adults is in progress
- Continue to promote attendance at the Receipt & Scrutiny training delivered by SWYPFT Mental Health Act Office.

6. ADULT SAFEGUARDING

Safeguarding adults is a statutory requirement under the Care Act (2014). Safeguarding adults means protecting a person's right to live in safety and free from harm, abuse, and neglect.

Monthly analysis of safeguarding data identified an increase in safeguarding referrals made against CHFT largely in relation to concerns regarding poor discharges in November and December 2020 to both Calderdale and Kirklees Local Authorities. Analysis of the data indicates this coincided with the second surge of the pandemic. This position was shared at Safeguarding Committee meetings which has representation from the four divisions. The Safeguarding team are working with local authority partners to ensure oversight and investigation of all these cases. Kirklees Local Authority have agreed that poorly managed discharges can be managed by a different approach by CHFT and are deemed concerns.

The discharge concerns include a variety of areas, including:

- Patients being discharged by the use of inappropriate transport (e.g. a taxi service for patient with dementia who asked to get out before he reached home and was missing for several hours)
- Lack of communication with family or community care providers
- Vulnerable patients being discharged in the night from ED
- No written information provided to care providers
- Lack of correct medication/dressings etc being sent with patient on discharge.

- Lack of correct equipment in place for patient to be safe at home
- Medication being sent after patient left hospital, via taxi to an incorrect address.
- Care packages not being started or restarted.
- Patients being discharged with cannulas in place
- Patients with dementia and at risk of falls not being assessed before discharge.

These issues were quickly identified, and it was acknowledged that with redeployment of staff during the pandemic and the rapid turnaround for discharge may have unfortunately contributed towards some of these issues. Some rapid responses were introduced which included a new standard operating procedure implemented in the Emergency Departments regarding the discharge process. The CHFT dementia lead is now in post and is made aware of poor discharges of patients with dementia.

Chart showing ineffective discharge data for April 2020-March 2021

Overall 19/20	**33**
Overall 20/21	**105**
Q1 data	35
Q2 data	10
Q3 data	34
Q4 data	26

Whilst several rapid actions have already been implemented, further work is required and will be overseen by the SAFER quality improvement team which will include representation from the Safeguarding team.

Key Achievements

- Developed the Was Not Brought Policy for adults at risk
- Reviewed the Missing Persons Policy.
- CHFT Established and implemented a Discharge Quality Improvement Group which is part of the SAFER quality improvement programme representation from key partners to drive further quality improvement in this area.
- Adult Safeguarding worked closely with Kirklees Local Authority to agree that the increased number of ineffective discharges could be managed internally by CHFT via the Discharge Improvement Group as opposed to formal individual Care Act (2014) Section 42 investigations.

Priorities 2020-21 (including actions from 2020-22 Safeguarding Strategy workplan)

- Streamline safeguarding processes and investigations.
- Systems approach to embed learning (i.e. Multi Agency Audit programmes)
- Working with the new Lead Nurse Children to progress the embedding of the Transition Policy

7. CHILDREN SAFEGUARDING

CHFT is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children - 2018,'the Children Act 1989/2004 and to joint working with both the Calderdale and Kirklees Safeguarding Children Partnerships. The Trust works within the West Yorkshire Safeguarding Children Policies and Procedures for the protection of all children who attend CHFT.

CHFTs' safeguarding responsibilities are effectively discharged by the provision of day to day advice, supervision, support and promoting good professional practice. This includes identifying the training needs of all staff and volunteers in relation to safeguarding children and delivering a comprehensive mandatory programme of training, which includes key safeguarding messages from research, safeguarding incidents, and child practice safeguarding/ learning lessons reviews.

Key Achievements

- Additional staff trained to facilitate mandatory safeguarding supervision in maternity services especially in the community setting, NICU and our Matron for Learning Disabilities who will lead safeguarding supervision with all matrons.
- Developed a Children Mental Health Policy with CAMHS and Paediatric services.
- Robust oversight of paediatric patients who have mental health concerns and closer working with the paediatric department.
- Developed a risk assessment tool and care plan for children and young people with mental health needs to ensure patient safety on paediatric wards.
- Reviewed the Children's DNA policy to develop the Children's Was Not Brought policy
- Review of the recommendations from the 2016 and 2018 Children's Looked After and Safeguarding CQC inspections and provide assurance to the CCG's in relation to embedding and monitoring of these

Priorities 2020-21 (including actions from 2020-22 Safeguarding Strategy workplan)

- Map other areas that may need review of safeguarding supervision processes and include establishing robust safeguarding children's champions.

8. MENTAL HEALTH

CHFT works in partnership with SWYPFT formally through the service level agreement and the clinical working protocol. We are using the values described in our 4 pillars in developing a mental health strategy with our partners though the Mental Health Operational Group. There are reciprocal representatives and papers shared at SWYPFT's Mental Health Act Committee and CHFT's Safeguarding Committee meeting, and we continue to work in close partnership to meet the needs of our patients.

The Mental Health Liaison Team (MHLT) support and work with CHFT trust staff to ensure that all patients who are referred are reviewed and supported in a timely way.

In line with NHSE the Five Year forward View for Mental Health (NHSE February 2016), the MHLT has transitioned to become an all age service for CHFT. From December 2020 the on-site team see all referrals from the Emergency Department of all ages between the hours of 8pm and 9am. During office hours the MHLT see adults and CAMHS see children. By seeing children and young people during this out of hours period the response time is quicker and the mental health needs of our children and young people are met in a timelier manner; staff caring for our young patients have access to advice and support throughout a 24 hour period. Mental Health Act assessments continued to be carried out by CAMHS Consultant for children and young people throughout the 24-hour period.

An adult safeguarding team representative attends the Mental Health Operational Group and also the multi-agency Suicide Prevention Action Group.

Key Achievements

- An audit in 2020/'21 in relation to the NCEPOD Standards (Treat as One 2017), provided assurance that the MHLT robustly and consistently ensure that there is contemporaneous documentation in the patient records in line with these standards.
- The Department of Health and Social Care (DHSC) and NHS England (NHSE) have provided guidance to professionals on the use of the Mental Health Act during the pandemic.: The Court and Tribunals Department instructed the MHA office to carry out their functions remotely during the Coronavirus period Mental Health Act Tribunals and Hospital Managers hearings have been carried out remotely on our wards co-ordinated by the MHA Office (SWYPFT).
- The MHA office took a similar position in relation to the hospital managers' hearings. This has effectively ensured our patients' rights to appeal have been discharged throughout this period.
- The Safeguarding Team have continued to support the MHA Office with their scrutiny and reporting mechanism.
- The Service Level agreement between SWYPFT and CHFT has been re-reviewed and signed for a further 12 months.
- There are honorary contracts in place for Consultants who work for SWYPFT and based in the Mental Health Liaison Team.
- There has been a change on December 1st to the Statutory Forms for detaining and serving MHA papers to CHFT patients. The transition period has ended, and the safeguarding team have worked with SWYFPT MHA to change and distribute new paper and electronic packs.
- Additional training dates provided to improve compliance with Receipt and Scrutiny training

Priorities 2020-21 (including actions from 2020-22 Safeguarding Strategy workplan)

• "Reforming the MHA" White paper Consultation took place and the Government has now published its response to the Consultation. When more information becomes available, CHFT will consider the proposals and ensure that policies and procedures are updated

accordingly. There may be changes to the Mental Capacity Act policy and procedures that will need to be implemented. .

- The Joint working Protocol is being re-reviewed in line with changes to the working arrangements in the Mental Health Liaison Team. Not sure about this
- Embedding of new processes for electronic submission of forms related to detaining and serving of MHA papers
- Promoting MHA receipt and scrutiny training to improve compliance.

9. CHILDREN LOOKED AFTER AND CARE LEAVERS (CALDERDALE)

Our Children Looked After Team, work in partnership with Calderdale Metropolitan Borough Council (CMBC) to ensure that the health needs of children who are looked after (CLA) and young people in Calderdale are met. The team provides advice and support to health and social care practitioners to improve health outcomes for CLA and young people. A Looked after Child is subject to a care order (placed into the care of local authorities by order of a court), and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live in foster homes, residential placements or with family members (connected carer's).

Following the Covid- 19 Prioritisation of Community Services document issued by the Government in March 2020 Review Health Assessments (RHA) completed by the team were initially stopped. Three members of the CLA team were initially redeployed frontline to support the delivery of acute nursing services in Paediatrics and the PPE team, leaving an Administrator and the Named CLA Nurse to carry on essential functions of the service. Our Consultant Paediatrician and Designated Doctor for Children Looked After was also re-deployed to support the paediatric service in the hospital and continued to undertake Initial health assessments (IHA) virtually and adoption medicals face to face as highlighted in the prioritisation document

The reduced team that remained prioritised a cohort of young people on their caseload and a letter was sent to all children young people who were due a RHA in April/May/June explaining that the team would not be completing them. Included in the letter was information around local services for health/current public health guidance and advice on hand washing and contact details for support. This was followed by a phone call to support their physical health and wellbeing for all children who were due an RHA in the 3 months during the first lockdown period; signposting them to services and updating social workers ensuring support and health information was available and attending strategy/safeguarding meetings virtually.

Initial Health Assessments (IHA) completed by the Designated Doctor continued virtually and the first Review health assessment (RHA) following a virtual initial health assessment (6 or 12 months depending on the age of the child/ young person) is completed face to face at Brighouse health centre following PHE guidance and use of appropriate PPE.

The CLA team also wrote to all care leavers up to the age of 25 years and Calderdale Children placed over 50 miles away out of the local area; with health advice and guidance and information around services and how to contact the team.

The nurses returned into the team at the end of May to continue supporting children and young people from a health perspective and so ensuring all children and young people in the first quarter cohort were spoken to. The Designated Doctor returned shortly afterwards.

RHA are carried out virtually either via teams/phone or other formats if that is what young people will engage with to review their health. All multi-agency meetings/panels/ reviews etc. were re-instated.

Key Achievements

- Every 18-25-year-old care leaver was sent a letter from the team offering support and advice and ways to contact the team including up to date public health advice around dentists, hand washing etc.
- A health and well-being intervention was completed initially with children/ young people which supported initial prioritising needs, and then with all children and young people who were due an RHA in Quarter 1.
- From July 2020 review health assessments have been carried out virtually by the team.
- The team have achieved 100% compliance with Initial Health Assessments with the exception of November 2020 achieving 74% and over 95% with the Review Health Assessments.

Priorities 2020-21 (including actions from 2020-22 Safeguarding Strategy workplan)

- Continue to support links for care leavers over 18.
- Explore use of continued virtual assessments.
- Audit to review children placed in Calderdale from out of area and impact this has on their unmet health needs, Calderdale Health Service provision and to highlight any gaps.
- Working with Calderdale Childrens Services to improve completion of SDQ's (Strengthening Difficulties Questionnaire)

The Children Looked After Team in Calderdale provide support and guidance to children and young people who are the most vulnerable in society. Developing professional relationships are key in engaging with young people to make positive health changes in their life to improve their health outcomes which improves other aspects of their life. Despite the pandemic challenges this case study highlights that these relationships can develop virtually.

Case Study 1

CLA health team completed virtual IHA on a baby born in Calderdale within timescales at the end of 2020. He was subsequently seen face to face to complete an adoption medical in December 2020. It was arranged with the foster carers to complete BBV(Blood Born Virus) screening at 3 months of age due to additional maternal risk factors being present increasing the risk of hepatitis C and lack of screening being completed in pregnancy.

I subsequently agreed to see face to face as needed to complete an adoption medical and the issue regarding his feet remained unresolved. Child was seen in temporary clinic location at Calderdale Royal Hospital in June 2020. Child diagnosed with bilateral 'rockerbottom' feet (congenital vertical talus). Following the clinical appointment I arranged genetic

investigations and liaised directly with paediatric orthopaedic team requesting an urgent clinical review. The child was seen in a suitable clinic the following week and a treatment plan was initiated resulting in pre-operative casting and then surgery in September 2020.

The child had also been referred by the GP to a local paediatrician prior to seeing me for support with the symptoms of Gastroesophageal reflux and was awaiting an appointment. I liaised directly with the paediatrician involved to keep them informed of the orthopaedic and genetic findings to prevent a duplication of appointments. I referred the child to the regional clinical genetic team for more detailed clinical review and requested the parent's GP tried to engage them with a genetic referral and/or genetic investigations. At the same time as the clinical situation was evolving the CLA doctor continued to work with OneAdoption to support the child's adoption journey keeping the EPP carers in touch at all times.

This case demonstrates:

CLA health team working in a collaborative way with other clinical specialists in the best interest of the child

Maintaining regular contact with children's carers and supporting the adoption journey to completion

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Safeguarding Adults and Children Annual Report March 2020-April 2021

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Safeguarding and Covid

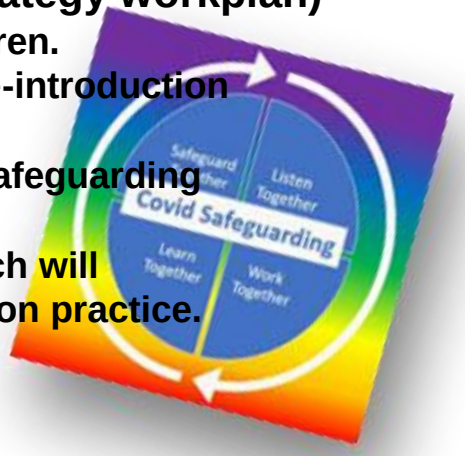
The Coronavirus Act 2020 did not suspend safeguarding duties and responsibilities

Key Achievements

- Developed safeguarding contingency plan to ensure safeguarding continued as business as usual.
- Worked closely with and supported the work of the Safeguarding Boards/ Partnerships.
- Provided assurance to CCG's and partnership that CHFT continues to meet its statutory responsibilities.
- Updated, developed and contributed towards policies and procedure development.
- Held a trust Virtual Safeguarding week Sept 20.
- Listened to staff concerns about safeguarding during the pandemic and developed a Safeguarding /Covid 19 intranet resource page for staff and distributed 7-minute briefings including top tips for virtual assessments to staff.
- Delivered virtual safeguarding supervision.
- Delivered bespoke and mandatory safeguarding training to maintain compliance with the Intercollegiate documents and covid restrictions.

Priorities 2021-2022 (including actions from 2020-22 Safeguarding Strategy workplan)

- **Continue to work with Divisions ensuring that safeguarding adults and children. including domestic abuse is part of all considerations when managing the re-introduction of services.**
- **Continue to learn from the effects of the pandemic on families, influencing safeguarding practice with what we have learned.**
- **Review the recommendations from the Domestic Abuse Bill (April 2021) which will include training, staff updates and policies and procedures that may impact on practice.**
- Review the Domestic Abuse Policy.



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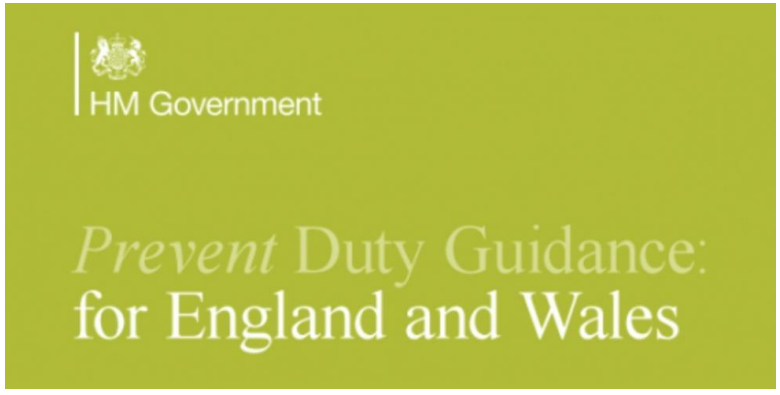
Prevent

Prevent is about safeguarding people and communities from the threat of terrorism

Key Achievements

- All staff received Prevent Wrap training.
- Our training compliance has remained consistently above 90% throughout the year.
- Prevent activity and information is shared quarterly with NHSE and our Designated Safeguarding Nurses in the CCG.
- CHFT Safeguarding Team attend Channel panel meetings where partner agencies discuss individuals in the pre-radicalisation phase to prevent them being drawn into terrorism.

- **Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)**
- Further explore the role of Prevent Champions.



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Hidden Harms

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Hidden Harms take place behind closed doors or away from view eg domestic abuse, sexual abuse, child sexual abuse and modern slavery.

Key Achievements

- Promoted the Police Partnership Intelligence Portal.
- Attend local partnership meetings for Child Exploitation.
- Monitored our safeguarding data and linked with National Safeguarding Children Professional meetings to benchmark other regional trends in safeguarding activity.
- Flag hospital records of young people at risk of exploitation.
- Developed the under 18 and adult at risk proforma and introduced this in Gynaecology, paediatrics and maternity services.
- Continued to deliver bespoke safeguarding training to ED staff, which includes Contextual Safeguarding.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- Provide updates to staff post Domestic Abuse Bill (April 2021).
- **Review the impact that the Covid 19 Pandemic has had upon the emotional wellbeing of pregnant women, there is a planned audit due in quarter 2 reviewing perinatal mental health.**
- **Continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multiagency meetings to share intelligence around this.**
- Develop awareness and training regarding the under 18's and adults at risk safeguarding proforma.
- **Raising awareness of the Making Every Adult Matter (MEAM) agenda in conjunction with partner agencies.**

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MCA and DoLS/ Liberty Protection Safeguards

The MCA protects and restores power to vulnerable people who may lack capacity to make decisions

Key Achievements

- The number of Urgent Authorisations reflects CHFT's commitment to protecting the Human Rights of their patients. Patients have not usually been assessed for a Standard Authorisations (by the Supervisory Body) as either the patient has been discharged, successfully treated or have regained the mental capacity to consent to their care and treatment arrangements.
- These continue to be quality assured determining interventions are least restrictive and, in the patients' best interest ensuring the statutory requirements of a DoLs is met.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- **Provide detailed report to the Executive Board regarding the Liberty Protection Safeguards, implications of the Bill and Codes of Practice.**
- **Develop a strategic implementation plan and implement LPS with digitized documentation.**
- Review Trust Safeguarding Team resources to implement the new LPS scheme including staff recruitment, training across the Trust, new processes and expertise.
- **Continue to ensure that all staff are trained in the Mental Capacity Act according to their role.**
- Continue to work with our local networks and partners to ensure successful implementation.

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Adult Safeguarding

Is protecting a person's rights to live in safety, free from abuse and neglect

Key Achievements

- Reviewed the Missing Persons Policy.
- Developed an Adult 'Was not brought to Hospital' Appointments Policy.
- Established and implemented a Discharge Quality Improvement Group which is part of the SAFER quality improvement programme with representation from key partners to drive further quality improvement in this area.
- Adult Safeguarding worked closely with Kirklees Local Authority to agree that the increased number of ineffective discharges could be managed internally by CHFT via the above group as opposed to formal individual Care Act (2014) Section 42 investigations.
- Development of a toolkit to support patients who decline pressure area care.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- **Streamline safeguarding processes and investigations.**
- **Systems approach to embed learning (i.e. Multi Agency Audit programmes).**
- **Working with the new Lead Nurse Childrens to progress embedding of the Transition Policy.**

Kirklees Safeguarding Adults Board

Partners in preventing abuse and neglect

Calderdale Safeguarding Adults Board

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Safeguarding Children

Working together to protect the welfare of children and protect them from harm

Key Achievements

- Additional staff trained to facilitate mandatory safeguarding supervision, including a focus upon maternity services in community services, NICU and an agreed model to support all Matrons.
- Developed a Childrens Mental Health Policy.
- Developed a mental health risk assessment tool and care plan to support learning from previous cases
- Mandatory safeguarding questions for paediatric ED attendances in EPR.
- Updated the Childrens Supervision Policy.
- Developed a 'Childrens Was Not brought' to appointments Policy.
- Increased awareness of the ICON programme.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- **Map other areas that may need review of safeguarding supervision processes and include establishing robust safeguarding children's champions.**
- **Work is ongoing to update the content of the safeguarding training packages to ensure ongoing compliance with the Intercollegiate documents and to reflect feedback from staff regarding methods of learning.**

Kirklees Safeguarding Children Board

Calderdale Safeguarding Children Partnership

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Mental Health Act

The Mental Health Act covers the assessment, treatment and rights of people with a mental health disorder.

Key Achievements

- Continued support to the MHA office with scrutiny and reporting framework.
- Implementation and full roll out of new documentation reflecting changes to the Statutory Forms for detaining and serving MHA papers to CHFT patients.
- Receipt and Scrutiny training compliance 64.5% at 03/21.
- Updated the MCA DoLs Policy.
- Referrals for DoLs during '20-'21 have increased showing an awareness with staff to ensure the best interests of our patient are met.
- Ongoing quality assurance of all referrals for DoLs provided by the team.
- Bespoke training sessions have been developed.
- Developed a digital mental capacity assessment form which has been placed on EPR.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy) workplan

- **Embedding of new processes for electronic submission of forms related to detaining and serving of MHA papers**.
- **Additional Receipt and Scrutiny training dates planned for 21/22 to improve compliance.**
- Strategic implementation plan is being developed to support the implementation of the Liberty Protection Safeguards (LPS).
- Provide a detailed report to the Executive Board regarding the LPS implications of the Code of Practice.
- **Review Safeguarding Teams resources to implement the LPS, including additional staff recruitment.**

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Children Looked After (CLA)

Children and Young people in the care of the Local Authority. The CLA team works with Calderdale Council to ensure the health needs of looked after children in Calderdale are met

Key Achievements

- Letter sent in Q1 to every Care leaver offering support.
- Prioritised needs of all in Q1 due a RHA.
- From July 20 review health assessments have been carried out virtually by the team.
- The team have achieved 100% compliance with Initial health assessments (with the exception of Nov 2020 = 74%) and over 95% with the Review Health Assessments.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- **Continue to support links for care leavers over 18.**
- Explore use of continued virtual assessments.
- **Audit to review children placed in Calderdale from out of area and impact this has on their unmet health needs, Calderdale Health Service provision and to highlight any gaps.**
- **Working with Calderdale Children's Services to improve completion of SDQ's (Strengthening Difficulties Questionnaire).**

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Training Compliance

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	31.03.2020					31.03.21					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	5842	21938	20155	1783	91.87%	6063	23284	21618	1666	92.84%	0.97%
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %						
NHS|MAND|Mental Capacity Act - 3 Years|	285	285	277	8	97.19%	237	237	208	29	87.76%	-9.43%
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NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1660	1660	1625	35	97.89%	1683	1683	1638	45	97.33%	-0.56%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3616	3616	3325	291	91.95%	3654	3654	3408	246	93.27%	1.32%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	545	545	437	108	80.18%	561	561	538	23	95.90%	15.72%
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	81	81	47	34	58.02%	86	86	56	30	65.12%	7.10%
372|LOCAL|Safeguarding Supervision|	595	595	358	237	60.17%	631	631	407	224	64.50%	4.33%
Grand Total	5842	21938	20155	1783	91.87%	6063	23284	21618	1666	92.84%	0.97%

Key

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

The chart above indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee. As of March 2021, overall compliance was at 92.84%.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Safeguarding is Everyone's Responsibility

19. Quality Report

- Maternity Services Update

To Note

Presented by Ellen Armistead

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title:	Quality Report (Reporting period June to July 2021)
Author:	Lindsay Rudge, Deputy Director of Nursing
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Quality Committee

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 for consideration.

It is to ensure that the Board of Directors is provided with a level of assurance around key quality and patient experience outcomes. The report provides confirmation that during the COVID pandemic and as the Trusts implements its recovery programme in response to the pandemic, the processes and systems within the Trust to ensure quality and safety are fit for purpose.

To provide high level updates on the Trust's preparedness for relevant regulatory scrutiny.

Key Points to Note

The Quality Report aims to provide further detail on areas of key focus and complements the Integrated Performance and Quality Priorities Report.

Care Quality Commission (CQC)

- During June & July 2021, the CQC work streams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Mangers, Trust's recovery plan, national guidance and CQCs Emergency Support Framework
- Substantial work was undertaken to revise and update the Focus Support Framework, the review toolkit has been updated to reflect CQC's Core Service Frameworks. The review has been rebranded and launched as the 'Journey 2 Outstanding Review'.
- CHFT & CQC had a full engagement meeting during the reporting period, which focused on the Trusts Elective and Outpatient recovery plan.
- the one 'must do' action MD1 - *The trust must improve its financial performance to ensure services are sustainable in the future* remains rated green (substantial assurance) pending further consideration of the quality and financial position of the Trust. This is different to the risk described within the HLRR report.
- Enquiries and incidents:
  - 5 new enquiries have been opened since April 2021, 12 enquiries have been closed since April 2021, there are currently 11 Open enquiries. There is one Serious Incident, three Orange incidents, three concerns/complaint and four safeguarding Concerns

- CQC were also informed of the work which has been undertaken to self-assess the Trusts position against the IPC board Assurance Framework (Feb 2021 updates, CQC IPC Transitional Monitoring Approach Framework and the Health & Safety Executive IPC Requirement.

- Three Journey 2 Outstanding Reviews have taken place to date on Ward 8B at CRH, Ward 5 at HRI and Ward 17 at HRI. A full inspection regime and staff allocation is now in place for 2021/22.Thematic analysis is contained in the report in section 2.4

Central Alert Systems

- To note the current position and actions being undertaken for the Central Alert System (CAS) indicators which has 4 overdue alerts (an increase of 1 from previous reporting period) and 2 alerts in progress within timescale (an increase of 1 from previous reporting period) and 2 closed alerts

Dementia Screening

- The note the Trust overall compliance for dementia training which exceeds the target of 95%, however the corresponding dementia screening remains significantly below the target. Substantial improvement activity is being undertaken with the Dementia Lead and Clinical teams across the Acute Floors and Assessment Areas (Surgical and Frailty SDECs) to improve performance. Depression and Delirium performance is significantly below target in this new Key Performance Indicator.

Experience, Participation, Equalities

- The Patient Experience and Caring Group have continued to meet and have prioritised key focus areas for the next 6-month reporting period.
- An approach to systematically involving our BAME communities approved at Patient Experience & Caring Group and connection made with CHFT BAME engagement officer
- The Friends and Family test has seen steady month on month progress with number of responses for each service, interim targets have been introduced ahead of national averages being published
- Improving the experience of patients with visual impairment **- Four** organisations (Disability Partnership Calderdale, Halifax Society for the Blind and Kirklees Visual Impairment Network) held their second meeting to review the feedback the service user engagement events
- Observe and Act (O&A) - Co-designed new format of the O&A framework with NHSEI, with particular focus on equality and diversity; decision made to pause programme due to current pressures (in line with decision re Journey to outstanding ward assurance toolkit); The Non-Executive Director lead for Quality is involved in sharing learning with NHS Providers
- Equality Delivery System (EDS): Planning is underway for the EDS community events

Complaints

- To note the Trusts position in relation to complaints performance. The Head of complaints and PALS has commenced in post and will be reviewing current processes whilst maintaining the increased level of performance achieved year to date.

Legal

- To receive the legal report outlining the Trust position for the reporting period.

Incidents

- To note the summary of patient safety incidents
- A delayed never event was reported in June and is currently under investigation. The incident relates to a retained foreign object post procedure (Retained wire). Immediate actions taken once the incident was identified where for all future procedures to scan the route of access when the wire is removed.
- There has been a significant reduction in the numbers of open actions which are overdue by six months.
- A new Patient Safety Incident Framework is being introduced into the NHS from the Summer of 2021 and this will have an impact on the Trust's current serious incident

policy and processes. A gap analysis will be undertaken and reported to a later Quality Committee meeting.
- A total of 9 StEIS (Strategic Executive Information System) incidents were reported; 6 for June and 3 in July.

Medicine Safety
- To note the priority work streams, the progress to date including use of electronic CD registers and Active temperature systems. Both systems are due to go live in the next few, and training will be required to be supported.
- To note the need to improve attendance at the Medicines safety and compliance group.

Maternity
- To receive the monthly maternity governance assurances in response to the Ockenden review
- Maternity services submitted evidence against the 7 Immediate and Essential Actions of the Ockenden Report by 30th June. We have been advised that the next step would be a site visit by the Regional Chief Midwife and her team, and that the visit should be completed by the end of July 2021. Maternity services are currently awaiting a date for the site visit.
- Maternity services were informed of the outcome of the national funding bid submission on 6th July. CHFT maternity services had submitted a bid for 20 whole time equivalent midwives and 4 PA's of Consultant hours, we have been successful in achieving funding for 10.9 wte midwives and 0.2 wte Consultant hours.
- Continuity of carer remain an NHSEI priority with an expectation that providers will submit their outline plans for continued roll out of continuity of carer teams by July 21. With an aim that all women would be placed on a continuity of carer pathway by March 2023. There is recognition that workforce challenges remain one of the greatest barriers to the successful roll out. The allocation of funding for 10.9 wte midwives will support the roll out of continuity of carer at CHFT however, recruitment to the posts will remain challenging.

Healthcare Safety Investigation Branch (HSIB)
- There are currently 3 open cases at varying stages of investigation.

Maternity Staffing
- To note the current percentage of 1:1 care in relation to NICE guidance on safe midwifery staffing and the provision of 1:1 care reported on the maternity services dashboard 99.6% YTD
- Midwifery has recruited 13 wte newly qualified midwives as part of the Local Maternity System (LMS) wide recruitment, with a further 7 wte vacant posts plus the newly funded 10.9 wte midwifery posts currently in the process of advertisement.
- Obstetric Staffing remains challenging with gaps in the middle grade rota as a result of deanery gaps in the obstetric training rota. This has been mitigated by the recruitment of trust grade doctors and is reflected on the Directorate risk register

Quality Priorities
- To note the updates to the Quality Account Priorities and the Focussed Quality Priorities for 2021 / 2022:

  <u>Quality Account priorities</u>
  - Recognition and timely treatment of Sepsis
  - Reduce number of Hospital Acquired Infections including Covid 19
  - Reduce waiting times for individuals attending the ED

  <u>Focussed Quality Priorities</u>

- Falls resulting in Harm
- End of Life
- Clinical Documentation
- Clinical Prioritisation
- Nutrition and Hydration
- Pressure Ulcers
- Making Complaints Count

All Quality Account Priorities and the Focussed Quality Priorities for 2021 / 2022 have discussed at Divisional Performance Review meetings (PRMs) with the focus that the quality priorities form an integral part of the divisional quality agenda and strategy. Further work is being undertaken to ensure flow of data into the PRMs is consistent across divisions and templates align to the reporting framework for the quality priorities and the performance management framework.

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.

This report considers the impact on all 'protected` groups under the Equality Act 2010 including parents/carers and/or socio-economic groups.

It is not anticipated that the contents 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 to include improvements for dementia screening for our patients aged 75 and over.

The Equality Impact Assessment is an ongoing process, and every effort is made to ensure it is 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.

Recommendations

- The Board of Directors 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.
- The Board is asked to **NOTE** the Maternity Quality report update.

Contents

Bi-monthly reports

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.

The Trust Quality Board paper seeks to brief the Board on the developments and progress against the Quality Strategy and improvement work underway.

This report provides assurances that as a Trust we are working towards the Outstanding CQC rating, the question for any Trust committee should be one of 'Am I assured and am I confident that we know where the risks lie'. Through the transparent reporting and the robustness of the reports we seek to give the Board the clarity and assurance required.

This report provides an update on assurances against several quality measures for the last quarter the progress updates for the Quality Account Priorities and the Focussed Quality Account Priorities for 2021/2022.

The Quality Committee continues to provide the scrutiny, monitoring and assurance on the quality programmes that are in place within the Trust. The Committee has and continues to recognise the challenges that has been placed upon the Trust during the COVID -19 Pandemic and continues to acknowledge the hard work from all colleagues to continue to provide one culture of care for patients and colleagues. As we implement the recovery programme it is more than ever important that as a Trust, we are sighted on the quality agenda and any associated risks.

2. Care Quality Commission (CQC) workstreams

During June & July 2021, the CQC workstreams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Mangers, Trust's recovery plan, national guidance and CQCs Emergency Support Framework.

During June and July substantial work was undertaken to revise and update the Focus Support Framework, the review toolkit has been updated to reflect CQC's Core Service Frameworks. The review has been rebranded and launched as the 'Journey 2 Outstanding Review'.

CHFT & CQC had a full engagement meeting during the reporting period, which focused on the Trusts Elective and Outpatient recovery plan.

2.1 2020/21 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions

Of the outstanding actions from the 2018 CQC inspection, the Trust now has one action to complete.

In brief the one 'must do' action is not yet embedded in the Trust and remains incomplete pending further consideration of the quality and financial position of the Trust as set out in Table 1.

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

Table 1

Compliance	Current Position	Further Actions	Assurance
MD1 - The trust must improve its financial performance to ensure services are sustainable in the future	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. Very long-term strategic recommendation, the plans linked to this were around reconfiguration. We continue to progress but due to current environment we are breaking even on a month-on-month basis to support Covid activity. Planning for the next financial year is taking place	This action is a long-term action which continues to progress a further update is scheduled to be received at the April 2021 CQC & Compliance Group.	**Substantial Assurance**

2.2 CQC Engagement Meetings

Regular catch-up meetings between CQC and CHFT have continued to take place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services. These catch ups are scheduled to continue monthly with the last full engagement meeting taking place on 17th June 2021. The meeting focused on the Trust Recovery plans for Elective and Outpatients, CQC requested that CHFT submit details of the recovery plan in line with structed key lines of enquiry.

Updates were shared regarding current position with all open enquiries as set out below:

5 New Enquiries Opened since April 2021
12 Enquiries have been closed since April 2021
Currently 11 Open Enquiries.

1 x Serious Incident
3 x Orange Incident
3 x Concerns/Complaint
4 x Safeguarding Concerns

Awaiting patient ID for x 4 enquiries

CQC were also informed of the work which has been undertaken to self-assess the Trusts position against the IPC board Assurance Framework (Feb 2021 updates, CQC IPC Transitional Monitoring Approach Framework and the Health & Safety Executive IPC Requirement. Current (see table 3).

Table 3

Infection Prevention & Control Action Plan – 16.06.21				
Guidance	**Fully Compliant**	**Partially Compliant**	**In Progress**	**Total Requirements**
IPC Board Assurance Framework Recommendations - February *2021 Guidance*	93	7	5	109
CQC Infection Prevention & Control Transitional Monitoring Approach (TMA)	37	0	2	39
Health & Safety Executive (HSE) Recommendations	30	3	3	36

2.3 Journey 2 Outstanding Review

The Journey 2 Outstanding Review (J2O) has been developed with the aim to provide a 360-degree evaluation of the ward environment, workforce, patient safety and patient experience.

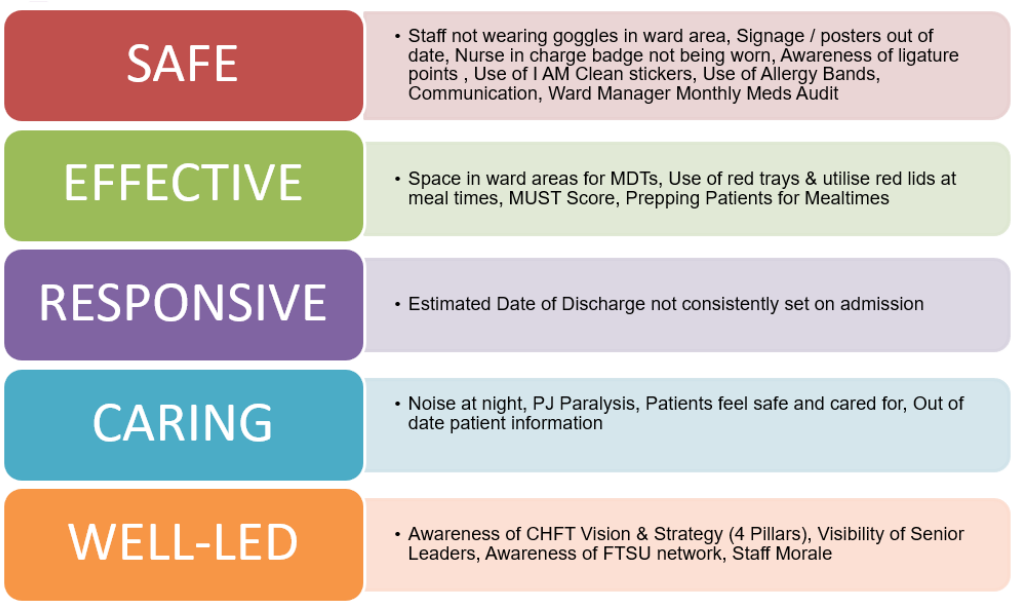
The aim of the J2O Review is to give Ward Managers and their Teams the opportunity to showcase the Safe and Compassionate Care which is delivered to patients across the Trust every day.

The framework is also designed to identify where extra support may be needed to support services on their Journey 2 Outstanding.

The review framework is a combined Patient Safety & Patient Experience Review. The Patient Experience is assessed using the Observe & Act Framework the findings from both elements of the review are reported as one under the name Journey 2 Outstanding.

2.4 Reviews to Date

Three Journey 2 Outstanding Reviews have taken place to date on Ward 8B at CRH, Ward 5 at HRI and Ward 17 at HRI. A full inspection regime and staff allocation is now in place for 2021/22. Some emerging themes from the reviews are:



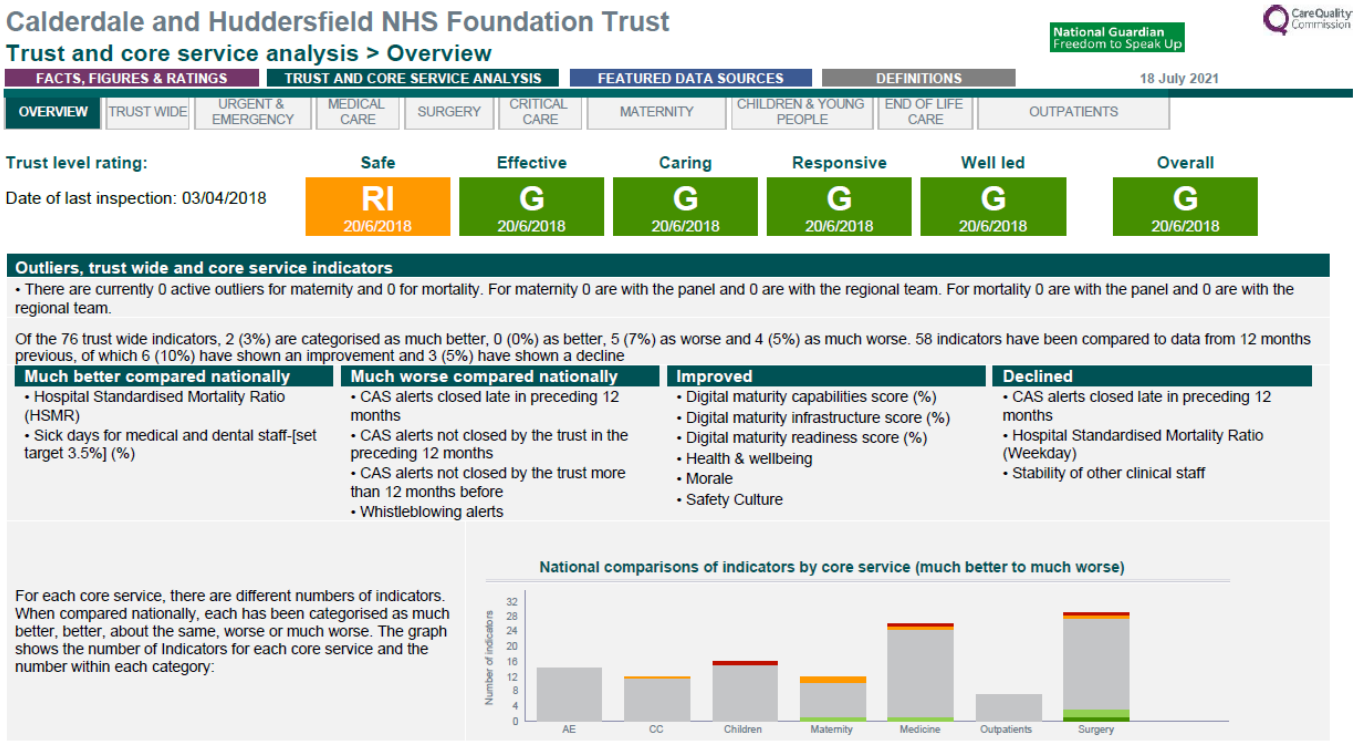
2.5 Future Reviews

Due to current staffing and operational pressures which have been impacted by staff isolation, the decision was made to suspend the three J2O reviews planned from mid-July to the end of August. The inspection programme will recommence from 1st September with a full Trust wide relaunch

2.6 CQC Insight Report

The most recent CQC Insight Report was published in July 2021 with the previous report been published in May 2021. The insight report indicators and outliers continue to be monitored via the CQC and Compliance Group.

CHFT Performance Summary



Calderdale and Huddersfield NHS Foundation Trust

Trust and core service analysis > Overview

National Guardian Freedom to Speak Up

CareQuality Commission

FACTS, FIGURES & RATINGS | TRUST AND CORE SERVICE ANALYSIS | FEATURED DATA SOURCES | DEFINITIONS | 18 July 2021

OVERVIEW | TRUST WIDE | URGENT & EMERGENCY | MEDICAL CARE | SURGERY | CRITICAL CARE | MATERNITY | CHILDREN & YOUNG PEOPLE | END OF LIFE CARE | OUTPATIENTS

Trust level rating:

Date of last inspection: 03/04/2018

Safe	Effective	Caring	Responsive	Well led	Overall
RI 20/6/2018	G 20/6/2018	G 20/6/2018	G 20/6/2018	G 20/6/2018	G 20/6/2018

Outliers, trust wide and core service indicators

• There are currently 0 active outliers for maternity and 0 for mortality. For maternity 0 are with the panel and 0 are with the regional team. For mortality 0 are with the panel and 0 are with the regional team.

Of the 76 trust wide indicators, 2 (3%) are categorised as much better, 0 (0%) as better, 5 (7%) as worse and 4 (5%) as much worse. 58 indicators have been compared to data from 12 months previous, of which 6 (10%) have shown an improvement and 3 (5%) have shown a decline

Much better compared nationally	Much worse compared nationally	Improved	Declined
• Hospital Standardised Mortality Ratio (HSMR) • Sick days for medical and dental staff-[set target 3.5%] (%)	• CAS alerts closed late in preceding 12 months • CAS alerts not closed by the trust in the preceding 12 months • CAS alerts not closed by the trust more than 12 months before • Whistleblowing alerts	• Digital maturity capabilities score (%) • Digital maturity infrastructure score (%) • Digital maturity readiness score (%) • Health & wellbeing • Morale • Safety Culture	• CAS alerts closed late in preceding 12 months • Hospital Standardised Mortality Ratio (Weekday) • Stability of other clinical staff

For each core service, there are different numbers of indicators. When compared nationally, each has been categorised as much better, better, about the same, worse or much worse. The graph shows the number of Indicators for each core service and the number within each category:

National comparisons of indicators by core service (much better to much worse)

2.7 CAS Alerts

CHFT continue to be performing much worse compared nationally in relation to actioning and completing CAS Alerts, this continues to be monitored monthly via the CQC & Compliance Group.

The status of patient safety alerts which have passed their deadline:

Issued	Completion Due Date	Alert Title	Current Status	Progress
RESPONSES REQUIRED FOR CAS				
3 March 2020	5 March and 3 June 2020	NatPSA/2020/001/NHSPS Ligature and ligature point risk assessment tools and policies	OVERDUE	**Lead:** Janet Youd **Update 1 July 2021:** Task and Finish Group met on 1 July 2021 to review Policy, agree process for training of use of ligature cutters, and place risk on risk register. Ligature packs have now been procured, and due to be delivered next week, and

				placed on all crash trollies. The Policy will be submitted to the Quality Committee on 19 July 2021 for ratification. Further T&F Group arranged for 12 August 2021 in order to finalise this alert.
13 Aug 2020	13 May 2021	**NatPSA-2020-005-NHSPS** Steroid emergency card to support early recognition and treatment of adrenal crisis in adults	**OVERDUE**	**Lead:** Carole Gregson Three of four actions complete **Update 1 July 2021**: Task and Finish Group met on Tuesday, 29 June 2021, to review alert, with actions to liaise with EPR regarding a flag for patients at risk and for communications to be produced for a screensaver regarding steroid cards. Next meeting to be scheduled for w/c 19 July 2021.
1 Sept 2020	1 June 2021	**NatPSA-2020-006-NHSPS** Foreign body aspiration during intubation, advanced airway management or ventilation	**OVERDUE**	**Lead**: Sue Wilkinson Two of four actions complete **Update 1 July 2021**: Actions 3 and 4 are overdue. Sue Wilkinson has contacted Sarah Bray to ask if we need to implement some education/protocols for ODPs as this will mean a change in their practice.
1 Dec 2020	1 June 2021	**NatPSA-2020-008-NHSPS** Deterioration due to rapid offload of pleural effusion fluid from chest drains	**OVERDUE**	**Lead:** Cath Briggs One of two actions complete **Update 1 July 2021**: Cath Briggs followed up with Steven Thomas (Respiratory Consultant) on work for observation chart to be uploaded onto EPR. In the meantime, the paper bedside observation chart will be used and scanned into the patient record, until the electronic observation chart can be embedded into EPR. **Alert due to be closed, once confirmation received from Respiratory Consultant.**

The following patient safety alerts are currently within deadline date:

Issued	Completion Due Date	Alert Title	Current Status	Progress
19 May 2021	19 August 2021	**NatPSA-2020-002-NHSPS** Urgent assessment / treatment following ingestion of 'super strong' magnets	**Ongoing**	One of four actions complete **June 2021**: Alert circulated to Trust PSQB, Divisional Directors, Clinical Directors, Directors of Operation, Associate Directors of Nursing, General Managers and Quality Governance Leads for all divisions on 20 May 2021. One action has now been completed by Radiology, with their guidelines updated to reflect the alert. Taken to Trust PSQB meeting on 3 June 2021, with a decision that a Task and Finish Group is convened to include representative from the Emergency Department, General Surgery, Radiology and Paediatrics.
16 June 2021	16 November 2021	**NatPSA-2021-003/NHSPS** Eliminating the risk of inadvertent connection to a medical air via a flowmeter	**Action underway**	**Lead**: Medical Gases and Non-invasive Ventilation (NIV) Group Five of six actions complete **Update 1 July 2021:** Taken to Trust PSQB on 1 July 2021, with five of the actions already completed by Medical Engineering. One action to be led by the Medical Gases and NIV Group. Work underway.

The following patient safety alerts due for closure

Issued	Completion Due Date	Alert Title	Current Status	Progress
23 June 2021	17 December 2021	**NatPSA-2021-005/MHRA** Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds	**Due for closure**	**Lead**: Robert Ross **Update 1 July 2021:** No affected devices at CHFT.

The following patient safety alert is closed:

Issued	Completion Due Date	Alert Title	Current Status	Progress
16 June 2021	21 June 2021	**NatPSA-2021-004/MHRA** Recall of Co-codamol 30/500 Effervescent Tablets, Batch 1K10121, Zentiva Pharma UK Ltd due to precautionary risk of causing overdose	**CLOSED**	Co-codamol not stocked or supplied at CHFT

3. Dementia Screening

Subject standard	Update	Risk(s) identified	Forthcoming action for the next two months	Assurance
National Driver Dementia screen Target 90%	**July 2021 performance** Medicine 23.29% Surgery 21.74% FSS N/A Trust 22.93%	There is a risk that the whiteboard functionality on EPR will not increase compliance.	▪ The band 7 Dementia Lead will focus on dementia screening and will work closely with the medical teams to increase compliance on acute floor and assessment units, including frailty ▪ Daily email sent for overdue screens to consultants ward managers and matrons in these focussed areas ▪ Development of the whiteboard on EPR is ongoing ▪ Increased compliance for doctors undertaking Dementia Screening via the EPR – daily emails sent re incomplete screen ▪ Weekly performance reviewed by Dementia Lead ▪ SOP developed on how to complete screen	**Limited Assurance**
National Driver - Dementia training Target 95%	Overall compliance for Dementia training across the Trust is 98.10%.	Not applicable	A full review of how person-centred dementia training can take place across the Trust.	**Substantial assurance**

Subject standard	Update	Risk(s) identified	Forthcoming action for the next two months	Assurance
Local Driver - Person centred dementia care training	This training has always been delivered face to face in small groups of up to 10 people. During the COVID pandemic this training stopped and has now been evaluated so the training can now be re-established in small groups socially distanced	Inability to deliver training to staff to enable them to identify dementia patients and deliver high quality care	▪ Training to be arranged for small socially distanced groups ▪ Training programme under review to facilitate ease of access ▪ Bite size training under development to support education in practice	**Limited Assurance**
Local Driver - Delirium and Depression screening Target 90%	**This is a new indicator:** **July 2021 performance** **Depression** / **Delirium** Medicine 3.4% 6.65% Surgery 4.5% 8.42% FSS 14.8% 14.81% Trust 4.4% 7.34%	The Trust is unable to screen for Dementia due to the low levels of depression screening	The development of the quality project for delirium Depression, delirium, and dementia to be accessed on EPR.	**Limited Assurance**

4. Patient Experience, Participation and Equalities Programme

The Patient Experience group has continued to meet following it reinstatement as part of the recovery

Workstream	Progress this period	RAG	Next Period
Strategy, Policy & Programme	• First meeting of the Patient Experience & Caring Group (PE&CG) held, 2nd meeting taking place 2.8.21 • Strategy developed as a slide pack – shared with PE&CG and Quality committee. • Decision made to pause some of the Corporate programme, due to current staffing pressures in the team		• Structure the PE&CG so that meetings alternate between corporate programme reporting and Divisional reporting • Draft guidance for Divisional reporting to be approved by Patient Experience and Caring Group
Equality	• **Ethnic Diversity Index (EDI):** Initial indications is that there appears to be a higher level of advocacy amongst the BAME community than the non-BAME when it comes to making complaints; Maternity specific complaints –are too few complaints to draw any conclusions around IMD or ethnicity • **Equality Delivery System (EDS):** Planning underway for the EDS community events • **Impact Assessments:** Refreshed impact assessment of the clinical model for reconfiguration completed		• **Ethnic Diversity Index (EDI):** Undertake further analysis of EDI to test assumptions arising from the T&F project • **Impact Assessments:** PMO continue to monitor usage and receive feedback reporting via the quarter report to quality committee
Experience	• **Commitment to carers (unpaid):** Outline proposal for collaborative group agreed • **Making complaints count:** New Head of Complaints and PALS commenced in post along with an Interim Team Leader for the service; Q1 quality priority reported • **Winter and Covid Volunteering programme:** Ward volunteer helper role commenced on SAU (HRI) and Ward 6AB (CRH)		• **Commitment to carers (unpaid)**: Hold first meeting and confirm phase 1 priorities • **Making complaints count:** Deputy Director of Nursing reviewing the position with the collaborative priorities with group members • **Winter and Covid Volunteering programme:** Complete mid-programme evaluation of the projects
Experience / Participation	• **Improving the experience of patients with visual impairment:** Four organisations (Disability Partnership Calderdale, Halifax Society for the Blind and Kirklees Visual Impairment Network) held their second meeting to review the feedback the service user engagement events • **Observe and Act (O&A):** Co-designed new format of the O&A framework with NHSEI, with particular focus on equality and diversity; decision made to pause programme due to ward staffing pressures (in line with decision re Journey to outstanding ward assurance toolkit); Non-Exec Director lead for Quality involved in sharing learning with NHS Providers		• **Improving the experience of patients with visual impairment:** Two areas identified for further QI work: Signage /orientation and staff awareness • **Observe and Act:** Feedback regarding nutrition and hydration to be shared with Nutritional Steering Group; Programme of visits to be deferred to September in line with Journey to Outstanding pause

Workstream	Progress this period	RAG	Next Period
Participation	• **Engagement activities:** Making connections with Calderdale CCG Engagement Co-ordinator and Involving People Network; Various engagement carried out as part of the Transformation and Business Better than Usual Programmes • **BAME:** Approach to systematically involving our BAME communities approved at Patient Experience & Caring Group; Connection made with CHFT BAME engagement officer		• **Engagement:** Review current engagement activities and how these can be captured through a central reporting system • **BAME:** Agree a reporting route for patient experience insight gathered by the BAME engagement officer
Continuous quality improvement	• **Friends and Family Test:** Standardised reporting format shared with Divisional leads; Steady month on month progress with number of responses for each service; Interim targets introduced ahead of national averages being published • **Chaplaincy:** Band 7 Chaplaincy lead advertised • **Every story matters:** Changes to the senior staff who were taking this project forward has resulted in delays to the introduction of this process (receiving 'stories' in the organisation and identifying organisational learning) • **Learning lessons to improve patient experience:** Programme for populating 'Impact Narratives / Stories has been delivered through corporate and divisional narratives, including a you said / we did feature in the monthly IPR; Decision made to pause other elements of the learning lessons activities for 3 months due to current staffing pressures in the team		• **Friends and Family Test:** Revisit targets and use for July 2021 data and incorporate in KP+ reporting • **Chaplaincy:** Interview for Chaplaincy Lead to take place in August 2021; Draft baseline assessment of NHS Chaplaincy guidelines 2015 to be picked up by the new appointment • **Every story matters:** Confirm the way forward with the process with organisational approval • **Learning lessons to improve patient experience:** Newsletter to be paused for 3 months. Continue with impact stories monthly, with a relaunch including building capacity & capability

RAG rating (progress against next period actions) : None of the actions delivered, no plan in place, Some actions delivered, with plan for others, All actions delivered, Project complete

Risk/ Issue	Risk Owner	Action	Progress
Due to work on Covid 19 and limited capacity, certain projects have had to be paused	Lindsay Rudge	The programme plans are under further review / prioritisation by the Patient Experience & Caring Group	A revised programme plan is in progress. But further adjustments can be expected

5. Patient Advice and Complaints Service (PACS)

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

Key Objectives

The Patient Advice and Complaint team's main objectives are:

Objective	Current level of assurance	Comments
1. Working with the divisions effectively to deliver strong complaints performance and user centric service	**REASONABLE Assurance**	Progress continues and implementation of new processes is underway with a continued improvement in performance which has resulted in an increase from red to amber in the assurance rating
2. Making Complaints Count & Working Together to Get Results: Delivering on collaborative action plan/ quality priority	**REASONABLE Assurance**	Good progress.

Progress against key objectives

Complaints and Patient Advice and Liaison Service (PALS) Performance Summary

	June	July
Complaints received	49	31
Complaints closed	18	38
Complaints closed outside of target timeframe	1	12
% of complaints closed within target timeframe	94%	68%
Complaints reopened *1	7	8
*1 Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix		
PALS contacts received	172	225
Compliments received	47	51
PHSO complaints received	0	0
PHSO complaints closed	0	1
Complaints under investigation with PHSO	1	1

Making Complaints Count Collaborative

The Making Complaints Count (MCC) steering and operational groups are currently being reviewed to ensure effective use of colleague input across both groups. Implementation of focussed process improvements continues. Please refer to the quality priority update for further detail.

6. Legal Services

Calderdale and Huddersfield NHS Foundation Trust is committed to:

1. Promoting the highest possible standards of care for patients in an environment that is safe and effective for staff and visitors.
2. Dealing with claims that arise in a competent and consistent manner, in a culture of openness between the parties to facilitate early resolution, and thereby minimise the financial loss to the Trust/ NHS Resolution (NHS R).
3. Using learning arising from claims and inquest investigations to promote improvements to the quality of care provided to patients. Service Performance / Activity Data.

Recent Data

This report covers the period 1 June – 31 July 2021.

Clinical Negligence

- 175 active clinical negligence claims
- 15 new clinical negligence claims were received.
- 15 clinical negligence claims were concluded.
- Damages totalled £664,414

Employers' and Public Liability (EL/PL) Claims

- 23 active EL/PL claims
- 2 new EL/PL claims were received
- 6 EL/ claims were concluded
- Damages totalled £40,284

Inquests

- 162 active inquests
- 12 inquest files were opened
- 4 inquest files were closed

Exception reporting

With the Interim Head of Legal Services in post (3 days per week), a permanent Head of Legal Services has now been recruited, with a start date being finalised, but expected to be late September/early October 2021.

Forward plan

In May 2021, "Learning from Litigation Claims: The Getting It Right First Time (GIRFT) and NHS Resolution best practice guide for clinicians and managers" was issued. This provides a timely opportunity to benchmark the Trust's Legal Services function against these best practice standards; an initial review has been carried out with more detailed work planned, to build on the existing improvement programme as detailed below.

Matter of High Interest

A death in custody inquest before a jury, regarding a death from 2016, which was the subject of a red Serious Incident investigation, took place over 42 days, 20 April – 22 June 2021. Please see Appendix B for further details.

Assurance

Appendix A: Legal services improvement programme

Objective	Comment	Progress	Assurance
Improve communication and response times between legal team and third parties / external partners	Enrolling assistance from bank staff in PALS to assist in reviewing email correspondence and ensure uploaded to Datix case management system.	0.6 WTE commenced 1.6.21, induction carried out and some early progress made.	**Limited assurance**
Improve response time in dealing with request for disclosure of patient records, reduce complaints and missing records	Enrolling assistance of redeployed staff to assist disclosure team. Training planned.	After some induction and training, it became apparent that redeployed staff lacked required technical skills. To trial using above 0.6 WTE bank staff.	**Limited assurance**
Ensure consistent use of Datix for case handling and document storage	Encouraging greater attention to detail and recording of routine correspondence. Assistance with objectives above will allow more time to be spent ensuring files are up to date. In due course, to implement file reviews for compliance.	Encouragement continued. With assistance of 1 above, showing early signs of improvement.	**Limited assurance**
Ensure learning for legal activity is captured	Meeting with executive team and key partners to share best practice. Case management system needs more robust use in first instance to identify learning to be conveyed.	More robust use of case management system commenced.	**Limited assurance**

Appendix B: Legal matters of interest

A death in custody inquest before a jury, regarding a death from 2016, which was the subject of a red Serious Incident investigation, took place over 42 days, 20 April – 22 June 2021.

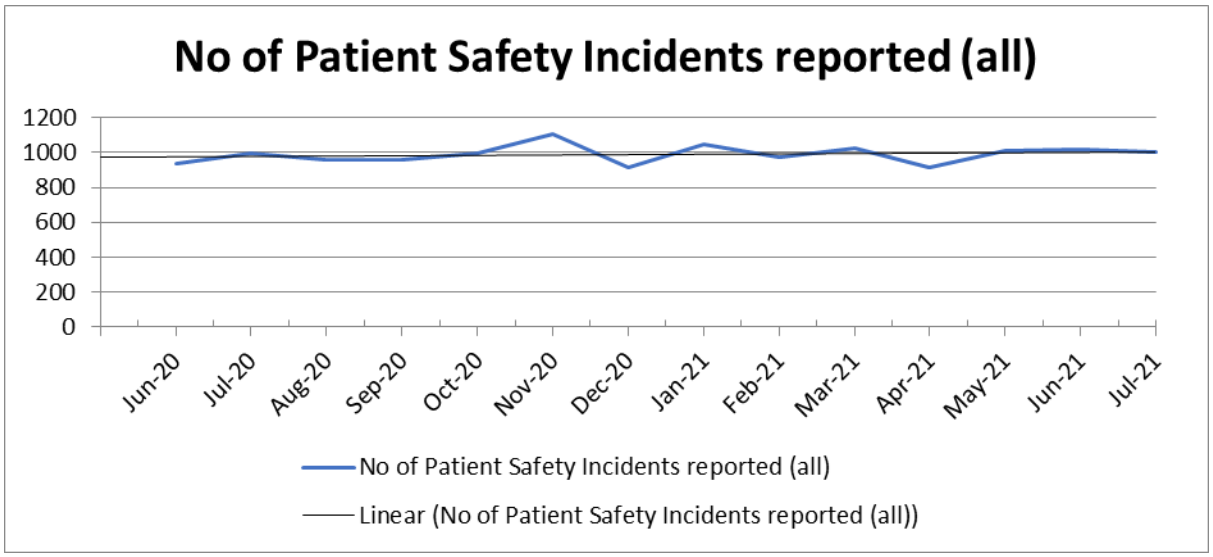
A Narrative conclusion was delivered: The main learning from the incident included the need for staff to undertake mental capacity assessments at the point of refusal of treatment, and the development of a return to custody form to be completed with medical information/advice relating to a patient being discharged into police custody. The importance of both these issues was reiterated at the inquest. HM Coroner did not find it necessary to issue a Report to Prevent Future Deaths.

7. Incidents

Below is a summary of patient safety incidents and incidents with severe harm or death, for the year June 2020 to July 2021, and number of serious incidents (SIs) reported by month.

Following review, the number of incidents resulting in severe harm or death during the period reported has been amended to reflect the current position, post investigation.

Month reported	Number of Patient Safety Incidents reported (all)	Number of Patient Safety Incidents of severe harm or death	Serious Incidents by the month externally reported on StEIS
June 2020	936	6	9
July 2020	998	2	2
Aug 2020	958	2	2
Sept 2020	958	5	4
Oct 2020	997	6	2
Nov 2020	1102	25	1
Dec 2020	911	13	3
Jan 2021	1046	32	5
Feb 2021	971	16	2
Mar 2021	1023	6	2
April 2021	917	6	4
May 2021	1010	6	2
June 2021	1021	8	6
July 2021	1003	4	3



Never Events
A delayed never event was reported in June and is currently under investigation. The incident relates to a retained foreign object post procedure (Retained wire).

Immediate actions taken once the incident was identified where for all future procedures to scan the route of access when the wire is removed.

The team considered it was an equipment failure and therefore have reported this to the MHRA and the supplier.

Summary of Progress with Serious Incident Actions

- Work continues across divisions to manage outstanding actions, to include the development of a robust process to ensure all action owners are aware of their actions and that they are responded to in a timely manner. There has been a significant reduction in the numbers of open actions which are overdue by six months.
- A new Patient Safety Incident Framework is being introduced into the NHS from the Summer of 2021 and this will have an impact on the Trust's current serious incident policy and processes. A gap analysis will be undertaken and reported to a later Quality Committee meeting.
- A total of 9 StEIS (Strategic Executive Information System) incidents were reported; 6 for June and 3 in May.

Learning from Safety Incidents

Serious incident reports submitted to the Clinical Commissioning Group (CCG) in June 2021 and July 2021 are as follows:

Incident Summary	Learning Need and Organisational Learning
Medisoft – system upgrade	System upgrades can impact in unanticipated ways and upgrades to 'fix' an issue may inadvertently create another system issue. Staff should ensure they are aware of system changes and be vigilant to look for emergent unanticipated issues.
Governance processes for dissemination, evidencing the response to, and embedding of actions to mitigate risks identified by National CAS Alerts	Risk should be afforded adequate time for discussion and given an appropriate level of challenge. Internal audit reviews should be clear on their scope, and the Trust should understand gaps in the review so that assurance is not misinterpreted.
Administration of oxygen. Portable oxygen not activated.	Staff working beyond the scope of their role and skillset increase risk of incidents and potential for patient harm. Where circumstances on a ward necessitate deviation from policy to ensure patient care is responsive, then this should be escalated and risk assessed.
Road traffic accident. No full body trauma examination.	Emergency Department clinicians should remain cognisant of the lower threshold for looking for injuries in the elderly.
Clinical negligence claim. Failing to prescribe anticoagulants after surgery for a pacemaker.	The patients age is often a significant factor in risk assessment, and where an imminent significant birthday may put the patient at higher risk bracket, then there should be a plan for consideration or commencement of the indicated therapy.
Further investigations were not planned following incidental findings reported by a Radiologist.	Obtaining a further opinion from peers or within a MDT is helpful if the clinician is unsure whether action is required in respect of the incidental finding. The patient should be told of incidental findings whether or not further investigation or treatment is indicated at that time, so that if they become symptomatic in future, they are aware of the previous finding and can highlight it.

Incident Summary	Learning Need and Organisational Learning
A review of previous imaging showed kidney tumour present on previous MR performed 14 years back but was not reported on.	Where there is a focus on reporting a known or suspected clinical condition, there is a risk that Radiologists and Radiographers may not identify incidental findings elsewhere on the imaging. The reporter should review the whole imaging.
A retrospective review of CT scans in 2015 revealed and reported small lesion on the left kidney. No clear evidence about any actions made at that point and the lesion was not further assessed.	The recipient of an imaging report may miss reported incidental findings where these are in the body of the report, and not clearly stated as 'For action'. [This requirement is now in place for radiology reporting]

8. Medicines Safety

The Medication Safety and Compliance Group (MSCG) continues to raise awareness of the importance of safe storage, prescribing and administration of medication.

The priority MSCG work streams are:

- Development of an electronic recording solution for controlled drug (CD) registers to improve our CD documentation and compliance with legislative requirements
- Phase one of installation of electronic medication storage cabinets. This first phase is for installing the required cabinets in our Emergency Departments to ensure we have robust storage facilities, reduce risk of medication error selection, reduce risk of medication diversion and free up nursing time to care
- Go live for active temperature monitoring for medication stored in fridges and then expansion of system to include ambient temperature monitoring

Main concerns/ escalations:

- Lack of quoracy at MSCG due to gaps of divisional / cancellation of last meeting due to operational pressures
- Training requirements of ward staff for use of electronic CD registers and Active temperature systems. Both systems due to go live in the next 3 months and will require release of ward staff to complete training.
- Initial review of ambient active temperature monitoring reports shows 60% areas where medicines are stored, the temperature is >25 degrees

Issue	Update	Risks	Mitigations	Next steps	Assurance
Non-compliance of the medicines management 'must do's **Ongoing objective requiring continual monitoring**	Bi-annual pharmacy audits continue to be completed and highlight both areas of good and poor practice. Meds Management nurse working closely with Trust WEB designer team to produce an electronic annual medicines management audit tool for ward managers to complete. Trials of audit tool currently being completed in 3 areas.	Audits only give a snapshot of routine practice	Ad hoc spot checks by pharmacy team and senior nurses to ensure required standards are consistently met	Trial of electronic audit system and feedback from users Roll out to all ward managers to complete annual audit electronically by October 21. Due to current operational pressures, may be a requirement to delay this audit/ extend completion date. To be discussed/ confirmed at next MSCG meeting	**REASONABLE ASSURANCE**
Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100% compliant. Repeated audits continue to show poor compliance. **Go live for Active temperature monitoring system- target completion date 31st Aug 21**	Temperature assets placed in clinical areas for monitoring ambient temperatures to identify any potential areas of noncompliance before system go live. SOP for how to access and update active temp system shared with Digital Ops board and Nursing and Midwifery Committee for approval	Staff may tamper with new temperature devices as they may not know what they are Staff have turned off current' traditional' fridge thermometer alarms (reliant on for manual monitoring of fridges until the active system go live). This results in no audible alarm i.e., when fridge door left Once we go live with ambient temperature monitoring there is a financial risk for any areas whose temperature is consistently above 25 degrees Celsius as they may need air con installing	Screensaver and comms issued to clinical staff showing pictures of monitoring devices including instruction stating not to tamper with devices Daily manual recording of fridge temperatures continues until active system Go Live (Aug 21) Pharmacy audits continue to check 'traditional' fridge monitor alarm correctly switched on and daily monitoring of temperatures is recorded For any areas storing meds at higher than recommended temperatures, there is a pharmacy led process of reducing expiring dates (depending on exposure length and temp reached). This carries the added risk of increased waste of medication/ cost	Identify those staff requiring Training Stanley Active temperature monitoring system. Not all areas have a phone or zebra device so review of how to receive alerts in those areas. The Imprivata single sign on has been withdrawn and there will be a generic ward log in.	**REASONABLE ASSURANCE**

Issue	Update	Risks	Mitigations	Next steps	Assurance
To improve medical gas training to ensure compliant with HTM requirements	New oxygen group as a subgroup of medical gas group. Remit is to review medical gas and oxygen training and ensure both cylinder device training and clinical oxygen therapy training compliance is clearly available to divisions	Not all clinical staff may be up to date with training	Completion of Datix reports when any incidents relating to medical gases including poor practice occur	New training package out for comment (in Sway training format). Oxygen training sub-group meeting on Wed 11th Aug to review feedback. Next steps to take training package to the Nursing and Midwifery Practice Education Group. The training will be via the internet, with completion of the embedded questions as proof of training. Managers would then submit a declaration to ESR for monitoring. Promotion of the training would include posters, bite size info on the monthly newsletters, block emails to managers, etc, and their ESR would be put on red until it completed	**LIMITED ASSURANCE**
Requirements for areas administering Entonox and nitrous oxide to complete annual occupational exposure checks	Site visits completed by Peritus. Compliance report produced for HRI. Awaiting CRH report. HRI report showed no major concerns.	Not all staff using gas were tested (just a sample) and exposure levels were dependent on amount of Nitrous oxide/ Entonox being used during the clinical session. The test may have been completed on a day of 'light' exposure/ low gas use	Good ventilation in NO/ Entonox areas Repeat testing in 12 months	Meeting planned for 1st September with Health and Safety lead, pharmacy and directorate leads to discuss CRH and HRI exposure reports and the recommendations in the report as some appear nice to have rather than essential for staff safety.	**SUBSTANTIAL ASSURANCE**

9. Maternity Services

9.1 Ockenden report

Maternity services submitted evidence against the 7 Immediate and Essential Actions of the Ockenden Report by 30th June. We have been advised that the next step would be a site visit by the Regional Chief Midwife and her team, and that the visit should be completed by the end of July 21. Maternity services are currently awaiting a date for the site visit. The second Ockenden report is likely to be received towards the ned of the year and it is likely the focus could be extended to neonatal services.

The Perinatal Quality Surveillance Meetings continue to be held monthly with attendance from CHFT maternity safety champions CCG and LMS colleagues. The agenda for the meetings is continuing to be revised and developed following each meeting.

On the 6th May 2021 maternity services submitted a bid for funding from the additional £95.6 million NHSEI made available to support sustained improvement in maternity services. The submission criteria was closely aligned to midwifery staffing and the requirement for a current Birth Rate Plus (maternity staffing tool) report. NHSEI and the regional midwifery leads have reviewed all the submissions and CHFT maternity services have received notification that we have been awarded funding for 10.9 wte (whole time equivalent) midwives (against a submission for 20wte midwives) and 0.2 wte Consultant hours (against a submission for 4 PA's) for the current financial year. At the moment it is unclear whether the funding will be available in the next financial year. NHSEI's workforce department will be providing written confirmation to providers from the 12th July.

9.2 Better Births

On the 25th March NHSEI released its Maternity and Neonatal transformation priorities with a commitment to women receiving continuity of carer. There is a recognition of the potential barriers which includes inadequate staffing and ensuring that the model is based on a team approach with a named Obstetrician attached. Within the document there are 9 objectives, but particularly relating to continuity of care (COC) are:

*Put in place the building blocks by March 2022 so that **continuity of carer** is the default model of care offered to all women by March 2023, specifically:*

a) *Undertake a Birth-rate Plus assessment to understand the current midwifery workforce required and follow this through with recruitment.*

CHFT's are compliant with this objective with a Birth Rate Plus report received into the organisation in November 2020. The Birth Rate Plus team use local factors such as demographics of the population, socio-economic needs, and complexity including neonatal complexity to calculate the number of midwives required to provide maternity care. The report suggested a deficit of 20 wte midwives to deliver the current model of care (4 COC teams and all other women receiving a traditional model of care) with a further 5wte midwives required to deliver the vision of all women booked on to a COC pathway.

b) *Co-design a plan by July 2021 with local midwives, obstetricians and service users for implementation of continuity of carer teams in compliance with national principles and standards and phased alongside the fulfilment of required staffing levels. This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.*

CHFT's plan for the continued roll out was shared with the Local Maternity System (LMS) on the 14th July, with plans in place for further support virtual visits from the LMS and NHSEI and the national lead for the COC programme.

c) *Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022.*

CHFT maternity services currently have 2 continuity of carer teams with a focus on health inequalities and our BAME communities., One team is based at the Jubilee Children's Centre in the Park Ward of Halifax and the second based around the Chestnut Centre in Huddersfield. Maternity services submit monthly statistics to the LMS of percentage of all women and percentage of BAME women booked on to COC pathway.

Month	% women booked onto COC pathway	%BAME women booked onto COC pathway
Jan 21	22%	40%
Feb 21	25%	55%
March 21	20%	47%
April 21	21%	49%
May 21	20%	51%
June 21	23%	47%

d) *Develop an enhanced model of continuity of carer which provides for extra midwifery time for women from the most deprived areas for implementation from April 2022.*

This piece of work is yet to be undertaken; the national lead for COC describes a Band 3 MSW being attached to each COC team to deliver additional support to women for example healthy eating on a budget, additional social support visits.

9.3 NHS Resolution Maternity Incentive Scheme

NHS Resolution is operating a third year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. As in year two, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. In order to mitigate the financial impact of Covid-19, CNDT MIS contributions were not taken in April 2020 as would otherwise have occurred. Effectively this means that trusts have had a "year off" paying their contributions and additional time to implement the three-year scheme which was relaunched on 1st October 2020 with a further revision in March 2021.

The scheme incentivises 10 maternity safety actions and CHFT maternity services will be reporting compliance with all 10 safety actions. The safety actions encompass areas such as staff training, workforce metrics, the ATAIN (avoiding term admissions into the neonatal unit) and Saving Babies Lives Care Bundle (SBLCB) work streams and accurate and timely reporting of cases to the national Perinatal Mortality review Tool (PMRT), Healthcare Safety Investigation Branch (HSIB), and NHS resolutions Early Notification (EN) scheme.

CHFT submitted compliance with all 10 Safety Actions on the 22nd July.

9.4 Stillbirth/ Late Fetal Loss

All cases of stillbirth or late fetal loss are reviewed at the weekly maternity governance meeting, however the Midwifery Reader and Clinical Governance Midwife are reviewing all the cases from 1st June 2020 to 31st May 2021 as there has been noted an increase in cases when compared to the same time period in the last year, January – June 2020 (n=3) January- June 2021 (n=13). The results of the audit will be reviewed through maternity forum. To note, early indications suggest that women have accessed antenatal care (there have been nationally reported concerns that some women were hesitant to access antenatal care early in the pandemic, not an issue at CHFT.

9.5 Neonatal Deaths

One neonatal death has been reported in June 2021. The death has been reported to HM Coroner but is not HSIB reportable due to the gestation of the baby.

9.6 Healthcare Safety Investigation Branch (HSIB)

As of 27th July, the maternity services position is:

Cases to date	
Total referrals since Dec 2018	22
Referrals / cases rejected	4
Total investigations to date	18
Total investigations completed	15
Current active cases	3
Exception reporting	0

9.7 Maternity Incidents

Maternity incidents reviewed at weekly maternity governance MDT meeting. All incidents are reported via Datix and coded as maternity incidents.

	Total
Unplanned transfer to specialist care unit	21
PPH- no adverse outcome	7
Delay or failure to monitor	7
Delayed transfer for ARM/Augmentation	7
Unexpected admission to the Neonatal Unit	6
2nd Theatre opened	5
Lack of/ delayed availability of operating theatre	5
3rd or 4th Degree perineal tear	5
Delay in Emergency Caesarean Section	5
Cord pH<7.15	4
Total	**72**

9.8 Maternity Complaints

Maternity services currently have 4 open complaints under investigation and within timescale.

9.9 Maternity Staffing

In 2015 NICE produced it's guidance on safe midwifery staffing and the provision of 1:1 care is a recognised recommendation within the guidance and as such is reported on the maternity services dashboard.

	Dec 2020	Jan 2021	Feb 2021	Mar 2021	April 2021	May 2021	June 2021	YTD 2021/2022
1:1 Care in labour	100%	100%	99.7%	99.7%	98.9%	100%	100%	99.6%

Unfortunately, this metric is not recorded on the regional dashboard, so it is not possible to benchmark CHFT against other services.

Midwifery has recruited 13 wte newly qualified midwives as part of the Local Maternity System (LMS) wide recruitment, with a further 7 wte vacant posts plus the newly funded 10.9 wte midwifery posts currently in the process of advertisement.

Obstetric Staffing is more challenging with gaps in the middle grade rota as a result of deanery gaps in the obstetric training rota. This has been mitigated by the recruitment of trust grade doctors and is reflected on the Directorate risk register.

9.10 User feedback

Following the 12th April mandate from the Secretary of State for Health for the full introduction of support for pregnant women accessing maternity services maternity services are able to report that birth partners can support women at all contacts throughout their pregnancy journey both in the hospital and community environments.

The Head of Midwifery and Community Midwifery Matron attended the quarterly Maternity Voices Partnership (MVP) meeting in July, where the audit of women's' experiences of maternity care at CHFT from September 2020 was shared. Whilst there was much positive feedback, there were areas for improvement such as ensuring women have sufficient information to make informed decisions, waiting times in clinics, women feeling isolated in single room accommodation and postnatal visiting. The report has been shared with ward managers to share with teams at ward meetings to develop local action plans, and the new MVP Chair will be invited to co-produce an overarching action plan.

10. Quality Priority updates

Set out below is the first report in relation to the Quality Account Priorities for 2021/2022. The report details each priority and the measures to be monitored and reported into the Quality Committee this coming year.

Quality Account Priorities

CQC Domain: Effectiveness	CQC Domain: Safety	CQC Domain: Experience
Recognition and timely treatment of Sepsis 	**Reduce the number of Hospital Acquired Infections including COVID-19** 	**Reduce waiting times for individuals in the Emergency Department (ED)** 

Focussed Quality Priorities

CQC Domain: Caring	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Responsive	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Effective
Reducing the number of Falls resulting in harm 	**End of Life Care** 	**Increase the quality of clinical documentation across CHFT** 	**Clinical Prioritisation (Deferred care pathways)** 	**Nutrition and Hydration for in-patient adult and paediatric patients** 	**Reduction in the number of CHFT acquired pressure ulcers** 	**Making complaints count: Implementation of the national regulations & PHSO standards (phased introduction)** 

10.1 Recognition and timely treatment of Sepsis

We will this year undertake quality improvements to:

- Improve the recognition and timely treatment of Sepsis

What do we aim to achieve?		Update – June 2021	Progress rating
QP1.	Increase our concordance with the administration of intravenous antibiotics in the emergency depts. within 60minutes of recognition of sepsis to 80% for the severely septic patient. This will be measured by using the Red Flag Criteria for severe sepsis recognition. Concordance is captured by the timing from the earliest suspected sepsis alert to the administration of the first intravenous antibiotic through the electronic patient record system.	**June 2021 = 59.1%** **July 2021 = 80%** *(may change as still in month)* The above percentages are based on all patients with suspected sepsis in the Emergency Department (ED) at both sites. Red flag data collection requiring further work to ensure accuracy. **Update** ▪ Meeting with Informatics taken place 22/7/21, agreed sepsis nurse and ED consultant will look at 3 months of non-compliant patients so issue can be identified. ▪ (ED) consultant monitoring non-compliant patients and feeding back issues at the ED handovers for learning and action. Compliance from this clinical audit indicates ED performance at 85-90% ▪ Consultant also updating ED specific sepsis training presentation for clinicians. ▪ Sepsis nurse requested to attend ED QI Forum in September 21 ▪ Sepsis trollies purchased and in use at both sites. ▪ Macoset device being trialled in HRI ED to assist speed in mixing Pip Tazocin. ▪ Sepsis nurse training the ED health care assistants about NEWS 2/sepsis. ▪ ED clinical educator addressing sepsis on Registered Nurse (RN) induction. **Risks identified** ▪ Flow issues through the EDs have been noted to effect administering of intra venous antibiotics within 60 minutes. ▪ Consistent use of sepsis trollies and storage when not in use remain an issue. ▪ Macoset device supply delay for onward trial. **Actions** ▪ (ED consultant) to monitor that suspected sepsis patients are categorised as level 2 and seen in rapid assessment where appropriate. ▪ ED Consultant to report results of noncompliant patients in ED monthly plus feedback issues to ED clinicians. ▪ Lead Sepsis Nurse to oversee and support consistent use of sepsis trollies. ▪ Lead Sepsis Nurse to follow up request for further Macoset devices so audit of usage versus Pip Tazocin doses can commence.	**Reasonable Assurance**

What do we aim to achieve?		Update – June 2021		Progress rating
QP2.	Compliance of all elements of the sepsis 6 (BUFALO) to be improved to 50% **single elements to be improved to 90%**	**June 2021**	**July 2021**	
	Blood cultures	82.9%	68.3%	**Reasonable**
	Urine output	59.7%.	51.2%	**Limited**
	Fluids	98.4%.	100%	**Substantial**
	Antibiotics	96.9%.	100%	**Substantial**
	Lactate	Unable to add Lactate to EPR		
	Oxygen	87.6%.	97.6%	**Substantial**
	Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.	**Update** ▪ Oxygen data now being reported on compliance if received oxygen or the patient's oxygen saturation is between the target of 92-98% or 88-92% (risk of hypercapnic respiratory failure). Some improvement noted, agreed to wait for next month's data results and audit 20 non-compliant patients to check if any issues/learning points within the data pull from EPR. ▪ Sepsis care bundle addressed on training and through communication channels (Trust News, Sepsis Press, Sepsis Teams Channel, Training, poster drops, ward meetings). ▪ No date available for Lactate adding to EPR, RM advised business case with digital Transformation Director. ▪ Sepsis nurse working to improve recording of blood cultures as compliance variable- focussing on the front-end areas. 20 non-compliant patient audit taking place will be completed by 6/8/21 ▪ Sepsis nurse attended Chief Nurse band 7 forum to deliver information about 3 sepsis QP and how ward and department managers can influence clinicians using the sepsis screening tool and prompt their staff to complete their sepsis essential training when on ESR. **Risks identified** ▪ Blood cultures not consistently recorded on EPR. ▪ Urine output pulling through to Nerve centre. ▪ Oxygen compliance (with new measures) has not improved as expected. ▪ Awaiting Lactate to be added to EPR. **Actions** ▪ The Clinical operational lead to contact the CMIO regarding ABGs and VBGs being pulled through to EPR. ▪ Lead Sepsis Nurse auditing 20 non-compliant patients for blood cultures to pull out any issues. ▪ Lead Sepsis Nurse to continue working with front end areas regarding improving the recording of blood cultures on EPR. ▪ Urine output being addressed by separate working group.		

What do we aim to achieve?	Update – June 2021	Progress rating
QP3. Establish sepsis skills training as part of essential safety training and achieve 40% concordance for eligible staff in year 1. This will be measured by training compliance records extracted from ESR and Lead Sepsis Nurse presentations.	**Update** ▪ Training application form for ESR and combined sepsis presentation for clinicians/registered nurses approved by Sepsis Collaborative Members. 250 RN have received sepsis training, there are currently 9 clinician sepsis champions and 45 RN champions. Sepsis nurse meeting with Divisional Matrons to deliver sepsis updates. ▪ Junior doctor induction- EPR sepsis power plan is in the handbook with video link to training presentation. EPR team asked to raise the importance of viewing the slides during the Induction programme. ▪ Business intelligence have now provided the training numbers: - Consultants (except Obstetrics and Gynaecology) 250 - Foundation years (except Obstetrics and Gynaecology) 82 - CT (except Obstetrics and Gynaecology) 31 - ST (except Obstetrics and Gynaecology) 69 - Clinician Total **432** - Registered Nursing Total **672** **Risks identified** ▪ Sepsis recognition and treatment not currently part of essential safety training. ▪ New ESR manager recruited, delays setting up due to backlog of ESR requests. **Action** ▪ Lead Sepsis Nurse submitted training application form with Presentation and Quiz to ESR manager, meeting taken place to discuss setting up, requested date to be submitted to nursing midwifery/WEB ▪ Lead Sepsis Nurse to continue delivering face to face and Teams sepsis training.	**Limited assurance**

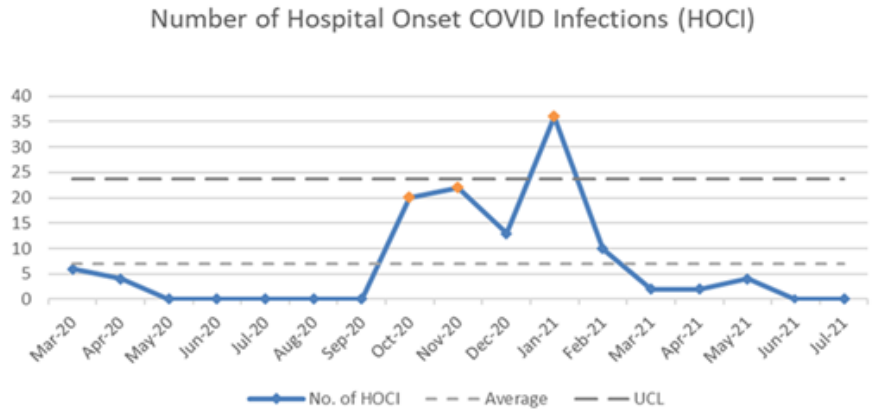
10.2 Reduce number of Hospital Acquired Infections including COVID-19

We will this year undertake quality improvements to:

- Reduce the number of Hospital Acquired Infections including COVID-19

What do we aim to achieve?	Update	Progress rating
QP1. Through the testing workstream we will ensure that all CHFT patient and colleague testing strategies are compliant with National and Local guidance. This will be measured by performance against patient testing regimes and colleague lateral flow device (LFD) testing.	CHFT are compliant with the minimal national patient testing regime and also include based on review of testing additional tests are undertaken as part of our local guidance Lateral Flow Device (LFD) testing is in place as per national guidance We have seen a decrease in reported testing and through leadership briefing and the MUST Do we encourage colleagues to undertake LFD testing	**Substantial assurance**
QP2. Support a system wide approach to Covid-19 vaccination programme through CHFT vaccine centres and support to the national programme.	The trust continues to plan for its anuual vaccine programme and will implement this alongside national guidance	**Substantial assurance**
2a Establish specialised vaccine clinics for people with Learning Disabilities (LD)	Specialised clinics have been established to support people with a learning disability to receive their vaccines and will be included in future planning	**Substantial assurance**

What do we aim to achieve?		Update	Progress rating
2b	Establish clinics for people with allergies	Specialised clinics for patients with multiple allergies and/or previous anaphylaxis were undertaken, again outside of the routine clinics, supported by a Consultant Anaesthetist, senior nursing, and administration staff. A total of 17 allergy patients have been through the clinics. The final allergy clinic session is planned for 28 June 2021 for the administration of second doses. All future allergy referrals for the whole of West Yorkshire where there is the need to administer the vaccine in an acute setting will be managed at Airedale Hospital.	**Substantial assurance**
2c	Through our community teams support the vaccine programme across Calderdale	The community healthcare division has proactively supported the vaccination programmes across Calderdale place and has included this in the system wide winter planning.	**Substantial assurance**
2d	Through our partnerships support the vaccine programme across Kirklees	CHFT have remained an active partner on the Executive Partnership meeting for Kirklees and have contributed both in leadership activities and resource support to the programme	**Substantial assurance**
	This will be measured as a narrative against the indicators and numbers of people vaccinated where data is available.		
QP3.	Reduce the number of preventable Clostridium Difficile infections	A 'deep dive' of the 49 C-diff cases from 2020/2021 was undertaken in May 2021; key learning was identified, and an action plan has been developed which is being led by the Infection Control Doctor/Consultant Microbiologist. Awaiting National healthcare associated infections (HCAI) objectives.	**Substantial assurance**

What do we aim to achieve?		Update	Progress rating
	This will be measured by ensuring we do not exceed the threshold of 40 cases set in 20/21 (awaiting national guidance 21/22 target)	The targets have now been published and will be monitored in the Integrated Performance Report (IPR) from next month.	
QP4.	Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection (HOCI) This will be measured by the rate of HOCI each month.	COVID patient pathways are in place to minimise the risk. Any HOCIs identified are reported immediately and a rapid RCA completed. HOCIs are currently reported weekly to Infection Prevention and Control (IPC) Gold and monthly to IPC Performance Board. Every action count tools are being used to support alongside the updated IPC guidance Lessons learnt from HOCI are shared to support organisational learning. The IPC Board Assurance Framework (BAF) is reviewed within the governance structures. 	**Substantial assurance**

10.3 Reduce waiting times for individuals in the Emergency Department

We will this year undertake quality improvements to:

- Reduce waiting times for individuals attending the Emergency Department

What do we aim to achieve?	Current update	Progress rating
QP1. Implement and monitor effectiveness of the standard operating procedure to prevent any 12-hour breaches within the ED department This will be measured by: • Number of (NHSE/I) reportable 12-hour breaches	Presented to DQB in June that new reporting mechanism (on discharge) implemented April 2021 ensures that all length of stay (LOS) in the ED are captured and reported accurately. **No change still capturing any LoS >12 hours**	**Reasonable Assurance**
• Internal standard: Number of patients who waited >12 hour within the department from time of arrival	Zero tolerance as reportable. There were two patients over 12-hour breaches last month discharged home non-reportable. **This has increased to 36 patients having a LoS over 12 hours non-reportable**	**Limited assurance**
• Training delivered for on call teams to support implementation of the SOP	Surge and escalation document in use ensuring wide communication between all on call elements and tactical leads. **In use and distributed to clinical commanders / night matrons. Next step to distribute to on-call managers following engagement session scheduled to be held in October 2021.**	**Limited assurance**
QP2. To align reporting systems with Cerner and the DATIX incident reporting system. This will be measured by • Establishment of >12hr DTA breach report from Cerner that matches incident reporting	New datix format for 12-hour LOS implemented by risk	**Substantial assurance**

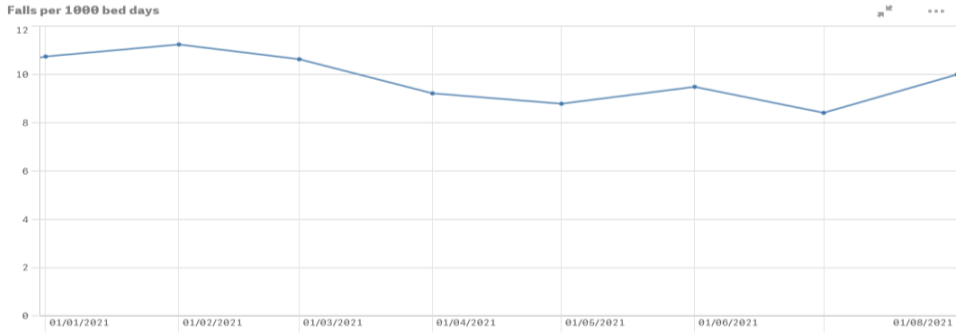
What do we aim to achieve?	Current update	Progress rating
QP3. Improved documentation of Intentional care rounds to ensure patients are receiving effective pressure area care, nutrition and hydration. This will be measured through: • No of colleagues who undertake training for intentional care rounds	Documentation audit in place to provide assurance to lead nurses that standards are met. Requires further monitoring to establish success. **Ongoing**	**Reasonable Assurance**
• Monthly audit of patient cases to review compliance with clinical documentation	Care is reviewed via datix	**Reasonable Assurance**

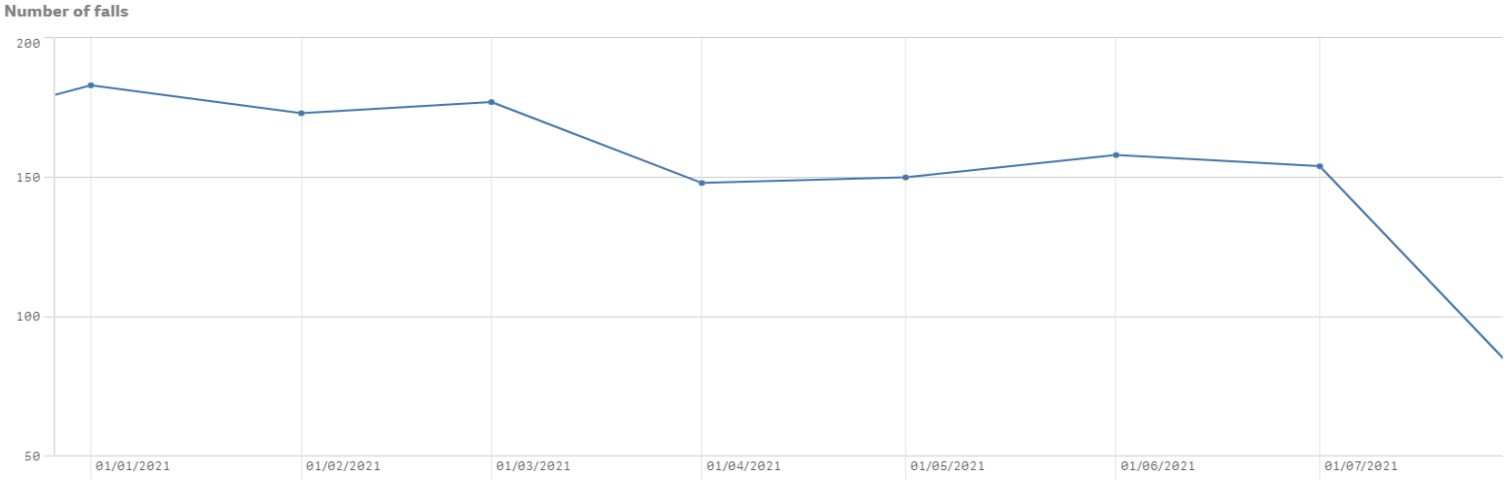
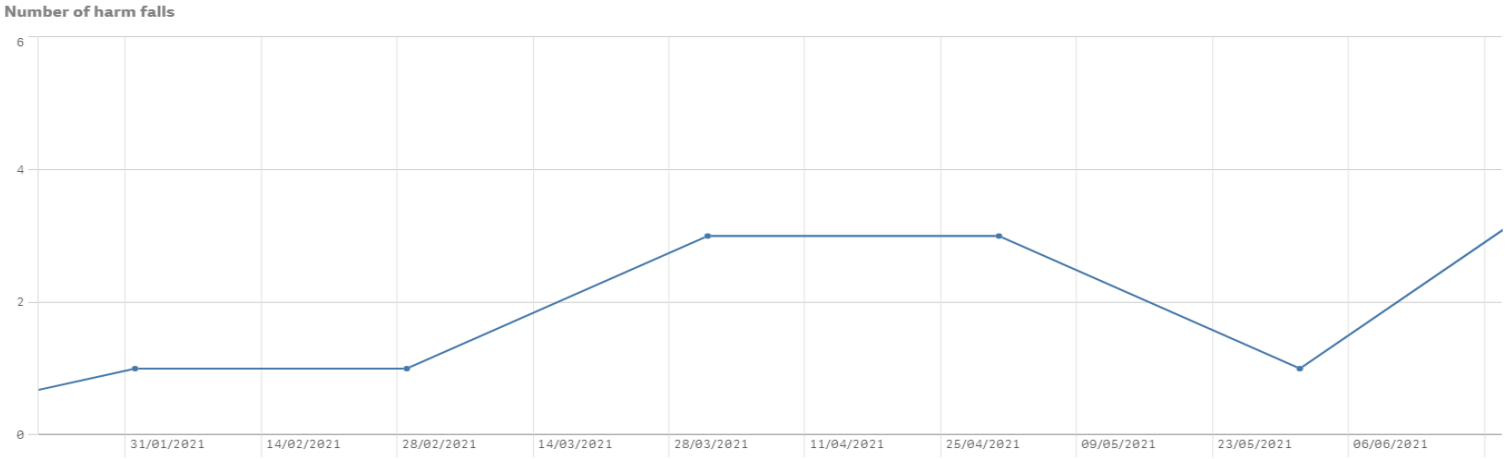
Set out below is the first report in relation to the Trust Focussed Priorities for 2021/22. The report details each priority and the measures to be monitored and reported into the Quality committee this coming year.

10.4 Reducing the number of falls resulting in harm

We will this year undertake quality improvements to:

- Reduce the number of inpatient falls and those resulting in harm by 10%, by the end of 2021 / 2022

What do we aim to achieve?	Current update	Next steps	Progress rating
Reduce the total number of falls. Reduce number of harm falls by 10%	Number of harm falls plateaued to two harm falls each month for last three months. Total Number of falls on downward trajectory since January. Have reduced harm falls by four since 2019 – 2020 from 22 - 18. However, this may not be a true picture due to COVID-19 pandemic. Number of total falls is gradually reducing. 	Trialling “Call, Don’t Fall” posters on Acute Floor CRH with a view to roll out across the trust. Medication reviews, Lying and standing BP and encouraging multifactorial assessment in falls, tailored to patient’s needs. Reintroduced the FISH tool since COVID outbreak. Therapy are looking into purchasing red zimmer frames for patients with a visual /cognitive impairment. LG to chase with Therapy leads.	**Reasonable assurance**

What do we aim to achieve?	Current update	Progress rating
	 **Number of falls**  **Number of harm falls**	

What do we aim to achieve?	Current update	Next steps	Progress rating
Slip trip policy to include measurable falls assessment risk target	Slips, trips, and falls policy updated to include time frame for falls assessment on admission and transfer for patients over age 65 to new ward to be completed within two hours. Post falls review algorithm completed, being reviewed in falls collaborative on 27/5/21 then will be updated in policy accordingly.	Falls policy to be updated to include algorithm. This is ongoing as reviewing comments from Safeguarding regarding the policy. LG is reviewing the Slip, Trip and Falls Policy in relation to dementia. AC and LG to update policy to be reviewed by the Clinical Outcomes Group in October 2021	**Reasonable assurance**
Implement audits to check progress against targets	Lying and standing blood pressure taken on admission on ward 6 – plan to roll out to other wards in June/July. Currently ward 6 are at approximately 46% compliance. Lying and standing blood pressure target straightforward to audit, support is needed to audit medication review and mobility review (as need to go through patient notes and is time intensive).	Two hour falls assessment to be audited. Continue to audit 2 hour falls assessments Lying and standing BP, mobility assessments and medication reviews are being audited on ward 6 with a view to roll out across the trust.	**Reasonable assurance**
Implement Learning from Serious Incidents (SIs)	Learning disseminated through falls collaborative and divisional Patient Safety and Quality Board (PSQB) meetings: • Need to implement bite sized learning and disseminate • develop falls link practitioner role to support learning through the Falls collaborative. • Helen Hodgson (Matron) and Lauren Green (LG) (Dementia Lead) meeting 18th June to develop the learning outcomes from recent SI's. • LG is gathering data and information from other Trusts to support implementation of changes in this organisation.	Falls Collaborative has been reviewed – Learning from Serious investigations are reviewed and implemented through the Falls Collaborative. Falls Link Practitioner role – names of staff collected, LG in process of developing a training programme of learning for allocated fall link staff. Falls Week – collaborating with Locala. Visiting each ward to educate staff on falls prevention – to discuss further in Falls Collaborative. LG to collate information collected and present findings to next Falls Collaborative.	**Limited assurance**

10.5 End of Life Care

We will this year undertake quality improvements to:

- Ensure the needs of both the patient and their families/carers does not vary in quality because of an individual's characteristics by ensuring care provision is individualised, timely and relevant.
- Ensure improved resources for relatives and carers relating to breaking bad news relating to End of Life (EoL) care

What do we aim to achieve?	Current update	Progress rating
QP1. Implement a 7-day service across community services Measure impact of 7 day working across the Key Performance Indicators EoL dashboards	7-day service commenced within Calderdale community specialist palliative care (SPCT) in April/May this year. Dashboard to be approved. A prospective audit was undertaken during the months of April and May 2020 at the height of the COVID 19 outbreak at CHFT. The audit was undertaken to determine numerically how many patients benefitted from the 7-day service the team provided at that time, and to capture our work at weekends / bank holidays to showcase the difference the service made to patients, families and colleagues.	**Reasonable Assurance**
QP2. Implement a 7-day service within the in-patient areas Measure impact of 7 day working across the Key Performance Indicators EoL dashboards	Due to current sickness levels in palliative care the move to a 7-day SPCT service has been paused. Modelling has suggested that the current workforce could support a 7-day service, however, due to documented and evidenced concerns a business case for an enhanced SPCT model has been developed and will be submitted in July 2021.	**Limited Assurance**
QP3. Improve access to ePaCCs for patients within Frailty service This will be measured through an audit of records every quarter	ePaCCs is accessible to the frailty team and work is ongoing to make this accessible to clinical staff. Ward 6 and SDEC areas have gained access and teaching provided. The plan will then be to roll this out across elderly care	**Reasonable Assurance**
QP4. Introduce a standard(s) that will improve a person's experience pre and post bereavement delivered by the ward teams This will be measured by qualitative narrative quarterly by EoL care facilitator.	The bereavement service as highlighted in QP5 will act on negative and positive person's experience gained from the bereavement telephone service. Currently the Educational Facilitator and assistant work with wards and groups to improve overall care but specific areas are targeted based on feedback from the bereavement service where necessary.	**Reasonable Assurance**

What do we aim to achieve?	Current update	Progress rating
	A business case has been prepared and will be submitted to support the maintenance of the bereavement service as 'business better than usual' moving forward. The bereavement service will feed back person narrative and improvements to the End-of-Life Care Steering Group quarterly in a 'you said, we did' style report.	
QP5. Review the Bereaved relatives telephone support service This will be measured by a qualitative and quantitative review of the service established during the pandemic	Ongoing review of the bereavement support service. We now have the bereavement service as part of the Datix reporting to enable us to look at trends and implement changes. Writing a business case to look for substantive funding for this service – building back better than usual. Overwhelming positive feedback from the relatives we speak to. Q2 will establish data capture of number of calls undertaken as a percentage of people who died within in-patient areas.	**Reasonable Assurance**
QP6. Review Visitors guidance in line with national guidance and monitor compliance This will be measured by a Quarterly audit of the guidance in relation to EoL patients	Visiting adhered to national guidance. Further local safety issues were taken into consideration when needed. Two general visiting audits were completed in the last quarter 20/21 which highlighted improvements in compliance. From an end-of-life point of view regular audits are completed as part of the bereavement telephone service. Improvements and complements are fed back into the system through the actions resulting from QP4 above.	**Substantial assurance**

10.6 Clinical Documentation

We will this year undertake quality improvements to:

- Measure this piece of work is to ensure that the clinical record gives an accurate picture of the patients diagnoses, the care provided to that individual, that it reflects the standards laid down by the Trust and that information is recorded consistently.

What do we aim to achieve?	Current Update	Progress rating
QP1. Optimise the Clinical Record 1a. Complete the in-depth analysis	Company identified – stuck in the procurement process at the moment. July 21 – Meeting arranged with company 20.07.21	**Reasonable Assurance**
1b. Benchmark	Subject to the outcome of the in-depth analysis	**Reasonable Assurance**
1c. Set local standards	Subject to the outcome of the benchmarking	**Reasonable Assurance**
QP2. Trial the use of the Digital White Board Identify areas to trial over a 4-week period - implement the white boards identifying data that can be pulled and measured to determine progress and future planning.	Trial period commenced – end date 15th June 21. July 21 – evaluation of the trial underway.	**Substantial assurance**
QP3. Carry out a full review of the Ward Assurance within the KP+. 3a. Look at current data captured with service users	This will be reviewed by the SME's and Ward Managers following the Work Together Get Results (WTGR) piece. Work to commence July 202. July 21 – Task and Finish Groups to be formed now WTGR completed to look at data capture.	**Reasonable Assurance**
3b. Assess whether data relevant	Full review of data to be carried out regarding not only relevance, but also how staff can make it more meaningful to them in addressing shortfalls. July 21 – Task and Finish Groups to be formed now WTGR completed to assess whether data relevant.	**Reasonable Assurance**
3c. Agree metrics for collection	Metrics already agreed upon – review of data being extracted.	**Substantial assurance**

What do we aim to achieve?	Current Update	Progress rating
QP4. Ensure Ward Managers and Matrons own their own ward data using KP+ 4a. Ensure that all Ward Managers and Matrons have access to KP+	Staff groups contacted already – awaiting feedback. Aim to complete this by end of June 2021. July 21 – engaged with Matrons and Managers – access arranged for those who did not have access.	**Reasonable Assurance**
4b. Provide training in the use of KP+ for Ward Managers and Matrons	This was carried out in November 2020 – further engagement with staff on the 6th August 2021 through Ellen's briefing.	**Substantial assurance**
4c. Embed review of KP+ into daily practice	This will be an action from the WTGR – start end of July 2021. July 21 – further training 6th August 2021 at Ellen's briefing.	**Reasonable Assurance**
QP5. Audit clinical records using an audit tool. Audit 5 sets of records per week by Ward Manager reporting and act upon findings.	Audit to be carried out by Matrons – one per month per each of their wards – to start end of July 2021. July 21 – roll out delayed due to delay in completion of WTGR	**Reasonable Assurance**
QP6. Identify and establish a project team that can drive the improvement of data entry into EPR across the Trust. 6a. Identify the team	This will include Associate Director of Nursing, Matron and Ward Managers across the Trust.	**Substantial assurance**
6b. Identify outcomes wanting to achieve	Working Together Get Results completed at the end of July, face to face to ensure optimum engagement obtained. Action Plan to be completed from the results of the WTGR.	**Reasonable Assurance**
6c. Agree defined goals and action plan that reflects this	Outcome of the WTGR will determine the action plan – aim for this to be available by the end of July 2021. July 21 - Sessions completed end of July – working towards action plan middle of August 2021.	**Reasonable Assurance**
QP7. Ensure training in the use of EPR reflects the standards laid down by the Trust and that it reflects training needs of the staff 7a. Support the Training team to ensure training meets the needs of the service user – fully aligned to roles and responsibilities	Task and Finish Group set up 2/12 ago to review the training plans for medical, nursing and HCA groups as a priority. Some representation from nursing but not medical teams – seeking support from them. July 21 - Progressing well with projected completion by the end of August 2021.	**Reasonable Assurance**

What do we aim to achieve?	Current Update	Progress rating
7b. Encourage Training Team to explore ways in which service users can be supported e.g. online, face to face, digitally	This is being reviewed within THIS. Initial plans e-Learning developer starting in post on 21.06.21 with an immediate action to create e-Learning modules for medical, nursing and HCA roles for August 2021. July 21 – E Learning Developer now in post and e learning sessions already underway.	**Reasonable Assurance**

10.7 Clinical Prioritisation

We will this year undertake quality improvements to:

- Maintain a clear and comprehensive understanding of deferred care pathways as a result of COVID 19

What do we aim to achieve?	Current update	Progress rating
QP1. Ensure recovery plans assess and align the impact of health inequalities for people accessing services. This will be measured by: • Number of patients within the backlog assessed by using health inequality determinants within data sets	The Board of Directors have agreed clear Health Inequalities priorities Capacity and capability are being built to ensure we fully understand the Health Inequality agenda. This is clinical, operational and informatics. A Clinical Reference Group on Health Inequalities has been established and meeting regularly to steer this element of recovery Work has commenced looking at health inequalities data and how this will be used to compliment clinical prioritisation and our post COVID-19 delivery model for both planned and unplanned care. This includes IMD, ethnicity and learning disability	**Reasonable Assurance**
QP2. Monitor compliance with agreed clinical prioritisation process this will be measured by: • using the KP+ data set established monthly through the Integrated Performance Report (IPR)	Trajectories have been developed to monitor delivery of the Board priorities Monitoring undertaken weekly at Divisional level to ensure early investigation of variance and corrective action Further assurance through Performance Review Meetings and IPR	**Substantial assurance**
QP3. The 'Buddy' system is in place for each specialty where it was agreed. This will be measured by monitoring process in place at speciality level	The buddy system is being reviewed to align with national requirement to implement Patient Initiated Follow Up. This is being developed through the Outpatient Transformation Board	**Substantial assurance**
QP4. Measure any Harm as a result of delayed pathways • monitoring of incidents & complaints related to backlogs and establish key themes for learning	All colleagues reminded to complete Datix for any concerns and will be managed in line with Trust Risk management procedures This, along with complaints data, will be reviewed with a clear focus on identifying themes for learning.	**Substantial assurance**

What do we aim to achieve?	Current update	Progress rating
QP5. Establish Learning disability pathway This will be measured through the KP+ portal for Learning Disability	The Trust is prioritising patients with a Learning disability who are treated as a priority regardless of their clinical prioritisation status. To date, 76% of patients have now received treatment. A new pathway from referral is being developed to ensure ongoing prioritisation of patients with a Learning Disability	**Substantial assurance**

10.8 Nutrition and Hydration for in-patient adult and paediatric patients

We will this year undertake quality improvements to:

- The delivery of safe and high-quality nutrition and hydration care for all in-patients at CHFT.

What do we aim to achieve?	Current update	Progress rating
1. A minimum of 90% of staff required to complete Malnutrition Universal Screening Tool (MUST) training will be compliant	July 2021 = 90.5% compliance. This is a slight reduction from last month's 91.3% but still above target	**Substantial assurance**
2. A minimum of 90% of staff required to complete Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) training will be compliant	July 2021 = 73.5 % static position June 2021 = 73.6%	**Reasonable assurance**
3. 100% of adult in-patients will have a MUST assessment within 24 hours of admission & weekly thereafter	July 2021 = 15.2 % Slight reduction on June 2021 = 15.7 % **Mitigation** ▪ Safety huddle inclusion within clinical areas as prompt for completion for clinical staff. ▪ Inclusion within Journey to Outstanding clinical area reviews. **Actions** ▪ The nutritional specialist nurses and dieticians have undertaken some partnership working with Bradford colleagues to review the mandated fields within the MUST assessment to aid with automated calculation of the MUST following completion of 3 mandated fields. The aim is that this will help to improve compliance. ▪ Changes are live and staff are being reminded during other training sessions ▪ WTGR improvement work planned for clinical documentation to include work on nutrition and hydration risk assessment and compliance monitoring. ▪ The WTGR meeting occurred on 14/7/21. Further meeting to be arranged	**Limited assurance**

<table>
<tr><th>What do we aim to achieve?</th><th>Current update</th><th>Progress rating</th></tr>
<tr><td>4. Trust aspiration to achieve 100% of paediatric in-patients having a STAMP assessment within 24 hours of admission & weekly thereafter</td><td>Data collated on nutritional dashboard. This data isn't currently available on the ward assurance dashboard on K+, a request was made on 03 June 2021 to include this</td><td>Reasonable assurance</td></tr>
<tr><td>5. 100% of adult in-patients with a MUST score of 2 or above will be referred to the dietetic service</td><td>July 2021 = 3.1% minimal improvement on June 2021 2.9 % compliance

Again, in partnership with Bradford colleagues, if the MUST calculated score is of 2 or above an automatic referral will be populated to the dietetic team who will screen the patients records and determine appropriate action linking with ward areas appropriately.

The above figures don't reflect the current position. The automated system has resulted in an increase in referrals daily. Jonathan Wood will investigate this further.

This aims to capture a more accurate number of our patients requiring nutritional support from the dietetic team and not be reliant on a separate referral process, as is the system at the current time. This proposed work will be shared with the Digital health group soon.</td><td>Limited assurance</td></tr>
<tr><td>6. 100% of paediatric in-patients with a STAMP score of 4 or above will be referred for nutritional support (i.e., dietician, nutritional support team or consultant)</td><td>This data is not currently available on the ward assurance dashboard on K+, a request was made on 3 June 2021 to include this.</td><td>Limited assurance</td></tr>
<tr><td>7. A minimum of 90% of staff from wards that are regular users or high users of nasogastric tube feeds will be compliant with nasogastric training</td><td>June 2021
<table>
<tr><th colspan="5">High Users</th><th colspan="4">Regular Users</th></tr>
<tr><td>17</td><td>ICU</td><td>Paeds</td><td>Comm Paeds</td><td>HOOP</td><td>5A-D</td><td>6AB</td><td>8C</td><td>7AD</td></tr>
<tr><td>93.7%</td><td>56.4%</td><td>75.0%</td><td>91.7%</td><td>83.3%</td><td>68.5%</td><td>21.0%</td><td>53.8%</td><td>71.0%</td></tr>
</table>
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<tr><td>80.0%</td><td>56.4%</td><td>75.0%</td><td>91.7%</td><td>83.3%</td><td>78.4%</td><td>21.0%</td><td>57.1%</td><td>81.4%</td><td>35.0%</td></tr>
</table></td><td>Reasonable assurance</td></tr>
</table>

What do we aim to achieve?	Current update	Progress rating
	There has been a reduction on ward 17 due to new starters. Nutritional specialist nurses has started to train these and expects numbers to increase shortly Improvement has been seen on respiratory floor and stroke floor , other areas remain static Nutritional specialist nurses has undertaken a period of intense training with staff on ward 20 & 15 and have now reached 62% Divisional reporting via dashboard and monitoring monthly compliance. Initial training and ongoing management undertaken by Nutritional specialist nurses via simulation session. Update training undertaken every 3 years is undertaken through online training package and self-assessment and verification sign off by ward leader and confirming e mail sent through to nutritional specialist nurse (NSN) who collates the data. Areas with lower than 80% offered in reach training/support by NSN	
8. Nasogastric and STAMP training will be added to the ESR platform to enable monitoring by ward managers & matrons	Nasogastric tube training data is available via education and learning dashboard of Business Intelligence spine of ESR 3.6.21 update - ESR compliance is based on the target audiences on position not on an individual level. It must be everyone in that position as they do the same job. Option: To try to put through the EST proforma and ask it to be set up as an EST role specific course. This action will provide compliance if you identify that target audience. But if it gets agreed, the target audience will need to be everyone not i.e., 3/7 nurses on e.g., Ward 5. It must be the full 7 nurses. 3.6.21 update - STAMP training has been requested via EST process to be reported. Nutritional specialist nurse hasn't had a response from organisational learning to say whether a STAMP training package can be developed despite multiple attempts	**Limited assurance**
9. Meal service will be safe,	Divisional actions plan and observation of service delivery in ward areas.	**Reasonable**

What do we aim to achieve?	Current update	Progress rating
organised, and well led on all wards at CHFT	Patient feedback collated by ISS and CHS catering depts. Feedback through patient discussions and complaints/incidents Observation of mealtimes during Observe and Act framework, practice will be monitored through this process and shared at ward level. Leadership observations at ward level	**assurance**
10. The red tray/lid and jug lid alert system will be used consistently and appropriately on all adult in-patient wards	Trust wide initiative not consistently utilised in all ward areas. HRI site A recent review of red trays has resulted in catering dept purchasing further trays and reviewing condition of existing supply. CRH site utilise a red plate lid system for alert due to the meal delivery system, this is reliant on ward staff identifying a requirement for the lid when ordering the meals. Question included within Observe and Act observation tool to monitor local compliance (Theme D. Food and drink) Key themes to date (3 wards)-preparation and assistance at mealtimes and utilisation of red trays and red jugs lids	**Reasonable assurance**
11. CHFT guidelines, policies, strategies, pathways, decision making tools will reflect current NHS guidelines & NICE guidance	CHFT Policies and guidance is reviewed against current NHS guidelines & NICE guidance via the nutrition operational meeting. Includes: • Nutrition and hydration policy (including allergen management) • Food hygiene policy • Parenteral nutrition policy Reviews undertaken as new guidance released and via CHFT policy review process.	**Substantial assurance**
12. The ward assurance indicators for nutrition and hydration will be reviewed for appropriateness and accurate affiliation with CHFT's nutritional policies, guideline etc.	Ward assurance documentation indicators reflect the current guidance within the current Nutrition and hydration policy. Further actions-for discussion of ward assurance indicators at WTGR	**Reasonable assurance**

What do we aim to achieve?	Current update	Progress rating
13. A staff education plan to be developed and actioned to ensure staff know when a fluid balance chart is indicated and understand the importance of monitoring and recording correctly within EPR	No generic education plan No existing CHFT HCA competencies for nutrition and hydration. Nutritional specialist nurse has contacted Pam Wood, meeting will be arranged for end of Aug/beginning of Sept to discuss further Trust compliance with clinical recording of fluid balance on EPR **July 2021 = 19.4% June 2021 = 20.3%** <u>Risks</u> Inaccurate monitoring and recording of fluid balance chart on EPR impacting on patient's clinical outcome and patient experience. <u>Mitigation of risks</u> Clinical based actions-requests via medical team with clear guidance as to rationale for FBC. Accuracy of monitoring/compliance through ward assurance documentation <u>Further Actions</u> Lead to be identified to develop an education plan. NVQ team to devise HCA competencies. Review process of indication/recording/monitoring requirement through WTGR workshop.	**Limited assurance**
14. Theme D (Food & Drink) of Observe & Act reports to be monitored at monthly Nutrition Operational group meetings for information, discussion, and potential shared learning	Pilot areas completed utilising Observe and Act framework completed. <u>Further actions</u> Monthly agenda item for discussion and shared learning at nutrition operational meeting.	**Substantial assurance**
15. A CHFT Food & Drink strategy to be developed to sit alongside the comprehensive CHFT Nutrition and Hydration policy (recommendation of the 2014 Hospital Food Standard panel report DoH)	Strategy to be developed with identified lead- New Lead identified work will now commence of developing a CHFT Food & Drink strategy	**Reasonable assurance**

10.9 Reduction in the number of CHFT acquired pressure ulcers

We will this year undertake quality improvements to:

- Reduce the occurrence of pressure ulcers and improve healing rates for existing pressure ulcers. In doing so we can reduce harm and spend, while improving the quality of healthcare experience of our most vulnerable patients.

What do we aim to achieve?	Current Update – June to July 2021	Progress rating	Next period
Reduction in the Incidence* of hospital-acquired pressure ulcers by 10%. This will be measured by incident data	There has been a 18.1% reduction in the incidence of hospital acquired pressure ulcers from 2020/21 to June 2021. July data still being validated.	**Substantial assurance**	Continue to monitor and validate July Data
Reduction in the incidence* of hospital acquired medical device related pressure ulcers by 20%. This will be measured by incident data	The incidence has increased from 0.35 in March to 0.36 in June 2021. July data still being validated. May and June data would suggest increased incidence which aligns with upward trend in covid admissions requiring respiratory / ICU care. These patients are managed with many medical devices, especially to the face, where the skin is vulnerable.	**Reasonable assurance**	Continue to monitor and validate July Data
Reduction in the incidence* of hospital-acquired heel pressure ulcers by 20%. This will be measured by incident data	There has been a 7.3% decrease in the incidence of hospital acquired heel pressure ulcers from March to June 2021. July data still being validated. 1,000 ID badge sized mirrors distributed to staff to support heel skin assessment.	**Reasonable assurance**	Continue to monitor and validate July Data WT2GR meetings will be held in September 2021 to address heel pressure ulcer reduction.
Reduction in the number of Orange harm pressure ulcers by 50%	There was a reduction in Orange pressure ulcer harms from 10 in March to 4 in June 2021. Note: Level of harm and investigation can change depending on outcome of validation at Orange Panel. Data can therefore change over time. Joint working between Tissue Viability Service and Divisional Governance Leads to support Orange Panel processes.	**Reasonable assurance**	Actions in place to address lapses in care identified in RCAs.
No Red serious pressure ulcer incidents	No red incidents in April and July 2021.	**Substantial assurance**	

What do we aim to achieve?	Current Update – June to July 2021	Progress rating	Next period
95% or more of patients in hospital will have a pressure ulcer risk assessment within 6 hours of admission to Trust / transfer to ward. This will be measured by ward assurance	33% of patients received a risk assessment within 6 hours of admission/transfer. **Risk** Failure to implement or delayed implementation of preventative interventions. **Mitigation** Very limited opportunities to work with wards on this measure due to frontline pressures. Journey To Outstanding Review commenced in May 2021 and has been completed on wards 5, 17 and 8B to date. The pressure ulcer risk assessment measure is included in the J2O review and will feature in action plans for individual areas. Results identified compliance for pressure ulcer risk assessment as follows: 80% ward 8B, 80% ward 5, 40% ward 17. A pressure ulcer process mapping exercise has been completed for EPR documentation which feeds directly into the WT2GR documentation quality work.	**Limited assurance**	Align findings of J2O quality work to future pressure ulcer performance reports. Continue WT2GR documentation collaboration which includes a key focus on pressure ulcer documentation pathways.
95% or more of at-risk patients in hospital will have a sskin bundle identified and completed. This will be measured by ward assurance	Data incomplete. **Risk** Gaps in skin bundles poses risk for pressure ulcer development. **Mitigation** Actions in place with EPR and Informatics team to address data extraction difficulties. sskin bundles are in use across the Trust but EPR design requires review. Pressure ulcer investigations highlight skin bundles being initiated and completed. However, gaps in skin bundle completion are being identified suggesting that interventions such as repositioning and skin inspection are inconsistent. Skin bundle fields on EPR being reviewed jointly with BHFT	**Limited assurance**	Key focus for Pressure Ulcer Collaborative. Skin bundle fields on EPR being reviewed jointly with BHFT. Changes to EPR to require ED to initiate skin bundles.

What do we aim to achieve?	Current Update – June to July 2021	Progress rating	Next period
95% or more of at-risk patients in hospital will have a pressure ulcer care plan initiated. This will be measured by ward assurance	All patients with a Waterlow of 10 > had a pressure ulcer prevention care plan initiated. Joint work underway with BHFT in developing a new suite of pressure ulcer care plans. Expected completion is 1.11.21. Pressure ulcer care plans feature in the WT2GR documentation project. The group is seeking to eradicate inconsistency in the use of care plans across the Trust.	**Substantial assurance**	The Digital / EPR team are in process of updating and relaunching the SOP for completing pressure ulcer care plans for Powerchart. Task and Finish groups to be established for pressure ulcer documentation.
95% or more of patients will have a completed Waterlow pressure ulcer risk assessment within 7 days of admission to District Nursing caseload. This applies to patients who have been on caseload for more than 28 days. This will be measured by SystmOne audit.	Significant frontline pressures in community have prevented any progress being made with this measure. The division continue to understand the data to allow for robust reporting going forward.	**Not applicable**	
95% of relevant staff (RNs, Nursing Associates and HCAs) will have completed React To Red Pressure or equivalent Pressure Ulcer training in last 2 years. This will be measured by Essential Safety Training (EST) compliance data	84% of staff have completed React To Red Training. Additional virtual and ward-based training has been provided on pressure ulcer prevention to support staff. Monthly essential skills training compliance data now being sent to divisions to assist improvements in compliance with selected wards and staff. National pressure ulcer e learning tool in development which will replace React To Red. This forms part of the wider National Wound Care Strategy which CHFT is following closely.	**Reasonable assurance**	Actions in place to work with selected ward to address compliance. Divisions will agree their own action plans and align to this quality measure. Further work will take place to ensure correct staff are being required to undertake training

10.10 Making complaints count: Implementation of the national regulations and Parliamentary and Health Service Ombudsman (PHSO) standards (phased introduction)

Our focus for this quality priority is to:

Demonstrate an incremental improvement / compliance over the year against the national regulations and standards. Our implementation success measure will be a shift change in the assurance from red to green over the year. Improvements will be noted via performance reporting and within this bi-monthly report.

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
QP1. Through the MCCC strategic, operational group and tactical meetings we will ensure that CHFT is compliant with National regulations. This will be measured by aligned performance reporting			
QP1. Robust performance reporting against the national regs & PHSO standards /governance: National Targets • Acknowledgement of the complaint within 3 working days	• Weekly performance reporting has been revised in order to align more closely with the national regs and standards • Phase One Improvement plans and activity – to be focussed on process improvements • Weekly and monthly performance reporting ongoing • Weekly tactical meetings allow for a deep dive approach in the review of individual cases and their management • Realtime dashboard on Datix has been built for the divisions	**Reasonable Assurance**	• Fine tuning of the performance reporting to meet all stakeholders needs – additional narrative • IPR metrics requires revision to align more closely to the standards. Ongoing • Continues • Continues • Seek evaluation feedback from Division
QP2. Support a trust wide user led approach to making complaints count by focussing improvements on the following key draft PHSO standards that the MCCC has self-assessed as having limited assurance. Progress will be measured by self-assessment by the collaborative against the standards and recognised achievements / outputs against the MCCC WTGR improvement plan			
1.1. Staff know how they can deliver a just and learning culture in their role	• Making complaints count Collaborative (MCCC) operating framework and reporting schedule is in place – staff engagement. • Staff engagement - A learning /joint responsibility as a trust culture is being	**Reasonable Assurance**	• Briefing under development to lend further clarity around the MCCC roles and responsibilities. • Weekly tactical meetings to build in decision making process - which complex complaints require consideration at the Friday pm panel meetings

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
	deliberately built by the head of PACS and the Assistant Director – Patient Experience operating through the various forums to help move the Trust away from the previous 'them and us' thinking. • Focus on closing the learning reporting loop – Datix actions • Development of a process that will enable learning from stories (impact stories) to be incorporated within current trust reporting arrangements • Development of a page within the Datix complaint module to support the front end of the complaints process – risk assessment & proposed management plan • Development of a revised response report template arrangement / approach and Standard operating procedure (SOP)		• Ongoing comms/ engagement, training & support to embed the new approach & processes into practice • Current update last collaborative meeting was cancelled. Review of future working agreements to clarified
1.5. Seek feedback from those who raise complaints (as well as staff involved) on their experience	• Service user survey developed • 3Rs session held with MCCC staff	**Reasonable Assurance**	• Take forward findings from 3Rs as specific actions - Current update last collaborative meeting was cancelled. Review of future working agreements to clarified • Service user survey developed – waiting to be launched
2.7. Every stage of concerns / complaints meets the needs of minority and vulnerable groups and makes reasonable adjustments where required.	• Health inequalities task and finish project - IMD data / analysis indicates BAME communities are accessing the service above the current %population figures • Equality monitoring data is now captured as part of the service user survey and at the point of access into the service • Access to reasonable adjustment services are in place e.g., language line	**Reasonable Assurance**	• Further analysis of data is required • Further IMD T&F project – focus on maternity **Ethnic Diversity Index (EDI):** Initial indications is that there appears to be a higher level of advocacy amongst the BAME community than the non-BAME when it comes to making complaints; Maternity specific complaints –are too few complaints to draw any conclusions around IMD or ethnicity

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
2.9. Staff make sure they respond to concerns and complaints at the earliest opportunity - clear timeframes given	• Service has moved to negotiated timelines in partnership with families – Datix updated to reflect revised timelines	**Reasonable Assurance**	• Review at next collaborative meeting with Divisional Colleagues
3.1. Staff are properly trained and have the appropriate level of experience and authority	• Patient experience and quality support leads – action learning set approach in place • Investigation training programme is ongoing • Complaint Electronic Staff Record (ESR) learning module in place	**Reasonable Assurance**	• Conclude the work to build a 'complaints' element into the CD programme • Scoping / mapping of current investigators to be undertaken • Quality check of draft responses to identify which ones require additional / focussed support – further work required to work up an agreed process • Review at next collaborative meeting with Divisional Colleagues
3.2. Staff have the appropriate resources, support, and protected time	• Resources & support – please see above updates	**Reasonable Assurance**	• As above • Review at next collaborative meeting with Divisional Colleagues
3.3. Assign complaints to staff who have had no prior involvement or who have no actual or perceived conflict of interest.	• Careful consideration is given to complex complaints of sensitive nature on a case-by-case basis and where needed an investigator not involved / perceived conflict of interest is assigned • No specific action / focus as yet but need to move to a trust position of single list of investigators / sharing responsibility across all divisions – to be paused until next year	**Reasonable Assurance**	• In light of reset and recovery work underway. No planned action until next year • Build thinking into front end management plan

Risk/ Issue	Owner	Action	Progress
Ongoing workforce challenges are creating delivery capacity concerns	Lindsay Rudge	• Additional flexible support has been requested and additional recruitment has concluded • Risk assessment to expedite recruitment process	Substantive head of PACS will in post at the end of this month. Now in post. Substantive Complaints Team leader will in post Mid-September

Appendix 1 – Report BRAG rating assurance table

RAG RATING	Evidence of fulfilling RAG rating
WHITE	• Not yet started
Substantial assurance	• Progressing to time, evidence of progress • Full assurance provided over the effectiveness of controls. • No action required • This would normally be triggered when performance is currently meeting the target or on track to meet the target. • No significant issues are being flagged up and actions to progress performance are in place.
Reasonable Assurance	• Evidence available at the time of assessment shows that the outcome is mostly met or there is insufficient evidence to demonstrate the outcome is met. • Impact on people who use services, visitors or staff is low. • Action required is minimal • Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed at this moment but should improve. • There are a set of actions in place that is expected to result in performance coming closer to meeting the target by the end of the target or reporting period. • Delayed, with evidence of actions to get back on track.
Limited assurance	• Evidence available at the time shows that the outcome is not being met or there is no available evidence that the outcome is met. Impact on people who use services, visitors or staff is high/significant. Action is required quickly • Cause for concern. No progress towards completion. Needs evidence of action being taken • Close monitoring or significant action required. This would normally be triggered by any combination of the following: • Performance is currently not meeting the target or set to miss the target by a significant amount. • Actions in place are not believed to be enough to bring performance fully back on track before the end of the target or reporting period. • The issue requires further attention or action
Full assurance	• Completed with documented evidence • Evidence of compliance with standards or action plans to achieve compliance.

20. Complaints Annual Report

To Note

Presented by Ellen Armistead

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title of report:	Making Concerns & Complaints Count: 2020-21 Annual Report
Authors:	David Sullivan - Interim Head of Patient Advice & Complaints Rachel White - Assistant Director for Patient Experience
Sponsor:	Ellen Armistead – Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Quality Committee

Purpose of the Report

To present to the Board the annual report on complaints in line with reporting requirements.

Key Points to Note

- Increase in PALS contacts / concerns over a four-year period
- Decrease in complaints over a four-year period and a significant drop in complaint numbers this year as opposed to the previous 3 years, this is linked to the COVID pandemic.
- The top three concerns raised via PALs relate to appointments issues, communication with patients and communication with relative/carer.
- Complaint performance dipped earlier in the year, now seeing an improving picture.
- The top three complaint issues relate to clinical treatment, the fundamentals of care and communication.
- Despite significant and extraordinary pressures this year our staff have risen to the challenge and remain even more focussed on improving the care and experience for our complainants. Their commitment to learning from complaints and improving the care outcomes for our patients, families and carers is to be commended.

EQIA – Equality Impact Assessment

This report in itself does not give rise to any additional equality implications. It is recognised that the service and its delivery that is being reported on has an impact on the communities we serve and those individuals from protected characteristics. A service EQIA has been completed with plans to refresh this to incorporate a quality impact assessment. It is recognised that in order to understand the accessibility of the service in relation to communities with protected characteristics and health inequalities more robust equality monitoring and data analysis is required. Mitigating action: monitoring data is now being collected by the service and additional Datix fields introduced to support the collection of this data. Early emergent findings have been revealed following some task and finish project mapping complaints data against deprivation indices

Recommendation

The Board of Directors are asked to **NOTE** the content of this report and agree progression through to the Executive Board.

MAKING CONCERNS and COMPLAINTS COUNT
CONCERNS AND COMPLAINTS ANNUAL REPORT
2020/2021

1. INTRODUCTION

The Trust is accountable to the public, and the communities and patients we serve for providing high quality care that is safe, effective and focused on patient experience. When things go wrong, we want to make sure that our patients and their families receive an appropriate explanation and apology, delivered with compassion and recognition of the trauma that they have experienced. The Trust seeks to ensure that the organisation learns lessons to avoid similar episodes occurring again and to improve the experiences of our patients and their families and carers.

The Trust manages and investigates complaints in line with:

- The NHS Constitution for England.
- Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
- Parliamentary and Health Service Ombudsman's (PHSO): Principles of Good Complaints Handling (2009) and My expectations for raising complaints and concerns (2014).
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: CQC Regulation 16 Receiving and acting on complaints
- Calderdale and Huddersfield NHS Foundation Trust (CHFT) Complaints Handling Group Policy (Last reviewed March 2020)

2. CONTEXT

Due to the ongoing COVID-19 pandemic NHS England and NHS Improvement supported a system wide "pause" of the NHS complaints process from 26 March 2020 to 1 July 2021. Complaints were still being received into the Trust during this period. However, publically people were cognisant that there was an understandable emphasis on directing all available clinical resources to fighting the pandemic and recognised that there may be delays in the investigation of their concerns.

The current (interim) head of service was not in post during the reporting period for this Annual Report. The Assistant Director for Patient Experience was in post from August 2020. The information in this report has been based on analysis of data from the Datix Complaints module and an understanding of practice from the annual review that was undertaken in the Autumn of 2020 and provided the impetus for the formation of the Making Complaints Count Collaborative that is now in place at the Trust.

3. LEARNING FROM CONCERNS AND COMPLAINTS

We are committed to learning from concerns and complaints so that we can:

- Improve the quality of care our patients, carers and their families receive.
- Improve the services that we offer.
- Improve the experiences of our colleagues in line with The Cupboard, One Culture of Care.
- Share good practice.
- Reduce the number of complaints.

When considering learning from a complaint, we ask that each service and division is clear about:

- How the service records learning from complaints.
- How this learning is disseminated within the Trust.
- How it can point to the impact and outcomes arising from learning from complaints.

4. GOVERNANCE AND REPORTING ARRANGEMENTS

The Head of Patient Advice and Complaints (PACS) holds weekly tactical progress reports with the divisional Associate Directors of Nursing and their Patient Experience and Quality Support staff on a weekly basis. Weekly performance reporting is also provided to the trust executives and senior responsible officers and shared with the operational performance teams.

The governance route for monitoring, assurance and development of the Trust's complaints handling processes is via the Patient Experience and Caring Group into the Quality Committee.

5. PATIENT ADVICE AND LIAISON SERVICE

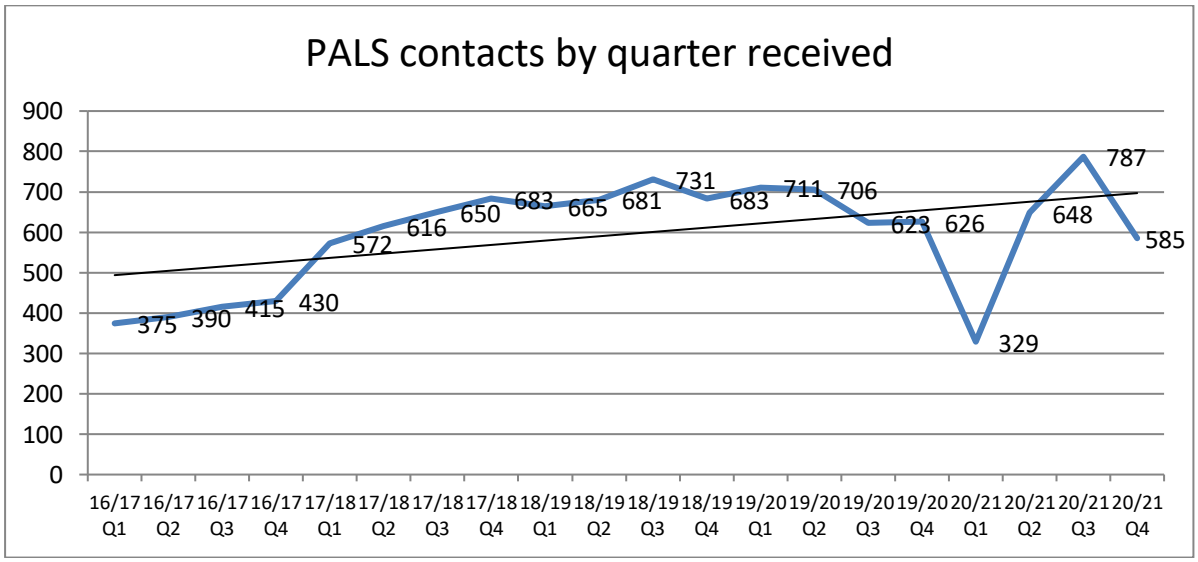
5.1 PALS Process

The Patient Advice and Liaison Service (PALS) supports patients, their families and their carers by listening to queries and concerns in confidence and helping people find solutions as quickly as possible.

Patients, their families and their carers can contact PALS via telephone or email, or face to face by appointment. A contact could be a compliment, enquiry, feedback, service to services, and a referral to external organisations. A concern is an issue raised which should be resolved within 72 hours.

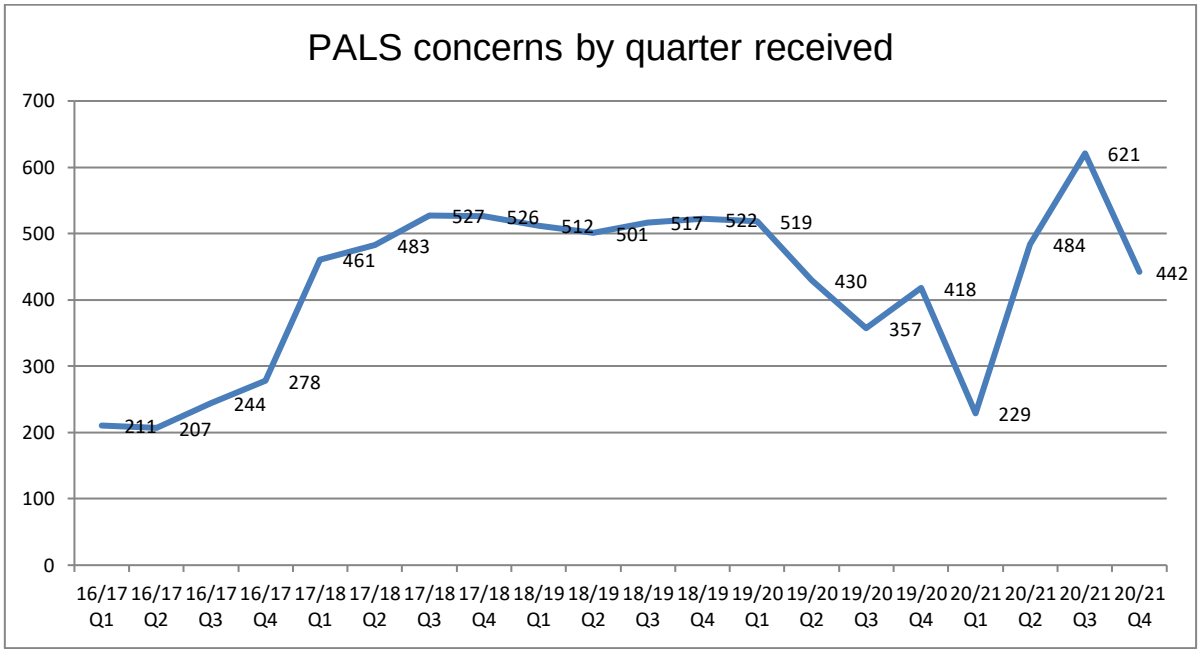
Activity data related to contacts and concerns, and themes of concerns is collected and the PALS teamwork with clinical and managerial teams to improve experience and share learning.

5.2 PALS Overall Contacts 2016/17 to 2020/21



During 2020 / 2021, the PALS team received 2349 contacts, a decrease of 11% compared with 2019 / 2020. However, there was a very significant dip in the first quarter of 2020 / 2021. This coincided broadly with the first UK COVID-19 national lockdown and therefore it is likely that this impacted significantly on the number of contacts. The longer-term trend, as indicated by the trend line in the chart, is for an increasing number of PALS contacts.

5.3 PALS Concerns 2016 / 2017 to 2020 / 2021



During 2020/21 the PALS team received 1776 concerns, a slight increase (3%) from 2019/2020. Thus people raising concerns reflected a greater portion of the PALS workload. This likely reflects the emphasis on resolving lower level expressions of dissatisfaction via the concerns process wherever possible, rather than these contacts proceeding to formal complaints.

As with overall PALS contacts, there was a significant decrease during the first quarter of 2020/1.

5.4 PALS Concerns: Themes

The top ten themes for PALS concerns were as follows:

Category	% of contacts categorised
Appointment issues	20%
Communications failure with patient (other than consent issues)	16%
Communications failure with relatives/carer (other than consent)	12%
Access to treatment or drugs	7%
Delay in receiving treatment	6%
Staff attitude	6%
Access to Trust Services	4%
Lost Property	4%
Cancelled appointment	3%
Visiting restrictions	2%

These are broadly in line with the 2019/2020 results. Although communication problems feature heavily, this was also the case for the previous year. There is no obvious indication that this aspect of care has seen an increase in the overall number of concerns generated as a result of Covid-19, at least from this simple thematic analysis.

6. COMPLAINTS

6.1 Complaints Process

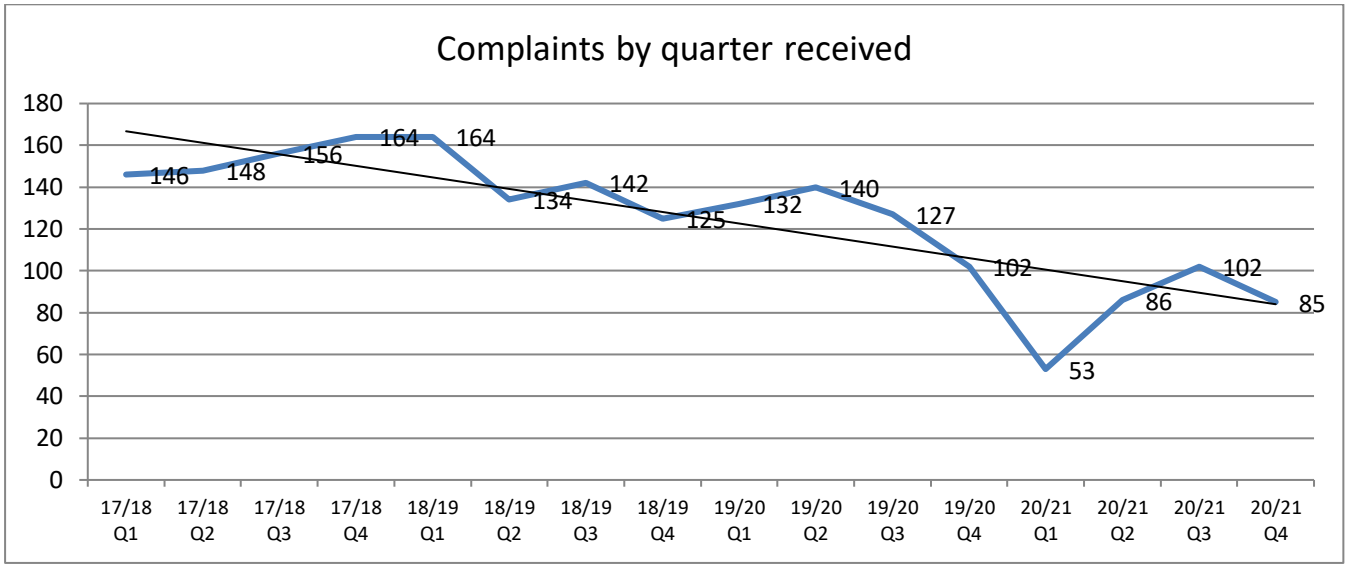
Complaints are received by the Patient Advice and Complaints Service and sent to the divisional senior management team. The divisional senior management team identifies a suitably trained investigator who will investigate the complaint and provide a written report of the findings and learning within the given timescale.

Once the investigator has concluded their investigation, their investigation response will be sent to the Divisional Assistant Director for Nursing for approval, the response will then be sent to the Complaints Management Team for quality checking. Following this there is a final review and sign-off by the executive team.

6.2 Complaints Key Performance Indicators 2020/21

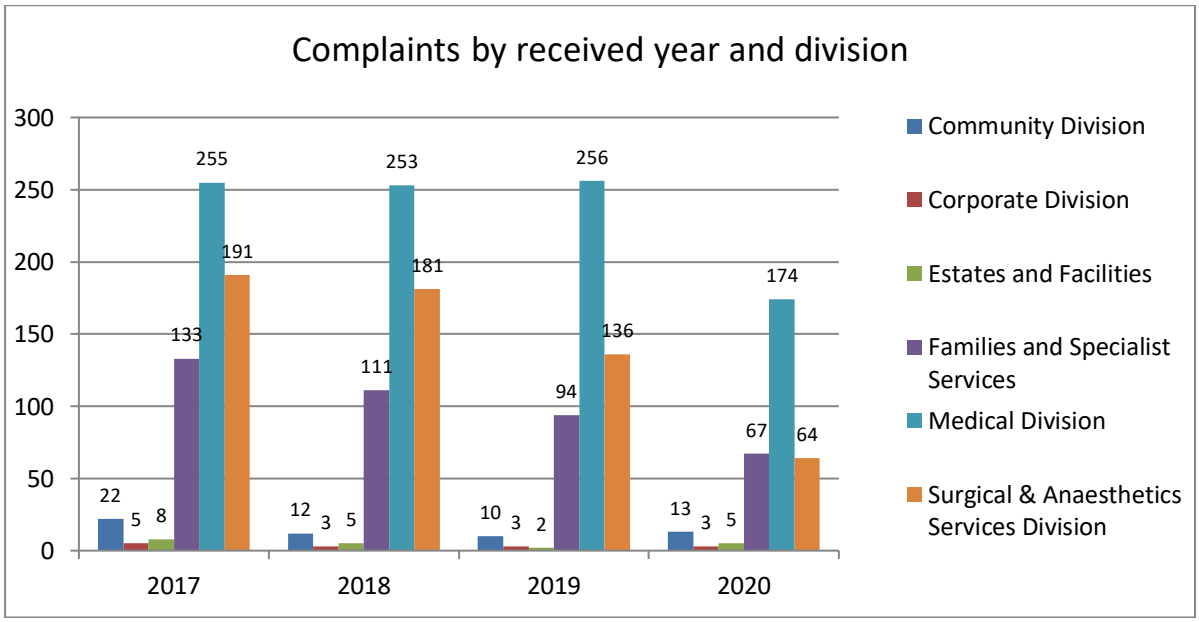
316 **Formal complaints**	This is a significant decline from 2019/20 (505). This is likely attributable to an enhanced emphasis on addressing concerns quickly and effectively via PALS and changing patterns of contact as a result of the Covid-19 pandemic. The reduction could also be attributed to a decline in elective, outpatient and non-essential clinical activity as part of the change in operational priorities across the organisation.
63% **Complaints closed within target**	Whilst there has been an improvement in the number of complaints closed within target, this appears to have correlated with the decline in the number of complaints received. However, it is positive that this figure represents a substantial improvement in complaints responded to within the target timescale compared to 2019/20 (42%). It is recognised that more work needs to be done to drive further improvements. This is being addressed through quality improvements initiated via the Making Complaints Count Collaborative and through close monitoring of, and support for, timely performance at divisional and corporate levels. Furthermore, as current guidance suggests that each complaint should be handled individually and timeframes can be negotiated with complainants which can be outside of the 40 working days, this will be introduced in the coming months to improve our performance in responding to complaints within target and agreed timescales.

6.3 No of complaints received by quarter



The overall trend is downward in terms of the number of complaints received. As noted, this is likely attributable to an enhanced emphasis on addressing concerns quickly and effectively via the PALS team. The first quarter of 2020/21 showed a significant decrease in complaint activity coinciding with part of the first national lockdown.

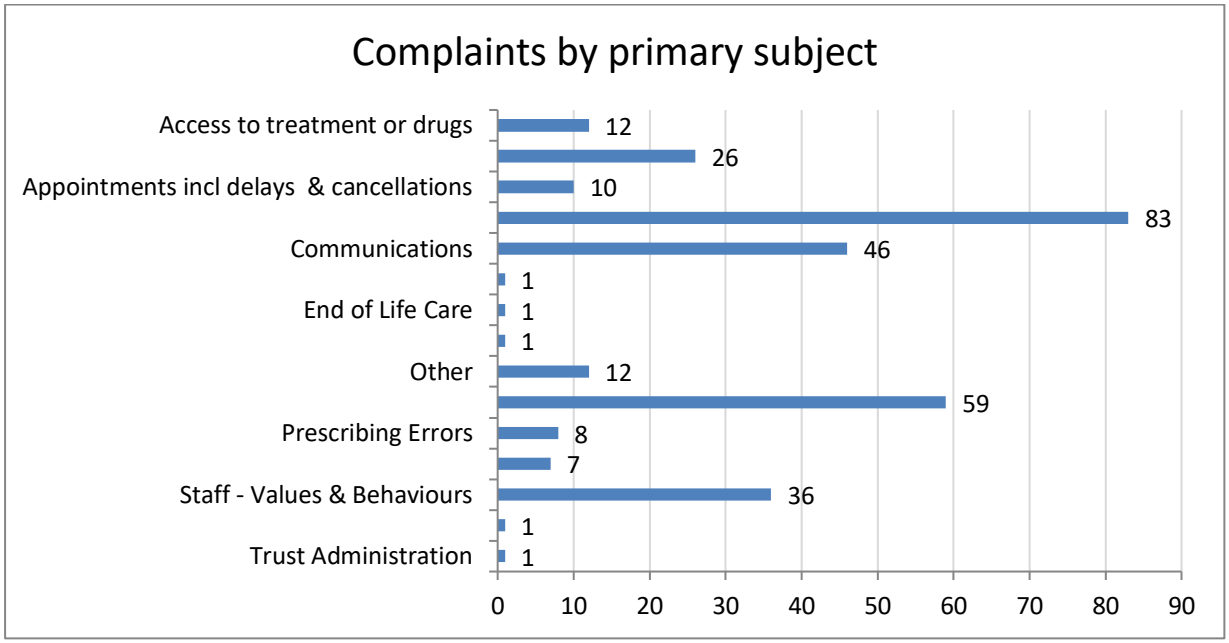
6.4 Divisional Complaint Numbers and Key Themes



The Medical Division (which acts as the front door to many acute Trust services via the Emergency Department) received the largest number of complaints. The spread of complaints across the divisions is in line with what would be expected for an acute Trust with CHFT's pattern of services.

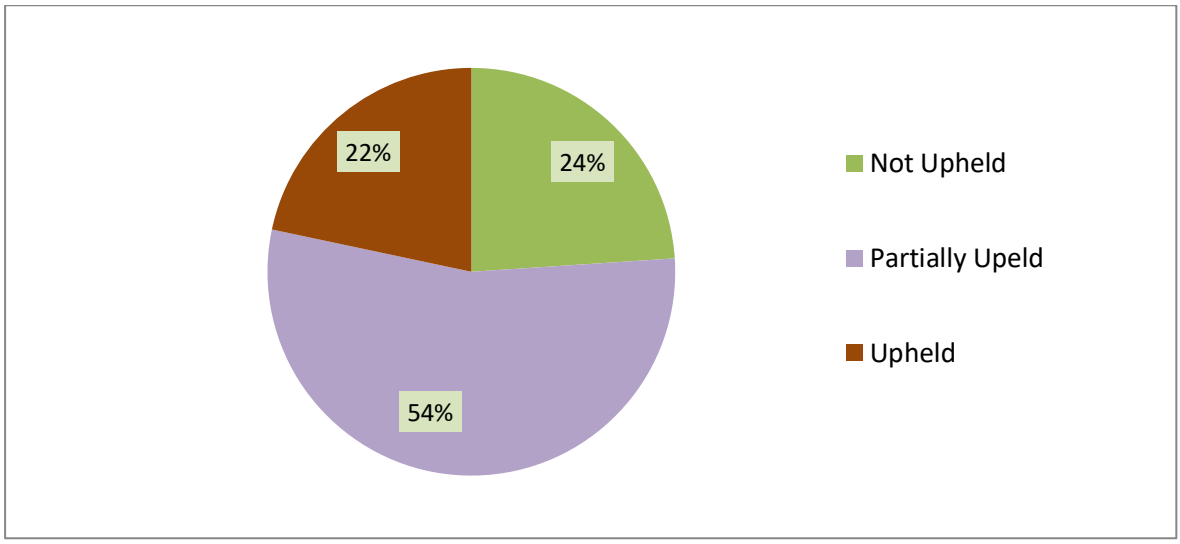
6.5 Themes

The primary issue identified in each complaint was as below. This is broadly in line with previous years, with clinical treatment remaining the major area of complaint.



6.6 Complaint outcomes

Of the complaints closed during 2020/1, the following outcomes were assessed:



There was a slight decrease in the number of upheld cases compared to the previous year. However, many complaints appear to have been assessed as partially upheld. For most complaints it is likely that the investigation will identify some aspects of care that could have been improved upon, while not necessarily upholding the entire complaint.

6.7 Lessons learned and actions

The Making Complaints Count Operational Group commissioned a review of outstanding open actions, which was undertaken at the end of the financial year, led by the Divisional Patient Experience and Quality Support. This enabled a number of actions to be closed, and also revealed that a number of the action leads had left the Trust or changed roles. There were also lessons learnt for consideration when preparing action plans going forward:

- ensure the actions are achievable
- Ensure that action leads are aware of the context of any actions they are asked to take forward
- Ensure colleagues know how to close actions.

These will be taken into consideration when developing future action plans and performance around closing actions following the investigation of complaints

Below are examples of how opportunities of learning following a complaint have been taken forward, by individuals, within teams and across departments.

Approaches to support these include the development of standard operative procedures to provide clarity for teams involved, learning form specialist colleagues through personal reflection, developing a poster to share with colleagues enabling extended learning

Complaint issue: Care and experience received from the Trust following an early miscarriage

Our learning:

This complaint has enabled the team to make changes to the following areas:

- Updated the student nurse and new starter induction packs to include examples of sensitive terminology to be used in these circumstances.
- A new SOP introduced for General office colleagues, amending current arrangements to include additional narrative and tighten up the process
- A summary of the issues raised has been anonymised and shared with gynaecology nursing staff.

Complaint issue: A poor patient experience when attending the endoscopy department for a gastroscopy

Our learning: A learning poster was disseminated around the Unit with details of the patient`s experience.:

- This focused on the issues raised such as the need to be sensitive towards anxieties, allowing patients to make informed decisions about whether to have throat spray, being clear about length of time before a patient can be picked up following sedation

Complaint issue: Attitude and lack of help regarding breast feeding, care and compassion from a colleague.

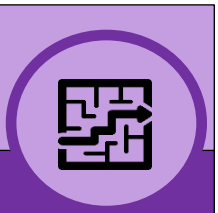
Our learning:

This complaint involved accessing support from the Infant Feeding Advisor:

- The colleague to re-familiarises practice with the Infant Feeding Policy
- Findings of the Infant feeding advisor shared for learning as an opportunity to reinforce any omissions in care.

Complaint issue:

Delay to surgery for a patient who developed a further cancerous lesion when they were on a skin cancer surveillance pathway.



Our learning:

This complaint resulted in the development of a Standard Operating Procedure for the treatment pathway:

- Improved communication arrangement between and within departments
- Enables timely access to the service for patients with worsening / new lesions

7 PARLIAMENTARY AND HEALTH SERVICE OMBUDSMAN

The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints where an organisation has not been able to resolve the complaint at a local level.

The Trust received 6 new PHSO cases during 2020/21.

It should be noted that the work of the PHSO was suspended for several months during the Covid-19 pandemic. Of the three cases for which outcomes are available during 2020/21 the PHSO upheld one case, partially upheld another, and did not uphold any concerns in relation to the Trust response for the third case.

8 PATIENT ADVICE AND COMPLAINTS SERVICE DEVELOPMENTS AND FOCUS DURING 2020 / 2021

During the year the team have focused on:

- Improving the timeliness of responses for complainants, so we respond in the timescale agreed. We have also ensured lead investigators keep complainants updated about the progress of their complaint and ensuring that processes are in place to escalate any delays.

- Improving how we respond to complaints following feedback we have received from service users.

- Responding quickly and effectively to service users' concerns, so that their problems are resolved and do not develop into a formal complaint.

- Creating a Making Complaints Count Collaborative with expertise across the divisional and corporate teams to help deliver long term and sustainable improvements to complaints handling within the Trust.

- Ensuring that the considerable operational pressures from the Covid-19 response had as limited an impact as possible on those patients and family members contacting the Patient Advice and Complaints team to raise concerns during those periods of peak pressure from the virus. However, we also recognise that it was not possible to mitigate the impact entirely and the patience shown to the team by the public during the difficult periods of the pandemic has been much appreciated

9 NATIONAL DEVELOPMENTS

The Parliamentary and Health Service Ombudsman (PHSO) have been working with the NHS and other public service organisations, members of the public and advocacy groups to develop a shared vision for NHS complaint handling.

The new PHSO Complaint Standards Framework sets out a single set of standards for staff to follow and provides standards for leaders to help them capture and act on the learning from complaints.

The PHSO has introduced some internal changes in relation to how they manage and handle their referrals. Any impact from this change is likely to emerge within the next financial year.

10 FORWARD PLAN FOR 2021 / 2022

The Trust continues to build a complaints team and service via integrated ways of working in order to meet regulatory standards, Trust priorities and the needs of our communities.

Work is ongoing to drive improvements in the trust aligned to achieving achievements against the PHSO standards. This work is being delivered operating through the Making Complaints Count Collaborative. The following key aspects of the work of the collaborative are as follows:

- Implementation of the PHSO draft standards in advance of a national requirement.
- Undertaking internal checks and audits so we can be assured of compliance against national regulations
- Shaping the service based on service user feedback to be more service user centric
- Understand the accessibility of the service for our health inclusion groups / communities and people with protected characteristics by the detailed analysis of available data
- Build on the work commenced in 2020 / 2021 on the quality priority aimed at supporting the trust in its ambition as a learning organisation.

21. Integrated Performance Report – July 2021

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2nd September 2021
Meeting:	Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance Kirsty Archer Deputy Director of Finance Cornelle Parker Deputy Medical Director Lindsay Rudge Deputy Chief Nurse Jason Eddleston Deputy Director of Workforce and OD Bev Walker Deputy Chief Operating Officer
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee

Actions Requested: To note

Purpose of the Report

To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of July 2021.

Key Points to Note

Trust performance for July 2021 was 73.4% which is a significant improvement on the June position with the key changes being in SHMI, Complaints and 28-day faster Cancer diagnosis although there has been a deterioration in sickness levels.

All domains with the exception of **Workforce** have improved and there are now 4 individual green domains. The **SAFE** domain is back to green following June's reporting of a never event. The **CARING** domain remains green with Complaints response back to 100% however Dementia screening has deteriorated further. **EFFECTIVE** domain remains green with SHMI improving to below 100 however #Neck of Femur access is still challenging. The **RESPONSIVE** domain is the most challenging as it contains the main planned access indicators with a mixed picture so remains amber however there has been improvements in cancer 28-day faster access. **WORKFORCE** is now amber with both non-Covid long and short-term sickness for July the highest in 12 months. Return to work interviews have also fallen in month to lowest levels since January. **FINANCE** is now green with improvement in the Agency Expenditure position following confirmation of the trajectory by NHSI/E, although cash is now amber.

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

The Board of Directors is asked to **NOTE** the narrative and contents of the report and the overall performance score for July 2021.

Calderdale and Huddersfield NHS Foundation Trust

Performance
July 2021

Quality, Workforce and Finance

We have looked at our main headlines from a Trust overview perspective and considered the impact that these areas are having on service performance.

We have seen unprecedented levels of attendances at both hospital sites during the last few months although these are not translating into admissions at the same rate, however the acuity is significantly higher with admissions through Emergency Medicine for the quarter April to June 9% higher than the same period in 2019. We have managed to maintain our 4-hour performance at 85% during the first 4 months and even with performance at 78.6% in July this was still better than any other Trust in West Yorkshire however we are seeing long waits in both emergency departments which is a poor patient experience. When comparing to all Trusts in the North CHFT also has the highest number of type 1 A&E attendances to open beds ratio at 91%.

Performance on key metrics across the organisation is being maintained during a time when these pressures mean we are now in strategic gold command and control. This of course could have a detrimental impact on these KPIs but we have initiated mitigations to keep the organisation safe for patients.

This mitigation includes additional costs of band at enhanced rates and agency staffing. Our year to date financial surplus has been offset in part by pay pressures in staffing in ED and other critical areas. This has driven an overspend in month 4 which means we are now eroding the financial surplus from the first quarter.

As noted in our Recovery programme we are facing challenges with increasing capacity due to staffing issues in theatres and waiting list initiatives not having the full desired impact on the backlog. In the first quarter the elective activity performance has exceeded the NHSI thresholds for receipt of Elective Recovery Funding (ERF) and NHSI has now asked for further increases in activity levels to receive ERF in future months. As a result and with a drop in activity in July we did not receive these funds.

We continue to look at links between sickness and vacancy rates and increased agency spend and their impact on quality metrics at ward level. We are also carrying out daily audits in ED to look at the continued increase in demand for both our emergency departments and what impact that is having on patient care and treatment.

We are also seeing an increase in patients on the transfer of care list due to capacity issues in social care packages of care and discharge to assess beds. This is partly driving an increase in medical outliers and occupancy levels. This position whilst escalated is not resolving, and system leaders will host a ‘Risk Summit‘ to understand how we balance risk across ‘Place’.

Staff availability remains a key issue with a daily focus on maintaining safe care for patients through the deployment of registered and non-registered staff members. Non-Covid and Covid (primarily self and household isolations) absence are at relatively high levels with a headcount absence of c430 colleagues a day across a range of roles. Nurse staffing levels over the holiday period will have had an impact on delivering safe, effective care. Patient flow and discharge planning have also been affected with failed discharges seen daily, this is due to the complexity of patients and the intensity of staff workload on ward when they are at times well below workforce models.

The Trust is reviewing staffing levels daily, has enhanced pay arrangements recognising the time

contribution from colleagues who work beyond their contract hours through the Trust bank, is utilising higher cost agencies for certain service areas and shifts to increase the pool of available trained/skilled practitioners and is focused on accelerating its recruitment activity in respect of vacant posts including wherever possible over recruiting where an excellent candidate pool is created.

Support to maintain the wellbeing of colleagues at work continues to be important, our health and wellbeing response following the easing of lockdown has been initiated. Bespoke focused and wraparound intervention and support is available for services/teams/individuals in need.

We are not seeing the same pressures within Medical staffing as those being experienced for Nurse staffing levels where we will continue to monitor Nurse Sensitive Indicators including falls, pressure ulcers and nurse staffing red flags.

We do have concerns around the more varied complex needs of the younger demographic that we are now seeing with long lengths of stay. They have different needs packages from the usual older patients that were previously more prevalent and this is an area where we will recommend further investigation as a result of the impact of Covid. We have seen the same pattern of younger patients in Acute Medical Units and recognise that these patients will be more resource intensive than the traditional aging population with social requirements and mental health needs that have resulted from deconditioning over the last 17 months.

We have seen an increase in the number of complaints received alongside an increase in contact to the PALS service with themes including appointment waiting times, chasing of results of investigations, poor communication (family and patients not feeling involved with decisions about their treatment and aftercare) and patients feeling increased anxiety due to Covid. This is further referenced with the Quality Report to the Board of Directors.

The Trust also continues to review the Friends and Family Feedback and whilst there are many positive comments received there are a number of comments which relate to the current operational pressures in terms of activity and staff absence including long waits in the emergency departments, staffing issues on the ward, continuity of care and communication regarding care and treatment, waiting times and current visiting guidance.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

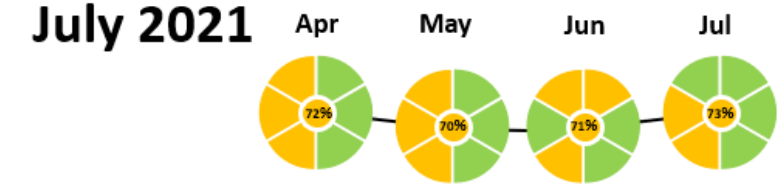
Integrated Performance Report

July 2021

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary



OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
FFT Inpatients FFT Outpatients FFT A&E	FFT Maternity FFT Community
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

July's Performance Score is at **73.4%** which is a significant improvement on the June position with the key positive changes being in SHMI, Complaints and 28-day faster Cancer diagnosis although there has been a deterioration in sickness levels.

All domains with the exception of **Workforce** have improved and there are now 4 individual green domains. The **SAFE** domain is back to green following June's reporting of a never event. The **CARING** domain remains green with Complaints response back to 100% however Dementia screening has deteriorated further. **EFFECTIVE** domain remains green with SHMI improving to below 100 however #Neck of Femur access is still challenging. The **RESPONSIVE** domain is the most challenging as it contains the main planned access indicators with a mixed picture so remains amber however there has been improvements in cancer 28-day faster access. **WORKFORCE** is now amber with both non-Covid long and short-term sickness for July the highest in 12 months. Return to Work Interviews also fallen to lowest position since January. **FINANCE** is now green with improvement in the Agency Expenditure position following confirmation of the trajectory by NHSI/E, although cash is now amber.

Key Indicators

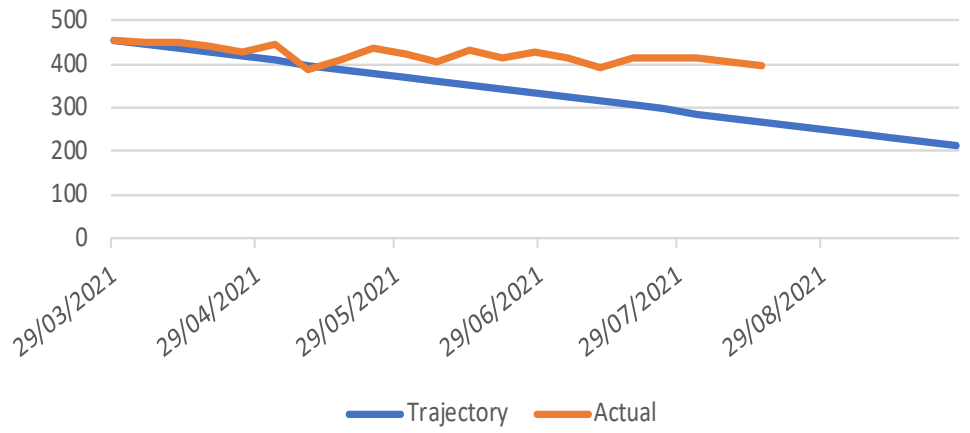
	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	YTD	Performance Range		
SAFE																			Green	Amber	Red
Never Events	2	0	1	1	0	0	0	0	0	0	0	0	0	0	0	1	**0**	**1**	0		>=1
CARING																			Green	Amber	Red
% Complaints closed within target timeframe	60.07%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	63.0%	52.9%	60.00%	100.00%	87.50%	100.00%	**in arrears**	**96.23%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	91.09%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.63%	93.46%	88.32%	96.82%	96.75%	95.62%	97.00%	**in arrears**	**96.78%**	>=90%	80% - 89.9%	<80%
Friends and Family Test Outpatients Survey - % Positive Responses	93.27%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.37%	93.10%	93.28%	92.38%	92.45%	92.20%	92.29%	**in arrears**	**92.31%**	>=90%	80% - 89.9%	<80%
Friends and Family Test A & E Survey - % Positive Responses	90.16%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	90.38%	90.91%	89.37%	90.48%	85.13%	85.90%	82.98%	**in arrears**	**84.67%**	>=90%	80% - 89.9%	<80%
Friends & Family Test (Maternity) - % Positive Responses	98.86%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	98.00%	100.00%	100.00%	91.89%	85.71%	90.00%	91.23%	**in arrears**	**90.67%**	>=80%	70% - 79.9%	<70%
Friends and Family Test Community Survey - % Positive Responses	100.00%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	100.00%	100.00%	100.00%	100.00%	99.50%	93.80%	93.37%	**in arrears**	**92.80%**	>=90%	80% - 89.9%	<80%
EFFECTIVE																			Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	6	1	1	2	2	0	0	0	0	0	0	0	0	0	1	0	**1**	**2**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.94	98.4	98.68	99.05	99.74	100.88	101.31	102.27	102.71	100.94	104.11	103.15	102.26	99.91				**99.91**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	90.49	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98	90.32	90.49	90.76	89.46	88.24	88.99			**88.99**	<=100	101 - 109	>=111
RESPONSIVE																			Green	Amber	Red
Emergency Care Standard 4 hours	88.81%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	87.82%	86.48%	87.83%	88.22%	86.70%	86.16%	**78.59%**	**84.77%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	65.30%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	56.06%	25.42%	38.60%	61.02%	49.06%	54.90%	**42.29%**	**51.29%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.74%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	98.55%	98.80%	98.76%	98.32%	98.96%	97.85%	**97.88%**	**98.23%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.86%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	97.35%	96.45%	97.34%	98.28%	98.04%	100.00%	**98.68%**	**98.78%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.08%	99.42%	97.37%	98.26%	97.83%	97.69%	100.00%	98.67%	96.23%	96.71%	96.82%	98.55%	99.22%	99.45%	99.41%	97.57%	**98.83%**	**98.77%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	90.99%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	73.91%	92.31%	100.00%	97.14%	100.00%	100.00%	**97.67%**	**98.61%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.15%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	100.00%	98.04%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=98%		<=97%
38 Day Referral to Tertiary	54.64%	76.00%	45.45%	40.00%	65.00%	47.06%	39.13%	58.33%	35.71%	50.00%	43.75%	61.54%	91.67%	50.00%	63.16%	52.94%	**77.78%**	**59.65%**	>=85%		<=84%
62 Day GP Referral to Treatment	91.47%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.76%	90.00%	90.10%	87.58%	95.65%	93.14%	90.09%	91.84%	**91.59%**	**91.66%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	63.98%	72.22%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	85.19%	83.33%	73.91%	100.00%	72.22%	57.89%	48.48%	**32.14%**	**53.45%**	>=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	79.84%	70.98%	85.89%	73.70%	80.21%	83.19%	82.94%	82.52%	80.91%	81.48%	71.76%	82.50%	80.21%	72.64%	66.98%	68.66%	**73.99%**	**70.47%**	>=75%		<=70%
WORKFORCE																			Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	4.52%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	4.59%	4.52%	4.37%	4.35%	4.44%	4.61%	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	3.07%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	3.07%	3.07%	3.01%	2.99%	3.07%	3.17%	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.45%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	1.52%	1.45%	1.36%	1.35%	1.38%	1.44%	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.90%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	94.85%	94.68%	95.64%	95.48%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	95.15%									95.15%	95.15%	95.15%	95.15%					-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	41.05%																	-	>=95%	>=90%	<90%
FINANCE																			Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	(0.00)	0.00	0.00	0.00	0.00	0.00	0.95	0.16	-1.00	0.41	0.58	1.18	0.55	2.39	0.28	**-0.22**	**3.00**			

SWOT Analysis

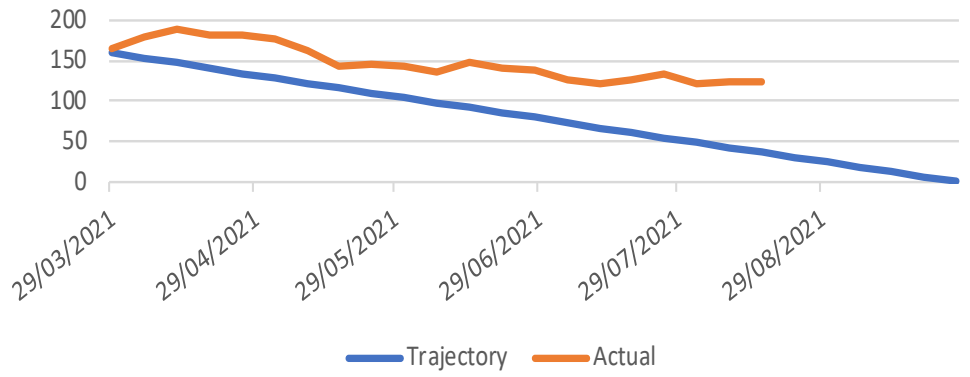
Strengths	• Continuing to focus on trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities. • Launched a comprehensive theatre staff engagement and workforce development programme. • Community Pharmacist roles continue to add significant value in Quality Improvement (identifying and managing medication incidents), supporting effective assessment and care planning across nursing and therapy services and helping manage some of the discharge based risks and issues with handover of medicines management. • Successful start of weekend ENT outpatient activity in partnership with an insourcing company to help address our backlog. • Continue to support Mid Yorkshire Hospital Trust with Non-Surgical Oncology care for breast and lung cancer. • The joint Neurology post with Leeds has gone through all their required recruitment process and has received royal college approval. The AAC is booked for 29th September and the post has been advertised in the BMJ. • Ongoing focus on clinical validation and prioritisation. • Agreed Recovery Framework.
Weaknesses	• High volumes of attendances through Accident and Emergency. • High volumes of planned care backlogs. • MRI scanner at CRH has had significant periods of downtime. IP work has been prioritised to ensure patient flow is not effected. • High volumes of staff sickness and isolation impacting on ability to cover all areas at optimal staffing levels including front line and back office functions and reduced ability to create additionality for backlog clearance. Although isolation guidance has been updated we have not seen this significantly impact on the staffing position. The staffing position is being closely monitored and managed on a daily basis through the Gold meetings. • Staffing shortages in theatres leading to continued reduced capacity to operate on patients. • Trust Estate and dual site configuration reduces flexibility. • Staffing High Increased focus on management of urgent and emergency care in and out of hours impacting on management capacity for recovery. • Urgent care additionality being staffed by CHFT colleagues.
Opportunities	• The SAFER programme continues to pull together existing workstreams and those stopped during the Covid period. • Planning for winter is now well underway. • There is a "perfect storm" session with external partners on 1st September for system winter preparedness. • Opportunities for acceleration of community based Early Supported Discharge and urgent response function for winter/surge plans plus maintaining elective recovery through control on non-elective demand i.e. increasing in-reach of Respiratory team and support for earlier discharge for oxygen weaning via CVW. • Pilot Urgent Care Hubs have been established at both HRI and CRH staffed by CHFT colleagues. These are operational Mon-Fri 08.00-18.00 with the service reverting to Local Care Direct outside of these hours. • Discussions with additional insourcing and outsourcing organisations to support with our surgical and outpatient backlogs in ENT, Ophthalmology and Orthopaedics. • A revised/simplified enhanced payments model for additionality could help unlock weekend theatre capacity to support recovery; take-up starting to increase as school holidays end. • Approval for proposal with "Healthcomms" to support waiting list validation across outpatients and inpatient elective waiting lists. • Development of theatre workforce plan including ODP apprentices, Nurse Associate role. • Community Division and development of Integrated Care Provider partnerships. • Collaborative working to better utilise estate and workforce in outpatients as part of recovery planning.
Threats	• We continue to see the significant and sustained increase in demand for both our emergency departments which continues to create pressure at the front door and driving ongoing increased staffing. • Staff being stretched due to increased number of Delayed Transfers of Care and increased Covid bed base. • Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and Long Term Condition (LTC) management. • Patients are presenting with increased acuity and complexity which is resulting in a longer length of stay and challenges around timely discharge into the community. • Staff fatigue due to ongoing pressures and frustration due to prolonged changing and increasing workloads. • Expected Paediatric medical surge from mid-September 2021. • Increasing numbers of covid patients being admitted with resulting pressure on Respiratory care, Critical care and overall bed capacity. • Winter pressures. • Limited uptake to date of enhanced payments scheme to support recovery during school holidays. • Increasing number of complaints due to prolonged waits and poor patient experience. • Changes to Elective recovery fund for Q2, after plans commenced impacting on income opportunity to cover additional costs of plans. • Lack of clarity on funding plan from NHSE/I for Quarters 3 and 4.

INPATIENT WAITING LIST - P2

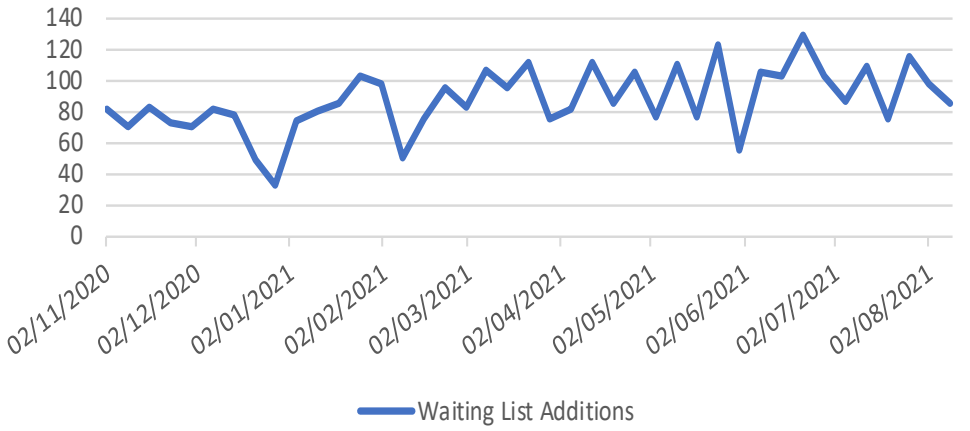
Trajectory vs Actual - Total P2s on Waiting List



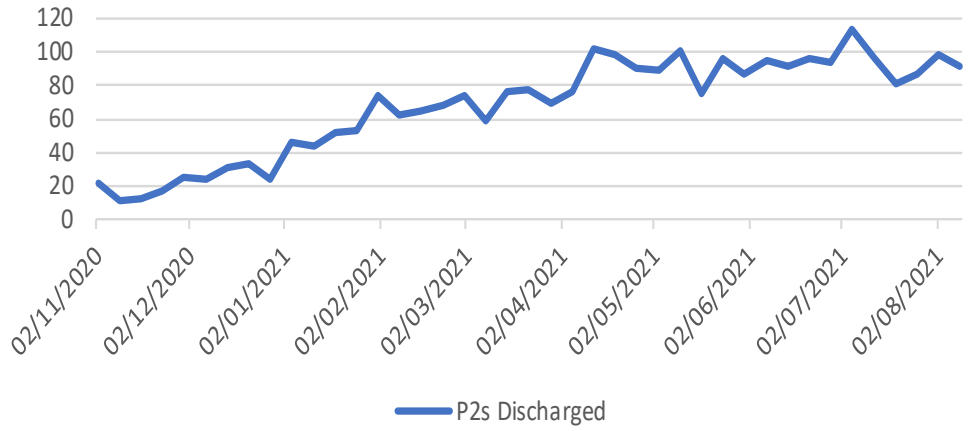
Trajectory vs Actual - Total P2s on Waiting List Over 1 month



P2 waiting List Additions

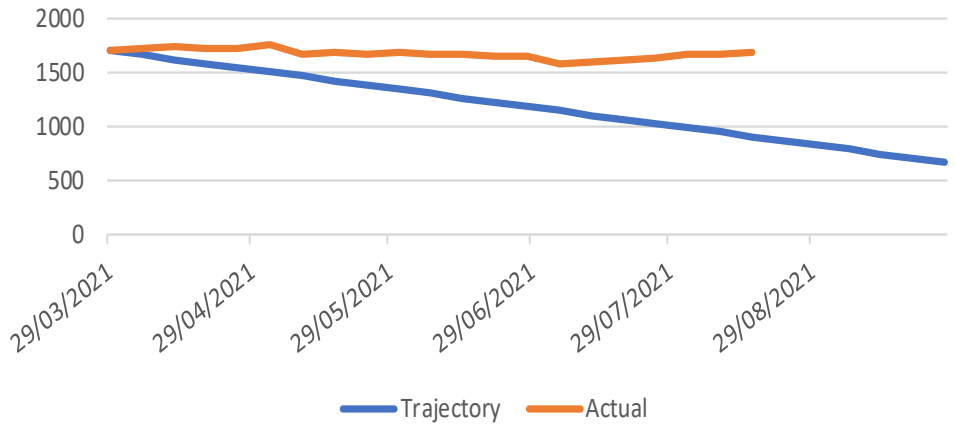


P2 Surgery done in the week

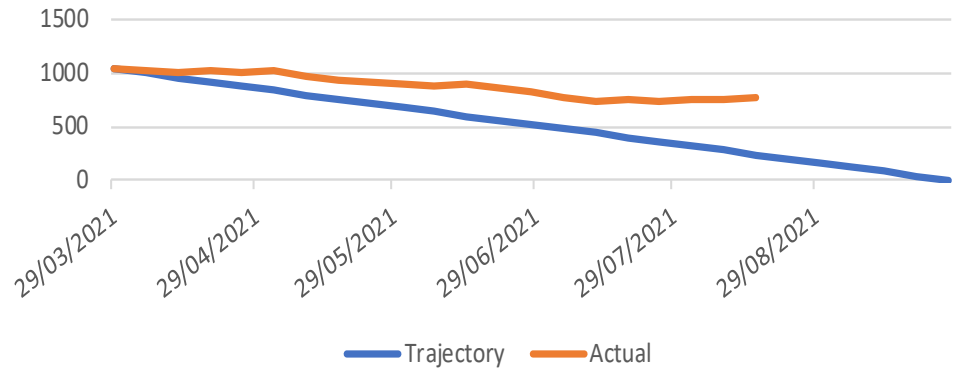


INPATIENT WAITING LIST - P3

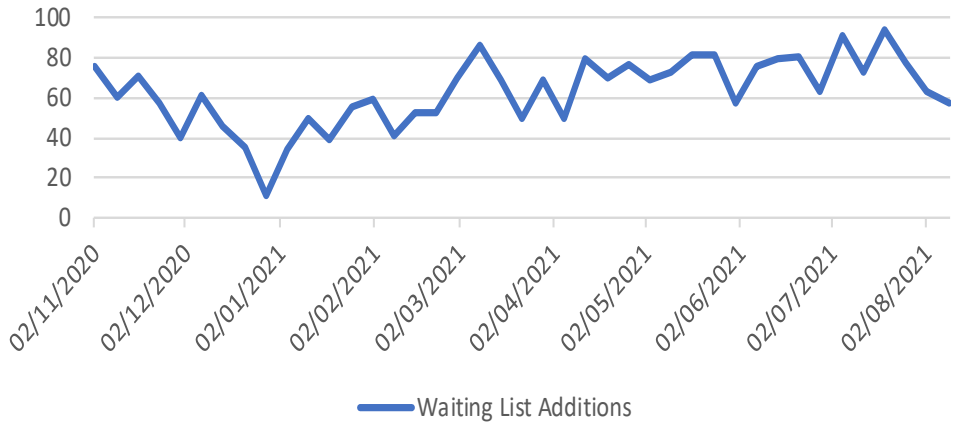
Trajectory vs Actual - Total P3s on Waiting List



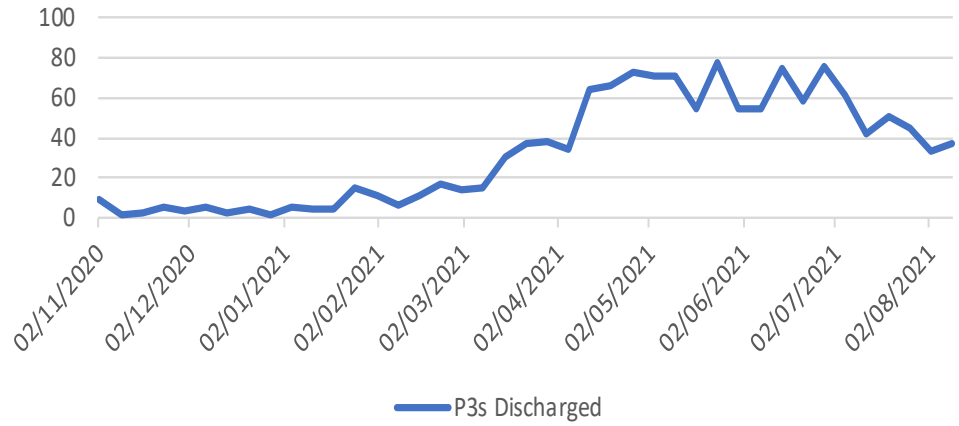
Trajectory vs Actual - Total P3s on Waiting List Over 3 months



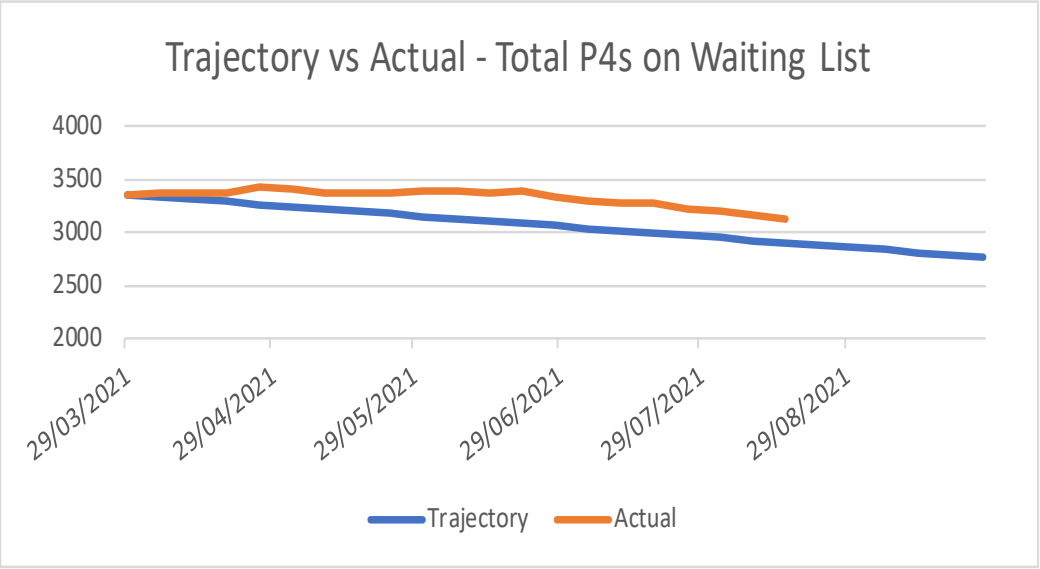
P3 waiting List Additions

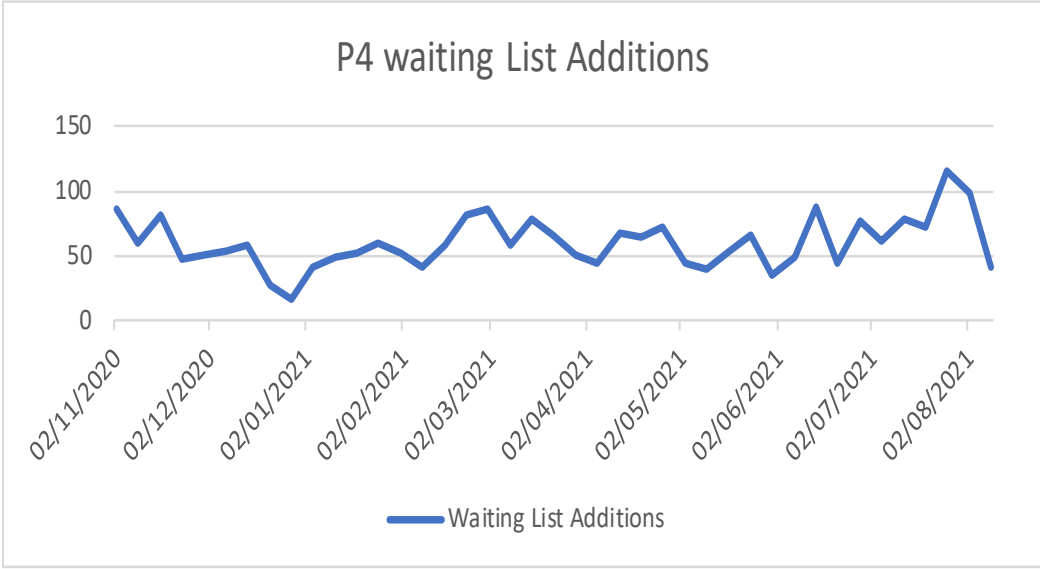


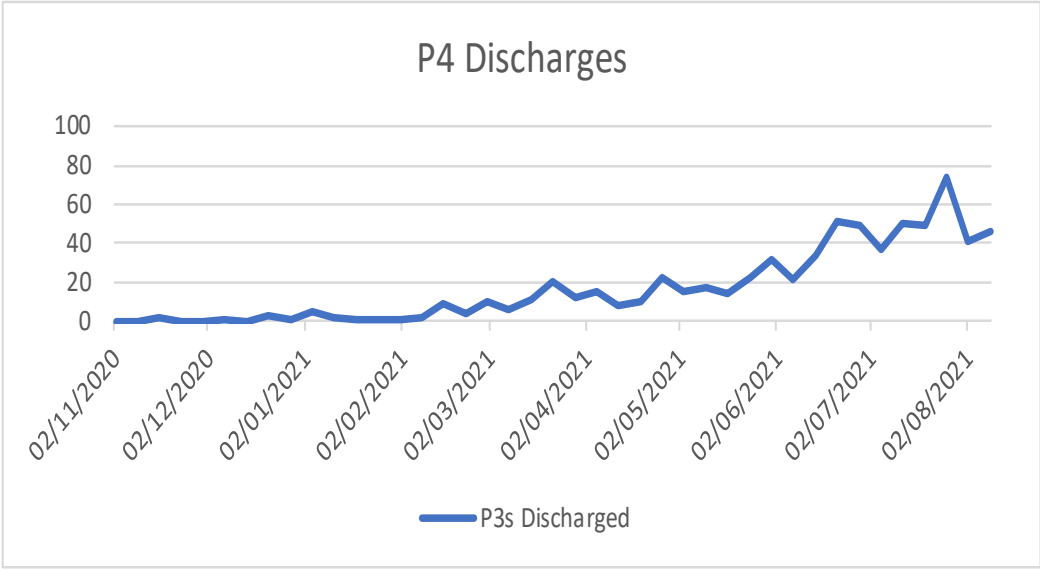
P3 Discharges



INPATIENT WAITING LIST - P4

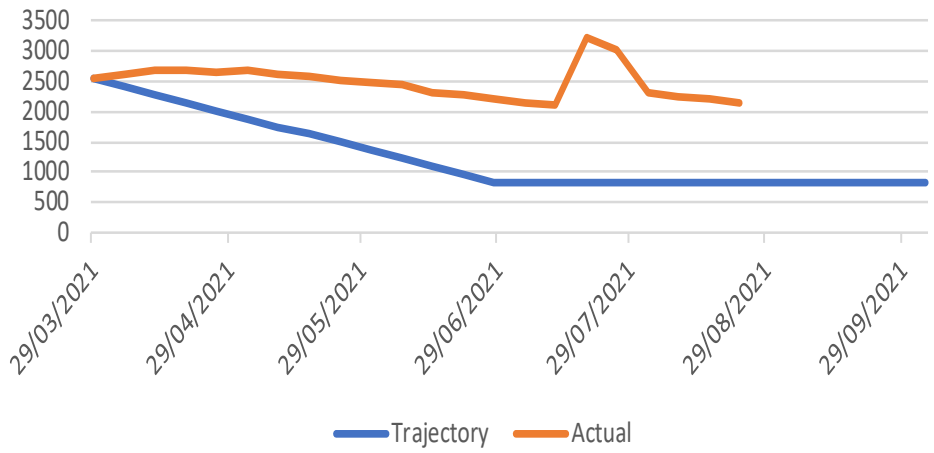




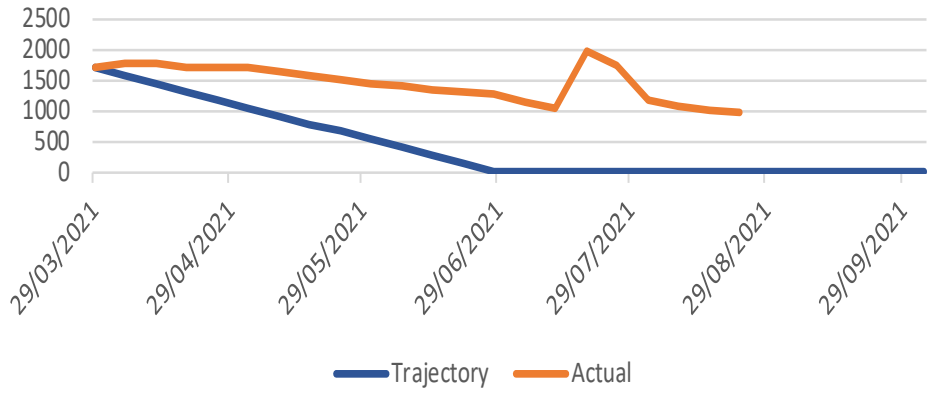


Endoscopy Waiting List

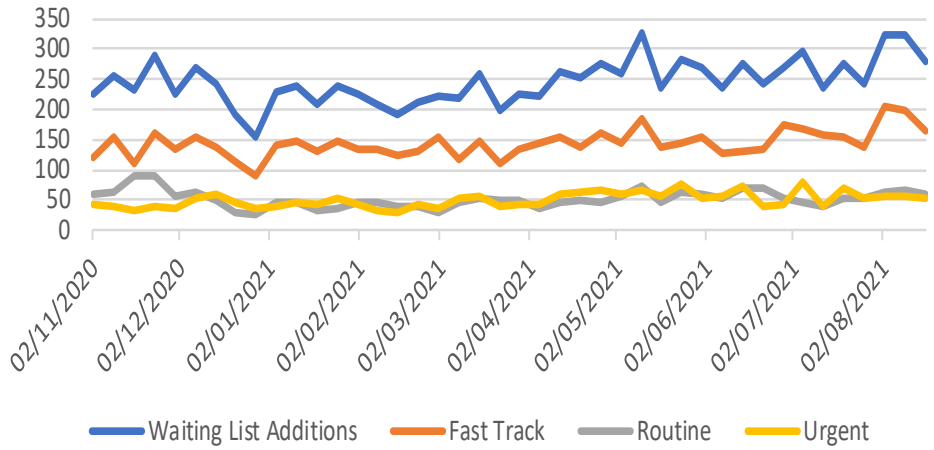
Trajectory vs Actual - Total Endoscopy Waiting List



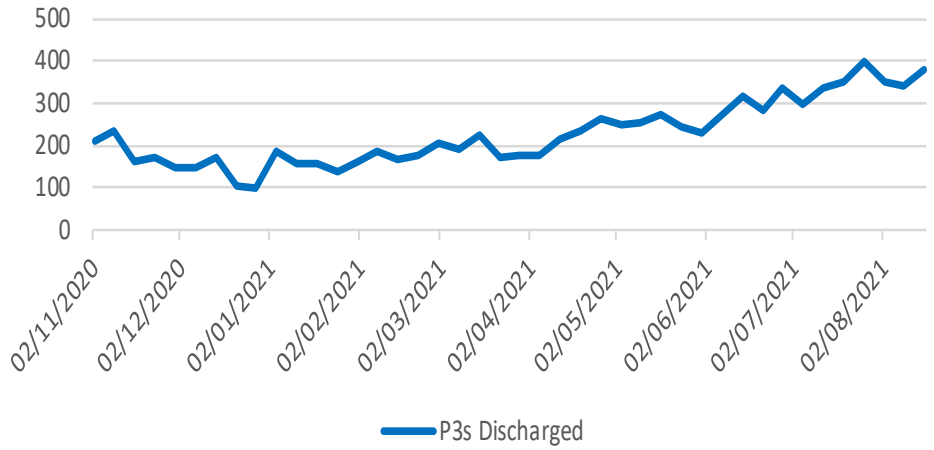
Trajectory vs Actual - Total Endoscopy Waiting List - Over 6 Weeks



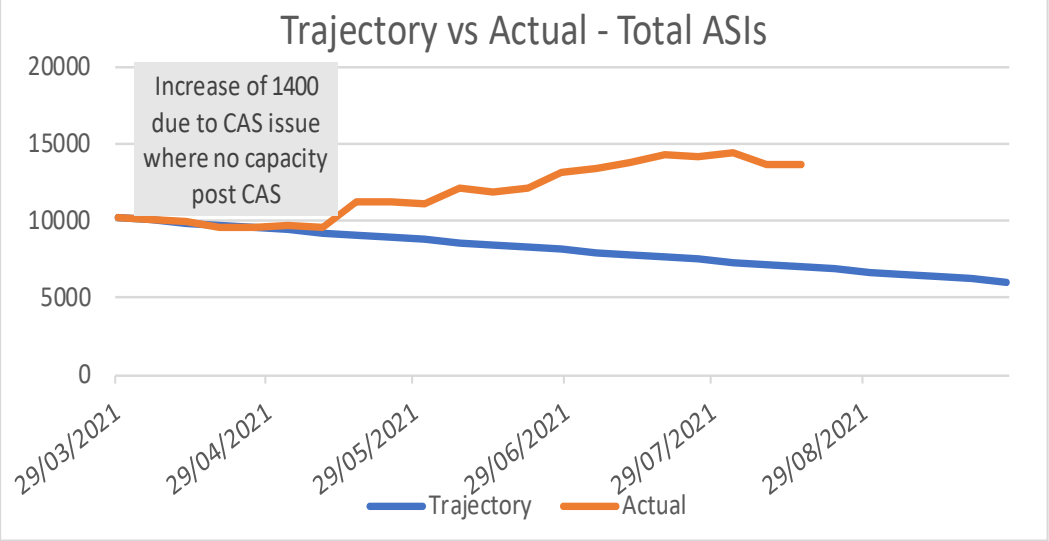
Endoscopy Additions

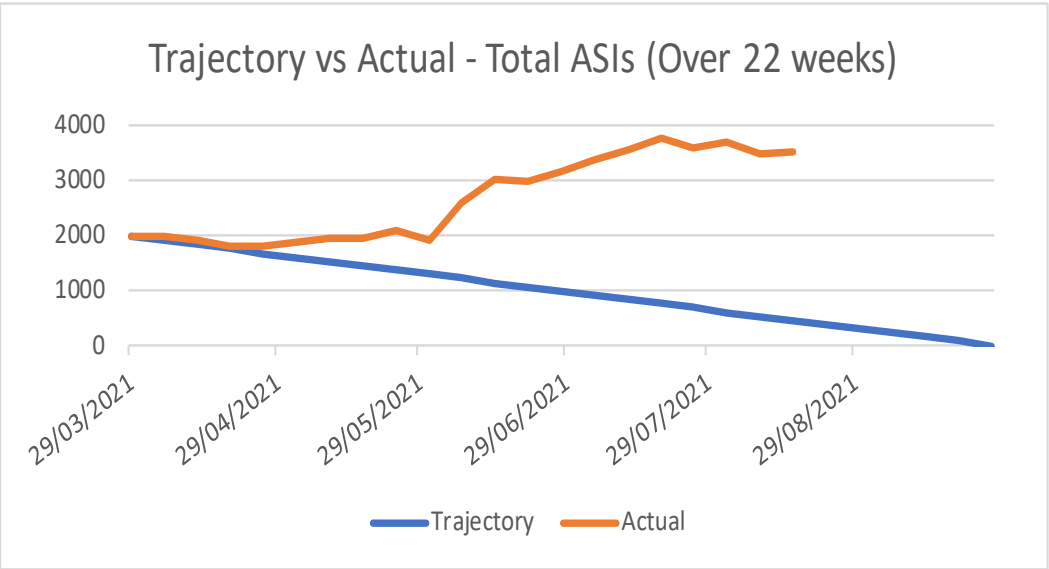


Endoscopy Discharges

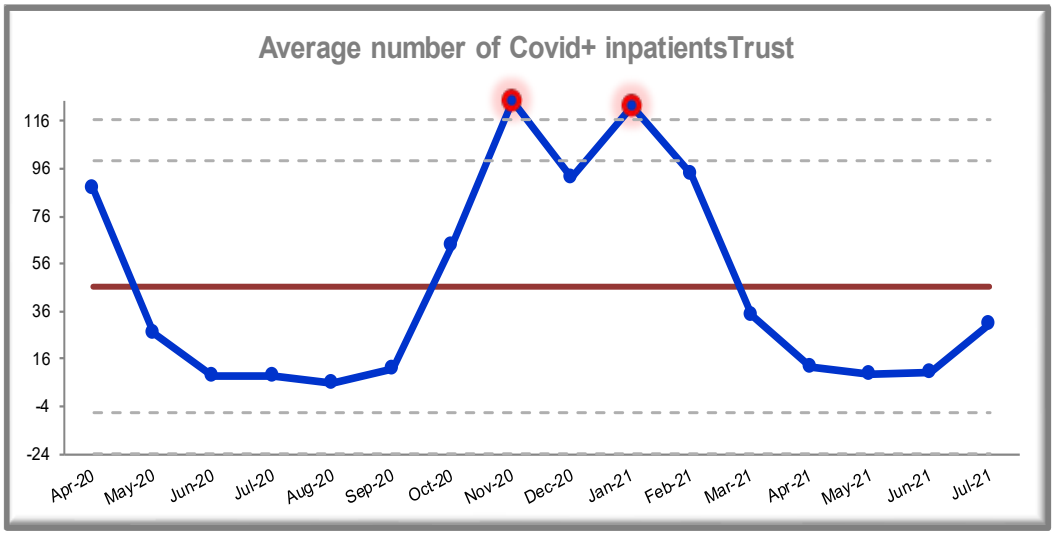


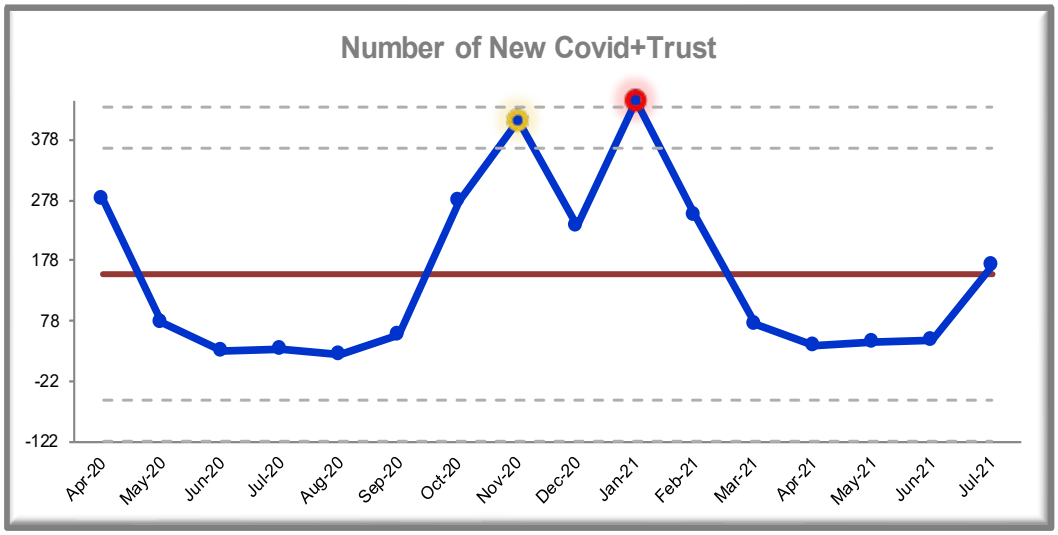
ASIs

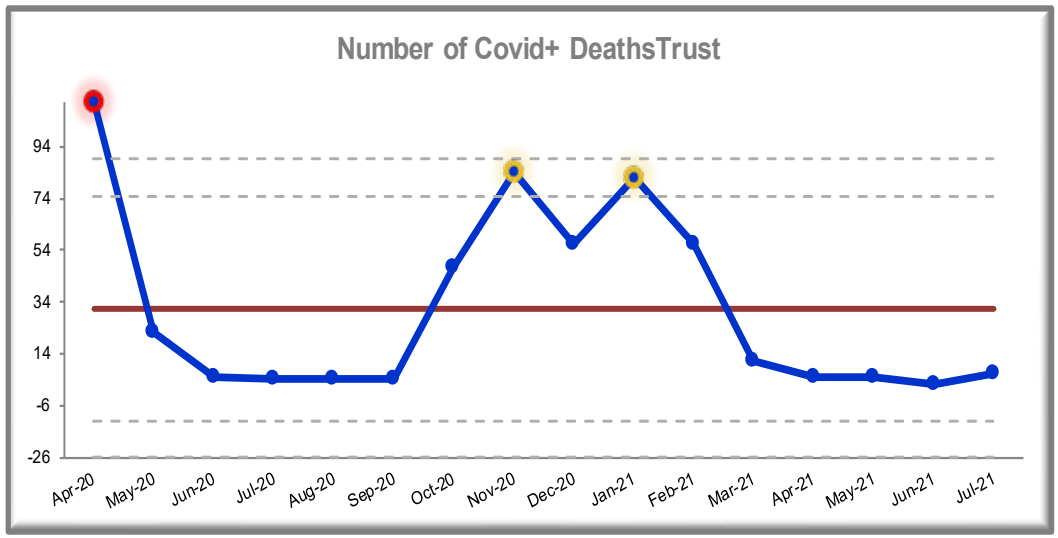

Trajectory vs Actual - Total ASIs
20000
15000
10000
5000
0
Increase of 1400 due to CAS issue where no capacity post CAS
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
Trajectory
Actual

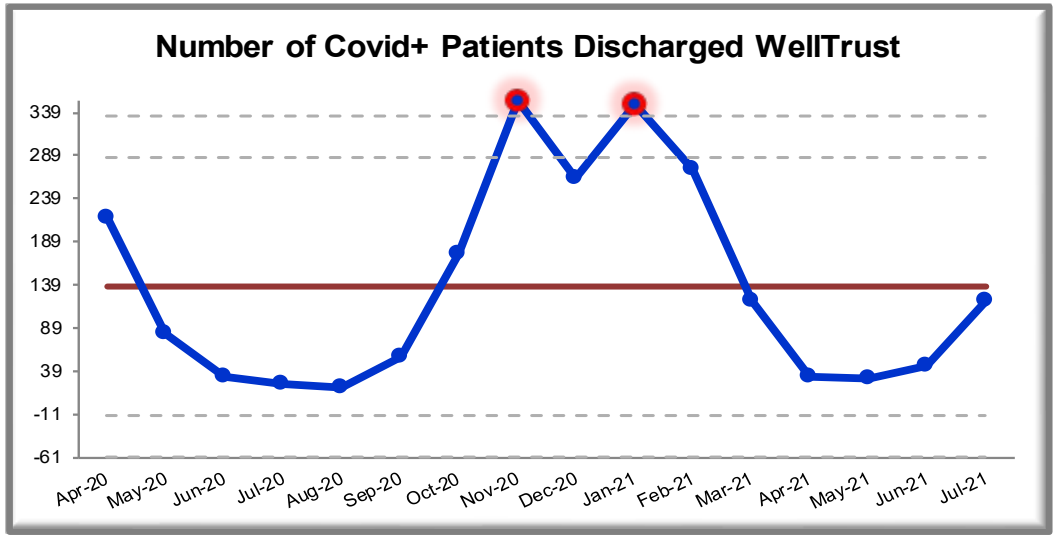

Trajectory vs Actual - Total ASIs (Over 22 weeks)
4000
3000
2000
1000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
Trajectory
Actual

Covid-19 - SPC Charts

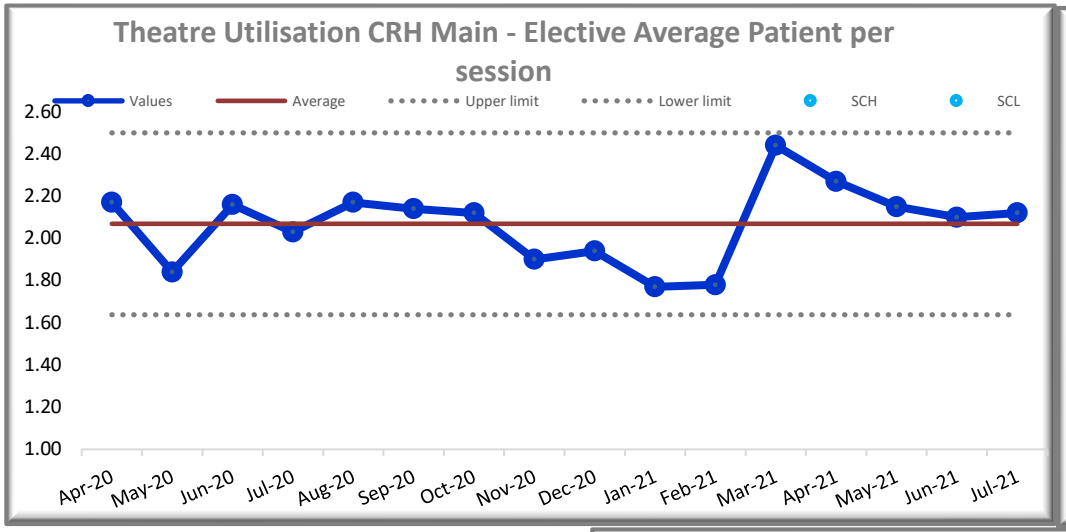


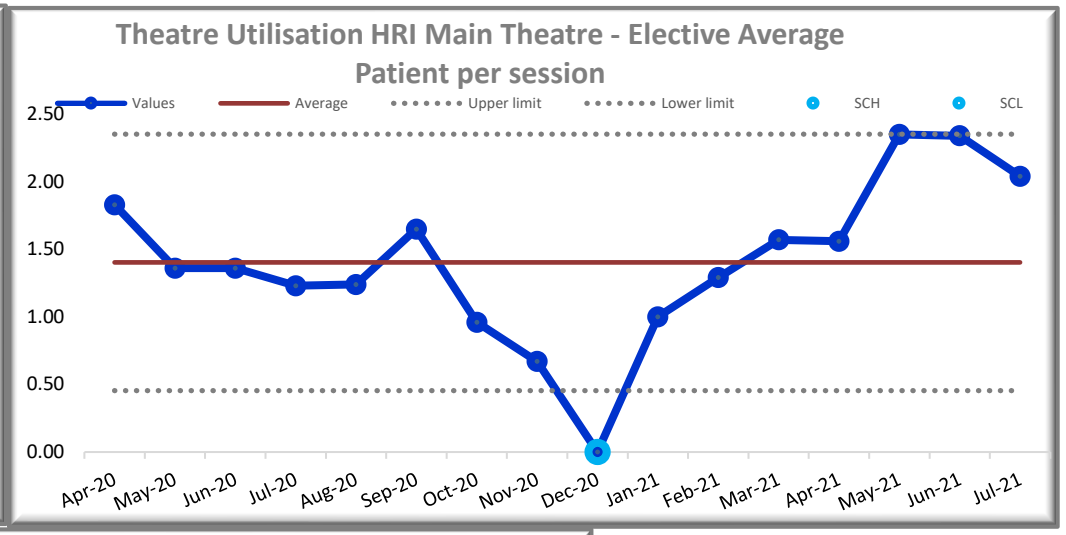


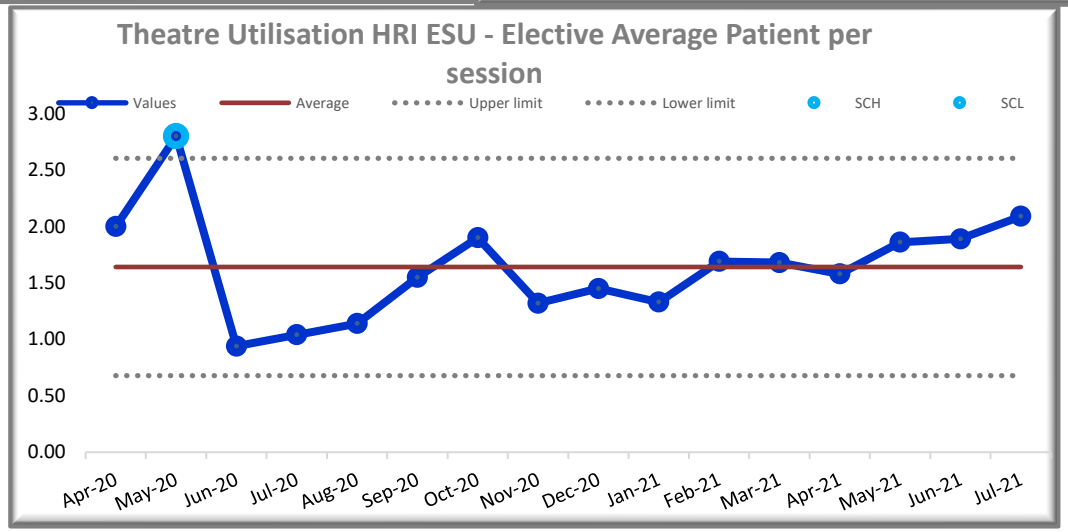




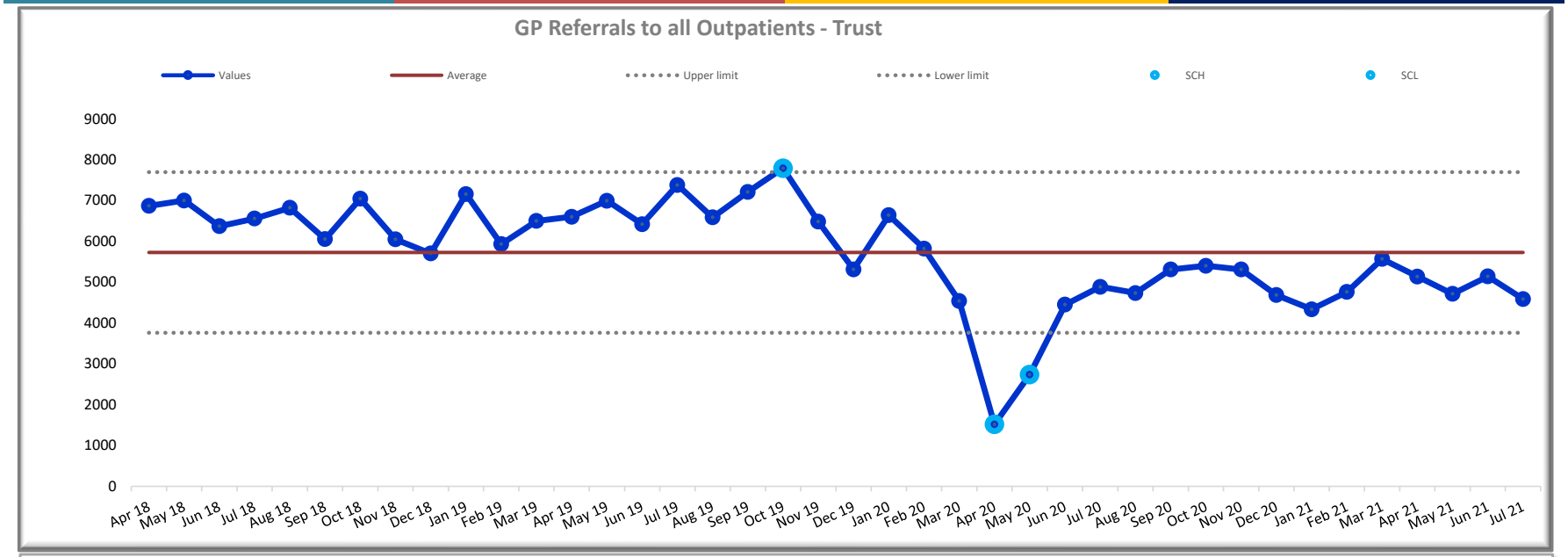
Theatres - SPC Charts

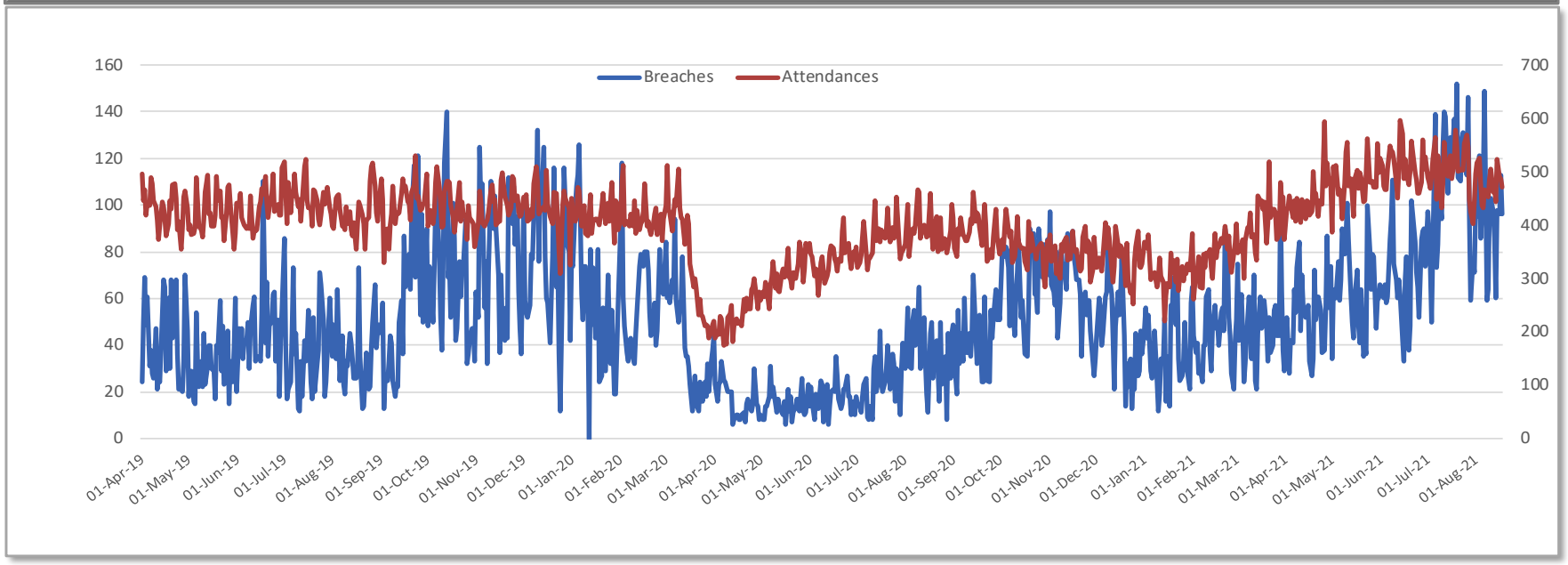






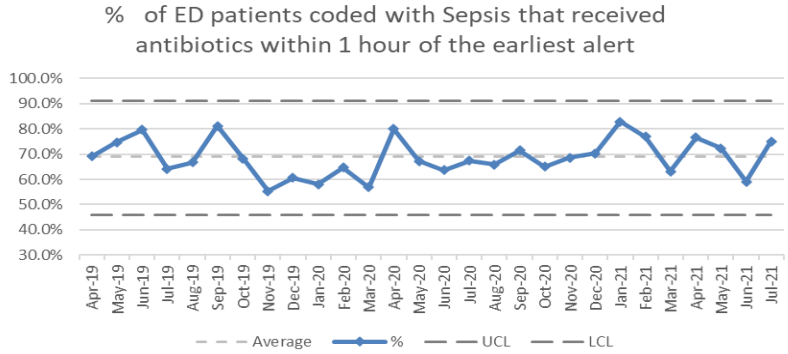
Capacity and Demand

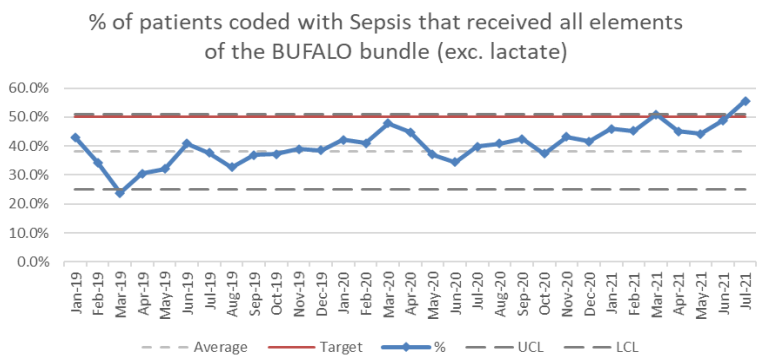




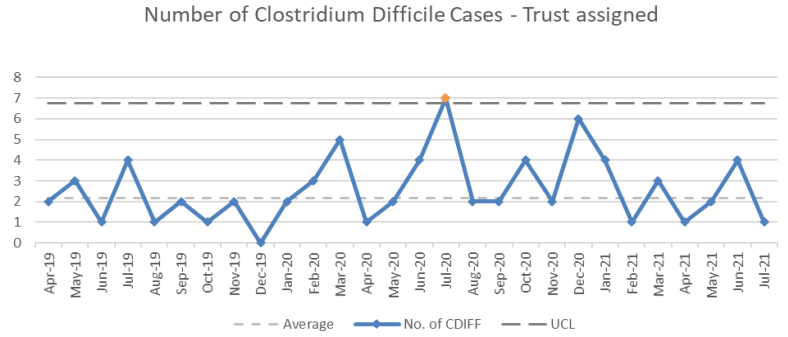
Quality Priorities - Quality Account Priorities

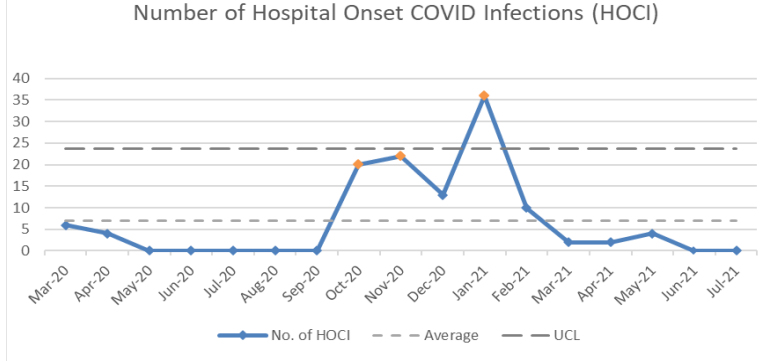
1. Recognition and timely treatment of Sepsis



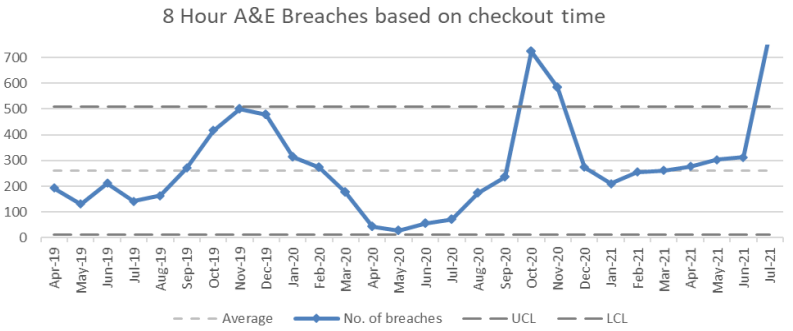


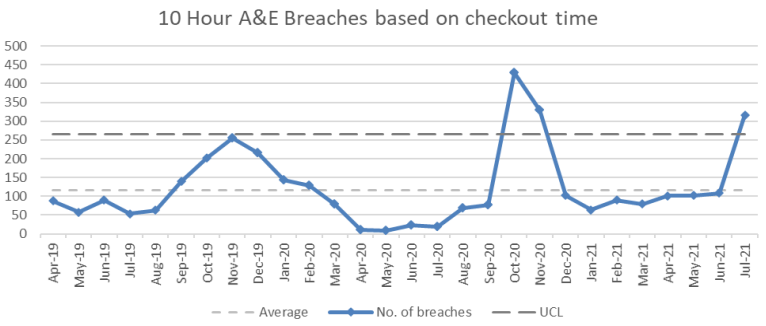
2. Reduce number of Hospital Acquired Infections including Covid 19





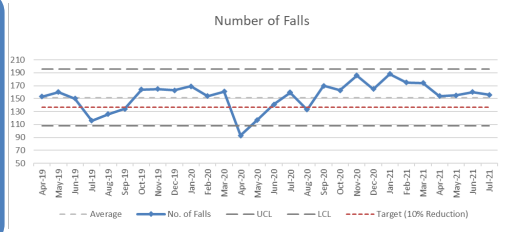
3. Reduce waiting times for individuals attending the ED



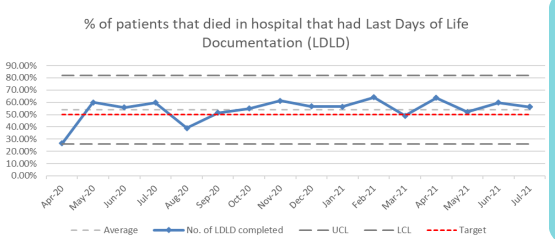


Quality Priorities - Focussed Quality Priorities

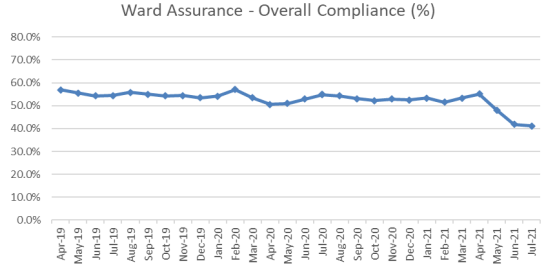
1. Falls Resulting in Harm



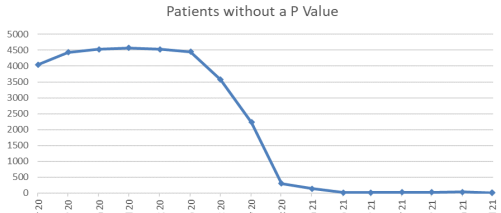
2. End of Life Care



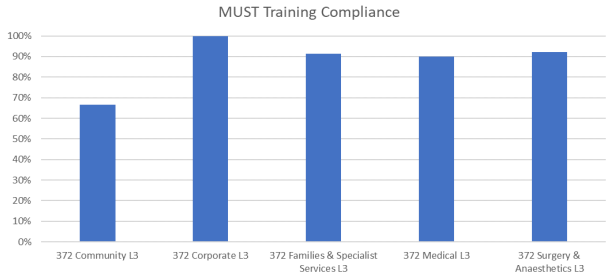
3. Clinical Documentation

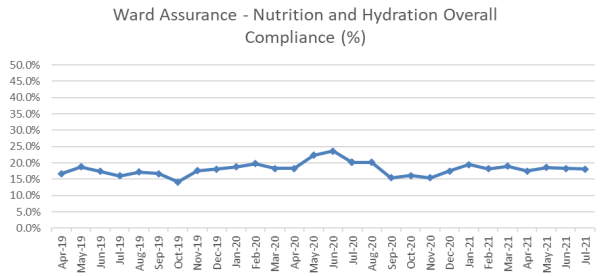


4. Clinical Prioritisation (Deferred care pathways)



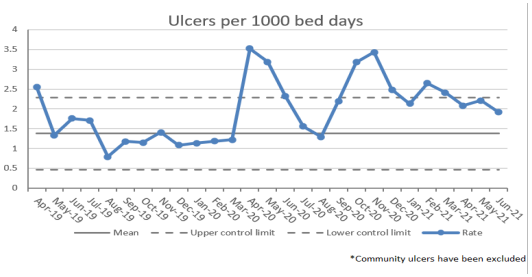
5. Nutrition and Hydration

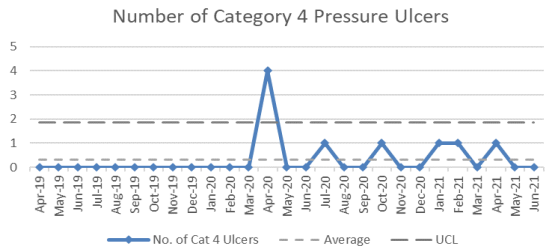




6. Pressure Ulcers

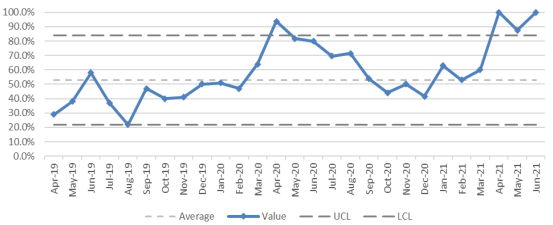
(Reported a month in areas)





7. Making Complaints Count

(Reported a month in areas)



Hard Truths: Safe Staffing Levels

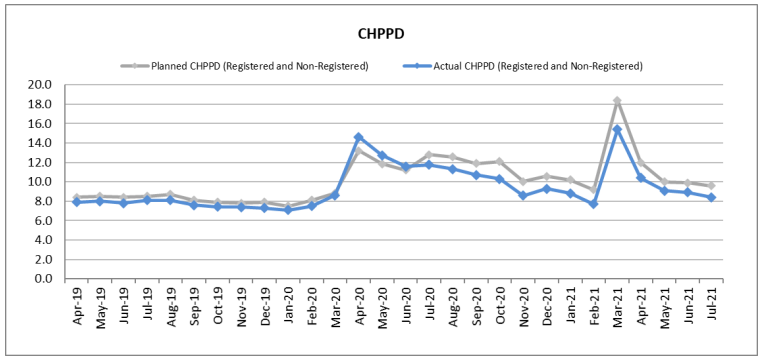
TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

	May-21	Jun-21	Jul-21
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	94.3%	93.5%	90.4%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	91.6%	91.3%	90.6%

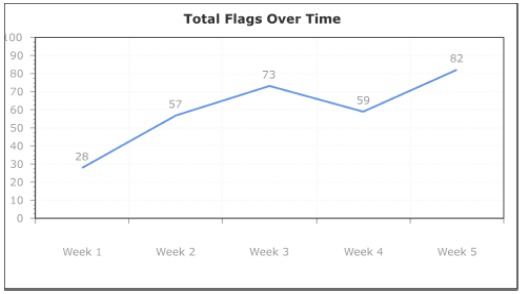
PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	10.0	9.9	9.6
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	9.1	8.9	8.4

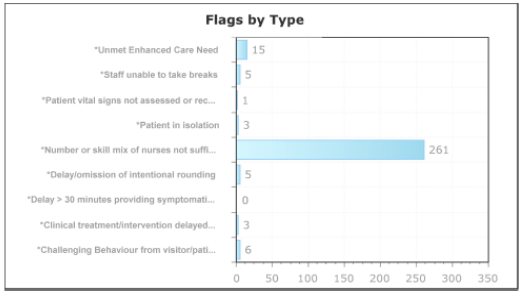
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

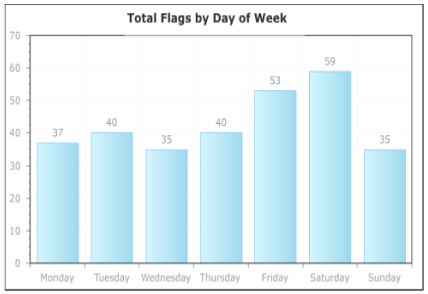
A review of July 2021 data indicates that the combined RN and non-registered clinical staff metrics resulted in 24 of the 28 clinical areas having fewer CHPPD than the planned. The July position shows a further deterioration on the June position which is reflective of increased staff absence due to Covid related absence, as well as increased unavailability of substantive staff and flexible workforce due to other sickness and annual leave. Professional judgement is used daily to establish safe staffing in these areas. Areas with CHPPD greater than planned is attributable to 1:1 enhanced care requirements, AHPs being included in CHPPD actual hours in Stroke, and some surgical units having many on-day discharges with subsequent reduction of patient count at midnight.
A review of the nurse sensitive indicators does not indicate a direct correlation between the CHPPD position and the number of falls and pressures ulcers reported.

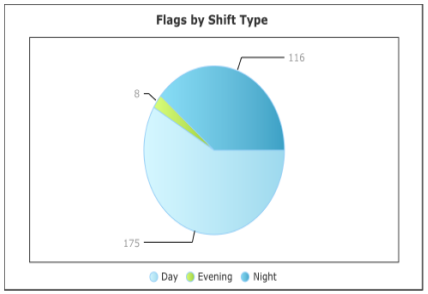


STAFFING RED FLAG INCIDENTS









A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and review monthly through the Nursing Workforce Strategy group.

The Red Flags are reviewed as part of the daily staffing meetings and immediate mitigate put in place as required. The increased red flags reported in July reflect the increased challenges in providing safe staffing.

Hard Truths: Safe Staffing Levels (2)

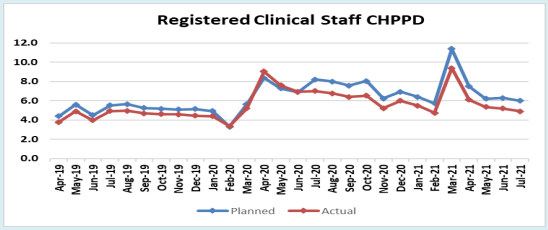
Aggregate Position | Trend | Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 6.0 for planned and 4.9 For actual for Registered Clinical Staff

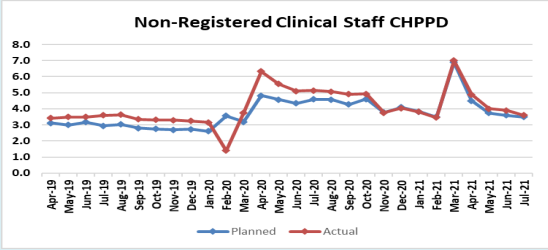


Overall there is a shortfall of 1.1 CHPPD against an overall requirement of 6.0. CHPPD. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas. A suite of nurse sensitive indicators have also been incorporated into this section of the report to monitor for any correlations alongside the CHPPD in line with national recommendations. For those indicators reported against there has been a slight increase in the number of falls, though not outwith normal variance and no increase in pressure ulcers.

Non Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 3.5 for planned and 3.6 for actual for Non-Registered Clinical Staff



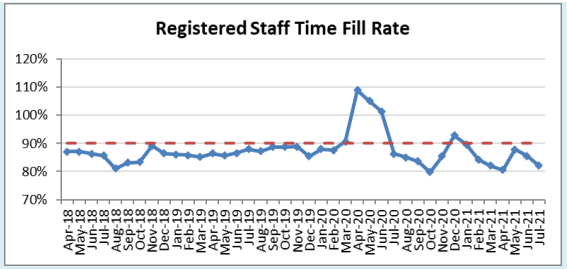
Overall there is an increase in the CHPPD of 0.1 for non-registered clinical staff, which is reflective of the national campaign to achieve a zero vacancy position (achieved April 2021). This also reflects an increased demand for enhanced 1:1 care for patients within some clinical areas. It is also a response to mitigate the risk to meet the needs of patients due to the shortfall in Registered Clinical Staff CHPPD.

FILL RATES BY STAFF AND SHIFT TYPE

Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

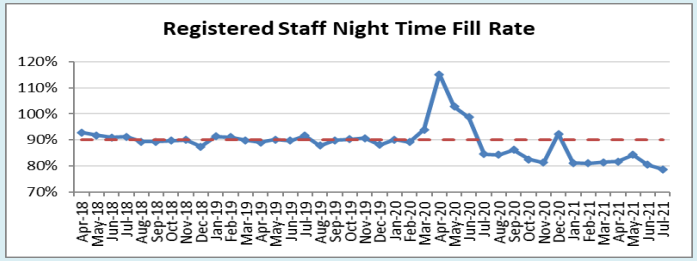
82.10% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

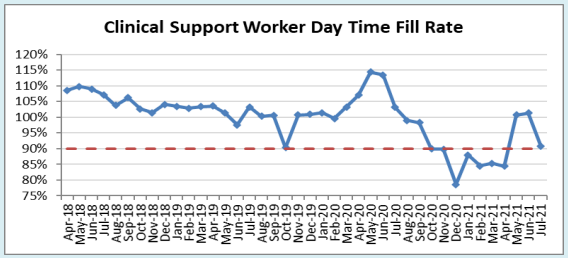
78.75% of expected Registered Clinical Staff hours were achieved for night shifts.



Non Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

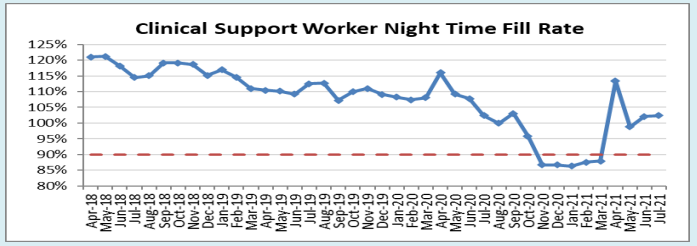
90.75% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.



Non Registered Clinical Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

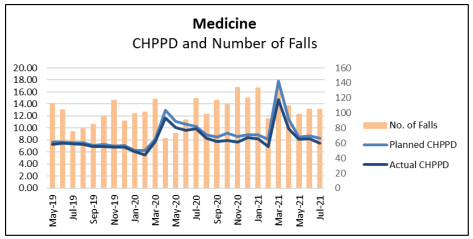
102.42% of expected Non Registered Clinical Staff hours were achieved for night shifts.

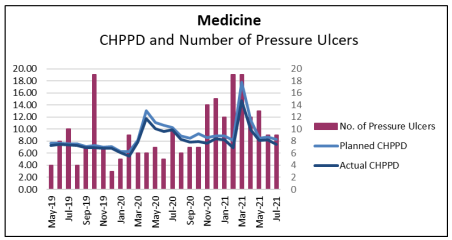


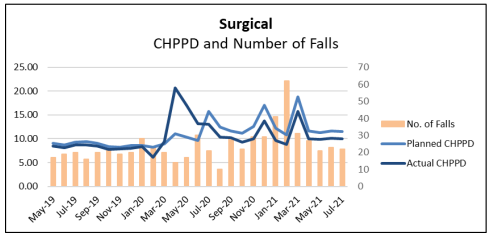
Hard Truths: Safe Staffing Levels (3)

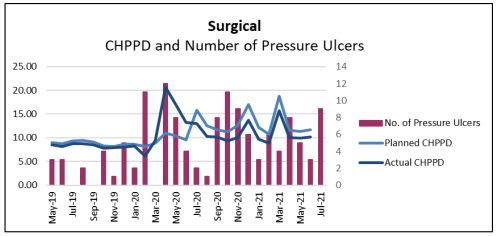
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

Ward	Average Fill Rates				Care Hours Per Patient Day		Nursing Quality Indicators					Safecare	
	DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month in Areas)	Falls	Ward Assurance	Staffing Red Flags	Number of red shifts	Number of amber shifts
Medicine	**84.0%**	**100.7%**	**78.8%**	**105.4%**	**8.3**	**7.5**	**0**	**17**	**108**	**53%**	**136**	**516**	**157**
CRH ACUTE FLOOR	100.6%	97.5%	93.3%	97.5%	8.0	7.8		2	25	57.0%	4	51	13
HRI ACUTE FLOOR	87.5%	90.0%	88.2%	91.7%	8.2	7.3		6	24	47.1%	15	48	17
RESPIRATORY FLOOR	64.9%	87.1%	65.5%	90.4%	11.3	8.4		3	3	44.4%	12	18	8
WARD 5	67.2%	121.5%	76.8%	140.1%	7.0	7.0			14	44.2%	25	42	7
WARD 6	78.7%	77.2%	100.0%	93.5%	4.3	3.7			13	51.8%	16	35	4
WARD 6C	93.0%	151.4%	105.8%	149.1%	9.8	12.0			3	50.6%		5	51
WARD 6AB	93.0%	151.4%	105.8%	149.1%	5.3	6.5			4	47.9%	10	34	6
WARD CCU	80.4%	72.5%	80.6%	-	9.1	7.5			1	51.8%	5	28	11
STROKE FLOOR	129.4%	135.4%	84.2%	104.0%	8.9	10.3		2	9	45.4%	21	7	8
WARD 12	98.6%	86.3%	100.0%	96.8%	7.3	6.9				48.7%	1	18	7
WARD 15	67.9%	89.5%	60.1%	111.9%	8.4	6.9		3	3	52.6%	21	63	6
WARD 17	82.0%	82.4%	70.3%	103.2%	6.8	5.6				42.0%	1	58	3
WARD 18	46.6%	83.8%	50.0%	76.0%	14.2	8.9		1	2	54.0%	5	42	9
WARD 20	62.8%	90.7%	59.3%	109.5%	8.3	6.6			7	54.0%		67	7
Surgical	**83.2%**	**97.8%**	**79.4%**	**95.7%**	**11.7**	**10.2**		**14**	**23**	**58.8%**	**40**	**205**	**61**
WARD 21	72.5%	98.1%	70.4%	111.9%	8.6	7.5		2	4	49.5%	2	14	7
WARD 22	86.3%	112.5%	80.7%	112.9%	6.9	6.5		1	3	49.3%	12	34	20
ICU	83.5%	80.3%	81.2%	60.4%	77.5	61.4		3		60.0%			
WARD 8A	85.0%	85.8%	82.3%	104.5%	17.0	14.7			3	66.8%		7	3
WARD 8B	100.2%	82.1%	100.0%	100.1%	7.5	7.1			1	44.9%	4	19	7
WARD 8D	63.8%	52.2%	41.9%	-	38.2	20.5				54.1%		4	
WARD 10	72.1%	148.3%	71.2%	87.1%	9.8	8.8			1	53.1%	10	26	3
WARD 11	117.3%	118.9%	132.2%	129.7%	5.9	7.3				48.3%	8	19	5
WARD 19	79.1%	105.0%	76.4%	108.9%	7.9	7.3		5	6	57.2%		23	6
SAU HRI	90.2%	92.9%	78.9%	107.8%	8.2	7.3		3	5	45.9%	4	59	10
FSS	**78.9%**	**89.2%**	**80.2%**	**103.1%**	**11.8**	**9.7**	**0**	**0**	**2**	**13.4%**	**8**	**0**	**0**
WARD LDRP	74.6%	81.3%	80.0%	98.5%	26.4	20.9				13.3%			
WARD NICU	84.4%	71.8%	81.6%	83.9%	16.0	13.2				11.7%	1		
WARD 3ABCD	76.2%	105.4%	75.4%	124.5%	12.8	10.4			2	15.1%	7		
WARD 4ABC	84.7%	92.4%	89.5%	100.0%	5.1	4.5				13.7%			
TRUST	**82.10%**	**98.78%**	**78.75%**	**102.42%**	**9.6**	**8.4**							









Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments.

On-going activity:

1. A revised dashboard has been approved as part of the Hard Truths section of the IPR which closely aligns the workforce position to an agreed suite of nurse sensitive indicators.
2. The Nursing and Midwifery Workforce Steering Group is progressing work to understand the detail of the vacancy position and potential leavers and aligning this to the recruitment/training strategy in partnership with the local HEI.
3. A section on Knowledge Portal Plus has been developed to support triangulation of the workforce position to the agreed suite of nurse sensitive indicators and has been supported with a staff engagement and training exercise.
4. A review of the current Nursing and Midwifery workforce plans is underway and supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment. In addition, training is underway to enable workforce model review using the Safer Nursing Care Tool (Acuity/Dependency Scoring). It is anticipated that as post-covid stability increases, a more accurate reflection of ward nursing dependency will be able to be measured.
6. International recruitment project continue to progress well with 27 recruits of the planned 70 resident in the UK at the end of July. A further 10 are in place for August arrival.
7. Trainee Nursing Associate apprenticeships and Registered Nurse Apprenticeships continue to be supported to assist the RN workforce recruitment strategy.
8. Daily senior staffing meetings, Chaired by the Chief Nurse, have been reintroduced to oversee staffing and patient safety.
9. Additional financial incentives have been introduced to enhance flexible workforce rates for both registered and non-registered staff.

22. High Level Risk Register

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title:	High Level Risk Register
Author:	Maxine Travis
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing
Previous Forums:	Risk Group – May, June and August 2021 Quality Committee meetings

Purpose of the Report

To provide the Trust Board with assurance as to the robust identification and management of risk across the Trust and to present an update on risks on the High-Level Risk Register.

Key Points to Note

There is an established governance processes for the identification, scoping, management, and oversight of risk in place through the remit of the Risk Group which continues to review the High Level Risk Register (HLRR) and make collective decisions for the proposed acceptance and removal of risks from the HLRR.

This paper reports the current HLRR and highlights changes from the Risk Group in May, June and August 2021. Appendix 1 details risk movement, the heat map and risk score history. Appendix 2 provides the full high level risk register.

As at 4 August 2021 there were 30 risks on the high-level risk register with the profile of the risk scores as follows:

Risk score	Number of risks
25	2
20	10
16	12
15	6

An overview of updates to risks are described below, with the risks presented in the High-Level Risk Register report.

New risks onto the HLRR since last report to Board (May 2021)

7479 (20) Caring for young people with acute mental health issues (FSS)

8021 (16) Theatre capacity for emergency obstetrics (FSS)

8037 (16) Insufficient estate to support community-based services (Comm)

8041 (16) Training and safe delivery of oxygen (Medicine)

8026 (15) Lack of estate in ED (Medicine)

8057 (20) Risk of not achieving the Full Year 2021/22 Financial Plan (Corporate)

7981 (15) Reduced senior cover in both Emergency Departments (Medicine)

8029 (20) Open Maternity pathway (FSS)

Existing top risks

7769 (25): Progression of eye diseases resulting in increased risk of sight loss (Covid risk)

7809 (25) Theatre and clinic capacity (Covid risk)

7454 (20): Radiology Staffing Risk

6345 (20): Nurse staffing risk

7078 (20): Medical staffing risk

7689 (20): Waiting for diagnostics, operations and outpatients (COVID)

7474 (20): Medical devices

7930 (20): Ophthalmology delayed treatment for glaucoma resulting in an increased risk of sight loss (Covid risk)

7479 (20) Caring for young people with acute mental health issues (FSS)

5806 (20): Infrastructure standards at HRI (CHS risk)

Risks removed from HLRR since last report to Board (May 2021)

7778 Staff becoming infected with Covid

7936 Social distancing, staff behaviours

7833 Increase in ASI and holding lists

7803 Delay in trauma surgery

7617 Non-compliance with Data Security Protection Toolkit

8029 Open Maternity pathway

7981 Reduced senior cover in both Emergency Departments

Rationale for risk removal from the HLRR is given at Appendix 1.

Movement of risks remaining on the HLRR (see Appendix 1 for rationale):

Risks **reduced** in score

7834 Elective orthopaedic inpatient theatre capacity (Covid risk) (25 to 16)

Risk i**ncreased** in score

7328 Uncovered tier one non-resident ENT (16 to 20)

EQIA – Equality Impact Assessment

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 of Directors is asked to:

- **NOTE** the current risks on the HLRR
- consider, challenge and confirm that potential significant risks within the high-level risk register are being appropriately managed and / or advise on any further risk treatment required
- **APPROVE** the current risks on the risk register

Appendices

Appendix 1 - Summary of movement, heat map and score history
Appendix 2 - High Level Risk Register

Appendix 1 High Level Risk Register: Summary of movement, heat map and score history

TOP RISKS

The following risks **score 25 or 20** on the high-level risk register:

NEW risks to the HLRR (**scoring 20 or above**):

8057 (20) Risk of not achieving the Full Year 2021/22 Financial Plan

7479 (20) Caring for young people with acute mental health issues

8029 (20) Open maternity pathway – risk later reduced to 12 and removed from HLRR

EXISTING risks (**scoring 20 and above**):

7769 (25): Progression of eye diseases resulting in increased risk of sight loss (Covid risk)

7809 (25) Theatre and clinic capacity (Covid risk)

7454 (20): Radiology Staffing Risk

6345 (20): Nurse staffing risk

7078 (20): Medical staffing risk

7328 (20): Uncovered tier one non-resident ENT on-call rota gaps

7689 (20): Waiting for diagnostics, operations and outpatients (COVID)

7474 (20): Medical devices

7930 (20): Ophthalmology delayed treatment for glaucoma resulting in an increased risk of sight loss (Covid risk)

5806 (20): Infrastructure standards at HRI (CHS risk)

NEW risks scoring 20 and above

7479 Caring for young people with acute mental health issues (C4 x L5=20) (FSS)

There is a risk that young people will be managed on the paediatric ward for an extended period of time waiting for a specialist bed or Children's Social care management,

due to a National shortage of inpatient provision for Young people with acute Mental health issues.

Resulting in staff caring for vulnerable young people in not an appropriate environment and without the appropriate skill set or professional training to manage patients safely, resulting in potential harm to the patient with mental health needs, other patients, carers and staff.

Skill set of staff to care for children with complex psychological needs. Inability to provide a one to one support from staff with the correct skill set and experience. Consistency of escalation during out of hours periods. Lack in joint pathway agreement between social care, CAMHS and CHFT.

8057 Risk of not achieving the Full Year 2021/22 Financial Plan (C5 x L4=20) (Corporate)

There is a risk that the Trust fails to meet their plan to break-even resulting in a deficit position

Due to a significant reduction in funding compared to the first half of the year. Funding for H2 is estimated and lack of a national funding settlement / national guidance means there is uncertainty regarding the funding regime for the second half of the year.

Resulting in a likely very high efficiency requirement estimated at £13.2m, which would equate to a 6.2% efficiency challenge.
Ongoing cost of Covid-19 and the potential for an Autumn / Winter surge.
Recovery plans generate costs in excess of budgeted levels, not offset by additional funding.

Divisional budgets have been set for the full financial year, but there remains uncertainly regarding the financial regime for H2. A further plan update will be required in advance of Month 7 to incorporate national guidance once it is published for H2. The Trust is undertaking an 'Efficiency Engagement Project' over the next few months to identify opportunities for efficiency. Recovery plans are due to be completed by the end of May and any expected expenditure / funding impact will be incorporated into the Trust Forecast.

8029 Open Maternity pathway (C5 x L4=20) (FSS)

There is a risk of increased levels of covid-19 infections,

due to the mandate from the secretary of state to open maternity pathways to a support person accompanying the woman to all maternity contacts.

Resulting in increased infection rates amongst patients, staff and visitors. Possible increased length of stay and additional treatment for patients. Staff sickness and absence. Possible increase in Hospital acquired community infections leading to reputational harm.

Woman and partner must wear fluid resistant surgical face masks whilst on CHFT premises If exempt then a face visor must be worn Women and partner will receive lateral flow tests through the post and will be encouraged to use these tests and inform staff of the result. Room risk assessments amended to accommodate the couple as a “bubble”. Woman asked to nominate named support person who will accompany the woman to each contact. Any decisions will be reviewed taking into account local and national restrictions and COVID.

Risk scoring reduced to 12, see risks removed from HLRR section

INCREASED RISKS

7328 Uncovered tier one non-resident ENT (C4xL4=16) to (C4xL5=20)

There is a risk of uncovered tier one non-resident ENT on-call rota gaps

Due to only 4 out of 6 posts currently filled.

Resulting in staff burn out and risk of uncovered on-call shifts. Possible knock-on effect includes impact on outpatient clinics and theatre lists activity post busy on-call if consultants end up covering the gap. This also adds a financial pressure

Reason for increase: One doctor from rota currently unable to work which has worsened the cover. On-call shifts have on occasion been covered by middle grades (consultant on-call alone). Likelihood score increased to 5. Mitigation in place has included external locums. ENT doctor recruitment ongoing

REDUCED RISKS

7834 Elective orthopaedic inpatient theatre capacity (C5 x L5 =25) to (C4 x L4=16) SAS

There is a risk that Orthopaedic elective patients are unable to have surgery within timescale
Due to no availability of elective theatres or ward staff
Resulting in lengthy delays and poor patient outcomes.

Reason for reduction: Reduce risk to 16 as we now have 2 all day elective theatres per day plus additional lists in the IS. LLP lists will commence weekend work from 26.6.21, giving a 7 day service. Looking into the offer of Community based solution. Weekly meetings being held to review patients waiting over 80 weeks and those of P2 Status.

RISKS REMOVED FROM THE HIGH-LEVEL RISK REGISTER (HLRR)

7778 Staff becoming infected with Covid (C4 x L1= 4)

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

Reason for Closure: Risks to be included on Divisional/service if required. Risk registers and risk score may vary by service

7936 Social distancing (Staff behaviours) (C4xL4= 16)

There is a risk of being unable to achieve national standard of social distancing of 2 metres,
due to staff behaviours and failure to follow government guidance.
Resulting in potential for cross infection from patients to/from staff, and staff to staff and reputational damage to the Trust

Reason for Closure: Social distancing to be reviewed in the context of the covid recovery programme. Risk, controls, scoring and lead will all be reviewed in this new context and by specific areas.

7981 Reduced Senior Cover in Both ED's (C3 x L3=9) MED

There is a risk of reduced senior cover in both ED's,
due to a reduction in consultant numbers due to retirement/maternity.
Resulting in both ED's operating on reduced senior cover

Reason for reduction: Retired Consultant agreed to come back on bank basis which will increase senior cover from 01 June 21

7803 Delays in trauma general surgery (C4 x L3 = 12) SAS

There is a risk of general trauma patients having delays to theatre
Due to reduced theatre efficiency because of Covid
Resulting in poorer surgical outcomes and experience

Reason for reduction: Likelihood reduced, daily trauma meeting to prioritise, provision of regular trauma lists has improved.

7833 Increase in ASI and holding lists (C3 x L3 =9) SAS

There is a risk that the ASI (appointment slot issues) and holding lists will continue to increase
Due to the lack of outpatient areas in Trauma and Orthopaedics
Resulting in delays in patients being seen and poorer outcomes.

Reason for reduction: Agreement in place for 10 rooms per day including a treatment room across CRH Main outpatients dept and Acre Mill. additional capacity in place from 5 July 2021.

8029 Open maternity pathways (C3 x L4 =12) FSS

There is a risk of increased levels of covid-19 infections
Due to the mandate from the secretary of state to open maternity pathways to a support person accompanying the woman to all maternity contacts.
Resulting in an increase in infection rates amongst patients, staff and visitors. Possible increased length of stay and additional treatment for patients. Staff sickness and absence. Possible increase in Hospital acquired community infections leading to reputational harm.

Reason for reduction: No incidents or complaints recorded. No IPC Issues raised.

7617 Non-compliance with Data Security Protection Toolkit (C4 x L1=4) Corporate

There is a 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**.**

Reason for reduction: DSPT Submitted on the 30th of June 2021 as 'Standards Met'. This was agreed at both divisional board and WEB. Target score is now met, and the risk is proposed for closure at the next divisional board (late July).

TRUST RISK PROFILE AS AT 04/08/2021

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 =7615 Emergency Care Standard =8026 Lack of estate in ED	= 6345 Nurse Staffing = 7078 Medical Staffing =7454 Radiology staffing =7689 Diagnostics, OPD, operations =7474 Medical Devices =7479 Caring for young people with acute mental health issues ↑ 7328 ENT staffing Shortage	=7809 Theatre and clinical capacity =7769 Progression of eye pathology and sight loss
Likely (4)				=6829 Pharmacy Aseptic Dispensing Service =7557 Meeting RCPCH guidelines ED =6596 Delay in SI investigations =7527 Maxillofacial follow up appointment =2827 Over reliance on locum middle grade doctors in A&E =7964 Delay treatment for eye conditions =7683 Isolation facilities =6453 Delay of surgical report #NOF =8041 Training for safe delivery of oxygen =8037 Insufficient estate to support community based services =8021 Theatre capacity for emergency obstetrics ↓ 7834 Elective orthopaedic theatre capacity	=7930 Ophthalmology delayed treatment Glaucoma =5806 Infrastructure standards at HRI !8057 Risk of not achieving 21/22 financial plan
Possible (3)					=5747 Vascular /interventional radiology service =7413 Fire compartmentation HRI =7414 Building safety
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 and 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		**SIGNIFICANT**

SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK as at 8th August 2021

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead/ Divisional Director	Risk Score history

KEY: = Same score as last period, ↓ decreased score since last period, **!** New risk since last report to Board ↑ increased score since last period

Newly added risks highlighted in bold.

					Feb 21	Mar 21	April 21	May 21	June 21	July 21
Quality and Safety Risks										
06/19	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (WA)	=15	=15	=15	=15	=15	=15
06/19	6453	Keeping the base safe	Delay surgical repair #NOF	Clinical Director	=16	=16	=16	=16	=16	=16
08/19	6596	Keeping the base safe	Delay in SI investigations	Director of Nursing (EA)	=16	=16	=16	=16	=16	=16
06/19	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (EA)	=15	=15	=15	=15	=15	=15
06/19	6829	Keeping the base safe	Pharmacy Aseptic Dispensing Service	Director of Nursing (EA)	=16	=16	=16	=16	=16	=16
10a/19	7328	Keeping the base safe	ENT Middle Grade rota gaps	Director of Operations SAS (TS)	=16	=16	=16	=16	=16	↑20
16/19	7474	Keeping the base safe	Medical Devices Risk	Director of Finance (GB)	=20	=20	=20	=20	=20	=20
06/19	**7479**	**Keeping the base safe**	**Young people with acute mental health needs**	**Divisional Director of FSS (NB)**	**=20**	**=20**	**=20**	**=20**	**=20**	**=20**
05/19	7527	Keeping the base safe	Maxillofacial follow up appointment	Divisional Director of SAS (WA)	=16	=16	=16	=16	=16	=16

08/19	7615	Keeping the base safe	Emergency Care standard	Director of Nursing (EA), Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15
02/20	7617	Keeping the base safe	Cyber risks	Managing Director Digital Health (MG)	=16	=16	=16	=16	=16	↓4
05/20	7683	Keeping the base safe	Isolation facilities	Medical Director (DB)	=20	↓16	=16	=16	=16	=16
05/20	7689	Keeping the base safe	Delay in diagnostics, OPD and operations	Director of Transformation (AB)	=20	=20	=20	=20	=20	=20
05/20	7769	Keeping the Base Safe	Ophthalmology disease progression	Director of Operations SAS (TS)	=25	=25	=25	=25	=25	=25
05/20	7778	Keeping the base safe	Staff infected with Covid-19	Chief Operating Officer (HB)	=16	=16	=16	↓4		
05/20	7803	Keeping the base safe	Delays in general trauma surgery	Divisional Director of SAS (WA)	=16	=16	=16	=16	↓12	
05/20	7809	Keeping the base safe	Theatre and clinic capacity SAS	Director of Operations SAS (TS)	=25	=25	=25	=25	=25	=25
05/20	7833	Keeping the base safe	ASI Orthopaedics appointment slots	Divisional Director of SAS (WA)	=16	=16	↑20	=20	=20	↓9
05/20	7834	Keeping the base safe	Orthopaedic elective surgery	Divisional Director of SAS (WA)	=25	=25	=25	=25	=25	↓16
05/20	7930	Keeping the base safe	Ophthalmology glaucoma	Clinical Director Head & Neck (PL)	=20	=20	=20	=20	=20	=20
06/19	7936	Keeping the base safe	Social distancing (staff behaviours)	Chief Operating Officer (HB)	=16	=16	=16	=16	=16	=16 closed
05/20	7964	Keeping the base safe	Ophthalmology capacity retinal problems	Director of Operations SAS (TS)	=20	=20	↓16	=16	=16	=16
05/20	**8021**	**Keeping the base safe**	**Theatre capacity for emergency obstetrics**	**Clinical Director FSS**				**!16**	**=16**	**=16**

05/20	**8026**	**Keeping the base safe**	**ED estate impact on patient safety and experience**	**Director of Operations MED**			**!15**	**=15**	**=15**	**=15**
06/19	**8029**	**Keeping the base safe**	**Open maternity pathway**	**Divisional Director of FSS**			**!20**	**=20**	**=20**	**↓12**
09/19 16/19	**8037**	**Keeping the base safe**	**Estate to support Community-based services**	**Director of Operations, COMM (MF)**			**!16**	**=16**	**=16**	**=16**
06/19	**8041**	**Keeping the base safe**	**Staff training in oxygen management**	**Director of Operations MED (JH)**			**!16**	**=16**	**=16**	**=16**
WORKFORCE RISKS										
01/19	2827	Developing our workforce	Over reliance on locum middle grade doctors in A&E	Medical Director (DB) Emergency Dept Clinical Director (AM)	=20	↓16	=16	=16	=16	=16
10b/19	7557	Keeping the base safe	Meeting RCPCH guidelines ED	Director of Nursing (EA)	=16	=16	=16	=16	=16	=16
10b/19	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (EA), Director of Workforce	=20	=20	=20	=20	=20	=20
10a/19	7078	Keeping the base safe	Medical Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) Director of Nursing (EA) Director of Workforce WA	=20	=20	=20	=20	=20	=20
10a/19	7454	Keeping the base safe	Radiology service provision staffing risk	Divisional Director of FSS	=20	=20	=20	=20	=20	=20
10a/19	**7981**	**Keeping the base safe**	**Reduction in ED Consultant cover**	**Emergency Dept Clinical Director (AM)**	**=15**	**=15**	**=15**	**=15**	**↓9**	
ESTATES / SAFETY RISKS										

09/19	7414	Keeping the base safe	Building cladding	Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15
09/19	7413	Keeping the base safe	Fire compartmentation at HRI	Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15
09/19	*5806*	*Keeping the base safe*	*Infrastructure (CHS risk)*		*=20*	*=20*	*=20*	*=20*	*=20*	*=20*
FINANCIAL RISKS										
13/19	**8057**	**Sustainability**	**Achieve financial plan**	**Director of Finance**				**!20**	**=20**	**=20**

Board Assurance Framework risks referenced above:

01/19	Risk re approval of the hospital services reconfiguration business cases
05/19	Risk that the resource, capacity and capability of full optimisation of the EPR system due to lack of optimisation of the system does not continue to further enhance quality and safety
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.
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.
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.
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.
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.
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and inclusive leadership to colleagues.

13/19	Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention
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
16/19	Compliance with Health & Safety
2/20	Investment for Digital Strategy ambitions
5/20	Unable to maintain current levels of Covid-19 capacity or response to surges in Covid-19 demand and non-Covid 19 patients

23. Risk Appetite Statement

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title:	Risk Appetite Statement
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Review of individual risks by respective Board Committees

Purpose of the Report

This report presents for approval revisions to the Trust's risk appetite.

Key Points to Note

Risk appetite is "the amount and type of risk that the Trust is prepared to pursue, retain or take" in pursuit of its strategic objectives and is key to achieving effective risk management. The Board needs to understand and apply the risk appetite so that they do not expose the Trust to risks it cannot tolerate, take opportunities when they arise or be over cautious and stifle innovation and development.

The Trust has a Board approved Risk Management Strategy and Policy, one of the components of which is to embed the risk appetite in decision-making. This states:

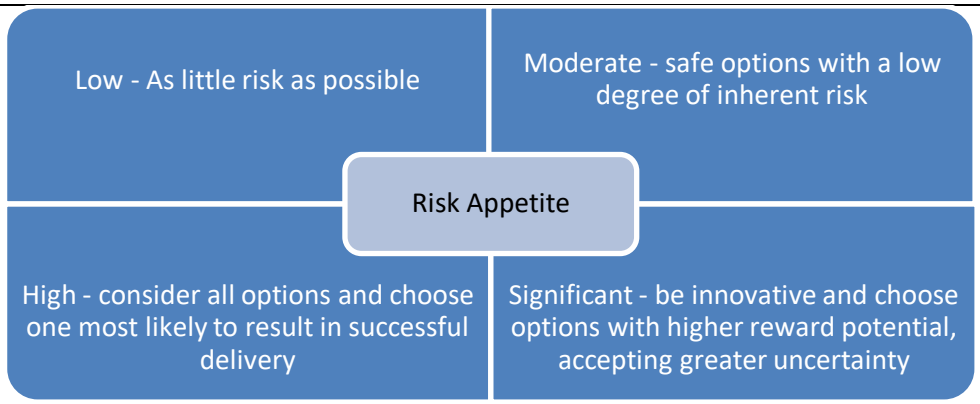
"The Board and its Committees need to ensure that they consistently apply the risk appetite to drive decisions made. The Board will annually review and approve a risk appetite statement which will assist decision makers to understand the level of risk the Trust is willing to tolerate."

The setting of risk appetite is a key tool in communicating the Board's assessment of the nature and extent of the principal risks that the Trust is exposed to and is willing to take to achieve its strategic objectives. The Board risk appetite model is based on the Good Governance Institute risk appetite matrix for NHS organisations and recommends an annual review of the risk appetite by the Board.

A review of the risk appetite took place in August with the Chair of the Audit and Risk Committee, which has oversight for risk management, the Director of Nursing, Director of Finance, Deputy Director of Finance and Company Secretary.

It was confirmed that there were no changes required to the risk categories, however there were some minor revisions to wording to clarify the meaning of two areas of risk, the reputation risk category and partnership category.

Risk appetite levels vary from low to significant and definitions of each are given below:



RISK APPETITE AUGUST 2021 (changes proposed in red font)

Risk Category / Type	Description	Risk Appetite
Strategic / Organisational	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	We will not shy away from making difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, 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 accept a level of risk in working with partners to support service transformation and operational delivery.	**SIGNIFICANT**

EQIA – Equality Impact Assessment

In assessing 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 risk appetite statement.

24. Governance Report

a) Annual Review of Non-Executive Director Roles

b) Board Workplan

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 September 2021
Meeting:	Public Board of Directors
Title of report:	Annual Review of Non-Executive Director Roles
Author:	Andrea McCourt, Company Secretary
Sponsor:	Owen Williams, Chief Executive
Previous Forums:	None

Purpose of the Report

This paper presents information on the current roles and responsibilities assigned to Non-Executive Directors.

Key Points to Note

The enclosed paper details the current roles and responsibilities of the Non-Executive Directors (NED).

On an annual basis the NEDs review their time commitments compared to their availability, including Board and Board Committee chairing roles and the additional activities undertaken by NEDs. This has identified issues of NED capacity and increasing competing pressures on their time.

In recognition of the capacity issue the Trust has agreed, through discussion with governors via the Nominations and Remuneration Committee of the Council of Governors, to pilot the use of an Associate Non-Executive Director role with a focus on the quality agenda, with project work relating to the lived experience of patients, to supplement our existing NED capacity. The appointed Associate NED will not participate in any formal vote at the Board. The recruitment process for this Associate NED is currently underway.

NHS England / Improvement has recognised that nationally there is an issue for NEDs who have limited capacity to carry out the increasing number of roles asked of them. They have reviewed which NED roles need to be retained (eg mandatory or functional roles), which can be removed and which roles can be discharged through relevant committee structures, removing the tension between the concept of an individual NED role and a unitary Board responsibility. It is expected that national guidance on these roles will be issued in 2022 when engagement work and sampling of the new approach has been completed. This will inform future reviews of NED time commitments once issued.

EQIA – Equality Impact Assessment

The content of this report does not adversely affect people with protected characteristics.

Recommendation

The Board is asked to **NOTE** the current responsibilities of the Non-Executive Directors.

PUBLIC BOARD WORKPLAN 2021-2022

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Date of agenda setting/Feedback to Execs	7 December 2020	1 February 2021	7 April 2021	27 May 2021	2 August 2021	30 September 2021	8 December 2021	31 January 2022
Date final reports required	31 December 2020	19 February 2021	23 April 2021	18 June 2021	20 August 2021	22 October 2021	31 December 2022	18 February 2022
STANDING AGENDA ITEMS								
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓	✓	✓
Financial Update	✓	✓	✓	✓	✓	✓	✓	✓
Health Inequalities	✓ **Defer to March**	✓	✓	✓	✓	✓	✓	✓
Quality Committee update & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Audit and Risk Committee update & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Finance and Performance Committee update & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Workforce Committee update & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓	✓	✓

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
COVID-19 Oversight Committee Minutes	✓	✓	✓					
Council of Governors Meeting Minutes		✓	✓		✓	✓		✓
STRATEGY AND PLANNING								
Strategic Objectives – 1 year plan / 10 year strategy		✓		✓ *- 2020/21 Strategic Objectives Progress Report*		✓		
Digital Health Strategy				✓		✓		
Workforce OD Strategy		**Defer to May**	✓					✓
Risk Management Strategy		✓					✓	
Service Reconfiguration Outline Business Case					✓* additional Board meeting may be required in later July TBC			
Annual Plan		✓	✓	✓				✓
Capital Plan	✓						✓	
Winter Plan					✓	✓		
Green Plan (Climate Change)			✓					
QUALITY								
Quality Board update	✓	✓	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓ Q2, Q3 2020/21		✓Q4		✓Q1	✓Q2	✓Q3	
DIPC Annual Report				✓				
Learning from Deaths Quarterly Report		✓ Q3		✓Q4	✓Q1	✓Q2		✓ Q3

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Safeguarding update – Adults & Children		✓			✓ (Annual report)			✓
Complaints Annual Report					✓			
WORKFORCE								
Staff Survey Results and Action Plan			✓	✓		✓		✓
Health and Well-Being			Deferred to September		✓			
Nursing and Midwifery Staffing Hard Truths Requirement (Bi-Annual report due annually in Sep; however, it will be Nov this year)		✓ (Bi-annual)				✓ (Bi-annual)		✓ (Bi-annual)
Guardian of Safe Working Hours (quarterly)	✓Q3		✓Q4		✓Q1	✓Q2	✓Q3	
Guardian of Safe Working Hours Annual Report			✓					
Diversity		✓						
Medical revalidation & appraisal Annual Report					✓			
Freedom to Speak Up Annual Report	✓ 6 month report FTSU themes				✓ Annual Report			
Workforce Committee Annual Report	✓ 2019/2020			✓ 2020/21				
Public Sector Equality Duty (PSED) Annual Report		✓						✓
GOVERNANCE & ASSURANCE								
Health and Safety Update	✓		✓	✓			✓	
Health and Safety Policy			✓					
Health and Safety Annual Report	✓						✓	

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Board Assurance Framework		✓ 3		✓ 1		✓ 2		✓ 3
Risk Appetite Statement					✓ with BAF			
High Level Risk Register	✓		✓		✓		✓	
Calderdale Huddersfield Solutions Managing Directors Report	✓	✓	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review			✓					
Non-Executive appointments		✓				✓		✓
Annual review of NED roles					✓			
Board workplan	✓	✓	✓	✓	✓	✓	✓	✓
Board meeting dates				✓				
Use of Trust Seal			✓	✓		✓		
Council of Governor elections		✓ timetable						
Declaration of Interests – Board of Directors (annually)		✓						✓
Attendance Register – (annually)			✓					
Fit and Proper Person Self-Declaration Register		✓						✓
Seek delegation from Board to ARC for the annual report and accounts 2020/21			✓					
BOD Terms of Reference		✓						✓
Sub Committees Terms of Reference	✓ Workforce ✓ NRC BOD	✓ QC	✓ F&P ✓ TPB	✓ Workforce	✓ ARC			✓
Constitutional changes (+as required)		✓	✓					
Compliance with Licence Conditions			✓					
Huddersfield Pharmaceuticals Specials Annual Report						✓		

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Health and Safety Annual Report	✓						✓	
Fire Safety Annual Report				✓				
Emergency Planning Annual Report (Bev Walker/Ian Kilroy/Karen Bates)					✓			
Charitable Funds Report 2019-20 and Accounts (Audit Highlights Memorandum)	✓							
Committee review and annual reports				✓	✓	✓		
Audit & Risk Committee Annual Report 2020/2021					✓ 2020/21			
Finance & Performance Committee Annual Report 2020/2021				✓				
Quality Committee Annual Report 2020/21						✓ 2020/21		
WYAAT/WY&H Partnership Reports	✓	✓	✓	✓	✓	✓	✓	✓
WYAAT Annual Report and Summary Annual Report	✓							

Colour Key to agenda items listed in left hand column:	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place (see Review Room papers)

25. Committee Review Annual Reports 2020/2021

- Audit and Risk Committee

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	2 September 2021
Meeting:	Board of Directors
Title:	Audit and Risk Committee Annual Report 2020-2021
Author:	Andrea McCourt, Company Secretary Andy Nelson, Non-Executive Director
Previous Forums:	Audit and Risk Committee 21 July 2021

Purpose of the Report

This paper presents the annual report of the Audit and Risk Committee for 2020-2021 which details the role of the Audit and Risk Committee including membership and attendance and describes the activities of the Audit and Risk Committee during the year in line with the duties within the terms of reference.

Key Points to Note

The role of the Audit and Risk Committee is to provide assurance to the Trust Board regarding the monitoring and review of financial and other risks and associated controls, corporate governance and the assurance frameworks of the Trust and its subsidiaries.

The Audit and Risk Committee confirms that it has fulfilled its role of providing assurance to the Board during 1 April 2020 to 31 March 2021 regarding the monitoring and review of financial and other risks and associated controls, corporate governance and the assurance frameworks of the Trust and its subsidiaries.

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 **NOTE** the assurances in the Annual Report that the Audit and Risk Committee met its duties for 2020-2021 and **APPROVE** the Report.

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

Version:	5
Approved by:	Board of Directors
Date approved:	Audit and Risk Committee – 21 July 2021 Board of Directors – 2 September 2021
Date issued:	2 September 2021
Review date:	July 2021
Next review:	July 2022

AUDIT and RISK COMMITTEE TERMS OF REFERENCE

1. Authority

1.1 The Audit and Risk Committee is constituted as a standing sub-committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit and Risk Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Audit and Risk Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit and Risk Committee.

1.3 The Audit and Risk Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The Audit and Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls corporate governance and assurance frameworks of the Trust and its subsidiary(ies).

2.2 The Audit and Risk Committee will have close working relationships with Quality Committee which has responsibility for oversight and monitoring of clinical risks and clinical audit.

2.3 The Board of Directors is responsible for ensuring effective internal control including:

- Management of the foundation trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Audit and Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control. In addition, the Audit and Risk Committee shall:

- Ensure independence of External and Internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Audit and Risk Committee; and
- Monitor corporate governance (e.g. Compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

3. Membership

3.1 The Committee shall be composed of not less than three Non-Executive Directors, at least one of whom should have recent and relevant financial experience. The Trust Chair will not be a member of the Audit and Risk Committee.

3.2 A quorum shall be two members.

4. Attendance

4.1 Only members of the Committee have the right to attend. The Director of Finance, Deputy Finance Director, Company Secretary, Senior Risk Manager, Head of Internal Audit and the Managing Director for Digital Health of the Foundation Trust shall generally be invited to routinely attend meetings of the Audit and Risk Committee.

4.2 A representative of the External Auditors may normally also be invited to attend meetings of the Audit and Risk Committee.

4.3 The Chief Executive should be invited to attend at least annually to discuss the assurance supporting the Annual Governance Statement and when considering the Internal Audit plan. Other Directors are expected to attend as required by the Audit and Risk Committee and where items relating to their areas of risk or responsibility are being considered.

4.4 The Foundation Trust Chair may be invited to attend meetings of the Audit and Risk Committee as required.

4.5 A representative of the Local Counter Fraud Service is invited to attend all meetings of the Audit and Risk Committee.

4.6 The Chair of the Board of Directors will appoint a Governor to attend the public meetings of the Audit and Risk Committee. The appointment will be reviewed each year.

4.7 Attendance is required by members at 75% of meetings. Members unable to attend should inform the Corporate Governance Manager as soon as possible in advance of the meeting except in extenuating circumstances.

4.8 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

5. Administration

5.1 The Corporate Governance Manager shall be the secretary to the Audit and Risk Committee and will provide administrative support and advice. Their duties include but are not limited to:

- Agreement of the agenda with the chair of the Audit and Risk Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

6. Frequency of meetings

6.1 Meetings shall be held quarterly, with an additional meeting to review the annual accounts, with other meeting arranged where necessary. The Committee must consider the frequency and timing of meetings required to discharge all of its responsibilities on a regular basis.

6.2 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

6.3 The Internal Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

7. Duties

7.1 Governance, internal control and risk management

7.1.1 To ensure the provision and maintenance of an effective system of integrated governance, risk identification and associated controls, reporting and governance of the Trust and its subsidiary(ies), unless otherwise identified in the governance reporting structure.

7.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

7.1.3 To review processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other board committees in relation to the Trust's overall internal control and risk management position

7.1.4 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

7.1.5 To review the adequacy of the Foundation Trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

7.1.6 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

7.1.7 The adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements. Policies for approval by the Committee are identified in the Audit and Risk Committee annual workplan.

7.2 Internal audit

7.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

7.2.2 To oversee on an ongoing basis the effective operation of Internal Audit including:

- Adequate resourcing;
- Its co-ordination with External Audit;

Complying with the public sector Internal Audit Standards

- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

7.2.3 To consider the major findings of Internal Audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

7.2.4 To consider the provision of the Internal Audit Service annually, the cost of the audit and any questions of resignation and dismissal. The appointment/dismissal of Internal Audit remains the responsibility of the Director of Finance.

7.3 External audit

7.3.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.3.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the foundation trust associated impact on the audit fee.

7.3.3 To assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.3.4 To oversee the conduct of a market testing exercise for the appointment of an Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

7.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.3.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

7.3.7 To consider the provision of the External Audit Service, the cost of the audit and any questions of resignation and dismissal.

7.4 Annual accounts review

7.4.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.2 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

7.4.3 Where required by national guidance in the NHS Foundation Trust Annual Reporting Manual, seek assurances regarding scrutiny of Quality Accounts by the Quality Committee and review of specific areas by External Audit

7.4.4 To review all accounting and reporting policies and systems for reporting to the Board of Directors.

7.5 Standing orders, standing financial instructions and standards of business conduct

7.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct. Standards of Business Conduct and Declarations of Interest; including maintenance of Registers.

7.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

7.5.3 To review the Scheme of Delegation.

7.6 Other

7.6.1 To review performance indicators relevant to the remit of the Audit and Risk Committee.

7.6.2 To examine any other matter referred to the Audit and Risk Committee by the Board of Directors and to initiate investigation as determined by the Audit & Risk Committee.

7.6.3 To ensure that the Quality Committee performs at least an Annual Review of the clinical audit plan and considers the findings and recommendations of in-year reports, ensuring the plan and extras are consistent with the strategic direction of the Trust.

7.6.4 To develop and use an effective assurance framework to guide the Audit and Risk Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these terms

of reference.

7.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

7.6.6 To review the work of all other Board sub-committees as part of the Audit and Risk Committee assurance role. The Audit and Risk Committee will receive a self-assessment and annual report from each of the committees for approval.

8. Reporting

8.1 The minutes of all meetings of the Audit and Risk Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Audit and Risk Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes via the Chair's highlight report.

8.2 The Audit and Risk Committee will report by a Chair's highlight report to the Board of Directors in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the governance statement; the assurance framework; the effectiveness of risk management within the foundation trust; the integration of and adherence to governance arrangements; its view as to whether the self-assessment against standards for better health is appropriate; and any pertinent matters in respect of which the Audit and Risk Committee has been engaged.

8.3 The Foundation Trust's Annual Report shall include a section describing the work of the Audit and Risk Committee in discharging its responsibilities.

8.4 The Committees that report into the Audit and Risk Committee are the Risk Group, Information Governance and Risk Strategy Committee, Data Quality Board, Health and Safety Committee and the CQC and Compliance Group.

9. Review

9.1 The effectiveness of the Audit and Risk Committee will be reviewed by members on an annual basis.

9.2 The Terms of Reference of the Audit and Risk Committee shall be reviewed by the Board of Directors at least annually.

26. Review of Sub-Committee Terms of Reference

- Audit and Risk Committee

To Approve

Presented by Andrea McCourt

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

Version:	5
Approved by:	Board of Directors
Date approved:	Audit and Risk Committee – 21 July 2021 Board of Directors – 2 September 2021
Date issued:	2 September 2021
Review date:	July 2021
Next review:	July 2022

AUDIT and RISK COMMITTEE TERMS OF REFERENCE

1. Authority

1.1 The Audit and Risk Committee is constituted as a standing sub-committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings. The Audit and Risk Committee shall not have executive powers in addition to those delegated in these terms of reference.

1.2 The Audit and Risk Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Audit and Risk Committee.

1.3 The Audit and Risk Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The Audit and Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls corporate governance and assurance frameworks of the Trust and its subsidiary(ies).

2.2 The Audit and Risk Committee will have close working relationships with Quality Committee which has responsibility for oversight and monitoring of clinical risks and clinical audit.

2.3 The Board of Directors is responsible for ensuring effective internal control including:

- Management of the foundation trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Audit and Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control. In addition, the Audit and Risk Committee shall:

- Ensure independence of External and Internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Audit and Risk Committee; and
- Monitor corporate governance (e.g. Compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

3. Membership

3.1 The Committee shall be composed of not less than three Non-Executive Directors, at least one of whom should have recent and relevant financial experience. The Trust Chair will not be a member of the Audit and Risk Committee.

3.2 A quorum shall be two members.

4. Attendance

4.1 Only members of the Committee have the right to attend. The Director of Finance, Deputy Finance Director, Company Secretary, Senior Risk Manager, Head of Internal Audit and the Managing Director for Digital Health of the Foundation Trust shall generally be invited to routinely attend meetings of the Audit and Risk Committee.

4.2 A representative of the External Auditors may normally also be invited to attend meetings of the Audit and Risk Committee.

4.3 The Chief Executive should be invited to attend at least annually to discuss the assurance supporting the Annual Governance Statement and when considering the Internal Audit plan. Other Directors are expected to attend as required by the Audit and Risk Committee and where items relating to their areas of risk or responsibility are being considered.

4.4 The Foundation Trust Chair may be invited to attend meetings of the Audit and Risk Committee as required.

4.5 A representative of the Local Counter Fraud Service is invited to attend all meetings of the Audit and Risk Committee.

4.6 The Chair of the Board of Directors will appoint a Governor to attend the public meetings of the Audit and Risk Committee. The appointment will be reviewed each year.

4.7 Attendance is required by members at 75% of meetings. Members unable to attend should inform the Corporate Governance Manager as soon as possible in advance of the meeting except in extenuating circumstances.

4.8 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

5. Administration

5.1 The Corporate Governance Manager shall be the secretary to the Audit and Risk Committee and will provide administrative support and advice. Their duties include but are not limited to:

- Agreement of the agenda with the chair of the Audit and Risk Committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

6. Frequency of meetings

6.1 Meetings shall be held quarterly, with an additional meeting to review the annual accounts, with other meeting arranged where necessary. The Committee must consider the frequency and timing of meetings required to discharge all of its responsibilities on a regular basis.

6.2 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

6.3 The Internal Auditor shall be afforded the opportunity at least once per year to meet with the Audit and Risk Committee without Trust staff present.

7. Duties

7.1 Governance, internal control and risk management

7.1.1 To ensure the provision and maintenance of an effective system of integrated governance, risk identification and associated controls, reporting and governance of the Trust and its subsidiary(ies), unless otherwise identified in the governance reporting structure.

7.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

7.1.3 To review processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other board committees in relation to the Trust's overall internal control and risk management position

7.1.4 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

7.1.5 To review the adequacy of the Foundation Trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

7.1.6 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

7.1.7 The adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements. Policies for approval by the Committee are identified in the Audit and Risk Committee annual workplan.

7.2 Internal audit

7.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

7.2.2 To oversee on an ongoing basis the effective operation of Internal Audit including:

- Adequate resourcing;
- Its co-ordination with External Audit;

Complying with the public sector Internal Audit Standards

- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and
- Meeting the internal audit needs of the Foundation Trust.

7.2.3 To consider the major findings of Internal Audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

7.2.4 To consider the provision of the Internal Audit Service annually, the cost of the audit and any questions of resignation and dismissal. The appointment/dismissal of Internal Audit remains the responsibility of the Director of Finance.

7.3 External audit

7.3.1 To make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an External Auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.3.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the foundation trust associated impact on the audit fee.

7.3.3 To assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.3.4 To oversee the conduct of a market testing exercise for the appointment of an Auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the Auditor.

7.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.3.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

7.3.7 To consider the provision of the External Audit Service, the cost of the audit and any questions of resignation and dismissal.

7.4 Annual accounts review

7.4.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;
- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.2 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

7.4.3 Where required by national guidance in the NHS Foundation Trust Annual Reporting Manual, seek assurances regarding scrutiny of Quality Accounts by the Quality Committee and review of specific areas by External Audit

7.4.4 To review all accounting and reporting policies and systems for reporting to the Board of Directors.

7.5 Standing orders, standing financial instructions and standards of business conduct

7.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct. Standards of Business Conduct and Declarations of Interest; including maintenance of Registers.

7.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

7.5.3 To review the Scheme of Delegation.

7.6 Other

7.6.1 To review performance indicators relevant to the remit of the Audit and Risk Committee.

7.6.2 To examine any other matter referred to the Audit and Risk Committee by the Board of Directors and to initiate investigation as determined by the Audit & Risk Committee.

7.6.3 To ensure that the Quality Committee performs at least an Annual Review of the clinical audit plan and considers the findings and recommendations of in-year reports, ensuring the plan and extras are consistent with the strategic direction of the Trust.

7.6.4 To develop and use an effective assurance framework to guide the Audit and Risk Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these terms

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7.6.6 To review the work of all other Board sub-committees as part of the Audit and Risk Committee assurance role. The Audit and Risk Committee will receive a self-assessment and annual report from each of the committees for approval.

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9. Review

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27. Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)

- Finance and Performance Committee – Minutes 01.06.21 & 28.06.21
- Quality Committee – Minutes 21.06.21 & 12.07.21
- Audit and Risk Committee – Minutes 21.07.21
- Workforce Committee – Minutes 09.08.21

To Note

Presented by Richard Hopkin, Denise Sterling, Andrea McCourt and Karen Heaton

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Richard Hopkin, Non-Executive Director
Date of meeting:	2 August 2021
Date of Board meeting this report is to be presented:	2 September 2021

ACKNOWLEDGE

Overall IPR score in June was slightly down at 69% due primarily to a never event. Emergency care continues to be a challenge due to demand levels and team to be thanked for their hard work. Overall cancer performance remains good and some slight improvement seen in stroke indicators.

Financial performance in Month 3 shows YTD surplus of £3.57m, £3m better than plan due primarily to Elective Recovery Funding. However, this will reduce in Q2 as funding thresholds increase and breakeven is forecast for H1 as a whole (in line with plan).

Recovery update identified that overall P2 backlog stabilising, average wait times are lower and gaps between higher and lower IMD categories also appear to be reducing. Good performance on treating patients with learning disabilities.

ASSURE

- Controls over agency staffing reviewed and confirmed
- THIS Commercial Strategy 2021-25 presented and approved
- HPS Commercial Strategy reviewed and noted external consultancy has confirmed key assumptions
- BBTU Progress Report to 30 June presented noting of the 12 key themes, 7 RAG rated green and 5 amber
- Work plan for 21/22 approved

AWARE

Overall patient backlogs and average wait times still not on trajectory, partly due to higher than planned Covid inpatients. Specific issues in urology and colorectal noted. New modelling for recovery plans to be undertaken but focus will remain on P2s.
Other challenges noted from IPR are pressures in endoscopy affecting day 28 cancer targets, dementia screening and #NofF access
Efficiency engagement project still being progressed with Creative Connection consultancy.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	19th July 2021
Date of Board meeting this report is to be presented:	2nd September 2021

ACKNOWLEDGE

IPR - May position, positive report 100% of complaints were closed within time

ASSURE

- Update received on Dementia Screening, Trust compliance 27% against target of 95%. Dementia Lead undertaking work to improve dementia screening across the Trust . Progress report to QC.
- Maternity Oversight Report - Information required for Ockenden submitted by the deadline, awaiting confirmation of site visit by Regional Chief Matron to review service. Confirmation received of additional funding to support the continuity of carer roll out at CHFT. The. Maternity Incentive Scheme has been reinstated, CHFT maternity services will be reporting compliance with all 10 maternity safety actions.
- Transforming Patient Experience Report- progress is being made against the objectives, further work required to achieve level of substantial assurance. Staffing issues is causing an impact and the programme plan is being revised for the next 6 months.
- CQC & Compliance Group Report – update on Trust CQC workstreams
- IPR- Noted a deterioration in stroke, cancer and fractured neck of femur,a representative from stroke team to be invited to future meeting to discuss issues with stroke services.
- Approved:
  Ligature policy
  Revised terms of Reference Quality Committee reinstated Cancer Board as sub committee .
  Terms of Reference Clinical Outcomes Group
  Terms of reference Medical Gases / Non-invasive Ventilation Group

AWARE

- Maternity services reported an increase in the numbers of still births in the reporting period Jan – June 2021(13) as compared to Jan – June 2020 (3) an audit is underway and the results are to be submitted to next QC.
- CHFT continue to be performing much worse compared nationally in relation to actioning and completing CAS Alerts, this continues to be monitored monthly via the CQC & Compliance Group. Current position is 4 CAS Alerts overdue and 1 ongoing in timescale.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Audit and Risk Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	21st July 2021
Date of Board meeting this report is to be presented:	2nd September 2021

ACKNOWLEDGE

- The committee conducts deep dives into the work of the 4 ARC sub-committees. This meeting we had a review of the work done by the Health and Safety Committee showing good progress across a range of activities although some more to do for new starter training and recording of all incidents

ASSURE

- Although Audit Yorkshire (AY) have been delayed in completing the Internal Audit (IA) plan for 2020/21 they have been able to make a good start on the plan for 2021/22
- Terms of reference and the annual plan for ARC were approved

AWARE

- Although the progress report from AY showed improvement in the numbers of open recommendations the committee remain concerned about prompt closure of open recommendations. The committee agreed that further actions, including the involvement of the ARC chair, would be taken to try and address this issue
- ARC approved a bad debt write-off of £231k
- The Trust submitted a complete Data Security Protection Toolkit (DSPT) response at the end of June. However, the Trust has still yet to achieve 95% compliance with IG training. This is required for our DSPT submission to be approved

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and Organisational Development Committee
Committee Chair:	Karen Heaton, Non-Executive Director
Date(s) of meeting:	Monday 9 August (Deep Dive)
Date of Board meeting this report is to be presented:	Thursday 2 September 2021

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 9 August 2021.

- Analysis of EDI recruitment data-progress being made on a more inclusive approach.
- Quality Performance Report – domain is green, sickness absence increased and a reduction in RTIs
- Deep dive into vacancies and into recruitment of AHPs- significant volume of activity and the international recruitment campaign is yielding good results.
- Presentation on Business Better than usual- good progress against metrics and those which are amber have a supporting plan in place.
- Deep dive into maternity specific essential safety training – need to improve capability to record the training which has taken place – currently under stated.
- FTSU self -assessment – not easy to complete and little knowledge of the national FTSU guardian. Actions supported.
- Introduction of associate NED role approved.

ASSURE

The Committee's action plan was approved Further work continues to be undertaken to update the Trust's Workforce Strategy and the contents of "The Cupboard". Good progress on staff survey action plans, leadership and management development and EDI. A number of significant deep dives , including into the BAF – Medical Workforce were undertaken at the meeting supported by detailed papers.

AWARE

No issues to bring to the attention of the Board.

28. Date and time of next meeting

Thursday 4 November 2021, 9:00 am

Venue: Microsoft Teams

To Note

Presented by Philip Lewer