Public Board of Directors

Schedule	Thursday 4 Mar 2021, 9:00 — 12:00 GMT
Venue	Microsoft Teams
Description	This meeting will take place via Microsoft Teams. In light of the Government restrictions to groups of people meeting, this Board meeting will take place virtually and will not be open to members of the public at this time. The meeting will be recorded and the recording will be published on our website after the meeting. The agenda and papers are made available on our website and in due course the minutes of this meeting will also be published. All items listed as Review Room items in green text, are to be received for information/ assurance and no discussion time has been allocated within the agenda.
Organiser	Jacqueline Ryden

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    Thursday 6 May 2021, 9:00 am
    Via: Microsoft Teams
    To Note - Presented by Philip Lewer

1. Welcome and Introductions:

To Note

Presented by Philip Lewer

2. Apologies for Absence: Stephen Baines

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

Standing Items

4. Minutes of the previous meeting held on 14 January 2021

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 14 January 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	Executive Director of Finance
Suzanne Dunkley	Director of Workforce and Organisational Development
David Birkenhead	Medical Director
Helen Barker	Chief Operating Officer (until end of item 08/21)
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
Jackie Ryden	Corporate Governance Manager (minutes)
Amber Fox	Corporate Governance Manager
Stephen Baines	Lead Governor
Alison Schofield	Public Governor
Christine Mills	Public Governor
Judy Jackson (Item 9/21)	Phlebotomist
Nicola Hosty (item 12/21)	Freedom to Speak Up Guardian
Richard Hill (item 14/21)	Head of Health and Safety

OBSERVING

Cath Hill	Director, Advancing Quality Alliance (AQuA)

01/21 Welcome and introductions

The Chair welcomed Judy Jackson who was attending to present a patient story on learning from a complaint in the Emergency Department, Nikki Hosty, Freedom to Speak Up Guardian, attending for the Freedom to Speak Up report, Richard Hill, Head of Health and Safety, attending for the Health and Safety report and Cath Hill, Director of Advancing Quality Alliance (AQuA), who was attending to observe the Board as part of Phase 3 of the Well-Led Review.

02/21 Apologies for absence

Apologies were received from Dr Anu Rajgopal and Annette Bell, public governor.

03/21 Declaration of Interests

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

04/21 Minutes of the previous meeting held on 5 November 2020

The minutes of the previous meeting held on 5 November 2020 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting 5 November 2020.

05/21 Action log and matters arising

The action log was reviewed and updated.

06/21 Covid-19 and Operational Update

The Chief Operating Officer gave a presentation compiled in conjunction with the Director of Workforce and Organisational Development, the Director of Nursing and the Medical Director to update the Board on Covid-19 and recent operational developments.

The key points to note were:

- The figures for the current position on testing, Covid+ patients, current inpatients, deaths, discharges and staff absence were provided together with the changes over the previous week.
- 1,282 tests have been carried out over the past week, a mammoth achievement by the Pathology Laboratory in particular.
- There are currently 115 in-patients in the bed base who are Covid+. It is believed that the position currently in the South of the country is starting to appear in the North, although this is not currently manifesting into critical care in the Trust.
- Staff absence remains a concern with 261 staff absent, an increase of 32. 229 are clinical staff and 52 of these are Covid+.
- The trends for West Yorkshire, together with the current situation on elective work and backlogs, were shared. A detailed presentation had been provided to the Finance and Performance Committee on 11 January 2021 and a wider discussion will take place at the Board Development session in February. CHFT is recording appropriately all planned activity ensuring that a robust and accurate position is known.

The Director of Nursing gave an update on the national message following a national call on 13 January 2021, highlighting a shift away from managing the pandemic as individual organisations and systems to a national response. To respond to further expected surges Trusts have been asked to:

- Expedite surge plans
- Prepare for mutual aid between organisations, particularly around critical care,
- Focus on discharges
- Use virtual ward models, e.g. remote monitoring at home, and other non-hospital beds
- Aim to maintain Priority 1 and 2 inpatients
- Make optimum use of private sector capacity
- Focus on recruitment of healthcare professionals and maximise use of unregistered workforce
- Retain priority on staff health and wellbeing

Usual planning and contracting guidance for 2021/2022 has been deferred and is expected around March/April.

The Director of Nursing expressed confidence that the Trust is in a good position following the huge amount of work that has taken place around surge planning.

The current active Covid-19 risks noted were staff availability, staffing ratios, backlogs and clinical risk and infection control guidance compliance. Staffing ratios are continually reviewed to ensure that all areas are safely staffed.

The Director of Nursing gave an update on the actions related to the Trusts 'Must Dos' which enable colleagues to remain focussed and on track.

The Chief Operating Officer provided details of the four scenario planning options reviewed by the Incident Management Team.

The worst case scenario noted was option 3, a Covid-19 positive position of 80 patients plus repeat of Wave 2 demand of 130, totalling 210 patients, with 24 critical care and 24 Continuous Positive Airway Pressure (CPAP) patients. Details of the operational planning and preparedness for this worst scenario case were given, with the associated staffing challenges and impact on Priority 2 activity noted. Triggers are in place to enact plans.

The Director of Workforce and Organisational Development outlined the additional potential support that could be required for the four scenarios, including the setting of a 24/7 helpline specifically for managers, provision of accommodation locally, additional child care support and support with transport for colleagues. She reiterated the importance of staff health and well-being and mental health. The CHFT Mental Health and Well-being Support poster has been updated for Autumn/Winter and will be further updated quarterly as the response to the pandemic changes.

In response to a question raised regarding use of the independent sector by AN, the Chief Operating Officer gave an assurance that all capacity offered is being used and described how both CHFT staff working in the independent sector and their own nursing staff could provide support in a worst case scenario.

DS asked if the Trust had any plans to utilise student nurses and the Director of Nursing advised that guidance from NHS England/Improvement (NHSE/I) is expected on this shortly, and that she would anticipate some relaxation on this.

Following a query from AG regarding delayed transfer of care, the Chief Operating Officer advised that this has improved over the last few days and numbers of patients are now back down to 34. Daily meetings are held but it is not reducing at the required level.

OUTCOME: The Board **NOTED** the update on Covid-19 and Phase 3.

07/21 Chair's Report

The Chair confirmed that the Trust response to the NHS E/I national consultation 'Response to Integrating Care Next Steps' was submitted before the deadline of 8 January 2021 following discussion at a private Board development session on 15 December 2020.

The Chair congratulated Marilyn Rogers on her recent award of an MBE in the New Year's Honours. Marilyn is a Registered Midwife and infant feeding advisor at CRH. The Chair will formally write to Marilyn to congratulate her on behalf of the Board.
Action: Chair to write a formal letter of congratulations to Marilyn Rogers on behalf of the Board.

The Chair gave a brief update on the Organ Donation Committee meeting held on 13 January 2021. The Trust is performing very well with organ donations even during the pandemic. There have been 10 donors since April 2020, providing 24 organs.
The Organ Donation Games are scheduled to take place in Leeds from 5-8 August 2021 and the Chair invited all to attend.

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

08/21 Chief Executive's Report

The Chief Executive gave a verbal update on the Trust's delivery of the Pfizer Covid-19 vaccination programme, with the first vaccine doses administered on 30 December 2020 in accordance with the guidelines set by the Joint Committee on Vaccination and Immunisation (JCVI).

Details were shared of the vaccination sites (Acre Mill, Huddersfield Royal Infirmary and Calderdale Royal Hospital, Halifax), the vaccination process, which is by appointment only and the vaccination regime, with the second dose now to be given within a 12-week timeframe in line with national guidance. It was noted that to avoid any vaccine wastage if possible, the second dose will be administered as and when it is appropriate to do so. The staffing of vaccination teams and hours of operation were also noted.

As of close of play on 12 January 2021, 6,382 vaccines had been delivered by the Trust, all of which have contributed towards approximately 1,800 care home and social care staff, being vaccinated, voluntary sector organisations involved in delivering frontline care and, together with working alongside primary care network colleagues, more than 50% of the 80-year-old and older, population, have been vaccinated across the geographical areas for which the Trust has responsibility. A total of 57% frontline colleagues across the Trust have been vaccinated. It is hoped to make further progress with colleagues in Calderdale and Huddersfield Solutions, as well as colleagues from Black British Caribbean and African backgrounds and those colleagues from Asian British Pakistani backgrounds. Vaccination rates slightly above the Trust average are being achieved for colleagues from a white British background.

Partnership working has been, and will continue to be, essential in maintaining momentum and the Chief Executive formally thanked local authority partners, as well as Clinical Commissioning Groups, primary care, mental health and Locala. He also thanked the Medical Director and all Trust colleagues who have involved in the vaccination programme to date.

Questions related to:

- Provision of the Oxford AstraZeneca vaccine to the Trust (KH), to which the Chief Executive advised CHFT has not been identified as a facility for the use of the AstraZeneca vaccine.

- Uptake from colleagues and staff concerns about the vaccine (AN) to which the Chief Executive advised that arranging vaccinations for colleagues in Calderdale and Huddersfield Solutions (CHS) where traditional communication routes do not apply can be an issue, but work is on-going as a priority to solve this as CHS colleagues work at the frontline and that ethnicity is a factor in staff take up, and many of these colleagues are also trusted members of their communities. Given the demographic make-up beyond the Trust, it is important to ensure that as many colleagues as possible receive the vaccine and advocate its take-up in their communities. Guidance has recently been received from NHS England/Improvement on specifically targeting these colleagues.

- Alison Schofield asked whether the Trust is working with partners in terms of learning and physical disabilities to access to the vaccine and the Chair advised that the Trust is working closely with all partners and he would contact Alison after the meeting to provide further details.

The Director of Workforce and Organisational Development added that following a straw poll to understand why colleagues had chosen to have or not have the vaccine, it was clear that any actions taken to improve take-up needs to be bespoke to different groups and a sophisticated communication and engagement plan is in the process of being drafted.

The Director of Finance advised the Board that the Trust is also playing a role in the community vaccine programme in Huddersfield and a contractual agreement with partners is being drafted.

OUTCOME: The Board **NOTED** the comments from the Chief Executive and the ongoing work on the Vaccine Programme.

09/21 Patient Story – Learning from a Complaint in the Emergency Department

The Director of Nursing introduced Louise Croxall, Emergency Department (ED) Matron and Judy Jackson who shared the story of her daughter and their experience of their visit to the ED. Following the receipt of a formal complaint from Judy and her daughter, the team have worked closely with them both to make improvements and put an action plan in place to ensure similar situations do not arise again.

Judy explained that her daughter has Diabetes insipidus and has a VIP passport recording this information and what is required when she visits the hospital. As a result of her daughter's attendance in the ED department it was recognised that the relatives and carers of patients are not being used as expert advisors, missing the opportunity to use the detailed knowledge that they have regarding the care and treatment of the patient. The ED team provide bespoke complaints training for the staff using real complaints and complainants and Judy has been invited to take part in this once the pandemic allows this to recommence.

Louise explained that the ED team have taken on board the learning from the complaint and appreciate what Judy has done to increase the knowledge of the team. If Judy's daughter needs to return to the ED it is hoped that she will experience a much improved process and this was acknowledged by Judy. Judy now works as a phlebotomist at CRH, which is another positive outcome.

DS thanked Judy for sharing her story and asked Louise if the lessons learned had been shared across the Trust. Louise advised that the lessons learned have been shared through the Medicine Division Patient Safety and Quality Board but she would work with the Assistant Director of Patient Experience to push these out more widely.
Action: Louise Croxall to share the lessons learned from the complaint more widely across the Trust.

OUTCOME: The Board **NOTED** the patient story provided and the lessons learned as a result of the patient's experience.

10/21 Month 8 – Financial Summary

The Director of Finance presented the Month 8 Financial Summary and highlighted the key points below.

For the second half of the financial year, the Trust submitted a revised plan to NHS Improvement (NHSI) that reflects the Phase 3 activity plan. Income flows remain largely on a block basis and system funding has been allocated to cover the majority of Covid-19 costs. Year to date the position is a surplus of £0.82m, a favourable variance of £1.11m compared to plan. The month1-6 plan has now been reset to actual expenditure, so the year to date variance represents only 2 months.

Pay costs are £1.68m below the planned level year to date due to some slippage on recruitment to the additional approved posts required to deliver Phase 3 activity plans and the timing of implementation of new Medical rotas.

The Trust continues to deliver some efficiency savings. The Cost Improvement Plan (CIP) achieved year to date is £3.25m, £6.60m below the original Trust plan. Compared to the Phase 3 Plan, the Trust has delivered £1.28m of savings in 2 months, slightly below the £1.46m described in the revised plan. RH advised that mechanisms are being reviewed to identify and measure CIP going forwards.

The arrangements for access to retrospective funding to cover Covid-19 costs have now ended. For month 7-12 (Phase 3), the Trust will be required to manage within the Integrated Care System (ICS) agreed financial envelope. The Trust has been allocated Covid-19 funding on a fair shares basis to cover the remainder of the year. The plan submitted to the ICS and NHSE/I originally included a £23m non-cash accounting adjustment and it has since been agreed that this transaction will now be delayed until 2021/22, with both the plan and forecast adjusted accordingly. This leaves an underlying unfunded gap (deficit) of £1.92m. The Trust forecast assumes that this plan is achievable. The in-month improvement and some ongoing slippage on recruitment should offset the unidentified place-based gap of £1.4m that was assumed to be delivered in the Trust's plan.

The forecast excludes the potential impact of the Elective Incentive Scheme, which based on the current activity forecast could drive a penalty of circa £4.25m.

In terms of the 2021/22 planning process discussions have taken place at the Finance and Performance Committee on 11 January 2021 with a proposed timetable agreed, which will be reviewed once national guidance is issued.

AG asked if the £23m non-cash accounting for CHFT will impact CHFT next year in the context of the Integrated Care System (ICS). The Director of Finance advised that this will remain a challenge, decisions have been deferred but that the Trust is working with regulators to deal with this, the ICS is aware and it is expected that the financial envelope will include an allocation for this.

PW asked if there is a point at which the financial plan would need to be revisited if Covid-19 activity increases. The Director of Finance explained that planned activity has been replaced by Covid-19 activity which generally incurs lower costs and the pay bill will not be significantly different. There may be a requirement to downgrade the forecast. The Trust has been advised not to change financial plans at month 9 and meetings are scheduled for the following week to review how this can be done collectively across the System.

OUTCOME: The Board **NOTED** the information provided in the Month 8 Financial Summary.

11/21 Capital Plan

The Director of Finance presented the Capital Plan for 2021/2022 providing an overview of the planned expenditure on capital for 2021/22 following the Capital Panel held on 16 November 2020, noting this had been approved at the Finance and Performance Committee on 11 January 2021. Guidance is still awaited on the capital regime for 2021/2022.

The capital resource for 2021/22 is estimated as £5.5m from internal resources. A full day planning session was held with bids assessed based on risk. From £9m worth of bids submitted, £4.9m were approved. £239k of this will be funded from revenue expenditure in 2020/21 and utilisation of £400k of residual contingency from 2020/21. Therefore, the call against next year's capital allocation will be £4.3m leaving a contingency of £1.2m to manage 2021/22 risk. This will be reviewed again once clarity is received relating to Theatre Monitoring devices for which a bid was received but more information was requested. It was noted that all approved bids will go through the usual business case governance process.

The Director of Finance explained that due to a delay in the planning application process for the demolition of the former Nursing Accommodation and Learning Centre at HRI due to

the need for a full bat survey to be carried out from April to September, re-prioritisation of the capital plan has been needed. CHS have flexed the timing of the capital plan to bring forward to 2020/21 £615k of schemes approved in 2021/22 capital plan, creating the capital resource to deliver the demolition in the 2021/22 financial year. This will meet the requirements of the Critical Infrastructure Risk capital award and allow the scheme to progress and meet the requirements of the planners.

OUTCOME: The Board **APPROVED** the Capital Plan for 2021/2022.

12/21 Freedom to Speak Up

The Freedom to Speak Up Guardian updated the Board on the position regarding the Freedom to Speak Up (FTSU) activity in 2020. The FTSU team has been focussing on promoting a 'speaking up' culture within the organisation that is inclusive for all, respected as a channel that will listen, is sensitive to the issues raised and acknowledged that anything raised will be fairly investigated. In 2020 the FTSU team was required to work differently and has expanded the use of digital correspondence, held all quarterly meetings via Microsoft Teams and promoted the Freedom to Speak Up portal.

The breakdown of key themes in 2020 shows the largest number of concerns related to 'attitude and behaviours' and the way the Trust worked through the pandemic. Concerns highlighted were around lack of preparation, colleagues feeling unsafe to come into work due to lack of PPE and colleagues feeling that managers were being inconsistent with guidance. Front line concerns were quickly raised to the Incident Management Team. The Team were quick to act and were responsive to the Guardian. Senior managers were able to engage with teams to understand their concerns and use the insight and subsequent learning.

The team of FTSU ambassadors continues to grow and they meet on a quarterly basis. The FTSU channel has paid a crucial part in working through the pandemic. In 2021 the plan is to utilise the equality groups and the well-being ambassadors to support the importance of speaking up which will increase visibility and enhance the support. An e-learning module is to be incorporated into the Leadership Development platform and a digital FTSU booklet produced and available via The Cupboard.

AG asked if the FTSU team were planning to produce a "You said, we did" sheet showing what actions have been put in place in response to people speaking up, which might encourage others to speak up. The Director of Workforce and Organisational Development advised that this was already planned.

OUTCOME: The Board **NOTED** the information provided in the Freedom to Speak Up report and **SUPPORTED** the recommended next steps identified in Section 5 of the report.

13/21 Workforce Committee Terms of Reference

The Director of Workforce and Organisational Development presented the updated terms of reference for the Workforce Committee following review by the Workforce Committee at its meeting on 5 November 2020.

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

14/21 Health and Safety Annual Report and Update

The Director of Workforce and Organisational Development and the Head of Health and Safety presented the Trust's Annual Health and Safety report to March 2020. An update was also provided on the progress made against the Trust's health and safety action plan following the external audit conducted by Quadriga in 2019.

The Director of Workforce and Organisational Development introduced the new Head of Health and Safety recruited to strengthen health and safety compliance in the Trust and provide a strategic lens of the organisation with partners.

The Head of Health and Safety outlined the key progress and actions undertaken from 1 April 2019 to 31 March 2020 and provided an update on the progress against the recommendations from the Quadriga audit. The Health and Safety Policy has been reviewed together with the Health and Safety Committee terms of reference which will be presented for approval at the Audit and Risk Committee on 26 January 2021.

Following a suggestion by AN, who attended the last Health and Safety Committee meeting in December 2020, a five year health and safety strategy is to be developed and will be a key target for 2020/2021.

A health and safety management framework is to be introduced in order to provide assurance and oversight to the Board through the use of the NHS Workplace Safety Standards which will be implemented during 2021.

An audit of Huddersfield Pharmacy Specials (HPS) has been carried out by the Head of Health and Safety and consultation on this is underway with the senior leadership team. The audit findings have identified the need to develop a health and safety management system and the Head of Health and Safety has a meeting planned regarding the action plan. RH asked for an explanation of the issues in order that these could be discussed at the next HPS Board meeting, as he is the Non-Executive Director (NED) representative on the HPS Board.
Action: Head of Health and Safety to share the report on HPS with RH and the Director of Finance.

AG asked about if a date had yet been finalised for completion of the five-year strategy for fire safety. It was agreed that the Director of Finance would feed back to the Chief Operating Officer, who had to leave the Board meeting early, that confirmation of the dates was required and that a post meeting note would be added to the minutes.

Post Meeting Note:
The Chief Operating Officer confirmed that the draft Fire Safety Strategy received from Mott MacDonald required significant further work. The final draft of the Fire Safety Strategy, will be further developed during January 2021 by Mott MacDonald, presented to the Fire Committee for sign off on 10 February 2021 and circulated to the Board of Directors on 12 February 2021.

Following a query from KH, the Head of Health and Safety advised that the RIDDOR and non-RIDDOR statistics contained in the report require some corrections and that the tables will be re-submitted and confirmed there are no red flags. KH also commented that benchmarking information with peers would be helpful.
Action: Richard Hill to re-submit RIDDOR and non-RIDDOR statistics.

PW suggested that the work in progress moving forward should include reference to oversight of health and safety related to Reconfiguration, given the impact this could have in the early stages.

OUTCOME: The Board **RECEIVED** the Trust's Annual Health and Safety Report to March 2020 and **NOTED** the progress made against the Trust's health and safety action plan following the external audit conducted by Quadriga in 2019.

15/21 High Level Risk Register

The Director of Nursing presented the high-level risk register (HLRR). The key points to note were:

- The Terms of Reference (TOR) of the Risk Group have been reviewed to re-focus the group on scrutiny and challenge of high-level risks with the remit for compliance being taken up by the CQC Response Group. The TOR are due for ratification at the Audit and Risk Committee on Tuesday, 26 January 2021
- A monthly deep dive of one high-level or longstanding Trust wide risk has been established which enables all divisions to contribute collectively to the discussion, considering barriers to mitigation, effectiveness of treatment plans to address gaps and risk scoring.
- Risks that have seen a significant slip of target achievement will be subject to a deep dive at Risk Committee in January 2021, namely 7078 (Medical staffing risk),7248 (Essential Safety Training), 7413 (Fire Compartmentalisation) and 7414 (Building safety.
- The Risk Management Strategy and policy have been reviewed and will be shared at the Audit and Risk Committee in January prior to presentation to Board in March 2021.
- Two new risks have been added: 7936 Social distancing (staff behaviours); 7942 Overarching staffing risk. Both of these relate to all divisions and are Trust-wide.
- One risk has increased 7474 Medical Devices with extra assurance being required.
- One risk has reduced, 7685 – PPE supply chain – there is a solid system in place and currently no supply chain issues. The risk will continue to be monitored weekly on the Covid-19 workstream risk register.
- One risk has been closed 7315 Delay in outpatient appointments – it was agreed that focus needs to be on the impact of delays in terms of the pandemic. This risk has been closed and superceded by risk 7689.

AN advised that as Chair of the Audit and Risk Committee he had attended the Risk Group meeting in December, and that he had subsequently discussed with the Assistant Director for Patient Safety and the Clinical Governance Team Leader the possibility of a quarterly report on compliance into the Audit and Risk Committee to provide assurance to the Board. The Director of Nursing agreed this could be actioned.

AN asked for an update on the radiology risk 7454 and the Medical Director advised that despite continuous work being undertaken on recruitment, some specialities remain challenged, including radiology. The service continues to remain safely managed with mitigation in place.

OUTCOME: The Board **CONFIRMED** that potential significant risks within the High-Level Risk Register are being managed appropriately and **APPROVED** the current risks on the High-Level Risk Register.

16/21 Director of Infection Prevention Control Quarter 2/Quarter 3 Report

The Medical Director presented the Director of Infection Prevention Control report for quarter 2 and quarter 3. Key points to note were:

- A higher number of cases of Clostridium difficile have been seen throughout 2020 than in previous years which could be caused by a number of reasons, including Covid-19 and long lengths of stay. The situation is being monitored closely.
- There have been 108 probable or definite hospital-acquired Covid-19 infections (HOCIs) since September 2020. An increase in HOCIs has been seen across all regional Trusts in the second wave of the pandemic. Some of these infections have resulted in ward based outbreaks despite best efforts to isolate or cohort patients, with a mixture of outbreaks in staff and patient areas, although staff outbreaks are relatively

small. Following the appearance of the new variant strain, which is increasing in Yorkshire, the position in outbreaks has deteriorated following a quiet period. The Trust has issues related to ventilation and the estate, for example the size of some wards, but these are being mitigated as far as possible, e.g. barriers between beds. All outbreaks are investigated in line with national recommendations and reported to NHSE and Public Health England in a timely manner.

The Chief Executive noted the significant difference in the performance of screening for MRSA bacteraemia in ED (94.8%) compared to the figure for screening electives (68.5%) and the Medical Director explained that staff are dealing with conflicting pressures but that a reminder has been sent to all divisions regarding screening and regular meetings are taking place with Divisions.

OUTCOME: The Board **RECEIVED** the Quarterly Director of Infection Prevention Control report for Quarter 2 and Quarter 3.

17/21 Guardian of Safe Working Hours Quarter 3 Report

The Medical Director presented the Quarter 3 Report covering the period from 1 October to 31 December 2020.

The key points to note were the increase in exception reports from the Medical Division as a result of higher patient acuity, increased workload and a rise in colleague absence. Phase 2 of the junior doctor rota in the Medical Division has been successfully implemented in response to the second surge of the pandemic. The Guardian continues to meet with the doctors on a regular basis and has formed excellent relationships with them.

OUTCOME: The Board **NOTED** and the Guardian of Safe Working Hours Quarterly Report.

18/21 Quality Report

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

- Regular engagement meetings take place with the CQC
- The CHFT Emergency Department took part in two reviews with the Care Quality Commission (CQC) in October 2020. The department was chosen to participate in the Provider Collaboration Review which focused on urgent and emergency care in eight Systems looking at how providers are collaborating to develop urgent and emergency care services together in light of Covid-19 prior to potential further peaks, and ahead of winter. An initial report has been received and a formal report is expected. The department was also required to present to CQC how the Patient FIRST toolkit has been implemented and is being used in the Emergency Department. A formal report from this is not expected.
- Of the outstanding actions from the 2018 CQC inspection, the Trust still have five actions to complete. It is anticipated that these actions will be closed at the next meeting of the CQC Response Group.
- The Focused Support Framework pilot has been undertaken and plans for roll out are being enacted. Plans to develop this to become a more multi-professional process are underway. It is anticipated that some of this work will be tested out with an unannounced inspection.
- Facing the Futures Standards for Children in Emergency Care settings – it has been identified that the Trust is not currently compliant with standards 9 and 10. The Chief Operating Officer has commissioned an urgent review of current cross site working arrangements and children's ED services. The Division has developed a set of

recommendations for managing urgent risks as well as more medium term arrangements for ED.

- An improved position has been seen for the Central Alert System indicators with two alerts outstanding which will be closed imminently.
- Pressure ulcers – there has been an increase in grade 1 level pressure ulcers and medical device induced pressure ulcers. This is related to Covid-19 and is being seen nationally. A deep dive is to be carried out by the Tissue Viability team which will be reported into the Quality Committee.
- Complaints – the strategy for complaint improvement was shared with the Weekly Executive Board and work is ongoing. Capacity has been increased at both corporate and divisional levels and an urgent piece of work is being undertaken to address the backlog.
- Maternity reporting – a deep dive into maternity reporting will be discussed at the Board Development Session in February 2021. The Ockenden Review was published in December 2020, a long-standing review into maternal and baby deaths at Shrewsbury and Telford Hospital. From the recommendations outlined in the review, the Trust was required to undertake a rapid review of 12 essential safety actions. CHFT made an initial submission on 21 December 2020 in response to the Ockenden review. Two areas were identified where the Trust needed to put in mitigating actions: One of these related to reporting of all maternity issues to Board and KH has volunteered to be the Non-Executive Director representative and Board Champion for this work. The other area for urgent action related to number of formal ward rounds on the labour suite. For many years there has been an informal ward round in the evening, and this has now been formalised. In all other areas there was a high level of assurance.

Following a query from AN regarding the limited assurance noted for dementia screening, the Medical Director reported that this could be linked to ongoing work pressures. Communications will be sent out to encourage colleagues to ensure these are undertaken.

DS noted that there has been a significant increase in the number of safety incidents recorded from October to November 2020. The Director of Nursing reported that a number of these relate to a backlog on reporting and closing down of the incidents. There has been a drive recently on the importance of reporting incidents and increasing understanding of what should be reported.

RH advised that the Finance and Performance Committee continues to scrutinise and monitor the Use of Resources. The external assessment planned is not possible due to the pandemic. The Director of Finance is to provide a paper at the next meeting to outline a potential internal review to monitor progress with the Trust's Use of Resources. The Director of Finance added that any possible measurable metrics are monitored by the Finance and Performance Committee.

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

19/21 Integrated Performance Report – November 2020

The Chief Operating Officer provided the Board with the performance position for the month of November 2020.

As the Chief Operating Officer was not present for this item, the Chief Executive advised that the Finance and Performance Committee had considered the performance report in detail with a focus on key indicators around diagnostics, ED performance and the 12 hour trolley waits.

Following a request from the Chief Executive, the Medical Director provided an update on the Trust's performance on Summary Hospital-level Mortality Indicators (SHMI) in terms of the direction of travel. The Medical Director noted that Covid-19 deaths were not the reason for the increase in SHMI. The SHMI figures have been slowly increasing over the past year and the Medical Director advised that the Trust is aware of how improvements have been made in the past and it is important that workstreams continue to address this. Work continues to expand learning from deaths and ensure immediate remedial actions are put in place.

The Director of Workforce and Organisational Development gave an update on the management of long term sickness absence noting Covid-19 has had an impact on this in that colleagues who are already absent are more anxious to return to work. Support is being put into place to review how these colleagues can work from home or from a different area.

RH reported that the Finance and Performance Committee have discussed the performance on stroke targets and that a deep dive into this was undertaken and specific actions agreed. Some of these actions are still to be implemented and it is anticipated that this will have a beneficial impact on the performance. RH also advised that the Finance and Performance Committee had discussed the concerns over patient backlogs and that further discussion will take place at the Board Development session in February.

OUTCOME: The Board **NOTED** the Integrated Performance Report and current level of performance and **NOTED** the ongoing activity across the Trust.

20/21 Governance Report

The Company Secretary presented a report to seek approval from the Board to ratify the use of the Chair's action for the Covid-19 vaccination plan, approve the terms of reference for the Board of Directors Nominations and Remuneration Committee and note the planned cycle of Board business for 2021/2022 detailed in the Board workplan.

On 23 December 2020 the Board was asked to approve an urgent decision regarding the operational plan to deliver the Pfizer/BioNTech Covid-19 vaccination programme for delivery from the week commencing 28 December 2020 and the associated internal governance reporting arrangements. Full details of the decision to approve the operational plan were provided in the paper.

The Chief Executive asked that the JCVI guidance referenced in the Equality Impact Assessment section of the report, should consider that the prioritisation on adults aged 80 (and over) may possibly have adverse health inequality impacts. For example, people who are 80 (and over) are more likely to come from the least deprived indices of multiple deprivation and are less likely to be from ethnic minority backgrounds. Therefore, any national guidance relating to vaccine roll-out needs to be considered alongside the demographic and potential inequality impacts of place.

At a meeting of the Nominations and Remuneration Committee of the Board of Directors on 7 December 2020 the terms of reference were reviewed and agreed. The changes were minor and were highlighted in the revised Terms of Reference attached to the paper.

The annual business cycle for the Board reflects the streamlined Board governance arrangements that were introduced last year to improve the handling of Board business, with greater clarity on the purpose of items presented at Board. AG highlighted that there are five items related to Strategy and Planning on the agenda for the meeting in March 2021 and asked this could be reviewed with a view to deferring some of them to the May meeting.

Action: Company Secretary/Chair to review the workplan and re-schedule a number of strategy and planning items from March 2021.

The Trust's Quality Accounts for 2019/20 were submitted to NHS England / NHS Improvement in mid-December 2020 in line with the revised timetable and national guidance for Quality Accounts issued during the Covid-19 pandemic. The Board delegated authority for approval of the Quality Accounts to the Quality Committee at its meeting of 7 May 2020, minute 52/20. The Quality Accounts were approved at the meeting of the Quality Committee on 26 October 2020. The Quality Accounts for 2019/2020 are available to the public via the Trust website.

OUTCOME: The Board **RATIFIED** the Chair's action for the Covid-19 Pfizer BioNTech vaccine, **APPROVED** the terms of reference for the Board of Directors Nominations and Remuneration Committee, **NOTED** the 2021/2022 Board workplan and **NOTED** the submission of the 2019/2020 Quality Accounts.

21/21 Annual/Bi-annual Reports

The Workforce Committee Annual Report for 2019/2020 was provided by the Director of Workforce and Organisational Development for assurance.

OUTCOME: The Board **RECEIVED** the Workforce Committee Annual Report for 2019/2020.

The Charitable Funds Annual Report and Accounts for 2019/2020 and the Charitable Funds Audit Highlights Memorandum for 2020 were provided for assurance.

OUTCOME: The Board **RECEIVED** the Charitable Funds Annual Report and Accounts for 2019/2020 and the Charitable Funds Audit Highlights Memorandum for 2020.

22/21 Receipt of Minutes of Meetings

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

- Finance and Performance Committee meetings held 2.11.20, 30.11.20
- Quality Committee meeting held 26.10.20
- Workforce Committee meetings held 16.11.20 and 9.12.20
- Charitable Funds Committee meeting held 25.11.20
- Covid-19 Oversight Committee meetings held 23.11.20, 22.12.20

RH advised that a paper had been presented at the Finance and Performance Committee meeting on 11 January 2021 by the Director of Finance and the Assistant Director of Nursing on additional staffing recruitment built into the Phase 3 plan. The Trust has not met the recruitment targets which has resulted in an under-spend. A detailed discussion had taken place on the risk mitigations including the utilisation of bank and agency staff.

DS advised that the Covid-19 Oversight Committee had reconvened. The meetings reviewed the deaths resulting from Covid-19 and the ongoing work on this. A detailed report on the 12 hour breaches had also been presented to the meeting together with an independent review undertaken in 2019 which will go back to the committee at a later date.

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

23/21 Items for Board Assurance in the Review Room

- Calderdale and Huddersfield Solutions Ltd – Managing Director Update December 2020

The Manager Director CHS highlighted the following:

- Both the Ward 18 isolation project and the Broad Street Plaza project have been completed. He thanked everyone for the support given to CHS to ensure the projects were completed on time.
- The sale of Acre House was completed bringing in £860k.
- CHS has taken on two interns with learning difficulties as part of Project Search and it is hoped to continue with this throughout 2021, supporting individuals with learning difficulties on work placements.

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

- WYAAT Annual Report 2019/2020
- WYAAT Summary Report 2019/2020

OUTCOME: The Board **RECEIVED** the WYAAT Annual Report and Summary report for 2019/2020.

24/21 Any Other Business

There was no other business.

Date and time of next meeting
Date: Thursday 4 March 2021
Time: 9:00 – 12:30 pm
Venue: Microsoft Teams
The Chair closed the meeting at 12.06pm

5. Action Log and Matters Arising

For Review

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 25.2.21

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

<table>
<tr><th>DATE DISCUSSED</th><th>AGENDA ITEM</th><th>LEAD</th><th>CURRENT STATUS / ACTION</th><th>DUE DATE</th><th>RAG RATING</th><th>DATE ACTIONED & CLOSED</th></tr>
<tr><td>05.11.20
115/20</td><td>CHFT Climate Change Update
Managing Director to share with the Board benchmarking data on performance of recycling of clinical waste</td><td>SS</td><td>Data for CHFT Recycling % (HRI/CRH)

<table><tr><td></td><td>CHFT</td><td>BDC*</td></tr><tr><td>April 2020</td><td>26</td><td>35</td></tr><tr><td>May 2020</td><td>34</td><td>39</td></tr><tr><td>June 2020</td><td>25</td><td>42</td></tr><tr><td>July 2020</td><td>27</td><td>39</td></tr><tr><td>August 2020</td><td>22</td><td>38</td></tr><tr><td>September 2020</td><td>27</td><td>40</td></tr></table>
Data from WYAAT is still awaited
No further updates received for 14.1.21 meeting
*Bradford District Care

Update 02/02/21 – Benchmarking data has been identified from one other Trust, York Teaching Hospitals, saying that they achieved around 19% across Q1-2 last year. Action closed and monitored within the emerging Green Action Plan.</td><td>January 2021</td><td></td><td>02.02.21</td></tr>
<tr><td>14.01.21
07/21</td><td>Chair’s Report
Chair to write a formal letter of congratulations to Marilyn Rogers on behalf of the Board</td><td>PL</td><td>Completed.</td><td>January 2021</td><td></td><td>25.01.21</td></tr>
</table>

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 25.2.21

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
14.01.21 09/21	**Patient Story – Learning from a Complaint in ED** Louise Croxall to share the lessons learned from the complaint more widely across the Trust	LC	Email sent to Louise with action 26.1.21	March 2021		
14.01.21 14/21	**Health and Safety Annual Report and Update** Head of Health and Safety to share the HPS audit report with Richard Hopkin	RH	Email sent to Richard with actions 26.1.21	January 2021		19.02.21
14.01.21 14/21	**Health and Safety Annual Report and Update** Head of Health and Safety to update tables for RIDDOR and non-RIDDOR and re-submit	RH	Email sent to Richard with actions 26.1.21 Jackie emailed the updated report on 04.02.21 to Board members.	March 2021		04.02.21
14.01.21 20/21	**Governance Report** Company Secretary/Chair to review the workplan and re-schedule a number of strategy and planning items from March 2021	AM	Board plan reviewed and updated. Two items deferred to March 2021 meeting: BBTU and the Workforce and OD Strategy.	January 2021		25.1.21

6. Chair’s Report

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

- Covid Vaccine Update

To Note

Presented by Owen Williams

Transforming and Improving Patient Care

8. Staff Story:

The impact of Covid Research on our Patients and the Trust

Presented by Asifa Ali, Research and Innovation Lead

To Receive

9. 2020/21 Strategic Objectives Update

To Note

Presented by Anna Basford

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4th March 2021
Meeting:	Public Board of Directors
Title of report:	2020-21 Strategic Plan – Progress Report as at 25 February 2021
Author:	Anna Basford, Director of Transformation and Partnerships
Sponsor:	Owen Williams, Chief Executive
Previous Forums:	None

Purpose of the Report

Provide an update on progress made against the 2020/21 strategic plan as at 25 February 2021.

Key Points to Note

This report highlights that of the 19 deliverables:

0	are rated red
4	are rated amber
14	are rated green
1	has been fully completed

EQIA – Equality Impact Assessment

For each objective described in the one year plan the accountable Lead Director is responsible for ensuring that Quality and Equality Impact Assessment is undertaken and where possible that this follows best practice to involve patients, public and colleagues in the process of assessment and the agreement of any required actions to mitigate risks or negative impacts.

Recommendation

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

compassionate care

Calderdale and Huddersfield NHS Foundation Trust
2020-21 Strategic Plan – Progress Report as at 25 February 2021

Purpose of Report

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

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

Structure of Report

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

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

For each area of delivery there is also a summary narrative of the progress and details of where the Board will receive further assurance.

Summary

This report highlights that of the 19 deliverables:

0	are rated red
4	are rated amber
14	are rated green
1	has been fully completed

Recommendation

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

2020 / 21 One Year Strategy

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

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual'.	**GREEN** On track	Through the involvement of colleagues, partner organisations and members of the public 12 learning themes were identified during June and July 2020 where there was agreement that new ways of working implemented during the pandemic have potential long-term benefit and should be sustained and amplified. In September the Trust Board approved the governance and management processes to take forward BBTU. Each theme has developed a 'blue-print' defining critical success factors, benefits, dependencies, and risks. A detailed progress report was submitted to the Transformation Programme Board in December, the Quality Committee in January, and the Finance & Performance Committee in February. Further work is being undertaken to confirm implementation plans against which progress and benefits realisation will be monitored during 2021/22. Further updates will be provided to Trust Board sub-committees in April.	**Lead: AB** Transformation Programme Board
Trust Board approval of reconfiguration business cases for HRI and CRH.	**GREEN** On track	Formal governance structures have been established and the Transformation Programme Board has oversight of the transformation and reconfiguration plans. The Trust has quarterly review meetings with NHSE and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). The Trust has procured the external professional and technical capacity and advice required. Involvement of stakeholders and local people about the estate plans has commenced prior to submission of planning applications to Calderdale and Kirklees Councils in May 2021. The Trust is on track to complete the CRH OBC and HRI FBC by Autumn 2021.	**Lead: AB** Transformation Programme Board NHSE/I
Progress implementation of the Trust's Clinical Strategy working with partner	**GREEN** On track	The clinical strategy describes the Trust position on service development across West Yorkshire.	**Lead: DB** Weekly Executive Board Quality Committee Trust Board

organisations across West Yorkshire.		A refresh of the clinical strategy by service is underway led by clinical leads meeting with all services, A refresh of the strategy will be available in Q1 2021.	
Trust Board approval of a 5-year digital strategy supported by an agreed programme of work and milestones.	**GREEN** On track	The 5-year Digital strategy was approved by the Trust BOD on 2nd July 2020. The key programmes are in flight and progress • Scan4 safety Project – 20/21 programme delivered to budget and 21/22 programme under development • Digital Aspirant Programme – 20/21 programme progressing some movement and project have changed in order to continue to benefit from available capital however this is now on track to be delivered on time and to budget. The programme for next year's funding has been agreed. • Optimisation plan an in-depth analysis programme to build the plan has been agreed a proposal has been developed with an external agency ready to start March 2021. Others to be agreed • Infrastructure Strategy – Engaged with external agency to develop strategy through to business case. • Information strategy – Gap analysis complete through HIMSS Standards trust score 4 and will develop the strategy using this analysis. • Integration and interoperability roadmap including core clinical systems – under development. Adult Social care now live, negotiations started with K2 Athena and EMIS integration project commenced. Early discussions with Endoscopy	**Lead: MG** Divisional digital boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.

Use population health data to inform actions to address health inequalities in the communities we serve.	**AMBER** Off track – with plan	The Trust has established real time data analysis of patient waiting lists in relation to index of multiple deprivation, ethnicity, and other protected characteristics. This analysis is being considered and discussed alongside clinical prioritisation to inform the Trust's elective recovery plans going forward. The aim is to ensure that for people who have had their care unavoidably delayed due to the pandemic that the recovery plans are informed by clinical need and support reduction in health inequalities. The Trust is taking forward work that aims to build relationships and listen to the views of local groups and communities in relation to their experience of accessing healthcare and to develop with them actions that can be taken to meet their specific needs and improve experience.	**Lead OW** Weekly Executive Board Board of Directors Learning Improvement Review Board Health Inequalities Oversight Group (England)

Goal: Keeping the base safe

Deliverable	Progress rating	Progress summary	Assurance route
Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleague's safety.	**AMBER** Off track – with plan	Wave 3 Covid-19 inpatient activity surpassed the levels of its two predecessors (i.e., Waves 1 & 2) and as of 28/01/21 our full surge plan was in place and working to expectations given the known and emergent difficulties faced. In contrast to the two previous waves, we also have managed to increase capacity to deliver care for "Priority 2" inpatients requiring planned surgery. However, the backlog for this group of patients and other designated priority groupings remains challenging. Community capacity has remained reasonably stable and across all facets of service provision (i.e., hospital and community) the care and commitment of CHFT and partner colleagues remains exceptional.	**Lead: OW** Weekly Executive Board Trust Board

		Since the last update we have been challenged with a series of 12-hour decision to admit cases in the Emergency Department and have followed this up with full investigations around the quality of care given to each patient affected as well as developing a process of disseminating learning from this experience and revising our associated operating procedures. Nosocomial infection control management remains tough and even though we have sought and received external assurance that our approach has been reasonable there is ongoing work to do in this area. At the time of writing in excess of 20,000 Covid-19 vaccines have been administered by the Trust which included 75% of the CHFT workforce as well as health and care worker colleagues from multiple partner organisations. Sadly, since the start of the pandemic, 457 patients who were being cared for at our Trust and had tested positive for Covid-19, have died, 1,782 people who were admitted to hospital with Covid have been discharged home well.	
Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating.	**AMBER** Off track – with plan	The Trust has continued to meet with the CQC under the current arrangements put in place by the Regulator. CQC are currently not undertaking on-site inspections as such the Trust and the CQC have a regular engagement meeting. The Trust has maintained very positive relationships with the CQC and are viewed as being an open and transparent organisation. The internal CQC response group have continued to meet and outstanding actions have been closed and/or due to closed. The Focussed Support Framework (FSF) has been developed and used in a number of clinical areas, this builds on the Ward Accreditation programme. However, given the recent pandemic wave the schedule of visits has been suspended as a result of competing priorities. The FSF is a key element of our CQC compliance assurance and in it's absence there has been less opportunity to apply a level of independence to assess our compliance against the CQC key lines of enquiry and rating	**Lead: EA** Quality Committee Weekly Executive Board

		characteristics. The FSF programme will be re-instated in March 2021. The work with the Board around well-led assurance has continued. The rating has been reviewed to reflect the very limited roll out of the FSF as a result of the Pandemic response.	
Involve patients and the public to influence decisions about their personal care and improve patient experience by: • responding to the needs of people from protected characteristics groups • implementing "Time to Care". • achieving patient safety metrics	**AMBER** Off track – with plan	While some activity to progress a variety of initiatives has had to be suspended as a result of the Pandemic there has been significant activity across a number of clinical services. Examples include: • Co designed Children's service Vision with Youth Forum and nursing staff. Young Persons Charter – co created with young people /CHFT Youth Forum. • Co design of improvements to bereavement facilities at CHFT with a family, CHFT NHS charity and representatives from children's and maternity staff. • Volunteers: Recruitment is underway for two volunteers to work as part of the wider team to support gathering experiences of patients and carers. • We have started discussions with Calderdale Disability Forum regarding a QI project re improving the experience of visually impaired patients. • Cancer patient focus group has met (virtually) and helped develop virtual services as well as helping us understand the impact of COVID on them. • Tackling Inequalities: Cancer Improvement Collaborative. Working with NHS E but reaching into our Pakistani community to look at cancer information on diagnosis and the barriers to this community not accessing this information. • Bereavement Service: All listed next of kin are contacted following any inpatient deaths. Themes and specific feedback are actively addressed and used to inform service improvements.	**Lead: EA** Quality Committee Weekly Executive Board
Develop an outcome-based performance framework and deliver against key metrics.	**GREEN** On track **(PMF due end of March 21)**	Meetings held with all Execs, Non-Execs and Divisional teams on a review of the Performance Management Framework (PMF) with the principle of replacement not additional KPIs. Some concerns about the volume of additionality requested and the appropriateness for the IPR as potential duplication of	**Lead: HB** Integrated Board Report Weekly Executive Board Audit and Risk Committee Finance and Performance Committee

		reporting and inability to translate the objective with a measurable KPI. WTGR session arranged between Quality Team and Divisional colleagues to agree a shared result which will then be included in the PMF.	
Deliver the actions in the Trust's 2020/21 Health and Safety Plan.	**GREEN** On track	80% of health and safety actions completed. The remaining 20% of actions are progressing with the target date of March 2021. A self-audit has been carried out with an evidence file being prepared to offer assurance, this is being completed by the 12th February 2021.	**Lead: SD** Quality Committee Trust Board
Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**assurance route**
Develop and implement flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for Nurse staffing and specialist medical roles, thus retaining a turnover below 10%.	**GREEN** On track	The Trust has in place the following: - • a focus on recruitment and retention in our people strategy 'The Cupboard' • a 3-year recruitment strategy • a 3-year apprenticeship strategy • a 5-year equality, diversity, and inclusion strategy • Covid specific redeployment processes. Additionally, work has been progressed in the following areas:- • all job descriptions and adverts have flexible working options as standard, encouraging diversity of applications • increased cohorts of Trainee Nurse Associate and Health Care Assistant apprentice • recruitment to Enhanced Care Support Worker roles which enhance our therapeutic care to patients • participating in the NHSE/I international recruitment programme for qualified nurses	**Lead: SD** Workforce Committee

		• participating in the nationally sponsored Health Care Support Worker recruitment programme.	
Develop an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions.	**GREEN** On track	We have in place the following: - • a focus on Talent Management through The Cupboard • an Executive Board approved succession planning tool • Board level as well as divisional and directorate succession plan assessments • an agreed recruitment and selection policy • an agreed equality of opportunity policy • a recruitment statement about open competition • leadership development programme open to all • the Empower programme which nurtures talent from across the organisation • a commitment to create a 'development for all' programme of learning activity • The operational HR team is working with senior management teams to embed the use of the succession planning tool across Divisions as a must-do in order to establish a more robust understanding of the capability and readiness of individuals to fulfil their aspirations and/or critical roles.	**Lead: SD** Workforce Committee
Roll out our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams.	**GREEN** On track	The Trust's on-line leadership development programme was launched on 31 July 2020. Bespoke modules for medical Consultants; nurses and midwives; and Allied Health Professionals were made available on 2 October 2020. The final module 'mental health - working well under pressure' for each bespoke group was made available at the end of December 2020.	**Lead: SD** Workforce Committee
Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of the workforce. (SD)	**GREEN** On track	The NHS People Plan emphasises the importance of improvement work in relation to equality and diversity and recruitment and makes specific reference to an 'overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.'	**Lead: SD** Workforce Committee

		An end to end review of recruitment processes is scheduled for 15 February 2021 and involves colleagues from our established equality networks. 20 colleagues have been identified as participants on selection panels.	
Assign a wellbeing champion to each Ward/Department/Service to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey. (SD)	**GREEN** On track	The Trust has 130 Wellbeing Ambassadors in place covering 72% of teams. A network has been established with regular communication and bi-monthly meetings. Work continues to expand the network to ensure all teams have access to an Ambassador. A Board level Wellbeing Guardian will be identified in May 2021. Results from the 2021 national staff survey will be published on 11 March 2021	**Lead: SD** Workforce Committee
Goal: Sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver the 20/21 regulator approved financial plan. (GB)	**GREEN** On track	The Trust is forecasting to deliver the plan agreed within the ICS for 20/21. This was based on quarter 3 and 4 only as balanced for quarter 1 and 2 in the current finance regime. Additionally, a risk share agreement is established across the ICS for mutual support and currently the ICS is forecasting to underspend against the 20/21 plan.	**Lead: GB** Reported to Finance & Performance Committee / Estates Sustainability Committee Monthly regulator discussions
Demonstrate improved performance against Use of Resources key metrics.	**GREEN** On track	The finance use of resource metric that is presented monthly at Finance and Performance committee shows improvement which is largely due to the improved cash position and reduced levels of borrowing. This metric is no longer being collected by NHSIE but we continue to monitor. A decision was taken at Finance and Performance Committee to amend the scoring methodology to better reflect the revised debt regime for NHS providers. Work continues with clinical teams to provide evidence of improvements regarding wider use of resource metrics and an internal assessment has been commissioned by Finance and	**Lead: GB** Reported to Finance & Performance Committee Quality Committee Monthly regulator discussions

		Performance Committee to assess progress and further opportunities.	
Trust Board approval of a 10-year sustainability plan to support reduction in the Trust's carbon footprint.	**BLUE** **Completed**	On the 5th November 2019, the Trust Board adopted the NHSE targets for carbon neutrality and approved the proposed strategy set out in the report for its delivery through the adaptation plan.	**Lead: SS** Transformation Programme Board Trust Board
Collaborate with partners across West Yorkshire and in place to deliver resilient system plans.	**GREEN** On track	The Trust continues to work with WYAAT and the West Yorkshire and Harrogate Integrated Care System (ICS) and with place-based leaders in Calderdale and Kirklees to deliver system plans. The Trust Board has responded to the recent consultation supporting proposed changes in the legislative footing of Integrated Care Systems in 2022.	**Lead: AB** Plans reviewed by Board and WYAAT Committee in Common System Leadership Meetings with NHSE and ICS

10. Health Inequalities

To Approve

Presented by Helen Barker, Ellen Armistead and Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th March 2021
Meeting:	Public Board of Directors
Title:	HEALTH INEQUALITIES
Authors:	Helen Barker, Chief Operating Officer Ellen Armistead, Director of Nursing Anna Basford, Director of Transformation and Partnerships
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	N/A

Purpose of the Report

To provide the Board of Directors with an update on the work being undertaken within the Trust in relation to Health Inequalities (HI) and highlight some examples of the data available to facilitate discussion.

Key Points to Note

Health inequalities should be embedded in everything that we do. We should always be viewing healthcare through a health inequalities lens.

The Trust has broken down the development of Health inequalities knowledge into three themes:

1. The external environment, how we connect with our communities and use this to inform our business as usual planning
2. The lived experience, with initial focus on families accessing our maternity service
3. Health inequalities data and how we use this to compliment clinical prioritisation and our post Covid delivery model

Progress is being made on all three themes.

Awareness of Health Inequalities as a priority agenda is increasing.

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.

An EQIA will be required for the prioritisation of patients with a learning disability in recovery planning. This is underway.

Recommendation
The Board are asked to: • **Note** the 3 focus themes in relation to HI and the decision to split the leadership of these to maximise impact at pace. • **Note** the progress already made in relation to Continuity of Carer for BAME families access to maternity services. • **Approve** the proposal to prioritise Learning disability patients for treatment next after cancer and urgent patients, pending the final EQIA, that allows Theatre planning to commence. • **Approve** that an update on Health Inequalities becomes a standing item at the Board of Directors going forwards.

Health Inequalities

Background

The Health inequalities agenda has had an increased profile internally and nationally since the onset of Covid 19 with a national focus and the identification of 8 urgent actions included in the national stabilisation and reset priorities letter in July 2020 reinforced in December 2020.

Internally we recognise the importance of this in relation to our current service models, our own stabilisation and reset plans and the strategic case for change that is guiding our reconfiguration planning. To ensure we make truly informed decisions we need to ensure that as a Board we fully understand the Health inequality agenda, can accurately analyse data and interpret feedback in a meaningful way.

Reflecting the complexities of this and the need to learn at pace the agenda has been split into three themes with a director lead for each them who will then bring this together to help shape our response and disseminate this learning across the organisation and wider Health and Social care system.

The three themes are:

1. The external environment, how we connect with our communities and use this to inform our business as usual planning [Anna Basford, Director of Transformation & Partnerships]
2. The lived experience, with initial focus on families accessing our maternity service [Ellen Armistead, Chief Nurse/Deputy Chief Executive and Executive lead for Health Inequalities]
3. Health inequalities data and how we use this to compliment clinical prioritisation and our post Covid-19 delivery model [Helen Barker, Chief Operating Officer]

This paper describes the current position in relation to the three areas of focus.

The External Environment

As part of the Business Better than Usual programme, work is being taken forward to develop new ways of involving local communities to listen and understand their needs and co-produce responses to reduce inequalities. The aim of this work is to build relationships and listen to the views of local groups and communities in relation to their experience of accessing healthcare and to develop with them actions that can be taken to meet their specific needs and improve experience. To shape and guide this work the Trust is seeking advice from the West Yorkshire ICS Programme Lead and is currently meeting with local stakeholders to collaboratively agree specific groups of people to work with initially.

A survey of patients was undertaken in 2020 to understand their views and experience of accessing services during the pandemic and in particular the use of digital technology and remote consultations. The feedback from this, along with the findings of a review undertaken by Healthwatch that asked people with protected characteristics about their views in relation to the use of telephone and video healthcare appointments, is being used to inform the programme of outpatient transformation and ensure that adaptations to support the use of digital technology are made (e.g. provision of British Sign Language and translation options in digital consultations).

The Trust is continuing to work with partners in Calderdale to support and contribute to actions agreed that have been informed by Calderdale Council Public Health team engaging with people living or working in Park ward and surrounding areas to address the disproportionate impact of Coronavirus on Black Asian and Minority Ethnic (BAME) communities.

The Lived Experience: Maternity Services

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. The most recent MBRRACE-UK (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries) published in December 2020 suggests that compared to babies of white ethnicity babies of Black or Black British ethnicity remain at over twice the risk of stillbirth and increased risk of neonatal mortality. Babies of Asian or Asian British ethnicity are at 57% increased risk of stillbirth and 59% increased risk of neonatal mortality compared to babies of white ethnicity. All of which suggest national safety initiatives are failing to reach many women from higher risk BAME groups.

There is also a direct relationship between higher levels of socio-economic deprivation and higher stillbirth and neonatal mortality rates with a 4% reduction in stillbirth rates for those living in the most deprived areas compared to a 13% reduction for those living in the least deprived areas. Rates for neonatal mortality are 2.20 per 1,000 live births among babies born to mothers living in the most deprived areas and 1.23 per 1,000 live births among those living in the least deprived areas. The connection between risk and poverty is also clear, with women living in the most deprived areas are at an 80% higher risk of their baby dying.

While there is a lot of data in terms of outcomes there is much less research into the experiences of women from the more deprived communities.

There have been some studies that have concluded there is a high level of mistrust between mothers from BAME communities and healthcare. Those with negative views perceived health professionals as rude, discriminatory and insensitive to their cultural and social needs. These women therefore avoided continuously utilising maternity care. 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.

Some studies have shown that Healthcare Professionals (HCPs) can find the provision of culturally sensitive care a challenge. HCPs highlighted the importance of education and training in this regard.

In terms of local experience, the table below highlights some of the data from the maternity satisfaction survey (this includes both CHFT and MYT).

The data demonstrates a less favourable perception among women from BAME communities.

Demographic	Virtual antenatal appointments	Face-to-face antenatal appointments	Ultrasound appointments	ANC over all	Intrapartum care (%)	Postnatal care (%)	Feeding support
Overall experience	67%	86%	73%	87%	77%	79%	84%
Ethnicity							
White	67%	87%	73%	88%	79%	**80%**	**86%**
BAME/ Non white	67%	87%	82%	80%	69%	**71%**	**67%**
Sexual orientation							
Heterosexual	68%	87%	73%	88%	78%	79%	84%
Bisexual/ Lesbian	57%	92%	69%	63%	78%	67%	71%

Further work is required to map this to “perception by postcode”.

Continuity of Carer

Following publication of the Maternity Transformation Programme in 2017 there is an expectation that by March 2021 Trusts will have achieved 35% of all women should be booked onto a Continuity of Carer pathway.

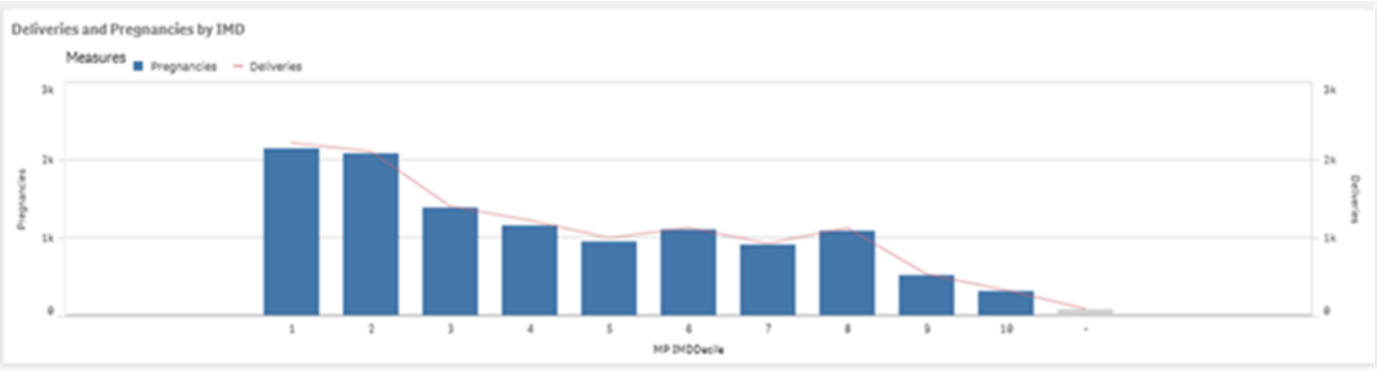
The ambitions of Continuity of Carer is to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions. Given the link between Continuity of Carer and better outcomes successful delivery of the programme is a key element of maternity services improvement plans.

This means every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally. It enables the co-ordination of a woman's care, so that a named individual takes responsibility for ensuring all the needs of a woman and her baby are met, at the right time and in the right place. It should facilitate the development of a relationship between the woman and the clinician who cares for her over time and for the specific and personal needs to be responded to without variation.

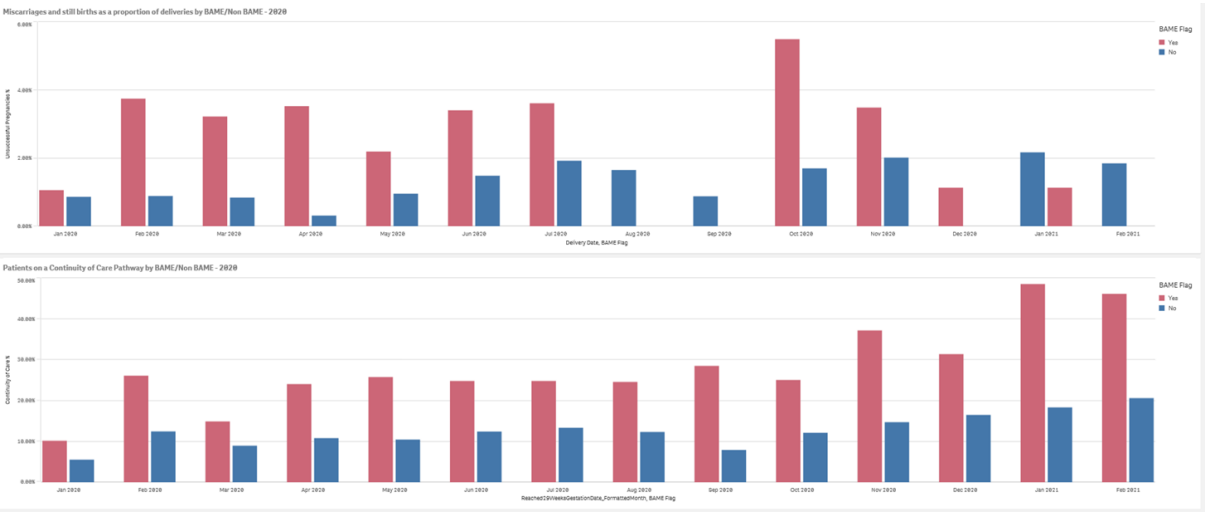
Implementing Continuity of Carer has been a challenge nationally, it has significant resource implications both financially and on the workforce and has required a more fluid response to ensure the assigned midwife is available when the mother commences in labour therefore impacting on the work:life balance of staff.

Within CHFT, focus has been given to the implementation of this standard for BAME mothers given the challenges described above. The Trust has exceeded its target of 35% for BAME families by March 2021, currently there are 40% of BAME women booked onto a pathway.

If we look at CHFT data on Health inequalities there is a greater percentage of pregnant BAME women in the most 2 deprived groups.



The tables below demonstrate that locally mothers from BAME communities are more likely than non BAME mothers to experience miscarriage or stillbirth. The second table indicates the impact of the current Continuity of Carer strategy to target mothers from BAME groups.



All of the above demonstrates why maternity services should be a Trust health inequality priority.

Using Health Inequalities date to inform stabilisation and reset planning

The Trust has an excellent track record in relation to the timely capture of data in relation to patient demographics and, using the expertise of The Health Informatics Service, has started to develop a selection of dashboards within its Knowledge Portal+ that allows interrogation of this data.

Whilst the data is good there is not yet enough expertise to safely use this to directly inform all decision making. There is now, however, sufficient to be able to start more detailed conversations with clinicians and leaders within CHFT and the wider system that will lead to more definitive, and potentially different decisions on the prioritisation of services and patients. The exception to this is Learning Disabilities where internal expertise and focus has enabled us to progress to a recommendation.

The Trust, in line with all other Trusts nationally, has a significant backlog of patients awaiting access to outpatient, diagnostic and inpatient services. For inpatients and a percentage of outpatients these have all been clinically reviewed and a priority status assigned that links to the optimal waiting time based on their clinical presentation. This data is now being incorporated into the HI dashboard where we can then look at it through different lenses including:

- Patients with a learning disability
- By ethnicity
- By Index of Multiple Derivation
- By their Frailty score

By reviewing the waiting list data we have been able to look more holistically at patient groups and individuals with a view to moving away from the traditional urgency profile, then chronological dating of patients to one where we may want to prioritise based on different risks factors.

The two areas currently in focus are patients with a learning disability and patients from a BAME background.

Learning disability

It is known that people with a learning disability have a shorter life expectancy and therefore the impact of waiting for treatment can both further reduce this as well as disproportionally impact on their quality of life whilst waiting.

CHFT has 66 patients on the waiting list who also have a learning disability. They have been clinically prioritised based on their medical presentation and would, without a HI lens, be treated in chronological order. This means they will have extended waits as a consequence of Covid-19.

The proposal is, on the basis that this will reduce their inequality, that these patients are prioritised next after cancer and urgent patients. The environment these patients require, to ensure they have the best experience they can, is different to non-learning disability patients and it is proposed that dedicated theatre sessions are established that put primacy on the learning disability need before clinical specialty. This means that sessions will require flexibility of the surgical team with for example, 3 patients with a learning disability of different specialties on a single theatre list rather than placing a patient with a learning disability on 3 separate specialty theatre lists. An EQIA is being undertaken to provide appropriate assurance.

BAME

Work has commenced to look at the composition of waiting lists by ethnicity, on initial review there is some unexplained variation in the waiting times for different groups. Being able to see this variation has facilitated more informed discussions on what this may mean and more importantly what do we need to do to address any inequalities that may come out of further analysis.

A series of meetings have been established with a small group of Consultants and leaders to establish how we need to further breakdown the data to start to understand what may be driving the variation. In addition, this group will help inform the approach we will take on internal clinical communications and, ultimately, decisions on changes to waiting list prioritisation.

Next steps

A health inequalities working group has been set up whose remit is to oversee the delivery of a health inequalities work plan. This will be the governance route for ensuring progress around Trust priorities and to ensure that the three programmes of work fully integrate providing the widest impact in the shortest time; and with longevity.

The three director leads will continue to meet and define the workplans which will also be incorporated into Divisional and corporate plans for 21/22 to ensure this becomes a core agenda that is regularly reported.

Recommendations

The Board are asked to:

- **Note** the 3 focus themes in relation to HI and the decision to split the leadership of these to maximise impact at pace.
- **Note** the progress already made in relation to Continuity of Carer for BAME families access to maternity services.
- **Approve** the proposal to prioritise Learning disability patients for treatment next after cancer and urgent patients, pending the final EQIA, that allows Theatre planning to commence.
- **Approve** that an update on Health Inequalities becomes a standing item at the Board of Directors going forwards.

Financial Sustainability

11. Month 10 Financial Summary

To Receive

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th March 2021
Meeting:	Public Board of Directors
Title:	Month 10 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 and forecast as reported at the end of Month 10 (January 2021).

Key Points to Note

Year to Date Summary

For the second half of the financial year, the Trust has submitted a revised plan to NHS Improvement (NHSI) that reflects the Phase 3 activity plan. Income flows remain largely on a block basis and system funding has been allocated to cover the majority of Covid-19 costs. Year to date the position is a deficit of £0.30m, a favourable variance of £0.52m compared to plan. The M1-6 plan has now been reset to actual expenditure, so the YTD variance represents only 4 months.

- Retrospective funding to cover M1-6 Covid costs has been approved and received. £7.24m of system Covid funding has been allocated for M7-10, with an additional £0.14m provided for Lateral Flow Testing. The Trust has requested a further £1.76m to Covid cover costs outside of the system envelope for testing, vaccinations and research costs.
- Year to date the Trust has incurred costs relating to Covid-19 of £26.70m. M10 costs incurred were £3.20m driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the expansion of the workforce, staff working additional shifts, the segregation of patient pathways, remote management of patients and backfill for increased sickness absence.
- The underlying position excluding Covid-19 costs is a year to date favourable variance of £3.37m, driven by the impact of lower levels of other activity on non-pay costs and staffing vacancies.
- The reported position includes only the M6 impact of the Elective Incentive Scheme (£0.11m). For Months 7, 8 & 10 it is expected that the System will be exempt from the scheme due to high numbers of Covid patients. There remains a risk for Month 9 which is yet to be confirmed and if imposed the penalty is estimated to be £0.57m. In the forecast, any potential future impact of the scheme has also been excluded and remains a financial risk.
- The Trust continues to deliver some efficiency savings. CIP achieved year to date is £4.55m, £7.76m below the original Trust plan. Compared to the Phase 3 Plan, the Trust has delivered £2.59m of savings in 4 months, slightly below the £3.09m described in the revised plan.

- Agency expenditure year to date is £3.61m, £0.23m below the revised planned level.

Key Variances (compared to Phase 3 plan submission)

- Clinical Contract income is largely in line with the Phase 3 plan due to fixed block and top up arrangements, which now includes a fixed monthly allocation to cover Covid-19 expenditure. Most Covid expenditure will have to be managed within that fixed allocation, although there remains an element of Retrospective Covid funding available for Testing, Vaccinations and NHS Nightingale. Income of £1.09m has been assumed to cover testing costs, with a further £0.45m for the vaccination programme and £0.09m for the R&D SIREN (SARS-COV2 Immunity & Reinfection Evaluation) project. In overall terms income is above plan by £2.47m.
- Pay costs are £1.11m below the planned level year to date due to slippage on recruitment to the additional approved posts required to deliver Phase 3 activity plans, offset to some extent by the requirement to account for the future cost of cancelled annual leave that will now have to be carried forward, (annual leave accrual).
- Non-pay operating expenditure is higher than planned by £3.07m. This is due to higher than planned Covid-19 related expenditure, an increase in provisions and some non-recurrent legal costs.

Forecast

For Month 7-12 (Phase 3), the Trust is required to manage within the Integrated Care System (ICS) agreed financial envelope. The Trust has been allocated Covid funding on a fair shares basis to cover the remainder of the year and can request access additional central funding to cover costs excluded from the system envelope such as Covid Testing and Vaccinations. The Trust is reporting a forecast deficit of £3.60m, £1.69m higher than planned due to an increase in the required Annual Leave accrual. This is an 'allowable' overspend from an NHS Improvement perspective and has been agreed with our system partners.

The forecast excludes the potential impact of the Elective Incentive Scheme on the M9-12 position, which based on the current activity forecast could drive a penalty of circa £0.80m.

Attachment: Month 10 Finance Report

EQIA – Equality Impact Assessment

The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

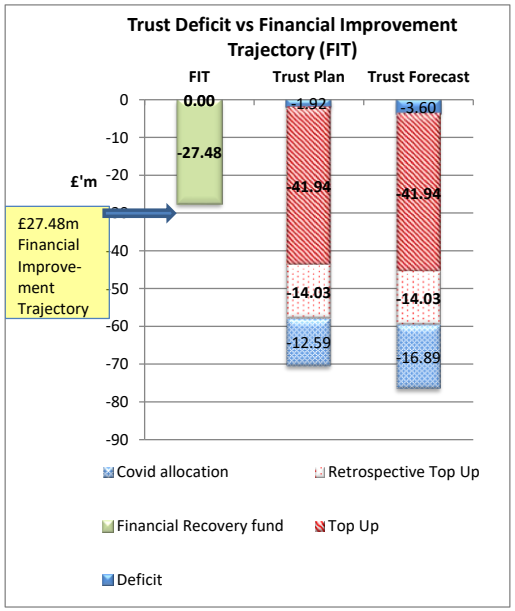
Recommendation

The Board is asked to receive the Month 10 Finance Report and note the financial position for the Trust as at 31 January 2021.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jan 2021 - Month 10

KEY METRICS

	M10				YTD (JAN 2021)				Forecast 20/21			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£0.47)	(£0.06)	£0.41		(£0.82)	(£0.30)	£0.52		(£1.92)	(£3.60)	(£1.69)	
Agency Expenditure	(£0.47)	(£0.43)	£0.04		(£3.84)	(£3.61)	£0.23		(£4.78)	(£4.50)	£0.29	
Capital	£2.11	£2.39	(£0.28)		£15.49	£13.19	£2.30		£20.85	£24.42	(£3.58)	
Cash	£56.57	£62.37	£5.80		£56.57	£62.37	£5.80		£28.04	£31.47	£3.44	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95%	93%	-2%		95%	88%	-7%					
CIP	£1.23	£0.64	(£0.59)		£12.31	£4.55	(£7.76)		£14.77	£5.89	(£8.88)	
Use of Resource Metric	3	2			2	2			2	3		



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- The forecast excludes the potential impact of the Elective Incentive Scheme on the M9-12 position, which based on the current activity forecast could drive a penalty of circa £0.80m.

Total Group Financial Overview as at 31st Jan 2021 - Month 10

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M10

CLINICAL ACTIVITY

	M10 Plan	M10 Actual	Var
Elective	1,710	1,360	(350)
Non-Elective	44,665	39,299	(5,366)
Daycase	22,036	20,967	(1,069)
Outpatient	241,498	250,317	8,820
A&E	110,923	103,447	(7,476)
Other NHS Non-Tariff	948,707	954,352	5,645
Other NHS Tariff	41,347	55,591	14,244
Total	**1,410,885**	**1,425,333**	**14,448**

TOTAL GROUP: INCOME AND EXPENDITURE

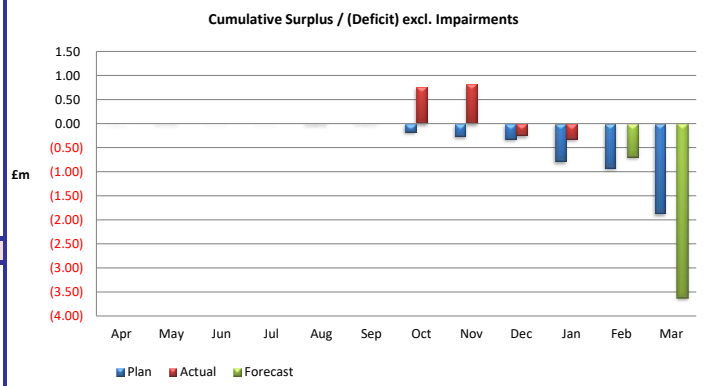
	M10 Plan	M10 Actual	Var
	£m	£m	£m
Elective	£14.76	£14.76	£0.00
Non Elective	£96.09	£96.09	£0.00
Daycase	£25.43	£25.43	£0.00
Outpatients	£38.21	£38.21	£0.00
A & E	£19.49	£19.49	(£0.00)
Other-NHS Clinical	£87.75	£86.18	(£1.58)
CQUIN	£3.16	£3.16	£0.00
Other Income	£39.17	£42.57	£3.40
Total Income	**£324.06**	**£325.88**	**£1.82**
Pay	(£236.98)	(£235.87)	£1.11
Drug Costs	(£34.88)	(£34.33)	£0.55
Clinical Support	(£24.82)	(£24.25)	£0.56
Other Costs	(£54.78)	(£58.97)	(£4.18)
PFI Costs	(£11.20)	(£11.20)	£0.00
Total Expenditure	**(£362.66)**	**(£364.61)**	**(£1.95)**
EBITDA	**(£38.60)**	**(£38.73)**	**(£0.13)**
Non Operating Expenditure	(£20.04)	(£20.09)	(£0.05)
Surplus / (Deficit) Adjusted*	**(£58.64)**	**(£58.82)**	**(£0.18)**
Conditional Funding (MRET/FRF/Top Up)	£57.83	£58.52	£0.69
Surplus / Deficit*	**(£0.82)**	**(£0.30)**	**£0.52**

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

DIVISIONS: INCOME AND EXPENDITURE

	M10 Plan	M10 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£15.18	£17.64	£2.46
Medical	£27.18	£27.67	£0.49
Families & Specialist Services	(£5.74)	(£4.42)	£1.32
Community	(£2.98)	(£1.90)	£1.07
Estates & Facilities	£0.00	£0.00	(£0.00)
Corporate	(£38.31)	(£39.47)	(£1.16)
THIS	£1.26	£1.59	£0.33
PMU	£2.53	£2.95	£0.42
CHS LTD	£0.58	£0.46	(£0.11)
Central Inc/Technical Accounts	(£1.26)	(£3.75)	(£2.49)
Reserves	£0.74	(£1.07)	(£1.81)
Unallocated CIP	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£0.82)**	**(£0.30)**	**£0.52**

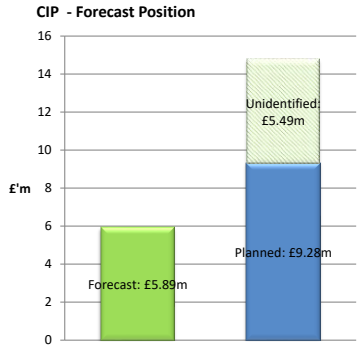
TOTAL GROUP SURPLUS / (DEFICIT)

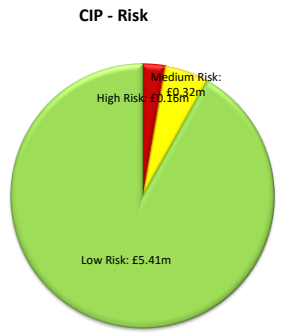


KEY METRICS

	Year To Date			Year End: Forecast		
	M10 Plan	M10 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£0.82)	(£0.30)	£0.52	(£1.92)	(£3.60)	(£1.69)
Capital	£15.49	£13.19	£2.30	£20.85	£24.42	(£3.58)
Cash	£56.57	£62.37	£5.80	£28.04	£31.47	£3.44
Invoices Paid within 30 days (BPPC)	95%	88%	-7%			
CIP	£12.31	£4.55	(£7.76)	£14.77	£5.89	(£8.88)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	2	2		2	3	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£14.77m**

Total Forecast **£5.89m**

YEAR END 20/21

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	2,245	1,643	(602)
Non-Elective	53,875	46,372	(7,503)
Daycase	28,176	26,333	(1,842)
Outpatient	298,401	310,371	11,969
A&E	133,952	122,930	(11,022)
Other NHS Non- Tariff	1,190,677	1,206,458	15,780
Other NHS Tariff	49,737	69,960	20,223
Total	**1,757,064**	**1,784,067**	**27,003**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£18.01	£18.01	£0.00
Non Elective	£114.89	£114.89	£0.00
Daycase	£30.72	£30.72	£0.00
Outpatients	£46.12	£46.12	£0.00
A & E	£23.16	£23.16	(£0.00)
Other-NHS Clinical	£105.17	£105.18	£0.01
CQUIN	£3.79	£3.79	£0.00
Other Income	£47.57	£50.95	£3.38
Total Income	**£389.43**	**£392.83**	**£3.39**
Pay	(£286.54)	(£287.01)	(£0.47)
Drug Costs	(£41.90)	(£41.47)	£0.42
Clinical Support	(£31.01)	(£30.62)	£0.39
Other Costs	(£64.57)	(£72.69)	(£8.11)
PFI Costs	(£13.44)	(£13.41)	£0.03
Total Expenditure	**(£437.46)**	**(£445.19)**	**(£7.73)**
EBITDA	**(£48.03)**	**(£52.37)**	**(£4.34)**
Non Operating Expenditure	(£24.06)	(£24.10)	(£0.04)
Surplus / (Deficit) Adjusted*	**(£72.08)**	**(£76.46)**	**(£4.38)**
Conditional Funding (MRET/FRF/Top Up)	£70.17	£72.86	£2.70
Surplus / Deficit*	**(£1.92)**	**(£3.60)**	**(£1.69)**

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

DIVISIONS: INCOME AND EXPENDITURE

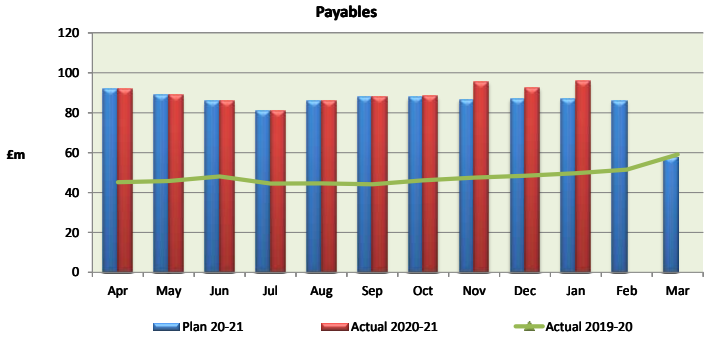
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£17.51	£20.31	£2.80
Medical	£31.43	£31.29	(£0.14)
Families & Specialist Services	(£7.45)	(£5.77)	£1.68
Community	(£3.90)	(£2.48)	£1.42
Estates & Facilities	£0.00	£0.00	(£0.00)
Corporate	(£46.03)	(£47.47)	(£1.44)
THIS	£1.49	£1.51	£0.02
PMU	£3.00	£3.35	£0.35
CHS LTD	£0.71	£0.57	(£0.14)
Central Inc/Technical Accounts	£0.38	(£4.10)	(£4.48)
Reserves	£0.94	(£0.81)	(£1.75)
Unallocated CIP	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£1.92)**	**(£3.60)**	**(£1.69)**

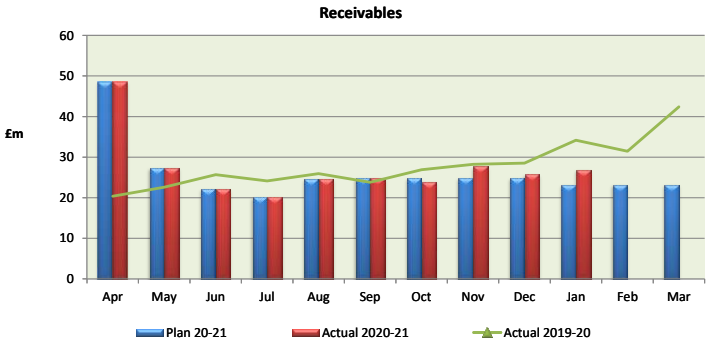
Total Group Financial Overview as at 31st Jan 2021 - Month 10

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

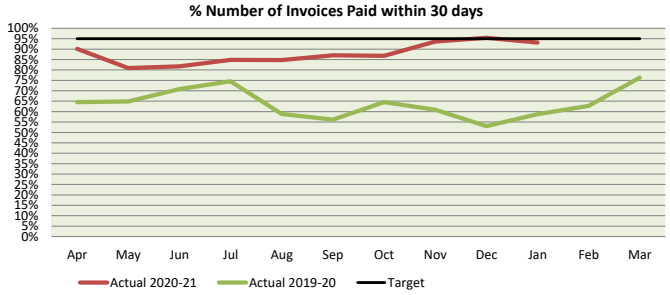
WORKING CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Payables (excl. Current Loans)	(£86.83)	(£95.78)	£8.95	
Receivables	£23.27	£26.97	(£3.70)	



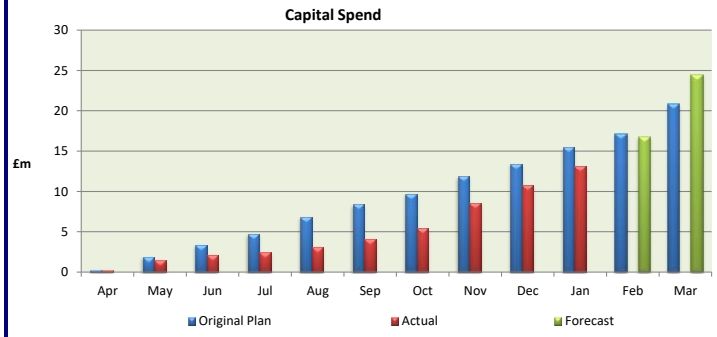


BETTER PAYMENT PRACTICE CODE



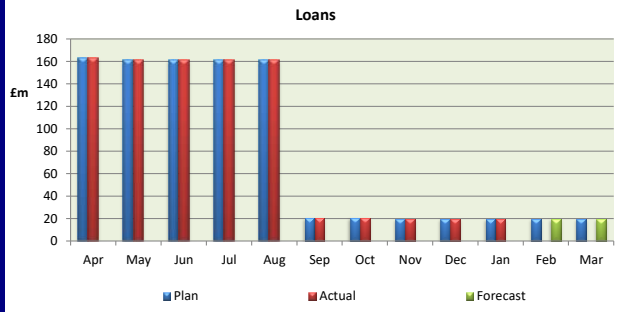
CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Capital	£15.49	£13.19	£2.30	

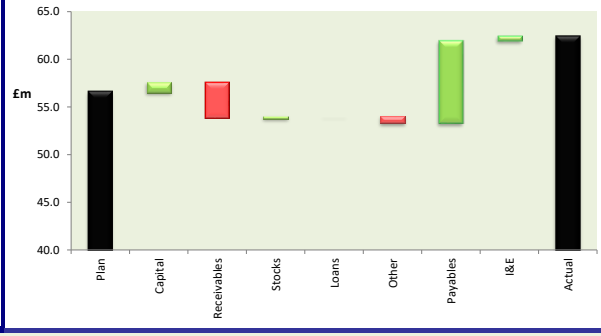


CASH

	M10 Plan £m	M10 Actual £m	Var £m	M10
Cash	£56.57	£62.37	£5.80	
Loans (Cumulative)	£19.88	£19.88	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust is now working to the revised plan for Phase 3 of 2020/21 (M7-12) that was submitted in October. Income flows remain largely on a block basis and system funding has been allocated to cover the majority of Covid-19 costs. Year to date the position is a deficit of £0.30m, a favourable variance of £0.52m compared to plan. The M1-6 plan has now been reset to actual expenditure, so the variance only represents M7-10.
- Clinical Contract income is largely in line with the Phase 3 plan due to fixed block and top up arrangements, including a fixed monthly allocation to cover Covid-19 expenditure. The reported position includes the M6 impact of the Elective Incentive Scheme (£0.11m) For M7, 8 & 10 it is anticipated that the System will be exempt due to Covid activity and the position excludes any potential impact on M9. If this were to be levied the impact of this penalty is estimated to be £0.57m.
- Whilst Outpatient activity remains above the Phase 3 plan Year to date, all other areas of activity are below plan due to increased Covid-19 admissions.
- Year to date the Trust has incurred costs relating to Covid-19 of £26.70m. M10 costs incurred were £3.20m.
- Year to date Capital expenditure is lower than planned at £13.19m against a planned £15.49m.
- Cash balance is £62.27m, £5.80m above the Phase 3 plan: the Trust continues to receive Block and Top Up income one month in advance.

- Year to date CIP schemes have delivered £4.55m of savings, £7.76m lower than the Trust's original 20/21 Target.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 2. This excludes the exceptional adverse impact on the Capital Service Cover Metric of the repayment of Interim revenue and capital support loans, due to changes in the NHS cash regime.

NOTES

- For Month 7-12 (Phase 3), the Trust will be required to manage within the ICS agreed financial envelope. The Trust has been allocated Covid funding on a fair shares basis to cover the remainder of the year and can request access to additional central funding to cover costs excluded from the system envelope such as Covid Testing and Vaccinations.
The Trust is reporting a forecast deficit of £3.60m, £1.69m higher than planned due to an increase in the required Annual Leave accrual. This is an 'allowable' overspend from an NHS Improvement perspective and has been agreed with our system partners.

- The Trust is forecasting delivery of £5.89m savings against a Trust CIP Target for 20/21 of £14.77m.
- The Forecast excludes the potential adverse impact of the Elective Incentive Scheme on the M9-12 position, which based on the current activity forecast could drive a penalty of circa £0.80m.
- The total loan balance at year end is forecast to be £19.88m as planned. All Revenue and Interim Capital Loans (totalling £140.72m) were repaid and replaced by PDC funding during September.
- Capital expenditure is forecast at £24.42m, £3.58m more than the resubmitted 20/21 Capital Plan, due to confirmation of further additional external funding for: Adopt & Adapt, Cyber Security Yorkshire & Humber Care Records and Medical E-Rostering / Job Planning.

RAG KEY: (Excl: UOR)
- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

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

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

FORECAST

YEAR END 20/21

	Plan £m	Forecast £m	Var £m	
Elective	£18.01	£18.01	£0.00	
Non Elective	£114.89	£114.89	£0.00	
Daycase	£30.72	£30.72	£0.00	
Outpatients	£46.12	£46.12	£0.00	
A & E	£23.16	£23.16	(£0.00)	
Other-NHS Clinical	£105.17	£105.18	£0.01	
CQUIN	£3.79	£3.79	£0.00	
Other Income	£47.57	£50.95	£3.38	
Total Income	**£389.43**	**£392.83**	**£3.39**	
Pay	(£286.54)	(£287.01)	(£0.47)	
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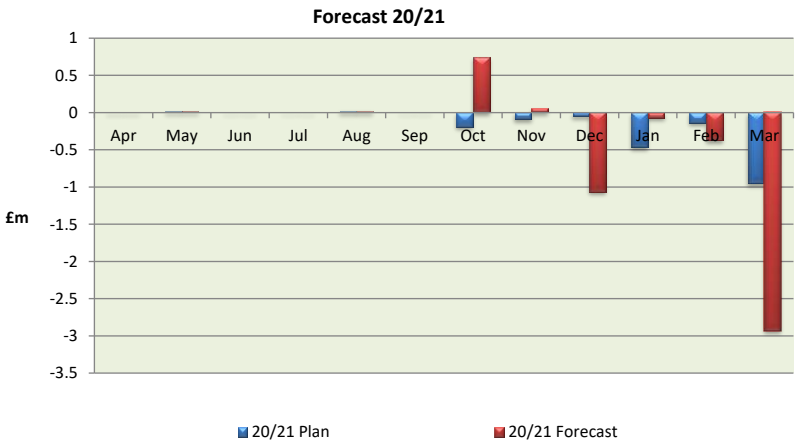
Clinical Support	(£31.01)	(£30.62)	£0.39	
Other Costs	(£64.57)	(£72.69)	(£8.11)	
PFI Costs	(£13.44)	(£13.41)	£0.03	
Total Expenditure	**(£437.46)**	**(£445.19)**	**(£7.73)**	
EBITDA	**(£48.03)**	**(£52.37)**	**(£4.34)**	
Non Operating Expenditure	(£24.06)	(£24.10)	(£0.04)	
Surplus / (Deficit) Control Total basis*	**(£72.08)**	**(£76.46)**	**(£4.38)**	
Conditional Funding (MRET/PSF/FRF)	£70.17	£72.86	£2.70	
Surplus / Deficit*	**(£1.92)**	**(£3.60)**	**(£1.69)**	

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

Forecast



Month 7-12 (Phase 3) Financial Plan

The current Block and Top Up arrangements with access to retrospective funding to cover Covid costs have now ended. For Month 7-12 (Phase 3), the Trust will be required to manage within the ICS agreed financial envelope. The Trust has been allocated Covid funding on a fair shares basis to cover the remainder of the year. The plan submitted to the ICS and NHSI assumes an underlying unfunded gap (deficit) of £1.92m as described below:

	£'m	
Technical Accounting Adjustment:	£0.00	*Removed from Plan and Forecast*
Loss of 'Other' Income:	£1.61	
Annual Leave Accrual:	£0.50	
Residual difference between funding and planned expenditure:	-£0.19	
Total Planned Deficit	**£1.92**	

The Trust is now forecasting a £3.60m deficit which is £1.69m more than planned due to an increase in the required Annual Leave accrual. This is an 'allowable' overspend from an NHS Improvement perspective and has been agreed with our system partners. Excluding the Annual leave accrual, the Trust is now confident of achieving the planned position and a combination of the year to date improvement, some expected ongoing slippage on recruitment and an additional funding allocation of £0.81m from the ICSs has allowed the Trust to include in the forecast a £1.5m provision to cover the estimated cost of the 'Flowers' national legal case (relating to back-dated annual leave claims).

Key Assumptions:

- The forecast does not include any potential financial impact for M9-12 as a result of the Elective Incentive Scheme, estimated at circa £0.80m.
- Assumes that all future PPE requirements are provided through National Procurement.
- Assumes that the incremental costs incurred as a result of Covid-19 Testing and the Vaccination programme are recovered in full through additional 'outside of envelope' funding.
- Excludes the potential impact of Brexit on prices / costs.
- Assumes that any additional outsourced activity to the Independent Sector will be recoverable through additional funding.

Risks and Opportunities:

- National funding for Covid Testing has been identified, but the cost per test incurred on existing testing platforms exceeds the recommended value and the approval process for confirming funding in this situation remains unclear.
- Current operational pressures due to Covid-19 may increase the required Annual Leave accrual further compared to the forecast level.
- If the improvement seen in Month 10 continues, there may be the opportunity to reduce the current forecast deficit to some extent.
- The forecast currently excludes any potential benefit if additional funding is released nationally to cover lost income (eg. Car Parking income) or the Annual Leave accrual and Flowers legal case

COVID-19

Revenue Impact of Covid-19 - YTD JAN 2021					
Division	**Annual Leave Accrual** £	**Covid-19 Direct Costs** £	**Impact on activity** £	**Loss of Income** £	**Total** £
Central & Technical	0	9,259,527	42,208	0	9,301,735
Medicine	0	10,036,134	(252,342)	0	9,783,792
Families & Specialist Services	0	1,481,649	(180,999)	619,370	1,920,020
Calderdale & Huddersfield Solutions Ltd	0	1,244,882	(109,501)	103,000	1,238,381
Corporate Services	0	1,049,571	(48,081)	2,000,430	3,001,920
Community	0	1,139,455	0	30,346	1,169,802
Health Informatics	0	130,740	0	0	130,740
Surgery & Anaesthetics	0	2,357,513	(2,949,394)	0	(591,881)
NHS Nightingale (Hosted Costs)		3,264			3,264
Total costs identified	**-**	**26,702,735**	**- 3,498,108**	**2,753,146**	**25,957,773**
Retrospective Top Up requested (M1-6)					**14,031,213**
Covid System Top Up (M7-12)					**7,244,000**
Covid funding 'outside of envelope'					**1,759,509**
Total funding					**23,034,722**

Capital Impact of Covid-19 - JAN 2021	
Details	**Covid-19 Costs** £
NPEX (PDC received)	330,000
Equipment	444,578
Asset Tracking	105,422
Total costs identified	**880,000**
PDC Confirmed	**844,000**

The Trust has incurred Covid-19 direct costs totalling £26.70m year to date as shown in the table and these have been reported to NHSI in support of the requested 'Retrospective Top Up' (M1-6), Covid system funding provided from M7 and additional funding requested to cover 'outside of envelope costs'. Additional Covid funding totalling £1.62m has been assumed to cover costs for: Covid-19 Testing £1.11m, Covid-19 Vaccination Programme £0.45m and NIHR SIREN £0.09m. This funding is yet to be confirmed and paid. The Trust has also been allocated funding of £0.14m to cover the cost of delivering Lateral Flow Testing.

Key areas of spend are as follows:

Pay - £14.09m

Key area of pay expenditure categorised as within system envelope and therefore covered by Top Up allocations are follows:
- Existing staff to working additional shifts, during both wave 1 and again over the last 3 months as the number of Covid-19 cases have once again increased across the two hospitals.
- Additional costs in community services for bank holiday cover and other additional shifts to support 7 day working.
- Almost 150 students (nursing, therapies and medical) were added to the payroll up until mid August in support of wave 1.
- Changes to medical rotas with additional enhancements paid to junior medical staff.
- The extension of winter initiatives to release bed capacity including the Discharge Lounge and Home First team.
- The facilitation of patient flow and segregation of pathways, particularly in the Emergency Department.
- Backfill for substantive staff who are sick or clinically extremely vulnerable and the cost of paying bank staff who are shielding.

Pay expenditure that requires additional funding as 'outside of envelope' is as follows:
- £0.036m for staff costs to support PCR virus testing using platforms procured prior to Sep 20.
- £0.238m to support the Vaccination programme delivered within the hospital setting.
- £0.005m for NIHR SIREN

Non Pay - £12.61m

Non pay costs categorised as inside of system envelope total £11.24m, including: £5.23m for locally procured PPE, costs related to increased ICU capacity of £1.00m, £1.12m on Covid testing, £1.61m for segregation of patient pathways, £1.05m for decontamination and £0.53m to support remote management of patients.

Non pay expenditure that requires additional funding as outside of envelope is as follows:
- £1.07m for testing kits and associated equipment for PCR virus testing using platforms procured prior to Sep 20.
- £0.20m for the Huddersfield Vaccination Centre at the Johns Smiths Stadium and £0.01m for the Hospital based Vaccination programme.
- £0.09m for NIHR SIREN

Income Losses

The Trust has lost income totalling £2.75m including: loss of Car Parking Income, (£1.90m which is a combination of income from staff permits and income from patients and visitors), loss of catering income (£0.07m), loss of apprentice levy income (£0.08m from pausing of HCAs apprenticeships delivered internally) and loss of private patient income (£0.62m mainly from Yorkshire Fertility).

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

Capital funding for Covid-19 costs has also been requested as shown and the Trust has now had the majority approved as shown.

12. Annual Plan 2021/22

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title:	2021/22 Planning Update
Author:	Kirsty Archer, Deputy Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	N/A

Purpose of the Report

The purpose of this report is to update the Board on the financial planning process for 2021/22.

Key Points to Note

The Trust has been informed that the national requirement for submission of annual activity, financial and workforce plans has been extended from the normal timescales in recognition of the operational position in supporting the third wave of Covid pressures. It has been confirmed that the existing financial framework will be rolled over until at least the end of Quarter 1 of 2021/22. Further guidance for 2021/22 is awaited.

It is recognised that a huge amount of work on planning has been undertaken so far and significant progress has been made in understanding both the underlying but also re-set financial values. It is proposed that the planning process is now broken into stages. The 2021/22 financial year will commence with a baseline budget with separate funding identified for Covid expenditure. The extended planning window will then be used to confirm further investment and disinvestment decisions, efficiency requirements and activity recovery plans.

EQIA – Equality Impact Assessment

The attached 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

To note the plan to have a three staged approach to forming the 2021/22 financial plan.

2021/22 Planning Update

Board of Directors 4 March 2021

Purpose

The purpose of this report is to update the Board on the financial planning for 2021/22.

National context

The Trust has been informed that the national requirement for submission of annual activity, financial and workforce plans has been extended from the normal timescales in recognition of the operational position in supporting the third wave of Covid pressures.

It has been confirmed that the existing financial framework will be rolled over until at least the end of Quarter 1 of 2021/22, with the option left open of this being extended to the end of Quarter 2. Guidance on the financial arrangements is expected imminently but the arrangements seen in the second half of 2020/21 have comprised system funding envelopes, incorporating Covid top up funds and separate funding streams outside of the envelopes for items such as Covid testing costs and vaccinations. The expectation of delivery of Cost Improvement Programmes has been paused throughout 2020/21 and indications are that this allowance will continue with the roll over of the regime for Quarter 1. That said, details are still subject to agreement with Treasury which may affect the total funding available. At the time of writing the financial envelopes for the Integrated Care System (ICS) and in turn for the Trust are unknown with information anticipated in March.

From Quarter 2, it is still the intention to move to the proposed financial framework described in the letter received from NHS Improvement on 23rd December 2020. The key points from this were:

- Revenue funding will be distributed at system level. System envelopes will be consistent with the Long-Term Plan financial settlement and will be based on published CCG allocations and the Financial Recovery Fund each system would have been allocated in 2021/22. There will be additional funding to offset some of the efficiency that systems were unable to deliver in 2020/21.

- Baseline contract values will need to align with these system envelopes and should be based on 2019/20 outturn contract values adjusted for non-recurrent items, 2020/21 funding growth and service changes.

- Organisations should start to develop plans for how Covid-19 costs can be reduced and eliminated since we start to exit the pandemic.

In addition, it is expected that further funding will be made available to support backlog activity catch up, again the distribution of this is not yet known. Operational planning guidance for Quarters 2 to 4 is due in early April with an indicative national planning submission deadline of the end of June 2021. There is however some more certainty around capital funding and system capital envelopes are due to be issued in February, with an expected submission date of April for capital plans.

Trust position

The Trust will still need to agree an internal budget for 2021/22 in advance of Month 1 reporting: for ongoing financial governance; to support budget holders; and to provide a baseline from which to understand and describe any changes due to the uncertain operational situation.

With this in mind, the planning exercise has progressed based on a set of assumptions (pending further national guidance). To date this has been managed through a bottom up process combining the forward view of each off the divisions.

The planning timetable below was approved by the Finance and Performance Committee at the start of February 2021.

Revised timetable for Planning	**Divisional Deadline**	**Approval Required**
Pressures and Activity Changes Final	13th Jan 21	Divisional Performance Review Meetings Jan 21/ Director Approval Feb 21
21/22 developments to Commercial Investment Strategy Committee (CISC)	18th Feb 21	Commercial Investment Strategy Committee: 25th Feb 21
Planning update to Finance and Performance Committee / Board of Directors		1st / 4th Mar 21
Internal Financial Plan including Capital Plan to F&P		29th Mar 21
Detailed Budgets agreed and signed off by Budgets Holders	30th Apr 21	
Budget Book to Board of Directors		6th May 21
Updated External Plan to F&P and Board of Directors		1st June 21 / 3rd June 21[1]
Indicative National Planning Deadline (Q2-Q4)		End of June

[1] Assumes that the NHSI planning submission deadline will be delayed until late June and Board sign off will be required prior to submission. This timetable may be amended depending on National guidance and confirmed submission deadlines.

This process indicated an initial planning 'gap' to the potential funding available of c.£32m prior to further review, challenge, prioritisation and identification of efficiencies. Performance Review Meetings (PRMs) held with each of the clinical divisions reviewed the make-up of these initial plans in detail and it was clear from these discussions that the scale of this financial planning gap was an indicator of (a) the level of uncertainty around the continuing Covid position and the emergent activity recovery plans; and (b) the level of ambition for innovation and new ways of working in the development bids.

It is recognised that a huge amount of work has been undertaken so far and significant progress has been made in understanding both the underlying but also re-set financial values. The discussion at the PRMs highlighted the complexity of planning in the current environment and the key interdependencies between the divisions competing for a constrained staffing resource.

There is an opportunity to think differently about budgets going forward and in particular staffing models and to consider how we want to operate both now and in the longer-term plan. For this reason, following the PRMs the decision was taken not to consider the new pressures and developments independently on a simplistic case by case basis through the usual Commercial Investment Strategy Committee (CISC) approvals process. Rather, the opportunity of the extended planning window will be used to give meaningful consideration to the best use of resources.

A key feature of budget setting has traditionally been to agree and develop efficiency plans. Whilst there will be a renewed focus nationally on efficiency and a requirement to deliver, we are considering our historical approach and opportunities to change the way we engage, develop, deliver and monitor. Whilst our previous approach has been successful, a revised approach may be beneficial that incorporates business better than usual, supports delivering additional activity to reduce backlogs and supports new models of working as we move towards reconfiguration. This work is ongoing and the pause or delay in national planning should allow us develop this new approach.

Next steps

It is proposed that the planning process is broken into stages.

Stage 1

To normalise current budgets for Quarter 1 2021/22. This will adjust budgets for items such as unachieved prior year efficiencies (requirement suspended due to Covid), pay award, inflation, full year effects and other technical adjustments. Then resolve cases previously agreed by CISC, items agreed in previous PRMs, plus other approved adjustments such as agreed existing pressures and reinstating non recurrent funding.

Covid funding will be set aside separately rather than applied to individual budgets at a level informed by the divisional intelligence but constrained within the Covid funding made available (once known).

This will allow for a working budget position to be set for the opening of the financial year, in advance on Month 1 reporting in line with the timetable for budget holder and committee sign off, as above.

Stage 2

New pressures and developments considered separately under a cross cutting process taking into account a number of factors such as: recruitment capacity, different models of working, existing budgeted establishments and actual expenditure run rates by staff group.

This process may also be an opportunity to make choices, redirect resource and minimise efficiency requirements. Dependent upon the outcome of this exercise further efficiency savings targets will be set accordingly. This stage would be undertaken by the end of May for sign off in advance of the anticipated national planning deadline in June.

Stage 3

Overlay financial plans for activity backlog based on operational approach to recovery. National funding is expected to be made available in support of recovery and this stage of planning would need to run in parallel with Stage 2.

Summary

In summary the Trust proposes to commence the 2021/22 financial year with a baseline budget made up of the adjusted carry forward position including pre-approved and committed items. Separate funding will be identified for Covid expenditure. The extended planning window will then be used to confirm further investment and disinvestment decisions, CIP requirements and activity recovery plans.

Recommendation

To note the plan to have a staged approach to forming the 2021/22 financial plan.

A Workforce for the Future

13. Diversity Update

- Response to WY&H Partnership BAME review report on health inequalities

To Approve

Presented by Suzanne Dunkley and Ellen Armistead

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title:	Response to West Yorkshire & Harrogate Partnership BAME Review Report on Health Inequalities
Authors:	Suzanne Dunkley, Director of Workforce & Organisational Development Ellen Armistead, Director of Nursing Anna Basford, Director of Transformation and Partnerships
Presented By:	Suzanne Dunkley, Director of Workforce & Organisational Development
Previous Forums:	None

Purpose of the Report

The paper updates the Board on the West Yorkshire & Harrogate (WY&H) Partnership BAME Review Report on Health Inequalities and CHFT's progress and actions in response to the recommendations in the report.

Key Points to Note

- The WY&H Partnership BAME Review Report on Health Inequalities was launched in October 2020 in response to the Public Health findings in relation to disparities in risk outcomes from COVID 19
- The report recommended a series of actions arising from the review
- CHFT contributed to the review and has progressed a series of actions in line with the recommendations in the report
- Further actions have been identified and are presented in this report for approval

EQIA – Equality Impact Assessment

The West Yorkshire and Harrogate report identifies a series of actions to ensure equality of outcome in relation to COVID 19. The report can be found here.

CHFT will continue to progress actions identified in the report as recommended to remove disparity in outcomes as a result of COVID 19.

Recommendation

1. The Board is asked to **note** the actions identified in the report published by WY&H, shown in section 2 of this report
2. The Board is asked to **note** the progress CHFT has made against actions to date, also shown in section 2 of this report
3. The Board is asked to **approve** and support actions to progress and improve our compliance with the recommendations identified in section 2 of this report
4. The Board is asked to **delegate** monitoring of CHFT's progress against the plan to Quality Committee (recommendation 4 in section 2 of this report) Workforce Committee (actions 1 and 2) in section 2 of this report and Transformation Programme Board (recommendation 3 in section 2 of this report) with an annual review presented back to Board in March 2022.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

4 MARCH 2021

RESPONSE TO WEST YORKSHIRE & HARROGATE PARTNERSHIP BAME REVIEW REPORT ON HEALTH INEQUALITIES

1. BACKGROUND

In June 2020, Public Health England (PHE) published their findings into a review of the disparities in risk outcomes of COVID 19. To build on this review, West Yorkshire and Harrogate (WY&H) Health and Care Partnerships launched a further review into the impact of COVID 19 on health inequalities and support needed for Black, Asian and Minority Ethnic (BAME) communities and staff.

The review was independently commissioned, and was chaired by Professor Dame Donna Kinnair, Chief Executive and General Secretary of the Royal College of Nursing (RCN.)

The review was co produced by leaders from the NHS, Local Government and the Voluntary and Community Sector (VCS) with the report findings launched in October 2020.

CHFT participated in this review and was supported by our Chief Executive, Owen Williams.

2. KEY PROGRESS AND ACTIONS

The report led to the publication of four key recommendations:

1. Improving access to safe work for BAME people in WY&H
2. Ensuring partnership leadership is reflective of the communities it serves
3. Population planning – using information to ensure services meet the needs of different groups
4. Reducing inequalities in mental health outcomes by ethnicity

An action plan from the report appears in Appendix A.

An analysis of CHFT progress against the main 4 recommendations appears below

Recommendation	CHFT progress and support
Improving access to safe work for BAME people in WY&H	~17% of CHFTs workforce is from a BAME background – higher than the local community average in Calderdale (10.3%) but lower than the community average in Kirklees (20.9%) All CHFT roles are subject to equality of opportunity CHFT's Health and Wellbeing Risk Assessment was co produced with our BAME network. It covers physical and mental health risk as well as any personal circumstances which may impact on the risk to colleagues of COVID 19 CHFT ran a local anti racism campaign as part of Black History month 2020

	Equality, Diversity and Inclusion role created and recruited to in 2019 offering support to our BAME network and colleagues Five year Inclusion Strategy launched 2020 Positive action recruitment for a Colleague Engagement Advisor conducted successfully in 2020 BAME Community Engagement colleagues appointed February 2021
Ensuring partnership leadership is reflective of the communities it serves	15.4 % of the Board of CHFT is BAME CHFT's leadership behaviours developed as part of our COVID Health and Wellbeing Strategy Disciplinary and grievances are reviewed and monitored as part of our WRES data 2 x Board appointments have adopted an inclusive approach to ensure that we attract BAME candidates with the skills and experience to fulfil the roles successfully CHFT's new recruitment strategy to launch July 2021, including positive statements for candidates thinking about choosing CHFT for their employer
Population planning – using information to ensure services meet the needs of different groups	The Trust has established real time data analysis of patient waiting lists in relation to index of multiple deprivation, ethnicity, and other protected characteristics. This analysis is being considered and discussed alongside clinical prioritisation to inform the Trust's elective recovery plans going forward. The aim is to ensure that for people who have had their care unavoidably delayed due to the pandemic that the recovery plans are informed by clinical need and support reduction in health inequalities. The Trust is taking forward work that aims to build relationships and listen to the views of local groups and communities in relation to their experience of accessing healthcare and to develop with them actions that can be taken to meet their specific needs and improve experience. The Trust is continuing to work with partners in Calderdale to support and contribute to actions agreed that have been informed by Calderdale Council Public Health team engaging with people living or working in Park ward and surrounding areas to address the disproportionate impact of Coronavirus on Black Asian and Minority Ethnic (BAME) communities.
Reducing inequalities in mental health outcomes by ethnicity	Progress under review

It is proposed that further work is done to progress improvement against the recommendations.

These proposed actions can be found below.

Recommendation	**Further actions**
Improving access to safe work for BAME people in WY&H	Roll out a Health and Wellbeing Risk Assessment 'light' for all colleagues who have not yet filled out CHFT's Health and Wellbeing Risk Assessment, focusing on physical risks only Carry out annual Health and Wellbeing Risk Assessments Support the development of an anti racism campaign developed at WY&H level Conduct a review our of our transformation programmes and recovery plans to ensure equality of opportunity for BAME groups Review our recruitment and advertising strategy to include bold and ambitious statements for equality of opportunity Report ethnicity breakdowns for all roles advertised at CHFT to the Workforce Committee, including application stage, longlisting stage and shortlisting stage
Ensuring partnership leadership is reflective of the communities it serves	CHFT's talent management strategy to include specific targets to achieve a reflective ethnic balance in all roles above band 6 within the next 5 years CHFT will nominate colleagues to participate in the WY&H Leadership Programme CHFT website and recruitment site to include a positive commitment from the CHFT Board to pledge to achieving a leadership reflective of our communities CHFT website and recruitment site to include features on some of our senior BAME colleagues confirming CHFT as an employer of choice A legal review of the proposed independent discrimination panels to preview all cases of racial discrimination in disciplinaries and complaints prior to progress through formal stages
Population planning – using information to ensure services meet the needs of different groups	To be confirmed
Reducing inequalities in mental health outcomes by ethnicity	Review the Mental Health Strategy to ensure issues around health inequalities are addressed.

	Enlist specialist Mental Health training support into ED that focusses on the needs of MH service users form BAME groups To develop an educational programme to deliver Culturally Competent Care To include on the Trust Health Inequalities work plan specific issues in relation to BAME patients with MH presentations

3. RECOMMENDATIONS

The Board is asked to note the actions identified in the report published by WY&H.

The Board is asked to note the progress CHFT has made against actions to date, identified in section 2 of this report.

The Board is asked to approve and support actions to progress and improve our compliance with the recommendations in the report outlined in section 2 of this report.

The Board is asked to delegate monitoring of CHFT's progress against the plan to Quality Committee (recommendation 4) Workforce Committee (actions 1 and 2) and Transformation Programme Board (recommendation 3) with an annual review presented back to Board in March 2022.

Suzanne Dunkley
Director of Workforce and Organisational Development

Ellen Armistead
Director of Nursing

Anna Basford
Director of Transformation and Partnerships

Keeping the Base Safe

14. Covid-19, Phase 4 Update

To Note

Presented by Helen Barker, David Birkenhead and Ellen Armistead

15. CHFT Fire Strategy

To Approve

Presented by Helen Barker

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title:	CHFT Fire Strategy
Author:	Stuart Baron, Associate Director of Finance
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	CHFT Fire Committee, WEB

Purpose of the Report

This Fire Strategy seeks to inform the Trust Fire Policy and acts as the primary control point for each of the individual building Fire Risk Assessments. These risk assessments take the physical and operational specifics of the Trust properties and apply the principles identified in this strategy and Trust Fire Policy.

This Fire Strategy adopts the structure and approach of NHS: HTM 05-03: Operational provisions which defines the national framework for fire safety in healthcare accommodation.

The overall objective of this Fire Strategy is to create one single and coherent approach to fire safety principles within the Trust. As such the document is broken into three core parts:

- The Trusts approach to fire management, identifying those key principles of fire safety;
- The activities which the Trust continue to implement; and
- The recommendations of this strategy to be embedded into the Trust Fire Policy and individual building Fire Risk Assessments.

Key Points to Note

The overall aim of this Fire Strategy is to define and highlight the actions which the Trust are taking in order to best ensure that all aspects of Trust fire safety are clearly documented. This will further assist in the ongoing fire safety management of the premises and ensure that any future alterations do not negate the original fire safety objectives.

This strategy heads the core principles of fire safety within the Trust and determines actions within the Trust Fire Policy as well as informing the individual building Fire Risk Assessments. All documents are interlinked and derive direction and information from each other.

This strategy follows the guidance set out in 'Firecode – Fire safety in the NHS: HTM 05-03: Operational provisions' sets out the contents for a model fire strategy document. This strategy applies this guidance and tailors this as to how the Trust operates and manages the risk of fire across its estate. The strategy identifies the need for specific overviews of each of our premises, clarity around who occupies the buildings, our evacuation strategy and methodology, our fire detection systems, fire spread, fire rescue service access, ventilation systems, special considerations and fire risk assessments.

From this position this Trust Fire Strategy has been established and key actions identified.

CHFT is committed to ensuring people's safety whilst on its premises. It will best achieve this by:

a) Providing a safe working environment which, as far as is reasonably practicable, removes or reduces the fire hazards present on site;
b) Provide a safe environment for patients and visitors;
c) Carrying out fire risk assessment to identify, manage and reduce risks;
d) Providing guidance to management and staff on operational requirements relating to fire safety i.e. instructions, training, evacuation drills, plans etc.;
e) Implementing measures to mitigate the impact of fire on life, safety and delivery of service, property and assets; and
f) Creating a 'fire aware' culture across the organisation to minimise the risk of an instance of fire.
g) Horizon scanning of future regulatory changes and ensure building schemes will, where possible, be compliant at opening and in the first 5 years of life.

Our Fire Strategy follows the guidance set out in 'Firecode – Fire safety in the NHS: HTM 05-03: Operational provisions' and covers;

a) Design Codes and Guidance;
b) Overview of Our Premises;
c) Building Occupants;
d) Evacuation Strategy and Methodology;
e) Automatic Fire Systems;
f) Means of Escape;
g) Fire Spread;
h) Fire and Rescue Service Access;
i) Ventilation Systems; and
j) Special Considerations.

The Fire Risk Assessments developed for each Trust facility will provide the specific guidance associated with fire safety in that building. They will be structured in line with HTM 05-03.

The Trust commissioned a comprehensive baseline audit, undertaken by Mott MacDonald. The recommendations from this will be reviewed by the Fire Committee and a defined schedule of works will be agreed with clarity of risk profile and associated priorities.

An ongoing programme of audits will be carried out by suitably experienced and qualified personnel. They provide a good opportunity for inter Trust collaboration, utilising the expertise and best practice of adjacent Trust to reinforce principles within CHFT. These will inform the annual fire safety capital programme.

New Clinical Infrastructure

As identified in the section "**Error! Reference source not found.**" above, all new clinical infrastructure will be developed and constructed in accordance to this Fire Strategy and in early consultation with and involvement of the Fire Safety Officer.

Formal horizon scanning of potential regulatory changes to fire safety requirements will be included in large capital schemes and, where possible, changes will be incorporated into the design to ensure compliance once completed.

Subject to the infrastructure under development, the Trust can consider (via the Trust Fire Safety Officer) whether the appointment of a specialist Fire Engineer could provide enhanced facility in conjunction with the infrastructure. With the complexities of clinical delivery, engineered solutions can provide stronger solutions than code or HTM compliance and these should be investigated early.

Adoption of Standards

As with all strategies, they remain constantly under review in order to accommodate new and emerging practices and standards.

The Trust Fire Officer and Fire Committee will be at the front of this ensuring that the Trust documentation is maintained in line with those developing fire management principles.

The following are the proposed next steps for the Trust to consider in relation to both the adoption of this Fire Strategy as well as other recommendations focused over the next five years:

a) Approve this Fire Strategy and associated Fire Policy which is due to be signed off at the Fire Committee in March 2021.
b) Develop and agree the Fire Investment Priorities to inform the Trust's Capital Programme over the next 5 years.
c) Agree the response to the audit and ensure implementation of any associated Action Plan.

EQIA – Equality Impact Assessment

The Fire Strategy 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 Strategy.

Calderdale and Huddersfield
NHS Foundation Trust

FIRE STRATEGY

2021 – 2026

To be approved by Trust Board of Directors
March 2021

compassionate care

Calderdale and Huddersfield
NHS Foundation Trust

Calderdale and Huddersfield Foundation Trust

Fire Strategy 2021-2026

Document Control

Document Particulars			
Strategy Reference No		XXXXX	
Executive Director Lead		Helen Barker, Chief Operating Officer	
First Version Issue Date		March 2021	
Latest Version Issue Date		March 2021	
Review Date		March 2026	
Approved By		Trust Board of Directors	
Change Record			
Date	**Author**	**Nature of Change**	**Version**
28 October 2020	Stuart Baron	Draft	0.1
22 January 2021	Keith Rawnsley	Draft to Issue	0.2
27 January 2021	Keith Rawnsley	Update for review comments	0.3
28 January 2021	Helen Barker	Update for final review	0.4
28 January 2021	Stuart Baron	Issue to Fire Committee	0.5
10th February 2021	Stuart Baron	Recommended to proceed to Trust Board for approval	Final

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Contents

Executive Summary

The Trust Board of Directors of Calderdale and Huddersfield NHS Foundation Trust ("the Trust") recognises the need for strong leadership associated with fire safety and the importance of strong fire management principles. This Fire Strategy document responds to that and seeks to set out those core principles upon which activity and the development of good practice shall be founded.

The Trust Board of Directors equally recognises the nature of their premises and how they each operate independently of one another, whilst combining to support the clinical care function for the local population. The properties vary in scale, age and condition, yet are each required to perform to a level which maintains safety for staff, patients and visitors.

Furthermore, new accommodation developments (or redevelopments) within the Trust need to conform to agreed standards, which this Fire Strategy seeks to define. Outputs for any and all new developments will include a Fire Risk Assessment undertaken at the design stage.

This Fire Strategy seeks to inform the Trust Fire Policy and acts as the primary control point for each of the individual building Fire Risk Assessments. These risk assessments take the physical and operational specifics of the Trust properties and apply the principles identified in this strategy and Trust Fire Policy.

This Fire Strategy adopts the structure and approach of NHS: HTM 05-03: Operational provisions which defines the national framework for fire safety in healthcare accommodation.

The overall objective of this Fire Strategy is to create one single and coherent approach to fire safety principles within the Trust. As such the document is broken into three core parts:

- The Trust's approach to fire management, identifying those key principles of fire safety;
- The activities which the Trust continue to implement; and
- The recommendations of this strategy to be embedded into the Trust Fire Policy and individual building Fire Risk Assessments.

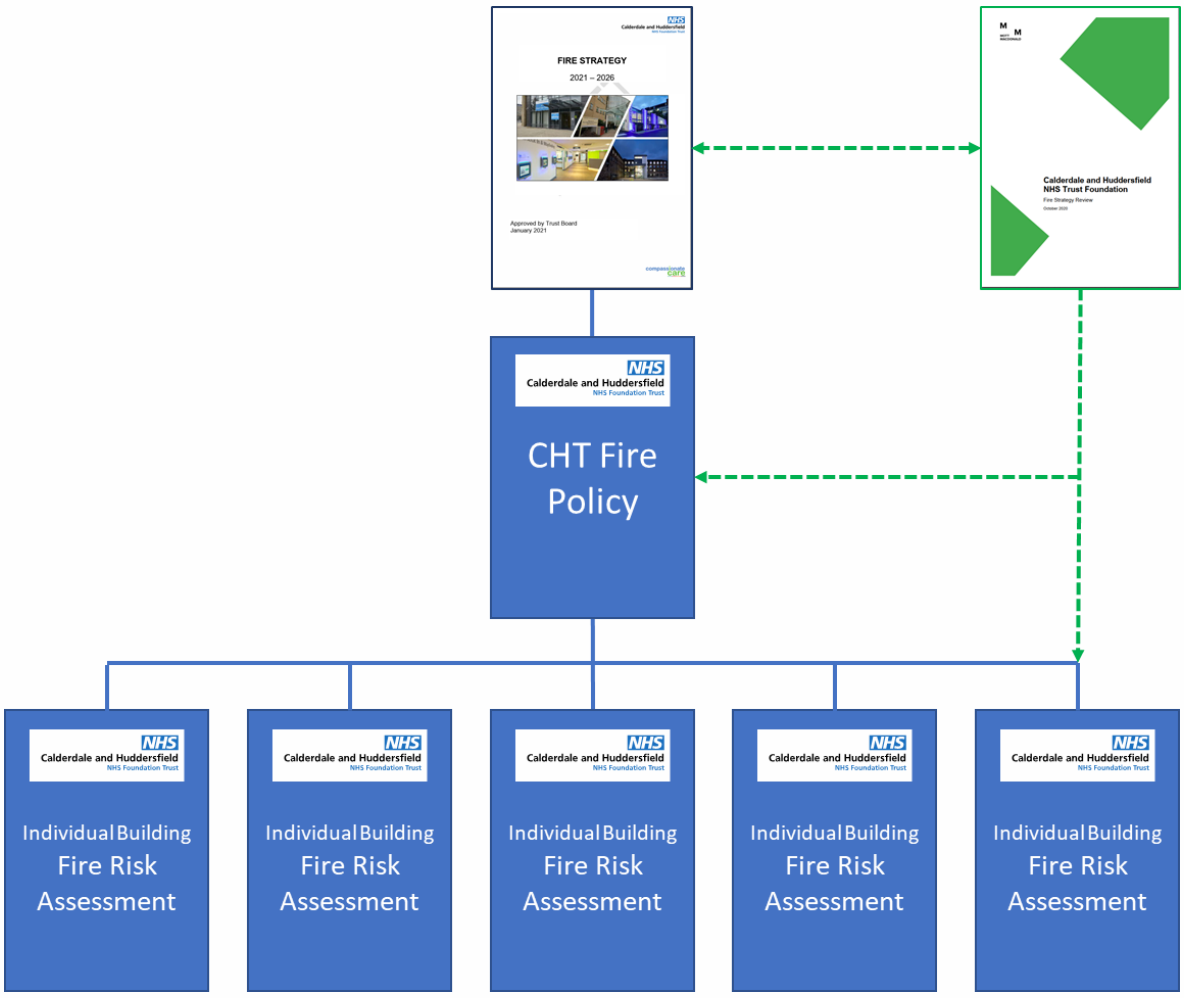
I. Introduction and overview

The overall aim of this Fire Strategy is to define and highlight the actions which the Trust are taking in order to best ensure that all aspects of Trust fire safety are clearly documented. This will further assist in the ongoing fire safety management of the premises and ensure that any future alterations do not negate the original fire safety objectives.

The Chief Executive (as “Responsible Person”) assumes overall responsibility for all fire safety matters within the Trust. Individual responsibilities of designated persons are outlined in the Trust Fire Policy. The Chief Operating Officer assumes responsibility at board level for all Fire Safety Policy matters.

It forms part of the suite of fire safety documentation developed by the Trust, in broad terms identified below.

Figure I.1 – Trust Fire Documentation Structure



In defining this current position and determining the five-year strategy of the Trust in respect of fire safety, an assessment was performed by Mott MacDonald in accordance with BS 9997 (Fire risk management systems – Requirements with guidance for use). This assessment has helped shape this strategy, will inform the Trust Fire Policy and reinforce the individual building Fire Risk Assessments. It also looks to provide an 'as is' position, an objective, independent review and shapes the next steps of this strategy. It is highlighted in green in Figure I.1

This strategy heads the core principles of fire safety within the Trust and determines actions within the Trust Fire Policy as well as informing the individual building Fire Risk Assessments. All documents are interlinked and derive direction and information from each other.

This strategy follows the guidance set out in 'Firecode – Fire safety in the NHS: HTM 05-03: Operational provisions' sets out the contents for a model fire strategy document. This strategy applies this guidance and tailors this as to how the Trust operates and manages the risk of fire across its estate. The strategy identifies the need for specific overviews of each of our premises, clarity around who occupies the buildings, our evacuation strategy and methodology, our fire detection systems, fire spread, fire rescue service access, ventilation systems, special considerations and fire risk assessments.

From this position this Trust Fire Strategy has been established and key actions identified.

II. Approach to Fire Management

CHFT is committed to ensuring people's safety whilst on its premises. It will best achieve this by:

a) Providing a safe working environment which, as far as is reasonably practicable, removes or reduces the fire hazards present on site;
b) Provide a safe environment for patients and visitors;
c) Carrying out fire risk assessment to identify, manage and reduce risks;
d) Providing guidance to management and staff on operational requirements relating to fire safety i.e. instructions, training, evacuation drills, plans etc.;
e) Implementing measures to mitigate the impact of fire on life, safety and delivery of service, property and assets; and
f) Creating a 'fire aware' culture across the organisation to minimise the risk of an instance of fire.
g) Horizon scanning of future regulatory changes and ensure building schemes will, where possible, be compliant at opening and in the first 5 years of life.

Our Fire Strategy follows the guidance set out in 'Firecode – Fire safety in the NHS: HTM 05-03: Operational provisions' and covers:

a) Design Codes and Guidance;
b) Overview of Our Premises;
c) Building Occupants;
d) Evacuation Strategy and Methodology;
e) Automatic Fire Systems;
f) Means of Escape;
g) Fire Spread;
h) Fire and Rescue Service Access;
i) Ventilation Systems; and
j) Special Considerations.

The Fire Risk Assessments developed for each Trust facility will provide the specific guidance associated with fire safety in that building. They will be structured in line with HTM 05-03.

Therefore, and as part of this Fire Strategy, each of the sections of the Firecode are included below in order to highlight the key principles which this Fire Strategy seeks to incorporate into the Fire Risk Assessments.

A. Design Codes and Guidance

This section identifies the design codes and guidance used in the development of the individual fire management strategies within Trust properties. When alternative or fire-engineered solutions have been incorporated, these are outlined in the individual property documentation and, where necessary, justified. As a Trust we have created a position where derogations associated with fire are not considered acceptable. However, where variations or deviations from recognised codes of practice exist, these are fully justified within those individual fire strategies.

The design codes listed below form the basis of this fire strategy and will be those which have and will shape the development of the Fire Risk Assessments at each of the Trust properties.

- NHS 'Firecode' Health Technical Memorandum (HTM's) 05-01; 05-02; 05-03;
- The Regulatory Reform (Fire Safety) Order 2005;
- Guidance for Fire Risk Assessment – Healthcare Premises (Guidance document 10, published by the Department of Communities and Local Governments);
- The Building Act 1984 as amended by Building Regulations 2013 – Approved Document 'B', Fire Safety, rewritten in 2019 & updated in 2020;
- The Health and Safety at Work Act 1974;
- The Management of Health and Safety at Work Regulations 1992 as amended 1999;
- The Workplace (Health, Safety & Welfare) Regulations 1992; and
- The Health and Safety (Safety Signs and Signals) Regulations 1996.

A full list of reference documents and associated links are provided within the Appendices to this strategy.

B. Overview of Our Premises

The Overview of Our Premises section shall provide a brief description of the premises included in the plan. This section will also address the Trust's responsibility for its own buildings but also for those properties where our colleagues operate in buildings and facilities that are not Trust owned.

Key elements of this section of the strategy include:

- Trust's responsibilities in owned, leased and accessed buildings;
- The signage in place to notify relevant parties (e.g. Fire Service, staff, patients) of key firefighting notices and equipment;
- The provision of first aid firefighting equipment and facilities;
- Methods of housekeeping across the site; and
- New building projects and major alterations

The detailed management of these are set out within the Trust's Fire Policy however the principles are set within this document.

B1 Trust's Responsibility

CHFT has a responsibility to manage fire safety within all properties belonging to the Trust (either owned or leased) and occupied by Trust staff. Where there are a number of services sharing the same building or site, the management of fire safety is undertaken by local Fire Wardens and managers.

Where there are Trust staff in host buildings (i.e. not managed by the Trust) this fire strategy seeks to best ensure they are familiar with the fire safety systems within the building. This will be achieved through accurate descriptions of those properties within the buildings' Fire Risk Assessment. The Trust will seek to ensure that Trust staff are aware of their own responsibilities when accessing host buildings through fire safety training.

Co-operation and co-ordination between host organisations and staff is important to ensure safe systems are in place in the event of a fire and these are to be identified as part of the building specific documentation.

Furthermore, those individual property Fire Risk Assessments will also contain details around:

a) Localised Emergency Plans;
b) Appropriate fire signage;
c) Provision of first aid firefighting equipment and facilities; and
d) Methods of housekeeping across the site.

B2 Trust accessed properties

In delivering our services the Trust accesses over 120 other properties that the Trust is not responsible for the maintenance and compliance of the building. This Fire Strategy acknowledges the Trust's responsibility as an employer to ensure that these buildings are safe and fit for purpose whilst ensuring that visiting colleagues are aware of their responsibilities upon entering these types of buildings.

It is noted that there are a number of 'outreach areas' which although not owned or leased by the Trust are frequented by staff for business purposes. For these outreach areas, the Trust have no legal obligation for fire safety of these buildings; however, the Trust has a duty of care to colleagues to ensure there are appropriate procedures within those buildings. This is also applicable to the Trust's community services who visit patients' homes.

The Trust shall manage this risk by providing access to annual fire awareness updates for all colleagues which covers individual's responsibilities for safe operation in all

environments. Trust employees have a responsibility to be aware of any local fire safety measures specific to the property they occupy.

B3 New building projects and major alterations

Where proposals for the alteration or change of use of existing Trust buildings, design and construction of new buildings or purchase/lease of additional premises are initiated by the Trust and delivered alongside the Capital Projects and Estates Planning Department of the CHS, the Trust's Estates and Facilities subsidiary and ENGIE for CRH.

The Trust recognises the requirement that adequate fire precaution measures form an essential part of the building management and design. This strategy highlights that the design specifications for the building must fully comply with the requirements of the Building Regulations Approved Document B Fire Safety and NHS Firecode HTM 05-02 Guidance. As identified earlier, where deviations or fire engineering principles are proposed, these shall be fully articulated within the design proposals.

In order to best comply with the recommendations of NHS Firecode HTM 05-01 together with the Trust Fire Safety Strategy, the Fire Safety Adviser should be consulted by the design team as soon as practicable to ensure that appropriate fire safety precautions are considered and included in the scheme.

As soon as detailed plans become available, the Trust Fire Safety Advisers must be consulted to ensure all appropriate fire precautions issues have been considered before the plans are submitted to Local Authority Building Control or to an Approved Inspector for formal approval under the Building Regulations.

C. Building Occupants

This section of the Fire Strategy identifies the requirement that the Trust fully consider the type of occupant likely to use the building and as a result, the provisions to be put in place. This includes matters such as training, personnel, fire safety activity and measures around materials stored within the facility (in relation to colleague safety) creating a bespoke 'people centric' approach to fire safety within our premises.

Assessments are to be based on the occupant descriptions contained in Health Technical Memorandum 05-02.

C1 Fire Safety Training

Fire Safety training for all staff is a legal requirement under the Health and Safety at Work Act 1974, the Management of Health and Safety at Work Regulations 1999 and the Regulatory Reform (Fire Safety) Order 2005.

The Trust recognises the importance of regular fire safety training and the Trust Fire Policy makes provision for training all employees. Training will also be provided on request for persons not employed by the Trust but at work on Trust premises (e.g. contractors, volunteers, Local Authority staff etc.).

In accordance with HTM 05-01, fire safety training is delivered to all staff at induction when joining the Trust. All staff are then required to undertake annual fire safety awareness training as part of the Essential Training. Local training is the responsibility of the relevant fire warden or line manager however fire safety training is provided tailored to each specific working environment.

Additional Fire Training will be provided to all Fire Wardens to ensure competency to deliver the role.

C2 Fire Wardens

Whilst fire wardens have no enforcing authority they will:

- Act as the focal point on fire safety issues for the local staff;
- Organise and assist in the fire safety regime within local areas;
- Lead the area response to fire or fire drill when warden for that shift;
- Raise issues regarding local fire safety with their line management; and
- Support line managers in their fire safety issues.

With the exception of Building 18 (which is not staffed) every building will have a number of trained Fire Wardens and this Fire Strategy will seek to best ensure that an appropriate amount of Fire Wardens are present across the Trust Estate.

This will be managed through Rostering for ward-based staff and through ensuring enough colleagues are trained as fire wardens in non-ward-based areas.

For information, the table below identifies the number of fire wardens identified within each of the Trust properties.

Building	Number of Fire Wardens per shift
Acre Mills OPD	At least 1 per floor
Acre Mills Personnel Building	Minimum of1 per floor
Beechwood Medical Centre	At least 1 per floor
Broad Street Plaza	At least 1 per floor
Building 18 Records Store	N/A
Calderdale Royal Hospital	At least 1 per ward/department
Equipment Loan Store and ICT Services (Elland)	Minimum of 1 per floor
Huddersfield Royal Infirmary	At least 1 per ward/department

Building	Number of Fire Wardens per shift
Park Valley Mills	At least 1 in the building
Pharmacy Manufacturing Unit	Minimum of 1 per floor
Spring Cottage Nursery	Responsibility of the Nursery Management Staff

C3 Dangerous Substances

The risk of storing highly flammable liquids, especially those stored in plastic containers, and the impact for safety of colleagues, can be reduced through careful management. At the time of this strategy the Trust has an increased storage capacity requirement for highly flammable alcohol-based hand sanitiser at CRH and HRI.

From a wider perspective the Trust will seek to:

- Ensure there are no potential ignition sources in the vicinity of the hand sanitiser store.
- Consider whether electrical equipment, including emergency lighting systems and fire alarms, are suitable for use in flammable atmospheres where vapours may accumulate.
- Account for the increased storage capacity through the COSHH risk management system; and
- Ensure stored quantities up to 50 litres are be stored in fire resisting cabinets while quantities greater than 50 litres should be stored in dedicated highly flammable liquids stores.

The Trust shall commission an annual Dangerous Goods audit conducted by the formally appointed dangerous goods safety adviser. This is governed and monitored by the Trust Health and Safety Committee which reports up to the Trust Board of Directors.

D. Evacuation Strategy and Methodology

This section of the Fire Strategy highlights the necessary principles associated with each of the Trust premises in relation to the evacuation strategies and methodologies that would be employed in the unfortunate event of a fire.

D1 Fire Alarm / Evacuation Procedure

Fundamental to this Fire Strategy is that CHFT can safely respond to the situation, buildings and its occupants in the event of a fire. To facilitate safety of all concerned, all evacuations will be led by Trust staff.

In the event of a fire the following types of evacuation will be adopted:

- **Immediate Evacuation** (used in off-site buildings, Acre Mill Out-patient department and community premises).
- **Progressive Horizontal Evacuation** in the hospital (the movement of patients and staff away from the fire on the same level through fire resisting doors towards a place of relative safety).
- **Delayed Evacuation** in areas where it is not appropriate to evacuate patients due to the level of risk that will be incurred (i.e. Theatres, ICU). In such situations the patients will be prepared for evacuation but only evacuated as a final resort.

Evacuation aids are to be made available in high risk areas where horizontal evacuation cannot be achieved and captured within the building Fire Risk Assessment. 'Ski Pads[1]' or other appropriate measures are to be located in fire escapes and used to aid vertical evacuation of patients down fire escape staircases. If horizontal evacuation is not an option; training in the use of evacuation aids shall be provided.

Each building and distinct area within a building shall complete a local evacuation protocol which defines places of relative safety or local assembly points, fire alarms information, evacuation aids available and requires the fire warden to identify any issues which may delay an evacuation. Methods of overcoming such issues must be agreed with the fire officer and the local fire warden / area.

All colleagues shall be familiar with the location of their assembly point on the site they work or places of relative safety.

D2 Fire Evacuation Training

Unannounced fire drills are to be carried out in areas where it is safe to do this. Where fire drills are not practicable, due to the unacceptable risk to patient care, suitable arrangements to give "effect" of fire drills are practiced by fire wardens and annual fire training is provided to all colleagues.

Personal Emergency Evacuation Plans (PEEP)

A PEEP must be documented for any patient group or colleague who has a disability that could affect their ability to evacuate their workplace. For in-patient areas the normal evacuation procedures shall cover the requirement for a PEEP. The PEEP details what additional measures or assistance is required in order to achieve safe evacuation.

The plans look to ensure the following:

- Hearing impaired individuals: In the event of staff working alone a visual or vibrating method of alert must be considered. This will be complimented by Fire Warden visual inspection of areas in the event of a fire.
- Temporary refuges: places of safety will exist within a building where people can wait for assistance. From here, the individual can be evacuated out of the building in a safe and controlled manner.
- Mobility Equipment: e.g. wheelchairs for ground floor level, vertical evacuation equipment for will be provided for upper floor evacuation.
- Sight impaired individuals: a buddy system to ensure they are accompanied to a place of safety or out of the building.

To ensure understanding and clarity of responsibilities and actions to take place in facilitating evacuation of Persons of Reduced Mobility, the Trust will have formalised arrangements through a Personal Emergency Evacuation Plan (PEEP) for each occupied building (if required).

E. Automatic Fire Systems

The Automatic Fire Systems section provides details of the fire alarm and detection system, automatic fire suppression systems and means for securing fire doors and exits electronically that are in operation across the estate.

Health Technical Memorandum 05-03 Part B – 'Fire detection and alarm systems' provides general principles and technical guidance on the design, specification, installation, commissioning, testing, operation and maintenance of fire alarm systems in healthcare premises. The Trust shall seek to fully comply with this guidance for the fire systems in place across its properties. Where deviation occurs, this shall be documented with mitigation measures approved by the Trust Fire Officer and ratified by the Fire Committee.

E1 Fire Detection and Warning Systems

Across its sites the Trust has a comprehensive level of detail for the fire alarm systems installed within each property. The following categories of system are in operation within each building:

- Level 1: A system installed throughout all areas of the building to offer the earliest possible warning of fire, so as to achieve the longest available time for escape.
- Level 2: A system designed to give a warning of fire at an early enough stage to enable all occupants, other than possibly those in the room of fire origin, to escape safely, before the escape routes are impassable owing to the presence of fire, smoke or toxic gases; with the additional objective of affording early warning of fire in specified areas of high fire hazard level and/or high fire risk.

- Level 3: A system designed to give a warning of fire at an early enough stage to enable all occupants, other than possibly those in the room of fire origin, to escape safely, before the escape routes are impassable owing to the presence of fire, smoke or toxic gases.

The Trust will continue to maintain existing fire provision in line with these identified necessary fire detection levels within each of the Trust Properties.

F. Means of Escape

This section of the Fire Strategy seeks to identify how occupants will exit accommodation in the event of a fire.

Details of specific travel distances shall be as set out in Health Technical Memorandum 05-02 and therefore it is inappropriate for this Fire Strategy to provide arbitrary definition here.

However, where these distances are exceeded a full explanation and justification is included in the property Fire Risk Assessment.

G. Fire Spread

The design, management and operational policies should allow all occupants to be able to move away from a fire to a place of safety as quickly as possible. As such, the primary provisions are as follows

G1 Compartmentation

Where appropriate and necessary, Trust premises are divided into a number of fire individual compartments; each compartment is designed to contain an outbreak of fire for at least 60 minutes enhancing fire safety for both occupants and accommodation. In some Trust premises, the configuration or use of accommodation may deem that no fire compartmentation is required or practical. These determinations would be highlighted within the building Fire Risk Assessment with any mitigating measures captured there also.

The principles of fire compartmentation would be captured as follows:

- Within each main fire compartment, certain high risk (hazard) rooms and intermediate walls and doors should be designed to contain fire for a period of not less than 30 minutes; and
- This structured fire compartmentation forms the basic fire protection for the occupants and the premises, but it must be emphasised within Fire Risk Assessments that effective compartmentation is dependent upon fire resisting doors being closed, thereby, maintaining integrity.

All parts of the premises are subject to Fire Regulations. Any proposal to materially change the structure, occupancy or use of any part of the premises will be referred to the Fire Officer for review and approval, ratified by the Fire Committee.

Where the Trust has identified areas of improvement to compartmentation in existing buildings they will seek, where able, to address these areas through capital investment. Where this is not possible, following risk assessment, it will ensure sufficient mitigating fire controls are in place, such as for example an L1 Fire Alarm System, additional Fire Wardens, Dry Riser installation, etc.

G2 Fire Resisting Doors

Fire doors are designed to resist the passage of heat and smoke for a specified period (minimum 30 minutes) and have two specific functions:

- To complete the fire resisting enclosure of fire tight compartments; and
- To protect escape routes (e.g. staircases and corridors) along which people may need to travel when evacuating the area.

Fire doors in all occupied buildings across site are to be checked weekly by the Fire Wardens and a more detailed inspection performed annually under the Fire Door Inspection Scheme.

H. Approach to Fire & Rescue Service Access

This section of the Fire Strategy contains details of the access and facilities for the Fire and Rescue Service. Where variations to the provision of the Firecode exist the Trust shall seek agreement with the West Yorkshire Fire and Rescue Service and these variations be documented within this strategy.

West Yorkshire Fire and Rescue Service (WYFRS) respond to any 999 call and the response is graded as to the information received from the caller, in our case switchboard.

In supporting the quick access for the Fire and Rescue Service will be met by Security or the building Fire Warden who will then take the fire crew to the location internally via the shortest route.

An operational information document is held by WYFRS detailing, access, facilities available, water supplies, fixed installations, etc. Risks are also noted from asbestos containing materials to radiation and MRI scanners, biohazards, medical gases, etc. Operational visits occur at their convenience.

If circumstances change, liaison takes place to update the operational information held.

I. Ventilation Systems

The Ventilation Systems section shall include information about the operation of the ventilation systems within the Trust premises, where the system should be allowed to continue to operate (for example operating departments) and any cause/effect information.

Each individual Trust premises and building will need to consider the operation of ventilation systems in the event of a fire. Such considerations are necessary to:

a) Prevent the spread of fire or smoke;
b) Prevent the propagation of fire; and
c) Aid the successful evacuation strategy for the building.

Each individual Fire Risk Assessment will seek to identify the specific operational parameters in order to facilitate the above.

J. Special Considerations

This section of the Fire Strategy seeks to outline any special considerations required.

There will be areas where the complexity of the building or clinical delivery will require a different fire intervention. These tend to be complex areas of estate, or accommodation which has specific needs for patients, staff or visitors. For example, the provision of large atria in buildings. For these a fire-engineered solution (a bespoke solution aimed at responding to a specific situation, approved by the Fire Officer and ratified by the Fire Committee) will be utilised to secure adequate fire safety provision. As such, a bespoke fire engineered solution offers a pragmatic solution to code compliance.

Fire engineering can provide an effective solution to complicated fire compliance activities. As Trust properties can often be complex in their operation, properly developed and implemented fire engineering solutions can provide similar or enhanced solutions to the issue. The Trust will utilise the Authorising Engineer to support this and seek approval from both local Building Control and the local fire authority.

In these circumstances the Trust Fire Officer will oversee the proposed solution in order to best ensure it meets the overarching requirements of this strategy and will reflect this within the localised Fire Risk Assessments.

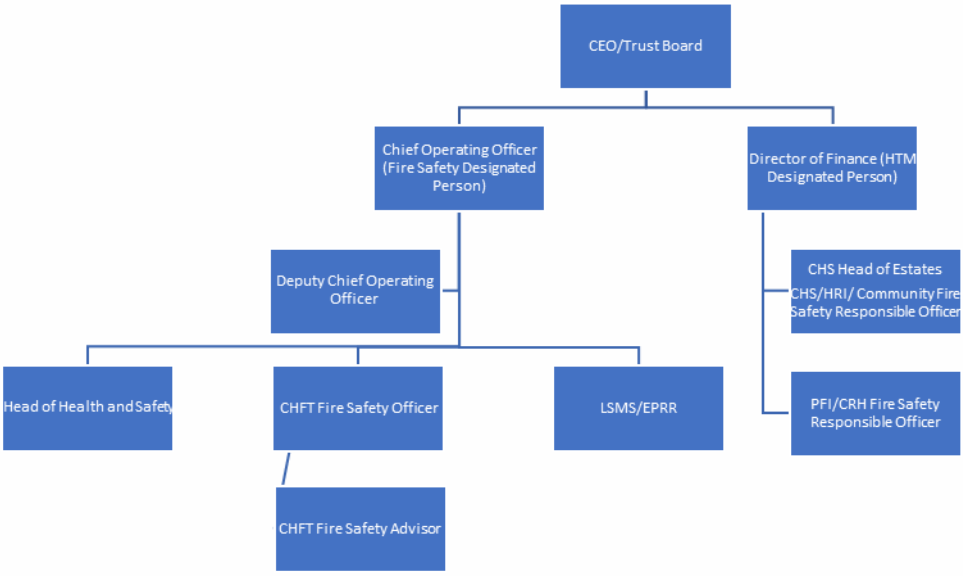
III. Fire Safety – Trust Enhancement Activity

In this section of the Trust Fire Strategy, the document seeks to identify current activities of the Trust in relation to fire safety measures.

A. Current Activity

A1. Fire Team Structure

The Trust has established a clear line of command and communication with regard to the maintenance of fire safety measures within Trust premises. An appointed Trust Fire Officer reports via the Deputy Chief Operating Officer into the Chief Operating Officer of the Trust who is the Trust Board of Directors Executive responsible for fire safety.



This structure empowers the Trust Fire Officer to implement measures which directly promote and support fire safety, with the technical competence of CHS to implement.

A2. Fire Investment Priorities

The Trust commissioned a comprehensive baseline audit, undertaken by Mott MacDonald. The recommendations from this will be reviewed by the Fire Committee and a defined schedule of works will be agreed with clarity of risk profile and associated priorities.

An ongoing programme of audits will be carried out by suitably experienced and qualified personnel. They provide a good opportunity for inter Trust collaboration, utilising the expertise and best practice of adjacent Trust to reinforce principles within CHFT. These will inform the annual fire safety capital programme.

B. New Clinical Infrastructure

As identified in the section “Approach to Fire Management ” above, all new clinical infrastructure will be developed and constructed in accordance to this Fire Strategy and in early consultation with and involvement of the Fire Safety Officer.

Formal horizon scanning of potential regulatory changes to fire safety requirements will be included in large capital schemes and, where possible, changes will be incorporated into the design to ensure compliance once completed.

Subject to the infrastructure under development, the Trust can consider (via the Trust Fire Safety Officer) whether the appointment of a specialist Fire Engineer could provide enhanced facility in conjunction with the infrastructure. With the complexities of clinical delivery, engineered solutions can provide stronger solutions than code or HTM compliance and these should be investigated early.

C. Adoption of Standards

As with all strategies, they remain constantly under review in order to accommodate new and emerging practices and standards.

The Trust Fire Officer and Fire Committee will be at the front of this ensuring that the Trust documentation is maintained in line with those developing fire management principles.

Amendments to either this strategy or corresponding Fire Policy will need to be approved by the Fire Committee ratified by the Executive Board. If considered appropriate, significant amendments will be brought to the Trust Board of Directors for approval.

D. Audit

In order to maintain the high standards which this strategy seeks to set, performance against this Fire Strategy will be audited on a bi-annual basis.

The audit will be carried out in line with BS 9997 (Fire risk management systems – Requirements with guidance for use) or any subsequent standards considered appropriate by the Trust Fire Committee.

Audits should be carried out by suitably experienced and qualified personnel and often provide a good opportunity for inter Trust collaboration, utilising the expertise and best practice of adjacent Trust to reinforce principles within CHFT. Additionally the Trust has access to a Fire Authorised Engineer who would be appropriate to carry out such reviews.

IV. Next Steps

Summary of Actions and Timescales

The following are the proposed next steps for the Trust to consider in relation to both the adoption of this Fire Strategy as well as other recommendations focused over the next five years:

a) Approve this Fire Strategy and associated Fire Policy.

b) Develop and agree the Fire Investment Priorities to inform the Trust's Capital Programme over the next 5 years.

c) Agree the response to the audit and ensure implementation of any associated Action Plan. To maintain the high standards which this Strategy seeks to set, performance against this Strategy will be audited on a bi-annual basis. The audit will be carried out in line with BS 9997 (Fire Risk Management Systems – Requirements with Guidance for Use) or any subsequent standards considered appropriate by the Trust Fire Committee.

Appendix A

References:

Reference	Document/Link
Health Technical Memorandum 05-01: Managing healthcare fire safety	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192065/HTM_05-01.pdf
Health Technical Memorandum 05-02: Firecode Guidance in support of functional provisions (Fire safety in the design of healthcare premises)	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/473012/HTM_05-02_2015.pdf
Firecode – fire safety in the NHS Health Technical Memorandum 05-03: Operational provisions Part A: General fire safety	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148476/HTM_05-03_Part_A_Final.pdf
Health Technical Memorandum 05-03 Part B – 'Fire detection and alarm systems'	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/148477/HTM_05-03_Part_B.pdf

Appendix B

Trust owned/leased properties

No.	Property	Description	Leased/Owned/PFI
1	Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield HD3 3EA	1960s NHS Hospital GIFA 65,000m²	Owned
2	Calderdale Royal Hospital, Salterhebble, Halifax HX3 0PW	2001 PFI Hospital GIFA 58,000m²	PFI
3	Acre Mill- Personnel building, Acre Street, Lindley, Huddersfield HD3 3EA	1900 Office Accommodation	Owned
4	Unit 17 &18 Acre Street, Lindley, Huddersfield HD3 3EA	1980s Warehouses	Owned
5	Huddersfield Pharmacy Specials Gate 2 Acre Mill School Street West Huddersfield HD3 3ET	2008 Manufacturing Unit	Owned
6	Park Valley Mills, The Lodge, Park Valley Mills, Meltham Road, Huddersfield HD4 7BH	Office Accommodation	Leased
7	Broad Street, 51 Northgate, Broad Street Plaza, Halifax, HX1 1UB	Office Accommodation / Health Centre	Leased
8	Beechwood Health Centre, 60B Keighley Road, Ovenden, Halifax, HX2 8AL	Health center clinic	Leased
9	Spring Cottage Nursery, Acre Street, Lindley, Huddersfield HD3 3EA	2004 temp accommodation for third party nursery	Owned
10	Acre Mill OPD, Z-Block, Acre Street, Lindley, Huddersfield HD3 3EA	Outpatient Facility and Administrative Building	Leased
11	Equipment Loan Store / THIS, Ainley Bottom, Elland HX5	Office and warehouse provision	Leased

16. Maternity Ockenden Review

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th March 2021
Meeting:	Public Board of Directors
Title:	Maternity Services Assurance Report
Author:	Karen Spencer, Associate Director of Nursing/Head of Midwifery Families and Specialist Services Division
Sponsoring Director:	Ellen Armistead Executive Director of Nursing/Deputy CEO
Previous Forums:	Quality Committee

Purpose of the Report

To present to the Board a suite of information that provides an oversight of key issues/ risks and challenges across Maternity Services.

To provide assurance that Maternity Services have responded to the Ockenden review recommendations and have plans in place to address all the actions in line with NHSE/I expectations.

Key Points to Note

Ockenden Report: The initial Trust submission in relation to 12 clinical priorities set out in the Ockenden Report. There were 2 areas where minor changes were needed to be put in place, one around the appointment of a NED lead and on in relation to the need to increase the number of safety huddles taking place on Labour ward. These have all been actioned and are in place.

To note the follow up submission of the Maternity Assessment and Assurance Template into NHSE/I. The template sets out actions to achieve the further recommendations of the Ockenden Review. Implementation of the action plan will be monitored through the Maternity Forum prior to reporting into Quality Committee.

Incidents: There were 384 incidents in Q3, 4 of which were categorised as Orange or Red incidents. The two orange incidents relate to neonatal events, one which meets the criteria for a HSIB investigation, the second is under investigation through Divisional Orange panel processes. The two red incidents relate to maternal incidents one is under investigation by HSIB and the second is under investigation through CHFT SI panel processes.

Healthcare Safety Investigation Branch (HSIB): Reports are at varying stages of cocomplete by HSIB. Resulting action plans will be monitored via FSS Divisional Orange Panel.

Continuity of Carer (CoC): Maternity services have continued to work towards the trajectory of 35% of women being booked on to a CoC pathway by March 2021, with 22% of all women booked on to a pathway in January 2021, however 40% of BAME women were booked onto a COC pathway.

Safety Dashboard: When compared and RAG rated with both Yorkshire and Humber and West Yorkshire and Harrogate data for Emergency and Elective Caesarean Section, third and fourth degree tears, postpartum haemorrhage and stillbirths CHFT maternity services are RAG rated Green.

Next Steps: To progress at pace work to achieve and exceed CoC targets. To progress at pace work around health inequalities.

EQIA – Equality Impact Assessment

There is significant evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor. In order to reduce this gap it is essential that services plan to target those at greatest risk. The Trust has made great progress around the Continuity of Carer.

Work is underway to explore the experiences of families from BAME groups.
More work needs to be undertaken to ensure service planning and improvement work streams include the needs of those at most risk.

Recommendation

The Board is asked to note the assurance provided within the report in respect of safety and quality of maternity services.

Maternity Service Update for Board

1. Ockenden Report

The Ockenden Report published on the 10th December reported on the emerging findings and recommendations from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust.

Following the publication NHSE advised that all providers were required to undertake a self-assessment against the 12 urgent clinical priorities highlighted by the Ockenden Report and submit this via the Local Maternity System (LMS) by 21st December 2020. CHFT were able to provide assurance that maternity services were compliant with all 12 clinical priorities. The submission can be found at Appendix 1.

There is also a requirement that providers submit a further assurance tool to assess their current position against the 7 immediate and essential actions in the Ockenden Report. The tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and support required. Submission of this tool was required by 15th February 2021; this can be found at Appendix 2.

One of actions within the assessment and assurance document is that trust's should have a plan to implement the perinatal quality surveillance model (PCQS model) the aims of which were set out by NHSE in December 2020 to improve oversight for clinical quality to ensure a positive experience for women and their families.

The five principles are:

- Strengthening trust level oversight for quality.
- Strengthening LMS and ICS role in quality oversight.
- Regional oversight for perinatal clinical quality.
- National oversight for perinatal clinical quality.
- Identifying concerns, taking appropriate action and triggering escalation.

At Trust level there are six requirements to strengthen and optimise board oversight for maternity and neonatal safety:

- To appoint a non-executive director to work alongside the board level perinatal safety champion to provide objective external challenge and enquiry.
- That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board.
- That all maternity serious incidents (SI's) are shared with trust boards and the LMS, in addition to reporting as required to HSIB.
- To use a locally agreed dashboard drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

- In collaboration with the LMS lead and the regional chief midwife, formalise how trust level intelligence will be shared to ensure early action and support for areas of concern or need.
- Review available guidance to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.

Trusts were also advised that they must create an independent senior advocate role which reports to both trust and LMS boards. The role of the advocate is to be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed. All providers are currently awaiting further guidance from NHSE with regard to the expectations of this role within trusts and the LMS.

Any action plans arising from the Ockenden Report assurance templates will be monitored through Maternity Forum and escalated via Divisional processes to PSQB.

2. Maternity Incidents and Complaints

Maternity services has a history of reporting high numbers of incidents with trigger lists embedded in each clinical area. This means that maternity services generate the largest number of incidents within the FSS Division. Low level (Green- no harm and Yellow- minimal harm) incidents are managed by the ward managers with the Divisional Patient Safety and Quality Lead spot check reviewing the all low level incidents generated on a random day each month to provide assurance that these low level incidents are graded and investigated appropriately.

Obstetrics/maternity incidents reported during Q3 2020/21 by type and date reported

	Oct 2020	Nov 2020	Dec 2020	Total
Abuse/Self-Harm	1	0	1	2
Appointment/Admission/Transfer/Discharge	37	30	25	92
Assessment/Treatment/Diagnosis	9	7	9	25
Blood Transfusion Related Issues	1	1	0	2
Confidentiality/Communication/Consent/IG	6	4	2	12
Health and Safety/Sharps/Security	2	3	2	7
Infection Control	2	2	1	5
Infrastructure/Resources/Staffing	19	7	1	27
Investigations (Scans/Tests/Results)	5	4	3	12
Maternity Incidents	66	74	46	186
Medication	1	1	3	5
Pressure Ulcers/Moisture Associated Skin Damage (MASD)	1	1	0	2
Safeguarding Adults	0	1	2	3
Safeguarding Children	0	2	1	3
Slips, trips and falls	0	1	0	1
Total	150	138	96	384

Obstetrics/midwifery incidents reported during Q3 by type and date recorded and level of investigation

	Green - Local review (no omissions)	Yellow - Local level investigation	Orange - Divisional level investigation	Red - Serious incident investigation	Total
Oct 2020	143	6	1	0	150
Nov 2020	124	11	1	2	138
Dec 2020	92	4	0	0	96
Total	359	21	2	2	384

The two incidents graded orange both relate to neonatal events. The October incident concerns a baby who received therapeutic cooling. This is currently under investigation by HSIB (case ID 2010-2618). The November incident relates to an unexpected admission of a term baby to the Neonatal Unit with hypoglycaemia (low blood sugars). The baby was later diagnosed with a hyperinsulinaemia (high levels of insulin), a metabolic condition which would have been undetectable until the baby became very unwell.

The incidents graded as red relate to a maternal death which is currently under investigation by HSIB (case ID 2012-2790), and a pregnant lady who received no antenatal care from her booking visit until 30 weeks of pregnancy when she was admitted to hospital. The case remains under investigation.

The maternity governance meeting is held weekly with a remit to review all term babies admitted to the Neonatal Unit, post-partum haemorrhages, third and fourth degree perineal tears, shoulder dystocia, any delays to Category 1 (immediate threat to the life of mother or fetus, delivery within 30 minutes) and category 2 Caesarean Sections (maternal or fetal compromise which is not immediately life threatening, deliver within 75 minutes). All the above complications are monitored through the maternity dashboard. The governance meeting also has oversight of all transfers from the Birth Centres to Labour ward.

All of these complications are predominantly no harm (green) or minimal harm (yellow) incidents however this weekly review documented within Datix ensures any learning is captured and disseminated and any concerns escalated to Divisional Orange Panel.

Healthcare Safety Investigation Branch

CHFT had reported a total of 17 cases to HSIB since December 2018. Of these 1 case was rejected as it did not meet the criteria for investigation, 6 cases have completed reports and action plans, 3 cases have completed reports and ongoing action plans and there are currently 5 open and ongoing investigations, 2 cases referred but awaiting acceptance by HSIB.

Of the 14 cases accepted by HSIB 7 are cooled babies, 2 maternal deaths, 4 Neonatal Deaths and 1 Stillbirth, the two cases awaiting acceptance are cooled babies.

All cases referred to HSIB are also reviewed through Divisional Orange Panel and CHFT's Serious Incident Panel to ensure that any immediate learning is identified and acted upon.

HSIB cases
Date of Incident: 17/09/20 **Criteria:** HIE/cooling **Update:** • Received for FAQ
Date of Incident: 14/09/2020 **Criteria:** Cooled Baby • Received for FAQ
Date of Incident: 17 October 2020 (referred on 26 October 2020) **Criteria:** Cooled Baby • Draft report in progress
Date of Incident: Nov 2020 **Criteria:** Maternal Death **Update:** Under investigation
Date of Incident: Jan 21 **Criteria;** Maternal Death **Update:** Information gathering

Maternity Complaints

Maternity services currently have 1 open complaint under investigation and within timescales.

3. Continuity of Carer

Continuity of Carer is a key component of Better Births with an aim of ensuring safe care based on a relationship of mutual trust and respect in line with the woman's decisions. Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally. It enables the co-ordination of a woman's care, so that a named individual takes responsibility for ensuring all the needs of a woman and her baby are met, at the right time and in the right place. It enables the development of a relationship between the woman and the clinician who cares for her over time and for the specific and personal needs to be responded to without variation.

Continuity of Carer is proving to be quite challenging to implement nationally. It has significant resource implications both financially and on the workforce as it requires a more fluid response to ensure the assigned midwife is available when the mother commences in labour therefore impacting on the work/life balance of staff.

Within CHFT focus has been given to the implementation of this standard for BAME mothers given the known link between poor perinatal.

The most recent MBRRACE- UK (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries) from Perinatal deaths for births from January to December 2018 suggests that compared to babies of white ethnicity babies of Black or Black British ethnicity remain at over twice the risk of stillbirth and at increased risk of neonatal mortality. Babies of Asian or Asian British ethnicity are at 57% increased risk of stillbirth and 59% increased risk of neonatal mortality compared to babies of white ethnicity.

There is also a direct relationship between higher levels of socio-economic deprivation and higher stillbirth and neonatal mortality rates with a 4% reduction in stillbirth rates for those living in the most deprived areas compared to a 13% reduction for those living in the least deprived areas. Rates for neonatal mortality are 2.20 per 1000 live births among babies born to mothers living in the most deprived areas and 1.23 per 1000 live births among those living in the least deprived areas.

There is an expectation that 35% of women who are 29 weeks pregnant in March 2021 will be booked on to a continuity of carer (COC) pathway. At January 2021 22% of women were booked on to a COC pathway, with a forecast of 24% by the end of March. However 40% of BAME women were booked onto a COC pathway. There is an expectation that 50% of women would be booked onto a COC pathway by March 2022 and 74% of women from a BAME background by 2024.

4. Key Safety Metrics

The maternity dashboard is produced monthly and metrics shared within the Yorkshire and Humber regional Dashboard.

The table below is a flavour of a selection of Q3 metrics.

Metric	Oct 20	Nov 20	Dec 20	Yorkshire and Humber av (Dec 20)	West Yorkshire and Harrogate av (Dec 20)	CHFT RAG rated for December 20
Total Births	412	354	365	706	2811	

No. Emergency Caesarean Sections	67 (16.5%)	74 (21.01%)	65 (17.86%)	17.6%	17.2%	
No.Elective Caesarean Sections	39 (9.61%)	41 (11.65%)	43 (11.81%)	12.6%	11.8%	
Induction of Labour as % of births	39.2%	46.9%	48.6%	36.2%	38.5%	
3rd/ 4th degree tears from normal birth	5 (2%)	3 (1.5%)	4 (1.8%)	1.9%	1.8%	
3rd/4th degree tears from assisted birth	2 (4.4%)	2 (4.8%)	0 (0%)	5.5%	5.8%	
Post-partum Haemmorrhage above 1500 mls	15 (3.6%)	13 (3.41%)	9 (2.2%)	3.9%	4.1%	
Number of Stillbirths	3	2	0	3	3	

As previously described those indicators where harm has occurred (3rd/4th degree tears, stillbirths, delays to Emergency Caesarean Section) are reviewed at the weekly Maternity Governance meeting and any immediate learning disseminated to the wider team.

5. Baby Friendly Initiative

Maternity Services achieved Gold BFI accreditation in 2019 in conjunction with Locala. This was the first combined Gold accreditation awarded nationally and recognises the work the CHFT Breastfeeding Specialist Midwives undertake to support women in hospital and the community via Baby Cafes.

Dr Marilyn Rodgers has been integral to promoting breast feeding across Calderdale and Huddersfield and she was recognised for this work in the Queen's New Year Honours list.

6. Service User Feedback

CHFT maternity services in conjunction with Mid Yorkshire Hospitals NHS Trust, CCG's Maternity Voices Partnership, local authorities and Huddersfield University worked together to conduct a survey of pregnant women's experiences through the first covid -19 surge and national lockdown. One of the most important findings was that women felt they didn't have enough information about what to expect from maternity services during the pandemic. An action plan from the findings of this survey is in place supported by the Maternity Voices Partnership, with an immediate action taken to develop and disseminate a letter to all women explaining how maternity services are operating at each stage throughout a woman's pregnancy journey.

7. Patient Experience

The covid pandemic fundamentally changed the way maternity services delivered both hospital and community based care moving from a service that welcomed families to be part of a woman's pregnancy journey to one that limited access to family members attending appointments and visiting new mothers and their babies after birth. Comments from the maternity covid survey (below) support the efforts of midwives and obstetricians during the first national lockdown.

"I was made to feel so safe and looked after. I bonded so well in that 24 hours with my baby. I'm so grateful for that time."

"To be honest I actually liked having a couple of days with no visitors. It felt so much more peaceful and less stressful for me. It would have been nice for my husband if he could have visited but I actually enjoyed the quieter less busy ward."

"Same level of care I would have expected prior to lockdown and the staff were so helpful and understanding in such difficult times as a first time mum without been able to have the support of our families"

"I felt really safe and things were well organised e.g. masks and social distancing in the waiting room. I feel all the staff are so lovely and have done their best and smiling lots even under the masks. I have felt well looked after every time I have been."

"I was worried about my husband not being with me but he was allowed in pretty much from the start when we knew I wasn't going home again and it didn't feel rushed for him to leave afterwards, we are so grateful for that."

Summary

Maternity services will always represent a high risk to NHS Trusts given the inherently risky nature of the clinical specialty. The service is a high reporter of incidents in line with the characteristics of an organisation that is focused on safety. There are systems and processes in place to monitor outcomes and address any opportunities for learning.

There is more to do in order to deliver and exceed the CoC targets.

The service must now focus on more targeted work to address the health inequality issues for women from disadvantaged communities.

Karen Spencer, Head of Midwifery
February 2021

Appendix 1

12 Clinical Priorities

December 21st 2020

To Carol McKenna,

On behalf of Calderdale and Huddersfield NHS Foundation Trust, I can confirm that we are compliant with the 12 urgent clinical priorities as mandated following the publication of the emerging findings and recommendations from the independent report into Maternity care at the Shrewsbury and Telford NHS Trust.

The 12 urgent clinical priorities and accompanying assurance statements are detailed below.

We will provide full assurance for the CHFT position by submitting the NHSE assurance assessment tool by January 15th 2021.

I can also confirm that the full Birth Rate Plus acuity tool has been commissioned by CHFT and completed, and the final report has been received recently. We are currently reviewing the findings with consideration for the future development of the maternity services at CHFT.

Yours sincerely,

Ellen Armistead
Executive Director of Nursing / Deputy Chief Executive on behalf of Owen Williams
Chief Executive

	Action required	Response
Enhanced safety	A plan to implement the Perinatal Clinical Quality Surveillance Model, further guidance will be published shortly	The use and completion of the Perinatal Mortality Review tool is well embedded within the CHFT Maternity services. When further guidance is received regarding the Perinatal Clinical Quality Surveillance Model the current guidance will be amended as appropriate.
	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	All maternity SI's and HSIB recommendations are shared with the Trust Board via the Quality Committee and the quality report. CHFT will adhere to the SI submission process determined by the West Yorkshire and Harrogate LMS. The regional Maternity Clinical Expert Group is a quarterly forum where learning from SIs is a standing agenda item.
Listening to Women and their Families	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	15 step challenge undertaken in February 2020. The Deputy Head of Midwifery, maternity lead for patient experience and the Trust Quality Improvement manager have a quarterly triangulation meeting with the chair of the MVP and MVP member/s (suspended due to Covid), where a joint action plan is developed and monitored. The joint action plan includes patient feedback from Friends and family responses within the Trust, feedback from women via the MVP and feedback from the CQC National Maternity survey. Monthly meeting commenced with the Deputy Head of Midwifery, maternity lead for patient experience and the MVP chair in November 2020 to review recent Covid 19 maternity survey and to develop and monitor agreed action plan. Other mechanisms for patient feedback include complaints and concerns, CHFT Better Birth Facebook page, Trust website 'Give us your view' and prior to Covid 19 Graffiti boards were available in all areas.
	In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director	Non-executive director Karen Heaton will support Ellen Armistead (Executive Director of Nursing/Deputy Chief Executive) in her role of Board Maternity Safety Champion. The non-executive director role will develop to comply with any further guidance when it becomes available.

	who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Further guidance will be shared shortly	
Staff Training and working together	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.	Consultant resident - Monday – Friday 8am – 8pm Consultant resident - Saturday and Sunday 8am – 7.30pm Currently, we provide a consultant-led multidisciplinary ward round every morning and a consultant–led board round at 1pm on weekdays and 5pm at weekends. With effect immediately, a further multidisciplinary consultant-led ward round will occur at 6pm at both weekdays and weekends, to further enhance the high level of consultant support already available out of hours. The Obstetric Registrar responsible for labour ward has regular board rounds with the Co-ordinator throughout the night and escalates concerns to the Consultant on call.
	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented, In the meantime we are seeking assurance that a MDT training schedule is in place.	Throughout Covid-19 monthly multi-disciplinary PROMPT training continued virtually and dates are planned for the year including identified faculty and delegates. We are meeting trajectories to achieve MIS compliance of 90% of each staff group trained. The existing training will be reviewed against the further guidance when published.
	Confirmation that funding allocated for maternity staff training is ring fenced and any CNST Maternity Incentive Scheme (MIS) refund is used exclusively for	All funding for maternity staff training is held by the Family and Specialist Services Division and ring fenced for maternity services via the normal budgetary processes. Due to reduction in births at CHFT the MIS refund was re-invested into maternity staffing to maintain staffing

	improving maternity safety	levels and ultimately maintain safety for the women and their families who choose to birth at CHFT.
Managing complex pregnancy	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place	All women with complex history have a name consultant lead. Through the electronic patient record system (K2 Athena/Guardian) all women are risked assessed at booking. Any women with a risk factor has a pink flower automatically generated and attached to her record, this highlights to all staff accessing the woman's records that she has a risk factor. A monthly audit will be undertaken on the first of each month to review compliance that all women with complex pregnancies have a named consultant. The audit report and any subsequent action plan will be presented at the monthly maternity forum.
	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	The HOM is a member of the Yorkshire and Humber Maternity Clinical Expert Group, where maternal medicine is a standing agenda item. There has been in the initial scoping of regional medicine centres and CHFT remain involved in discussions around the proposed hub and spoke models. In addition, there is an established referral pathway to Leeds Teaching Hospitals for women requiring maternal medicine outside the scope of that provided at CHFT.
Risk Assessment throughout pregnancy	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	A risk assessment is undertaken at every antenatal contact; a SOP for ongoing risk assessment and preferred place of birth is in place. A quarterly audit will be undertaken to review compliance that all women have had a risk assessment completed at each antenatal visit. The audit report and any subsequent action plan will be presented at the maternity forum.
Monitoring Fetal Wellbeing	Implement the saving babies lives bundle. Element 4 already states there needs to be one	Named Consultant lead – Julie Goddard Name midwife lead – Nicola Paull

	lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines	Weekly multidisciplinary training sessions are undertaken and cases are reviewed at the weekly multi-disciplinary clinical governance meeting with learning shared across the maternity service. We have a 'saving babies lives' lead for the implementation of the care bundle and we are meeting trajectories to achieve MIS compliance.
Informed Consent	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website.	The CHFT Maternity service website is accessible through the CHFT internet page and is updated regularly allowing access to patient information. The website and maternity information leaflets are constantly evolving with support from the local MVP.

Appendix 2
Maternity Services Assessment and Assurance Template

Section 1

Immediate and Essential Action 1: Enhanced Safety
Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Link to urgent clinical priorities:
(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that we are learning at system and trust level?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?
Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.						

Maternity Dashboard in place which is shared with Obstetricians and midwifery leads and reviewed through maternity forum. Maternity clinical governance meetings review all cases of harm, for example PPH, shoulder dystocia, unexpected admission to neonatal unit with escalation to Divisional orange panel to review	Combination of review of all cases of clinical harm and clinical dashboard used to highlight areas for improvement or evidence area of good practice. For example accurate recording of measured blood loss at delivery rather than estimated to provide accurate rates of PPH recording.	Reduction in third and fourth degree tear rates as a consequence of OASI training, measured blood loss following delivery leading to accurate measurement of blood loss and impact on PPH rates Reduction in avoidable harm/SI's	LMS to provide details of arena for sharing and reviewing maternity Dashboards across the region	LMS	None	N/A
External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.						
100% of qualifying cases referred to HSIB	External review and investigation – open and honest culture, promoting local and national learning	Recommendations implemented Reduction in avoidable perinatal harm/SI's	The Trust will seek to secure external review of all serious incidents that are not HSIB reportable	HOM March 2021	None	All SI's reviewed by Trust SI weekly panel All SI's shared with CCG
All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months						
All maternity SI's and HSIB recommendations are shared with the Trust	Trust SI panel aware of all SI and HSIB cases within maternity	HSIB action plans monitored through Divisional Orange Panel and final sign off at Trust SI panel	Ensure overview of current and ongoing maternity	LMS HOM/Board Safety Champion	None	Weekly SI panel meeting outcome shared

Board via the Quality Committee and the quality report. West Yorkshire and Harrogate LMS Maternity Clinical Expert Group is a quarterly forum where learning from SIs is a standing agenda item.	Open and honest culture		SI's including HSIB cases is shared with LMS and trust Board every 3 months. LMS to provide details of reporting mechanism HOM to work with Board Maternity Safety Champion to ensure process for Trust Board overview of cases	LMS HOM/ Board Safety Champion		All SI's shared with CCG
A plan to implement the Perinatal Clinical Quality Surveillance Model (PCQS model)						
Model released 18th Dec 2020 Perinatal Clinical Quality Surveillance Model reviewed and gap analysis completed	The Trust will use the PCQS model to strengthen Trust Board level oversight of perinatal clinical quality promoting local learning The Trust will use the PCQS model to strengthen LMS level oversight of perinatal clinical quality promoting shared regional learning	Recommendations implemented Reduction in avoidable perinatal harm/SI's	Maternity dashboard to be reviewed and strengthened in line with model and local requirements The Trust will seek to secure external review of all serious incidents that are no HSIB reportable	HOM/DHOM March 2021 HOM March 2021	None	Current governance process Weekly clinical governance meeting Divisional Orange panel Trust SI panel Referrals to HSIB Completion of PMRT
Immediate and essential action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard. • Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.						

- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.

- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?
Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.
(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.

What do we have in place currently to meet all requirements of IEA 2?	**How will we evidence that we are meeting the requirements?**	**How do we know that these roles are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome.						
CHFT will be advised and develop the independent advocate role when we have received further information from the national team, which we	Independent advocate in post	Women report feeling supported when they raise concerns	Await advice from national team	HOM	Guidance from national team	Seek support from trust patient experience lead when women express that they need

are aware is in development.						additional support.
Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions. The non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard.						
Non- executive director in place and has attended first meeting with Board Safety Champion, HOM and DHOM	Named non-executive board member attends safety champion meetings and has oversight of maternity and neonatal services	All staff able to identify safety champions and non-executive director Non-executive director able to voice staff and service users feedback	Share names and roles of safety champions and non-executive director Non-executive director meet with MVP and staff	HOM Feb 2021 Non-executive director April 2021	N/A N/A	

Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services.						
Quarterly triangulation meeting with the chair of the MVP and MVP member/s (suspended due to Covid), where a joint action plan developed and monitored. The joint action plan includes patient feedback from Friends and family responses within the Trust, feedback from women via the MVP and feedback from the CQC National Maternity survey. Monthly meeting commenced in November 2020 to review recent Covid 19 maternity survey. Other mechanisms for patient feedback include complaints and concerns, CHFT Better Birth Facebook page, Trust website 'Give us your view' and prior to Covid 19 Graffiti boards were available in all areas. MVP meeting	The joint action plan includes patient feedback from Friends and family responses within the Trust, feedback from women via the MVP and feedback from the CQC National Maternity survey. Covid 19 maternity survey and agreed action plan. MVP minutes	Improved FFT response rate FFT score of 97% or more of extremely likely /likely to recommend Improved CQC maternity survey responses Action plan completed Reduced number of complaints Increase number of compliments	Continue to work with MVP chair Increase service user feedback from minority groups	DHOM Chair MVP/DHOM		

Immediate and essential action 3: Staff Training and Working Together
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	**What are our monitoring mechanisms?**	**Where will compliance with these requirements be reported?**	**What further action do we need to take?**	**Who and by when?**	**What resource or support do we need?**	**How will we mitigate risk in the short term?**
Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place						
Throughout Covid-19 monthly multi-disciplinary PROMPT training continued virtually. Dates are planned for the year including identified faculty and delegates	Training compliance overseen by Patient Safety and Quality Midwife to meet requirements of Maternity Incentive Scheme	Compliance reported at maternity forum and managed by patient safety and quality midwife	None	N/A	None	Monitor compliance through Maternity Forum

Not currently validated through the LMS but CHFT will adhere to process put in place by LMS Further guidance will be published regarding MDT training Dates are planned for the year including identified faculty and delegates	The existing MDT training will be reviewed against the further guidance when published Evidence of training schedule	PROMPT faculty meeting PROMPT faculty meeting	Agreed validation process through the LMS Review of guidance when published None	LMS PROMPT faculty N/A	None None	Continue current MDT training N/A
Working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.						
A multidisciplinary consultant-led ward round will occur at 6pm at both weekdays and weekends, to further enhance the high level of consultant support already available out of hours.	Safety huddle occurs prior to ward round and this is documented Consultant resident - Monday – Friday 8am – 8pm Consultant resident - Saturday and Sunday 8am – 7.30pm	N/A	None	N/A	N/A	N/A
Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only						
All funding for maternity staff training is held by the Family and Specialist Services Division and ring fenced for maternity services via the normal budgetary processes.	Individual training requirements identified at Appraisal and linked to maternity priorities and requests for external funding managed through Divisional SMT	Managed through appraisals and training needs analysis	None	N/A	N/A	N/A

Immediate and essential action 4: Managing Complex Pregnancy
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre.

- Women with complex pregnancies must have a named consultant lead
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	**What are our monitoring mechanisms?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.						
All women with complex history have a name consultant lead. Through the electronic patient record system (K2 Athena/Guardian) all women are risked assessed at booking.	A monthly audit will be undertaken on the first of each month to review compliance that all women with complex pregnancies have a named consultant	The audit report and any subsequent action plan will be presented at the monthly maternity forum.	None	N/A	N/A	N/A

Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.						
The HOM is a member of the Yorkshire and Humber Maternity Clinical Expert Group, where maternal medicine is a standing agenda item.	There has been in the initial scoping of regional medicine centres and CHFT remain involved in discussions around the proposed hub and spoke models.	Yorkshire and Humber Maternity Clinical Expert Group	Continue to be involved with Yorkshire and Humber Maternity Clinical Expert Group scoping and discussions	HOM/DHOM	None	Case by case discussions with Leeds
Immediate and essential action 5: Risk Assessment Throughout Pregnancy Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway. • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.						
Link to Maternity Safety actions: **Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?**						
Link to urgent clinical priorities: **a)** A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance.						
What do we have in place currently to meet all requirements of IEA 5?	**What are our monitoring mechanisms and where are they reported?**	**Where is this reported?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance						
Formal risk assessment document in place used by both midwives and	A quarterly audit will be undertaken to review compliance that all	The audit report and any subsequent action plan will be presented at the	None	N/A	N/A	N/A

Obstetricians that ensures risk assessment at every contact. The risk assessment is a scoring tool with guidance for escalation within document and covers suitability of place of birth.	women have had a risk assessment completed at each antenatal visit. The audit report and any subsequent action plan will be presented at the maternity forum.	maternity forum.	None	N/A	N/A	N/A
Within EPR documented safeguarding risk assessments in place at every antenatal contact.	Reports can be generated through electronic patient record. Where any harm has occurred timeline of events produced for Orange panel which includes review of appropriate and ongoing risk assessment	Where harm has occurred reported through Orange panel and investigation process. Ability for ad hoc reporting through EPR	Explore with K2 to create a "Hard Stop" at each antenatal contact that will force professionals to review current maternal and fetal risks	EPR Midwife March 2021	N/A	Audit undertaken quarterly

Immediate and essential action 6: Monitoring Fetal Wellbeing

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.

What do we have in place currently to meet all requirements of IEA 6?	**How will we evidence that our leads are undertaking the role in full?**	**What outcomes will we use to demonstrate that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.						
Professional development Lead Midwife and Obstetric Lead Consultant both lead on fetal monitoring training.	Involved in all aspects of role and have dedicated time. Lead midwife dedicated 15hours	Reduction in avoidable harm and shared learning	Ensure Obstetric lead has dedicated time planned to run departmental meetings and disseminate training	Escalate to CD at job planning	None	Fetal monitoring training included in PROMPT and weekly MDT training sessions undertaken by the lead midwife
Lead Obstetrician and lead midwife attend weekly maternity clinical governance meeting where cases in which harm has occurred are reviewed.	Minutes of meetings	Reduction in harm as a result of failure to recognise deterioration in fetal wellbeing.	None	N/A	N/A	N/A
Weekly multidisciplinary training fetal monitoring sessions by lead midwife	Attendance sheets and presentations	Role specific training compliance data	Lead obstetrician to also lead MDT training – dedicated time	CD	N/A	Weekly multidisciplinary training fetal monitoring sessions by

K2 fetal monitoring training is completed by midwives and obstetricians	Compliance of training		None	N/A		lead midwife N/A

Immediate and essential action 7: Informed Consent

All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.

All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care

Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care

Women's choices following a shared and informed decision-making process must be respected

Link to Maternity Safety actions:

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?

Link to urgent clinical priorities:

a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.

What do we have in place currently to meet all requirements of IEA 7?	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected						
All clinical guidelines		Women feel informed and	Working with K2 to create a	EPR midwife		

available on Trust Intranet. At booking all women receive information on place of birth. For those women who opt for Caesarean Section (maternal choice) receive an appointment to discuss with a Consultant Obstetrician		have access to information	platform hosted in the cloud which women can access from the point they know they are pregnant. This will generate a referral for booking and enable women to access local and national health information, leaflets and electronic links. Also incorporates personalised care plan. The platform has the ability to work with Google Chrome on the woman's electronic device to auto translate into the language of her choice	and K2 – plan for Go Live March 21		
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website						
The CHFT Maternity service website is accessible through the CHFT internet page and is updated regularly allowing access to patient information. The website and maternity information leaflets are constantly evolving with		Women feel informed and have access to information	Working with K2 to create a platform hosted in the cloud which women can access from the point they know they are pregnant. This will generate a referral for booking and enable women to access local and national health information, leaflets and electronic links. Also incorporates	EPR midwife and K2 – plan for Go Live March 21		

support from the local MVP.			personalised care plan. The platform has the ability to work with Google Chrome on the woman's electronic device to auto translate into the language of her choice.			

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Can you demonstrate an effective system of clinical workforce planning to the required standard?						
Consultant job planning is an annual process, and all job plans should be recorded on Allocate (electronic medical rostering). There is an individual, Directorate and MDO sign off process. We manage short and long term sickness /other absences – e.g. appointing a suitable locum, internal cover arrangements, annual and study leave management etc.	Use RCOG guidance from a number of years ago about consultant numbers required depending on multiple factors including number of deliveries, complexity of population cared for etc. One of the few units with a document which defines duties of consultants during hot week and when on call.	Link to Risk register for highlighting significant staff shortage concerns, escalation through Divisional Governance structure	The plan going forward is for introduction of Activity roster and Activity manager (electronic rostering) which would enable us to have an overview of workforce availability.	CD	N/A	N/A

Can you demonstrate an effective system of midwifery workforce planning to the required standard?						
Birth Rate + report received into organisation in November 2020. This has identified number of midwives required to meet 51% COC. Staffing gap added as a cost pressure to Divisional planning. COC roll out plan shared with LMS. Twice yearly trust Wide Nursing and Midwifery staffing Hard truths review in place.	Current Birth Rate + report available based on activity and acuity for 2020.	COC roll out plans shared with LMS. When reporting mechanism into board established COC will form part of Board report.	Continue to develop Board reporting mechanism	HOM Board Maternity Safety Champion Early 2021	None	Currently report into Board sub committees eg Quality Committee, SI Panel

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

HOM responsible to accountable to Deputy Chief Executive
Currently do not have a Director of Midwifery but HOM role sits within senior nursing and midwifery team across the organisation and is responsible for strategic development of midwifery services whilst Deputy HOM focuses on operational delivery of maternity services.

No Consultant Midwife but do have a Midwifery Reader who supports and advises across a range of maternity initiatives combining a background in education and research with clinical practice to improve outcomes for women and families.

We have a range of specialist portfolios including infant feeding, bereavement, substance misuse, perinatal mental health, safeguarding. All Band 7 midwives and above have been invited to join the in house leadership development programme, we have professional midwifery advocates at all grades across maternity services.

NICE GUIDANCE RELATED TO MATERNITY						
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.						
What process do we have in place currently?	**Where and how often do we report this?**	**What assurance do we have that all of our guidelines are clinically appropriate?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**
Local guidelines comply with NICE guidance where available. When new NICE guidance is made available guideline author is sent new NICE Guidance to update local guidance. Where we are non compliant this is recorded on the Compliance Register.	Reported monthly through maternity forum	Reviewed through maternity forum which is held monthly	None	N/A	None	N/A

17. Nursing and Midwifery Staffing Hard Truths Requirement

Presented by Lindsay Rudge, Deputy Director of Nursing

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title:	Nursing and Midwifery Safer Staffing Report
Author:	Lindsay Rudge - Deputy Director of Nursing Andrea Dauris - Associate Director of Nursing – Corporate
Sponsoring Director:	Ellen Armistead - Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	None

Purpose of the Report

In response to the Francis Report (2013) the Chief Nursing Officer for England and the Care Quality Commission made clear that all hospitals should publish information about the number of nursing and midwifery staff working on each ward. This includes the percentage of shifts meeting safer staffing guidelines. There is an expectation Boards will receive a Safer Staffing report in order to be assured that measures are in place to protect patients from harm. This has been in place at CHFT since 2014.

The purpose of this report is to provide assurance to the Board of Directors that the nursing and midwifery workforce has been reviewed in line with national guidance. The report details the ongoing response to the Covid-19 pandemic and the strategy to address key issues such as patient safety, safer staffing and quality. We take the care of our patients very seriously and already have several mechanisms in place to ensure that our wards are safely staffed.

Key Points to Note

The following details what are considered the key points to note:

- The risks the Trust carries if it fails to provide safe staffing numbers across all wards. Mitigation through the implementation of robust staffing plans, risk assessments, deployment of additional healthcare assistants and recruitment and retention plans.
- The current reality, particularly in the context of the pandemic response.
- Nurse recruitment and retention continues to be a challenge; however, the Trust is being proactive and innovative in terms of recruitment solutions.
- The continued focused leadership to support this agenda.

Calderdale and Huddersfield NHS Foundation Trust

EQIA – Equality Impact Assessment
Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non-English speakers and being a member of a social minority (e.g. migrants, asylum seekers, and travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing staff required to provide safe care. Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the scoping document. Evidence shows us a direct correlation between quality, safety and patient experience and nurse staffing levels. Failure to have staffing in place that meets the care needs of patients means there is a potential risk of poor outcomes for all service users. Should this be the case then people from protected characteristic groups could have been disproportionally impacted given the evidence to suggest a less favourable experience for people from these groups across all NHS services.
Recommendation
The Board is asked to note the content of the report for assurance.

Calderdale and Huddersfield NHS Foundation Trust

CONTENTS	
1.0	Introduction
2.0	Safer Staffing
3.0	Sickness and Absence levels
4.0	Hard Truths data
5.0	Strengthening the escalation and reporting arrangements for Quality and Safety
6.0	Recruitment and Registered Nurse Trajectory
7.0	Recommendations

1.0. INTRODUCTION

NHS England and the Care Quality Commission (CQC) issued guidance in 2014 detailing their ongoing commitment to publishing staff data, referred to as "Hard Truths". The choice of "Hard Truths" was a key message following the Francis report in 2013 and the public enquiry into the Mid Staffordshire NHS Foundation Trust. Whilst a clear call for greater openness and transparency there is also a breath of research that has long demonstrated that staffing levels are linked to the safety of care and that staff shortfalls increase the risks of patient harm and poor-quality care.

The purpose of the report is to provide information as set out by the Hard Truths for the reporting period July to December 2020.

In addition to providing the Board with key nursing and midwifery data describing staffing levels, information will also be reported against safe nursing indicators including patient experience, pressure ulcers and falls

The paper will also review mitigations, recommendation and how this correlates with the Trust priorities.

CHFT's Reality

2.0 SAFER STAFFING

The challenges to the NHS workforce are well recognised and reported on by the government and national bodies. However, within the overall picture, the most urgent challenge is in relation to the nursing workforce where the government has pledged to have an additional 50,000 more nurses working in the NHS by 2024/25. This is in response to a current national shortage of more than 45,000 nursing and midwifery vacancies.

The national picture is reflected locally with the Trust running circa 150 qualified vacancies for quite some time. During the Covid-19 pandemic the Trust has seen this gap broadening as a direct consequence of the Trust providing a number of enhanced workforce models which has further compounded the challenge. The requirement for the enhanced workforce models was to meet increasing demand within certain clinical areas for example: critical care, in addition to creating Covid secure patient pathways that reflected the national infection prevention and control guidelines. This resulted in staff being deployed from other clinical areas to support the increased workforce models to safely meet the needs of patients.

Adding to the challenge in following the 1st wave of the pandemic was the expectation to restart more elective work to prevent waiting lists becoming unmanageable and the impact this may have on clinical outcomes. Additional workforce that had been released in wave one was retracted. In order to manage the complexity of the staffing

resource the Nursing and Midwifery Workforce Safer Staffing Group set up in wave 1 was reinstated. The group's role was to ensure we were prepared for the further surge and developed enhanced workforce models, to ensure the right skills, would be in the right place at the right time. This included:

- Enhanced Critical Care beds
- Enhanced Respiratory floor including the Red Squad
- HRI Acute floor including the Red Squad
- Enhanced Emergency Departments – cross site
- HRI Green Surgical pathway (located on Birth Centre)
- CRH Ward 4d

The totality of the impact in preparing for a further surge and phase 3 planning resulted in the below workforce position (Figure 1) as set out on the 2nd November 2020.

Additional Phase 3 Posts By Staff Group	No. of Posts	Already In Post (M6)	Recruitment Required
	FTE	FTE	FTE
Allied health professionals	5.71		5.71
Career/Staff grades			0.00
Consultants (including Directors of Public Health)	7.00		7.00
Health Care scientists	3.50		3.50
NHS Infrastructure support	34.00		34.00
Registered nursing, midwifery and health visiting staff	109.93	(12.69)	97.24
Support to allied health professionals	1.50		1.50
Support to nursing staff	104.39	(6.30)	98.09
Support to STT & HCS Staff	1.73		1.73
Grand Total	**267.76**	**(18.99)**	**248.77**

(Figure 1)

Illustrating an additional registered nursing and midwifery vacancy position of 97.24 FTE, alongside the 150 qualified vacancies the totality of posts required across the registered nursing and midwifery workforce equates to 247.24 FTE. Phase 3 planning included 42.62 FTE registered nurses deployed from other areas to support the workforce shortfall.

3.0 SICKNESS AND ABSENCE LEVELS

Figures 2 - 5 show the sickness level at the Trust during the reporting period. Data has also been included from "Covid-19 related absence" which is coded differently within the electronic staff records, however, is an impact of the pandemic which directly affects the availability of the nursing and midwifery and nursing support workforce.

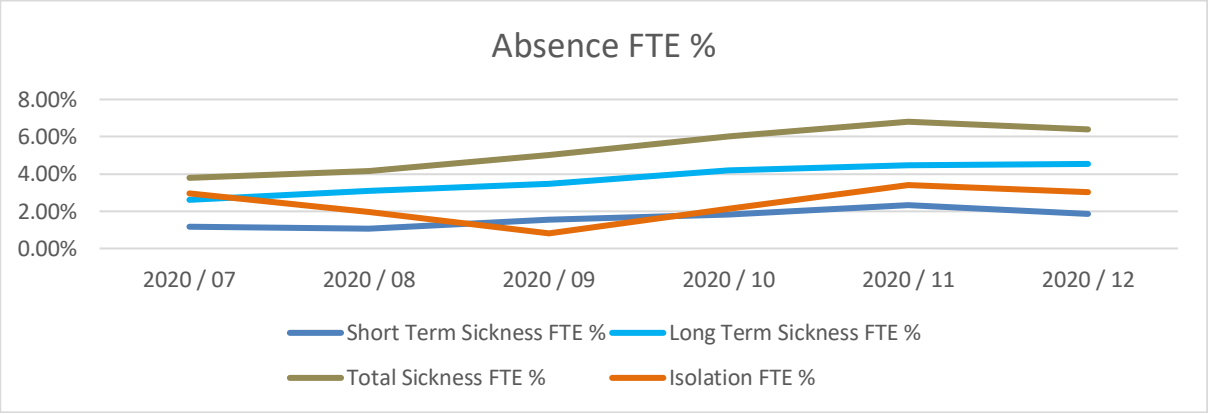
In the main the data demonstrates an upward trend in total absence which begins to dip from November. Within both workforce groups anxiety and stress is the highest

category recorded against sickness absence. Whilst these findings are not peculiar to nursing and midwifery, CHFT recognises that support for colleague wellbeing is vital pre, during and post the pandemic and additional resources have been refined and approved to develop a small Wellbeing Team and associated interventions. This service provides a range of wellbeing options to support the diversity of our people and tailor the support to their needs and is a critical response to support the health and well-being of nursing and midwifery colleagues given the reported impact.

Qualified Nursing & Midwifery

	Sickness Absence						Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Short Term Sickness FTE %	Long Term Sickness FTE %	Total Sickness FTE %	Isolation FTE Lost	Isolation FTE %	Total Absence
2020 / 07	582.96	1,290.71	1,873.67	1.18%	2.61%	3.79%	1,456.49	2.95%	6.74%
2020 / 08	523.90	1,519.59	2,043.49	1.06%	3.08%	4.14%	967.10	1.96%	6.10%
2020 / 09	742.08	1,659.76	2,401.84	1.55%	3.48%	5.03%	387.29	0.81%	5.84%
2020 / 10	912.37	2,100.78	3,013.15	1.82%	4.19%	6.00%	1,066.72	2.13%	8.13%
2020 / 11	1,134.68	2,185.27	3,319.95	2.33%	4.48%	6.80%	1,660.72	3.40%	10.21%
2020 / 12	940.04	2,299.28	3,239.32	1.86%	4.54%	6.39%	1,525.91	3.01%	9.41%

(Figure 2)

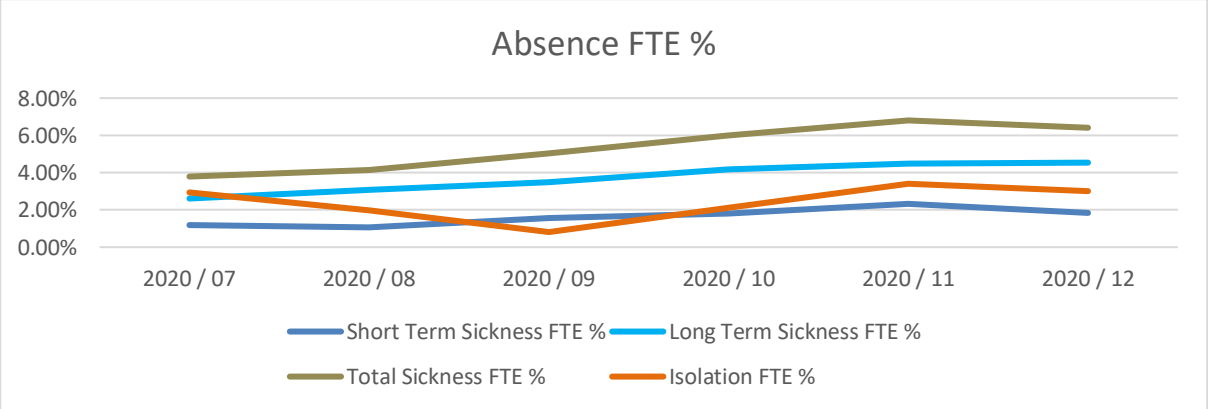


(Figure 3)

Nursing support

	Sickness Absence						Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Short Term Sickness FTE %	Long Term Sickness FTE %	Total Sickness FTE %	Isolation FTE Lost	Isolation FTE %	Total Absence
2020 / 07	582.96	1,290.71	1,873.67	1.18%	2.61%	3.79%	1,456.49	2.95%	6.74%
2020 / 08	523.90	1,519.59	2,043.49	1.06%	3.08%	4.14%	967.10	1.96%	6.10%
2020 / 09	742.08	1,659.76	2,401.84	1.55%	3.48%	5.03%	387.29	0.81%	5.84%
2020 / 10	912.37	2,100.78	3,013.15	1.82%	4.19%	6.00%	1,066.72	2.13%	8.13%
2020 / 11	1,134.68	2,185.27	3,319.95	2.33%	4.48%	6.80%	1,660.72	3.40%	10.21%
2020 / 12	940.04	2,299.28	3,239.32	1.86%	4.54%	6.39%	1,525.91	3.01%	9.41%

(Figure 4)



(Figure 5)

4.0 HARD TRUTHS DATA

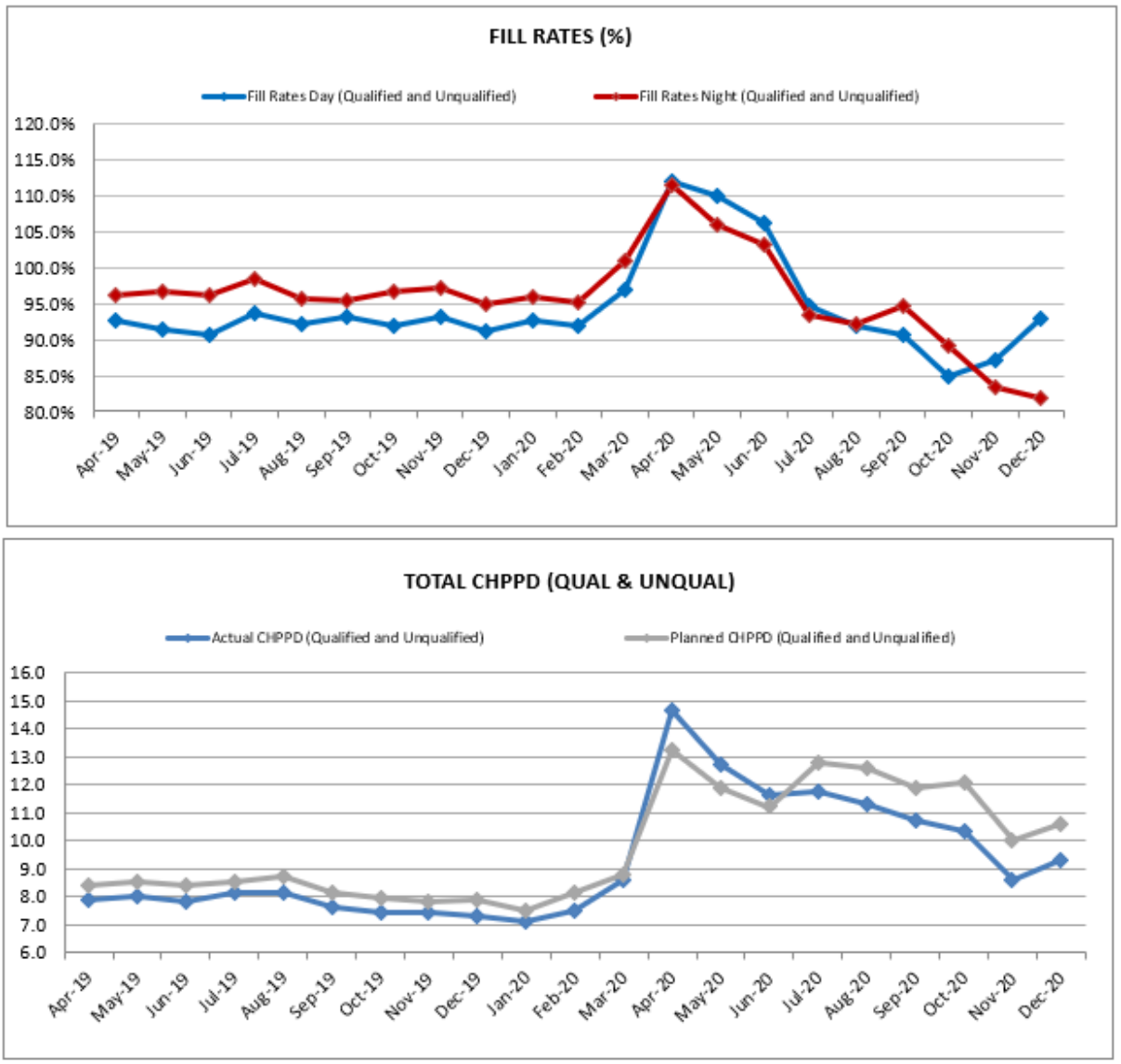
As indicated earlier Hard Truths is a commitment to greater openness and transparency and this is achieved by publishing staffing data regarding nursing, midwifery and care staff levels. This is provided through the Trust reporting nursing and midwifery staffing numbers including registered and unregistered to NHS England via a monthly nursing and midwifery staffing return. The data includes oversight of both the fill rates and care hours per patient day (CHPPD).

CHPPD provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units and is now seen as the national measure for safer staffing and is submitted by the Trust in line with national reporting requirements.

CHPPD is the unit of measurement recommended in the Carter Report (2016) to record and report deployment of staff working on inpatient wards. As stated previously, this became the primary benchmarking metric from September 2019.

It is calculated by combining the total number of registered nurse and healthcare assistant hours on each ward and dividing by the number of patients. The aim of this is to enable national benchmarking, reduce variation and increase efficiency.

Fill rates and CHPPD



(Figure 6)

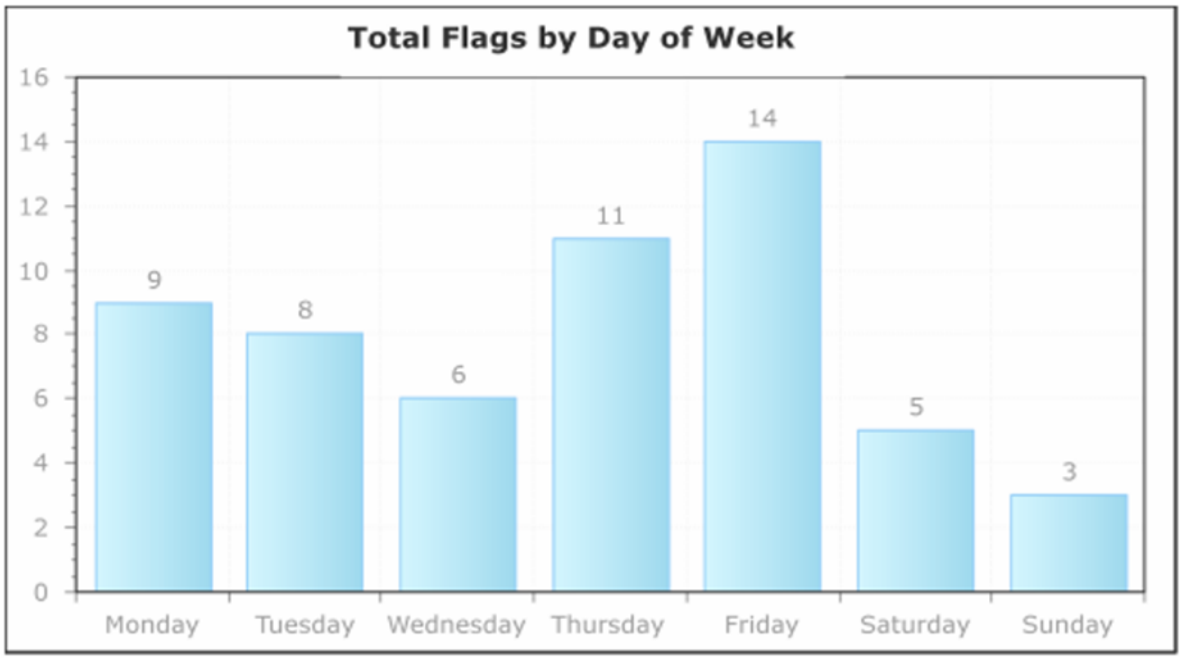
Pre pandemic the fill rate position trended around the 90-95% position. From March to April a sharp upward trend can be seen in both charts which is reflective of the deployment of nursing students as part of the wave 1 response and then the retraction of that workforce group in early summer. From that period a downward trend is seen to December 2020 where fill rate for the night were 82%. Similarly, a broadening gap

between planned and actual care hours can be seen during the pandemic, factors which are reflective of the requirement to restart elective work alongside the ongoing requirement for enhanced workforce models in critical areas.

4.1 Red Flag Escalation

To supplement the process of rating the current status of staffing requirements within the roster system, a system of Red Flag escalation has been developed in line with NICE (2014) guidance. Nursing Red Flags are events that have an impact on the way care is delivered to patients, therefore requiring a prompt response by the Nurse in Charge or a more senior nurse to mitigate patient safety concerns. Nursing Red Flags can be raised at any point during a shift.

During the Covid-19 pandemic given the significant staffing challenges there would be an expectation of escalation via the Red Flag process. However, during December 2020 there were a total of 56 Red Flags reported. Following this a Perfect Week was undertaken week commencing 11th January 2021. During the week 98 Red Flags were reported, broken down by days of the week in Figure 7.



(Figure 7)

Key findings are listed below;

- 90/96 selected “number of skill mix of nurses not sufficient” as the reason for the Red Flag
- 56 were reported during the day, 1 in the evening and 37 at night (2 were discounted in error)
- 43/96 were reported by Matrons
- 53 were closed, with a further 41 remaining outstanding

The Perfect Week focused staff to work within current processes and escalate concerns via the Red Flag system which indicates there is clearly an impact. However, the initial data did not provide an understanding of the actual impact upon patient experience, or the workforce in delivering that patient care where there is an insufficient number and skill mix of nurses. Recommendations from the Perfect Week are currently developed within the Nursing and Midwifery Workforce Safer Staffing Group.

4.2 Quality

As highlighted earlier there is a well-established correlation between staffing levels and safe care and patient experience.

As such it is important for any staffing review to take into consideration the quality of the care provided using nurse sensitive indicators. For this report three recognised nurse sensitive indicators have been used: Friends and Family Test, falls and pressure ulcer data.

4.21 Friends and Family Test

In line with National guidance, the FFT programme was suspended at the beginning of the Covid-19 pandemic to focus on Covid-19 priorities and reduce infection risks. Guidance in May 2020 allowed an FFT restart if implemented safely, CHFT restarted in a small number of inpatient areas, ahead of a formal restart and commencing data submissions to NHSE&I for December 2020 responses.

The performance data reported below is a combined rating of any responses submitted between July and December 2020. The main FFT question changed in April 2020 to: ***Thinking about your recent stay in hospital... Overall, how was your experience of our service?*** With options ranging from very good to very poor. The breakdown of positive vs negative results is a useful barometer to monitor performance through a patient feedback lens

	Very Good	**Good**	**Neither Good nor Poor**	**Poor**	**Very Poor**	**Don't Know**
% of Total	86%	11%	1%	1%	0.4%	0.2%
Combined	**Positive**			**Negative**		
	97%			1.4%		

Supplementary questions are also asked of patients, providing an opportunity to comment on what went well and anything that could be improved. The Health Informatics team are developing an approach which will make greater use of this rich data via an automated tool to identify themes which reinforce good practice and also opportunities for service improvements.

Examples of these messages related to ‘staffing/ staffing levels’ during the July – Dec 2020 period:

Positive:

- *Staff so happy always polite and helpful and nothing too much for them to do.*
- *The staff were really good and made you feel that nothing was too much trouble even though short staffed. Always done with a smile.*
- *Great care even though short staffed. Always felt looked after. Nothing witnessed that needs improving.*

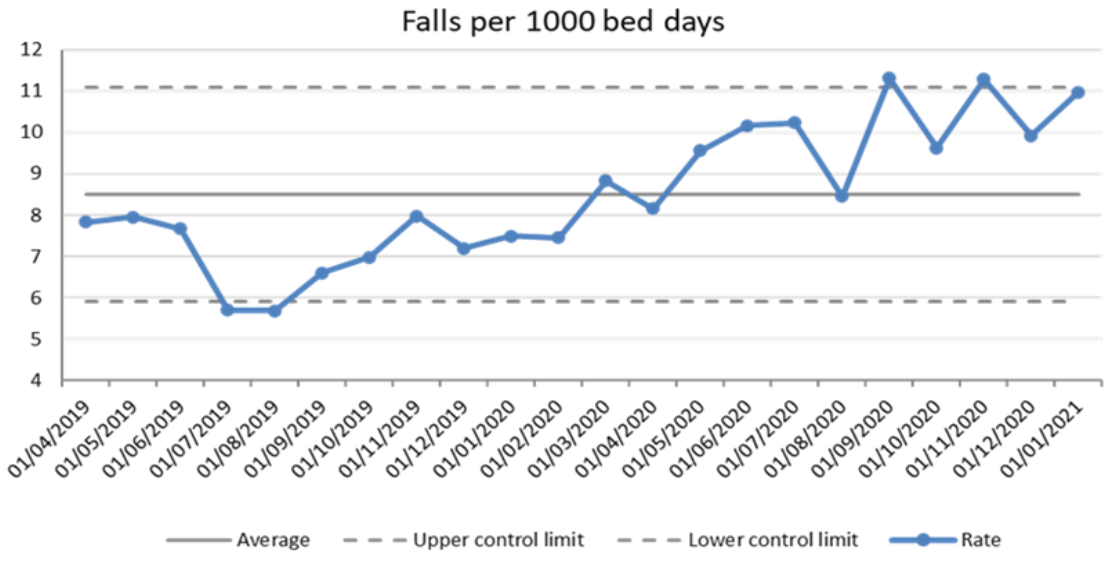
Negative:

- *Do things when they say they will instead of having to request something two or three times*
- *The nursing staff are attentive and caring but clearly are over-worked and under resourced and do not have enough time to properly read and understand patient notes particularly if the patient notes are lengthy.*
- *To leave a patient who asked for pain killers in pain for over 2 hours is poor. Despite asking 3 different members of staff.*

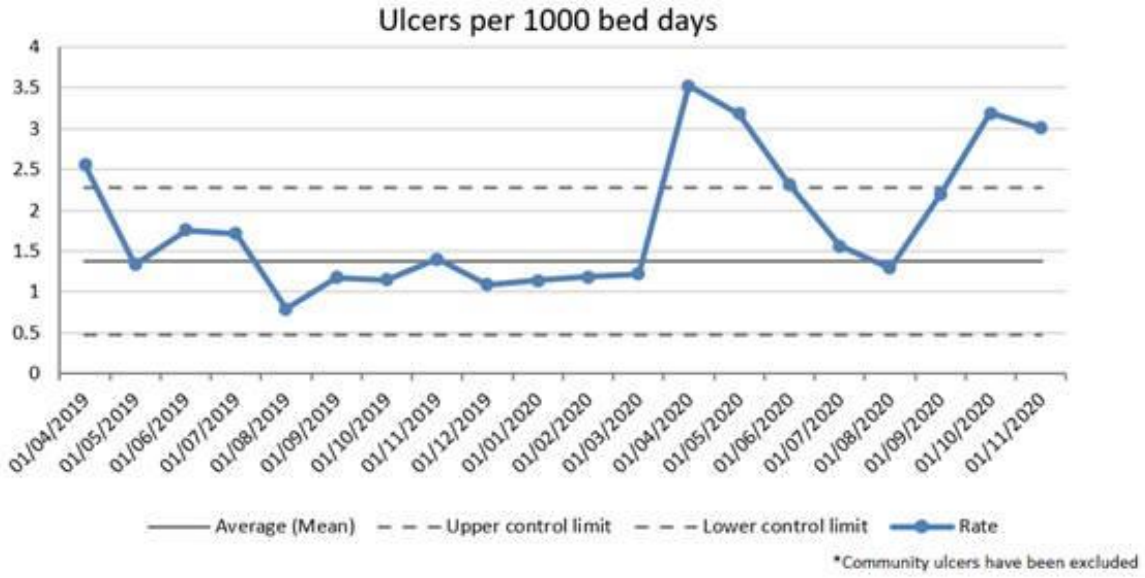
Whilst the overall findings demonstrate in the main a positive experience, feedback related to staffing/staffing levels provides a more detailed insight.

4.22 Falls and Pressure Ulcers

The charts below provide an overview of the reporting of incidents related to falls per 1000 bed days (Figure 8) and ulcers per 1000 bed days (Figure 9). Across both areas both outcome measures demonstrate an upward trend in the incidences reported.



(Figure 8)



(Figure 9)

Analysis of the data indicates an increasing incidence of the two nurse indicators that coincides with a deteriorating fill rate position.

Further work is required to understand the correlation between the nurse sensitive indictors data presented and the CHPPD. Going forward the intention is to develop an approach that will overlay the CHPPD onto a range of nurse sensitive indicators to enable further analysis of any impacts. However, in terms of Hard Truths it is reasonable to suggest that the impact of the pandemic in terms of staffing levels has impacted.

It should equally be noted that a detailed plan has been developed in response to the pressure ulcers which includes but is not limited to;

- Champions / Link practitioners identified for all areas of Trust and training programme in progress
- Community Pressure Ulcer Investigation template revised in line with national guidance and local learning
- Datix fields amended to enable reporter to add care home details to allow future monitoring of pressure ulcer ‘hot spots’
- NHSI ASSKING framework promoted via Stop the Pressure MDT film endorsed by Chief Executive
- Compliance with NHSI (2018) Pressure Ulcer Recommendations in reporting all CHFT acquired pressure ulcers regardless of avoidability (with effect from October 2020)

Similarly, a number of actions have been developed in response to the falls position which includes but is not limited to;

- The development of post fall review guidelines – quick reference flow chart.
- Falls leaflets are being updated in line with the national NAIF (National Association for Inpatient Falls) guidelines for patients and their families.
- Slip Trip and Falls policy is to be reviewed through the Falls collaborative to ensure it is also updated in line with NAIF Guidance. This will include parameters for ensuring multi factorial falls assessments are done for new patients rather than JUST an assessment of their falls risk – e.g. to include vision, continence, mobility, cognition etc.
- Research study to start in October 2021 in conjunction with Bradford University – Practice of Falls Risk Assessment and Prevention in Acute Hospital Settings" funded by NIHR _ - National Institute for Health Research. Dr Chakraborty is the collaborator for the study, supporting PHD students.
- Pursuing work with Falls link Practitioners and Falls Workshops.

CHFT's Response
Short-term strategies

5.0 STRENGTHENING THE ESCALATION AND REPORT ARRANGEMENTS FOR QUALITY AND SAFETY

Throughout the pandemic and increasingly so during the second surge Safe Staffing has been a key focus and is one the Trust Must Do priorities. Addressing this has been a key focus of the senior nursing team, and a range of actions put in place to manage risk.

Twice daily nursing and midwifery staffing meetings chaired by the Associate Director of Nursing (Corporate) are now in operation 7 days a week, operating with a revised term of reference.

The purpose of this meeting is to review the real-time safer staffing assessments and agree actions required to respond to short-term staffing escalations and changing acuity and dependency to assist with staff deployments.

Real-time staffing is provided through Safecare which gives a live view of the nursing staffing position measured against the acuity & dependency of our patients, facilitating comparisons of staffing levels and skill mix to the actual patient demand to maintain safe staffing across the Trust as a whole. Safecare LIVE plays a pivotal role in these meetings providing visibility across wards, transforming rostering into an acuity based daily staffing process that unlocks productivity and safeguards patient safety.

In addition, Safecare allows the nursing team to assist the ward manager with real-time roster management to ensure we have the right person, in the right place, at the right time to inform operational decisions to maintain safer staffing Trust wide.

Decision making within this forum is informed by an appraisal and risk assessment of the divisional information presented and any staffing shortfalls are mitigated against.

The twice daily nursing and midwifery safer staffing meetings have a direct escalation now established to the Nursing and Midwifery Workforce Safer Staffing Group.

In noting the ongoing mitigations to address the workforce shortfalls work is in place to overlay the nursing and midwifery outcomes measures to ensure teams are sighted on any impact because of mitigating actions. The proposed approach is referenced in Appendix 1 and will be further refined within the Nursing and Midwifery Workforce Safer Staffing Group.

In addition to the staffing meeting a daily Nursing and Midwifery Workforce Safer Staffing meeting was established in response to the Covid-19 pandemic chaired by the Executive Director of Nursing. The membership of this forum includes Divisional Associate Directors of Nursing, the Associate Director of Therapies, and divisional Human Resource Business Partners. The group was established in response to the pandemic, to provide clear oversight of the safer staffing agenda and provide a forum for rapid escalations. The work of the group includes but is not limited to: -

- Reporting of any escalations from the twice daily safer staffing meeting.
- Review and approval of workforce models in response to the Covid-19 pandemic.
- Oversight of specific staff groups affected by the pandemic in response to the changing national guidance including the clinically extremely vulnerable, clinically vulnerable and the pregnant workforce.
- Induction packs for colleagues deployed to new areas.
- Phase 3 scenario testing.
- Bi-annual establishment reviews to assess staffing requirements for 2021/22 nursing establishments.
- The development of a specialist skills passport for the care of the critically unwell patient
- A rapid initiation of additional health and well-being interventions in response to senior nurse escalation based on front-line intelligence

Finally, a 7-day senior nurse leadership rota has been established supported by the Executive Director of Nursing, Deputy Director of Nursing and Associate Directors of Nursing to provide ongoing visibility of clinical areas, provide on-going dialogue and support staffing escalations across the 7 days.

5.1 Staff Health and Well-Being

The nursing workforce recognise the ongoing impact of the Covid-19 pandemic on NHS staff well-being. This continues to remain an area of significant focus with ongoing support from colleagues within workforce and organisational development departments (WOD). The interventions provided during the peak of the pandemic continue and include:

- Ongoing daily coaching/debrief for critical care staff
- Ensuring staff feel safe and protected

- Ensuring safe spaces for rest and recuperation
- Ongoing health and well-being conversations with managers, WOD colleagues and the senior team
- Psychological support and treatment
- Appraisal of flexible working
- Close monitoring of shielding colleagues
- Ongoing promotion and completion of the Trusts health and well-being risk assessment
- Duty Matron and buddy Duty Matron rota established 7 days a week
- 7-day senior nurse leadership rota
- Weekly Leadership Assurance audit (including staff health and well-being)

Medium-long term strategies

6.0 RECRUITMENT AND REGISTERED NURSE TRAJECTORY

As indicated earlier in Figure 1 the financial ledger showed that the Trust has a registered nursing and midwifery vacancy position based on phase 3 plans equivalent to 97.24FTE, this is in addition the Trust running with circa 150 qualified vacancies for quite some time. Overall, this gap needs to be addressed by a comprehensive, multi-pronged recruitment strategy.

This strategy includes CHFT's commitment to working with the local Integrated Care System's (ICS) Workforce Transformation Board to inform and maximise strategies as a collective system to shorten the gap in nursing and midwifery vacancies. In addition, our strategy aligns to the NHS People Plan and government mandate which includes specific commitments around:

1. **Looking after our people** – with quality health and wellbeing support for everyone
2. **Belonging in the NHS** – with a particular focus on tackling the discrimination that some staff face
3. **New ways of working and delivering care** – making effective use of the full range of our people's skills and experience
4. **Growing for the future** – how we recruit and keep our people, and welcome back colleagues who want to return

Our local approach includes 4 rolling adverts out (Staff Nurse Medicine, Staff Nurse Surgery, Return to Practice and Staff nurse student), and maximising opportunities to attract the next cohort of new graduates in 2021.

In addition, we have created opportunities to recruit to Health Care Assistants (HCA) or Nurse Associate roles and there are a number of these in the pipeline:

- The trainee Nurse Associate (TNA) cohort (15) commenced in Dec 20 with 26 TNA's.

- 15 TNA will graduate and progress onto the register and into qualified Nursing associate roles
- 38.4 wte clinical apprentices commenced in Dec '20/ Jan '21.
- 25 Bank HCAs were made permanent in Nov '20, with a further 9 given temporary contracts until Jan 21.
- A further 38 HCA posts are also out to offer (11 of these are internal applicants)

Recruitment from the 2020/2021 3rd year student cohort is being prioritised. In the absence of the usual recruitment fairs, the education team are working with the Workforce and Organisational Development Teams to create promotional materials, suitable for distributing via email, social media and other digital platforms to attract the summer graduates. We also use these materials to attract new graduates from beyond the Huddersfield catchment area.

Our local approach also includes:

- Pastoral support from the point of recruitment into a preceptorship period. This is currently 12months with consideration of extending to18months
- A key partner in the REPAIR Health Education England work around the transitional stage from a final year student to taking up employment as a newly qualified practitioner
- Introduction of soft skill training during induction and preceptorship including human factors, resilience, stress management.
- The use of Social media and networking to target our recruitment campaigns
- Further development of the apprenticeship schemes has seen CHFT secure funding for 2 new apprenticeship programmes (full RN and NA top up to RN). These programmes provide opportunity for career development to those who may not be able to attend University in the traditional sense.

6.1 Funding awards NHS England/Improvement (NHSE/I)

NHS E/I recently invited NHS provider organisations to submit expressions of interest to accelerate the arrival of international nurses to support winter pressures. The Trust has been awarded funding to accelerate the arrival and training of an additional 11 international nurses due to arrive by 31st March 2021. This includes an opportunity to recruit 4 critical care nurses. We are also keen to explore the appetite within paediatric services. This work will allow us to work in partnership with Health Education England (HEE) on a Global Learner Programme which is part of a national drive to increase international nursing recruits. All nurses will be supported to transition into life in the UK along with preparing for the Nursing and Midwifery Council's (NMC) test of competence. All nurses are expected to move into shift fill between April and July 2021.

6.2 International Nurse Recruitment

Further to the above we plan to recruit an ambitious 40 international nurses between now and month end October 2021, taking our total for 2021 to 21. We continue to work with our agency partners as well as participating in the HEE Global Learner Programme (GLP). GLP should allow us to expand our international recruitment and aid us in recruiting suitable candidates and reaching our target of 51 international nurse recruits throughout 2021.

We have a robust training package and wrap around pastoral support that has seen positive results with low attrition, and we anticipate that all 51 candidates will be NMC registered or exam ready by the end of year.

6.3 Health Care Support Workers (HCSW)

We now have dedicated resource to link with the national programme aimed to accelerate the supply of health care support workers (HCSW) to ensure that current operational requirements are met without reliance on bank/agency usage e.g. enhanced care and that vacancy positions are significantly minimised. A focus this autumn will assist with winter preparedness and create additional surge capacity should it be required. It will also enhance the pool of HCSWs looking to support the nursing workforce pipeline.
The focus will be made on the creation of new HCSWs as to not destabilise other sectors and we will work with cross departmental partners e.g. DWP to support delivery. Given the revised need to enhance supply of HCSWs, we will look to raise the profile of the HCSW role through a national campaign, enhance our educational and onboarding practices and offer support to systems who have high vacancies.

6.4 Business Better than Usual

The COVID-19 pandemic has provided an opportunity to fast-track and implement new ways of working. As part of the 2021-2022 quality priorities the “Impact of Business Better than Usual” was identified as a key area to comprehensively capture this learning and evaluate the impact on patient safety and quality and determine a process for sustainable implementation**.** Through a focused engagement with key stakeholders, 12 strategic themes have been identified which will directly shape our organisational response to the nursing and midwifery shortage and align to our future workforce transformation plans**.**

7.0 RECOMMENDATIONS

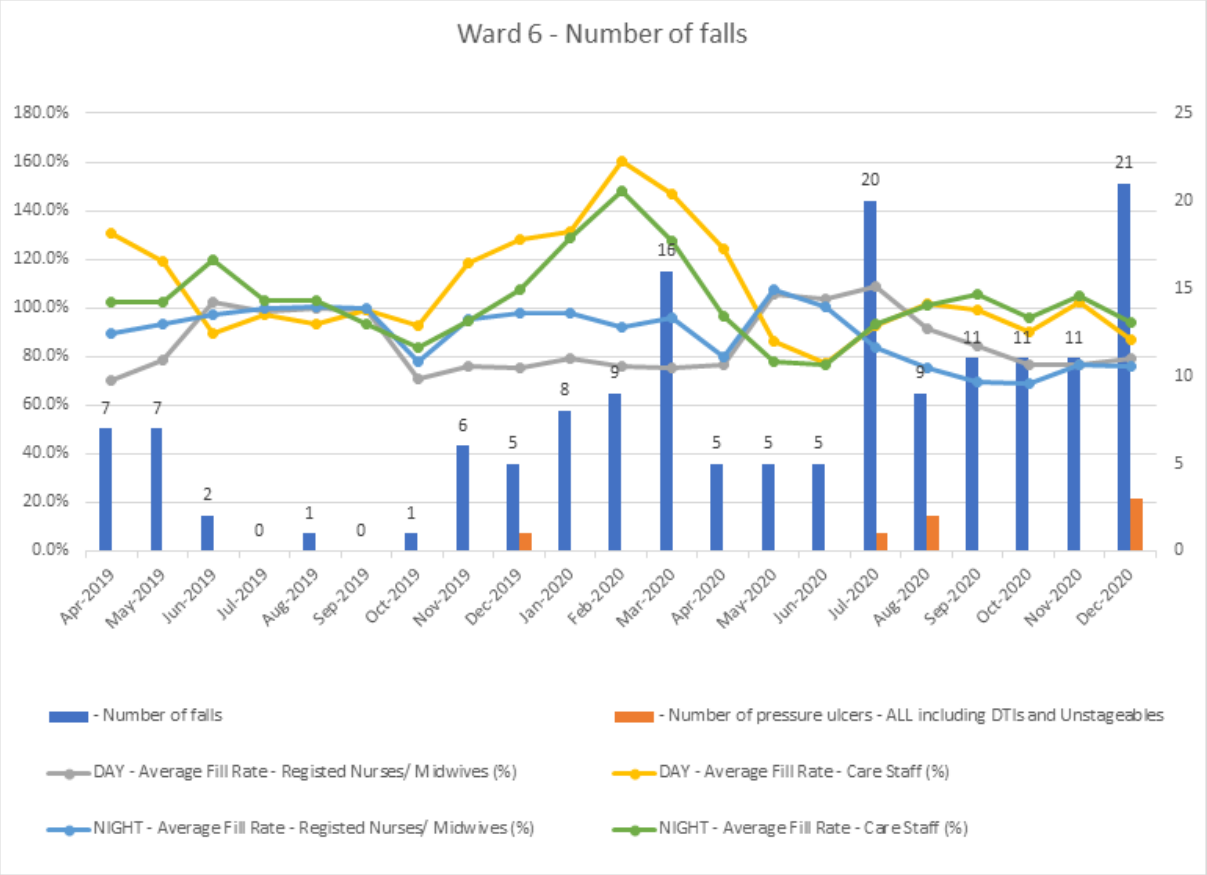
The Board is asked to: -

- Note the content of this report and the progress in relation to key work streams.
- Gain insight and assurance regarding the daily process to monitor and manage nurse staffing levels at ward level, including the proposal to refine this approach going forward.
- Be assured that arrangements are in place to monitor, support and mitigate any impact of reduced staffing levels or skill mix in relation to patient safety.

Appendix 1

Proposal for ongoing monitoring of nursing and midwifery staffing levels and the measurement of impact across a suite of nurse sensitive indicators.

The approach has been initially tested using Ward 6, which was selected based on the data which indicates the fill rates during the reporting period has dropped below a threshold of 80%.



	July 19 - Dec 19	July 20 - Dec 20
DAY - Average Fill Rate - Registed Nurses/ Midwives (%)	86.6%	86.1%
DAY - Average Fill Rate - Care Staff (%)	104.8%	95.3%
NIGHT - Average Fill Rate - Registed Nurses/ Midwives (%)	95.2%	75.0%
NIGHT - Average Fill Rate - Care Staff (%)	97.5%	99.1%
Average number of falls	2	14
Average number of pressure ulcers	0	1

In comparing fill rates, with the exception of “Night - average fill rates for care staff” the fill rates between the two reporting period indicates a drop in 2020 data, which correlates with the increasing vacancy position described within the paper impacted upon by the enhanced care models developed to support the pandemic. In trending the number of falls and pressure ulcers the data is indicating an upward trend in both areas.

18. Risk Management Strategy

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday, 4 March 2021
Meeting:	Public Board of Directors
Title:	Risk Management Strategy and Policy
Author:	Doriann Bailey, Assistant Director of Patient Safety
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing
Previous Forums:	Risk Group - 13 January 2021 Audit and Risk Committee – 26 January 2021

Purpose of the Report

The Trust is committed to ensuring that effective risk management is an integral part of its management approach, underpinning all activities, performance and reputation. As such, the Trust's approach to risk management is one of proactive identification, mitigation, monitoring and review.

Effective risk management is an essential part of any successful organisation and must be integrated into the culture of the organisation and led by the Trust Board and senior management. It should address the risk surrounding delivery of the organisation's activities in the present and in the future to support the improvement of services and delivery of high-quality care through continuous learning.

The delivery of healthcare will always involve a degree of risk however, a positive risk management culture empowers staff to make sound judgement and decisions concerning the management of risk and risk taking.

The purpose of the report is to present the updated Risk Management Strategy and Policy.

The Trust previously had two separate documents, a Risk Strategy, and a Risk Policy. There was a lot of overlap with both documents and as the documents were up for review it presented an opportunity to amalgamate both documents whilst maintaining the clarity of the Trust approach to the management of risks both operationally and strategically.

Key Points to Note

The Board of Directors is asked to note the revisions and updates to the combined Risk Management Strategy and Policy outlined below:

- Removal of the duplication from the individual Risk Management Strategy and Policy and combined into one Risk Management Strategy and Policy
- Revision to the reporting structure for Risks
- Revision to membership at the Risk Group meeting
- Clarification for the reporting into the Audit and Risk Committee
- Revision to policy to reflect organisational changes
- The updated Governance structure has been integrated into the Risk Management Strategy and Policy

EQIA – Equality Impact Assessment
In undertaking the Equality Impact Assessment, this ensures that the Trust is sited on all aspect of our care delivery and the impact this can have on the diverse patient group. This in turn demonstrates that as a Trust, we are considering the needs of all in our care and ensures that services we provide do not have a disproportionate impact on individuals or groups that share a protected characteristic under the Equality Act 2010. It is also appropriate that we consider the impact on other groups not 'protected 'under the Equality Act including parents/carers and/or socio-economic groups. It is not anticipated that the Risk Management Strategy and Policy 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 risks associated with or impact on the protected characteristics and ensure high quality and safe care for all. The Equality Impact Assessment is an ongoing process and should be an integral part of service delivery and enables 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 will be well-placed to respond positively to external scrutiny from the Commission for Equality & Human Rights, the Care Quality Commission, and the Audit Commission.
Recommendation
The Board of Directors is asked to note the content of the updated Risk Management Strategy and Policy for the management of operational and strategic risks across the Trust.

Signed off by: Ellen Armistead
Date signed off: 26 January 2021

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Facilities Management

RISK MANAGEMENT STRATEGY AND POLICY

V3.1.1

2021-2022

Document Summary Table		
Unique Identifier Number	G-101-2017	
Status	TBC	
Version	3.1.1	
Implementation Date	TBC	
Current/Last Review Dates	January 2020	
Next Formal Review	January 2022	
Sponsor	Executive Chief Nursing & Deputy CEO	
Author	Assistant Director of Patient Safety	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Board of Directors		14 January 2021
Executive Board		7 January 2021
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Risk Group	Assistant Director of Patient Safety	13 January 2021
Audit and Risk Committee	Non-Executive Director (outside of formal meeting)	26 January 2021
Other Stakeholders Consulted		
N/A		
Does this document map to other Regulator requirements?		
Regulator details		
CQC	Regulation 12: Safe care and treatment Regulation 13: Safeguarding Regulation 15: Premises and Equipment Regulation 16: Complaints Regulation 17: Good Governance Regulation 19: Fit and Proper Persons	
NHS Improvement	Single Oversight Framework	

Document Version Control	
Version no	
1	Risk Management Strategy incorporating Raising Concerns / Freedom to Speak Up
1.1	Minor amendment made to section 9.5 to include additional information in relation to compliance registers following internal audit report
2.1	Changes to titles, removed Head of Risk & Gov, added Assistant Director Patient Safety, Assistant Director Patient Experience Updated App 3 Governance Structure, App 2: Risk Appetite statement
3.1	Updated the Risk Management Strategy as part of its planned review
3.1.1	Updated the Risk Management Strategy as part of its planned review and merge with Risk Management Policy

CONTENTS

1. Overview

The Calderdale and Huddersfield NHS Foundation Trust (CHFT) recognises that the principles of good governance must be underpinned by an effective risk management system designed to ensure the proactive identification, assessment and mitigation of risks to ensure that CHFT achieves its Strategic Objectives and in doing so maintains the safety of its staff, patients, services users and visitors.

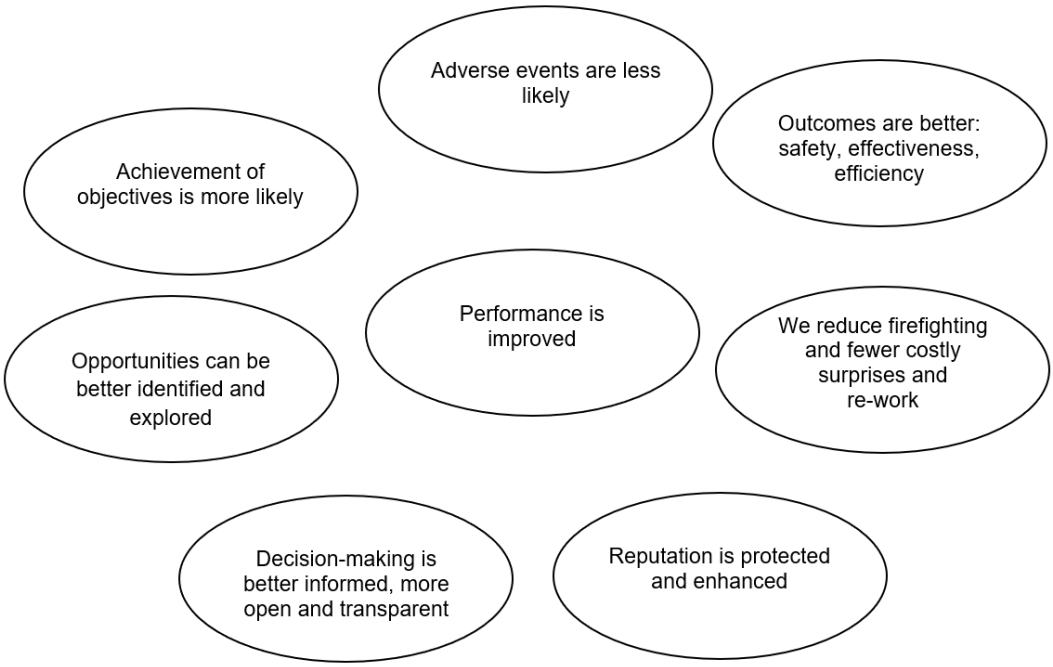
Risk Management is an integral part of CHFT's management activity and is a fundamental pillar in embedding high quality, sustainable services for the people CHFT serves. As a large and complex organisation delivering a range of services to a diverse population in a challenging and ever-changing health landscape, it is accepted that risks are an inherent part of the day-to-day operation of CHFT. Through the implementation of this Risk Management Strategy and accompanying Policy, CHFT ensures that it has in place a systematic approach for the mitigation of risk that enables the organisation to realise its ambition through the achievement of its Strategic Objectives.

Risk Management is the responsibility of all employees and requires commitment and collaboration from both clinical and non-clinical staff. Managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational working and service delivery. Specific roles, accountability and responsibilities are defined later in this document.

CHFT has a fully integrated Board Assurance Framework and Risk Management System (See Appendix 1 Glossary of Terms); the Board Assurance Framework is combined with the High-Level Risk Register which includes additional serious risks to the organisation.

2. Benefits of Managing Risk

CHFT is committed to the effective management of risks which, among others, has the following benefits.



3. Scope

This Strategy and Policy is intended for use across Calderdale and Huddersfield NHS Foundation Trust (CHFT), which includes Calderdale and Huddersfield Solutions Limited (CHS). Where responsibilities state all staff, managers, senior managers and directors, this also includes CHS staff groups, those on temporary contracts, contractors, membership councillors, and bank/agency staff, volunteers and Private Finance Initiative (PFI) partners. It is also relevant to all those who partner with or work with CHFT.

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

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

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

4. Vision and Statement of Intent

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

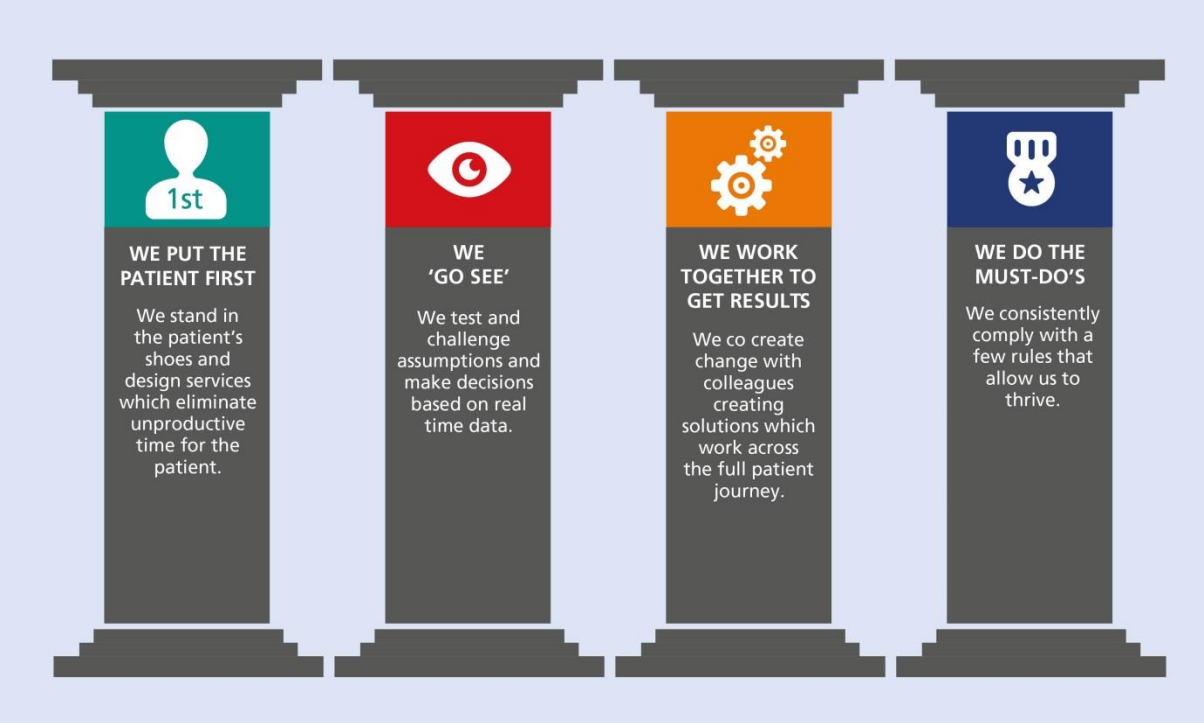
"Together we will deliver outstanding compassionate care to the communities we serve".

Our strategic objectives to deliver this aim are to:

- Transform and improve patient care
- Keep the base safe
- Have a workforce fit for the future
- Ensure financial sustainability

The way we work

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



CHFT recognises that by its very nature, delivering health care is an activity which involves a high degree of risk and risk management is the key system through which the organisation's risks; either clinical or non-clinical are managed through a comprehensive system of controls.

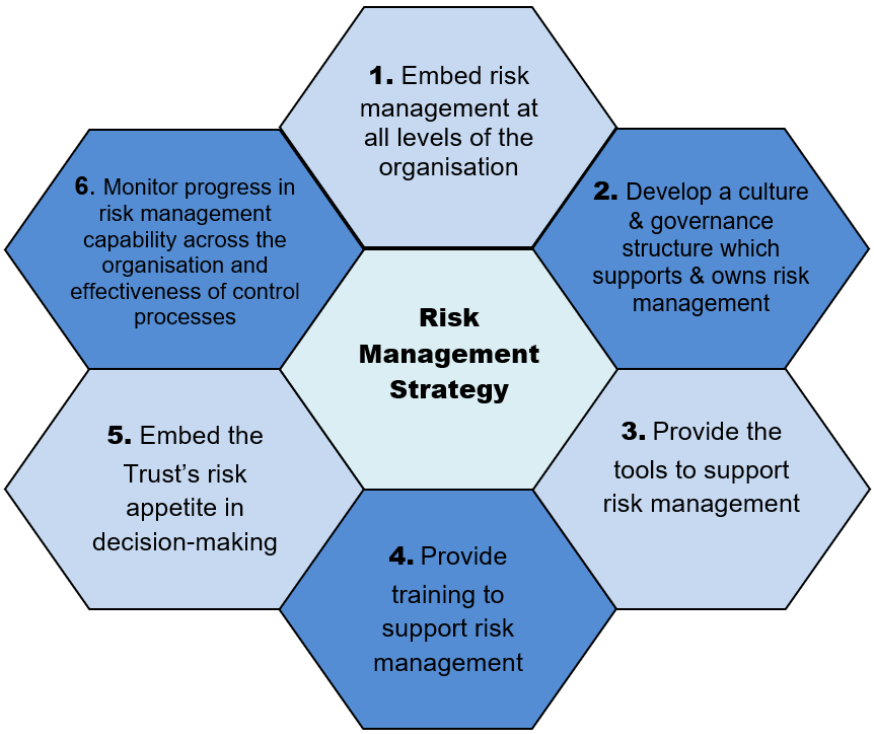
The process of risk management is an integral part of the Trust Board's system of internal control for identifying and managing risks which may threaten the ability of CHFT to meet its strategic objectives and its effectiveness is reviewed annually by internal and external auditors.

Key strategic risks are identified and monitored by the Board and operational risks are managed on a day to day basis by staff throughout the CHFT. The Board Assurance Framework and High-Level Risk Register provide a central record of how CHFT is managing its highest risks.

To ensure the effectiveness of CHFT's risk management processes, the Board and senior management team will rely on 'Three lines of defence', including the monitoring and assurance governance arrangements within the organisation. Details on how CHFT will implement its 'Three lines of defence' can be found in Section 12 – Assurance.

5. CHFT's Risk Management Strategy

CHFT's Risk Management Strategy is composed of 6 components as illustrated in the diagram below:



- **Embed risk management at all levels of the organisation**

  CHFT will ensure that risk management forms an integral part of the organisation's thinking, is an integral part of strategic objectives and management systems, including performance management and planning and that responsibility is accepted at all levels of the organisation.

  CHFT will ensure that staff are aware of their role, responsibilities and accountabilities for risk management and this is embedded at all levels of the organisation.

- **Develop a culture and governance structure which supports & owns risk management**

  CHFT is committed to building and sustaining an organisational culture that encourages appropriate risk taking, effective performance management and organisational learning to continuously improve the quality of services provided, improve safety and reduce harm.

- **Provide the tools and specialist advice to support risk management**

  CHFT will ensure a range of tools are in place to support individuals in risk management which use consistent language to articulate risk. This will be complemented by the expertise of risk management specialists.

- **Provide training to support risk management**

  CHFT will provide risk management and awareness training and support staff in their knowledge and understanding of risk management and its concepts (e.g. risk registers, risk assessment, Health and Safety, Root Cause Analysis, Information Governance, Complaints)

- **Embed the CHFT's risk appetite in decision-making**

  CHFT will enable decision-makers to understand risks in any proposal and the degree of risk to which CHFT can be exposed or extent to which an opportunity can be pursued. 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 (See Appendix 2).

- **Monitor progress in risk management capability across the organisation and effectiveness of control processes**

  CHFT will ensure a review process is in place to assist with the evaluation, grading, monitoring and mitigation of risks.

6. CHFT's Risk Management Objectives

In support of CHFT's Risk Management Strategy and Policy the following objectives have been devised and CHFT will endeavour to ensure that they are applied through its risk policies, procedures and systems. CHFT will also ensure that it monitors compliance with its Risk Management Strategy and Policy (See Section 14 Monitoring and Audit). The objectives are:

- Risks are identified, assessed, documented and effectively managed locally to a level as low as possible, using a structured and systematic approach.

- Risks are managed to a level that aligns with the CHFT's risk appetite meaning that staff have a clear understanding of exposure and the action being taken to manage significant risks.

- Risks are regularly reviewed at team, directorate, division and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated.

- All staff can undertake risk management activities in a supportive environment and have access to the tools they need to report, manage, monitor, and escalate risks effectively.

- All staff recognise the importance of their personal contribution to risk management.

- Assurance on the operation of controls is provided through audit, inspection and gaps in controls are identified and appropriate proportionate actions are put in place.

7. Policy

Risk Management

Definitions of Risk and Risk Management

A risk is the chance of something happening that will have an adverse impact on the achievement of the Trust's objectives and the delivery of high-quality care.

Risk Management is the proactive identification, classification and control of events and activities to which the Trust is exposed. See Appendix 1 for further definitions that relate to this strategy and policy.

Principles of successful Risk Management

It is the role of the CHFT Board to lead and support risk management across the organisation. The principles of successful risk management are:

- to embrace an open, objective and supportive culture
- to acknowledge that there are risks in all areas of work
- for all staff to be actively involved in recognising and reducing risk
- to communicate risks across the Trust through escalation and de-escalation processes
- to learn from mistakes.

Responsibilities and accountabilities for Risk Management

Each area of the Trust must undertake an ongoing and robust assessment of risks that may have an impact upon the delivery of high quality, effective and safe care.

Responsibilities and accountability for risk management is the responsibility of all staff and formal governance processes map out the escalation route of risks.

8. Organisational Structure for Risk Management

Organisational Structure

The full organisational structure with delegated responsibility for implementing risk management systems within CHFT is given at Appendix 3.

Roles and responsibilities

Board of Directors

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

Board members must ensure that the systems, policies and people that are in place to manage risk are operating effectively, focused on risk mitigation and are driving the delivery of actions to reduce the likelihood or impact of risk materialisation on delivery of the strategic objectives.

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

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

- Be collectively responsible for determining CHFT's vision, mission and values

- Set corporate strategy and priorities and monitor progress against these; the Board must decide what opportunities, present or future, it wants to pursue and what risk it is willing to take in developing the opportunities presented

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

- Set CHFT's risk appetite and review on an annual basis

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

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

- Ensure that its Committees review, and monitor risks submitted via the internal governance system

- Ensure that its Committees and have oversight for each risk on the Board Assurance Framework (BAF) and that risks are cross-referenced to the risks on the High Level Risk Register (HLRR).

Audit and Risk Committee

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

The **Risk Group, Information Governance and Records Strategy Group**, **Health and Safety Committee** and the **Data Quality Board** also report to the Audit and Risk Committee. They are responsible for the effective management of risks within their remit and undertake a self-assessment of performance annually and submits their assessments to the Audit and Risk Committee for assurance.

Risk Group

The Risk Group reports to the Audit and Risk Committee. Its role is to promote effective risk management and to maintain dynamic risk registers through which the Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality.

The Risk Group promotes local level responsibility, accountability and challenges risk assessments and risk assurance arrangements in areas of CHFT's activity, where robust controls are not evident, in order to raise standards and ensure continuous improvement.

Each CHFT Division has responsibility for assessing its risks these are reviewed monthly by Patient Safety and Quality Boards (PSQB) ahead of their monthly reports to the Risk Group.

Finance and Performance Committee

The Finance and Performance Committee has delegated authority from the Board to oversee, co-ordinate, review and assess the financial and performance management arrangements. This includes monitoring the delivery of the 10 Year Plan and supporting Annual Plan decisions on investments and business cases. It is responsible for identifying any financial and performance risks.

Workforce Committee

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

Quality Committee

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

A number of groups support the work of the Quality Committee and directly report to it, as depicted in the governance structure at Appendix 3.

Transformation Programme Board

The Transformation Programme Board provides assurance to the Board of Directors that there is oversight of the significant strategic investment; and management of risk in the delivery of CHFT's transformation and reconfiguration programme for the 'Transforming and improving patient care' objective.

9. Management Accountabilities, Roles and Responsibilities for Risk Management

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

The Chief Executive has overall accountability and responsibility for:

- ensuring CHFT maintains an up-to-date Risk Management Strategy and Policy, is committed to the risk management principles in the CHFT statement of intent and has a risk appetite endorsed by the Board

- promoting a risk management culture throughout the organisation

- ensuring an effective system of risk management and internal controls are in place with a framework which provides assurance to CHFT management

- ensuring that the Annual Governance Statement contains the appropriate assurance requirements for risk management

- ensuring priorities are determined and communicated, risk is identified at each level of the organisation and managed in accordance with the Board's appetite for taking risk.

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

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

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

The Senior Independent Non-Executive Director is also the Deputy Chair of the Board.

Executive Directors
The following Executive Directors have particular responsibilities in respect of assurance and the management of risk as summarised below. The Chief Executive will delegate responsibilities in relation to partnership working as appropriate.

Lead Executive Director	Risk Area
Executive Director of Nursing / Deputy Chief Executive Executive Director of Nursing is the Executive lead for risk management and patient safety in partnership with the Medical Director. They ensure organisational requirements are in place which satisfies the legal requirements of CHFT for quality and safety, patients and staff. This includes delivery of processes to enable effective risk management and clinical standards. The Board Assurance Framework lead is the Company Secretary.	• Board lead for clinical risk management: – Risk Management Strategy and Policies – Risk appetite – Monitoring the management of risks across divisions and escalate as needed • Serious Incidents and Incident Reporting • Patient Advice and Complaints Service • Patient Experience • Quality and Quality Improvement • Safeguarding and Deprivation of Liberties • Mental health act compliance • Quality regulatory compliance • Legal Services
Medical Director The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Executive Director of Nursing and leads the quality improvement strategy. Responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation. The Medical Director is supported in this by the Deputy Medical Director and Associate Medical Directors.	• Clinical medical risk • Infection Prevention and Control • Caldicott Guardian information risks – delegated to the Deputy Medical Director • Responsible Officer for GMC • Medicines Management – delegated to Chief Pharmacy Officer • Clinical audit and effectiveness • Compliance with NICE guidance • Quality Improvement • Research & Development – delegated to Deputy Medical Director
Director of Finance The Director of Finance has executive responsibility for financial governance and financial systems, is the lead for counter fraud and responsible for informing the Board of the key financial risks within CHFT and actions to control these.	• Financial risk • Procurement risk • Counter fraud and reporting to NHS Counter Fraud Authority • Financial regulatory compliance • Estates risk • PFI contract
Chief Operating Officer The Chief Operating Officer has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation and management of performance of all clinical services through divisional management teams.	• Performance risks • Performance regulatory compliance • Safe and sustainable operational services • Security Management • Trust Resilience • Fire Safety risk
Director of Workforce and Organisational Development The Director of Workforce and Organisational Development has executive responsibilities which include identification and assessment of risks associated with recruitment, employment, supervision, training, staff development and staff well–being.	• Freedom to Speak Up Guardian • Staffing risks including training, workforce planning, recruitment and retention, • Health and Safety, including external reporting for RIDDOR • Workforce Policies • Professional registration • Staff Well Being

Executive Directors

The following Directors also have responsibilities for assurance and management of risk.

Director of Transformation and Partnerships The Director of Transformation and Partnerships has lead responsibility for service redesign and reconfiguration and working together with our partners across the local health and social care economy.	• Risks in relation to service reconfiguration and transformation • Partnership risks
Managing Director – Digital Health The Managing Director promotes the need to manage information and IT risks for the security of patient records and IT business continuity arrangements.	• Information governance risks, including General Data Protection Regulation (GDPR) and external reporting to the Information Commissioners Office (ICO) • Senior Information Risk Officer – delegated to Head of Informatics, is responsible for ensuring CHFT manages its information risks, through the development of information asset owners and information asset administrators • Electronic Patient Record risks

Calderdale and Huddersfield Solutions (CHS) Limited, a company wholly owned by CHFT, provides:

- A comprehensive estates and facilities management service to Huddersfield Royal Infirmary, Broad Street and Beechwood premises
- A medical engineering service
- A fully managed procurement service for the whole of CHFT
- A property management service for other properties leased by CHFT

CHS provides Subject Matter Expert (SME) advice on the following risks:

- Fire safety
- Compliance with regulations/guidance on specialised building and engineering technology for healthcare
- Medical Engineering.

For these risks there is generally shared responsibility for the risk between CHFT and CHS, with the element of risk that sits with each entity described in the respective risk register. Both entities have governance structures in place to manage these risks.

Accountability for these aspects of risk is via a number of service level agreements and key performance indicators with Calderdale and Huddersfield Solutions Limited. These are monitored via the Joint Liaison Committee which includes executive and non-executive membership and reports to the Board via a bi-monthly report.

Assistant Director of Patient Safety
The Assistant Director of Patient Safety supports the **Executive Director of Nursing / Deputy Chief Executive** and Medical Director in their clinical quality and safety and risk management responsibilities as well as quality improvement. This includes overseeing the risk management function, including the risk register and compliance with the requirements of CQC standards.

Assistant Director of Patient Experience
The Assistant Director of Patient Experience supports the **Executive Director of Nursing / Deputy Chief Executive** and Medical Director in their quality management and quality improvement responsibilities (effectiveness, experience and safety). Specific responsibilities include overseeing the Complaints/ PALS, Patient/ Carer Experience and Legal functions, developing greater public participation /co production within CHFT and working with the **Executive Director of Nursing / Deputy Chief Executive** to understand the health inequalities in our communities and identify ways to close inequality gaps.

Clinical and Divisional Directors
Clinical and Divisional Directors have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They are responsible for ensuring effective systems for risk management within their division and directorates and ensuring that their staff are aware of the risk management policy and their individual responsibilities.

In addition to Divisional Directors and Clinical Directors the divisional management team includes an Associate Director of Nursing and a Director of Operations. They are responsible for demonstrating and providing leadership of risk management within their division, directorates and teams. They are accountable for:

- Pro-actively identifying, assessing, reporting and managing all risks, including information risks in line with Trust risk management framework.
- Establishing and sustaining an environment of openness and learning from adverse events to prevent recurrence and creating a positive risk management culture.
- Seeking assurance through their governance arrangements of the effectiveness of risk management.
- Ensuring clinical risks, emergency planning and business continuity risks, project and operational risks are identified and managed.
- Enabling general managers, operational managers, matrons, ward managers, departmental team managers to be responsible for ensuring effective systems of risk management including risk registers.

All Staff

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that are affected by Trust business.
- Be aware of, identify and minimise risks, taking immediate action to reduce hazards or risks.
- Identify, assess, manage and control risks in line with Trust policies and procedures.
- Be familiar with local policies, procedures, guidance and safe systems of work
- Be aware of their roles and responsibilities within the risk management strategy, policy and supporting policies, e.g. comply with incident and near miss reporting procedures.
- Be responsible for completing essential safety training and other training necessary to safety undertake their role.

- Undertake risk assessments within their areas of work and notify their line manager of any perceived risks which may not have been addressed.

Risk Specialist Roles
The table below identifies a number of specialists employed by CHFT. Further details on these roles can be found in Appendix 4.

Role	Responsibility
Caldicott Guardian – Deputy Medical Director Senior Information Risk Owner (SIRO) Information Governance Manager	Information Governance Risks
Company Secretary	Strategic Risks Foundation Trust risks
Executive Director of Nursing / Deputy Chief Executive	Clinical Risk
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Head of Midwifery	Maternity Risks
Emergency Preparedness	Emergency Planning and business continuity risks
Fire Safety Manager Health and Safety Advisor Local Security Management Specialist (LSMS) Director of Estates and Facilities Director of Security	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability Security Management
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Assistant Director of Patient Experience Legal Services Manager Complaints	Patient Experience Risks
Local Counter Fraud Specialist	Fraud Risks
Assistant Director of Patient Safety Quality Governance Leads Clinical Governance Leads	Central alert systems risk Risk Management Systems, tools, training Quality and safety risks
Head of Safeguarding / Safeguarding Team	Safeguarding Risks

Contractors and Partners
It is the responsibility of any member of Trust staff who employ contractors, and their partners, to ensure they are aware of the Safe Management of Contractors' policy and undergo Trust induction via the relevant Estates Department at either HRI or CRH. This will ensure that all contractors working on behalf of CHFT are fully conversant with CHFT's health and safety rules and the staff member responsible is fully aware of the contractor's activity for which they are engaged and, if applicable, are in possession of the contractor's risk assessment and method statement for their activity.

10. Risk Management Systems

Policies
There are a number of key policies which support the effective management of risk. These supporting policies are detailed in Section 15.

All operational policies, procedures and guidance also support the effective management of risk. These can be found on the CHFT intranet.

Incident investigation, reporting and learning
The formal reactive method of identifying risks within CHFT is through the electronic risk management system, Datix where all staff can report incidents, accidents and near misses. This should be done in a timely way, with incidents categorised by type and graded for severity. This enables the organisation to identify themes and trends, investigate to establish contributory factors and root causes, and identify learning to make improvements in patient safety and reduce risk.

An Incident Reporting and Management Policy is in place which details the processes for reporting, grading, investigating and learning from incidents, including serious incidents and is a key part of our effective risk management processes.

RIDDOR (Reporting of Incidents, Injuries, Diseases and Dangerous Occurrences Regulations 2013) incidents should be reported on Datix and externally to the Health and Safety Executive (HSE) via the HSE link on Datix.

Formal root cause analysis is used throughout CHFT providing a structured approach for the analysis and identification of learning from incidents. This is used in investigations to identify how and why incidents occur and informs actions and learning to prevent harm.

CHFT uses the Yorkshire and Humber contributory factors' framework, a tool from the Improvement Academy with an evidence-base to optimise learning and address causes of patient safety incidents from incidents within hospital settings. It takes a systems approach and identifies situational factors, local working conditions, latent/organisational factors and latent/ external factors and general factors that contribute to error, providing an opportunity to learn from errors and prevent factors that cause harm to patients.

CHFT has a clear framework for undertaking root cause analysis for moderate and above harm incidents. This ensures that action is taken to prevent the potential for recurrence locally and at a corporate level. Specific root cause analysis templates and frameworks have been developed for specific incident types, i.e., pressure ulcers, infection related incidents to ensure a consistency of approach and commonality of structure to allow for collation and analysis of themes. These are detailed in the Incident Reporting Policy.

CHFT is committed to continue to improve its reporting culture throughout all professional groups of staff and others who work with it. It achieves this by ensuring that action is taken, changes in practice are implemented and services are improved as a direct result of the review and investigation of incidents and by identifying and reacting to themes.

Board Assurance Framework (BAF)
The Board Assurance Framework (BAF) provides the Board of Directors with an oversight of the strategic risks to meeting CHFT's objectives together with the controls and methods of providing assurance that controls are effective. Risks on the BAF are owned by Trust Directors, with either the Board or Board Committee identified as having oversight for each risk on the BAF.

The BAF maps out the controls already in place and the assurance mechanisms available so that the Board can be confident that they have sufficient assurances about the effectiveness of the controls. The risks are cross-referenced to the risks on the High-Level Risk Register (HLRR).

All risks on the BAF are presented to the Board at its public meetings three times a year. All other Board committees may make recommendations for including or amending strategic or significant risks. The BAF forms part of the evidence to support the Annual Governance Statement produced as part of the Annual Report and Accounts.

A standard operating procedure is in place describing the process for managing the BAF and gaining assurance on the management of risk.

The assessment of risk within the BAF is reviewed by the relevant Board Committee. The risks on the BAF are scrutinised three times a year by the Board of Directors with input from the Quality Committee, the Finance and Performance Committee, Audit and Risk Committee, Transformation Programme Board and the Workforce Committee. Each committee has been allocated specific BAF risks and these risks are regularly reviewed at committee meetings. Any issues or concerns are reported to Board. Oversight of the system of risk management, including the BAF, is provided by the Audit and Risk Committee. CHFT will continue to review and amend both the risk register and the BAF content in line with best practice identified.

The BAF is closely linked with the high-level risk register (HLRR), which reflects the high to very high risks (significant risks) identified at both a corporate service and divisional level. The Company Secretary and Assistant Director of Patient Safety will ensure that the link between the High-Level Risk Register and the Board Assurance Framework is maintained, and that the Audit and Risk Committee is satisfied that this is occurring.

Risk Registers

All areas assess, record and manage risk within their own remit, reporting on the management of risks through the risk register system, using the risk grading system detailed at Appendix 7. All risks are linked to strategic objectives.

A bespoke database is used to capture all risks to the organisation. A framework is in place for assessing, rating and managing risks throughout CHFT, ensuring that risks are captured in a consistent way. Risks can be analysed by risk score, risk type, division, directorate and team.

In exceptional circumstances when an Incident Management Team (IMT) is in place, e.g. a pandemic, there is a process for the development of the specific risk within the risk register further to discussion of identified risks within the IMT and ensuring that this feeds into the usual Risk Management framework to give assurance that risk is captured and discussion of mitigation takes place in a timely way.

It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the high-Level Risk Register which is an integral part of CHFT's system of internal control.

The high-level risk register includes those significant risks which may impact on CHFT's ability to deliver its objectives, with a risk score of 15 or above. These are reviewed on a monthly basis by the Risk Group and through the governance cycle to CHFT Board three times a year.

Adding risks to the High-Level Risk Register
The Quality Governance Leads or other non-clinical divisional leads for risk management, are responsible for flagging risks from the division with a score of 15 or above that require a review by the Risk Group for consideration on the high level risk register and alerting the Senior Risk Manager to this. This should follow discussion within the division and ideally by the Patient Safety Quality Board, time permitting.

The division will arrange for the appropriate lead to present and discuss the risk at the Risk Group at the earliest opportunity. Following discussion and any amendments to the risk or score, a decision will be made by the Risk Group as to whether:

- the risk is added to the high-level risk register (or not)
- further information is needed before making a decision

Discussions will be recorded in the Risk Group minutes to ensure a clear audit trail regarding the decision to add or not add the risk to the high-level risk register,

Where it is decided that the risk should not be added to the high-level risk register this will continue to be monitored within the divisional risk management processes. Some risks may remain on the divisional risk registers at a score of 15 or above where there is a linked risk on the high-level risk register – e.g. specific staffing issues in a specialty.

Removing Risks from the High-Level Risk Register
Where it is deemed that a risk should be removed from the High Level Risk Register (e.g. because mitigating actions have been successful in reducing the risk score below 15 or the risk is to be closed completely) these risks should be reviewed for closure by the Risk Group, prior to removing the risk from the high level risk register or reducing the score for management within the local risk register.

The Quality Governance Lead should highlight to the Senior Risk Manager any risks proposed for removal from the high-level risk register (i.e. where risk score has reduced below 15). These will be added to the agenda of the Risk Group and presented by the division, with rationale for removal from the high-level risk register. The decision regarding removal from the high-level risk register should be recorded in the minutes of the Risk Group.

All additions and removals to the high-level risk register and changes in scores will be highlighted to the Trust Board via high level risk register reports. The Board, in reviewing the high-level risk register at Board meetings, is engaged in reviewing, challenging and approving risk closure.

The flow chart in Appendix 9 depicts the flow of risks throughout the organisation from identification to assessment and management according to severity throughout CHFT.

11. Risk Management Process

Risk identification involves examining all sources of potential risk that CHFT may be exposed to from the perspective of all stakeholders throughout the organisation.

Step 1: Identify Risk

Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats.

Risks need to be clearly described to ensure there is a common understanding by stakeholders of the risk. The recommended way for describing a risk is

"**risk of ..... due to ..... resulting in",** as follows:

Steps to write a risk	
Identify the risk	There is a Risk **of** .....
Identify the cause of the risk	The Risk **due to** .....
Identify the impact of the risk	The Risk **results in** …….

Appendix 5 Risk Register Guidance includes guidance on how to write a risk.

The identification of risk is an ongoing process and is never static but is particularly aligned to the annual planning process and compliance requirements.

Staff may draw on reasonably foreseeable failures alongside incident trends, complaints, claims, patient/staff surveys, observations, formal notices, audits, clinical benchmarks or national reports to identify risk. This list is not exhaustive.

Step 2: Assess the Risk

All risks must be assessed in an objective and consistent manner. Risks are assessed on the probability, i.e., the likelihood of a risk happening and on what would happen (impact/consequence) should the risk occur.
The magnitude of a risk can be estimated by multiplying the severity of impact by the likelihood of the risk occurring using a standard 5x5 risk scoring matrix to score likelihood and impact of a risk.

CHFT has a risk appetite which details the amount of risk that the organisation is willing to take in pursuit of its strategic objectives. The risk appetite can be found in Appendix 2 of this Strategy and Policy and on CHFT's intranet.

CHFT procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed without existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured

- **Current risk score -** this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target/residual risk score as action plans to mitigate risks are developed and implemented

- **Target/residual risk score -** this is the score that is expected after the action plan has been fully implemented.

Staff should be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to calculating target/residual risk and risk scoring matrix guidance is provided at Appendix 6.

Step 3: Respond to the Risk

There are a number of different options for responding to a risk. These options are referred to as risk treatment strategies. The main options most likely to be used include:

Action	Definition
Eliminate	Appropriate remedial action by the organisation will result in the elimination and subsequent closure of the risk. E.g. by doing things differently we could remove the risk immediately or by implementing counter measures, where it is feasible to do so, this could prevent the threat or problem from occurring or prevent it having any impact on the activity
Reduce	Appropriate remedial action will result in the severity and/or likelihood of the risk being reduced to a level where: ▪ The risk has been reduced to its inherent or natural level and can now be managed through CHFTs normal operational activity and procedures. ▪ The risk has not been reduced to its inherent or natural level and now CHFT must Tolerate or Accept this risk.
Tolerate	Remedial action has reduced the severity and/or likelihood of the risk to a rating of 'Moderate' or 'High'. Further remedial action by is not possible without additional resources in terms of effort, time or cost, or it requires remedial action is the responsibility of a Third Party (e.g., another Trust or a Commissioner). The risk will continue to be monitored to ensure the controls remain effective and that the risk is being reported/escalated to the relevant Third Party.
Accept	Remedial action has reduced the severity and/or likelihood of the risk to a rating of 'Low'. Further remedial action is now no longer practical in terms of effort, time or cost, the risk will continue to be monitored to ensure that the controls remain effective.

Step 4: Develop an Action Plan

Key aspects to consider when developing an action plan in order to mitigate/reduce the risk are summarised below.

- What are the existing controls?
- Are there any gaps?
- What further controls are practical and sustainable? (Check with staff who work in the area)
- Is the design of the control right? Is it helping you achieve your objectives?
- What further actions are needed to manage the risk?
- How will you assure that the control measures implemented will remain effective and not result in the risk re-emerging?

Action Plans should be focused on gaps in controls and should include the following:

- A list of any actions that are needed to manage the risk indicating the agreed time scale for each action
- A designated person who is responsible for each action on the list.
- Each action identified should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely).
- Action plans must be appropriate to the level of the current risk.

Action target dates and risk review dates should be set in accordance with the level of risk, and compliance with these must be monitored appropriately through the directorate / divisional review and monitoring meetings prior to submission for assurance to the relevant committee.

Further Actions recorded on the register must be dated with the most recent date to the top

Step 5: Report Risk

All risks must be recorded on the Risk Register. It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the high-level risk register which is an integral part of CHFT's system of internal control and defines the risks which may impact on CHFT's ability to deliver its objectives (BAF Risks).

The consequences of some risks, or the actions needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level. An integral part of effective risk management is ensuring that risks are escalated through the organisation in line with the relevant governance committee structures. This will ensure visibility of risks throughout the organisation, the appropriate level of management and prioritisation of resources.

Risks are escalated according to their initial risk profile scores as summarised in the table below.

Risk Rating	Risk Level	Level of approval, escalation and management
1 - 6	Low Risk	– Managed at ward / office level – Approved by Divisional PSQB – If meeting target/residual, only need reviewing annually at Risk Group on business plan by division. – If not at target/residual risk, then reviewed at directorate meetings
8 - 12	Medium Risk	– New Medium Risks reviewed by Risk Group which can either: approve, escalate or de-escalate and include explanation. – Divisional PSQB report to the Risk Group and an explanation for increase or decrease in risk. – Risk Group may decide in exceptional circumstances to add 12 rated risks to HLRR

		– Risk Group may decide if risk trust-wide – Existing medium risks reviewed every other month by Risk Group.
15-16	High Risk	– Risk Group report must include statement for increase and or escalation in risk. – Initial Risk rating or increased risk rating can only be approved by Risk Group who can either: approve, escalate or de-escalate and include explanation – Record on HLRR and notify Company Secretary to consider effect on the BAF – Monitor monthly in sequence by Risk Group / Executive Board / Subcommittee of Board / Board
20 - 25	Very High	

NB Staff/Health and Safety risks are reported and managed via Health and Safety related Sub-Groups and Health and Safety related specialist leads. The Health and Safety Committee provides the same functions as the Risk Group towards Health and Safety Risks as shown above. However, Health and Safety risks which need to be considered for the HLRR still require going through the Risk Group.

Risks which score 15 or higher must be brought to the attention of the Senior Risk Manager for escalation to the appropriate committee for consideration and potential inclusion on the high-level risk register. In exceptional circumstances the Risk Group will also consider for inclusion on the high-level risk register risks scored at 12 as highlighted by the divisions. The high-level risk register prioritises risk populated from risk assessments carried out both at a strategic and operational level.

The Risk Group, on behalf of the Audit and Risk Committee and Board, oversees the high-level risk register (i.e. mainly risks with scores 15 and above), together with identified Board Committees or groups overseeing the management of BAF risks on behalf of CHFT.

Key outputs from the risk management system will be reported to relevant staff/committees depending on the residual risk score.

The **Risk Group**, which **is a sub-committee of the Audit and Risk Committee**, will receive reports to monitor the quality, completeness and utilisation of risk registers, and oversee the extent / levels of risk across CHFT. Reports will cover the risk description, the residual risk (exposure after control), main controls, date of review and risk owner.

The Quality Committee, which has a specific role for clinical risks, it receives the HLRR on a monthly basis.

Risk registers from divisions are scrutinised through their Patient Safety Quality Boards and every two months by the Risk Group. They are reviewed to ensure that risks within the division and their directorates are captured. Each division reports on their risk registers on a quarterly basis to the Quality Committee.

The Executive Team will be informed by the Executive Director of Nursing (or relevant Executive Director) of any new significant risk arising at the first meeting opportunity.

Step 7: Risk Closure

A risk can be closed and moved to the closed section of the electronic risk register system for audit purposes when:

i. There is a change in practice which removes the hazard
ii. Where the risk/event has passed
iii. Where it is clear that the action taken to treat the risk eliminates all reasonably foreseeable exposure to that risk.

Completion of actions does not necessarily mean that a risk can be eliminated and closed.

Each division should have governance arrangements which define a clear process for authorising the closure of risks by managers/through appropriate directorate/department or divisional meeting and ensure that all staff are aware of this. The reason for closure must be stated on the risk register.

It is good practice to periodically audit closed risks to be assured that the risk is no longer present. It should be noted that risks removed from the high-level risk register may continue to be managed on a divisional risk register at a risk score of 12 or below, so will not necessarily be closed.

Compliance Registers

To ensure that CHFT manages risks and response to issues highlighted in external reviews, each division and corporate services maintain a Register of Compliance.

The register is a systematic approach to recording details of all external assessments, inspections and accreditations and provides an overview of compliance with regulatory standards (financial, performance, quality) in line with CHFT External Agency Visits, Inspections and Accreditations Policy. Guidance is provided to divisions on the content of the compliance register to ensure consistency of content and this is enclosed at Appendix 8.

The register details the date and type of assessment, level of compliance, actions required, consequence of non-compliance and any associated risks. It also includes the date the next assessment is due, whether any recommendations from previous visits are outstanding and identifies any risk areas. The compliance registers are reviewed at divisional Patient Safety Quality Board meetings and.by the CQC Response Group

12. Assurance

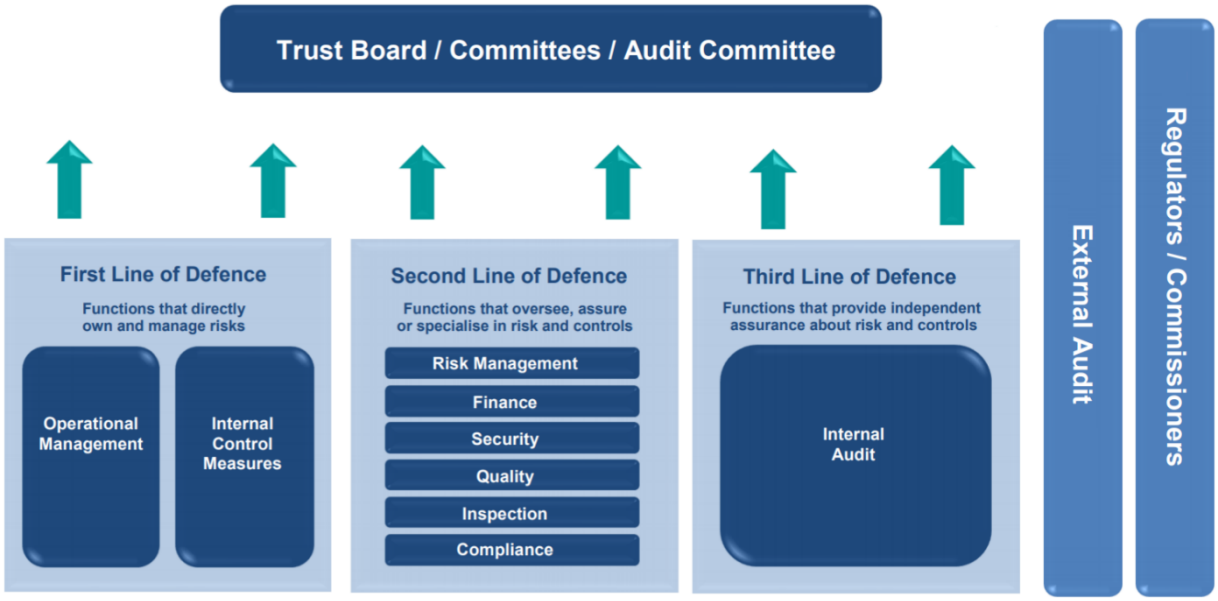
CHFT's approach to risk assurance is based on the widely adopted Three Lines of Defence model as endorsed by professional bodies such as the Chartered Institute of Internal Auditors, the Chartered Governance Institute, and the Institute of Risk Management. Appendix 9 presents a high-level diagram to show how the Three Lines of Defence model operates in CHFT.

The first line of defence contains operational functions that directly own and manage risks. CHFT's first line of defence constitutes teams and managers in operational or service delivery functions and in support functions.

The second line of defence contains 'corporate' or 'central' functions that oversee, assure or specialise in risk management or related control and compliance activities.

The second line of defence provides the frameworks, policies, procedures, guidelines, tools, techniques and other forms of support to enable first line operational managers and staff to manage risk well. The second line also carries out quality assurance, monitoring and reporting activities relating to risk management.

The third line of defence contains functions that provide independent and objective assurance regarding the integrity and effectiveness of risk management and related controls in CHFT. Internal audit is the key function in CHFT's third line of defence. Reporting to CHFT Board via the Audit Committee, internal audit provides risk-based evaluation of the effectiveness of risk management, governance and internal control in the organisation. The third line of defence has interfaces with other external providers of independent and objective assurance, including external audit, regulators (such as the Care Quality Commission) and commissioners (such as NHS England / Improvement - NSHEI).



13. Training

Risks may be identified pro-actively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:

a) Risk Register

The Risk Register provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto the risk register.

b) Risk Management Training

Training is required to effectively manage risks in line with the process set out above. Regular Risk Register training sessions are offered on a monthly basis with dates available published on the Quality and Safety intranet page. Bespoke risk management training will be available to teams, tailored to their specific needs. This could include sessions on:

- Operational use of the electronic risk register system and guidance on how to articulate a risk, controls and actions (group or individual)
- Advice and guidance on management of risk in their area
- Peer review of risk registers
- Support with the development of risk registers.

c) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive training and/or briefings on the risk management process by staff from the Risk Management team. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.

d) Divisional, Ward and Departmental managers will have further detailed risk management process training incorporating how to use the Risk Register database before access to the database is enabled.

14. Monitoring and Audit

The following indicators will form the Key Performance Indicators (KPIs) by which the effectiveness of the Risk Management Process will be evaluated:

- All relevant significant risks are discussed at the appropriate group depicted in the Governance structure (see Appendix 3) and formal meetings of Committees of the Board
- Risks of ≥15 are reviewed by the Risk Group, with risks of 12 also reviewed when requested by divisions
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and >80% of risks are within review date and none are overdue for review by 6 or more months

Compliance with the above will be monitored by the Company Secretary, Assistant Director of Patient Safety and reviewed by the Executive Director of Nursing and reported within an annual report submitted to the Audit and Risk Committee.

15. Associated Documents / Further Reading

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

- Incident Reporting, Investigation and Management policy
- Complaints policy
- Claims policy
- Being Open/Duty of Candour policy
- Major Incident policy
- Blood Transfusion policy
- Capability policy
- Central Alerting System
- Claims policy
- Complaints policy
- Control of Substances Hazardous to Health (COSHH)
- Consent policy
- Domestic Violence policy
- Electronic Patient Record Standard Operating Procedures
- Emergency Preparedness, Resilience and Response policy
- Falls Prevention and Management policy
- Fire Safety Strategy
- Freedom of speech/Whistleblowing policy
- Health and Safety policy
- Induction policy
- Infection Control policies
- Information Governance Strategy and associated policies (including GDPR and Data Protection policies)
- Inquest policy
- Mandatory Training policy
- Managing External Visits policy
- Maternity Risk Management Strategy
- Medicines Management policies
- Medical Devices policy
- Mental Capacity Act and Deprivation of Liberty Standards Policy
- Moving and Handling policy
- Patient Identification policy
- Personal Development Review
- Policy on the Appointment of Medical locums
- Policy for Developing Policies
- Policy on the implementation of NICE guidelines
- Promoting Good Health at Work policy
- Race Equality Scheme
- Raising Concerns policy
- Risk Management policy
- Safe Management of Contractors
- Safeguarding Adults
- Safeguarding Children
- Security policy
- Waste policy

All operational policies, procedures and guidance also support the effective management of risk.

16. Trust Equalities Statement

CHFT 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. A separate equality impact assessment has been completed. 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.

APPENDIX 1
Glossary of Terms used within Policy

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

Board Assurance Framework	The BAF - Risks which impact upon the Trust achieving its strategic objectives	**Risk**	Effect of uncertainty on objectives
Control	An intervention used to manage risk	**Risk Acceptance**	Informed decision to take a particular risk
Exposure	Extent to which the organisation is subject to an event	**Risk aggregation**	Process to combine individual risks to obtain more complete understanding of risk
Hazard	Anything that has potential for harm	**Risk analysis**	Process to comprehend the nature of risk and to determine the level of risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	**Risk appetite**	Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate
Inherent risk	Exposure arising from a specific risk before any intervention to manage it	**Risk assessment**	Overall process of risk identification, risk analysis and risk evaluation
Level of Risk	Overall magnitude of a risk. It can be Very high, high, moderate, low or very low.	**Risk avoidance**	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Material Risk	Most significant risks or those on which the Board or equivalent focuses	**Risk management**	Coordinated activities to direct and control the organisation with regard to risk
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	**Risk owner**	Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
Operational Risk	The risk of loss or gain, resulting from internal processes, people and systems or from external events	**Risk Register**	A record of information about identified risks.
Programme Risk	Risk associated with transforming strategy into solutions via a collection of projects	**Significant Risk**	A risk that has a high probability with significant harm which requires recording on the HLRR.
Residual risk	Current risk. The risk remaining after risk treatment	**Target Risk**	A level of risk being planned for

APPENDIX 2

Risk Appetite and CHFT Annual Risk Appetite Statement

No organisation can achieve its objectives without taking risks. The Board will determine and continuously assess the nature and extent of the principal risks that CHFT is exposed to and is willing to take to achieve its objectives – known as the CHFT's risk appetite. The Board should also ensure that planning and decision-making reflects the level of risk with which CHFT aims to operate.

The risk appetite provides a structure for CHFT to work within, by enabling the organisation to take decisions based on an understanding of the risks involved. The organisation will communicate expectations for risk taking to managers.

CHFT uses the risk appetite matrix for NHS organisations developed by the Good Governance Institute (Board guidance on risk appetite, May 2020) to express its risk appetite.

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

Risk Categories

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

CHFT will agree categories of risk and will publish these, which will cover the over-arching areas of:

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

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

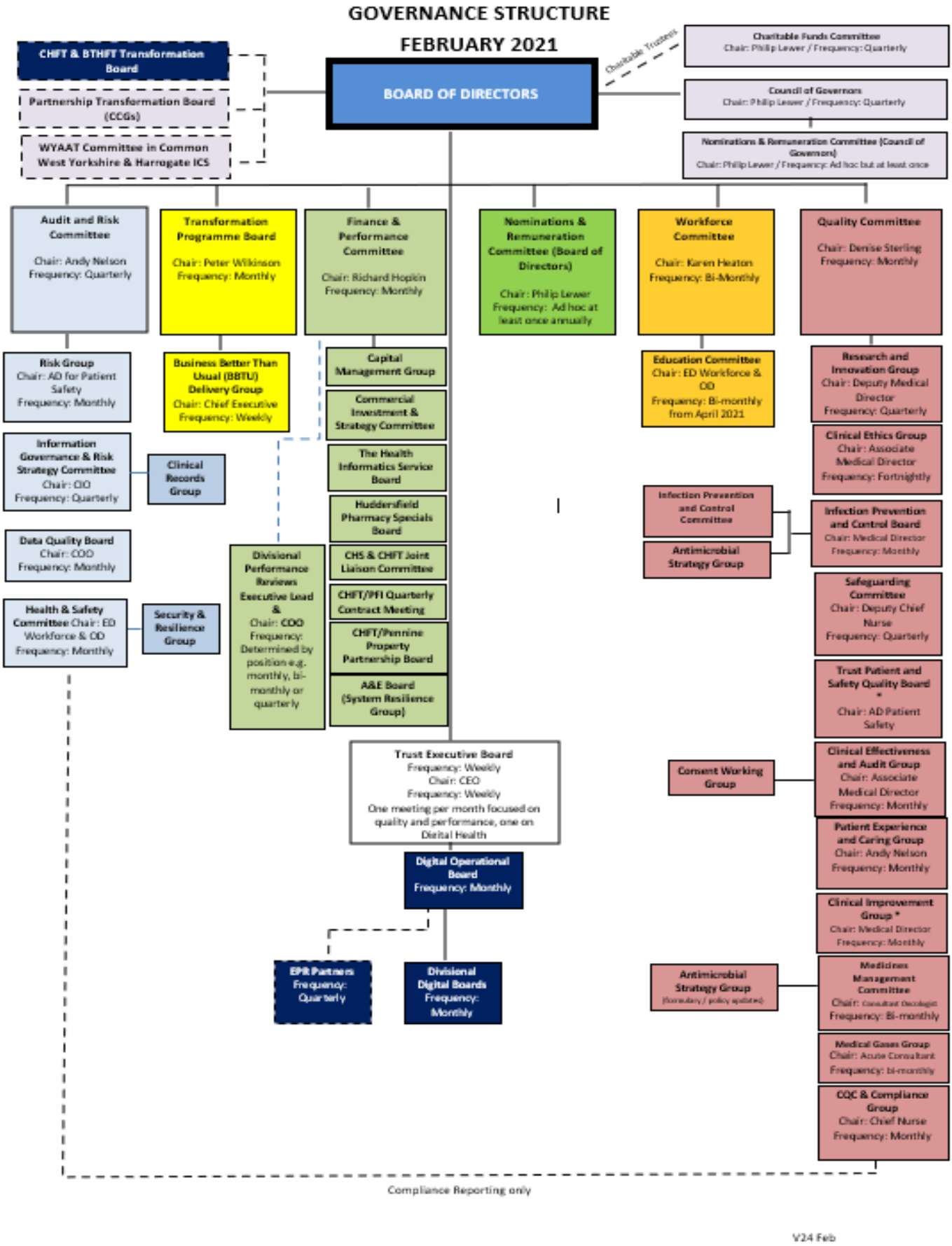
The Risk Group and Quality Committee will review the high – very high risks on the HLRR to ensure that risks are acceptable within CHFT risk appetite and that the CHFT's overall portfolio of risk is appropriate, managed, balanced and sustainable.

The Audit and Risk Committee will ensure that the CHFT risk appetite through its auditing and reporting process is being appropriately implemented to provide assurance to the Board

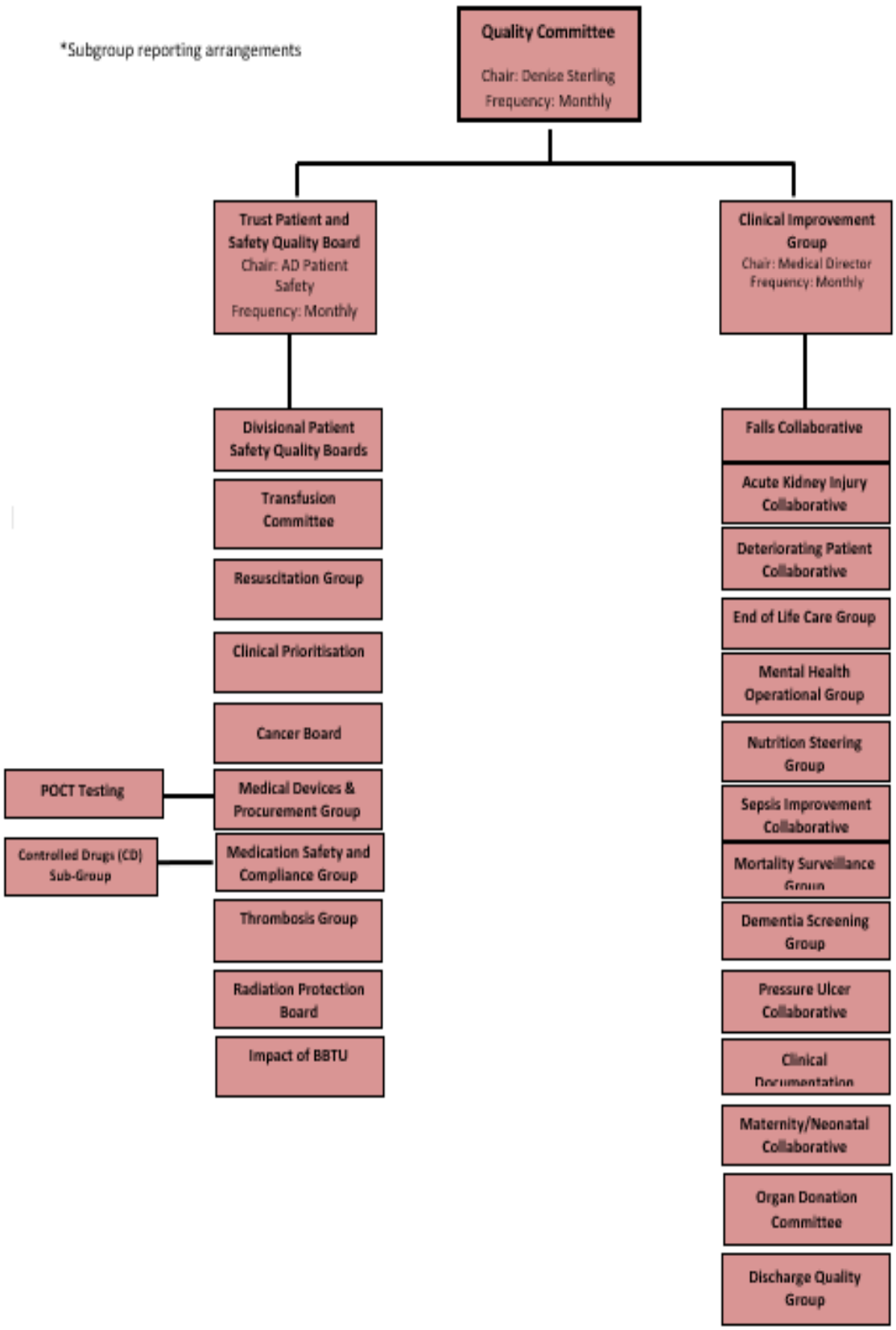
CHFT RISK APPETITE STATEMENT - August 2020

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

APPENDIX 3


GOVERNANCE STRUCTURE
FEBRUARY 2021
CHFT & BTHFT Transformation Board
Partnership Transformation Board (CCGs)
WYAAT Committee in Common West Yorkshire & Harrogate ICS
BOARD OF DIRECTORS
Charitable Trustees
Charitable Funds Committee
Chair: Philip Lewer / Frequency: Quarterly
Council of Governors
Chair: Philip Lewer / Frequency: Quarterly
Nominations & Remuneration Committee (Council of Governors)
Chair: Philip Lewer / Frequency: Ad hoc but at least once
Audit and Risk Committee
Chair: Andy Nelson
Frequency: Quarterly
Transformation Programme Board
Chair: Peter Wilkinson
Frequency: Monthly
Finance & Performance Committee
Chair: Richard Hoplin
Frequency: Monthly
Nominations & Remuneration Committee (Board of Directors)
Chair: Philip Lewer
Frequency: Ad hoc at least once annually
Workforce Committee
Chair: Karen Heaton
Frequency: Bi-Monthly
Quality Committee
Chair: Denise Sterling
Frequency: Monthly
Risk Group
Chair: AD for Patient Safety
Frequency: Monthly
Business Better Than Usual (BBTU) Delivery Group
Chair: Chief Executive
Frequency: Weekly
Capital Management Group
Commercial Investment & Strategy Committee
The Health Informatics Service Board
Huddersfield Pharmacy Specials Board
CHS & CHFT Joint Liaison Committee
CHFT/PFI Quarterly Contract Meeting
CHFT/Pennine Property Partnership Board
A&E Board (System Resilience Group)
Education Committee
Chair: ED Workforce & OD
Frequency: Bi-monthly from April 2021
Research and Innovation Group
Chair: Deputy Medical Director
Frequency: Quarterly
Clinical Ethics Group
Chair: Associate Medical Director
Frequency: Fortnightly
Information Governance & Risk Strategy Committee
Chair: CIO
Frequency: Quarterly
Clinical Records Group
Data Quality Board
Chair: COO
Frequency: Monthly
Health & Safety Committee Chair: ED Workforce & OD
Frequency: Monthly
Security & Resilience Group
Divisional Performance Reviews Executive Lead & Chair: COO
Frequency: Determined by position e.g. monthly, bi-monthly or quarterly
Infection Prevention and Control Committee
Antimicrobial Strategy Group
Infection Prevention and Control Board
Chair: Medical Director
Frequency: Monthly
Safeguarding Committee
Chair: Deputy Chief Nurse
Frequency: Quarterly
Trust Patient and Safety Quality Board *
Chair: AD Patient Safety
Trust Executive Board
Frequency: Weekly
Chair: CEO
Frequency: Weekly
One meeting per month focused on quality and performance, one on Digital Health
Consent Working Group
Clinical Effectiveness and Audit Group
Chair: Associate Medical Director
Frequency: Monthly
Patient Experience and Caring Group
Chair: Andy Nelson
Frequency: Monthly
Digital Operational Board
Frequency: Monthly
Clinical Improvement Group *
Chair: Medical Director
Frequency: Monthly
EPR Partners
Frequency: Quarterly
Divisional Digital Boards
Frequency: Monthly
Antimicrobial Strategy Group
Medicines Management Committee
Chair: Consultant Oncologist
Frequency: Bi-monthly
Medical Gases Group
Chair: Acute Consultant
Frequency: bi-monthly
CQC & Compliance Group
Chair: Chief Nurse
Frequency: Monthly
Compliance Reporting only
V24 Feb

*Subgroup reporting arrangements



APPENDIX 4

Risk Management Specialists

Caldicott Guardian
The Caldicott Guardian is a senior health professional who oversees all procedures affecting access to person-identifiable health data, protecting the confidentiality of patient and service user information.

Senior Information Risk Owner
As CHFT Senior Information Risk Owner (SIRO), the Chief Information Officer is responsible for ensuring that CHFT creates and manages its information risks, through the development of a network of Information Asset Owners (IAOs) and Information Assess Administrators (IAAs).

Information Governance Manager
The Information Governance Manager is responsible for ensuring that CHFT has robust strategies, policies and procedures for the management of CHFT's information, both corporate and clinical/patient.

The Information Governance Manager liaises with CHFT's Caldicott Guardian and Senior Information Risk Owner to ensure that CHFT meets and complies with the standards set out in the Data Security and Protection Toolkit.

Data Protection Officer – the Data Protection Officer is responsible upholding standards for the protection of personal data and ensures CHFT follows the law and appropriate regulations.

Company Secretary
The Company Secretary is responsible for ensuring the strategic risks for the organisation are captured in the Board Assurance Framework and that there are effective processes in place for managing central alerts. The role also ensures that the supporting Committee structure of the Board and their terms of reference reflect the Committee risk responsibilities system. This role also ensures that CHFT is aware of any compliance issues, i.e. via the Single Oversight Framework from NHS Improvement, and that any risks associated with new business or service change which may impact on CHFT ability to adhere to the Single Oversight Framework are appropriately reported throughout the organisation.

Executive Director of Nursing / Deputy Chief Executive
The Executive Director of Nursing is the Executive lead for risk management and patient safety in partnership with the Medical Director, ensuring organisational requirements are in place which satisfy the legal requirements of CHFT for quality and safety, patients and staff, including delivery of processes to enable effective risk management and clinical standards.

Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) has the following role and responsibilities: oversee local control of infection policies and their implementation; responsibility for the Infection Prevention and Control Team within the healthcare organisation; report directly to the Chief Executive and the Board; challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions; assess the impact of all existing and new policies and plans on infection and make recommendations for change; be an integral member of the organisation's clinical governance structures.

Medical Director
The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the and leads the quality improvement strategy. The Medical Director is responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation.

The Medical Director is also responsible for managing safety incidents in NHS screening programmes where CHFT is involved.

The Director of Workforce and Organisational Development has executive responsibility for health and safety.

The Director of Finance's responsibilities includes management of the PFI provider and Calderdale Huddersfield Solutions to manage estates risks.

The Chief Operating Officer has responsibility for security management and Trust resilience.

Head of Midwifery
The Head of Midwifery is the professional and management lead for midwives and is responsible for the co-ordination of clinical risk, providing expert advice for risk management within maternity services and responsible for supporting and embedding the implementation of risk management within maternity services. A Maternity Risk Management Strategy supports the continual improvement of the quality of clinical care through effective management of clinical risks and details roles and responsibilities for maternity risk management.

Fire Safety Manager
This includes the provision of a fire safety strategy and fire training for all staff in terms of prevention, fire precautions and safe evacuation. The role also includes ensuring each area has a current fire risk assessment. The Fire Safety Manager provides specialist advice to design consultant/architects in respect of statutory structural fire safety incorporating the requirements of health technical memorandum 05 Fire Safety requirements.

Head of Health and Safety
The Health and Safety Advisor is responsible for monitoring all staff related incidents on a regular basis and ensuring these are reported to the Health and Safety Committee. They will organise health and safety training and education of staff to support CHFT's compliance with health and safety requirements. Duties of all employees are detailed in the health and safety policy.

Resilience & Security Manager
The overall objective of CHFT Resilience and Security Management Specialist is to serve two separate functions as a designated Emergency Planning/Business Continuity Manager and the Local Security Management Specialist (LSMS) is to identify the work programs required to comply with both the Civil Contingencies Act (2004) and the NHS Protect Security Management Standards, as dictated by national service provision contract standards. The associated corporate work programs will form the basis of ongoing developmental work and an implementation plan to deliver compliance against legislation and standards.

Controlled Drugs Officer
The Clinical Director of Pharmacy is the controlled drugs accountable officer for CHFT (CDAO) in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006) and has responsibility for all aspects of controlled drugs management within CHFT, including standard operation procedures for controlled drugs, procurement and storage arrangements and oversight of the safe practices for prescribing and administration of controlled drugs, investigation of medication incidents.

The Clinical Director of Pharmacy is also the Chief Pharmacist and is responsible for policy and strategy in respect of medicines management.

Medication Safety Officer
CHFT has a Medication Safety Officer who oversees medication error incident reporting and learning to improve medication safety.

Radiation Protection
CHFT has a Radiation Protection Board chaired by the Divisional Director, with specialist and technical advice on radiation provided by the Radiology department and external radiation protection advisors.

Freedom to Speak Up Guardian
The Guardian acts as an independent and impartial source of advice for staff on raising concerns and will signpost staff to other sources of advice where necessary. In addition, the Guardian will help to support CHFT to become a more open and transparent place to work.

Senior Risk Manager - has day-to-day responsibility for risk management process, quality governance and safety management including:

- Challenging, grading and development of risks
- The development of risk management strategy and policies
- Administration of risk management systems
- Oversight of risk exposures facing the business
- Provision of risk management training and support to divisions
- The maintenance of the corporate service risk register
- Support the development of local risk registers
- Lead in triangulating and sharing lessons for learning from adverse events
- Liaise with the Company Secretary with regards inclusion of risks in the HLRR and/or BAF
- Involvement in internal and external audits related to risks

The Senior Risk Manager and Risk Manager also provide advice and support on risk management to staff.

Head of Safeguarding - has day to day responsibility for ensuring risks relating to safeguarding adults and children are managed in line with local policies and through collaborative working with other agencies and safeguarding practitioners.

APPENDIX 5

Risk Register Guidance - Risk Description

Describing Risk and Assigning Controls

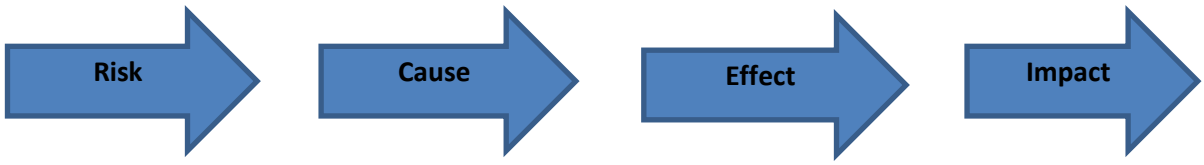
Risks are described in a clear, concise and consistent manner to ensure common understanding by all (including the public) with acronyms spelt out in the first instance. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

Staff should carefully consider the wording of risks as risk registers are subject to Freedom of Information requests i.e., copies of risk registers can be requested and be disclosed to individuals / organisations. Where risk assessments concern specific patients or employees and contain confidential information, they must not be added to the Risk Register in order to avoid breaching patient or staff confidentiality. Such risk assessments must be stored in the patient's health record, or employee personnel folder.

When wording the risk, it is helpful to think about it in four parts. For example:

"There is a risk of/that..... This is caused/due to by ..... and would result in.... leading to an impact upon....."

The Trust's standard for recording risks is to define risks in relation to:



- A **Risk** is described as something uncertain that may happen and could prevent us from meeting its objectives.
- The **Cause** is the problem or issue that 'could' cause the risk to happen.
- The **Effect** is the result of something that will happen if we do nothing about the risk
- The **Impact** is the wider impact of the risk on the objectives if we do nothing

An example of describing risk in the Trust standard is detailed below:

Objective: To ensure safe staffing levels

Risk: Risk of failure to maintain safe staffing levels

Cause:

- High staff sickness rate
- Difficulties in recruiting clinical staff
- Inability to release clinical staff for mandatory training

Effect: Staff not receiving compulsory training in resuscitation or blood safety

Impact:

• Increased safety risk to patients

APPENDIX 6

Assessing Risk and Calculating Residual Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring, i.e. multiplying the consequence / severity score by the likelihood score.

CHFT procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured

- **Current risk score -** this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target / residual risk score as action plans to mitigate risks are developed and implemented

- **Target / residual risk score -** this is the score that is expected after the action plan has been fully implemented and refers to **the amount of risk remaining after treatment**.

CHFT uses a standard 5 x 5 scoring matrix set out at Appendix 7

APPENDIX 7

Risk Grading Matrix

1. Impact

Impact is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

2. Likelihood

Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment and using relative frequency where this is appropriate.

1. Impact Score

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury (physical/ Psychological)	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, first aid treatment needed Health associated infection may/did result in semi-permanent harm Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Moderate injury or illness requiring professional intervention to resolve the issue RIDDOR / Agency reportable incident (7- 14 days lost) Adverse event which impacts on a small number of patients Increased length of hospital stay by 4 – 15 days	Incident leading to avoidable death Multiple permanent injuries or irreversible health effects

Environmental Impact	Potential for onsite release of substance Minimal or no impact on the environment	Onsite release of substance but contained Minor impact on the environment Minor damage to Trust property – easily remedied <£10K	On site release of substance Moderate impact on the environment Moderate damage to Trust property	Offsite release of substance Major impact on the environment Major damage to Trust property – external organisations required to remedy	Onsite /offsite release with catastrophic effects Catastrophic impact on the environment Loss of building / major piece of equipment vital to CHFTs business continuity
Staffing & Competence	Short term low staffing level (<1 day) – temporary disruption to patient care Minor competency related failure reduces service quality <1 day	On-going low staffing level - minor reduction in quality of patient care Unresolved trend relating to competency reducing service quality 75 % staff attendance at mandatory / key training	Ongoing low staffing resulting in moderate reduction in the quality of patient care Late delivery of key objective / service due to lack of staff Error due to ineffective training / competency 50% - 75% staff attendance at mandatory / key training	Loss of key staff Uncertain delivery of key objective / service due to lack of staff Serious error due to ineffective training and / or competency 25%-50% staff attendance at mandatory / key training	Loss of several key staff Non-delivery of key objective/service due to lack of staff Critical error leading to fatality due to lack of staff or insufficient training and / or competency Less than 25% attendance at mandatory / key training on an on-going basis
Business/ Service Interruption	Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services	Short term disruption, of >8 hours, with minor impact	Loss / interruption of >1 day Disruption causing impact on patient care Non-permanent loss of ability to provide service	Loss / interruption of > 1 week. Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked Temporary service closure	Permanent loss of core service / facility Disruption to facility leading to significant 'knock-on' effect across local health economy Extended service closure

Inspection/ Regulatory Compliance/ Statutory Duty	Inspection/ Regulatory Compliance/ Statutory Duty Small number of recommendations which focus on minor quality improvement issues Minimal breach of guidance / statutory duty Minor non-compliance with standards	Single failure to meet standards No audit trail to demonstrate that objectives are being met (NICE; HSE; NSF etc.)	Challenging recommendations which can be addressed with appropriate action plans Single breach of statutory duty Non-compliance with > one core standard	Enforcement action Multiple breaches of statutory duty Improvement Notice Trust rating poor in National performance rating Major non compliance with core standards	Multiple breaches of statutory duty Prosecution Severely critical report on compliance with national standards Zero performance rating Complete systems change required
Adverse Publicity / Reputation	Rumours Potential for public concern	Local Media – short term – minor effect on public attitudes / staff morale Elements of public expectation not being met	Local media – long term – moderate effect – impact on public perception of Trust & staff morale	National media <3 days – public confidence in organisation undermined Use of services affected	National / International adverse publicity >3 days. MP concerned (questions in the House) Total loss of public confidence
Financial	Small Financial loss < £1K	Loss <£1k - £50K	Loss of £50K - £500K	Loss of £500K - £1M	Loss > £5M

Fire Safety/ Security Management	Minor short term (<1day) shortfall in fire safety system. Security incident with no adverse outcome	Temporary (<1 month) shortfall in fire safety system / single detector etc (non-patient area) Security incident managed locally Controlled drug discrepancy – accounted for	Fire code non-compliance / lack of single detector – patient area etc. Security incident leading to compromised staff / patient safety. Controlled drug discrepancy – not accounted for	Significant failure of critical component of fire safety system (patient area) Serious compromise of staff / patient safety Loss of vulnerable adult resulting in major injury or harm Major controlled drug incident involving a member of staff	Failure of multiple critical components of fire safety system (high risk patient area) Infant/young person abduction Loss of vulnerable adult resulting in death
Complaints/ Claims	Informal / locally resolved complaint Potential for settlement / litigation <£0.1 million	Overall treatment / service substandard Formal justified complaint (stage 1) Minor implications for patient safety Claim >£0.1 million	Justified complaint (stage 2) involving lack of appropriate care Potential for independent review Moderate implications for patient safety Claim(s) between £10K - £500K	Multiple justified complaints Findings of Inquest suggesting poor treatment or care Non-compliance with national standards implying significant risk to patient safety Claim(s) between £500K - £1M	Multiple justified complaints Single major claim Ombudsman inquiry Totally unsatisfactory level or quality of treatment / service Claims >£1M

2. Likelihood score

What is the likelihood of **the impact / consequence** occurring?

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur within a year	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	Less than 10%	11 – 30%	31 – 50%	51 – 70%	Greater than 70%

Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst-case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register**

Risk Grading

Risk grading makes it easier to understand the Division/Directorate/Trust risk profile. It provides a systematic framework to identify the level at which the risks must be managed and overseen in the organisation, prioritise actions and resources to address risk and direct which risks should be on the HLRR register.

Having assessed and scored the risk using the 5x5 risk scoring matrix, use the table below to grade the risk as low, moderate, high or very high.

Table 3
Risk scoring = Impact / Consequence x likelihood

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

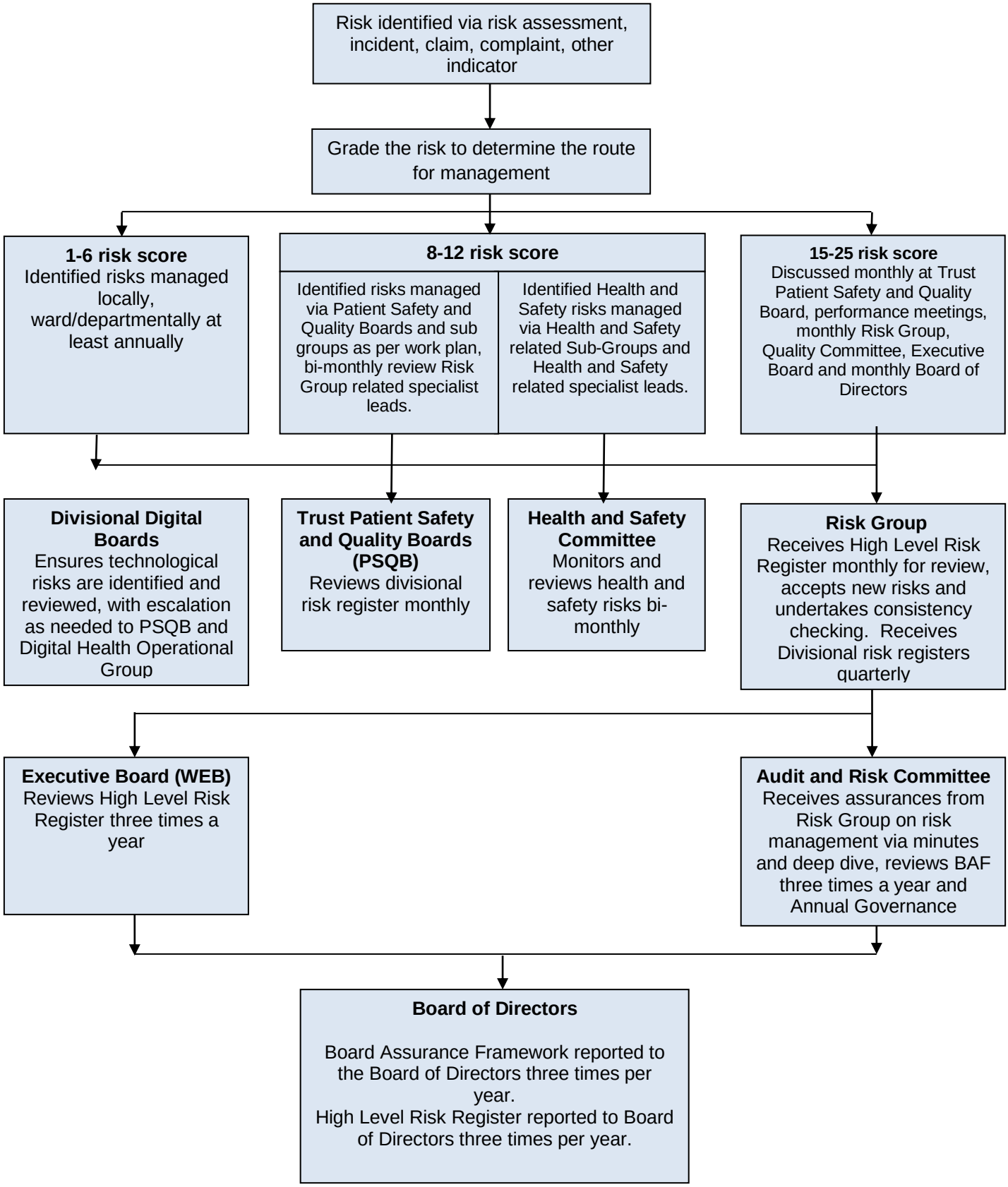
1 - 6	Low Risk	
8 - 12	Medium Risk	
15-16	High Risk	Significant Risks to be included in the High Level Risk Register (HLRR)
20 - 25	Very High	

APPENDIX 8

Compliance Registers Content Guidance: External inspections / reviews

CQC must do actions which are a failure to meet regulatory standards	CHFT position will be captured in the corporate service register, any that relate to a specific core service to feature on the associated divisional register. Actions not driven by compliance register, acknowledge they are monitored elsewhere
Quality surveillance programme (previously cancer peer review):	Self-assessments or visits
Other peer review programmes	Include national, regional, local networks
Health & safety executive NHS Improvement NHS England NHS Digital Health Education England GMC	Outcome of any specific assessment of CHFT
National audits	Capture any audits where CHFT services are significant outlier – high level messages
NICE guidance	Include any guidance where CHFT services will remain non-compliant, not those where we are working towards compliance. These can be listed as one entry referencing that they feature on CHFT NICE database and are monitored through Clinical Audit and Effectiveness Group and Divisional PSQB Reference should be made to the specific recommendation relating to the non-compliance
NCEPOD	Include any recommendations of significant non-compliance. These can be listed as one entry referencing that they feature on CHFT NCEPOD database and are monitored through Clinical Audit and Effectiveness Group and Divisional PSQB Reference should be made to the specific recommendation relating to the non-compliance
Service reviews: - National screening programmes - Accreditations (mandatory and voluntary) - Quality Assurance - Royal college	Outcome of any specific assessment of CHFT
Ofsted inspections (health aspects)	Main inspection will sit with lead organisation
Internal audits	Limited assurance reports
Invited service reviews: - Clinical - Non clinical / corporate services (e.g. ISO stds)	

APPENDIX 9


Risk identified via risk assessment, incident, claim, complaint, other indicator
Grade the risk to determine the route for management
1-6 risk score
Identified risks managed locally, ward/departmentally at least annually
8-12 risk score
Identified risks managed via Patient Safety and Quality Boards and sub groups as per work plan, bi-monthly review Risk Group related specialist leads.
Identified Health and Safety risks managed via Health and Safety related Sub-Groups and Health and Safety related specialist leads.
15-25 risk score
Discussed monthly at Trust Patient Safety and Quality Board, performance meetings, monthly Risk Group, Quality Committee, Executive Board and monthly Board of Directors
Divisional Digital Boards
Ensures technological risks are identified and reviewed, with escalation as needed to PSQB and Digital Health Operational Group
Trust Patient Safety and Quality Boards (PSQB)
Reviews divisional risk register monthly
Health and Safety Committee
Monitors and reviews health and safety risks bi-monthly
Risk Group
Receives High Level Risk Register monthly for review, accepts new risks and undertakes consistency checking. Receives Divisional risk registers quarterly
Executive Board (WEB)
Reviews High Level Risk Register three times a year
Audit and Risk Committee
Receives assurances from Risk Group on risk management via minutes and deep dive, reviews BAF three times a year and Annual Governance
Board of Directors
Board Assurance Framework reported to the Board of Directors three times per year.
High Level Risk Register reported to Board of Directors three times per year.

19. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title:	Board Assurance Framework – Update 3 2020/21
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee 26 January 2021 Quality Committee 22 February 2021 Review of individual risks by respective Board Committees

Purpose of the Report

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

This report presents the third and final update of the Board Assurance Framework (BAF) for 2020/21 approval following review of the BAF by the Audit and Risk Committee and recommendation for approval.

Key Points to Note

Risk Profile
The Trust has the following risk profile for its strategic risks as at 23 February 2021:

BAF Risks	Total Number of Risks	Change
Red Risks	14	↑ 2
Amber Risks	7	↓ 2
Green Risks	1	0
Total	22	0

All BAF risks have been reviewed and updated by the lead Director, with a specific focus on identification of gaps in control and actions to mitigate risks towards the target scores. Updates are shown in red font for ease of reference in the enclosed full BAF document.

There have been no new risks added to the Board Assurance Framework (BAF) since the last report presented to the Board on 5 November 2020.

There have been increases in two risks scores following review by the Quality Committee and Executive Director of Nursing:

- *4/19 Patient and Public Involvement* - increased risk score from 12 to 16 due to the current pandemic impacting on the progression of actions to mitigate the risks

- *4/20 CQC rating* - increased risk score from 12 to 16, with an increase in the likelihood score from 3 to 4 as a result of the gaps in assurance and gaps in control, namely as a result of the change in the way CQC is currently operating and the scaling back of internal CQC preparation and assessment activity in response to pandemic response priorities.

The other change to note is that a review of the wording of risk 9/19 relating to the Trust current and future estate has taken place and overlap with risk 14/19, capital funding has been removed from the 9/19 risk description.

Risk Exposure

Where a BAF risk score is higher than the risk appetite (eg risk score of 15 or above where risk appetite is moderate or low) this has been identified as a breach of the risk appetite.

In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of information and assurance on the management of risks with risk exposure.

Given the increased scores for risk 4/19 patient and public involvement and 4/20 CQC rating and their risk appetites this adds to the Trust's risk exposure with eight areas of risk exposure summarised below:

Strategic Goal: Transforming and Improving Care	Risk Score	Risk Appetite category	Risk Appetite
4/19 Patient and Public Involvement	16 ↑	Regulation	Moderate
7/20 Reducing health inequalities	16=	Harm and safety	Low
Strategic Goal: Keeping The Base Safe			
4/20 CQC rating	16 ↑	Regulation	Moderate
7/19 NHS Improvement Compliance	15=	Regulation	Moderate
8/19 Performance targets	20=	Regulation	Moderate
5/20 Service capacity due to Covid-19	20=	Harm and safety	Low
Strategic Goal: Sustainability			
14/19 Capital funding	16=	Financial/Assets	Moderate
18/19 Long term financial sustainability	25=	Financial/Assets	Moderate

These areas of risk exposure are shaded in grey in the summary sheet of risks in the enclosed BAF.

Board Committee review of risks

Board Committee Chairs reviewed the spread of BAF risks by Committee on 10 February 2021. Following discussion, it was agreed that the Transformation Programme Board was the most appropriate Board Committee to review risk 9/19 relating to the Trust estate. There were no other changes made. The full list of Board oversight of BAF risks is given below and a review of risks is scheduled into the workplans of each Committee.

Board / Board Committee	BAF Risk
Audit & Risk Committee	16/19 Health and Safety Compliance

Board	7/19 Compliance with NHS England / Improvement 7/20 Health inequalities
Transformation Programme Board	1/19 Reconfiguration 2/20 Digital Strategy 3/20 Business Better Than Usual – service transformation 1/20 Clinical strategy 6/20 Climate action failure 9/19 Estates (moved from Finance and Performance Committee 10/2/21)
Workforce Committee	10a/19 Medical Staffing 10b/ 19 Nurse staffing 11/19 Recruitment/ Retention inclusive leadership 12/19 Colleague engagement
Quality Committee	3/19 Seven day services 4/19 Patient and Public Involvement 6/19 Compliance with quality and safety standards 4/20 CQC rating
Finance & Performance committee	5/20 Service Capacity (Covid) - reconfirmed 10/2/21 8/19 National and local performance targets 14/19 Capital funding 15/19 Commercial growth 18/19 Long term financial sustainability

EQIA – Equality Impact Assessment

The BAF has a specific risk, risk 07/20, which relates to the Trust making slow progress addressing health inequalities in the 20% of the most deprived patients in our communities. The Trust's response to and progress with actions identified in the West Yorkshire and Harrogate Health and Care Partnership report on 22 October 2020 on tackling health inequalities for Black, Asian and minority ethnic communities and colleagues is being presented to the Board under a separate paper and is expected to become a standing item on Board agendas following discussion.

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

Recommendation

The Board is asked to **APPROVE** the updated Board Assurance Framework as at 23 February 2021, noting the movement in risk scores and areas of risk exposure.

Update 3 23 February 2021 for 4 March 2021 Board of Directors
2020/21

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2020/21

Contents:

compassionate care

CHFT RISK APPETITE STATEMENT - Revised August 2020

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

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming and Improving Patient Care								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**15 =**	10	AB	2827, 5806,7413,7414	Strategic/ Organisational	Significant
03/19	Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	15	**6 =**	4	DB	None	Regulation	Moderate
04/19	Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a a meaningful way to patient and service user feedback resulting in services not designing services using patient recommendations	12	**16 ↑**	4	EA	None	Regulation	Moderate
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce	15	**15 =**	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	12	**12 =**	9	MG	7279, 7617	Innovation/ Technology	High
03/20	Risk the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation, resulting in the Trust not being able to stabilise the future delivery of services and missing opportunities for improvement in the quality, experience and efficency of service delivery.	12	**12=**	8	AB	None	Strategic/ Organisational	Significant
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete data, mismatch between service and deprivation, lack of quality priorites to advance health equity and health prevention, ineffective partnership working a resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	**16=**	8	EA	None	Harm and safety	Low
Keeping the base safe								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**12 =**	10	EA	19 risks see individual sheet	Regulation	Moderate
07/19	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement resulting in enforcement action	25	**15 =**	10	OW	None	Regulation	Moderate
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**20 =**	12	HB	7615	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**15 =**	8	GB	5806	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage	9	**9 =**	4	SD	7413, 7414 , 7474	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation	12	**16 ↑**	6	EA	None	Regulation	Moderate
05/20	Risk that services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand and non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is a potential for an adverse impact on health inequality.	20	**20=**	8	OW	7778, 7797, 7315, 7689, 3793, 7796. 7683, 7778, 7809, 7834	Harm and safety	Low

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

A workforce fit for the future								
10a /19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	9	DB	2827,7078, 5747	Quality/Innovation & Improvement	Significant
10b /19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	9	EA	6345, 7557	Quality/Innovation & Improvement	Significant
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues	16	**12 =**	9	SD	7248	Quality/Innovation & Improvement	Significant
12/19	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to a lack of robust engagement mechanisms	12	**9 =**	4	SD	None	Workforce	Low
Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**16 =**	12	GB	None	Financial/Assets	Moderate
15/19	Risk that the Trust will not deliver external growth for commercial ventures resulting in potential lost financial contrbution..	**9 =**	**9 =**	6	GB	None	Commercial	High
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16=**	12	GB	None	Financial/Assets	Moderate
06/20	Risk of climate action failure resulting in adverse impacts on public health, patients, natural environment and reputation denotes risk with risk exposure	16	**16 =**	9	SS	None	Strategic/ Organisational	Significant

HEAT MAP

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

= no change to risk score

Assessment is Likelihood x Consequence

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

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

Gaps in Control	Timescales	Lead
1.Trust and CCGs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH and a hospital travel plan is required.	1. Discussions are taking place with YAS and activity modelling and clinical protocols will be agreed and confirmed in the OBC. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been drafted and is progressing to completion. 4. The Trust is finalising a business case for the development of a multi-storey car park facility for CRH. The Trust will then seek to progress this forward ahead of the reconfiguration. The travel plan has been developed and will be submitted for approval at TPB on 3rd February 2021. 5. The site plans for CRH and HRI are beng finalised and planning applications are scheduled for submission in May 2021.	AB for all actions

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021** **Risk category: Regulation** **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
3.19	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days due to staffing pressures resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Governance systems and performance indicators in place • Rosters focussed on managing Covid-19 providng extended cover • Early implementer to trial new NHSE methodology of Board assurance and sign off. Survey completed twice yearly (Spring/ Autumn) • Programme to extend 7 day working across medical specialities - now includes elderly medicine, respiratory, cardiology, gastro, stroke, haematology, acute medicine, diabetes with discussions progressing in palliative care • Reconfiguration of medical services: elderly medicine, cardiology, respiratory, gastroenterology has facilitated the introduction of speciality on-call rotas to expand provision of 7 day speciality cover	First line HSMR and SHMI within expected range. Audit to assess impact of expanded 7 day working on outcomes: HSMR and weekend vs weekday mortality trends over the last 2 years Second line Deep dive report on this risk to Quality Committee 30.12.20. minor amend to risk description Integrated Board report Benchmarked against four priority seven day standards - full compliance at most recent audit in May 2018. Bi-annual submission for compliance against the seven day standards to NHS England / Improvement approved at WEB (20/06/19, 12/12/19 confirmed compliance against all four NHSE priority standards) Single Oversight Framework. Quality Accounts 2019/20 confirmed compliance against standards 2018/19. Third line Positive feedback from NHSI/E, NHSE-led, WYAAT-wide implementation scheme Benchmarking exercise against remaining 6 non-priority standards to report to WEB	Radiology staffing pressures present risk of continued delivery of standards 5 and 6 - access to diagnostic tests and access to consultant -directed interventions Improved staffing in Accident and Emergency, however remains insufficient to deliver extended Consultant presence in accordance with National Guidance. Diagnsotic capacity in Radiology and Endoscopy limited by requirements of Covid-19. Resource to audit 4 standards to be confirmed, report of audit to Quality Committee	• Scope for futher implementation limited without service reconfiguration or additional investment NHS I suspended collection of reports on seven day service standards due to Covid-19 in March 2020 - lack of clarity nationally on whether the sevem day service assurance process will continue. Action: Explore local audit measures Lead: Deputy Medical Director Future response to a second Covid-19 wave may impact delivery of 7 days services in some specialities as a result of changes to both medical and nursing rotas.	**5x3 = 15**	**3x2= 6**	**2x2 = 4**

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

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
TRANSFORMING AND IMPROVING PATIENT CARE

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4.19	Quality Committee	Executive Director of Nursing / Deputy Chief Executive	**Risk** Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a meaningful way to patient and service user feedback resulting in not designing services using patient recommendations **Impact** - poor patient experience Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group in place which mandates the workplan and oversees progress and audit activity for patient experience Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs • Patient engagement in Outpatient Transformation Programme • Pilots of changes to service models being tested with patients • Patient Engagement champions in clinical areas to support staff in engaging with patients and service users • Public and patient engagement events re: business better than usual Strategic Outline Case • Nursing and Midwifery Strategy which enables staff time to care for patients • Health Inequalities group set up • Matron assigned to Reconfiguration Team to lead on patient experience	<u>First line</u> Public involvement and engagement included in Patient Experience Group, Areas of good practice with service users identified within the Trust, eg Youth Forum Introducing Observe and Act observation tool initiative to "see through the patient eyes" . Range of local initiatives have either been progressed or in the planning (detailed in deep dive report to Quality Committee January 2021) <u>Second line</u> Patient Story to Board meetings Governor attends Patient Experience Group Patient Experience Group reporting to Quality Committee add dates. Review of risk at Quality Committee January 2021 and increase of score from 12 to 16. <u>Third line</u> Quality Account to NHS Improvement, CCGs and other stakeholders CQC rating of Good - report referenced positive examples of patient engagement Healthwatch reports (Outpatients post Electronic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and involvement data - lead Assistant Director for Patient Experience, March 2021 Lack of consistent approach when seeking patient input to re-designing services - plan for clinical attachments to Transformation porject support to consider impact of service change on patient experience. Senior Nurse has now been identified to work as part of the reconfiguration central team, November 2020 Lack of mechanism for systematic involvement of members of BAME communities. Action: To be considered within development of Patient and Service User Engagement Strategy , Assistant Director Patient Experience December 2020 Patient and service User Engagement Strategy to be developed by new Associate Director Patient Experience March 2021. Covid response has impacted on the pace of progression of some workstreams.	Well-led developmental review identifies actions to improve patient involvement and Equality & Diversity - action delayed due to repsonse to Covid-19 pandemic. Action to pick up as Business Better Than Usuual, lead: Director of Nursing and Associate Director of Patient Experience - timescale March 2021 due to current situation	**Initial** 3x4 = 12	**Current** 4x4 = 16	**Target** 1x4 = 4

Action	**Timescales**	**Lead**
1. Develop central system of patient engagement	31/03/21	AD Patient Experience
3. Mechanism for systematic invovlement of BAME communities	March 2021	Ellen Armistead
4. Patient and Service User Engagement Strategy	March 2021	AD Patient Experience AD Patient Experience

Links to risk register:
No risks on the high level risk register

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
TRANSFORMING AND IMPROVING PATIENT CARE

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2021 Risk Category; Innovation/Technology Risk Appetite: High		
								Initial	Current	Target
02 /20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the 10 year digital strategy Digital Aspirant and Scan for Safety Funding for next 2 3 years and committed capital funding from the Trust Dedicated Digital Transformation Director co-ordinating digital programmes and providing leadership Governance via Digital Health Forum and Digital Operations Board. Digital Operations Board chaired by Managing Director Digital Health Monthly meetings with Managing Director Digital Health and Director of Finance reviewing progress with digital investment strategy - Divisonal Digital Boards	**First Line:** Digital Health Forum meeting bi-monthly, programme of work and progress presenned at each meeting **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2021/22 secured as part of capital planning meeting November 2020. Progress update on paper reduction to WEB 18.2.21. **Third Line:** Digital Aspirant Trust Scan for Safety	Lack of consistent attendance at Digital Operational Board meetings - Action: Divisional Directors and Chief Operating Officer to ensure appropriate resource identified to attend divisional digital Board meetings - still inconsistent but improving Review terms of reference for Divisional Digital Boards to ensure clarity of purpose of group and consistent approach Action: Divisional Director of Operations Review Digital Operations Group terms of reference Lead: Managing Director Digital Health to become executive Sponsor	Managing Director Digital Health to launch Strategy at Divisonal Digital Boards Annual review Board 2021 July	4x3 = 12	4x3 = 12	3x3=9

Action	Timescales	Lead
Review terms of reference of Divisional Digital Boards (Divisional Directors) and Digital Operations Group (Managing Director - Digital Health)	February 2021 for 4 March 2021 Board	Divisional Directors for divisional digital Boards / COO /Mandy Griffin
Ongoing monitoring via Finance and Performance Committeee 1/10 reconfiguration	Ongoing	Gary Boothby

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
TRANSFORMING AND IMPROVING PATIENT CARE

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								Initial	**Current**	**Target**
03/20 July 2020	Transformation Programme Board	Director of Transformations and Partnerships	**Business Better Than Usual (BBTU)** There is a risk that the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation. As a result the Trust may not be able to stabilise the future delivery of services and will miss opportunities for improvement in the quality, experience and efficency of service delivery.	CHFT has engaged colleagues, patients and partners across the Calderdale and Greater Huddersfield health and social care system to capture learning from experience of their responses to the COVID -19 pandemic. The findings from this were presented to the Trust Board on 2nd July 2020 and 12 key learning themes of transformational changes that should be sustained and amplified were agreed by the Board. Governance and management arrangements to provide assurance on the implementation of this have been agreed by the Trust Board and are being implemented. This includes: - appointment of theme leads - establishment of BBTU Delivery Group - oversight by Transformation Programme Board	**First Line** - A BBTU Delivery Group chaired by the CEO has been established and includes membership of a named Lead for each learning theme. The Delivery Group will lead implementation and provide progress reports to the Transformation Programme Board. **Second Line** - the Transformation Programme Board will provide oversight of the BBTU programme of delivery and and provide reports on progress to the Trust Board. (16.10.20.) **Third Line**. External - the Trust will collaborate and work with external stakeholders (e.g.CCGs, acute and mental health Trusts, community providers, hospices, voluntary sector, social care, the West Yorkshire ICS, and NHSE) to progress and provide regular updates on actions to respond to learning from the pandemic.	Impact Assessments to be completed: Additional work is required to ensure and demonstrate that implementation of BBTU includes assurance of robust EQIA, QIA, digital impact assessment and patient involvement and to provide reports on this to the Workforce and Quality Committees. As the plans for implementation of each theme develops further work will be needed to assess the financial impacts of BBTU and provide reports on this to the Finance and Performance Committee. Lead: Anna Basford Timeframe: March 2021	The work to implement BBTU is at an early stage and key milestones need to be agreed to enable monitoring and reporting on progress.	**3x4=12**	**3x4=12**	**2x4=8**
Action					**Timescales**			**Lead**		
Theme lead to develop blueprint of critical success factors -benefits, enablers, dependencies for each theme					Progress report was considered at the TPB in December and will be submitted to the Trust Quality Committee and Finance & Performance Committee at end of January / early February 2021. Further work to confirm enabling costs, measurement of benefits and implementation milestones for 2021/22 will be concluded by March 2021.			Theme leads		
Links to risk register:None										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
TRANSFORMING AND IMPROVING PATIENT CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021 Risk category: Harm and Safety Risk appetite: low**		
07/20 July 2020	Trust Board	Director of Nursing / Deputy Chief Executive	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Director of Nursing named Board Executive providing accountable leadership for tackling health inequalities. Chief Executive expertise in health inequalities. Reset and stabilisation and winter plan EQIA Equality impact assessment (EQIA) process for service and policy changes. Equality Impact Assessment discussion at Board development session 6 August 2020, on Marmot Review Health Equity in Engalnd 10 Years and review A&E activity data by index of multiple deprivation and local super output area to increase knowledge of Board members on why addressing health inequalities is important and provide insight to local health inequality issues Diversity - 1 Executive and 1 Non-Executive BAME members of the Board brings lived experience to help tackle health inequalities. Trust Diversity and inclusion networks and 5 year plan for inclusion (Staff). West Yorkshire and Harrogate Healthcare Partnership (ICS) - Trust plays a full part in Health and Well-Being Boards and place-based partnerships, where reducing inequality is an ICS goal and exemplified in the Professor Dame Donna Kinnair DBE review. CHFT part of the Health Inequalities Academy to share best practice and agree workstreams. Nominations and Remuneration Committee (Board of Directors) agreed actions to improve Board diversity as part of succession planning and Inclusive Recruitment Strategy for Director vacancies 12.2.21.	**First Line** - developing data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. Project in Maternity Services underway to look at outcomes and experiences of those from most deprived areas in the community. **Second Line** - Board development sessions: 6.8.20. to increase knowledge and understanding re health inequalities locally and nationally,4 February 2021 on planned care backlog and prioritisation with view from health inequalities lense EQIA referenced in all Board paper front sheets **Third Line**. External - none to date.	Health Inequalities Academy workstreams to be defined by February 2021 Leadership - Reflect our diverse community through a 5 year Board action plan for Board and senior staffing to match the BAME workforce by 2025. Action: Progress Board diversity actions agreed at Nominations and Remuneration Committee February 2021 Lead: Director of Workforce and Organisational Development Timescale Ongoing	Restoration service activity performance monitoring to include deprivation data (index of multiple deprivation) for patients from 20% most deprived neighbourhoods and communitties: Lead: EA/HB Timescale: February 2021	**Initial**	**Current**	**Target**
								4x4=16	4x4=16	2x4=8

Action	**Timescales**	**Lead**
Finalisation of action plan to address 8 urgent actions on health inequalities	Feb-21	Ellen Armistead
Agree Board plan	Feb-21	Director of Workforce and Organisational Development
Restoration service activity performance monitoring to include deprivation data (index of multiple deprivation) for patients from 20% most deprived neighbourhoods and communities	Feb-21	Ellen Armistead/Helen Barker

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2 KEEPING THE BASE SAFE

Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2021 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
06/19	23 February 2021 for 4 March 2021 Board of Directors	Executive Director of Nursing / Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Review of quality governance arrangements • SI investigation process identifies recommendations to improve care with strong governance in place • Strengthened risk management arrangements at divisional level, including compliance registers • Programme of assurance visits in place • Consistent mandatory and essential training compliance • Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry/ Emergency Support Framework • Refreshed risk management strategy. • Quality Governance structure reviewed. • Learning and Improving: Quality and Safety Strategy agreed. • Regular leadership assurance visits are in place and findings uploaded onto Knowledge Portal.	First line Assessment of compliance with NICE guidance Ward accreditation - Performance against saferty must dos reviewed at ward / matron level HSMR & SHMI Mandatory training compliance at Jan 2021 95.18% Improved real time assurance on impact of safety staffing and quality -Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed Bi-monthly Quality Report to Quality Committee and Board KPIs in Integrated Performance Report PSQB reports to Quality Committee Infection Prevention and Control report to Board IPC Board Assurance Framework approved at Board 2 July 2020, provided assurance on IPC activity Serious incident report to Quality Committee Safer Staffing Hard Truths report to Board 3.9.20. Third line CQC rating of Good Quality Account reviewed by External Auditors and stakeholder bodies Independent assurance on clinical audit strategy Feedback through ongoing relationship with arms length regulatory bodies Independent Service Reviews (ISR) and accreditations. ISR March 2019 assurance on process for responding to NPSA alerts Health Services Investigation Branch reports	• Investigator capacity to support Si investigations and standard of serious incident investigations needs further improvement Alternative model for investigators to Quality Committee • Safety "must do's" to be embedded on wards - Quality Governance - quality governance arrangements and structures to be reviewed Lead: Director of Nursing / Medical Director • Quality and Safety Strategy to be rolled out Q4 2020/21 and Q1 2021/22	• CQC assessed the Trust as requires improvement for safe domain • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements - see 10a/19 (Allocate) • There has been a move away from non essential activity by relevant regulators in response to the pandemic.	3x5 = 15	3x4= 12	2x5 = 10

Action	Timescales	Lead
Develop alternative model for serious incident investigtaors and present to Quality Committee	TBC	EA
Quality and Safety Strategy to be rolled out	Q4 2020/21 and Q1 2021/22	EA

Links to risk register:
Risk Opthalomology (7930 glaucoma. 7769 eye pathology, 7964 macular / medical retina eye conditions, 7809, clinical capacity, 7689 waits for diagnostics, operations and outpatients, 7683 isolation capacity, 7474 Medical devices, 7809 theatre and clinic capacity, 7834 Elective orthopaedic inpatient theatre capacity, 6453 delay of surgical repair of #NOF, 7527 risk of progression of cancer due to booking issues with follow up appointments, 2827 ED middle grade medical staffing capacity, 2830 Delays in patients having Mental Health Act assessments, 7833 appointment slot issues for Trauma and Orthopaedics, 7942 Staffing levels due to covid infections, 7796 staffing shortages (self isolation), 7797 infection control outbreaks, 7803 surgery delay general trauma patients, 7615 emergency care delays not meeting the 4 hour emergency care standard, 6715 inconsistent completion EPR documentation

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2021 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
7.19	Board of Directors	Chief Executive	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement (NHS E/I) **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• Board approved 10 Year Strategic Plan •Board member participation in Place based system meetings with NHS E/I(1 Kirklees, 1 Calderdale) with ICS feedback letter • ICS system financial regime • Standing Financial Instructions and budget management • Review of monthly NHS E/I bulletins to assess any required actions • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Transformation project support in place • Use of Resources work steered by Finance and Performance Committee • Executive leads assigned for 5 Use of resources areas with working groups reporting to Executive leads • Post project evaluation reported at Capital Management Group for capital schemes and Commercial Investment Strategy group for revenue investment	First line Transformation project support Weekly monitoring of performance and Covid spend (incident Management Team and Finance) Minutes from Capital Management Group and commercial investment strategy group, reporting into Finance and Performance Committee. Second line Integrated Board report monitoring of key regulatory standards to every Board public meeting and Finance and Performance Committee, most recent F&P discussion 12.1.21 ,Board 5.11.20., 14 .2.21. WEB Use of Resources report (9 July 2020) and Finance and Performance Committee (29 June 2020) describes preparatory approach to next assessment. Finance and Performance Committee (2.11.20-,12.1.21) updated on progress with 5 Use of Resource workgroups and approach to validation of assessment discussed. At month 8 the Trust is reporting a favourable position compared to re-set plan and is forecasting to deliver an improvement against the internal plan set and in line with the plan submitted. Finance and Performance Committee, Board 14 January 2021) All cash requests in support of Covid-19 have been fully supported. Third line Current use of resource score has been a 2 from April to August 2020 which was an improvement from 3. However due to loan repayments in September 2020 the capital service cover element of the score becomes a 4, and overall rating must default to a 3. This is a technical anomaly and was discussed in detail at Finance and Performance Committee and with NHS E/I. A decision was taken to adjust the score to report a score more reflective of current performance. This improves the score to a 2. Further autonomy granted from NHS E/I as result of performance and delivery of the 2019/20 control total from NHSE/I.	Financial envelopes have been issued at ICS level for the remainder of the year and plan submitted with recognised gap c£9m. This included a gap c£1.5m held at CHFT. At month 8 most providers are underspent against plans and forecasting that the gap will be closed. A system financial risk share methodology has been agreed by ICS Directors of Finance and shared at Finance and Performance Committee 12.1.21. Current use of resources methodology has not been adjusted to reflect government policy on loan repayments. NHS E/I will not be reviewing use of resources scores in 20-21	• Performance against key targets • Use of Resources rating of requires improvement. Use of Resources score calculation Use of Resources assessment validation to be undertaken via CHFT peer to peer internal review across 5 UoR groups (planned for end of Q3 20/21 but delayed until Feb 2021 due to capacity priorities), explore system/regional review to give independent scrutiny (Q4 20/21) Lead: Deputy Director of Finance ICS Next steps White Paper with legislative proposals issued 11 February 2021	5x5 = 25	3x5 = 15	2x5 = 10

Action	Timescales	Lead
Review Use of Resources assessment testing and undertake audit	Q4 2020/21	Kirsty Archer

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021 Risk category: Regulation Risk appetite: Moderate**		
8.19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets due to a needs-based stabilisation and reset plan **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders Clinician dissatisfaction	Clinical prioritisation of all patients on waiting lists to identify current priority status and a process for regular review of clinical need Increased number of outcome metrics within performance reporting monitored through performance framework Current Covid-19 management and governance arrangements in place to oversee the delivery of needs-based care Daily escalation of performance issues from divisional hubs into Covid-19 tactical (daily meetings) and if required to Incident Management Team (IMT) for review. Local triggers for phase 3 agreed by IMT and reviewed by Outer Core - working well and used for wave 3 monitoring Daily touchpoint meeting with IMT & Divisional teams for timely escalation, action and joint visibility Wave 2 pressures seen from September with further wave therefore PRMs cancelled until 2020/21. Monthly review of Performance metrics with COO & Directors of Operations. Planned care backlogs collated & presented to Finance & Performance Committee January 2021 Thematic reviews commenced. Workforce and Respiratory service model underway	First line Daily Incident Management Team meetings including escalation of risks, incidents, complaints and staff concerns Weekly review of Covid-19 risk register Integrated Performance report focus of one WEB each month for detailed scrutiny with wider representation from divisions. Regular monitoring of waiting time past due date for clinically prioritised Second line Board sub committee detailed appraisals of position & actions. Integrated Board Report discussed at each Board sub committee and Board of Directors. Detailed review of backlog position across planned care through Finance & Performance Committee, 11 January 2021 Third line New modelling for wave 3 and scenario planning complete	Performance monitoring currently in divisional silos, Action: review current divisional performance review process and opportunity to undertake more thematic reviews: Lead: COO Timescale: commence September 2020, complete by March 2021 • System responsiveness dependent on formal escalation by CHFT when agreed triggers reached. Action: Awaiting system performance framework to be established . Lead: NHS England /Improvement Timescale: Place based meetings focussed on COVID assurance however thematic reviews in place via AED Delivery Board but still dependent on CHFT escalation. System based discussion scheduled	Developing outcome metrics however a recognised time lag for outcome to be evident. Action: Requires further investigation to establish real-time alert. Lead: Assistant Director of Performace Timescale: Q3 2020/21 No national triggers for cessation of phase 3 plans	**Initial** 4x5 = 20	**Current** 4x5 = 20	**Target** 4 x 3 = 12
Actions					**Timescales**			**Lead**		
Revised PRM process once Covid wave 3 allows					Q1 2021./22			HB		
Links to risk register: 7615 4 hour Emergency Care standard										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021 Risk category: Strategic Risk appetite: Significant**		
9.19	Transformation Programme Board	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Medical device and maintenance policies &procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, * Capital Infrastructure Risk Allocation of £4.633m approved to reduce HRI backlog maintenance. Plans in place to demolish nurses home, Learning Centre, DATs building and Saville Court to reduce backlog maintenance.	First line • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS Review of CHS SLAs (Quantitive KPIs & Qualitative Performance) carried out Q4 2020 Audits of routine checks, estates * Newly appointed Trust Health & Safety Manager with oversight of H&S across Trust & between partners Second line H&S Update to Board: January 2021. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports Assurance provided by HTM Compliance reports via external Authroised Engineers inspections against HTM standars. WEB reports on medical devices July 2019 H&S Training 95% target achieved, 97% as at 7.7.20. 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line PLACE assessments *1 CQC Compliance report Premises Assurance Model (PAMs) now available and illustratesto patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe. HSE review of water management Familiarisation visits by local operational Fire and Rescue teams External assurance from authorising engineers for high voltage/ low voltage systems,	A revised estates strategy, in line with reconfiguration has now been commissioned and the initial data collection has begun. Timescales for completion of Strategy is 3 months, ending April 2021. Action Chris Davies. * HRI investment (£20M) full business case to be agreed by regulators, however current funding for early drawdown 2020/21, overseen by Transformation Programme Board • Funding for prioritised HRI work but does not cover all backlog maintenance. Discusssions ongoing with regulator and ICS on resolution to shortfall, lead Director of Finance	There are 44 Estate Risks held on the CHS Risk Register and differences in some of risk scores between the CHS Risk Register and the Trust Risk Register. Chris Davies to attend the Risk Group to ensure a common view. Action Chris Davies *1 PLACE inspections will not take place in 2020 or in the first quarter of 2021 due to COVID-19	**Initial** 4x4 = 16	**Current** 5x3= 15	**Target** 2x4 = 8
Action					**Timescales**			**Lead**		
Ongoing discussions regarding funding Revised Estate Strategy to be developed. CHS to attend the Risk and Compliance Committee to align Risk Register					Ongoing April 2021			G Boothby Chris Davies		
Links to risk register: Risk 5806 - Urgent estate schemes not undertaken Risk 7414 - Building safety risk, HRI Risk 7413 - Fire compartmentation risk, HRI Risk 7474 - Medical Devices										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2021 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
16.19 9/1/20	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage Internal audit review of H&S action plan underway	• SLA in place for CHS to provde Health and Safety Training for CHFT colleages. • Director and Non-Executive Director Health and Safety Champion identified Operational responsibility for H&S across sites sits with CHS for HRI and our partners at CRH - recently appointed interim technical advisor in CHS • Proactive Health & Safety Committee • Head of Health and Safety in post • Annual report on Health and Safety to Board • Health and Safety action plan • Training: 'Leading Safely' IOSH training for Board members February 2019 • Health and Safety mandatory training for staff (3 years) • Health and Safety training on staff induction • COSHH training • Risk assessment training	<u>First line</u> Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health and Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and securitry information . <u>Second line</u> Board joint responsibility for risk understood following the Board IOSH training in February 2019 WEB reports on mandatory training, health and safety training compliance currently at target levels 9 January 2020 external Health and Safety review presented to Board • 2019/20 Annual Health and Safety report and action plan to Board - 9 January 2020 • 2020/21 Annual Health and Safety action plan developed and presented to Audit & Risk Committtee in July 2020, Board 3 September 2020 • Head of Health and Safety appointed. H&S deep dive to ARC 22 July 2020 Updates to Board on H&S 3 September 2020, 14 Januayry 2021 and 2019/20 annual report <u>Third line</u> External health and safety review (Quadriga) 2019 (reference also to fire safety)	The current health and safety measures for overseeing and assurance seeking to be reviewed and a paper prepared and shared with a view to seeking the introduction of a formal health and safety management system, specific to the NHS that will also help provide better oversight of compliance including that of our service providers and subsidary partners. This will form part of a 5 year Strategy for Health and Safety developed by March 2021 Health and Safety Policy to be revised to include statement of intent with supporting policy / procedural guidance and provide clarity on roles and responsibilities - lead Head of H&S - Specific policies identified in Quadriga report under review with final sub committee (slips trips and falls) being established in Jan 2021	• Review RIDDOR reporting, Develop Risk Assessment Policy & matrix, ensure compliance with fire safety, share and discuss joint CHS & Trust risks & mitigation at Joint Liaison Committee meetings. lead CHS technical advisor Jan 2021 Board update on H&S, Lead: H&S Richard Hill / S Dunkley Day to day h&s activity is lead by CHS with ultimate responsibility through the Managing Director, CHS. CHFT needs to assure itself that these activities provide a health & safe environment for staff, patients and visitors. Lead: Stuart Sugarman / Suzanne Dunkley Review exisiting audit and inspections arrangements for monitoring health and safety compliance within the Trust and our partner organisations so that the audits and inspection content align comfortably into the needs and expectations of a formal health and safety management system.	3x3 = 9	3x3 = 9	2x2 = 4

Action	Timescales	Lead
Internal audit review of health and safety	Internal audit review being scoped October 2020	Audit Yorkshire
5 year Health & Safety Strategy to be developed	March 2021	Head of H&S
Health & Safety Policy review	TBC	Head of H&S

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2021 Risk category: Regulation Risk appetite: Moderate
04/20 July 2020	Quality Committee	Director of Nursing / Deputy Chief Executive	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC response group meets monthly, oversses divisional compliance with regulatory standards/ compliance registers and reports to Quality Committee Regular engagement meetings with CQC - currently working within Emergency Support Framework Process for internal assessment against CQC standards Dedicated CQC lead Independent Well-led Governance development review, phase 2 completed Appointed to Assistant Director for Quality and Safety to increase capacity CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes aligned to CQC standards	**First Line:** Reports to CQC Response Group from divisions **Second Line:** Quality Committee reports from CQC Group Quality update report to Board (2 July 2020) Review by Quality Committee and Board of progress with CQC action plan . Quality report to 2 July, 3 September and 5 November 2020 Board report describes monitoring of 5 actions to be completed from 2018 inspection. CQC well-led governance phase 2 report shared at Board workshop 10 September 2020 **Third Line:** Quarterly formal engagement meetings with CQC Current CQC rating of "good" including well-led governance	CQC preparation visits have been scaled back in response to Covid priorities Uncertainty of direction of future CQC inspection and rating regime - currently Emergency Support Framework replaces earlier regime Developments identified from well-led governance review to be progressed Lead: Ellen Armistead/ Suzanne Dunkley	Due to Covid-19 no latest view of performance - restart September 2020 •3 CQC outstanding actions (2 must do and 3 should do) with limited assurance (MD8 critical care, SD9 Emergency Department). Action monitoring by CQC Response Group. Timescale: All actions to be closed by end of February 2021 CQC engagement underway on revised strategy for well -led governance framework and changed approach to regulation (Due February 2021)	Initial: 4x3=12 Current: 4x4=16 ↑ Target: 3x2=6

Action	Timescales	Lead
Roll out of new clincial division self assessments CQC Response Group monitoring 3 outstanding CQC actions with a view to closure	Q3 2020/21 End of February 2021	Divisional Nursing Ellen Armistead

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021 Risk appetite: Low (Ham and Safety)**		
								Initial	**Current**	**Target**
05/20 July 2020	Finance and Performance Committee	Chief Executive	Risk that: - services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand. - non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is a potential for an adverse impact on health inequality. See also BAF 08/19 re performance targets and BAF 7/20 health inequalities	All current Covid-19 plans (and revisions) submitted for Incident Management Team approval and cross reference with relevant reset and stabilisation plan workstream and have an EQUIA, These must be able to describe a rapid re-escalation prior to sign off. IPC pathways amended to reflect national guidance, cross checked with Board of Directors principles on patient and staff safety Utilising independent sector capacity for urgent diagnostics and treatment. Retained additonal diagnostic capacity to supplement reduced internal capcaity or provide additional capacity for backlog clearance All inpatient waiting lists clinically reviewed and priority status identified. Criteria for outpatients agreed and clinical review ongoing. Reviewing waiting lists and cross referencing with deprivation index. Working with system partners on referral pathways Health & Well-Being risk assessment of staff Scenarios modelled for various configurations of covid activity including a Wave 3 signifciantly greater than wave 2. Planning exercise with operational and clinical leaders & response for ach scenario agreed. Interdependencies and risks clearly articulated and Covid specific risk register updated.	**First Line:** Records of daily meetings and decisions of IMT (Inner Core) Triggers for Prority 2 restart reviewed by Outer Core Daily review of Covid-19 activity and weekly review of all other waiting list data Submission of national data sets. All admitted waiting lists clnically prioritised with consistency checking process in place and monitoring of waiting time against priority score **Second Line** Finance & Performance Committee deep dive review of all planned waiting lists (11th Jan 21) Performance reports to relevant Board Sub-Committees (Finance and Performance, Quality Committee, Workforce Committee) **Third Line** Scenario testing	1. Reset plans have interdependency risks on workforce that will limit capacity and connected triggers not yet in place -Triggers for Priority 2 restart agreed cross divisionally, Triggers for recovery post wave 3 to be developed 2.Health inequalities deprivation data and how to assimilate with clinical data for holistic needs assessment	Clinically prioritised waiting list at IMD level in place, gaps in assurance between P2 status and IMD position not yet understood. Ongoing development and sharing of data to improve understanding before this data can be used for decisno making Lead: Chief Operating Officer, Clinical prioritsation - New tool within EPR developed to support outpatient prioritisation and reporting now in place for roll out from 25th January. Will require close monitoring to provide assurance on data completeness and consistency Admitted waiting list prioritisation highlighted some inconsistencies on priority socres at P2. Consistency panel estabiliched be Clinical Directors	4 x 5 - 20	4 x 5= 20	2x4=8
Action:					**Timescales**			**Lead**		
1. Clinical review for out patient activity					Ongoing			Medical Director David Birkenhead		
Links to risk register: 7778 staff infection from Covid-19, 7797 IPC compliance, 7796 staffing shortages due to covid-19 testing 7315 out patient appointment capacity, 7689 out patient waits, 3793, Opthalmology follow up appointments, 7683, isolation capacity, 7778, staff infections, 7809 theatre and clinical capacity, 7834 elective orthopaedic in patient theatre capacity,										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2021 Risk Category: Quality, Innovation & Improvement Risk appetite: Significant		
								Initial	Current	Target
10a/19	23 February 2021 for 4 March 2021 Board of Directors	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Scenario planning for Covid wave 3, Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for all Consusltants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity • Revisions to rotas for Consultants, registrars,trainees with clincians & medical HR to support training, staff and activity backlog • CESR programme to increase Consultant workforce in appropriate specialties supports recruitment and retention • Recruitment and retention success, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals, use current staff effectvely - all new employees opted in to a bank contract (unless opt out) • Service improvement in cardiology, respiratory and frailty, with developmnent of acute floor and frailty service at HRI to aid recruitment • Mitigate shortages in specialties nationally,eg Radiology by network working, explore advanced pratitioner to support Consultant workforce, use external reporting for Radiology • WYAAT networking approach to pressured specialties, eg Vascular Surgery agreed network, Interventional Radiology and programme of work • ED business continuity plan in place; ED Clinical Fellows with 30% education time to provide additional clinical cover • Ongoing recruitment -segmentation approach & vacancy tracker (maps medical workforce to establishment, tacks vacancies, pipeline, retention) ensures focus on clinically high risk and likelihood of appointment. Focus on alternative workforce models, allied health care professional roles – Physician Associates and Advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts • Medical Workforce Programme Steering Group meetings reinstated (late summer 2020) provides overview of the programme. Meeting monthly with highlight reports from workstream leads. Recruitment through external agencies for posts which are difficult to recruit to (eg Interventional Radiology) Trust Associate specialist role – helps with retention and provides stable medical workforce. Junior doctor awards.Adopted SAS doctor charter	First line Staffing levels, training & education compliance and development reported to WEB, Divisional business meetings and PSQBs consider staffing levels as part of standard agenda, IPR with key KPIs shows slight decrease in sickness levels, and reduction in agency spend Weekly meeting on agency spend and report to Turnaround Executive 6 additional PA posts recruited to Improvements in mortality (HSMR / SHMI). Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend - reduction in medical agency spend based on forecast. Vacancy tracker broadly shows improvement in some medical specialties. Medical workforce programme steering group meetings reinstated monthly. Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – Consultant vacancies have reduced by 21.45 FTE from 33.22 FTE in April 18 to 11.77 in September 2020. Offers to Global Fellows in Radiology to mitigate risk created by Radiology the consultant vacancies. Medical Appraisal and revalidation report to Board, demonstrates high quality workforce. Guardian of Safe Working annual and quartetly report (2.7.20., 7.12.21.) on working hours to Board - investing in improved facilities for trainees PSQB reports to Quality Committee Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship with arms-length bodies, GMC Report on Junior Doctor Experience	Medical E-rostering only partially implemented for doctors - Implementation of NHSE/I Medical Deployment systems project August 2021 – Phase 1 completion. Pensions rules impact on willingness of medical staff to deliver additional work.Regional procurement exercise for e rostering and job planning systems, led by WYAAT, with Trust leading on E-rostering). Lack of awareness of vacancies arising from trainee rotations allocated by HEE - these are not permanent gaps and we do not have control over allocation. Succession planning for future - Discussion with Divisions for Planning for retirements Sickness absences are unpredictable and contribute to rota gaps.	• Need to embed workforce plan	4 x 4= 16	4 x5= 20	3 x 3 = 9

Action	Timescales	Lead
E-rostering being rolled out to medics- current phase 1 implementation deadline is August 2021,subject to change depending on Covid operational pressures. Objectives 100% Consutlant & SAS doctors have electronic job plans/85% junior doctors electronically rostered,55% Consultants electronically rostered To start discussions with divisions around succession planning Explore Global fellowships in other areas difficult to recruit	March 2021 (may slip due to Covid-19 priorities) Lisa Cooper, Medical Workforce with Claire Wilson and Pauline North /procurement team Dr S Tumula, Associate Medical Director with Pauline North	Associate Medical Director Workforce

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2021 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant
10b.19	Workforce Committee	Executive Director of Nursing	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Daily staffing meetings, Workforce meetings increased in areas of greatest need (can this go as the first bullet point) •Daily and weekly nurse staffing escalation reports • Nursing and Midwifery Strategy- implementation of "Time to Care" • Ongoing recruitment programme in place, including international recruitment • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes • Risk assessments in place • Nursing and Midwifery Group, monthly meeeting reviews operational issues, strategy and seeks assurance	First line Divisional business meetings and PSQBs consider staffing levels as part of standard agenda Bi-annual review of ward nursing levels 6 additional PA posts and nursing associate posts recruited to Trust recruting to fill all HCSW vacancies Second line Monthly performance meetings (PRM) review workforce reports Workforce Commitee receives updates on recruitment and retention issues., Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board Septemner 2020 KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee Third Line Performance reported into NHSE/I Assurance process with CQC colleagues - feeback from relationship wth arms-length bodies	Nursing Despite controls in place there will still be occasions where capacity does not meet demand, eg increasing staffing sickness **Pace of embedding all elements of the Nursing and Midwifery Strategy has been impacted by Covid response** **Action:** To refocus nursing workforce on key deliverables of Time to Care **Lead:** Andrea Dauris **Timescale: Q1 2021**	New ward accreditation process Focussed Support Framework has been delayed due to Covid priorities.	Initial: 4x4 = 16 Current: 4x5 = 20 Target: 3x3 = 9

Action	Timescales	Lead
To refocus nursing workforce on key deliverables of Time to Care	Q1 2021	Andrea Dauris

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2021 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant
11.19	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale.	• Organisational Development Strategy, The Cupboard recipe cards for Working Together to Improve (leadership and engagement), equality, diversity and inclusion and talent management recipe cards which set out key actions in these areas and measures for monitoring success. • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. • Performance appraisal based around behaviours with temperature check guide introduced to help colleagues to think about the four pillars and their contribution to one culture of care • Development of new roles across professional groups, eg physicians associates., development of five new career ladders for apprentices alongside new strategy for Apprenticeships • Development of Managers Essentials programme and leadership development programme designed collaboratively with colleagues Leadership development programme launched 31 July 2020 includes 3 core modules - Working Together to Get Results, Management Essentials, Leading One Culture of Care plus bespoke modules for nursing and midwifery, consultant and AHP leaders. the programme also includes sessions on mental health awareness • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. • Development of specific behavipours to support 4 pillars by BAME network Development of 24/7 helpline for colleagues to receive support with their mental health including specialist psychological help if required Well being hour and appointment of 130 well being Ambassadors	First line Clinicians leading of transformation programmes e.g. cardio /respiratory Recruitment to key Consultant roles across the Trust - report to Workforce Committee 5.11.19. New microwebsite for recruitment due last 1/4 2020. New appraisal documentation for 2020 appraisal season.Hot house- 19 October 2020 on new roles/skill mix Second line Integrated Performance Report and Workforce Committee reports show a rolling absence rate of 4.25% and rolling turnover score of ~7% as at December 2020. Revalidation report to board Third line Investors in People (IIP)Silver Accreditation to 2021 based on assessment of the IIP principles of leading, improving and supporting. Very positive feedback from interim IIP annual review from October 2019 and October 2020. Armed Forces Silver status awarded June 2020. BMA referring to CHFT as an employer of choice for junior doctors due to level of support for trainees Feedback from Royal Colleges Junior doctor GMC questionnaire feedback Positive feedback from Junior doctors on medical training - Health Education England survey, July 2019, showed improved scores in Anaethesia, Paediatrics, Urology, Obstetrics and Gynaecology, Trust moved from 8th in region to 5th, with 100% response rate OFSTED Interim report has given reasonable progress on all actions relating to the clinical assessment team for Apprentices (August 2019)	• CHFT currently offers support for colleagues facing disciplinary action. This will be extended to colleagues facing legal action/complaints • Health and Wellbeing further developed with assistance by Halsa Wellbeing, focusing on the basics of physical and mental health: sleep, breaks, hydrations, nutrition, facilities. HRI showers being updated • Induction further enhanced, as well as new recruitment website • Plans developed to hold annual health and wellbeing risk assessment for colleagues with support for colleagues facing domestic abuse	None - response to Covid-19 has enabled us to further embed the meaning of one culture of care, which willl be further embedded through the leadership progamme. The programme, launched in July 2020, is not only mandatory for all people manager, it is also open to all colleagues wishing to develop. As a predomininantly online programme, colleauges are able to participate in the learning at a time, venue and date to suit them Improvements in future staff survey scores would enable reduction of risk score Engagement score for 2020 staff survey expected in Feb / March 2021	Initial: 4x4 = 16 Current: 3x4 =12 Target: 3x3 = 9

Actions	Action, Lead, Timescales	Lead
Extend support to colleagues facing legal action / complaints	TBC	Suzanne Dunkley
Plan for annual health and well being risk assessment and support for colleages facing domestic abuse	Q1 2021	Suzanne Dunkley
2020 Staff survey report (engagement score) to be received and reported with action plan to Board	Spring 2021	Suzanne Dunkley

Links to risk register:
Risk 7248 - essential safety training

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
A WORKFORCE FIT FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021** **Risk Category: Workforce** **Risk appetite: Low**		
12.19	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to lack of robust engagement mechanisms. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Colleague engagment is a key recipe card in The Cupboard which set out key actions in these areas over the next 3 - 5 years and measures for monitoring success. • Hot house events to ensure all strategic colleague policies and practices are developed collaboratively across the Trust ,topics agreed by Workforce Committee • Appraisal process for 2020 revised to reflect and evidence one culture of care with all managers set an objective relating to their management of people in new appraisal documentation • Leadership visibility - back to the floor sessions and assurance visits ensure senior clinical and non clinical visibility and engagement based on themes • Quarterly staff FFT in place provides interim feedback on whether colleagues would like to receive treatment by the Trust • 'Ask Owen' and Freedom to Speak Up established as a communication channel for colleagues to use and raise issues/concerns • CHuFT portal for colleagues to congratulate and thank each other for a job well done • CHuFT celebrating success event programme reflecting feedback from colleagues about tone, style and logistics • Staff survey action plan with key principles and activities for 2020/21 approved by Board • Enhanced fo cus on health and wellbeing, self-care resources in The Cupboard, 24/7 wellbeing telephone access, listening and debriefing sessions and access to external counselling/psychology services • Wellbeing Champions roles established and rolled out • Inclusion Charter • New Equality Impact Assessment process • Equality group development - Colleague Disability Action Group, LGBTQ network and BAME network in place and well attended • Clear communication and branding one culture of care to colleagues • CHuFT app • Mindfulness events • Schwartz Rounds • Wellebing hour	<u>First line</u> CQC preparation for self assessment shows areas reporting GOOD in well led domain A total of 93 concerns were raised through Freedom to Speak Up between June 2019 and June 2020 reflecting better communication and engagement with the process <u>Second line</u> Integrated Board report shows a positive range of workforce metrics - attendance, trunover, vacanacies, appraisal compliance and essential safety training compliance Freedom to Speak Up annual report review by Workforce Committee following delegation by the Board of Directors on 2 July 2020 and themes noted at Board 14 January 2021 Hot House events held focusing on a range of topics including Health and Well Being, Equality and Diversity, Apprenticeships, Staff Survey demonstrating engagement and collaboration informing people management policices and processes Staff survey results 2019 to 2 July 2020 Board - position maintained and action plan approved Board development session 22June 2020 on leading one culture of care indicated full commitment from the Board to being role models for One Culture of Care <u>Third line</u> Staff FFT / staff survey provides some positive feedback, 2018 survey had highest respose rate of 51%,slight dip 2019 survey to 46% due to shorter survey period and early winter /operational pressures Investors in People accreditation - Silver award to 2021, which shows a more qualitiative review of Trust culture than the annual NHS staff survey. Annual review in December 2020 shows good progress against our agreed action plan CQC rating of Good	Hot House events have been translated to online events - with a focus on skill mix and new roles in 2020. A programme of events for 2021 will be agreed at Workforce Committee in February 2021 •A Wellbeing team has been created, reinforcing the wellbeing approach developed in our response to COVID •A community engagement post has been created with external funding to work with staff and communities •Focus given to increased diversity of our engagement team will be prioritised		**Initial**	**Current**	**Target**
								3x4 = 12	3x3 = 9	1x4 = 4
Action to address gap in control					**Action and timescale**			**Lead**		
2021 Hot House event Programme to be finalised Focus to increased diversity of engagement team					March 2021 Ongoing			Workforce Committee Suzanne Dunkley		
Links to risk register: No high level risk register related risks scoring over 15.										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021** **Risk Category: Financial / Assets** **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
14.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Prioritised capital programme. Small contingency remains in place to cover any further changes. Transformation Programme Board established with oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience	<u>First line</u> Reporting through WEB on capital prioritisation 2019/20 Capital Plan delivered <u>Second line</u> Scrutiny at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes <u>Third line</u> Monthly return to NHS E/ I NHS E/I round table meeting to discuss reconfiguration Critical infrastructure funding of £4.6m granted in September 2020 to support £ for £ reduction in backlog maintenance. Urgent emergency care capital of £2.2m awarded September 2020. Business case for reconfiguration continues to progress through NHS E/I approval process Capital update provided to Transformation Programme Board each meeting	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Lead: Director of Finance	Ongoing discussions and clarity required relating to shortfall of capital monies. Approach agreed with regulators and recognised as a requirement against the system allocated capital total in future years. Agreed to leave a residual unidentified funding gap in the HRI OBC. Lead: Director of Finance, awaiting national guidance on capital Backlog maintenance costs will remain in excess of planned capital spend.	**4x5 = 20**	**4x4 = 16**	**3x4=12**
Action					**Timescales**			**Lead**		
Ongoing monitoring of financial position through Finance &Performance Committee and Board					Ongoing			GB		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021 Risk Category: Commercial Risk appetite: Moderate**		
15.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Huddersfield Pharmacy Specials (HPS), Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place Health Informatics Service (THIS) contract income for all customers approved and monitotred via quarterly contract review meetings THIS Executive Board meeting with Non-Executive attendance Escalation process if THIS targets not met Finance and Performance Committee and THIS Contract meeting. CHS Board chaired by Non-Executive Director. HPS Board attended by Non Executive Director	**First line** Individual boards (THIS, HPS, CHS) and report on performance against targets into Finance and Performance Committee **Third Line** Successful bid for digital aspirant funds to support both digital development and ongoing capital requirements.	HPS requires further capital investment to continue to grow. Exploring future commercial options - lead: Director of Finance THIS have been succesful in bidding for external work to close the gap and have been set a deliverable plan. additional risk has emerged due to project delays following COVID. The 2020/21 financial plan for both THIS and HPS is unlikely to be met due to reduced demand following COVID. HPS produce products used in elective surgery and demand for these products is reduced. For THIS many organisations have reduced in year developments that required THIS support. The financial plan for 2020/21 protects the Trust from this risk.	HPS requires capital investment to meet its ambitious growth plans. This was discussed in Private Board workshop in December 2020. Recognised that investment is needed to deliver the commercial strategy and increased revenue returns. Further work agreed with a review at Board in 2021. Lead: Director of Finance	**Initial**	**Current**	**Target**
								3x3 = 9	**3x3 = 9**	**2x3= 6**
Action								**Lead**		
Ongoing monitoring of financial position through F&P and Board Explore future commercial options					Ongoing ongoing			GB GB		
Links to high level risk register: None										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021** Risk Category: Financial / Assets Risk appetite: Moderate		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit –and reliance on cash suppport. Whilst the Trust is developing a business case that will bring it back to unsupported financial balance in the medium term. this plan is subject to approval and the release of capital funds **Impact** - financial sustainability - loss of financial recovery funding (FRF) - increased regulatory scrutiny - Impact - financial sustainability - insufficient cash to meet revenue obligation - inability to invest in patient care or estate - adverse impact on Use of Resources rating	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Project Management Office in place to support the identification and delivery of CIP Escalation forum to support CIP schemes off track Budgetary control process with increased profile and ownership Business better than usual forum being established to drive improved and more efficient pathways. Accurate activity, income and expenditure forecasting Development of: - 25 year financial plans in support of Business Case - 5 year Long Term Financial Plan forms part of ICS financial plan Standing Financial Instructions set authorisation limits Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes. Aligned Incentive contract with two main commissioners. On-going dialogue with NHS Improvement	<u>First line</u> Reporting on financial position, cash and capital through divisional Boards and Performance Review meetings and WEB monthly Capital Management Group meeting receives capital plan update reports <u>Second line</u> Scrutiny at Finance and Performance Committee and Board Reports on progress with strategic capital to Transformation Programme Board (monthly) Board Finance reporting ICS delivered financial plan in 2019/20 <u>Third line</u> 2020/21 pre COVID planning - challenge and recovery trajectory would have been accepted. Monthly return to NHS E/ I Strategic Outline Business Case submitted April 2019 and 5 year plan submitted October 2019.	Pre COVID plan required a CIP of £15m to be delivered and this had not been fully identified at 1.4.20 Pressures on capacity planning due to external factors. Competing ICS priorities for resources Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. Project Echo reliant upon external approval to progress. Limited additional revenue costs have been included for the development of the Reconfiguration Business Case. Additional funds agreed and funded in year and added to pressures funding bids for 2021-22. Additional increase of £500k per annum	Year to date COVID costs have been funded and the Trust forecasts expenditure within the agreed remaining allocation for 2020-21 Initial high level budget setting for 2021-22 has commenced prior to the issue of national guidance. This indicates asignificant financial challenge but is based on a number of assumptions. Use of resources review being undertaken.	5x5 = 25	4x4 = 16	3x4=12

Action	**Timescales**	**Lead**
2020/21 Financial Plan	31/03/2020	G Boothby
2021/22 Financial Plan	31/03/2021	G Boothby
Development of financial modelling for reconfiguration Outline Businss Case	31/12/2020	G Boothby

Links to high level risk register risks: None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2021
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2021 Risk Category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	**Risk** Risk of climate action failure including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	Energy - 100% energy bought from green sources and installation of LED lighting to reduce energy consumption Signed up to NHS pledge to reduce plastic usage in hospital Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS Green Planning Committee established to oversee delivery of sustainbility action plan which will report to Transformation and Programme Board on quarterly basis. Reconfiguration design and build principles led by a Sustainability design brief and overseen by Transformation Programme Board. Internal climate change group meets quarterly, focusing on idea generation and initiatives to reduce carbon emissions, eg re-usable items. External controls- Environment Manager and MD of CHS connected into a range of West Yorkshire sustainability groups involving the WYCA, WYATT, Kirklees & Calderdale Councils	<u>First line</u> monthly monitoring of the Trusts energy consumption <u>Second line</u> 1. monitor against our Sustainability Development Management Plan (SDMP) 2.annual Board paper on sustainability/climate change Climate change sustainability brief for the reconfiguration agreed and taken to Board 5 November 2020 <u>Third line</u> working towards ISO14001 accreditation as a means of assuring environmental management systems across the CHFT	A Sustainable Development Management Plan and Action Plan is already in place and this is being transposed into a Green Plan Green Plan in development, including interventions to address carbon emissions and to further promote climate resiliance, to be reviewed by Transformation programme Board 8 March 2021, and Trust Board May 2021 Green Planning Committee Terms of Reference to be aproved by Transformation Programme Board 8 March 2021	CHS MD will produce an annual report to Board on climate change and progress with actions - Date tbc.	4x4 = 16	4x4 = 16	3x3=9
Action					**Timescales**			**Lead**		
Development and approval of Green Plan					Green Plan paper presented to May 2021 Board meeting			Stuart Sugarman		
No related risks on high level risk register										

ACRONYM LIST

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

	New risk
	Breach of risk appetite

INITIALS LIST

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

20. Learning from Deaths Q3 Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title:	Learning from Deaths Report - Quarter 3 2020/2021
Authors:	Dr Sree Tumula, Deputy Medical Director Gemma Pickup, Quality Governance Lead
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	N/A

Purpose of the Report

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

Key Points to Note

In Quarter 3 (October – December 2020), there were 525 adult inpatient deaths at CHFT recorded on Knowledge Portal+. Of those deaths, 187 occurred in Covid positive patients.

Further focused reviews of the CHFT Covid positive deaths are currently being undertaken and will feature in future reports.

EQIA – Equality Impact Assessment

The Learning from Death annual report paper examines the mortality for our local population in respect of gender, age and ethnicity. The 2020/2021 annual report is due to be presented to Board in July 2021.

Additional aspects of EQIA include:
Deaths of those with learning difficulties aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities will be reported externally and reviewed, regardless of the cause of death or place of death. This process runs alongside our internal mortality reviews and does not replace out internal process. All deaths are reviewed internally using a Structured Judgement Review (SJR). These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group (MSG).

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

Maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on Datix to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly

maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports are presented to the Mortality Surveillance Group.

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

Recommendation

The Board is asked to note the Learning from Deaths Quarter 3 report.

Calderdale and Huddersfield NHS Foundation Trust

Learning from Deaths Report
Quarter 3 2020/2021

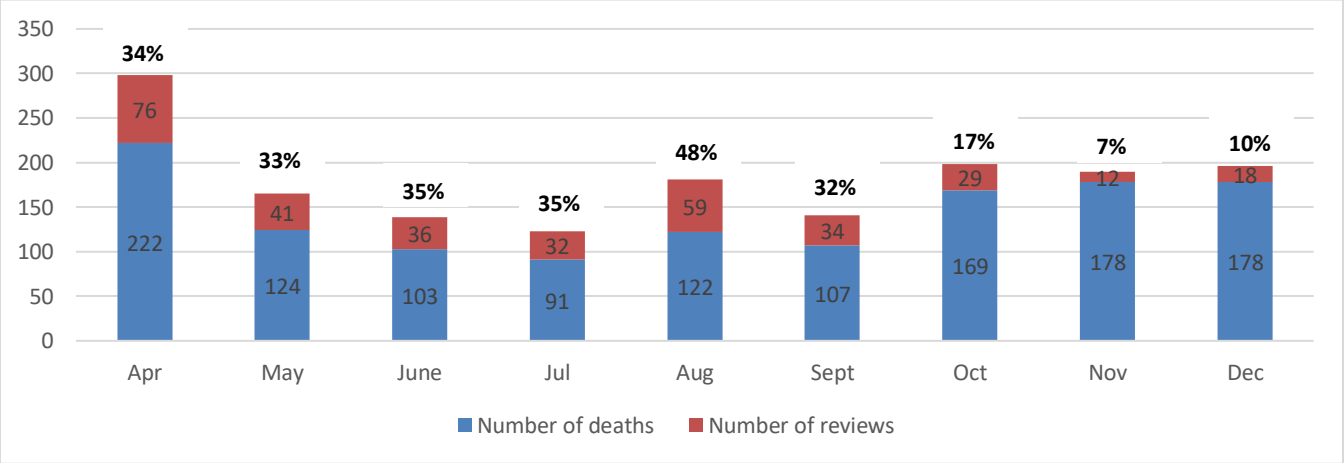
In Quarter 3 (October – December 2020), there were 525 adult inpatient deaths at CHFT recorded on Knowledge Portal+. 187 of those deaths occurred in Covid+ patients.

Further focused reviews of the CHFT Covid+ deaths are currently being undertaken and will feature in future reports.

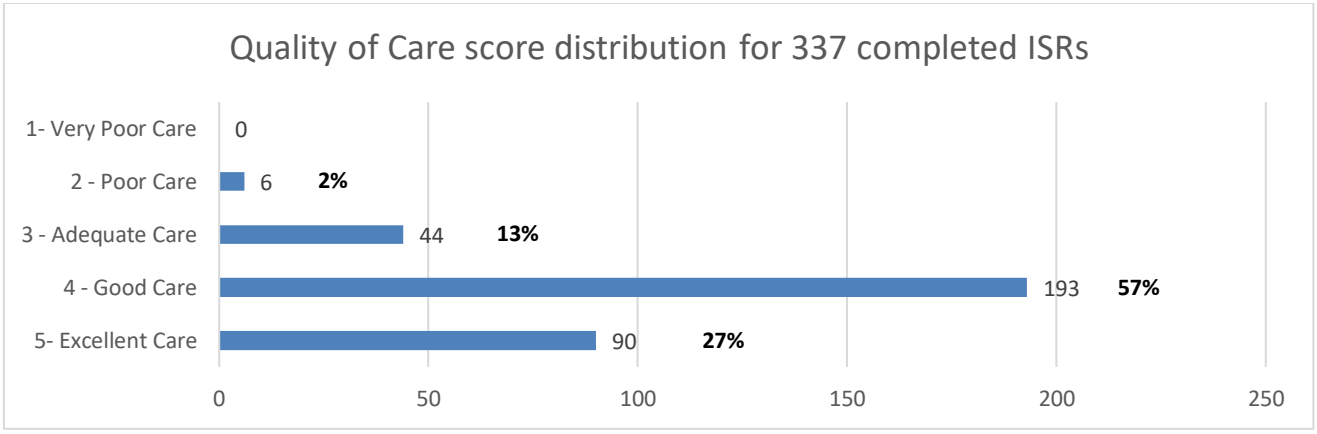
Initial Screening Reviews (ISR)

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

Of the 1294 adult inpatient deaths recorded in the first 3 Quarters of 2020/2021 337 (26%) have been reviewed using the initial screening tool. Whilst this is an increase on the previous quarter's total, this falls short of the 50% target for mortality reviews as a result of the ISR process being suspended as part of the initial Covid response and the subsequent increased pressure on clinical activity.



The quality of care was assessed as follows:



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

Dr Sree Tumula, Deputy Medical Director & Gemma Pickup, Quality Governance Lead

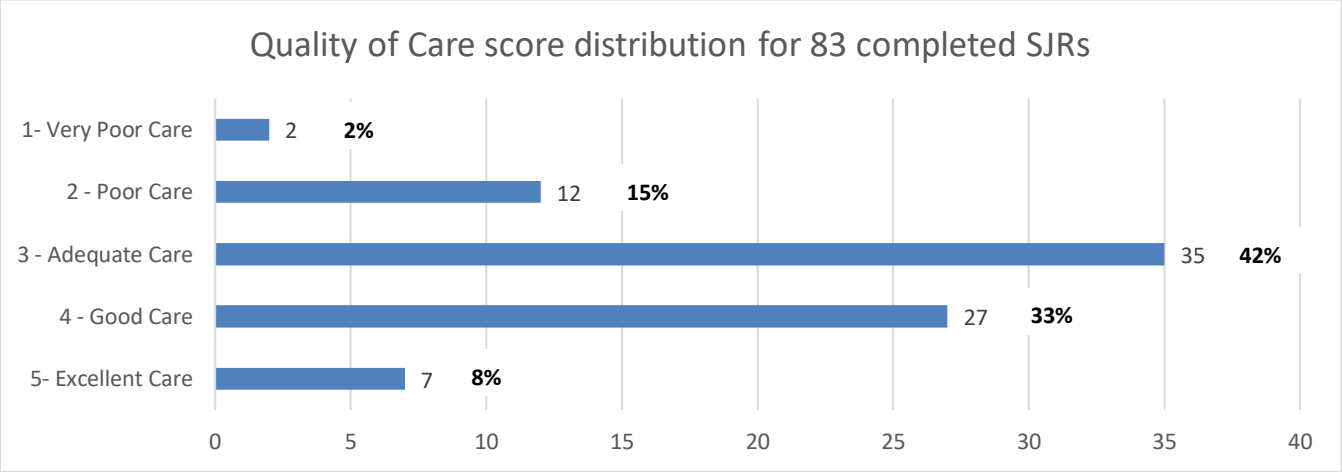
Structured Judgement Reviews

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

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Total
Escalated from ISR	0	0	0	1	0	3	0	3	2	**9**
Complaint	0	0	1	0	1	1	0	0	0	**3**
SI Panel	0	0	0	0	0	0	0	2	0	**2**
Elective	0	0	0	0	0	1	0	0	1	**2**
LD	0	2	1	0	1	1	0	2	0	**7**
2nd Opinion SJR	0	1	3	2	2	2	0	1	2	**13**
Coroner	0	0	0	1	1	2	0	0	0	**4**
Escalated by ME	-	-	-	-	-	-	-	-	1	**1**
Other	9	11	0	17	0	8	0	1	0	**46**
Total Requested	**9**	**14**	**5**	**21**	**5**	**18**	**0**	**9**	6	**87**

A total of 87 SJRs were requested across the first 3 Quarters of 2020/21 of which 83 have been completed. 4 cases remain under review at the time of writing. The findings from SJRs are shared with the speciality mortality lead and appropriate Clinical Director.

The quality care scores for these are below



From the 20 SJRs completed in Quarter 3 2020/2021 the following learning themes and concerns were identified:

- Lack of observations completed on poorly patient
- Overall poor documentation of care
- Misdiagnosis and incorrect discharge
- Consideration not given to physical presentation of patient when prescribing anti-coagulant medication
- The Medical Certificate Cause of Death (MCCD) was incomplete with no mention of the significant co morbidities or cardiac arrest. Inappropriate use of abbreviations. Discussion with the coroner may have been appropriate
- Died without an obvious cause but ne referral for post mortem – coroners or hospital
- Inconsistent recording of decisions regarding Computed Tomography Pulmonary Angiogram (CTPA) for readmitted patient – conflicting information

The following good practice was identified:

- Multidisciplinary approach and pre-emptive decisions recognising the futility of escalation of treatment.
- Prompt senior review and consultant review in first 24 hours
- Good differential diagnosis, involvement of multidisciplinary specialist team, including swallow assessment, which was done within first 24 hours from admission and also early gastroscopy booking
- Thorough discussion with family regarding care options
- Appropriate identification of safeguarding concerns, and involvement of Learning Disabilities matron.
- Compassionate approach to a very complex family situation

Progress against recommendations in relation to LfD for 2020/21 proposed in annual report

- **50% of all in-patient deaths to be reviewed by June 2021:**
  - The pandemic still presents challenges with regards to capacity however number of reviews increase month on month

- **Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities:**
  - The LfD team continue to consider the working groups that themes can be aligned to.
  - Reinstate meetings with the groups established already to support with improving quality for some of the themes identified from SJR's (Sepsis collaborative, Deteriorating patient group, palliative care group etc)
  - SJR findings are currently shared with speciality mortality leads and clinical directors.
  - The next step is to develop the process for the specialities to feedback their responses to SJR findings in their 6 monthly updates to the Mortality Surveillance Group.

- **To work alongside the new Medical Examiner (ME) team and align the LfD processes:**
  - Chief Medical Examiner now attends Mortality Surveillance Group.
  - Discussions taking place as to how processes can be streamlined.
  - Medical Examiner team is scrutinising medical certificate of cause of death and identifying certification errors. This should result in an improvement in completing the medical certificate of cause of death.
  - Medical Examiner office is now escalating quality of care issues identified on initial review for SJR

Recommendation to the Board

The Board is asked to note the Learning from Deaths Quarter 3 report.

Dr Sree Tumula, Deputy Medical Director & Gemma Pickup, Quality Governance Lead

21. Safeguarding Update – Adults & Children

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th March 2021
Meeting:	Public Board of Directors
Title:	Safeguarding Adults and Children Update
Author:	Andrea Dauris - Associate Director of Nursing – Corporate Victoria Thersby - Head of Safeguarding
Sponsoring Director:	Ellen Armistead - Executive Director of Nursing/Deputy Chief Executive
Previous Forums:	Quality Committee - 22nd Feb 2021 Safeguarding Committee - 2nd Feb 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 – December 2020.

The report provides assurance to the Quality Committee highlighting key performance activity and information of how its statutory responsibilities are being met, and of any significant issues of risks, and how these are mitigated.

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, MCA DoLS, FGM and Prevent competencies.
- We have maintained a business as usual functionality throughout the pandemic, continuing with day to day operations and attendance at multi-agency virtual Safeguarding Adults Boa rd meetings and Children's Partnership meetings for Kirklees and their sub- groups.
- A Discharge Quality Improvement Group with partner agencies has been re-established to improve the quality of hospital discharges.
- An audit of NCEPOD Standards (Treat as One 2017), gave assurance of the Mental Health Liaison Team having contemporaneous documentation in the patient records.
- Mental Health Act Tribunals and Hospital Managers hearings have been carried out remotely on wards co-ordinated between the MHA Office (SWYPFT) and our Safeguarding Team.
- We have continued to make Deprivation of Liberty Authorisations throughout the pandemic ensuring the rights of our patients are safeguarded. These have increased in Q3 showing a maintained awareness with staff to ensure the rights of our patients are safeguarded.
- 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 achieved 100% compliance, Review 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. The team will continue to ensure equality in accessing services for those from protected characteristics.
Recommendation
The Board of Directors is asked to receive the Safeguarding Children and Adults update report for the reporting period April 2020 – December 2020 and note the key highlights.

Safeguarding Adults and Children Update Report for Board of Directors 4 March 2021

1. INTRODUCTION

This report is the 6 monthly Safeguarding Adults and Children update for the Trust Board, for the reporting period April 2020 to December 2020.

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 have met its statutory responsibilities with the key achievements set out below: -

Key Achievements

- All staff are now receiving Prevent Wrap training. This has previously been developed as 2 levels of 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.
- We are working towards increasing our number of Prevent Champions.
- CHFT Safeguarding Team attend Channel panel meetings where partner agencies discuss individual cases in the pre-radicalisation phase to prevent them being drawn into terrorism.

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Implement Home Office Prevent Training Programme once released.
- Increase number of Prevent Champions.

3. SAFEGUARDING AND COVID

The Coronavirus Act 2020 did not suspend professionals' duties to safeguarding children and adults during this difficult time, and now more than ever protecting our most vulnerable in society is paramount.

The Safeguarding team have maintained the safeguarding service consistently throughout the pandemic, ensuring our key statutory roles were maintained. We have seen several changes in the team. The previous Named Professional and Specialist Practitioner for adults resigned in September 2020 and we appointed and inducted a new Named Professional and Specialist Practitioner. We have also recruited to a Name Midwife who commences on 1st March 2021. During a gap in cover arrangements a comprehensive action plan was implemented supported by our Safeguarding Team and the FSS division, supporting the ongoing fulfilment of our statutory obligations.

We saw a significant reduction of children and adults attending the emergency departments in April and May resulting in a reduction in the number of safeguarding referrals CHFT made to both children and adult social care. This was escalated to the Safeguarding Boards, whilst

internally we used the opportunity to further promote the safeguarding agenda. We have seen several complex mental health patients over the last few months 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.

Key Achievements

- We have carried out business as usual within the team and continued to maintain our operational service throughout.
- 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 package and delivery of Level 2 MCA DoLS.
- 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 Childrens Partnership meetings for Kirklees, and their safeguarding subgroups.
- Met regularly with our Designated Nurses for Adults and Children.
- We have seen benefits to the virtual approach to training allowing staff to attend bespoke training via Microsoft teams.
- During Q1 we reduced the frequency of the Safeguarding Committee and Operational Group in response to the pandemic.
- Maintained our mandatory FGM and Prevent reporting and submissions to NHSE.
- Held a virtual Safeguarding Week in the Trust in September 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.
- Developed a Safeguarding / Covid 19 intranet page resource for staff.
- 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.

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 which will include training, staff updates and policies and procedures that may impact on practice.
- Review the Domestic Abuse Policy.
- Review the hospital support worker role that can support frontline staff at both hospital sites.

3.1 Hidden Harms

Crimes such as child abuse, child sexual exploitation, domestic abuse (including "honour"-based abuse), sexual violence and modern slavery, typically take place behind closed doors, hidden away from view. The Coronavirus measures risk making these crimes more prevalent and less visible.

In May 2020 the Prime Minister hosted a Hidden Harms summit; focussing on how to tackle such crimes, which may have been impacted by the coronavirus lockdown. In working in collaboration with the Safeguarding Partnership Boards these were agreed as key priority areas to ensure we have robust arrangement in place.

The summit prompted a number of national changes: -

- 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/ Modern day slavery. The Police use this information which prompts targeted work within our Districts.
- Attendance at local partnership meetings for Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE).
- We flag hospital records of children/ young people at risk of CSE/CCE.
- We have successfully used the under 18 CHFT bespoke proforma that has key questions in place in relation to vulnerability in gynaecology, sexual health and midwifery. This is now being 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 plan and 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 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.

- Building a digital risk assessment.
- Review the impact that the Covid 19 Pandemic has had upon the emotional wellbeing of pregnant women.
- Continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multiagency meetings to share intelligence around this.

4. MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

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. This guidance remains in place until it is withdrawn by the pandemic. DoLS assessors were instructed not to visit hospitals unless a face-to-face visit is essential. When life-saving treatment is being provided, including treatment of COVID-19, the person will not be deprived of liberty as long as the treatment is the same as would normally be given to any person without a mental disorder. The DoLS will therefore not apply. In appropriate cases when an authorisation is needed CHFT have followed our MCA DoLS policy.

All CHFT DoLS applications are quality assured by the adult safeguarding team providing evidence that these applications are of good quality care and treatment is in place to protect the person's human rights.

4.1 DoLS Data in Q1, Q2 and Q3

	Number of Urgent DoLS Authorisations	Number of Standard Authorisations	Number cancelled	Average p/month
2018-19	145	5	67	14
2020-21	136	0	102	13

The number of Urgent Authorisations reflect CHFT's commitment to protecting the Human Rights of their patients. Standard Authorisations have not been required as either the patient has been discharged; successfully treated or has 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.

The Deprivation of Liberty Safeguards still apply during Covid-19 and despite seeing a decrease in the number of applications in Q1 we have continued to make applications that are appropriate. Referrals have increased in Q3 showing a maintained awareness with staff to ensure the rights of our patients are safeguarded.

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

- 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 deprivation 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 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 there will be approximately 6 months for successful implementation.

Key Achievements
Referrals in Q3 have increased showing a maintained awareness with staff to ensure the rights of our patients are safeguarded.
Quality assured all referrals by ward staff
Developed a digital mental capacity assessment form

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan)
- Consider implications for CHFT Acute and Community Services once the public consultation commences regarding to MCA and DoLS Codes of Practice anticipated in Spring 2021.
- Provide detailed report to Board of Directors regarding Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- Develop a strategic implementation plan.
- Review Trust Safeguarding Team resources to implement the new LPS scheme including training, new processes and expertise.
- 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.
- Review the MCA DoLS Policy.

5. TRAINING

During the Covid-19 pandemic we were directed to stop face to face training. In ensuring we kept the base safe and continued to raise awareness safeguarding training was moved to an e-package, available on the Safeguarding intranet pages enabling staff to complete these and self-declare their compliance. We have 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.

As part of our re-stabilisation of training and whilst the Covid Pandemic is current we are proposing that our safeguarding and MCA DoLS training is delivered via eLearning packages that combines the elements of adults and children. 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.

5.1 Safeguarding Training and supervision

	31.03.2020					31.12.2020					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	5842	21938	20155	1783	91.87%	5907	22819	21423	1396	93.88%	2.01%
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
NHS|MAND|Mental Capacity Act - 3 Years|	285	285	277	8	97.19%	238	238	217	21	91.18%	-6.01%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3254	3254	2960	294	90.96%	3218	3218	3047	171	94.69%	3.73%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	639	639	582	57	91.08%	656	656	625	31	95.27%	4.19%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1663	1663	1631	32	98.08%	1666	1666	1625	41	97.54%	-0.54%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3602	3602	3315	287	92.03%	3581	3581	3400	181	94.95%	2.92%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	557	557	473	84	84.92%	555	555	517	38	93.15%	8.23%
372|LOCAL|Female Genital Mutilation|	488	488	456	32	93.44%	489	489	446	43	91.21%	-2.23%
NHS|MAND|Prevent WRAP - No Renewal|	4953	4953	4669	284	94.27%	5907	5907	5528	379	93.58%	-0.69%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1660	1660	1625	35	97.89%	1664	1664	1631	33	98.02%	0.13%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3616	3616	3325	291	91.95%	3582	3582	3406	176	95.09%	3.14%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	545	545	437	108	80.18%	557	557	525	32	94.25%	14.07%
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	81	81	47	34	58.02%	85	85	49	36	57.65%	-0.37%
372|LOCAL|Safeguarding Supervision|	595	595	358	237	60.17%	621	621	407	214	65.54%	5.37%
Grand Total	5842	21938	20155	1783	91.87%	5907	22819	21423	1396	93.88%	2.01%

Key

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

5.2 Safeguarding Children's Supervision and Receipt and Scrutiny Training.

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. This training was paused until September 2020 due to the pandemic. We have focused on promoting this through our Safeguarding Committee meeting and provided additional training dates to improve compliance in this area.
Safeguarding Children's 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.

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.

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Review delivery of the Level 3 Safeguarding Training
- Continue to share compliance reports with Divisions.
- Update the Supervision Policy to include Adult Supervision and develop local supervision models for staff who work primarily with adults
- 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.

Through monthly analysis of data the team have 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.

Some of the themes related to the discharge of our patients are failure to inform care homes, families of the discharge; failing to wait for a social services assessment, re-starting packages of care, not sending medication or discharge related information. We have shared these concerns with the Safeguarding Committee meeting in December 2020 and February 2021.The Safeguarding Team are working with our local authority partners to ensure oversight and investigation of all these cases.

Whilst a number of rapid actions have already been implemented to respond to this issue, the Discharge Quality Group will be re-established under the leadership of the Deputy Chief Operating Officer to provide a focused approach to improving the quality of discharges across CHFT.

Key Achievements

Reviewed the Missing Persons Policy

- Developed an Adults 'Was not Brought' to hospital appointments policy.
- Established and implemented a Discharge Quality Improvement Group with representation from key partners to drive further quality improvement in this area.

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 embedding of the Transition Policy.
- Finalising the toolkit to support patients who decline pressure area care.
- Maintain involvement with multi-agency partners to look at a systems-based approach to safeguarding alerts looking at a risk-based methodology to reduce the number of low-level discharges relating issues in relation to safeguarding. This approach would manage the large number of alerts whilst still providing good outcomes for patients.

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 to ensure patient safety on paediatric wards.
- Developed a 'Children's Was Not brought to hospital appointments policy.

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.

Key Achievements

- An audit this year 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 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 is out for consultation. SWYPFT will invite CHFT partners to collaborate with this piece of work which will inform an internal review at CHFT as some of the changes will impact acute hospital trusts (i.e.) potentially using a section 5(2) in the Emergency Department.
- The Joint working Protocol is being re-reviewed in line with changes to the working arrangements in the Mental Health Liaison Team.
- 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 20 review health assessments have been carried out virtually by the team.
- The team have achieved 100% compliance with Initial Health Assessments 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.

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

Whilst our Children Looked After (CLA) team in Calderdale ensure the health needs of children and young people are met, they also ensure that they meet our safeguarding children and adults' responsibilities as part of their work.

Covid has brought many challenges including not seeing our young people in Calderdale face to face for these assessments however, the virtual assessments the team carry out are also a platform where they can be identified and should not be seen as a barrier to identification and reporting concerns.

One of our specialist practitioners during an assessment and gathering information around a young person's mental health and family dynamics became aware of concerns in relation to her sibling who was also a looked after child; she was in the early stages of pregnancy and was staying in the household which was not in the agreement with Children's social care.

Following the virtual visit with the sibling the CLA nurse reviewed the records and spoke to her social worker who confirmed that she was in the early stages of pregnancy she was living in her birth family's household which was an unsafe placement, she was not registered with a GP or had booked her pregnancy with the midwife. The father was a previous looked after child and presented with a complex background of poor mental health/living on food parcels/sharing benefits/ substance misuse, all of which were exacerbated by national lockdown.

CLA nurse identified she had some unmet health needs and supported her to register with a local GP, book her pregnancy and offer ongoing support and advice. The CLA nurse shared concerns with midwives and requested a professionals meeting. The meeting not only focused on the concerns but also about her wellbeing and support around pregnancy. The CLA nurse remained involved in regular meetings including pre-birth planning meetings to safeguard the unborn. Following delivery and initial children protection conference a family intervention worker would be involved to support the young person with other key workers. During the pregnancy a domestic abuse incident between the young parents was shared with the CLA nurse who attended a core group meeting to ensure the unborns safety was paramount. Through bail conditions the new father was prevented from seeing the mother and baby to ensure their safety.

The baby is now on a child protection plan and the CLA nurse continues to support her as she remains a looked after child. Many Looked after children are drawn back to their birth family despite having been in the care system for many years and have complicated historical neglect/abuse backgrounds. The CLA nurse was key in identifying and responding to the concerns presented that has ensured that both mother and baby are safe.

22. Quality Report

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4th March 2021
Meeting:	Public Board of Directors
Title:	Quality Report (Reporting period Dec 2020 to Jan 2021)
Author:	Doriann Bailey, Assistant Director for Patient Safety
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Quality Committee - February 2021

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

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

Key Points to Note

The Quality Report aims to provide further detail on areas of key focus and complements the Integrated Performance Report.

- **Dementia Screening** continues to be a challenge for the Trust. The Associate Director for Patient Safety is commencing a piece of work, led by the Quality Governance Leads, to raise the awareness of the dementia training within the divisions.
- **CQC**:
  - CQC are adapting and developing their methods of regulation by using a transitional approach to monitoring services. This focuses on safety, how effectively a service is led and how easily people can access the service. Our Maternity Services will be first to present to the CQC in line with this new approach.
  - The Focused Support Framework reviews have been temporarily suspended due to the COVID-19 pressures and infection prevention control implications. These will be re-instated in March.
  - Recommendation 9 & 10 (Facing the Future Standards) work requires a re-focus now the pandemic surge has eased.
  - CQC' new strategy, which was published for consultation in January 2021, the four themes in CQCs draft strategy. The consultation will run for 8 weeks, closing on 4 March 2021.
  - The CQC Workstream priorities for Quarter 4 have been reviewed and refreshed

- **Central Alert Systems** CHFT is showing an improved position for the Central Alert System (CAS) indicators.
- **Sepsis** – the work on Sepsis continues and shows some areas of improvement. However, this remains a key safety priority given the potential impact on patients.
- **Incidents** – there are 94 open actions against serious incident investigations however there is a reduction in the number of overdue actions.
- **Pressure Ulcers**– There remain areas of limited assurance, the Quality Committee have commissioned a deep dive and an improvement plan to be developed and monitored through the Quality Committee.
- **Nutrition and hydration** – assurance remains limited with 2 outstanding actions in relation to training and dietetic cover.
- **Complaints:** there has been significant focus on the complaint turnaround time and extra capacity assigned to ensure an improvement in performance going forward.
- **Venous Thromboembolism** VTE – to note the achievement of the >95% target of patients being risk assessed for developing a VTE
- **Ockenden Review:** CHFT has made both submissions in response to the Ockenden review.

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.

Recommendation

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

Contents

1. Introduction

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

This report has been formatted to ask the question *'Are we assured'*. As a Trust 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'.*

The Quality Committee continues to provide the scrutiny, monitoring and assurance on all the quality programmes that are in place within the Trust. The Committee recognises the challenges placed upon the Trust in the face of the COVID -19 Pandemic and acknowledges the hard work from all staff as we seek to keep all our patients safe and continue to provide high levels of care.

This report provides an update on assurances against several quality measures for the period December 2020 to January 2021.

2. CHFT Care Quality Commission (CQC) Workstreams – Summary

During December 2020 and January 2021, the CQC workstreams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Managers, Trusts recovery plan, national guidance and CQCs Emergency Support Framework.

Extensive work has taken place in January revising the CQC Response Group function and terms of reference. This group will be relaunched in April 2021 as the CQC and Compliance Group which will report to both the Quality Committee and the Audit and Risk Committee. A robust work plan has been created which incorporates all elements of the Trusts Compliance agenda including CQC, Accreditations, Audits and Compliance Registers.

The Focused Support Framework (FSF) reviews remain largely suspended due to the operational pressures and the infection, prevention and control implications conducting these reviews may have. The Trust remains assured that Must Do audits continue to be undertaken such as the leadership walk arounds and the COVID-19 assurance monitoring. The FSF will be stepped up again in March and progressed at pace.

The full Trust quarterly engagement meeting took place in December 2020, this was attended by CQC and senior CHFT colleagues. The meeting focused on COVID-19 operational updates for both Acute and Community services. CQC expressed no concerns and were assured with all updates received. The next full Trust meeting with CQC is scheduled to take place in March 2021, the CHFT CQC Compliance Manager continues to have regular meetings when required with the CQC Relationship Manager.

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

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

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

Action leads were asked to present a position statement and plans to further progress all remaining 2018 CQC actions at the January and February CQC Response Group, our position currently remains the same. It was requested at the February 2021 CQC Response Group that extensive work must be carried out in order to close the remaining actions at the March 2021 Group.

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

Compliance	Quarter 3 20/21	Plan for Q4	Assurance
MD1 - The trust must improve its financial performance to ensure services are sustainable in the future	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	It was agreed at the CQC Response Group that this action will be finalised long term and no further update is needed until April 2021. **Progress Update Feb 21:** 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**
MD8 – The Trust must ensure medical staffing at Calderdale is in line with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards.	Current position, future position and all risk mitigations in place were presented to the CQC Response Group in October 2020. A formal review of the rota's take place on a 3 monthly interim basis with a 6-month formal review. This action has been considered by the response group and has a review process in place with escalation if necessary. This should remain on divisional risk register and there is clear link between an incident and this risk and if an incident occurs an instant review takes place. The group agreed that this as far as mitigation can go and the 3/6 month reviews to be monitored via the Quality Committee. It was agreed that this risk be closed as a system and process is now in place.	Action now closed but to be monitored via the Quality Committee and formal 3- and 6-month review of rotas to be undertaken. In the interim the risk continues to be managed by the existing work force. **Progress Update Feb 21:** No further update action remains closed.	**CLOSED**
SD3 - The trust should develop processes to measure the outcomes of mental health patients in order to identify opportunities to improve care	There has been a lot of success around the current work undertaken to reduce the wait for a mental health assessment on attendance in ED and patients are usually seen by the Mental Health Liaison team within 1- 2 hours. A Standard Operating Procedure (SOP) has been developed to assess the quality of the care required within ED. The Mental Health Ops group holds ongoing meetings and the new dashboard is to be reviewed at each meeting and patient questionnaire is being developed.	To be presented back at the CQC Response Group in Jan 2021. There's a need to separate to separate out ED and requested that this be completed quickly to enable the action to be closed. **Progress Update Feb 21:** A small working group has been reformed to look at this action from a corporate level not just ED. Update from the group will be received at the CQC Response Group in March with the aim to close.	**Substantial Assurance**

	Ongoing improvement work is taking place via the mental health operations group to further seek feedback from mental health patients using the service within the Emergency Department with a questionnaire developed to go to the next operations meeting.		
SD6 - The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	Training compliance is now at 90% and forms part of the essential skills training framework. We have measures around DOLS with Safeguarding Committee reviewing all training statistics. Committee received 3 audits and more work to be done with an action plan in place. Evaluations have taken place and 7-minute meetings have taken place during Covid and a Mental Capacity act template is to be built into Cerner. Testing has now been incorporated into the FSF process. Overall governance currently sits with the Safeguarding Committee. The group felt that in terms of closing this action, positive work is taking place with audit of this made by the FS Framework therefore action is to be closed with assurance that there is a governance framework in place and regular audits are maintained. Closure was agreed by the group.	Action now closed. Monitoring to be continued via the FSF reviews and regular audits which will be monitored via the governance structure. **Progress Update Feb 21:** This action was closed in December 2020. But as this action relates directly to ED it was requested by the Chair of the CQC Response Group in January 2021 that a snapshot audit of MCA training and testing be presenting at the March 2021 group. This will ensure there is s suite of evidence available to support the decision to close.	**CLOSED**
SD9 - The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.	A piece of work around risk mitigation has been completed. Job planning is being examined but could take a few months to complete. The group requested that ED show how the division is managing the risk mitigation with completed actions i.e. minutes of meetings, available to view. To be closed after a couple of months of meeting minutes are available	Management of the risk mitigation to be presented back at the CQC Response Group in January 2021. **Progress Update Feb 21:** The clinical director and general manager will be presenting a paper to the CQC Response Group in March 2021 detailing mitigation of the risk as it is unlikely we will meet all requirements of the standard.	**Substantial Assurance**

CQC Engagement Meetings

Regular catch up meetings have continued to place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services Relationship Managers. These catch ups are scheduled to continue monthly with the next full engagement meeting scheduled for 18th March 2021.

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

- CQC update / arrangements during Covid-19

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

It was requested at the last meeting that there will be a requirement for a Core Service to present to CQC in line with CQCs Transitional Monitoring Approach, a decision was made for Maternity Services to present at the meeting in March.

CQC Enquiries

CQC currently have 14 open enquires with CHFT. This is an increase of 8 since December. 1 enquiry has been closed since last reported.

The CHFT CQC Compliance Manager manages the process within the Trust seeking updates from the relevant trust leads and provides CQC with regular progress updates and final reports from investigations.

CQC Transitional Monitoring Approach

CQC are adapting and developing their methods of regulation by using a transitional approach to monitoring services. This focuses on safety, how effectively a service is led and how easily people can access the service.

It includes:

- a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so they can continually monitor risk in a service
- using technology and local relationships to have better direct contact with people who are using services, their families and staff in services
- targeting inspection activity where we have concerns

After reviewing information about the service, CQC will have a conversation with Core Service leads either online or by telephone. This is not an inspection and CQC do not rate services following a call.

This call will help them to decide whether we need to take further regulatory action at this time, for example an inspection.

What does this mean for CHFT?

Core services are required to self-assess against the KLOEs set out in Acute Healthcare monitoring questions.

https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/monitoring-questions-acute-healthcare-services#accordion-1

Core Service senior management will then be required to present the findings to the CHFT CQC Relationship and Inspection Manager. The self-assessment and a suite of evidence will be submitted to CQC to provide assurance of compliance with all KLOEs.

The CQC Compliance Manager will be furnishing Core Services with templates and tools to assist with the self-assessment process. Core Services will be required to present regular progress updates at the CQC & Compliance Group. Maternity Services will be first to present to CQC in line with this new approach.

CQC & Compliance Group Terms of Reference

The newly formed CQC & Compliance Group terms of reference were presented and approved at the January Quality Committee and Audit and Risk Committee.

In brief the purpose of the group is:

- To ensure there is an effective and comprehensive system in place for pro-actively managing compliance Trust-wide and within each division through compliance registers. This includes developing and maintaining systems for the regular evaluation and monitoring of compliance against any relevant internal and external audit recommendations, external assessments e.g. Care Quality Commission, accreditations, service reviews, standards and criteria as directed by the Trust Board.

- To provide assurance of compliance against the CQC Well-Led and Use of Resources standards, and to monitor the progress of any recommendations as set out in associated internal or external reviews.

- Responsible, on behalf of the Trust, for ensuring there is a timely and effective response to the issues raised as part of the external review process, in order to address these in advance of receiving the formal report this is based on intelligence gathered from:

  - Lead inspector feedback
  - Data submitted.
  - Staff interviews
  - Focus groups.
  - Ward / department visits

- The group is also responsible for the ongoing monitoring progress of action plans.
- The group will work with core service areas to set direction for the achievement of an overall rating of outstanding.
- Any internal reviews which take place Trust Wide will be reported to the group, such as trends from the Focused Support Framework reviews.
- All regulatory related information and updates from CQC will be communicated direct to the group.

The group will launch in April 2021.

Focused Support Framework

The Focused Support Framework reviews have been temporarily suspended due to the COVID-19 pressures and infection prevention control implications. There are a number of processes in place to mitigate the risk including a much greater emphasis on Must Do compliance and leadership assurance visits. Continuous work is ongoing to develop the FSF, next steps for quarter 4 include:

- Standard Operating Procedure (SOP) to be developed outlining the final process and agreed.
- Where support packages are put in place from subject expert teams these can be easily accessible for other areas if the same support is needed. “Support Package Portfolio”.
- Process to share the learning from each review to be developed.
- FSF Digital – plans have progressed to make recording the FSF findings digitalised utilising Microsoft Forms which can then pull through to KP+, therefore Heatmap and FSF review findings will be accessible via 1 programme.
- Medic involvement and Medic Engagement section to be developed
- Review needs to take a more holistic approach and staff engagement to involve all disciplines with the ward area, domestic, AHP, HCAs.
- Safeguarding section to be tested in the next review by the safeguarding Team to ensure flow of questions and accuracy.
- The framework has been reviewed by paediatric and maternity services to ensure framework fits specialist areas – frameworks to be piloted

The programme will be re-instated in March 2021.

CQC Insight Report

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

A summary of the report can be found below.

What's new in the January 2021 release of CQC Insight for Acute Trusts …

Facts and figures

Refreshed data streams:

HES activity figures
Workforce statistics
SOF

Featured data sources

Refreshed pages:

A&E waiting times
Incidents
Mortality
National clinical audits

(The SSNAP feature page is currently under review. If you would like to view the SSNAP clinical audit results, you can access them here.)

Trust and core service analysis

Refreshed data streams:

Trust	STEIS Never Events, CAS, Whistleblowing, NRLS, SOF, ESR, SHMI, Dr Foster (HSMR), , GMC Enhanced Monitoring, Complaints
A&E	STEIS Never Events, CAS, A&E Sitreps, A&E Quality, Ambulance Turnaround
Medicine	STEIS Never Events, RTT
Surgery	STEIS Never Events, RTT
Critical Care	STEIS Never Events,
Maternity	STEIS Never Events, ESR, MBRRACE UK
CYP	STEIS Never Events
Outpatients	STEIS Never Events, RTT, HES DNAs, Diagnostic waiting times, Cancer waiting times

Notes

Next date for sharing: week commencing 15 March 2020

COVID-19

As previously communicated to providers, we will continue to share Acute Insight reports with NHS providers every two months during the COVID-19 crisis.

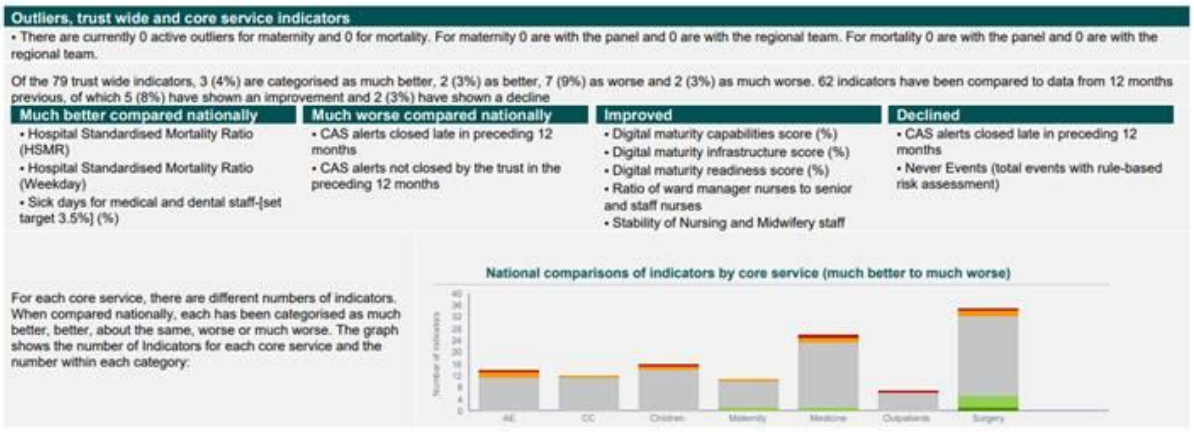
Covid 19 has had an impact on some data sets. Analyst and inspection teams will take the effects of Covid-19 into account when interpreting analysis. Publication of some data sets is suspended. Data will be refreshed as soon as it is available.

The Dr Foster 'deaths from low risk conditions' indicator has been suspended from Insight because many Covid-19 deaths are included in the 'low risk conditions' group.

Also due to Covid-19 pressures, the identification and publication of new outliers for maternity, mortality and audit data remains suspended. CQC outlier panels will only review urgent priority cases and responses, which will be assessed on a case by case basis. We are monitoring the situation closely and we will adapt CQC's outlier approach accordingly. Data from audits not impacted by Covid-19 will still be refreshed in the usual way.

The Trust Composite Indicator has now been retired.

A brief overview of the indicators in which CHFT is an outlier or performing better / much better nationally can be found below.



The CAS alert indicator in which CHFT is showing as “Much Worse Nationally” and a decline in performance, only reflects our position up to October 2020. There is a continued “CAS Alert Improvement Journey” workstream which is not yet reflected within the Insight report data. Our CAS alert position continues to be monitored via the CQC Response Group and an update on our position was provided to CQC at the December quarterly engagement meeting.

S6	**CAS alerts closed late in preceding 12 months** MHRA - CAS Alerts (23 Nov 2020)		>=25% & <50% alerts closed late Nov 18 - Oct 19	>= 50% alerts closed late Nov 19 - Oct 20	↓	MW
S6	**CAS alerts not closed by the trust in the preceding 12 months** MHRA - CAS Alerts (23 Nov 2020)		NA	>=5 alerts still open Nov 19 - Oct 20	NA	MW
S6	**CAS alerts not closed by the trust more than 12 months before** MHRA - CAS Open Alerts (23 Nov 2020)		NA	0 alerts still open Aug 14 - Oct 19	NA	S

As of February 21, the current position re CAS alerts is as follows:

Issued	Completion Due Date	Alert Title	Current Status
3 March 2020	5 March and 3 June 2020	NatPSA/2020/001/NHSPS Ligature and ligature point risk assessment tools and policies	AWAITING CLOSURE
2 April 2020	9 April 2020	NatPSA-2020-003-NHSPS Blood control safety cannula & needle thoracostomy for tension pneumothorax	AWAITING CLOSURE
23 July 2020	20 Aug 2020	MDA-2020-022 Philips sterilizable defibrillator internal paddles (specific models) – may fail to deliver therapy if pre-use checks are not followed	**CLOSED**
6 Aug 2020	6 Nov 2020	NatPSA-2020-004-NHSPS Risk of Death from unintended administration of sodium nitrite	AWAITING CLOSURE

We currently have 3 Patient Safety Alerts below, which are ongoing and in date:

Issued	Completion Due Date	Alert Title	Current Status
13 Aug 2020	13 May 2021	NatPSA-2020-005-NHSPS Steroid emergency card to support early recognition and treatment of adrenal crisis in adults	Ongoing
1 Sept 2020	1 June 2021	NatPSA-2020-006-NHSPS Foreign body aspiration during intubation, advanced airway management or ventilation	Ongoing
1 Dec 2020	1 June 2021	NatPSA-2020-008-NHSPS Deterioration due to rapid offload of pleural effusion fluid from chest drains	Ongoing and due for closure

A SOP for each alert type had been drafted, but this has been delayed by recent changes to guidance of issues of medical device alerts and others. An overall policy is also currently being drafted for comment.

Facing the Future Standards for Children in Emergency Care settings

In June 2018 the Royal College of Paediatric and Child Health (RCPCH) published Facing the Future: Standards for children in emergency care settings, developed by the Intercollegiate Committee for Standards for Children and Young People in Emergency Care Settings.

Following the publication of the Royal College of Paediatric and Child Health (RCPCH) published Facing the Future: Standards for children in emergency care settings in 2018, the CQC published a briefing guide. This was in recognition that two of the Workforce Recommendations (9 & 10) are particularly difficult to meet in DGHs where there is no separate Children's ED. The CQC guide outlines mitigation that should be in place should standards 9 &10 be less than fully compliant.

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

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

CHFT Current Position with Recommendation 9 & 10 & Next Steps

It has been identified that the Trust is currently not compliant with standards 9 & 10, this was also previously highlighted in the 2018 CHFT CQC inspection and is still an open action on the Kirklees Action Plan from the 2018 CQC Inspection of Safeguarding Children and Looked After Children Services. It is acknowledged by CQC that for some Trusts given their relative size and/or configuration full compliance may not be achieved.

Due to work pressures of Covid and non-elective activity there has been some slippage in terms of delivering the risk mitigation plan. There will be a renewed focus on this, and a report is expected into the March 2021 CQC Response Group.

Use of Resources

Work has progressed during 2020/21 on an internal review of the Use of Resources (UOR) key lines of enquiry with different groups collating evidence for each of the five areas and summarising the progress since the last external review. This work has been over an extended timescale due to the operational pressures of the pandemic. It is noted that many of the metrics are now quite historic and have not been refreshed during the Covid period. It is planned to round up this piece of work with a workshop to share the findings from each of the key lines of enquiry.

A further review of governance and decision-making processes has been scoped and discussed at Finance and Performance Committee. This will provide preparation for the well led element of the assessment and may identify opportunities for the Trust to use resources differently.

The Finance UOR score (rating 1-4) has continued to be routinely monitored through Finance and Performance Committee and the dynamics of this metric have been discussed. During the Covid pandemic, NHS Improvement have ceased monitoring of this metric through their monthly data submission requirements.

CQC Provider Collaboration Review in Emergency Department (ED)

CHFT were asked to partake in the Provider Collaboration Review in ED. The meeting took place on 14th October 2020.

The Provider Collaboration Review focused on urgent and emergency care in eight systems. CQC looked at how providers are collaborating to develop urgent and emergency care services together in light of COVID-19 prior to potential further peaks, and ahead of this winter. For each review CQC interviewed a range of providers, including NHS 111, out of hours, urgent treatment centres, Accident & Emergency, and ambulance services. They also spoke to providers who are likely to experience urgent and emergency care services.

In late January 2021 CQC published key areas of innovation and creatives approaches from across all the systems which were reviewed (link to full findings below):

https://www.cqc.org.uk/publications/themes-care/collaboration-urgent-emergency-care

West Yorkshire and Harrogate were recognised for the following innovations:

- *In West Yorkshire and Harrogate, Suffolk and North East Essex, and Cornwall and the Isles of Scilly, there was 'passporting' of staff between NHS trusts. An NHS competencies passport enabled staff to move between providers within a system more easily - the aim was to reduce gaps in staffing and improve patient care.*

- *In some places, local crisis care pathways were implemented where there were increases in the numbers of people attempting to, or taking, their own lives. The number of new referrals to mental health services showed the need for enhanced services. Across West Yorkshire and Harrogate for example, there was increased crisis phone line support in anticipation of the impact of the pandemic and the lockdowns on people's mental health.*

- *In West Yorkshire and Harrogate, there was a primary care urgent service just for people with COVID-19 symptoms. This was a collaboration between four primary care networks (PCNs) and a GP federation – a total of 27 GP practices. To protect patients and staff, and to reduce the risk of staff sickness, the COVID-19 urgent service was operated by a dedicated cohort of clinicians.*

- *Where there was less understanding about more vulnerable groups, there was a commitment to do more. For example, in West Yorkshire and Harrogate, an independent review was commissioned to examine the impact of COVID-19 on Black and minority ethnic communities.*

- *In West Yorkshire and Harrogate, the local system had a weekly briefing call for monitoring. They looked at bed occupancy and planning for what might happen. There was a system oversight group with plans in place for bed occupancy of the intensive care unit – and at a set percentage of bed occupancy, decision-making could be escalated to stop elective activity.*

The full report is now due to be published in Spring 2021.

CQC Strategy

CQC's new strategy was published for consultation in January 2021. The strategy is built on four themes that together determine the changes they want to make. Running through each theme is CQC's ambition to improve people's care by looking at how well health and care systems are working and how they're acting to reduce inequalities. We know that it is not

enough to look at how one service operates in isolation. It is how services work together that has a real impact on people's experiences and outcomes.

The four themes in the CQC draft strategy are:

- People and communities
- Smarter regulation
- Safety through learning
- Accelerating improvement

The full strategy can be viewed at: www.cqc.org.uk/strategy2021consultation

The consultation will run for 8 weeks, closing on **4 March 2021**.

Plan for Quarter 4 2020/21

Below sets out the CQC Workstream priorities for Quarter 4.

Quarter 4 Priorities	Trust Leads	Feb 2021 Progress Update
Continuous monitoring of outstanding MD & SD Actions from 2018 Inspection with the aim of closing.	CQC Response Group / Action Leads	Monitored via the CQC Response Group
Finalise the Focused Support Framework including a schedule of reviews across the Trust	Shelley Rochford / Janette Cockroft	Progress is been made to action all the points set out in section 7.
CAS Alert Improvement Journey	Andrea McCourt / Doriann Bailey	Improvements continue to be made. A clear process and SOP is to be developed.
Facing the Futures Standards – Clear position and mitigating risks report completed.	ED Senior Leadership Team	A working group has been formed and all mitigating risks to be presented back at the CQC Response Group in March.
Understanding the CQC Strategy and what this means for NHS Trusts	Doriann Bailey / Shelley Rochford	Continue to keep up to date with any CQC publications. This includes the implementation of the CQC Transitional Monitoring Approach Key Lines of Enquiry.
CQC Response Group Terms of Reference Review	Doriann Bailey / Shelley Rochford	Complete group to launch in April 2021

3. Venous Thromboembolism (VTE)

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

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

VTE Outcome	Oct and Nov 2020	Dec 2020 and Jan 2021	Assurance
To meet the 95% target of patients being risk assessed for developing a VTE	October – 96.4% compliance November data – 96.1% VTE committee will review the individual ward/clinical area level breakdown especially with recent ward moves, update the VTE cohort list appropriately and liaise with appropriate divisional governance leads for feedback and to facilitate improvement measures	Dec 2020 and Jan 2021 both 95.7%	**SUBSTANTIAL ASSURANCE**
Maintain the level of Hospital acquired VTE episodes, not more than 20% of all VTE episodes	Achieved Oct 2020 -3 HAVTE out of 35 VTE diagnosis Nov 2020 – 6 HAVTE out of 37 cases	Dec 2020 – 13 cases out of 45 (higher cases) Dec 2020 – trend suggesting Post-covid DVT / PE skewing results - 4 cases will be monitored during Jan 2021)	**SUBSTANTIAL ASSURANCE**
No Avoidable hospital acquired VTE Deaths	Achieved – Oct to Dec 2020	Dec 2020 – no avoidable HA-VTE	**SUBSTANTIAL ASSURANCE**
Audit actions plan and schedule of re audit	Await pharmacy led audit on VTE later this year Await presentation of GIRFT data on VTE to senior management	Pharmacy led audit on VTE later this year GIRFT data discussed in Thrombosis committee – awaiting presentation with senior management HA-VTE: trial of cases using coding data for Jan 2021 to see if this works better than current approach – radiology derived data	**REASONABLE ASSURANCE**

4. Pressure Ulcers

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

Pressure Ulcer Collaborative meetings are held on a monthly basis. Pressure Ulcer Collaborative reports are submitted to the Patient Safety Group and Safeguarding Operational Group.

The Quality Committee received a deep dive into the current challenges in terms of pressure ulcer prevalence. Data to be presented to Board in May 2021 on improvement work.

Objective	Oct and Nov 2020	Dec 2020 and Jan 2021	Assurance
Reduction in pressure ulcers	There were 108 pressure ulcers in October and 100 in November 2020 Compliance with NHSI (2018) Pressure Ulcer Recommendations in reporting all CHFT acquired pressure ulcers regardless of avoidability (with effect from October 2020)	There were 87 pressure ulcers in December 2020. January figures are still being validated. This represents a decrease from the previous month.	**LIMITED ASSURANCE** The Trust has been unable to evidence a sustained reduction in pressure ulcers. The reports outlined above demonstrate the initiatives in place.
No Category 4 declared	1 category 4 pressure ulcer was reported in October and 0 in November 2020.	2 category 4 pressure ulcers were reported in December 2020	**LIMITED ASSURANCE** The Trust has been unable to maintain zero incidence of category 4 pressure ulcers since October 2020
Reduction in CHFT Acquired Medical Device Related Pressure Ulcers (MDRPU)	There were 14 MDRPU in October and 15 in November 2020. This represents an increase from September 2020 (5)	There were 11 MDRPU in December 2020. This represents a decrease from the previous month.	**LIMITED ASSURANCE** The reduction is not sustained, and actions are in place to address MDRPU.
Reduction in Category 3 Pressure Ulcers	There were 2 category 3 pressure ulcers in October and 5 in November 2020	There were 3 category 3 pressure ulcers in December 2020	**LIMITED ASSURANCE**
Education and Training	Reduced attendance at virtual training due to Covid 19 pressures. Trust wide compliance with React to Red Pressure Ulcer Essential Training is 89% All clinical areas (hospital) provided with written guidance on maintaining, inspecting	Care home virtual training programme commenced in January 2021 for Calderdale care homes Face to face bedside training provided on HRI Acute Floor on weekly basis by Tissue Viability Team Moisture management pathway circulated to all clinical areas within Trust	**REASONABLE ASSURANCE**

Objective	Oct and Nov 2020	Dec 2020 and Jan 2021	Assurance
	and condemning mattresses All care homes in Calderdale footprint provided with pressure ulcer prevention educational resources as part of International Stop the Pressure day.		
Documentation	Community Pressure Ulcer Checklist revised in line with national guidance and aSSKINg framework Tissue Viability Service referral template devised for SystmOne patient record	Further testing of revised EPR templates for skin and wound management	**REASONABLE ASSURANCE**
Resources / Policies	All nursing homes across Calderdale footprint provided with heel inspection mirrors and pressure ulcer classification guides ASSKING framework promoted via Stop the Pressure MDT film endorsed by Chief Executive		**REASONABLE ASSURANCE**
Provision of appropriate pressure redistributing equipment	Additional pressure reducing cushions purchased for ward areas. Procurement exercise with NHS Supply Chain commenced in November 2020 for the replacement of hospital alternating pressure mattresses Training videos created for staff in the safe use of alternating pressure mattresses	Dressings and pressure redistributing aids disseminated to clinical areas to help reduce incidence of medical device related pressure ulcers Selection process for mattress tender underway Completion of trolley mattress replacement exercise.	**REASONABLE ASSURANCE**

5. Assessment and Dementia Screening

National Audit of Dementia
As a result of the ongoing pandemic and increasing pressure on hospitals there have been further delays to the plans for the annual dementia audit. Last year based on feedback from hospital staff and carers the Royal College of Psychiatrists created a 'top tips' document for caring for people with dementia whilst in hospital during COVID-19

Carers
Work has commenced through patient experience in the acute trust to promote the identification of the carers and how their vital importance in patient care and communication can be facilitated during the current pandemic.

Workforce in the enhanced care and support team
The band 7 is due to retire in May, recruitment has commenced for a new post holder. There has been a successful appointment for a Lead practitioner for dementia, this will provide further strategic direction for the team and enhance the Dementia Strategy commitments.

Screening compliance

Objective	Oct and Nov 2020	Dec 2020 and Jan 2021	Assurance
Dementia screen	Oct 2020 – 29.78% Nov 2020 – 24.78%	**Dec 2020 – 22.60%** **Jan 2021 – 22.17%** **AD of Patient Safety to liaise with the QGLs to raise the awareness and need for dementia screening.**	**LIMITED ASSURANCE**
Person centred dementia care training	This classroom training, which involves group work activities has been suspended due to COVID, and will be reviewed in the New Year	**No sessions held in Dec or Jan 21** **Training is a facilitated workshop and as such it is difficult to deliver virtually.**	**LIMITED ASSURANCE**
Dementia strategy	**Dementia Strategy**	**Carers work on going to identify and recognise carers as partners in care and signposting to local support networks**	**SUBSTANTIAL ASSURANCE**
Dementia training	Oct 97.64% Nov 97.77%	**Dec 97.76%** **Jan 97.84%.**	**SUBSTANTIAL ASSURANCE**

6. Nutrition and Hydration

The Nutrition Operational Group continues to meet monthly and is currently being chaired by the Head Nurse for the Division of Medicine with good representation from its multi-disciplinary team (MDT) members, however, there remains no clinical lead representative for nutrition and hydration. This has previously been escalated at the Clinical Improvement Group, further support is requested in this area to resolve the situation.

- **Training & Compliance**

  Enteral feeding training

  The online training module available for updating clinical staff in the ongoing care and management of nasogastric tubes is accessible on the intranet. Compliance in staff training are for wards identified as having regular or a high utilisation of nasogastric tubes. The training compliance is monitored monthly via the Nutrition Operational Group.

  The compliance rate for the Intensive Care Unit (ICU) is 52.80% and the Hospital Out of Hours Programme (HOOP) is 63.60%. Both areas are high users of nasogastric tubes. Additional training support continues via the nutritional specialist nurses for the Intensive Care Unit (ICU) for new nursing staff and to the Hospital Out of Hours Programme (HOOP) team to increase compliance to provide out of hours support and stroke services.

  The training for medical staff remains as a theoretical session at induction, but there is not a practical competency programme of assessment in place, unless it is undertaken at the individual's request. This currently sits on the risk register (risk 6924) scoring 10.

  Malnutrition Universal Screening Tool (MUST) training

  MUST compliance (nutritional screening for adults) online training remains good with all Divisions scoring 90% or above, with the exceptions of the Division of Medicine at 89% and Community at 50% which is due to small numbers of staff. The community division require only two members of staff to complete to achieve 100%.

  Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) training

  STAMP training (nutritional screening for children) has commenced now, and the training package was sent to all appropriate staff in late December 2020 for completion. Training is monitored by the nutritional specialist nurses and compliance rates are monitored monthly via the Nutrition Operational Group. Training compliance is currently 20% and the Division of Families & Specialist Services have defined actions to improve this. The possibility of adding the training to Electronic Staff Record (ESR) is currently being explored.

  Nutritional and Hydration documentation compliance

  Compliance in all aspects of clinical documentation remains of concern, with limited assurance provided in four out of five sections for nutrition and hydration. The completion of food charts compliance improved significantly in the last two months however in this reporting period compliance has reduced and reflects previous compliance rates.
  Compliance in relation to the completion of fluid balance charts has improved.

  At monthly Nutrition Operational Group meeting documentation compliance is monitored; reasons for fluctuations and actions required for improvement are discussed.

Objective	Oct and Nov 2020	Dec 2020 and Jan 2021	Assurance
All patients (>LoS 8hrs) have a completed fluid balance chart?	**10.2%**	**20.8%**	**LIMITED ASSURANCE**
Nutritional support care plans will be evident for all adults' patients with MUST of 2 or above?	**90.5%**	**92.7%**	**SUBSTANTIAL ASSURANCE**
Patients with a MUST score of 2 or above will be referred to a dietician	**2.9%**	**3.2%**	**LIMITED ASSURANCE**
Food charts will be completed for patients with a MUST of 2 or above	**25.3%**	**12.6%**	**LIMITED ASSURANCE**
All adult patients will receive a MUST assessment within 24 hours admission/ transfer to the ward?	**15.7%**	**15.1%**	**LIMITED ASSURANCE**

- **Incidents and Complaints**

  Governance relating to incidents are reviewed monthly at the Nutrition Operational Group with a monthly performance report. In the last reporting period, there were 11 incidents and no complaints. The 11 incidents are being reviewed to identify common themes and potential opportunities for improvement. There have been no never events reported. Currently incidents reported in paediatrics are not included however, these are to be added from March 2021.

- **Annual Naso-gastric Audit update**

  Patients have been selected and notes have been reviewed. A report of findings is currently being written for submission to the Audit Committee.

- **NHS Food Review update**

  The extensive paper has been reviewed by the Dietetic Service and has identified gaps in two specific recommendations:

  – **Ensure there is a named food service dietitian in every trust responsible for overseeing patient, staff and visitor catering, with appropriate funding to support this role outside of clinical responsibilities**.

    At present there is no dietician fulfilling this specific role.

  – **Make nutrition and hydration a mandatory part of health and care professionals' training, including existing doctors' continuing professional development.**

    There is no specific training module available on the electronic staff record (ESR) platform for nutrition and hydration for staff to access, and the healthcare assistant competencies do not have a module for nutrition.

Work has commenced to perform a full gap analysis. A template has been created that will support a multi- disciplinary approach where members of the multi-disciplinary team will review their relevant section of the paper. Results of the gap analysis will be brought to the monthly Nutrition Operational Group for discussion and action planning.

In the meantime, however, the two gaps identified as above will addressed by the Nutrition Operational Group, added to the groups action plan and progress monitored monthly.

7. Sepsis

The Sepsis Collaborative in June 2020 agreed the below measures would be reported on going forward:

- Antibiotic administration within the hour from the earliest alert in both Emergency Departments (ED) – an improvement trajectory of 10% to >72%
- Sepsis Care Bundle compliance – improvement trajectory to 50%

A robust 12-month action plan has been created and underpinned from the sepsis collaborative work.

Sepsis performance data is discussed with actions at the monthly sepsis collaborative meeting. There is varying compliance of antibiotic administration within 60 minutes in the emergency departments. Completion of the sepsis 6 care plan is inconsistent on Cerner, in particular, the oxygen and urine output aspects.

Introduction of a new sepsis power plan in the electronic patient record (EPR), recruitment of doctor and nurse sepsis champions and support of the communication team are assisting the improvement work. Additionally, sepsis training, education and learning from incidents within is strengthening the key messages of sepsis recognition, treatment and management.

Updated objectives	Dec 2020 and Jan 2021		Assurance
Increase compliance of antibiotic administration within hour for patients in emergency dept with suspected sepsis by 10%- from 62% to 72%	ED 64.1%. IP 73.7%.	ED 79.1% IP 56.5%	**REASONABLE ASSURANCE**
Improve number of patients receiving all 6 elements of the sepsis care bundle (BUFALO) to 50%:			
▪ Blood cultures	77.4%	83.8%	**REASONABLE**
▪ Urine output	71.2%	65.7%	**REASONABLE**
▪ Fluids	95.9%	100%	**SUBSTANTIAL**
▪ Antibiotics	99.3%	100%	**SUBSTANTIAL**
▪ Lactate	Waiting to be added		**N/A**
▪ Oxygen	67.1%	65.7%	**REASONABLE**
Total	**41.8%**	**46.5%**	

Work to improve the antibiotic within 60 minutes compliance includes:

- Emergency Dept consultant auditing red flag sepsis patients and feeding back issues and good practice at ED handovers. Also monitoring category 2 patients being seen sooner.
- Sepsis mortality rate increased in December 2020, informatics team looking to pull Covid related sepsis data then discuss at sepsis collaborative meeting.
- Recruitment of 58 registered nurse sepsis champions.

- Recruitment of 7 Doctor sepsis champions, further members planned from surgical division.
- Meeting planned in February 2021 to plan reporting key aims response to Red flag sepsis.
- Tazocin docking station planning underway to support faster administration times. Tazocin usage established and known to be greater in the HRI ED.
- ED matrons ordering sepsis trolleys.
- Sepsis portal now in use on KP+
- Key messages regarding antibiotic administration currently delivered on training. Sepsis nurse setting up Teams sepsis channel where all work and training will be sited. Doctors, nurses, AHP and HCAs will be able to access their specific narrated training, sepsis champions will be able to check progress and compare their areas performance with others. Award celebration planned at end of 2021 for sepsis training compliance.
- Sepsis newsletter used to deliver key messages monthly.
- Sepsis press (digital newspaper) under construction.
- Sepsis policy updated.
- Sepsis training strategy updated.

Work to improve the compliance of the sepsis 6 care bundle includes:

- Sepsis power plan on EPR updated to improve navigation for Doctors ordering tests and antibiotics.
- Power plan updated in the junior doctors EPR handbook.
- Sepsis 6 (BUFALO) screen saver.
- Power plan training slides to be added to Sepsis Teams channel.
- Sepsis nurse delivering awareness training including the importance of urine output on HCA apprentice training programme and ward-based HCA training.
- Meeting planned in February 21 to improve options for recording oxygen on care bundle as currently measured as Y/N (clinicians are sometimes leaving this blank if patient not requiring oxygen when sepsis screening tool initiated).
- Work underway for Nerve centre in Emergency Depts.

Archived progress from the Sepsis Collaborative

Progress	Assurance
Objective – EPR Sepsis bundle / Powerpoint presentation From June 2020, the WTGR action plan is updated monthly prior to sepsis collaborative meeting. Oct and Nov – no update	**REASONABLE ASSURANCE**
Objective: Further work to improve antibiotic administration compliance in ED continues. August = 62.8% September = 56.8% ED consultant monitoring cat 2 patients being seen sooner; purchase of sepsis trollies both EDs; improving escalation of IV access issues; micro teachings in EDs; new ED clinical skills trainer for nurses now in place. Sepsis 6 poster drop and sepsis information boards October 2020 = 52.8% November 2020 = 63.2%	**REASONABLE ASSURANCE**

ED consultant auditing non-compliant patients and feeding back issues at ED doctor handovers. Possible setting up of Piperacillin Tazocin docking stations for ED underway to support antibiotic administration within 60 mins from earliest alert. Sepsis portal accessible for inpatient and ED antibiotic, sepsis 6 compliance through KP+	
Sepsis dashboard will provide compliance figures monthly. Aug and Sept - Recording of all elements of the sepsis 6 care bundle August = 41.4% Sept = 42.4% showing an improvement of 2% Oct and Nov 2020 - Recording of all elements of sepsis 6 care bundle- October 2020=37.4 November 2020=43.2 Health care assistant training regarding urine output measurement accuracy ongoing. Sepsis nurse working with data collection team to improve recording oxygen and urine compliance for DRs in sepsis bundle on EPR.	**REASONABLE ASSURANCE**
New sepsis power plan for doctors launched on the 21/3/20 after media drive. Provides improvements with ordering tests, antibiotics and use of the sepsis treatment bundle. Sepsis 6 poster campaign commenced. Aug and Sept 2020 - Sepsis 6 CHFT screen saver arranged for month of October 2020 Oct and Nov - CHFT sepsis 6 screen-saver actioned in November.	**REASONABLE ASSURANCE**
Sepsis nurse is delivering training on new starter induction. Aug and Sept - Sepsis training and train the trainer ongoing at both sites Oct and Nov - Sepsis training ongoing.	**REASONABLE ASSURANCE**
Recruitment of sepsis champions completed at HRI, CRH ongoing. Aug and Sept - Sepsis champion doctors now being recruited from Medicine with support of Acute floor consultant Oct and Nov - Sepsis EPR power plan training has been arranged for Dr sepsis champions, further recruitment taking place in surgical division.	**REASONABLE ASSURANCE**
Monthly sepsis newsletter commenced April 2020 & distributed. Sepsis Press education digital newspaper being built for quarterly release. Newsletter ongoing monthly, Comms Dept assist in wider electronic distribution. Electronic digital news- paper aimed at education being built, agreed name - CHFT Sepsis Press	**REASONABLE ASSURANCE**

8. Patient Experience, Participation, Equalities

An Experience Participation Equalities Transformation Programme has been developed, this is a structured programme which is aimed at delivering against national policy / priorities and lends support to the ongoing trust wide activities.

- Annual workplan key priorities projects include:
  - Commitment to carers
  - Reducing noise at night
  - Making complaints count
  - Winter Volunteering (embedding a trust volunteer presence) – front of house 'meet and greet', property drop off / collection service and discharge support
  - Friends and family test – implementation of national changes
  - Quality priority - Learning lessons to improve patient experience.

- A robust infrastructure of support to underpin the programme functionality is in development, this includes:
  - The tools planning and reporting templates
  - The techniques – nationally recognised QI approaches
  - The support – leads, champions, experts, related teams

Programme Updates

- **Commitment to Carers**

  - The project team is currently benefitting from support from a re-deployed member of staff, this has enabled time to be dedicated to the plan and associated actions.
  - An assessment of the NICE guideline 150 - supporting adult carers, has been undertaken and has given an overview of the priorities for the Trust:
    - Identifying unpaid carers
    - Taking every opportunity to tell carers they have a right to information and support and how to get it
    - Supporting, working with and involving carers
  - Current workplan includes:
    - Introducing processes for early recognition of the carer
    - Developing a charter to agree the role of recognised carers e.g. inclusion of the carer in the patient's journey and the provision of services such as free parking / discounted meals
    - Exploring a means of recognising carers e.g. a 'Carers Key' (lanyard with supporting information) and flagging on EPR
    - Go see work to identify good practice from other Trusts and Carer services

- **Reducing Noise at Night**

  The research-based learning resource (an 8-minute ppt presentation) for promoting a positive sleep experience for patients and awareness raising in clinical areas to reduce unnecessary noise, is now available on the Participation and Experience intranet page: 10 min CHFT Reducing Noise Promoting Sleep video - YouTube.
  Implementation activities are as follows:

  - This learning resource been actively promoted via CHFT nursing forums.

- Support has been requested from the Practice Learning Facilitators to actively promote and support the training resource, for example with new starters, staff undertaking their revalidation and bank staff.
- Posters have been designed and distributed aimed at raising awareness and stimulating conversations and reflection.
- Ward-based champions identified in several areas in order to share good practice and positive experiences with support from the night matrons.

Further work is now required to review successes and identify if further support is required.

- **Making Complaints Count**

  - The first meeting of the Making Complaints Count collaborative was held on 19 January 2021. The Terms of Reference have been agreed, along with an agreed working model via the support of an operational group.
  - The Collaborative has been charged with providing assurance that:
    - The Trust is compliant with statutory and regulatory requirements
    - Developing a consistent approach across the Trust, humanising the process and the service becoming user led
    - Develop processes that promote learning with transparent impact which is visible and celebrated
  - Initial priorities for the operational groups include:
    - Gathering complainant experience and feedback
    - Developing processes to improve data quality and complaints pathway
    - Progressing work to inform a standard operating procedure which is aligned with the PHSO standards

- **Winter Volunteering**

  The winter volunteering project is currently underway following a successful NHSE/I bid. Redeployed staff into the Quality Division is currently providing project support. The project aims to stand up volunteering presence in the trust with a focus on:

  - Front of House meet and greet
  - Property drop up and pick up for relatives
  - Discharge support.

  The need for this service was identified as a result of learning from concerned members of the public. Recruitment to the coordinator post is underway and careful consideration re alignment to existing and forward strategic plans is ongoing.

- **Friends and Family Test**

  In line with National guidance, the FFT programme was suspended at the beginning of the covid-19 pandemic to focus on clinical priorities and reduce infection risks. Guidance in May 2020 allowed a FFT restart if implemented safely, CHFT restarted in a small number of inpatient areas, ahead of a formal restart and commencing data submissions to NHSE&I for December 2020 responses.

  Response rates for December 2020 for inpatients / day cases and maternity are very low. The process depends on staff offering patients the opportunity to give their feedback and current staffing pressures and priorities are impacting on this happening. NHSEI have acknowledged that *'in some parts of some settings it will be*

difficult, or even not possible to collect feedback (either because patients are too ill; there is a risk of infection; staff have other priorities etc) and we don't expect providers to use methods that risk infection or distract from clinical practices, but patients should still be able to give feedback about their experience if they want to.'

As part of the Trust's relaunch the digital platform has been improved and as recommended by NHSEI we have posters with the URL link and QR code around the hospitals, to ensure we advertise the opportunity to give feedback

Outpatient services and the Emergency departments have continued with SMS messaging and the use of Interactive Voice Mails which have given a slightly better response rate

Performance data will be included in the January 2021 IPR

- **Learning priority:** Learning lessons to improve patient experience

  The update to the Quality Committee December 2020, recognised that previous work has taken place in relation to the learning portal, and that further discussions are needed in order to build on the previous work. This priority now sits within the Making Complaints Count Improvement Collaborative workplan as a shared priority.

As a result of the current pandemic response delivery of all of the ambitions of the programme has been impacted. As such there has been some slippage in the following areas:

- Develop a central system of patient engagement – 31/03/21
- Develop a mechanism for systematic involvement of BAME communities – 31/12/21
- Patient and Service User Engagement Strategy – 31/03/21
- Annual quality account priority, (learning portal) - 31/03/21
- Transformation Programme (infrastructure and delivery support to ensure integration and sustainability for the above priorities - 31/03/21

Assurance against the Programme Objectives

Objective	Oct / Nov 2020	Dec / Jan 2020 / 21	ASSURANCE LEVEL
A. Establish and deliver an annual Transforming Patient and Carer Participation and Experience Programme	▪ Trust-wide programme developed, based on national priorities and local insight ▪ Non-Exec director part of leadership team ▪ Commenced collaborative projects which will support the ambition to reduce inequalities – commitment to carers, caring for blind / partially sighted patients ▪ IPR metrics revised to give increased level of detail ▪ Divisional PSQB reporting template for Quality Committee updated	▪ Lead Nurse for Transformation is now in post with close working relationships with the Patient / Carer Experience team ▪ Redesign of roles within the Patient Advice & complaints team to dedicate time to improvement activities ▪ PMO infrastructure in place for all collaborative projects	**REASONABLE ASSURANCE**
B. Support the principles of the NHS Long Term Plan (2019) to provide high-quality services that are accessible and convenient for patients and a commitment to prioritising more integrated care	▪ System working to deliver the unpaid carer programme, via West Yorkshire & Harrogate Health and Care Partnership ▪ Place-based approach to the submission for NHSE&I Winter Volunteering Programme	▪ Blind / partially sighted project being carried out in conjunction with Calderdale Disability Forum and representation from Halifax Society for the Blind ▪ Relationships established with local community leads for commissioning and service providers for carers	**REASONABLE ASSURANCE**
C. Ensure that patient experience and participation is embraced as part of organisational business / activities - Lord Darzi 'High Quality Care for All' (2008) established patient experience as one of the three elements of high-quality care, alongside clinical effectiveness and safety. Reasonable / substantial	▪ KPIs established to measure impact of activities that demonstrate a caring and responsive organisation ▪ Focused quality priorities being progressed to improve patient and carer experience ▪ Patient Experience team participating in the NHS QUEST learning QI network	▪ Go see (virtual) opportunities achieved in support of the volunteers' front of house project, via membership of the NHS Futures platform ▪ New project being scoped using the 'Observe and Act' tool - looks at a person's total experience of a service from the patient/carer perspective, this will be led by Non-Exec Directors	**REASONABLE ASSURANCE**

Objective	Oct / Nov 2020	Dec / Jan 2020 / 21	ASSURANCE LEVEL
D. Lead an organisational understanding of the relevant legal and policy requirements e.g. equality act and sections 242 of the health and social care act limited	▪ Undertaking an equality impact assessment of the Trust's visiting policy to ensure due regard is paid to the equalities act and identify any potentially negative impacts	▪ The design of the Making Complaints Count project aligns the project plan with the PHSO complaints standards framework ▪ A baseline assessment of the NICE guidance for adult carers has been carried out and being used to direct the project priorities ▪ EQIAs built into the project plans for volunteers' front of house, commitment to carers and making complaints count projects	**LIMITED ASSURANCE**

9. Complaints and Patient Advice and Liaison Service (PALS)

Making Complaints Count

There has been an increased focus on the complaint management process. The service has deployed support into the Divisions to support with any backlogs and to work alongside colleagues to improve the quality of responses. Extra capacity has been drafted into the corporate team to support with the quality assurance (QA) processes prior to responding to complainants. It is anticipated that there will be an improved performance once the current backlog has been addressed.

Work has been progressed to ensure accurate and consistent reporting and the development of a real time performance dashboard. Weekly tactical meetings with the divisions have been well received and have enabled a joint / supportive approach to managing the complaints process.

Redesign of the complaints / PALS structure and review of the team's roles and responsibilities is ongoing with the aim of gradually building a more flexible workforce capable of lending further improvement / 'learning from' support.

Making Complaints Count Collaboration - The inaugural meetings of the Making Complaints Count steering and operational groups have taken place. Key actions were set at the steering group which have been taken forward by the operational group:

- Patient Survey – Aligned to the Parliamentary Health Service Ombudsman (PHSO) standards which offers the opportunity to benchmark across to other providers; The design is in the final stages. The survey also has a 'help us improve our service and processes' form for anyone who would like to be involved in service improvement and co-production. We hope to encourage people who are 'experts by experience' to work in partnership with us.
- Trust wide consistent approach / Datix educational programme - A support programme is to be developed which will see a consistent trust wide approach to delivering against the process being adopted. Building on existing guides that are used and the narrative utilised on Datix a resource pack is to be developed.
- Matters for escalation to the steering group:
  - Risk Assessment - A review of the complaints grading system and associated rewrite of the policy / process flow chart is required. The process is to be more closely aligned to the risk / incident process
  - It was recognised that there are not enough investigators across trust / capacity issues and an associated need for training and buddying support.
  - Conflict resolution training is in need of a review in order to ensure it is fit for purpose.

Communications and Engagement

- Briefing sessions are being planned to ensure the operational group is fully sighted on the outcomes of the review and planned next steps.
- 3Rs session is being planned.
- Engagement work nationally and regional are ongoing to build relationships and create further 'go see' / learning from opportunities.

Performance Monitoring and Management

- Work has been completed to build a real time complaints dashboard – weekly tactical meetings and the collaborative are informing its development
- Building additional features into Datix complaint module to enable more accurate and sophisticated reporting e.g. ethnicity / ward-based reporting

Complaints & PALS Performance Summary - December 2020 to January 2021

	Dec	Jan
Complaints received	26	24
Open complaints	112	109
Breaching complaints	16	7
Complaints closed	24	27
Complaints reopened	0	0
PALS contacts received	198	271
Compliments received	33	46
PHSO complaints received	1	0
PHSO complaints closed	0	0
Complaints under investigation with PHSO	6	6

Assurance against the Programme Objectives

Objective	Oct And Nov 2020	Dec 2020 and Jan 2021	Assurance
Delivery against the Making Complaints Count Collaborative Work Plan		Inaugural meetings of both the steering group and the operational group have taken place. The steering group set the priorities for operational group to take forward. Significant progress against the initial objectives has been made	**SUBSTANTIAL ASSURANCE**
Senior divisional decision makers should receive all complaints and allocate accordingly	Audit spot check completed; Divisions are allocating complaints to investigation in a timely manner.	Audit spot check completed; Divisions are allocating complaints to investigation in a timely manner. Patient Experience and Quality Support Leads have been assigned to all Divisions to be the supporting factor between central Complaints and the Divisions. We now have a full complement of quality support leads in all divisions. Weekly joint performance/tactical meetings are ongoing	**SUBSTANTIAL ASSURANCE**
Database to be developed to provide an overview of colleagues with skills in more complex complaints and less experienced complaint handlers	Gathering information and contact details for current investigators to indicate where there are gaps	In light of the intensive focus on setting up the collaborative and operational group and delivering on the shared objectives to emerge from this joint work coupled with closing complaints within time and dealing with the backlog of breeching complaints. Progress on this specific objective has been paused and is subject to review	**LIMITED ASSURANCE**
The Trust should review its complaints training offer to include training in communication skills, strategies to build confidence in having difficult conversations and duty of candour as well as process	Complaints Training currently under review and working with Divisions.	In light of the intensive focus on setting up the collaborative and operational group and delivering on the shared objectives to emerge from this joint work coupled with closing complaints within time and dealing with the backlog of breeching complaints. Progress on this specific objective has been paused and is subject to review	**LIMITED ASSURANCE**
Audit of learning from PHSO cases	Cases to be reviewed to identify themes and trends, this will be shared with the Divisions	In light of the intensive focus on setting up the collaborative and operational group and delivering on the shared objectives to emerge from this joint work coupled with closing complaints within time and dealing with the backlog of breeching complaints. Progress on this specific objective has been paused and is subject to review	**LIMITED ASSURANCE**

10. Legal

Key Points to Note - Quarter 3 2020/21 (1 October – 31 December 2020)
Claims ▪ 14 new clinical negligence claims were opened in quarter 3. ▪ The Trust closed 13 clinical negligence claims in quarter 3. ▪ The Trust was successful in repudiating four claims with no damages paid. ▪ A further nine claims resulted in damages being paid. ▪ One new employee liability claim, and three new public liability claims were opened in quarter 3 Lost Property Claims ▪ 11 new lost property claims were opened in quarter 3 ▪ 23 lost property claims were settled in quarter 3, the total cost of which was £7,837.15 Inquests ▪ 19 new inquests were opened in quarter 3. ▪ Three inquest files were closed with no inquest taking place involving the Trust's care ▪ As of 1 February 2021, there were 117 open inquest cases.

Inquests

An inquest is a judicial inquiry in common law jurisdictions, particularly one held to determine the cause of a person's death. Conducted by a judge, jury, or government official, an inquest may or may not require an autopsy carried out by a coroner or medical examiner. Generally, inquests are conducted only when deaths are sudden or unexplained.

Opened Inquests

Summary:

- 19 new inquests were opened in Quarter 3.
- 1 concerning a patient cared for in the FSS Division
- 16 concerning patients cared for in the Medicine Division.
- 2 concerning a patient cared for in the Surgical Division.
- As of 1 February 2021, there were 117 open inquest cases.

Closed Inquests

Summary:

- 3 inquests cases were closed in quarter 3.
- No inquests took place

Regulation 28

In quarter 3, the Trust received no Prevention of Future Death Orders (Regulation 28)

11. Incidents

This is a summary of patient safety incidents and incidents with severe harm or death, for the year January 2020 to January 2021, and number of serious incidents (SIs) reported by month.

There has continued to be higher than normal levels in the number of severe harm and death incidents reports for December 2020 and January 2021 due to Hospital Onset Covid-19 Infections (HOCI) where patients have died. The SI Panel is reviewing these cases and a detailed piece of work on the HOCI cases is being undertaken. The Covid-19 workstreams continue to manage and minimise risks.

Month reported	No of Patient Safety Incidents reported (all)	No of Patient Safety Incidents of severe harm or death	SIs By the month externally reported on StEIS
Jan 2020	1068	4	2
Feb 2020	962	3	2
March 2020	876	4	0
April 2020	625	2	1
May 2020	790	4	1
June 2020	931	7	9
July 2020	994	5	2
Aug 2020	937	3	2
Sept 2020	954	7	4
Oct 2020	992	4	2
Nov 2020	1079	31	1
Dec 2020	900	14	3
Jan 2021	1037	28	5

Never Events

There are no new reported Never Events:

Summary of Progress with SI Actions

Work continues with the division 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 reduction in the numbers of open actions which are overdue by 6 months. Divisions have been encouraged to pull together a process for reviewing and closing down all actions >12 months. The incident team continues to offer support alongside the Quality Governance Leads to divisions.

Learning from Safety Incidents

Serious incident reports submitted to the Clinical Commissioning Group (CCG) in December 2020 and January 2021 includes the learning for the Trust. 6 reports have been shared.

Lessons learnt were as follows:

- To ensure feedback from the patients and their families for part of the scope pf the investigation.
- A complex case involving children's services has now informed the training programme for medical staff
- An incident involving accessing records has led to a full review across the organisation. The action plan includes raising staff awareness, reviewing training programmes and the implementation of more thorough audit to ensure compliance ging forward.

12. Medicine Safety

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

The Pharmacy team continue to focus on safe storage and administration of Covid vaccine. Whilst no medication safety issues have been raised at CHFT during the vaccine programme, continued monitoring of standards is undertaken.

Oxygen cylinder management has improved, and we have had no further issues with return of empty cylinders from ward areas. Our current situation is an excess of cylinders which come with an additional rental cost. Our MSO is reviewing stock levels/ order frequency.

Objective	Oct and Nov 2020	Dec 2020 and Jan 2021	Assurance
Non-compliance of the medicines management 'must do's	Clinical areas continue to receive pharmacy bi-annual spot check audits. 95% of all clinical areas have been audited at least once by the end of November 20. 73% of those areas audited demonstrated improvement in standards in the follow up audit. Recent issue of theft from medicines trolley due to trolley not being locked indicates we can't claim substantial assurance of must do's adherence for all areas.	Pharmacy bi-annual spot check audits continue to be completed. 11 areas were audited in the last 2 months. Trends / themes of none compliance include loose strips of tablets/ not stored in original box, clinic room doors not locked, TTOs not securely stored and fridge alarms not set.	**REASONABLE ASSURANCE**
Non-secure storage of medication cupboard keys in those areas not open 24/7	Check of safe key storage included in bi-annual pharmacy spot check audit. Ward Staff reminded of importance of key security in induction/ must dos. No recent incidents reported of missing keys in those areas not open 24/7.	**No issues reported**	**SUBSTANTIAL ASSURANCE**
Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100% compliant (audit completed July/ results shared September 19)	**Delay in roll out of active temperature monitoring system due to** current Covid operation pressures. Situation to be reviewed in February 2021. Continue to monitor fridges manually on a daily basis. Issues still reported of days when a record of temperature has not been recorded.	Active temperature monitoring roll out to be reviewed on 23rd February by project team. Need to ensure robust process for receipt and action of out of hours temperature deviation alerts. Fridges continued to be manually monitored and any temp excursion recorded on temperature monitoring sheet. Auditing of temperature monitoring sheets is included in pharmacy spot check audits. Issue of fridge alarms not being set highlighted in recent medicines spot check audits.	**REASONABLE ASSURANCE**

To improve medical gas training to ensure compliant with HTM requirements	Medical device/ oxygen trainer has left the Trust. Interim plan is for Clinical nurse educators to support and new trainer starting in February 21	DNO training up to date but general nursing oxygen cylinder management update training has slipped. New oxygen trainer now employed but has been supporting in ICU and so limited time for nurse medical gas training. In the last 2 months: 57 clinical staff trained on Oxygen and 5 portering /ODO training. Training compliance records regarding oxygen Medical device training indicates >850 clinical staff with no record of oxygen/ medical device training.	**LIMITED ASSURANCE**
Requirements for areas administering Entonox and nitrous oxide to complete annual occupational exposure checks	New Health and Safety lead now in post. Initial meeting with CD of Pharmacy to fully brief H&S lead. He has produced an action plan and currently seeking suppliers to deliver this testing.	Meeting with service leads for each area where NO/ Entonox administered to discuss the requirement for occupational staff monitoring. Meeting with testing company to share detail of how testing is done and reporting process. Dates for testing TBC. Funding for testing (approx. £6k) to be agreed- request made to Health and Safety committee/ estates and Occupation health team if they can fund**. Decision awaited re funding**	**LIMITED ASSURANCE**

13. Maternity

On Thursday 4 February 2021, Karen Spencer (Head of Midwifery) and Dr Tahira Naeem (Clinical Director for Obstetrics and Gynaecology) were invited to the Board of Directors workshop to provide an overview of maternity services at CHFT, the regulatory frameworks maternity works within and essential and urgent actions arising from the Ockenden Report.

In December 2020, in response to the Ockenden report, NHSE produced a paper that set out the key principles for a revised quality clinical quality surveillance model, one element of which is that providers use a locally agreed dashboard to include as a minimum, the measures below (see table 1). A meeting has been arranged with The Health Informatics Service (THIS) colleagues to develop the tool for CHFT.

The Ockenden Report highlighted 12 urgent clinical priorities which all providers were required to respond to by 21 December 2020. CHFT were able to provide assurance that maternity services were compliant with all 12 clinical priorities.

There is also a requirement that providers submit a further tool to assess their current position against the seven immediate and essential actions in the Ockenden Report. The tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and support required. Submission of this tool is required by 15 February 2021.

<u>Maternity Incidents and Complaints</u>

Maternity services currently have five cases under investigation by Healthcare Safety Investigation Branch (HSIB), and a further two awaiting acceptance. All cases referred to HSIB are also reviewed through Divisional Orange Panel and CHFT's Serious Incident Panel to ensure that any immediate learning is identified and acted upon.

Maternity services have a further one incident classified as orange, under investigation.
Currently Maternity services have one open complaint under investigation which is within timescale.

Service User Feedback

CHFT maternity services, in conjunction with Mid Yorkshire Hospitals NHS Trust and Kirklees Council, worked together to undertake a survey of pregnant women's experiences through the first Covid-19 surge and national lockdown. One of the most important findings was that women felt they didn't have enough information about what to expect from maternity services during the pandemic. An action plan from the findings of this survey is in place supported by the Maternity Voices Partnership, with an immediate action taken to develop and disseminate a letter to all women explaining how maternity services are operating at each stage throughout a woman's pregnancy journey.

Appendix - BRAG rating assurance

Evidence of fulfilling RAG rating	RAG RATING
• 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.	**Limited 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.	**Reasonable 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.	**Substantial assurance**
• Completed with documented evidence • Evidence of compliance with standards or action plans to achieve compliance.	**Full assurance**

23. Quality Committee Terms of Reference - In the Review Room (Approved at the Quality Committee on 25.01.21 – minor change to add the role Assistant Director for Patient Experience to the membership)

To Note

Presented by Ellen Armistead

24. Integrated Performance Report – January 2021

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee, Quality Committee

Purpose of the Report

To provide the Board of Directors with the performance position for the month of January 2021.

Key Points to Note

Trust performance for January 2021 was 64.7%, small decline in month.

Narratives have been provided for any key indicators that are failing to hit target including Complaints, ED 4 hours, Cancer 62-day screening, 31 day subsequent surgery treatment, 38 day referral to tertiary, 28 day faster diagnosis and Stroke admitted directly to a stroke unit within 4 hours.

SHMI is above 100 however is below 100 for in-hospital deaths. 2 out of 4 stroke targets have been missed.

Overall sickness is now Red with a rolling 12-month peak in Long-term sickness.

A number of access indicators continue to be affected adversely by the COVID situation including Diagnostics 6 week waits which has deteriorated after 3 months' improved performance, ASIs and 52 week waits (2,683).

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

The Board of Directors is asked to note the contents of the report and the overall performance score for January 2021.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

January 2021

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Contents

RAG Key	
Not achieving target or threshold	
Achieving target	
Between target and threshold	

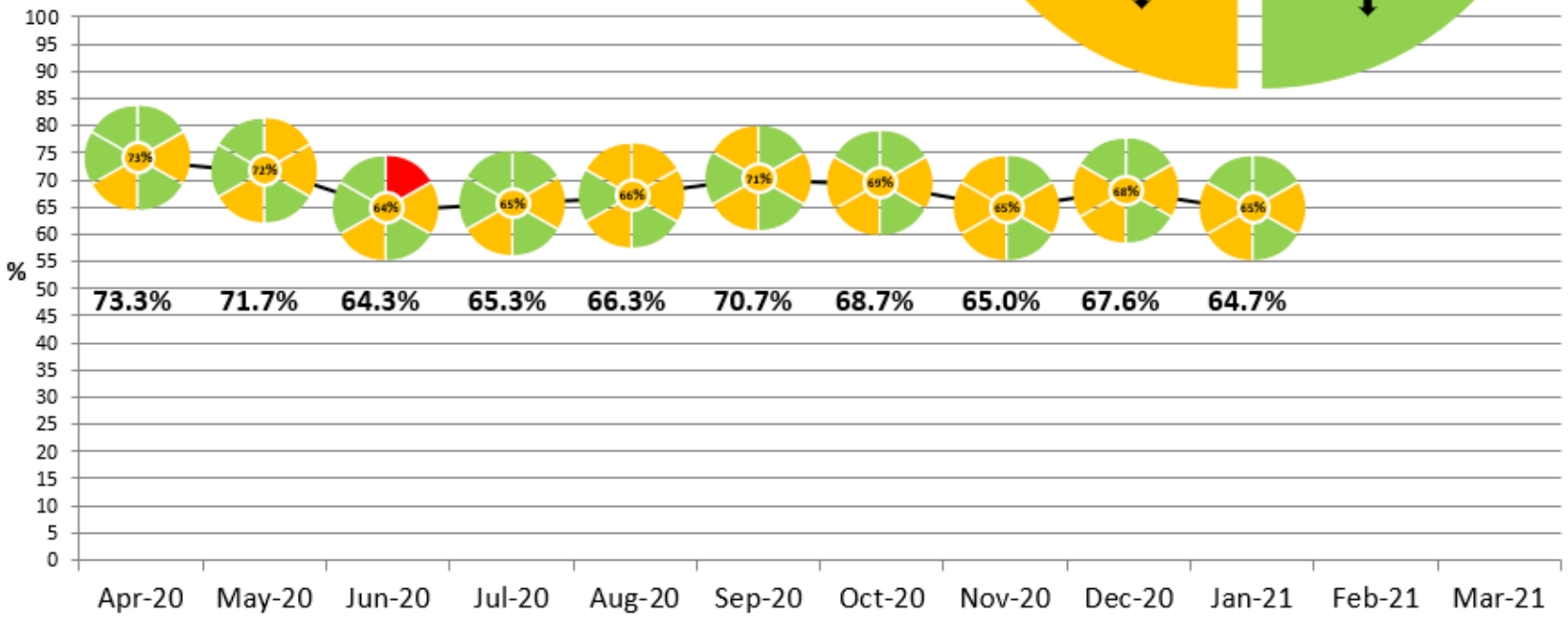
Performance Summary

January 2021

OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

RESPONSIVE	
Diagnostics 6 weeks	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover



Key Indicators

	19/20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Performance Range		
SAFE													Green	Amber	Red
Never Events	1	0	1	1	0	0	0	0	0	0	**0**	**2**	0		>=1
CARING													Green	Amber	Red
% Complaints closed within target timeframe	42.00%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	**in arrears**	**61.5%**	100%	86% - 99%	<=85%
EFFECTIVE													Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	1	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	5	1	1	2	2	0	0	0	0	0	**0**	**6**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.63	98.4	98.68	99.05	99.74	100.88	101.31	102.27				**102.27**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	88.6	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98			**92.98**	<=100	101 - 109	>=111
RESPONSIVE													Green	Amber	Red
Emergency Care Standard 4 hours	87.48%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	**87.82%**	**89.15%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	51.21%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	**56.06%**	**59.61%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.59%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	**98.56%**	**98.73%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.66%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	**97.32%**	**98.14%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.64%	99.42%	97.37%	98.26%	97.83%	97.69%	100.00%	98.67%	96.20%	96.62%	**95.77%**	**97.84%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	98.96%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	**71.43%**	**89.67%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	**98.15%**	**99.36%**	>=98%		<=97%
38 Day Referral to Tertiary	53.08%	76.00%	45.45%	40.00%	65.00%	47.06%	37.50%	58.33%	35.71%	52.94%	**55.56%**	**52.44%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.81%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.71%	89.89%	**88.76%**	**91.24%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	90.80%	72.22%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	86.96%	**81.82%**	**57.85%**	>=90%		<=89%
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	78.06%	70.98%	85.89%	73.70%	80.21%	83.25%	82.95%	82.58%	80.95%	81.54%	**71.43%**	**79.59%**	>=75%		<=70%
WORKFORCE													Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	3.93%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	2.50%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.43%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.81%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	97.63%									95.15%	95.15%	-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	84.10%											-	>=95%	>=90%	<90%
FINANCE													Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	9.76	(0.00)	0.00	0.00	0.00	0.00	0.00	0.95	0.16	-1.00	**0.41**	**0.52**			

Executive Summary

The report covers the period from January 2020 to allow comparison with historic performance. However the key messages and targets relate to January 2021 for the financial year 2020/21.

Domain	Area
Safe (75%)	**All key indicators are achieving target.**
Caring (50%)	• **Complaints closed within timeframe** - Complaints performance was 42% in December. The Making Complaints Count Improvement Collaborative steering group and operational group has met and key improvement actions are currently being taken forward. In order to address the current downward dip in performance, a realtime dashboard has been developed on Datix and an intensive response remains in place - Focus On: closing complaints within time and addressing breaching complaints. All divisions coupled with the central PALS/Complaints support team remain fully engaged in the improvement endeavours as led by the Collaborative and weekly tactical process.
Effective (80%)	• **SHMI -** The rolling 12-month SHMI (November 2019 – October 2020) is 102.27. The in-hospital SHMI is 96.14 and the out of hospital SHMI is 114.44. A paper from the Mortality Surveillance Group was present at Executive Board 25th February with a number of further areas to investigate highlighted. The out of hospital deaths are under current review with our community colleagues in Calderdale and Kirklees to ascertain if there are any concerns.
Responsive (53%)	• **Emergency Care Standard 4 hours** - Performance for December was 87.82%, further improvement on last month. We have continued with a number of actions which look to be driving some improvements in performance in month. The cross-divisional weekly breach investigation meetings are due to begin during February following review of the process with the Associate Director of Patient Safety. The main purpose is to ensure the true root cause of the breach is reached and that learning is maximised. The ED helpdesk function in now live for an initial trial period of 6 weeks. This will take some of the admin burden away from band 7 clinical colleagues. We have continued with the ward buddy system with a focus on reason to reside and ensuring there are clear medical plans in place on the wards and therefore shortening delays for scanning/therapy etc. National 111 appointments programme continues after going live during December with 2 slots bookable per site per day between 09.00-10.00 Mon-Fri. This is still in trial phase but is working well so far. Work has continued on the virtual consultant service with KPIs now defined. We have commenced work with Tytocare for a 12-month trial of equipment to aid virtual consultation with more complex patients. • **Stroke targets** - % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival is now at 56% against the 90% target, down from 65% last month. During January work has continued on the following: Continue to support early discharge through ESD to maximise capacity utilisation and this is continually reviewed. A new pathway is in place to enable quick transfer of stroke patients in ED at HRI to the CRH site. These patients currently account for 23% of all breaches. An audit will be completed in the coming weeks to measure effectiveness of this new pathway. Stroke assessment bed (SAB) open 24/7 instead of Mon-Fri 08.00-17.00. Initial discussions have started to enable MAU to triage all potential strokes referred direct from GP and redirect to CRH ED. Some delays are being seen with scanning due to the CT scanner requiring a deep clean after each patient. Potential opportunities to mitigate these delays are being explored with Radiology. • **62 Day Referral From Screening to Treatment, 31 Day Subsequent Surgery Treatment, 38 day referral to tertiary and 28 day faster diagnosis have missed target this month**. There have been capacity issues in theatre. Tertiary referrals capacity has reduced in other organisations which is also causing delayed pathways for patients. One stop Derm and Plastics clinics commenced w/c 14th December whave improved performance in 2ww breaches. Additional capacity implemented with Breast Services for Radiology. Appointing operational support to improve link with other organisations.
Workforce (65%)	• **Overall Sickness absence/Return to Work Interviews -** Sickness absence data does not include self / household / shielding isolation. Sickness rolling 12 month total has now tipped over into Red. Short-term sickness has remained round about the 1.5% target level whereas long-term sickness levels have peaked and on a rolling 12 month basis but have just reduced in January. Hotspot areas have been identified with regular focused deep dives taking place across Directorates. Data Security Essential Training target has increased to 95% hence performance is now amber for this area.
Finance (81%)	**All key indicators are achieving target.**

Safe - Key messages

Area	Reality	Response	Result
Health & Safety Incidents (RIDDOR)	1 Health & Safety RIDDOR Incident	Member of staff slipped on patient's property and fractured wrist.	Remind staff to be vigilant and try and learn from the incident to prevent it happening in the future. Accountable: All Staff

Safe - Key measures

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Performance Range		
																Green	Amber	Red
Falls / Incidents and Harm Free Care																		
All Falls	1,815	169	154	161	93	117	141	155	132	170	161	185	162	**182**	**1,498**	Refer to SPC charts		
Inpatient Falls with Serious Harm	25	1	1	4	0	0	3	4	1	5	2	2	2	**1**	**20**	Refer to SPC charts		
Falls per 1000 bed days	7.7	8.0	7.9	9.4	8.6	9.8	10.5	10.5	8.5	11.3	9.7	11.3	10.1	**11.1**	**10.2**	Ongoing Monitoring		
Number of Serious Incidents	36	2	2	0	1	1	8	2	2	4	2	1	3	**5**	**29**	Refer to SPC charts		
Number of Incidents with Harm	2,236	180	166	145	127	146	174	198	144	163	208	324	211	**281**	**1,976**	Refer to SPC charts		
Percentage of Duty of Candour informed within 10 days of Incident	99%	100%	100%	91%	100%	100%	100%	93%	90%	100%	100%	100%	100%	**100%**	**98%**	100%	96 - 99%	<=95%
Never Events	1	0	0	0	0	1	1	0	0	**0**	0	0	0	**0**	**2**	0		>=1
Percentage of SIs investigations where reports submitted within timescale – 60 Days	50.00%	none to report	0.00%	none to report	25.00%	0.00%	0.00%	0.00%	100.00%	33.00%	40.00%	0.00%	0.00%	**0.00%**	**15.00%**	Ongoing Monitoring		
% Emergency Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	75.00%	74.00%	72.00%	70.00%	78.00%	82.00%	88.00%	95.45%	82.14%	90.19%	79.25%	97.37%	97.44%	**in arrears**	**86.62%**	>=90%	86% - 89%	<=85%
% Inpatient Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	68.26%	71.43%	70.00%	68.75%	64.86%	60.00%	64.00%	86.36%	64.00%	77.14%	58.70%	84.91%	94.64%	**in arrears**	**72.73%**	>=90%	86% - 89%	<=85%
Maternity																		
Elective C-Section Rate	10.41%	8.96%	11.85%	11.89%	9.86%	9.30%	11.78%	13.03%	10.14%	10.42%	9.61%	11.65%	11.81%	**9.43%**	**10.71%**	<=10% Threshold		
Emergency C-Section Rate	15.77%	12.83%	14.88%	14.08%	14.25%	14.93%	15.18%	18.30%	14.52%	15.14%	16.50%	21.02%	17.86%	**19.41%**	**16.69%**	<=16% Threshold		
Total C-Section Rate	26.17%	21.79%	26.72%	25.97%	24.11%	24.23%	26.96%	31.33%	24.66%	25.56%	26.11%	32.67%	29.67%	**28.84%**	**27.41%**	<=27% Threshold		
% PPH ≥ 1500ml - all deliveries	3.06%	3.15%	2.75%	3.16%	3.01%	2.54%	4.19%	3.26%	4.11%	2.98%	3.69%	3.41%	2.20%	**2.43%**	**3.19%**	<= 3.0%	3.1% - 3.4%	>=3.5%
Antenatal Assessments < 13 weeks	92.13%	90.02%	91.79%	92.50%	92.93%	93.02%	92.84%	94.03%	94.74%	90.62%	92.70%	93.20%	90.65%	**90.02%**	**92.40%**	>90%	81% - 89%	<=80%
Maternal smoking at delivery	12.35%	9.69%	11.57%	13.11%	14.50%	11.80%	10.70%	9.00%	9.00%	10.90%	10.30%	11.40%	12.09%	**9.97%**	**10.95%**	<=12.9%		>=13%
Pressure Ulcers/VTE Assessments																		
Number of Trust Pressure Ulcers Acquired at CHFT	98	26	25	21	78	94	68	56	58	58	105	112	85	**under validation**	**714**	Refer to SPC charts		
Pressure Ulcers per 1000 bed days	1.38	1.23	1.28	1.22	3.70	3.18	2.32	1.56	1.29	2.20	3.19	3.43	2.48	**under validation**	**2.59**	Refer to SPC charts		
Number of Category 2 Pressure Ulcers Acquired at CHFT	291	23	23	20	29	40	36	27	34	25	43	47	36	**under validation**	**317**	Refer to SPC charts		
Number of Category 3 Pressure Ulcers Acquired at CHFT	33	3	1	1	7	10	2	2	1	1	3	6	3	**under validation**	**35**	Refer to SPC charts		
Number of Category 4 Pressure Ulcers Acquired at CHFT	0	0	1	0	4	0	0	1	0	0	1	0	2	**under validation**	**8**	0		>=1
Number of Deep Tissue Injuries	123	7	14	7	27	27	19	14	11	19	41	36	18	**under validation**	**212**	0		>=2
Number of Unstageable Pressure Ulcers	38	1	8	1	19	17	11	14	12	13	21	24	31	**under validation**	**162**	0		>=3
Number of patients with a Pressure ulcer	282	24	24	17	62	73	60	49	48	46	85	86	66	**under validation**	**575**	Refer to SPC charts		
% of leg ulcers healed within 12 weeks from diagnosis	92.07%	86.40%	80.00%	26.30%	40.00%	44.40%	12.50%	42.90%	50.00%	38.50%	43.80%	56.30%	84.60%	**81.80%**	**48.40%**	>=90%	86% - 89%	<=85%
Percentage of Completed VTE Risk Assessments	96.04%	95.97%	96.06%	95.46%	95.56%	96.05%	95.89%	96.26%	96.14%	95.54%	96.44%	96.13%	95.74%	**95.67%**	**95.96%**	>=95%	86% - 89%	<=85%
Safeguarding																		
Health & Safety Incidents	220	19	14	17	4	28	35	18	19	17	25	20	21	**20**	**207**	Ongoing Monitoring		
Health & Safety Incidents (RIDDOR)	4	1	0	0	2	2	1	0	1	0	0	0	2	**1**	**9**	0		>=1
Medical Reconciliation within 24 hours (excluding Children)	36.70%	38.80%	39.00%	39.60%	72.80%	57.60%	58.30%	61.20%	56.60%	58.90%	48.40%	54.60%	54.50%	**46.80%**	**56.30%**	>=68%		<=67%
Electronic Discharge																		
% Complete EDS	96.58%	95.15%	93.74%	93.58%	95.22%	95.00%	95.09%	94.36%	92.69%	95.21%	94.55%	94.02%	94.92%	**in arrears**	**94.55%**	>=95%	91% - 94%	<=90%

Caring - Key messages

Area	Reality	Response	Result
Friends and Family Test	The reporting format has moved away from response rates with a greater focus on *driving improvement*. % positive and % negative performance data now relates to how patients 'rate' their care, rather than whether they would 'recommend' the care received to friends and family. Supporting comments of what went well and what can we do better will help to inform improvements.	In line with national guidance FFT has been stood back up in the Trust. Numbers responding in December 2020 are extremely low for inpatient and maternity services: IP – 116 responses via postcards Maternity – 12 responses via web pages Low figures relate to current staffing pressures and priorities, along with adapting to new processes. Higher numbers achieved in services utilising SMS messaging: OPD – 2,285 responses via SMS and web pages A&E – 828 responses via SMS and web pages	To improve response rate : Relaunch / improvements to the digital platform Hospital posters with the URL link and QR code Senior colleague lead responsible for promotions and briefing of teams in line with SOP Accountable: Clinical Managers and Matrons

Caring - Complaints Key messages

Area	Reality	Response	Result
% Complaints closed within target timeframe	A total of 24 complaints were closed during December 2020: 42% (10/24) of complaints were closed within the target timeframe 0% (0/1) in Surgery and Anaesthetic Division 27% (4/15) in Medicine Division 86% (6/7) in FSS Division 0% (0/1) in Community Division 0 complaints were re-opened in December, the same as the previous month.	In line with other Trusts nationally the IPR report for complaints will be reporting a month in arrears from this month onwards – this approach affords a greater opportunity to address early indications of a performance dip. The Making Complaints Count Improvement Collaborative steering group and operational group has met and key improvement actions are currently being taken forward. Please see the bi-monthly quality report for further detail of the matters for escalation, mitigating actions and improvement T&F projects. In order to address the current downward dip in performance, a realtime dashboard has been developed on Datix and an intensive response remains in place – Focus On: closing complaints within time and addressing breaching complaints. All divisions coupled with the central PALS/Complaints support team remain fully engaged in the improvement endeavours as led by the Collaborative and weekly tactical process.	By implementing the recommendations highlighted in the recent service review, audits and improving complaint processes we will achieve our performance targets and evidence quality improvements for patients and staff alike. The overall improvement and development will take 1-3 years to achieve and will benefit positive culture change; however early improvements will be demonstrated in the first quarter of 2021/22. There is to be a focus on learning from complaints and the development of a robust training module (further details can be found in the Complaints Bundle, Quality Committee 30th November 2020). Accountable: Head of Complaints & PALS

Complaints background Q3 2020/21:

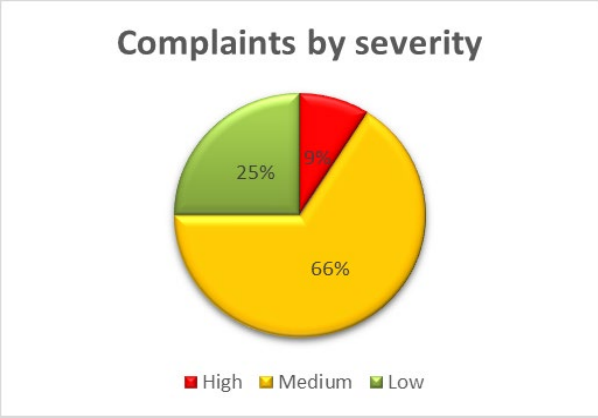
Top 3 complaints subjects (120 subjects recorded):
Patient care: 23 (23%)
Clinical treatment: 20 (20%)
Communications: 1 (12%)

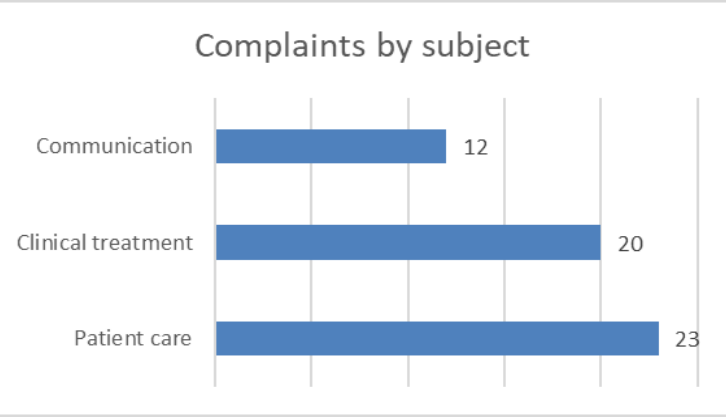
Complaints severity:
High: 9%
Medium: 66%
Low: 25%

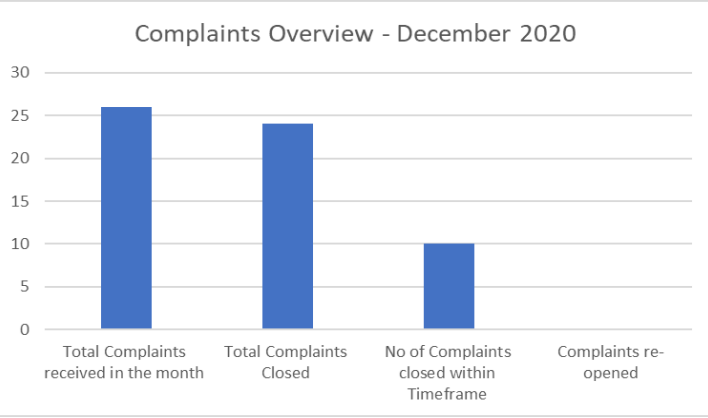
PHSO cases:
We currently have 5 cases being investigated by the PHSO and 1 case that is being reviewed, pending a decision by the PHSO to carry out a full investigation.

Caring – Key Measures:

Complaints	Dec 2020	YTD
% Complaints closed within target timeframe	42%	61.5%
Total Complaints received in the month	26	227
Complaints re-opened	0	16
Inpatient Complaints per 1000 bed days	data not available	
No of Complaints closed within Timeframe	10	123
Total Complaints Closed	24	200







Caring - Key measures

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Performance Range		
Complaints																Green	Amber	Red
% Complaints closed within target timeframe	42.0%	51.0%	47.0%	64.0%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	in arrears	61.5%	100%	86% - 99%	<=85%
Total Complaints received in the month	494	43	31	27	10	14	29	17	30	32	33	36	26	in arrears	227	no target		
Complaints re-opened	68	8	5	3	1	2	4	1	4	3	1	0	0	in arrears	16	no target		
Inpatient Complaints per 1000 bed days	2.12	2.13	1.64	1.57	0.93	1.17	2.17	1.15	2.26	2.26	2.1	2.39	1.67	1.4	1.75	no target		
No of Complaints closed within Timeframe	222	19	18	13	15	18	16	16	5	14	15	14	10	in arrears	123	Refer to SPC charts in Appendix		
Total Complaints Closed	545	36	40	21	16	22	20	23	7	26	34	28	24	in arrears	200	no target		
Friends & Family Test																		
Friends & Family Test (IP Survey) - % Positive Responses	96.88%	95.79%	96.44%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	98.19%	in arrears	98.19%	To be Confirmed		
Friends and Family Test Outpatients Survey - % Positive Responses	91.98%	92.68%	92.08%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.17%	in arrears	93.17%	To be Confirmed		
Friends and Family Test A & E Survey - % Positive Responses	84.54%	86.49%	86.25%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	90.10%	in arrears	90.10%	To be Confirmed		
Friends & Family Test (Maternity) - % Positive Responses	99.20%	99.30%	99.50%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	91.70%	in arrears	91.70%	To be Confirmed		
Friends and Family Test Community Survey - % Positive Responses	96.32%	97.46%	93.91%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	100.00%	in arrears	100.00%	To be Confirmed		
Caring																		
Number of Mixed Sex Accommodation Breaches	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		>=1
% Dementia patients screened following emergency admission aged 75 and over	46.23%	40.72%	42.89%	40.74%	35.28%	40.15%	40.09%	40.37%	42.49%	34.23%	29.78%	24.78%	22.60%	22.17%	32.60%	>=90%	88% - 89%	<=87%

Effectiveness - Key messages

Area	Reality	Response	Result
Local SHMI - Relative Risk	Data has been released in January 2021 for SHMI incorporating performance data up to September 2020 Looking at the rolling 12-month SHMI (November 2019 – October 2020) the score is 102.27. This is a declining position from the previous rolling 12-month period.	The national SHMI figure rose in April 2020 above 100, with the latest data release peaking at 100.60. The Trust's (12 month rolling) In Hospital SHMI is 96.14. The Trust's In Hospital SHMI ranks it 39th out of 124 Trusts putting it in the upper quartile. The Trust's (12 month rolling) Out of Hospital SHMI is 114.44. The Trust's Out of Hospital SHMI ranks it 93rd out of 124 Trusts putting it very close to the lower quartile. The top 5 diagnostic groups contributing to the Trust's overall SHMI are acute cerebrovascular disease, urinary tract infections, septicaemia, acute and unspecified renal failure or secondary malignancies, acute and unspecified renal failure, and secondary malignancies. It is likely that the Trust SHMI will continue to deteriorate due to the release of 12 month rolling data. Every data release will replace a stable performing month with one that is likely to be more volatile The out of hospital deaths are under current review with our community colleagues in Calderdale and Kirklees to ascertain if there are any concerns.	Accountable: Medical Director - Corporate
Preventable number of Clostridium Difficile Cases	The RCAs for CDiff have been 'in due process' longer than expected. This has been noted by the IPC and has resulted in the Trust showing activity for the beginning of this financial year.	There still remains a number which are still pending and this may alter the Trust's position in regards to preventable/unpreventable.	Accountable : Patient Safety Manager

Effectiveness - Key measures

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Performance Range Green	Amber	Red
Infection Control																		
Number of MRSA Bacteraemias – Trust assigned	1	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Total Number of Clostridium Difficile Cases - Trust assigned	26	2	3	5	1	2	4	7	2	2	4	2	6	**4**	**34**	No target		
Preventable number of Clostridium Difficile Cases	5	1	0	0	1	1	2	2	0	0	0	0	0	**0**	**6**	<=4 & YTD <=40		
Number of MSSA Bacteraemias - Post 48 Hours	19	4	1	0	0	2	3	2	1	2	2	0	0	**1**	**13**	No target		
Number of E.coli - Post 48 Hours	29	3	1	5	2	5	4	2	1	2	3	0	3	**2**	**24**	No target		
MRSA Elective Screening – Percentage of Inpatients Matched	96.22%	95.20%	94.90%	95.80%	87.00%	69.00%	73.00%	68.40%	61.40%	75.00%	66.40%	49.70%	55.90%	**51.90%**	**65.60%**	>=95%	94% - 93%	<=92%
Mortality																		
Stillbirths Rate (including intrapartum & Other)	0.16%	0.00%	0.00%	0.24%	0.27%	**0.00%**	0.26%	0.50%	0.27%	0.25%	0.49%	0.85%	0.00%	**0.80%**	**0.37%**	<=0.47%		>=0.48%
Perinatal Deaths (0-7 days)	0.10%	0.24%	0.27%	0.00%	0.00%	0.00%	0.00%	0.25%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.03%**	<=0.1%		>=0.11%
Neonatal Deaths (8-28 days)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**	<=0.1%		>=0.11%
Local SHMI - Relative Risk (1 Yr Rolling Data)	99.94	98.89	98.84	99.94	98.4	98.68	99.05	99.74	100.88	101.31	102.27	Due Mar 21	Due Apr 21	Due May 21	**102.27**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	89.64	90.35	89.34	89.64	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98	Due Mar 21	Due Apr 21	**92.98**	<=100	101 - 109	>=111
Crude Mortality Rate	1.25%	1.21%	1.14%	1.62%	4.66%	2.30%	1.69%	1.37%	1.87%	1.50%	2.25%	2.54%	2.44%	**2.81%**	**2.29%**	No target		
Coding and submissions to SUS																		
% Sign and Symptom as a Primary Diagnosis	8.11%	8.22%	8.05%	7.10%	5.34%	7.84%	7.82%	8.18%	8.17%	7.79%	8.16%	8.42%	8.16%	**7.48%**	**7.81%**	<=8.3%	8.4% - 9.4%	>=9.5%
Average co-morbidity score	5.52	5.55	5.65	6.38	7.00	6.66	6.62	6.44	6.91	6.13	6.36	6.42	6.58	**6.13**	**6.50**	>=5.08 / >=5.30 from April 20		<=4.7
Average Diagnosis per Coded Episode	6.06	6.03	6.24	6.64	7.86	7.97	7.74	7.61	7.94	7.52	7.69	7.87	7.95	**7.62**	**7.77**	>=6.14 / >=6.48 from April 20		<=5.8
Recruitment to Time and Target (Research)	83.33%	82.30%	83.50%	82.90%	83.34%	83.10%	73.68%	77.78%	79.98%	80.49%	81.82%	82.22%	86.36%	**83.72%**	**81.25%**	>=80%	76% - 79%	<=75%
Best Practice Guidance																		
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	75.96%	77.36%	67.57%	77.08%	56.10%	56.67%	66.67%	42.86%	51.06%	74.36%	75.68%	67.39%	61.70%	**45.83%**	**59.21%**	>=85%	84% - 83%	<=82%
IPMR - Breastfeeding Initiated rates	76.39%	75.50%	78.00%	76.40%	78.57%	77.70%	81.10%	76.30%	75.30%	72.90%	76.50%	77.70%	73.60%	**73.90%**	**76.30%**	>=70%	66% - 69%	<=65%
Readmissions																		
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Trust (excluding ambulatory)	8.80%	8.82%	8.81%	10.41%	14.48%	11.48%	11.41%	10.89%	11.73%	10.11%	9.17%	10.01%	10.30%	**10.71%**	**11.03%**	<=7.96% as per Model Hospital		>=8.99%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG (excluding ambulatory)	9.70%	9.15%	10.16%	11.85%	14.52%	11.47%	10.40%	11.23%	12.10%	10.73%	10.80%	10.88%	10.08%	**10.13%**	**11.23%**	<=7.96% as per Model Hospital		>=8.99%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG (excluding ambulatory)	9.62%	10.26%	9.19%	10.39%	14.95%	12.67%	13.13%	10.97%	12.39%	10.02%	8.70%	9.90%	11.95%	**12.27%**	**11.69%**	<=7.96% as per Model Hospital		>=8.99%
Community																		
% Readmitted back in to Hospital within 30 days for Intermediate Care Beds	5.78%	6.80%	5.10%	8.10%	17.50%	7.70%	2.00%	7.40%	6.30%	2.00%	3.80%	5.50%	6.10%	**7.55%**	**6.74%**	No target		
Hospital admissions avoided by Community Nursing Services	2,995	320	259	277	350	267	228	264	241	240	202	196	192	**181**	**2,361**	>=186		

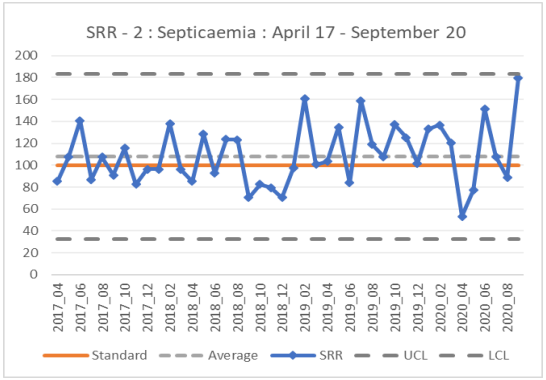
Summary for Integrated Performance Report

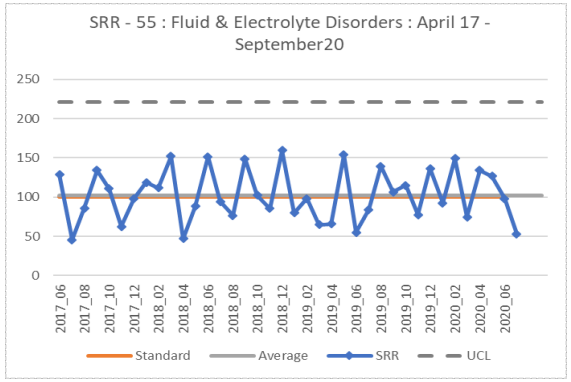
Outcome Indicators

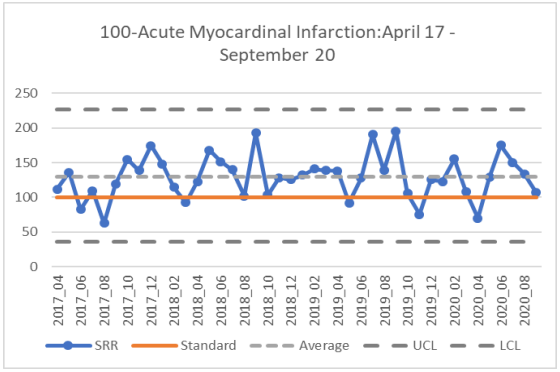
Approach taken - worked with our Benchmarking software providers Healthcare Evaluation Data (HED) to understand if they provided facility to monitor these areas as per Insight Report
Insight Report focuses on 10 Clinical Classification System (CCS) Diagnostis Groups - there are in total over 250, need to consider deep dive into all that are areas of potential concern.
HED advised that they do provide a facility within the Clinical Quality Module of their tool but it uses a marginally different methodology. The table below is used to illustrate how close the HED assessment is when balancing to the figures provided in the Insight report.
The latest 12 month figure from HED (March 19 to Feb 20) is also provided as is a graph for all 10 areas showing the trend over time going back to April 2017
In addition the number of additional readmissions than expected is provided as an attempt to illustrate the scale of any issue
All figures quoted in table are the relative risk score unless stated. A value greater than 100 means that the patient group being studied has a higher readmission level than NHS average performance

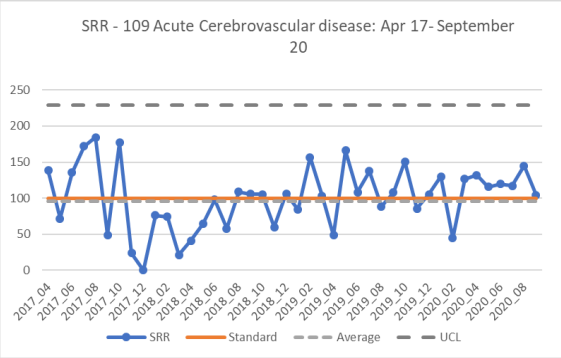
Insight Report Emergency Readmissions

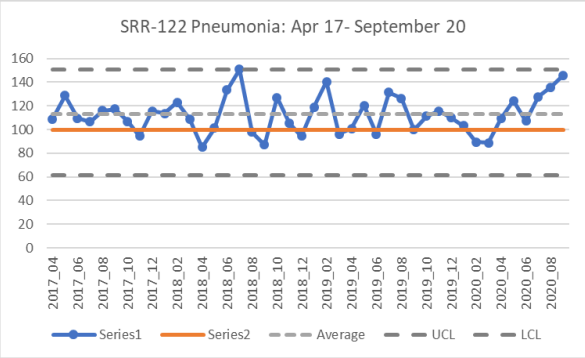
	Oct 17 - Sep 18		Oct 18 - Sep 19		Mar 19 - Sep 20			
CCS No & Diagnostic Group	Insight	HED	Insight	HED	HED	95% Confidence Interval	No of Discharges	No of Additional Readmissions
2 - Septicemia (except in labor)	101.5	102.2	112.7	107.2	27.2	(85.80, 113.70)	676	31.7
55 - Fluid and electrolyte disorders	110	105.8	106.9	97.1	99	(104.00, 139.60)	763	-2
100 - Acute myocardial infarction	137.8	139.2	134.8	138.1	131	(113.30, 150.70)	984	46.4
109 - Acute cerebrovascular disease	114.4	72.4	131.1	105	114.3	(96.50, 134.50)	955	18.1
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted diseas	117.6	105.8	114	107.7	98.4	(103.20, 119.10)	3208	75.5
125 - Acute bronchitis	113.1	98.6	112.2	99	107.1	(88.40, 109.20)	2079	-5.8
127 - Chronic obstructive pulmonary disease and bronchiectasis	117.9	119.7	106.9	111.8	113	(97.50, 117.50)	1516	30.4
157 - Acute and unspecified renal failure	122.5	121.9	108.3	108	108.6	(98.40, 129.20)	751	24.6
159 - Urinary tract infections	117.9	109.2	120.8	111.9	120.8	(100.10, 117.70)	2553	47.4
226 - Fracture of neck of femur (hip)	94	87.2	79.7	84.3	82.6	(66.40, 101.70)	676	-18.7

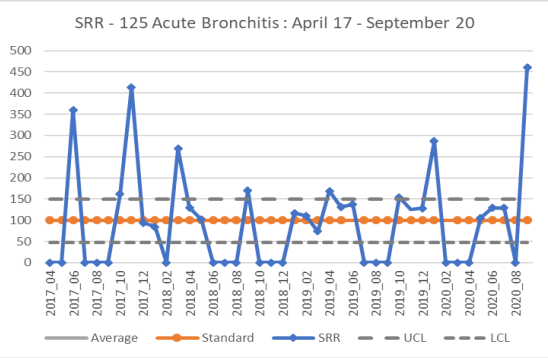


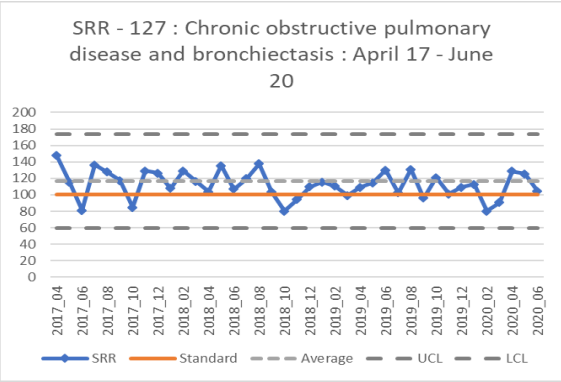


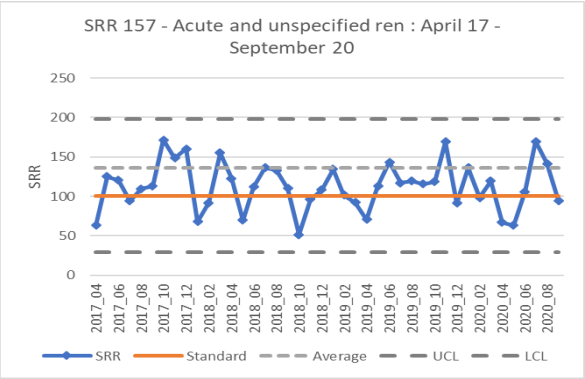


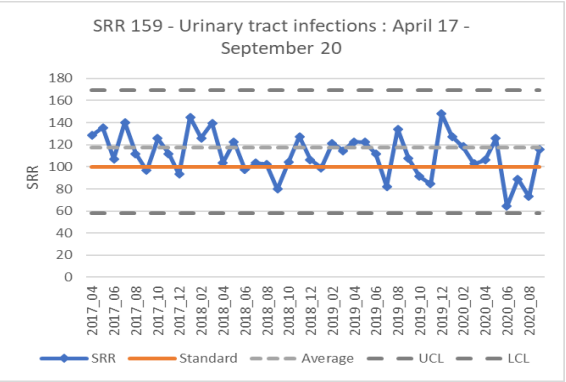

SRR - 109 Acute Cerebrovascular disease: Apr 17- September 20
SRR
Standard
Average
UCL

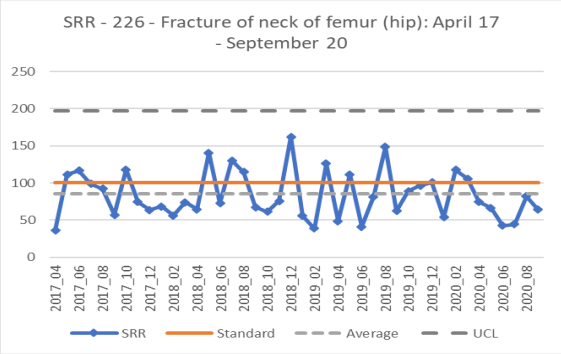

SRR-122 Pneumonia: Apr 17- September 20
Series1
Series2
Average
UCL
LCL


SRR - 125 Acute Bronchitis : April 17 - September 20
Average
Standard
SRR
UCL
LCL

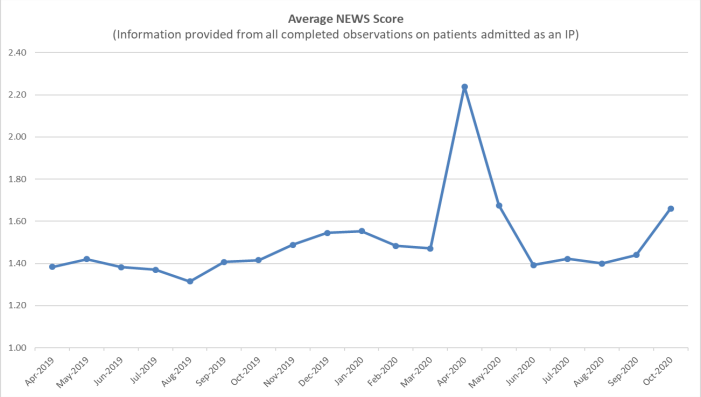

SRR - 127 : Chronic obstructive pulmonary disease and bronchiectasis : April 17 - June 20
SRR
Standard
Average
UCL
LCL

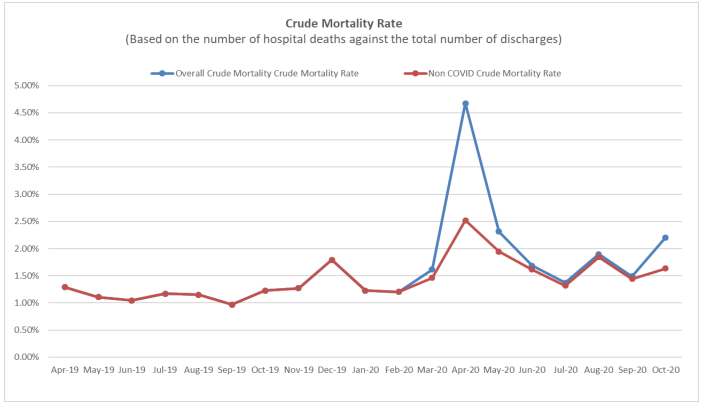

SRR 157 - Acute and unspecified ren : April 17 - September 20
SRR
SRR
Standard
Average
UCL
LCL

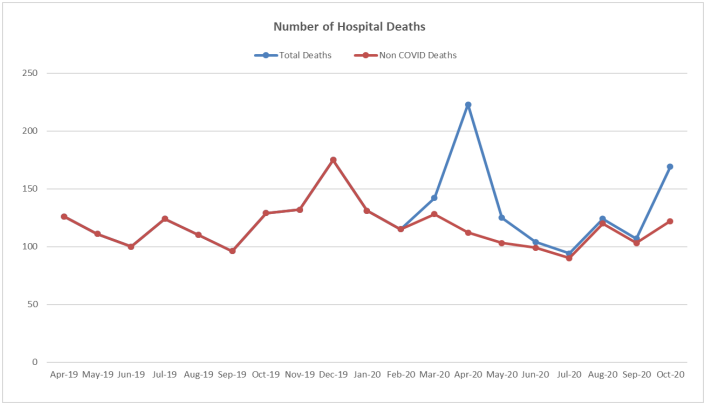

SRR 159 - Urinary tract infections : April 17 - September 20
SRR
SRR
Standard
Average
UCL
LCL

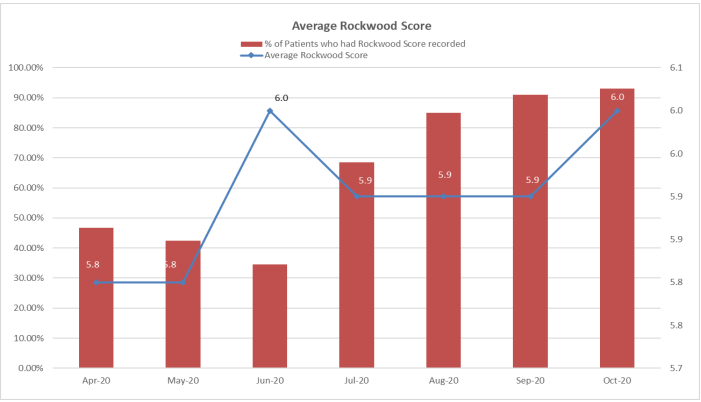

SRR - 226 - Fracture of neck of femur (hip): April 17 - September 20
SRR
Standard
Average
UCL

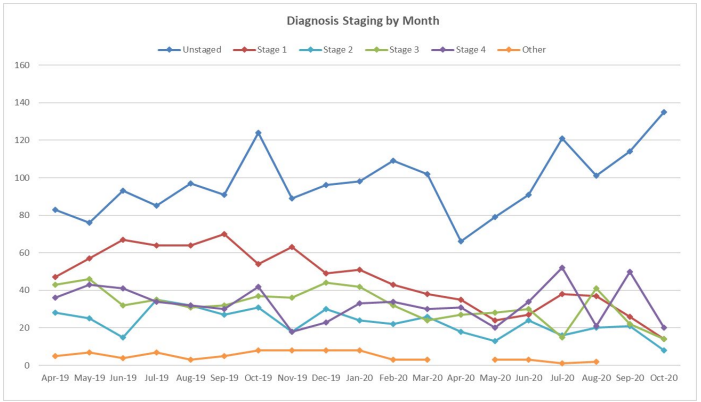
Outcome Measures

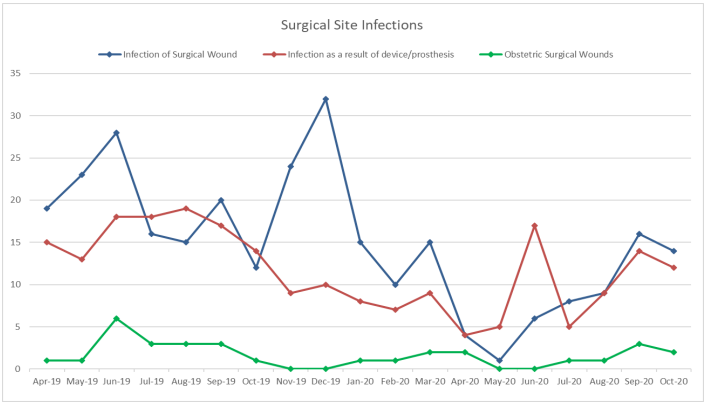












Responsive - Key messages

Area	Reality	Response	Result
Emergency Care Standard 4 hours	ECS - <4 hours performance - Slight improvement in month to 87.82% in January from 86.82% in December. YTD position of 89.15% A&E Ambulance Handovers 30-60 mins - 12 in month which is a significant decrease from 36 in December. A&E Ambulance Handovers over 60 mins - 3 in month which remains the same as last month. There have been 53 YTD. A&E Trolley Waits (from decision to admit) - 0 in month which remains the same as last month.	We have continued with a number of actions which look to be driving some improvements in performance in month, key actions being: - The cross-divisional weekly breach investigation meetings are due to begin during February following review of the process with the Associate Director of Patient Safety. The main purpose is to ensure the true root cause of the breach is reached and that learning is maximised. The data to support these meetings has now been developed on a dashboard in KP+. - The ED helpdesk function in now live for an initial trial period of 6 weeks. This will take some of the admin burden away from band 7 clinical colleagues. - National 111 appointments programme continues after going live during December with 2 slots bookable per site per day between 09.00-10.00 Mon-Fri. This is still in trial phase but is working well so far. - Work has continued on the virtual consultant service with KPIs now defined. We have commenced work with Tytocare for a 12 month trial of equipment to aid virtual consultation with more complex patients. - Work continues on developing our directory of services and we are currently looking at how these attendances can be coded, in conjunction with colleagues in the appointments centre. - Additional GP streaming continues on both sites 12-6pm until the end of March 2021. - Regular calls between ED GM and head of YAS are continuing to ensure any issues are addressed quickly and to ensure patients are in the right place. - The ED matron at HRI continues to work a number of twilight shifts to reduce the number of breaches, and to ensure band 7 nursing colleagues are trained in the same approach making any improvement sustainable. - We have continued with the ward buddy system with a focus on reason to reside and ensuring there are clear medical plans in place on the wards and therefore shortening delays for scanning/therapy etc.	A project team has been set up to look at improvements to ED performance and is currently confirming a realistic timeframe for this. Accountable: Director of Operations - Medicine
Stroke	Stroke - 2 out of 4 targets achieved in the month % Stroke patients spending 90% of their stay on a stroke unit is showing a slight decrease in month to 83.33%,. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival was 56.06% in month which is down from 65.30%. % Stroke patients Thrombolysed within 1 hour was up to 78.57% and is achieving the 55% target. % Stroke patients scanned within 1 hour of hospital arrival improved to 53.73% against the 48% target.	During January work has continued on the following: - There has been a greater emphasis on continuing to support early discharge through ESD to maximise capacity utilisation and this is continually reviewed. - Data continues to be validated prior to submission to prevent reporting errors with the use of the stroke assessment bed at CRH. - A new pathway is in place to enable quick transfer of stroke patients in ED at HRI to the CRH site. These patients currently account for 23% of all breaches. An audit will be completed in the coming weeks to measure effectiveness of this new pathway. - Stroke assessment bed (SAB) open 24/7 instead of Mon-Fri 08.00-17.00 although this is being managed flexibly. - Initial discussions have started to enable MAU to triage all potential strokes referred direct from GP and redirect to CRH ED. Some delays are being seen with scanning due to the CT scanner requiring a deep clean after each patient. Potential opportunities to mitigate these delays are being explored with Radiology.	Accountable: Divisional Director Medicine/Dr Rana.

Responsive - Key messages

Area	Reality	Response	Result
Cancer	Tertiary referrals capacity reduced in other organisations, which is also causing delayed pathways for patients. Head and neck - reduced theatre capacity, only 1 cancer doctor operating at the moment due to long term sick. Increased referrals in specialties due to national campaign/ increased screening appointments. Duplicate referrals from GPs. Reduced theatre capacity resulting in patients being delayed for treatment.	One stop Derm & plastics clinics commenced w/c 14th December help to support 2ww breaches now improving. Additional capacity implemented with Breast services for Radiology. Deep dive into breast capacity for long term trajectories and capacity management. Appointed operational support manager to improve link with other organisations. Head And neck – working to increase theatre / diagnostic capacity. Recruiting for locum head and neck cancer services. Improved 7 day for first – improved to 65%. Scope Surgical SDEC to obtain diagnostic capacity to improve Urology cancer breaches. Organisation of Meetings with Urology Consultants to improve Pathway. Meeting arranged to improve Urology diagnostic pathways. Skins biopsy pathway to be developed. Recovery plan for theatres. 38 day breaches are being reviewed to understand if this could have been improved. Dermatology achieved 100% compliance.	Communication to be improved between organisations Ensure that IPT targets are to improve Reduction in patients breaching pathways Improved position for skins/ plastics cancer pathways and patient experiences Appointment of Operational Support Manager has lead to improvement of KPI' – 2WW Referral % Improved complaints from patients relating to communication of results Improved 62 day breaches in all specialities Accountable: Director of Operations & GM for Respiratory/Integrated Medical Specialities

Responsive - Key measures

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Performance Range		
																Green	Amber	Red
Accident & Emergency																		
Emergency Care Standard 4 hours	87.48%	85.88%	85.55%	87.96%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	**87.82%**	**89.15%**	>=95%		<95%
Emergency Care Standard 4 hours inc Type 2 & Type 3	89.08%	87.70%	87.41%	89.26%	93.12%	95.52%	95.11%	94.10%	91.13%	90.04%	82.44%	82.67%	87.69%	**88.63%**	**89.88%**	>=95%		<95%
A&E Ambulance Handovers 15-30 mins (Validated)	9,469	802	632	641	255	254	253	395	411	406	491	463	515	**444**	**3,887**	0		>=1
A&E Ambulance Handovers 30-60 mins (Validated)	369	32	40	14	3	0	1	3	8	7	45	40	36	**12**	**155**	0		>=1
A&E Ambulance 60+ mins	20	1	5	0	0	0	0	0	3	2	17	25	3	**3**	**53**	0		>=1
A&E Trolley Waits (From decision to admission)	9	0	0	0	0	0	0	0	0	0	15	21	0	**0**	**36**	0		>=1
Patient Flow																		
Delayed Transfers of Care	3.30%	3.33%	3.65%	3.94%	0.15%	0.21%	0.17%	0.22%	0.47%	0.21%	0.30%	0.09%	0.20%	**0.02%**	**0.20%**	<=3.5%	3.6% - 4.9%	>=5%
Coronary Care Delayed Discharges	591		51	33	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	No target		
Green Cross Patients (Snapshot at month end)	25	104	106	25	17	48	49	52	47	51	60	53	61	**59**	**59**	<=40	41 - 45	>=45
Advice & Guidance responded within 48 hours	82.03%	76.96%	83.90%	83.50%	79.00%	84.30%	81.40%	78.90%	77.40%	82.30%	79.40%	72.90%	83.20%	**not available**	**79.60%**	>=80%	71% - 79%	<=70%
Stroke																		
% Stroke patients spending 90% of their stay on a stroke unit	73.62%	83.02%	79.49%	86.76%	92.86%	91.23%	74.14%	81.16%	82.98%	83.33%	83.87%	81.40%	83.67%	**83.33%**	**83.36%**	>=90%	89% - 86%	<=85%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	51.21%	49.06%	58.97%	55.88%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	**56.06%**	**59.61%**	>=90%		<=85%
% Stroke patients Thrombolysed within 1 hour	77.78%	100.00%	25.00%	75.00%	62.50%	53.85%	83.33%	90.00%	85.71%	75.00%	57.14%	66.70%	66.70%	**78.57%**	**73.81%**	>=55%		<=50%
% Stroke patients scanned within 1 hour of hospital arrival	53.99%	50.94%	48.72%	45.71%	48.84%	50.88%	57.63%	40.85%	48.98%	44.23%	61.29%	32.20%	51.00%	**53.73%**	**48.78%**	>=48%		<=45%
Cancellations																		
% Last Minute Cancellations to Elective Surgery	0.92%	1.06%	0.79%	0.81%	0.32%	0.30%	0.00%	0.13%	0.36%	0.38%	0.30%	0.23%	0.00%	**0.16%**	**0.22%**	<=0.6%		>=0.8%
Breach of Patient Charter (Sitreps booked within 28 days of cancellation)	0	0	0	0	17	0	0	0	0	0	0	1	2	**0**	**20**	0		>=2
No of Urgent Operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=2
18 week Pathways (RTT)																		
18 weeks Pathways >=26 weeks open	1,396	1,730	1,305	1,396	2,306	3,542	4,531	6,264	8,133	8,446	6,632	6,294	6,885	**7,425**	**7,425**	0		>=1
RTT Waits over 52 weeks Threshold > zero	5	7	6	5	28	76	176	331	509	777	1,063	1,523	1,989	**2,683**	**2,683**	0		>=1
% Diagnostic Waiting List Within 6 Weeks	95.04%	98.62%	99.70%	95.04%	40.24%	34.60%	46.98%	51.96%	46.14%	50.73%	60.36%	65.43%	61.05%	**57.45%**	**57.45%**	>=99%		<=98%
Cancer																		
Two Week Wait From Referral to Date First Seen	98.59%	99.07%	99.59%	99.20%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	**98.56%**	**98.73%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.66%	99.41%	98.66%	99.24%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	**97.32%**	**98.14%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.64%	99.45%	100.00%	99.30%	99.42%	97.35%	98.26%	97.83%	97.71%	100.00%	98.67%	96.20%	96.62%	**95.77%**	**97.84%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	98.96%	100.00%	100.00%	92.86%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	**71.43%**	**89.67%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	**98.15%**	**99.36%**	>=98%		<=97%
38 Day Referral to Tertiary	53.08%	57.69%	63.16%	61.11%	76.00%	45.45%	40.00%	65.00%	47.06%	37.50%	58.33%	35.71%	52.94%	**55.56%**	**52.44%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.81%	87.08%	96.15%	91.44%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.71%	89.89%	**88.76%**	**91.24%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	90.80%	95.45%	80.00%	90.48%	76.47%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	86.96%	**81.82%**	**57.85%**	>=90%		<=89%
104 Referral to Treatment - Number of breaches - Patients Treated	29.0	3.5	1.5	2.5	0	2	3	1.5	0.5	2.5	1.0	0.5	1.0	**1.5**	**13.5**	0		>=1
104 Referral to Treatment - Number of breaches - Patients Still waiting	7	7	5	7	4	6	11	11	9	10	9	8	9	**12**	**12**	0		>=1
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	78.06%	71.54%	79.41%	79.81%	70.98%	85.89%	73.70%	80.21%	83.25%	82.95%	82.58%	80.95%	81.54%	**71.43%**	**79.59%**	>=75%		<=70%
Elective Access																		
Appointment Slot Issues on Choose & Book	28.15%	18.26%	25.39%	20.40%	130.03%	112.99%	105.12%	85.56%	79.00%	85.48%	84.49%	66.65%	78.00%	**in arrears**	**93.67%**	<=20%		>=21%
ASI (Appointment Slot Issues) > 22 Weeks	354	112	183	354	800	999	1585	2244	2012	1234	845	1,118	1,622	**1,479**	**1,479**	0		>=1
Total Holding List	10,663	8,406	8,661	10,663	14,562	17,946	19,911	21,651	21,591	20,286	19,244	19,734	21,037	**21,517**	**21,517**	No target		
Holding List > 12 Weeks	1,832	1,090	1,513	1,832	3,081	4,314	5,497	6,757	9,195	7,192	6,545	5,767	6,085	**6,568**	**6,568**	0		>=1

Workforce - Key Metrics

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Target	Threshold/Monthly
Staff in Post																	
Staff in Post Headcount		5733	5733	5721	5858	5869	5876	5870	5724	5738	5762	5782	5796	5836	-	-	
Staff in Post (FTE)		5050.59	5044.89	5049.46	5168.35	5173.65	5184.72	5195.15	5064.84	5096.10	5106.28	5124.91	5195.36	5174.58	-	-	
Vacancies																	
Establishment (Position FTE)**		5248.92	5250.42	5219.02	5314.42	5312.37	5323.61	5373.84	5376.13	5381.86	5408.16	5418.98	5416.56	5387.67	-	-	
Vacancies (FTE)**		198.33	205.53	169.56	146.07	138.72	138.89	178.69	311.29	285.76	301.88	294.07	221.20	213.09	-	-	
Vacancy Rate (%)**		3.78%	3.91%	3.25%	2.75%	2.61%	2.61%	3.33%	5.79%	5.31%	5.58%	5.43%	4.08%	3.96%	-	-	
Staff Movements																	
Turnover rate (%) - in month		0.60%	0.41%	0.73%	0.48%	0.57%	0.40%	0.56%	0.74%	0.77%	0.45%	0.65%	0.60%	0.67%	-	-	
Executive Turnover (%)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-	-	
Turnover rate (%) - Rolling 12m		7.36%	7.35%	7.26%	7.09%	7.20%	6.86%	6.84%	6.98%	7.27%	7.24%	7.46%	7.47%	7.54%	-	**11.50%**	<=11.5% Green <=12.5 >11.5% >12.5% Red
Retention/Stability Rate (%) - rolling 12m		89.63%	89.55%	89.49%	90.38%	90.29%	90.53%	90.84%	90.70%	90.39%	90.62%	90.33%	90.48%	90.11%	-	-	
Sickness Absence - Rolling 12 month																	
Sickness Absence rate (%) - rolling		3.86%	3.84%	3.99%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	-	**4.00%**	=< 4.0% - Green 4.01% -4.5% Amber >4.5% Red
- Of which Covid related absence		0.00%	0.00%	0.04%	0.13%	0.18%	0.20%	0.20%	0.20%	0.21%	0.25%	0.34%	0.41%	0.51%	-	-	
- Of which Non Covid related absence		3.86%	3.84%	3.95%	3.99%	4.05%	4.05%	4.05%	4.04%	4.03%	4.05%	4.07%	4.05%	4.02%	-	-	
Long Term Sickness Absence rate (%) - rolling		2.48%	2.47%	2.51%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	-	**2.50%**	=< 2.5% Green 2.5% -2.75% Amber >2.75% Red
- Of which Covid related absence		0.00%	0.00%	0.00%	0.03%	0.06%	0.07%	0.07%	0.07%	0.07%	0.08%	0.12%	0.16%	0.20%	-	-	
- Of which Non Covid related absence		2.48%	2.47%	2.50%	2.58%	2.63%	2.66%	2.66%	2.67%	2.66%	2.70%	2.74%	2.77%	2.79%	-	-	
Short Term Sickness Absence rate (%) - rolling		1.38%	1.37%	1.43%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	-	**1.50%**	=< 1.5% - Green 1.5% -1.75% Amber >1.75% Red
- Of which Covid related absence		0.00%	0.00%	0.03%	0.11%	0.13%	0.13%	0.13%	0.14%	0.14%	0.17%	0.22%	0.26%	0.31%	-	-	
- Of which Non Covid related absence		1.38%	1.37%	1.40%	1.40%	1.41%	1.40%	1.39%	1.37%	1.37%	1.35%	1.32%	1.27%	1.23%	-	-	
Attendance rate (%) - rolling		96.14%	96.14%	96.07%	95.89%	95.78%	95.75%	95.75%	95.78%	95.78%	95.71%	95.59%	95.54%	95.47%	-	**96.00%**	
Sickness Absence - Monthly																	
Sickness Absence rate (%) - in month		4.29%	3.90%	4.67%	5.59%	4.61%	3.74%	3.61%	3.73%	4.09%	4.79%	5.45%	5.04%	5.11%	-	-	
- Of which Covid related absence		4.29%	3.90%	4.29%	4.36%	4.05%	3.55%	3.57%	3.70%	3.99%	4.29%	4.40%	4.19%	4.04%	-	-	
- Of which Non Covid related absence		0.00%	0.00%	0.38%	1.24%	0.56%	0.19%	0.04%	0.03%	0.11%	0.50%	1.05%	0.85%	1.07%	-	-	
Long Term Sickness Absence rate (%) - in month		2.53%	2.48%	2.75%	3.36%	3.16%	2.67%	2.51%	2.67%	2.74%	3.20%	3.49%	3.62%	3.20%	-	-	
- Of which Covid related absence		0.00%	0.00%	0.03%	0.29%	0.35%	0.14%	0.01%	0.00%	0.02%	0.15%	0.44%	0.47%	0.42%	-	-	
- Of which Non Covid related absence		2.53%	2.48%	2.72%	3.06%	2.81%	2.54%	2.50%	2.67%	2.72%	3.05%	3.04%	3.15%	2.78%	-	-	
Short Term Sickness Absence rate (%) - in month		1.75%	1.42%	1.92%	2.23%	1.45%	1.06%	1.11%	1.06%	1.34%	1.57%	1.98%	1.41%	1.90%	-	-	
- Of which Covid related absence		0.00%	0.00%	0.35%	0.94%	0.21%	0.05%	0.04%	0.03%	0.08%	0.35%	0.64%	0.38%	0.65%	-	-	
- Of which Non Covid related absence		1.75%	1.42%	1.57%	1.29%	1.24%	1.01%	1.07%	1.03%	1.26%	1.22%	1.34%	1.03%	1.25%	-	-	
Attendance rate (%) - in-month		95.75%	96.11%	95.37%	94.53%	95.48%	96.25%	96.39%	96.33%	95.92%	95.26%	94.51%	94.96%	94.89%	-	**96.00%**	
Attendance Management																	
Sickness Absence FTE Days Lost -in month		6628.90	5687.70	7238.10	8363.71	7244.23	5818.30	5801.84	5839.32	6195.16	7483.23	8260.64	7929.55	8101.55	-	-	
Average days lost (FTE) per FTE - Rolling 12 month		14.09	14.09	14.34	14.80	15.19	15.30	15.33	15.30	15.33	15.54	15.92	17.45	17.68	-	-	
Sickness Absence Estimated Cost (£) - month		£0.60M	£0.52M	£0.67M	£0.79M	£0.65M	£0.52M	£0.52M	£0.52M	£0.56M	£0.70M	£0.77M	£0.73M	£0.75M	-	-	
Return to work Interviews (%)		71.27%	69.43%	58.15%	51.54%	56.86%	60.32%	63.12%	65.03%	57.56%	61.39%	48.33%	51.61%	62.97%	-	**0.00%**	90% Green 65%-89% Amber <65% Red
Spend																	
Substantive Spend (£)		£20.05M	£19.95M	£20.15M	£21.07M	£20.89M	£21.34M	£20.25M	£21.38M	£20.92M	£21.25M	£20.93M	£20.78M	£21.40M	-	-	
Bank Spend (£)		£1.40M	£1.71M	£1.93M	£1.68M	£1.52M	£1.64M	£1.79M	£1.64M	£2.14M	£1.81M	£2.45M	£1.13M	£2.88M	-	-	
Agency Spend (£)		£0.45M	£0.46M	£0.47M	£0.37M	£0.21M	£0.23M	£0.32M	£0.43M	£0.40M	£0.37M	£0.44M	£0.61M	£0.43M	-	-	
Proportion of Temporary (Agency) Staff		2.06%	2.08%	2.07%	1.59%	0.94%	1.00%	1.42%	1.82%	1.69%	1.56%	1.85%	2.69%	1.76%	-	-	
Essential Safety (12m rolling)																	
Overall Essential Safety Compliance		94.79%	94.88%	94.81%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Conflict Resolution (3 Year Refresher)		95.96%	96.26%	96.27%	94.73%	95.94%	96.04%	96.04%	96.10%	96.41%	96.81%	96.86%	96.79%	96.60%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Data Security Awareness (1 Year Refresher)		93.94%	94.14%	94.32%	92.73%	90.76%	90.36%	90.36%	90.77%	92.13%	97.91%	92.27%	92.18%	92.13%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red
Dementia Awareness (No Renewal)		99.13%	99.39%	99.34%	97.49%	97.73%	97.72%	97.16%	97.48%	97.25%	97.64%	97.77%	97.80%	97.77%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Equality and Diversity (3 Year Refresher)		97.10%	97.26%	97.54%	96.07%	96.93%	97.16%	91.04%	97.21%	97.58%	92.96%	97.44%	97.45%	97.43%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Fire Safety (1 Year Refresher)		94.31%	94.77%	93.42%	90.40%	90.27%	91.04%	97.07%	90.29%	92.86%	97.88%	91.72%	91.51%	91.18%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Health and Safety (3 Year Refresher)		98.21%	97.95%	97.98%	96.28%	96.96%	97.07%	92.09%	97.32%	97.78%	93.43%	97.64%	97.54%	97.56%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Infection Control (1 Year Refresher)		94.04%	93.99%	94.86%	92.89%	92.84%	92.09%	90.36%	91.86%	93.17%	92.65%	93.67%	93.88%	93.52%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Manual Handling (2 Year Refresher)		90.90%	89.77%	89.81%	89.30%	91.57%	91.67%	91.67%	92.57%	94.29%	94.14%	93.33%	93.61%	93.56%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Safeguarding (3 Year Refresher)		89.62%	89.96%	89.55%	91.03%	91.62%	92.48%	94.43%	93.64%	93.64%	93.94%	92.86%	92.95%	92.68%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Appraisal																	
Appraisal (1 Year Refresher) - Non-Medical Staff		92.75%	91.62%	90.12%	6.20%	20.85%	33.49%	47.31%	56.27%	68.29%	92.32%	93.74%	95.15%	95.15%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)		82.21%	78.61%	84.10%	80.76%	76.37%	72.83%	67.25%	63.07%	58.38%	55.28%	53.61%	50.00%	46.26%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red

** Vacancy information is updated monthly and is based on the funded establishment held in ESR, this is updated monthly by Finance colleagues based on the establishment information stored in the Trust's financial systems.

- Sickness absence reporting has been enhanced to provide a clear split of the overall sickness rate composition by COVID / Non-COVID related absence, this will allow for post-COVID comparison to a non-COVID absence rate indicator
- Sickness absence data does not include self / household / shielding isolation due to COVID-19.
- Data is based on substantive ESR primary assignment information which may not be refelctive of temporary COVID-19 redeployments
- Staff in Post data, and therefore vacancy data, includes year 2 and 3 student nurses, recruited on a temporary basis to support the Trust during the COVID-19 crisis.
- Due to the postponement of Medical Appraisals, the monthly Metric is lower than would normally be expected

Workforce Key Metrics

Workforce - Key Metrics

WORKFORCE	Current Month Score	Previous Month	Trend	Change	NHSi Submitted Position
Staff In Post (Headcount)	**5836**	5796	↑	40	-
Staff In Post (FTE)	**5174.6**	5195.4	↓	-20.78	-
Establishment (FTE)	**5387.7**	5416.6	↓	-28.89	-
Starters	**83.25**	43.77	↑	39.49	-
Leavers	**32.80**	29.83	↓	2.98	-
Vacancies (FTE)	**213.09**	221.20	↑	-8.11	-
Vacancies (%)	**3.96%**	4.08%	↑	-0.13%	-
Turnover Rate (rolling 12 month) (%)	**7.54%**	7.47%	↓	0.07%	*11.5%

ATTENDANCE MANAGEMENT	Current Month Score	Previous Month	Trend	Change	Target
Sickness Absence Rate (rolling) (%)	**4.53%**	4.46%	↓	0.07%	4.0%
Long Term Sickness Absence Rate (rolling) (%)	**2.99%**	2.93%	↓	0.06%	2.5%
Short Term Sickness Absence Rate (rolling) (%)	**1.54%**	1.52%	↓	0.02%	1.5%
Sickness Absence Rate (month) (%)	**5.11%**	5.04%	↓	0.07%	4.0%
Long Term Sickness Absence Rate (month) (%)	**3.20%**	3.62%	↑	-0.42%	2.5%
Short Term Sickness Absence Rate (month) (%)	**1.90%**	1.41%	↓	0.49%	1.5%
Return to work interviews completed (%)	**63.0%**	51.6%	↑	11.36%	90.0%

APPRAISAL	Current Month Score	Previous Month	Trend	Change	Target
Appraisal (YTD)	**95.15%**	95.15%	↔	0.00%	95.00%
Medical Appraisal (YTD)	**46.26%**	50.00%	↓	-3.74%	-

ESSENTIAL SAFETY TRAINING	Current Month Score	Previous Month	Trend	Change	Target
Data Security Awareness (1 Year Refresher)	**92.13%**	92.18%	↓	-0.05%	95.00%
Infection Control (1 Year Refresher)	**93.52%**	93.88%	↓	-0.36%	90.00%
Fire Safety (1 Year Refresher)	**91.18%**	91.51%	↓	-0.33%	90.00%
Manual Handling (2 Year Refresher)	**93.56%**	93.61%	↓	-0.05%	90.00%
Safeguarding (3 Year Refresher)	**92.68%**	92.95%	↓	-0.27%	90.00%
Conflict Resolution (3 Year Refresher)	**96.60%**	96.79%	↓	-0.19%	90.00%
Equality & Diversity (3 Year Refresher)	**97.43%**	97.45%	↓	-0.02%	90.00%
Health, Safety & Wellbeing (3 Year Refresher)	**97.56%**	97.54%	↑	0.02%	90.00%
Dementia Awareness (No Renewal)	**97.77%**	97.80%	↓	-0.03%	90.00%

Key

- ↔ No movement from previous month
- ↑ Improvement from previous month
- ↓ Deterioration from previous month
- * Internal target rather than NHSi Submitted Position
- Not achieving target
- Achieving target

* The recruitment data has been realigned to take into account the National Streamlining agenda and targets set locally. Data shows agenda for change (AFC) recruitment and Medical and Dental (M&D) only and excludes recruitment activity relating to deanery doctors, retirement, volunteers and rolling adverts.

RECRUITMENT	AfC Current Month Avg Days	AfC Previous Month	Medical Current Month Avg Days	Medical Previous Month	All Current Month Avg Days	All Previous Month	All Trend	All Change	All Target (Days)
Vacancy approval to advert placement	6.0	5.7	6.5	9.0	**6.1**	5.9	↓	0.2	8
Shortlisting to interview	3.4	3.6	7.6	9.2	**4.0**	4.3	↑	-0.3	12
Interview to conditional offer	1.7	3.6	2.7	13.2	**1.8**	4.6	↑	-2.8	6
Pre employment to unconditional offer	21.3	18.6	22.3	51.0	**21.4**	22.4	↑	-1.0	18
Unconditional Offer to Acceptance	3.5	1.8	4.0	0.0	**3.5**	1.7	↓	1.8	3

Vacancy approval to advert placement-The average number of days between a vacancybeing submitted for approved and the advert being placed.

Shortlisting to interview- The average number of days between date vacancy closed and date invited to interview

Interview to conditional offer- The average number of days between the interview date and the date of informing of a decision.

Pre employment to unconditional offer -The average number of days between the date Conditional Offer letter sent & the date Unconditional Offer letter sent

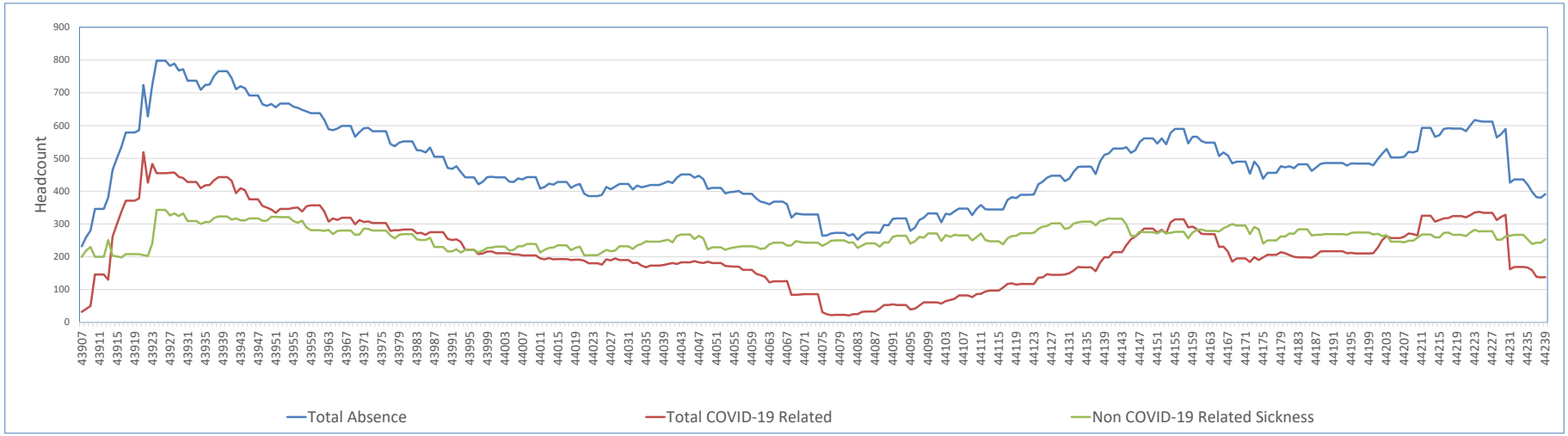
Unconditional Offer to Acceptance - The average number of days for Unconditional Offer to Acceptance

PAY	Current Month Spend	Previous Month	Trend	Change	Target (Budget)
Substantive Expenditure	**£21.40M**	£20.78M	↓	£0.62M	£22.58M
Agency Expenditure	**£0.43M**	£0.61M	↑	-£0.17M	£0.47M
Bank Expenditure	**£2.88M**	£1.13M	↓	£1.75M	£1.84M

COVID-19 - Key Metrics

* 4 February 2021 - CEV / pregnancy removed from NHSi submission figures to fall in line with WYAT reporting

ABSENCE



The data above is taken from the Trust daily situation report. 17-18 March represents ESR absence data only. 19 March to 1 April 20 represents combined ESR absence data and Occupational Health call log data. 2 April 20 includes Roster isolation information. 3 April 20 onwards represents the full absence picture, combining ESR absence data, Roster absence data, and isolations recorded via the Occupational Health call log.

Workforce Absence @ 12 February 2021

	Headcount	% of workforce
Absence - COVID-19 Related	138	2.2%
Absence - Sickness (Non COVID-19 Related)	253	4.0%
Total Absence	391	6.2%

* 4 February 2021 - CEV / pregnancy removed from NHSi submission figures to fall in line with WYAT reporting

Testing

Location	Number Tested
CHFT	3471
Locala	6
Home	65
External	453
Total	3995

Results *		
Negative	2996	77.5%
Positive	802	21%
Awaiting	69	1.8%

* Excludes inconclusive tests

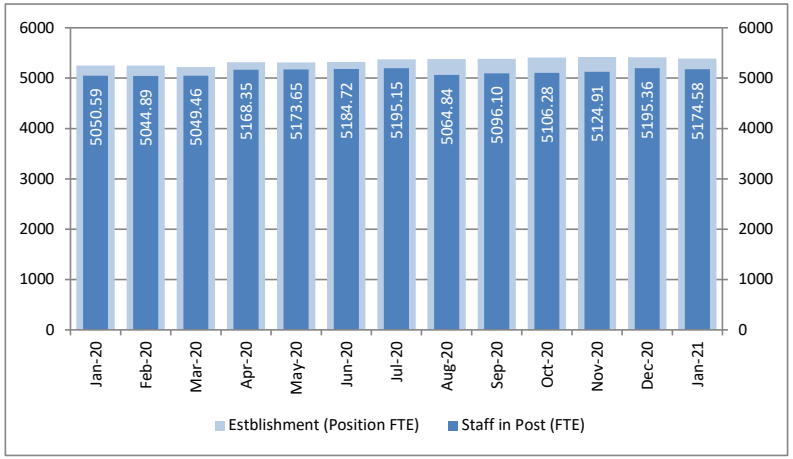
Self Isolation (Staff Presenting Symptoms) Testing

	Number Tested	Negative	Positive	Awaiting
BAME (incl mixed and other)	485	69%	28%	2%
White	1828	77%	21%	2%
Not Stated	103	72%	26%	2%

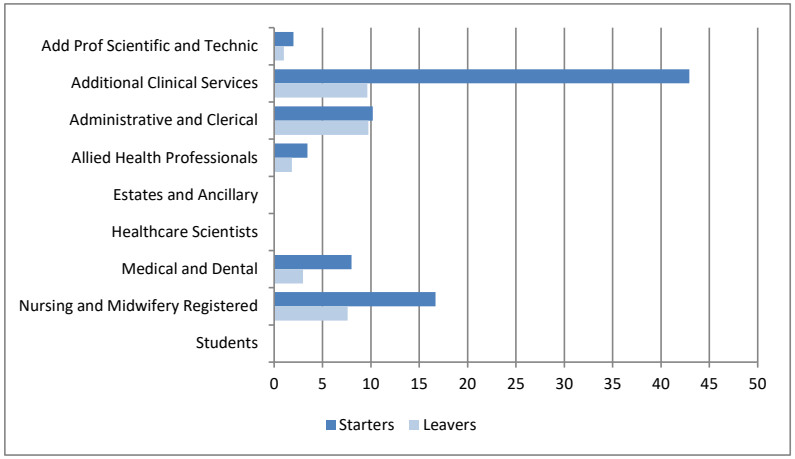
Covid Related Key Metrics

Reality

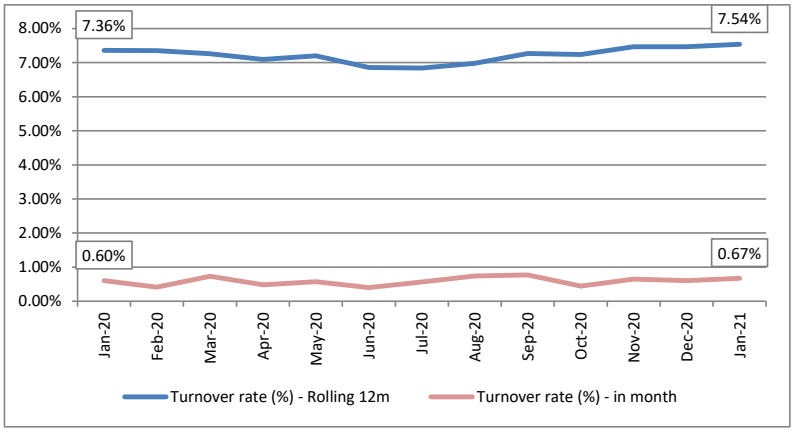
Staff in Post (FTE) v Establishment (FTE)



Starters & Leavers (FTE) by Staff Group - January 2021



Turnover



Turnover by Staff Group

Staff Group	In-Month	Rolling
Add Prof Scientific and Technic	0.49%	9.95%
Additional Clinical Services	0.87%	7.39%
Administrative and Clerical	0.96%	7.88%
Allied Health Professionals	0.47%	12.95%
Estates and Ancillary	0.00%	6.41%
Healthcare Scientists	0.00%	8.59%
Medical and Dental	0.78%	6.88%
Nursing and Midwifery Registered	0.46%	5.77%

Result

Have a Retention Strategy with interventions aimed at key staff groups which currently have a high turnover.

Response

The increase in staff in post seen in April 20 on the adjacent Staff in Post graph is due to the temporary recruitment of year 2 and 3 nursing students

Retention

The Trust has developed its People Strategy, which includes a focus on Recruitment and Retention. Specific initiatives have included:-

- More streamlined recruitment
- Improved induction
- Health and wellbeing
- Colleague engagement
- Recognition and Reward
- Career development

Further work is being developed to enhance our People Strategy in 'The Cupboard'.

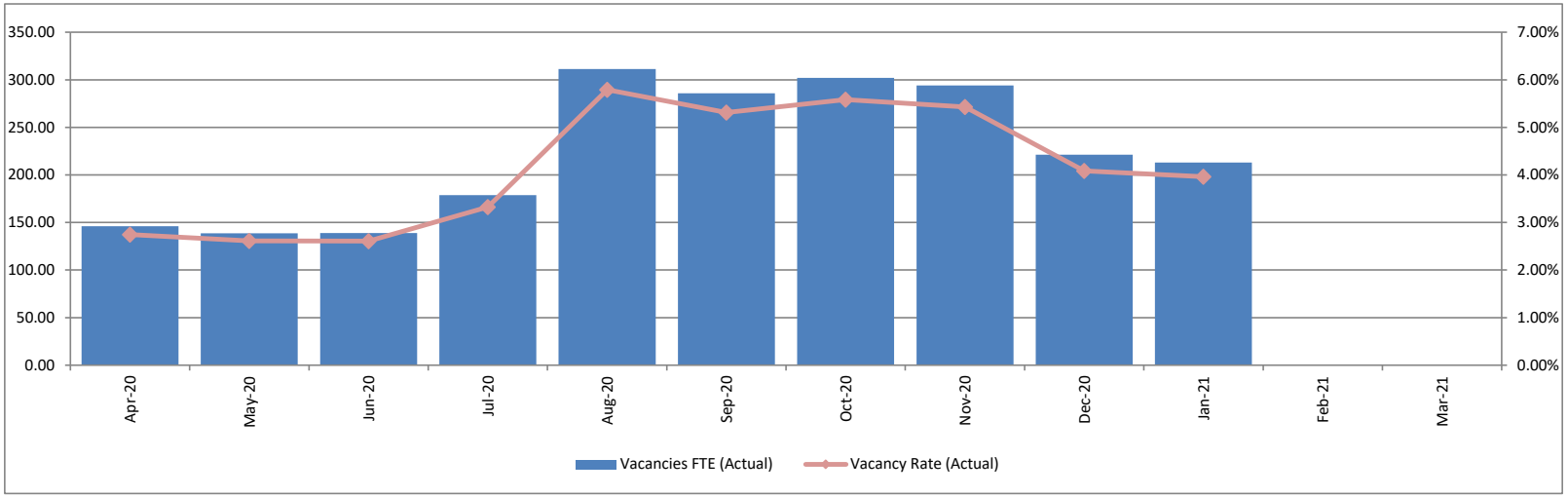
To support the retention of the Nursing workforce, the Trust offers a comprehensive induction and all new starters are enrolled on a year long graduate programme which is supported by the preceptorship programme.

The Trust is part of cohort 4 of NHSI Retention Direct Support Programme which is a clinically led programme aimed at supporting Trusts to improve their Nursing retention rates. The programme is currently on hold due to COVID-19 pressures.

Staff in Post / Starters & Leavers / Turnover

Reality

Vacancies



Vacancies by Staff Group

Staff Group	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Add Prof Scientific and Technic	222.56	205.28	17.28
Additional Clinical Services	1125.89	1110.25	15.64
Administrative and Clerical	1088.80	1016.01	72.79
Allied Health Professionals	383.11	403.26	-20.15
Estates and Ancillary	56.07	47.76	8.31
Healthcare Scientists	125.84	120.30	5.54
Medical and Dental	651.03	635.16	15.87
Nursing and Midwifery Registered	1734.37	1635.76	98.61
Students	0.00	0.80	-0.80
Total	**5387.67**	**5174.58**	**213.09**

Additional Clinical Services Breakdown

Role	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Asst./Associate Practitioner Nursing	0.86	1.85	-0.99
Health Care Support Worker	78.24	68.39	9.85
Healthcare Assistant	710.08	662.70	47.38
Nursery Nurse	1.83	1.03	0.80
Nursing Associate	10.91	39.40	-28.49
Trainee Nursing Associate	2.00	46.00	-44.00
Total (Unregistered Nursing)	**803.92**	**819.37**	**-15.45**
Other Additional Clinical Service	321.97	290.88	31.09

Result

CHFT to be the employer of choice in a competitive environment through a recruitment strategy which includes candidate attraction to the Trust.

Achieve and maintain a vacancy rate below 5.4%.

Response

Recruitment

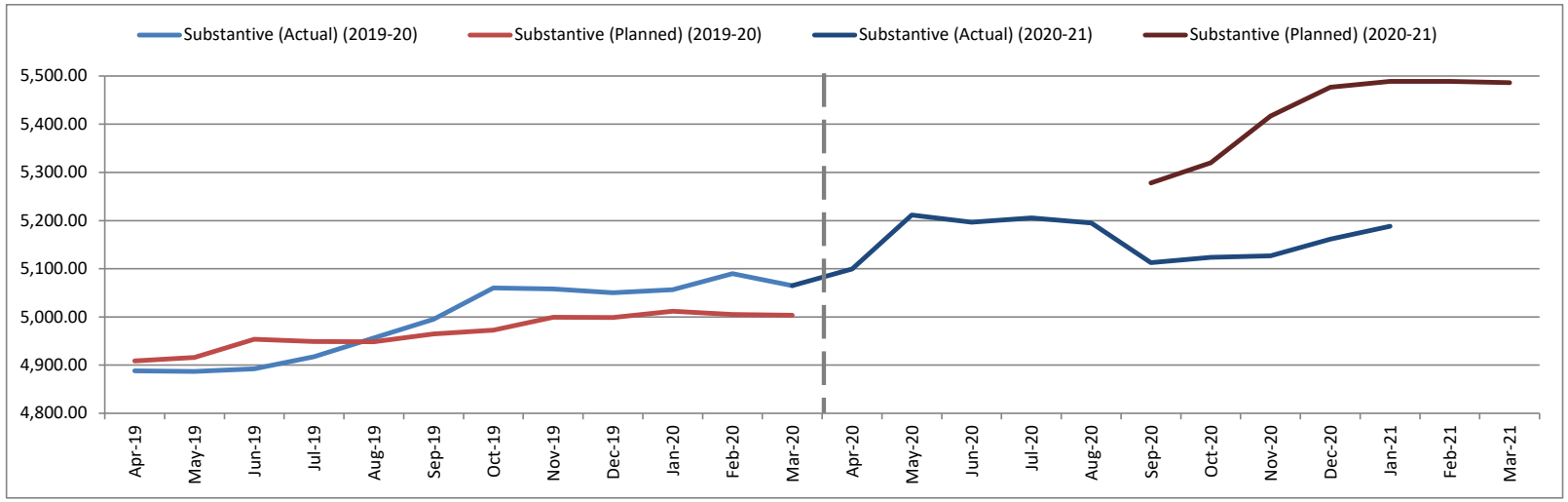
We are promoting the Trust as the place to launch your career by using various marketing strategies to attract this year's cohort of new graduates. We are creating a video to showcase the variation in career opportunities for new graduates as well as our unique well-being offerings through the One Culture of Care campaign. We will be attending virtual career fairs where students will have an opportunity to view the video and have live chat Q&A with clinical educators who will promote our preceptorship programme and some of last year's graduates. This route is anticipated to result in recruitment of 55-65 RNs in the summer of 2021..We are maximising the use of apprenticeship schemes to 'grow our own' RN's from the existing support workforce. These include the 3 yr HCSW to RN apprenticeship and the 2 yr top-up from Nursing Associate to RN apprenticeship. We are actively recruiting international nurses, using both HEE and agency connections, and supporting them through a comprehensive programme, including OSCE assessments, to enable them to register with the NMC. The aim is to recruit a further 56 international nurses before Oct 21.

Medical Recruitment

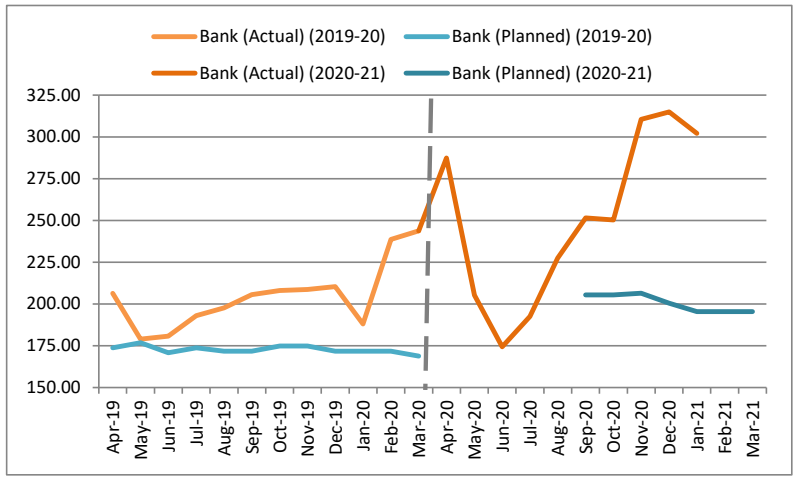
At present the medicine trainees remain on the phase 2 escalated rotas, however, parallel rota were only in place for a few days. The Health and Wellbeing team have worked to provide support sessions during February and March 2021, which are targeted towards the trainees and other medical and dental staff. The medical education team are also enhancing the wellbeing support for trainees in tandem with Health Education England. Trainees rotated as scheduled in February, with a number of new doctors joining the organisation. They were welcomed virtually and undertook a remote induction session provided by Medical Education. Recent consultant appointments have included Ophthalmology, and Stroke. The new stroke physician will have a joint job plan with Acute medicine commitments too. Further posts in Stroke and Neurology are out to advert, and targeted mail shots are being undertaken by BMJ Careers for people with Stroke Medicine experience. The BMJ have provided CVs for 2 Emergency medicine doctors at registrar level that the department are currently reviewing. Whilst there remain several vacancies in Emergency Medicine, progress has been made at a more junior level, as a number of Clinical Fellows have been appointed. A new initiative approved by the University has allowed the Trust to appoint 5th year Medical Students to undertake activity and provide support during this pressurised time.

Reality

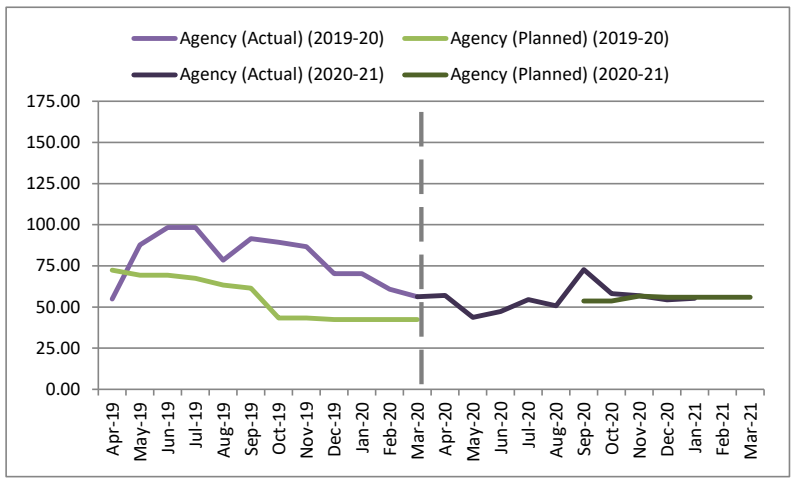
Substantive



Bank



Agency



Result

Increasing the substantive workforce whilst reducing the reliance on bank and agency usage.

These graphs show the FTE worked in-month for substantive, bank and agency workers, against the planned figures submitted to NHSi at the start of the

Response

These graphs show the hours worked in-month converted into FTE for substantive, bank and agency workers, against the planned figures submitted to NHSI at the start of the service year. In 2019/20 whilst the Trust reduced agency usage within the Medical & Dental staff group in particular, usage remained high in Nursing and Midwifery and The Health Informatics Service (THIS). This resulted in agency FTE being above plan.

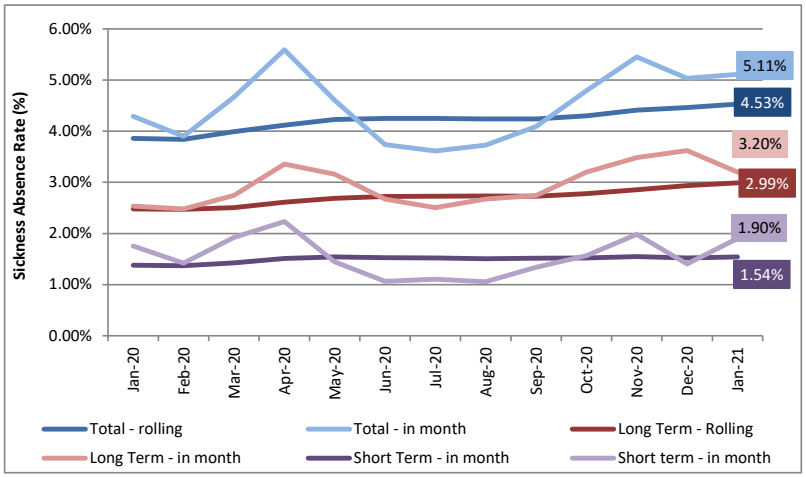
Operational planning was suspended by NHSi for an initial period of 1 April 2020 to 31 July 2020.

Final phase 3 workforce plans for the period September 20 to March 21 have been submitted to NHSI in September 2020.

Workforce Plan

Reality

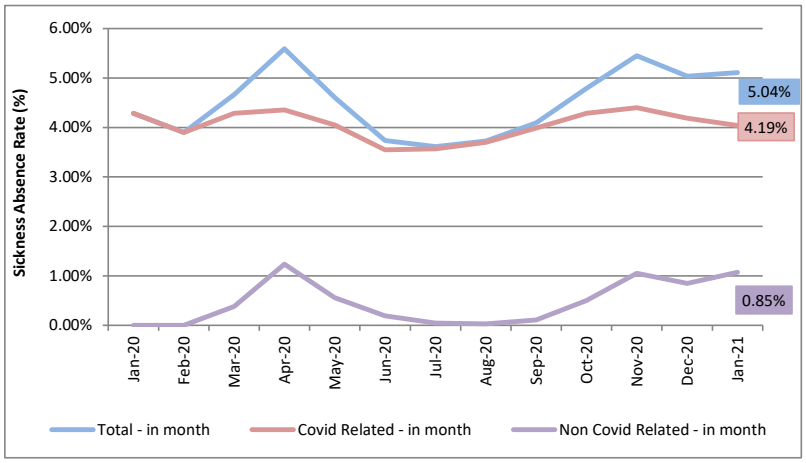
Sickness Absence



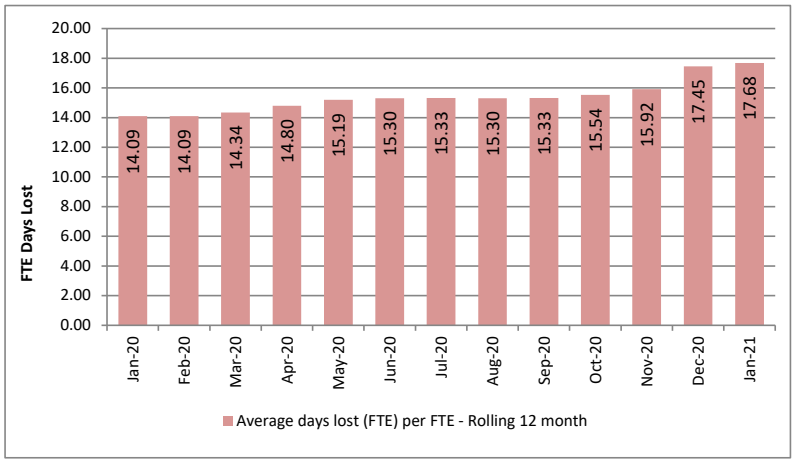
Sickness Absence Reasons - January 21

Reason	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	2357.84	28.88%
S15 Chest & respiratory problems	1786.77	21.89%
S13 Cold, Cough, Flu - Influenza	695.90	8.52%
S12 Other musculoskeletal problems	542.29	6.64%
S25 Gastrointestinal problems	465.99	5.71%
S11 Back Problems	441.07	5.40%
S28 Injury, fracture	280.81	3.44%
All Other Reasons	1592.88	19.51%

Covid / Non-Covid Related Sickness Absence (monthly)



Average Days Lost Per FTE - rolling 12 month



Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

Sickness absence data does not include self / household / shielding isolation.

The OH Service have responded to approx. 385 health and wellbeing assessments for Covid Age with letters of recommendations to managers where required. There have been no new forms since 8th Feb, and a short form of the questionnaire which focuses on health questions only is being developed.

Staff PCR swabbing continues, and the OH service is actively supporting track and trace activity for staff contacts within the workplace. Activity closely maps the local trends of cases and attendance data. There are currently 9 clinical areas of outbreak or concern (apparently unconnected cluster of cases in staff) to OH team, which is a reduction over the last 2 weeks. The service is continuing to operate a 7 day swab results and monitoring service at present working closely with the IPC team. The number of staff presenting to OH With symptoms has significantly reduced in the last week, and no new outbreak areas have been identified in February. Staff who test positive for Covid after receiving one or two vaccines for covid are being identified and reported to PHE for enhanced surveillance.

The Seasonal Flu campaign has delivered a vaccine to 81% of healthcare workers at CHFT which is a record and just ahead of last season's uptake at 80.5%. The campaign launched from 28 September 2020 and will conclude at the end of February 2021.

Staff immunisation for Covid-19 commenced on 30 December 2020, opening a full clinic at both CRH and HRI immunising approx. 250-300 people per site per day. This is a unique rollout and is providing significant coverage of vaccine to health and social care staff from across Calderdale and Kirklees CCG footprints. To date approx.. 80% of CHFT colleagues have been immunised with a single dose, and second dose scheduling is underway.

Sickness Absence

Reality

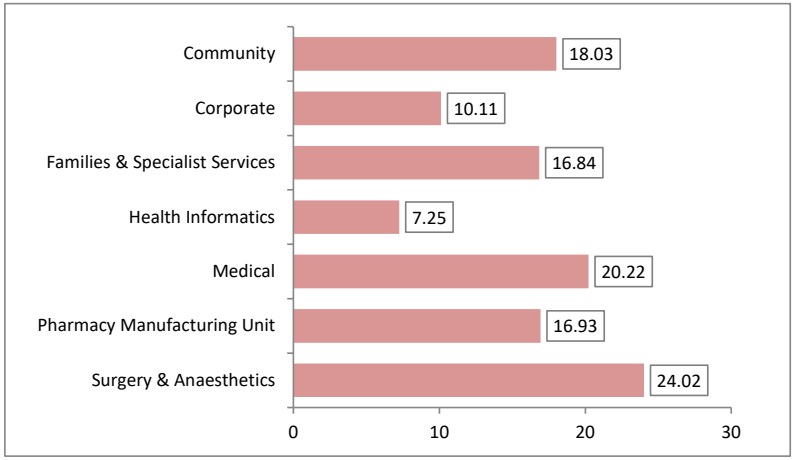
Sickness Absence - in-month

Division	Dec-20	Jan-21
Community	5.40%	4.94%
Corporate	3.05%	2.77%
Families & Specialist Services	5.18%	4.61%
Health Informatics	1.38%	1.99%
Medical	5.18%	5.54%
Pharmacy Manufacturing Unit	3.74%	4.64%
Surgery & Anaesthetics	5.93%	6.58%

Sickness Absence by Staff Group - rolling 12 month

Staff Group	Short Term	Long Term	Total
Add Prof Scientific and Technic	1.59%	1.83%	3.42%
Additional Clinical Services	2.25%	4.63%	6.88%
Administrative and Clerical	0.88%	2.31%	3.19%
Allied Health Professionals	1.01%	1.95%	2.96%
Estates and Ancillary	2.32%	3.99%	6.31%
Healthcare Scientists	1.05%	2.49%	3.54%
Medical and Dental	0.98%	0.94%	1.92%
Nursing and Midwifery	1.78%	3.67%	5.45%
Students	1.73%	0.48%	2.21%

Average Days Lost Per FTE - rolling 12 month



Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

In **Surgery & Anaesthetics**, The Surgical Division has seen a increase in LT absence, this is being supported and managed appropriately according to policy by the Operational HR team. Health and Wellbeing support is being provided to all colleagues who need it with the aim of reducing absence and keeping them in the work environment.
RTW data is a significant focus in all Directorates, weekly information is being shared to improve compliance with issues being reviewed individually to help increase this.

In **Medicine** the division continues to see absence rates over target during the pandemic. Absence management processes continue to be underway with support from the HR Advisor. The division will reinstate deep dives to provide focused support. An action plan relating to RTWI for the Trust has been agreed at Workforce Committee and is being implemented across all divisions to improve compliance.

In **FSS** the team continue to review cases and sickness deep dives/summits are held across the directorates regularly. Final Attendance panels are planned in for several cases from now and into the new year.
RTW compliance has seen an increase in December. Workforce reports have been shared regularly to teams throughout December and on an ongoing basis.

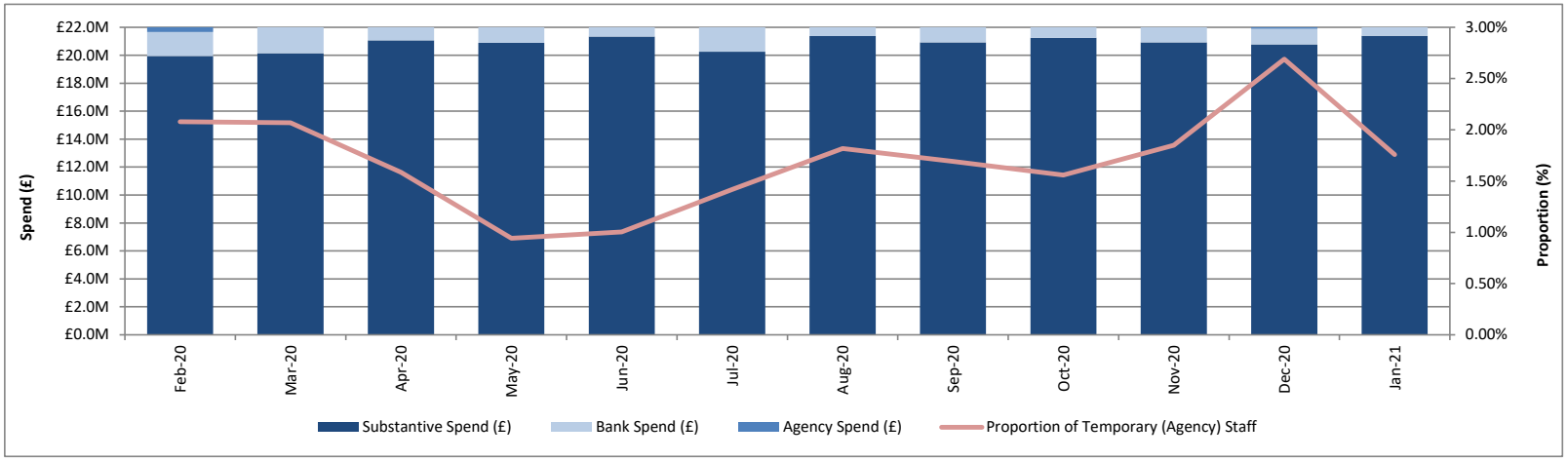
In **Community**, management of sickness absence continues. HR Adviser continues to support line managers with the management of Long term sickness Absence. Additional support has been provided to line managers in hot spot areas.

In **Corporate, PMU & THIS** HR Adviser continues to support line managers with the management of Long term sickness Absence. Additional support has been provided to line managers in hot spot areas.

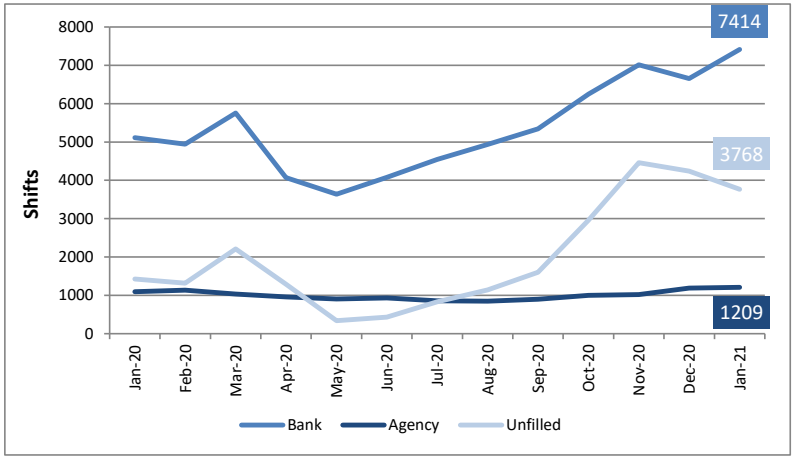
Sickness Absence - Divisional/Staff Group

Reality

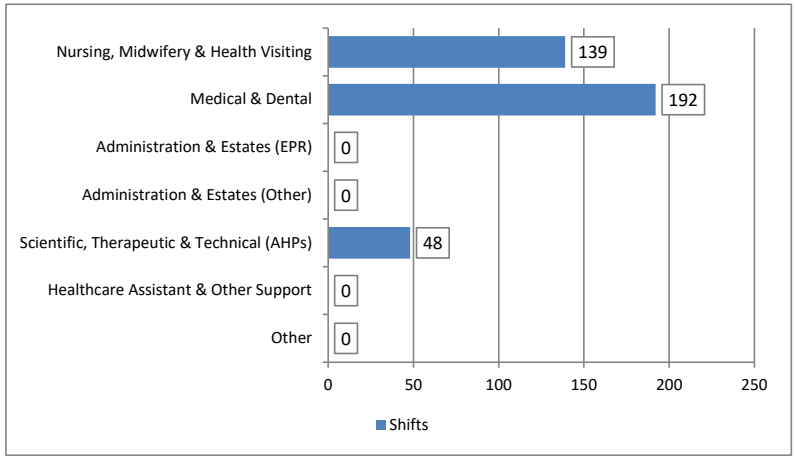
Workforce Spend



Agency, Bank and Unfilled Shifts



Number of shifts that broke the agency cap - January 2021



Result

Continue to reduce the use of agency colleagues and reduce the bank paybill in 2019/2020.

Response

A total of 379 shifts broke the agency cap in January 2021, this is an increase on 376 in December 2020

From 6 April 2020 the Trust removed usage of short notice, high cost Tier 3 agency shifts for Nursing and migrated Tier 2 agencies to Tier 1.

Whilst agencies that supplied at Tier 2 and Tier 3 were framework providers, the shifts still represented a significant cost to the Trust when in comparison to Registered Nursing Staff through Bank and Tier 1.

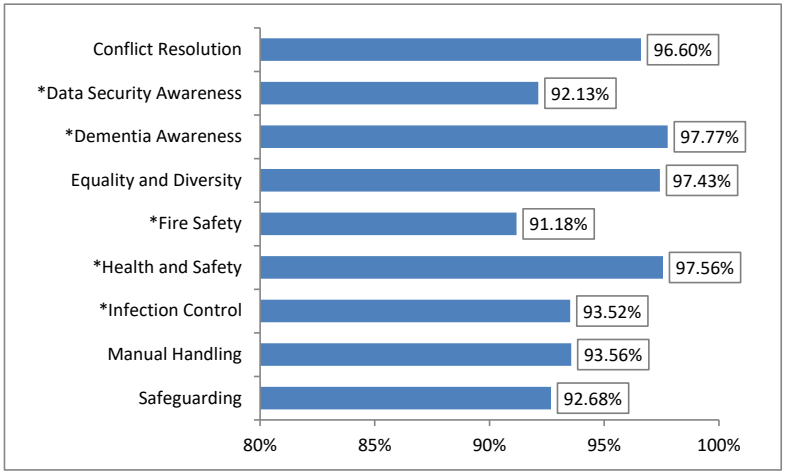
Removing these two Tiers has helped to achieve lower average hourly rates, from £34.01 to £31.17 per hour.

Agency usage remains low with 55.8% of Nursing shifts and 86.0% of Medical shifts filled by Bank.

Workforce Spend / Agency Usage

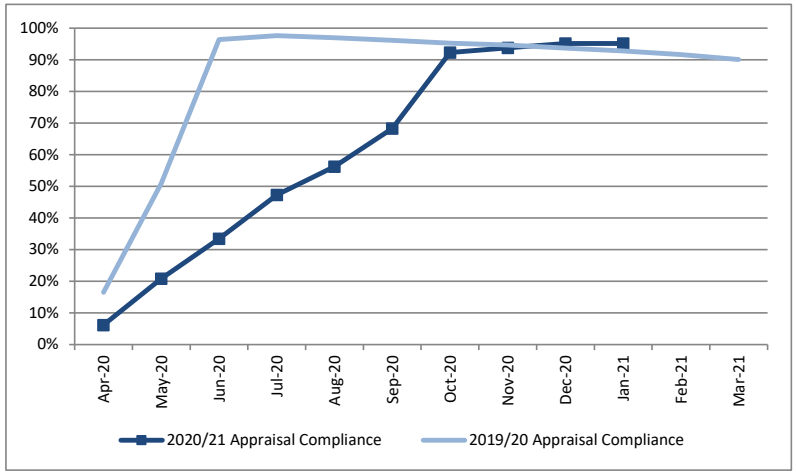
Reality

Essential Safety Training

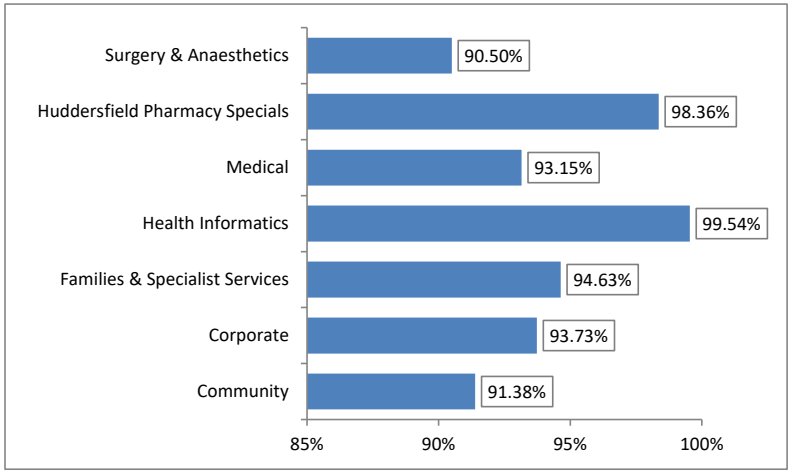


* Essential Safety Training elements that are covered at Corporate Induction.

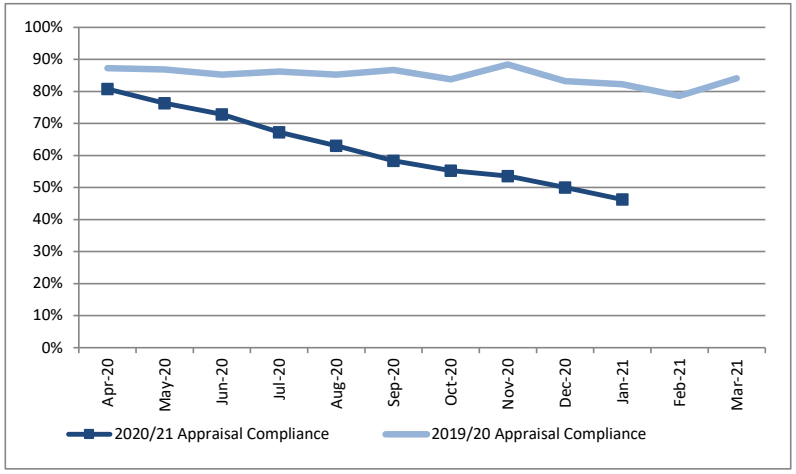
Non-Medical Appraisal Compliance



Non-Medical Appraisal Compliance by Division



Medical Appraisal Compliance



Result

Appraisal compliance is consistently above 95%.

Essential safety training compliance is consistently above 90% stretching to 95%.

Response

Essential Safety Training
A paper is presented weekly to Executive Board highlighting the compliance figures for all EST including role specific training.

The focus remains on improving role specific subjects with less than 85% compliance.

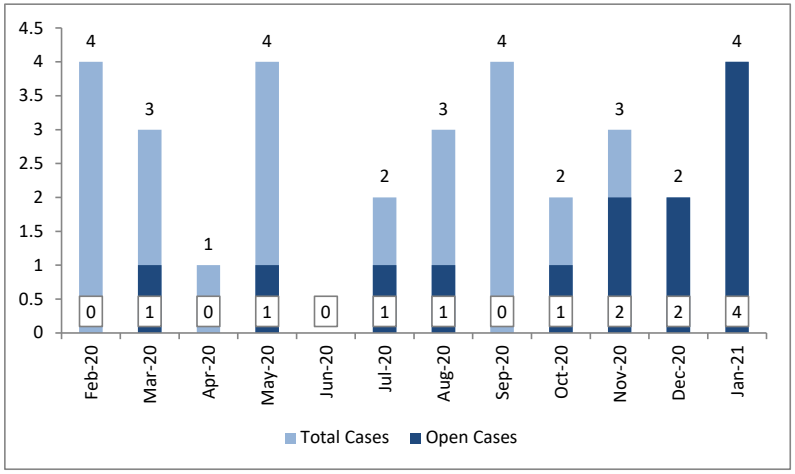
Appraisal
The Trust now adopts an appraisal season approach. The appraisal season ran from 1 July to 31 October this year. The final position for the 2020/21 appraisal season was 95.15%.

The appraisal season and Medical appraisals for 2020/21 is postponed due to the ongoing COVID-19 situation.

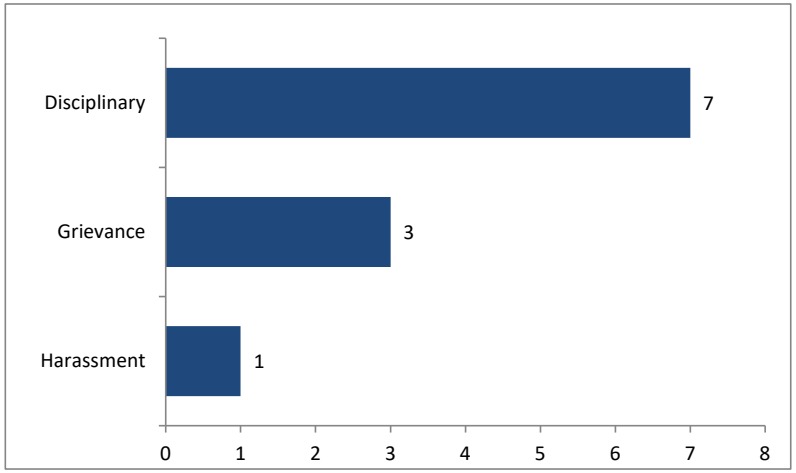
Essential Safety Training / Appraisals

Reality

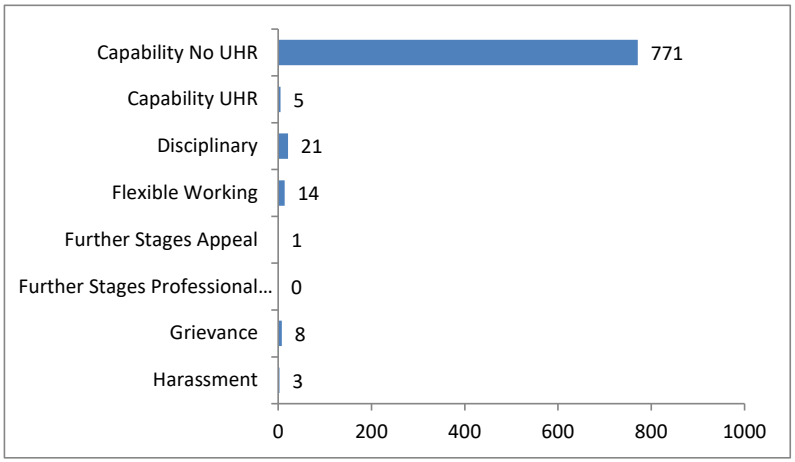
Disciplinary, Grievance, Harassment cases opened last 12 months



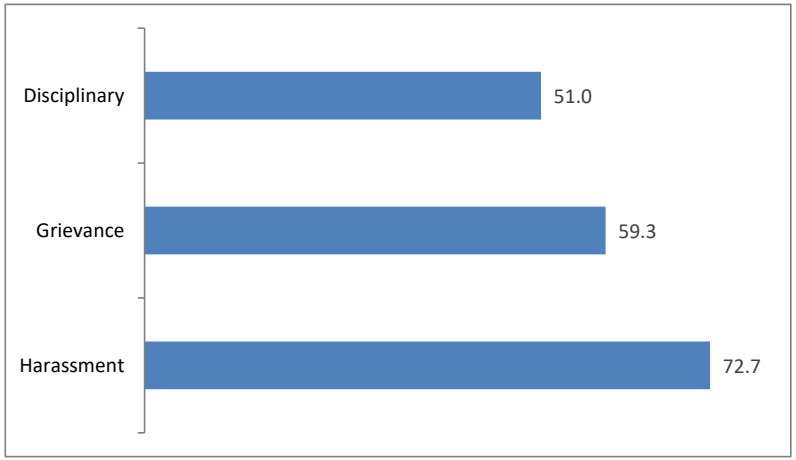
Open Disciplinary, Grievance, Harassment cases by type



All cases opened in the last 12 months by case type



Average number of days to close cases



Result

Maintain a robust capturing process.

Response

Following a deep dive into employee relations cases, the HR Team reviewed the way in which employee relations cases were been recorded and updated. This has resulted in a number of changes which will ensure consistency and enable automated reporting of case management.

- ESR will now be the sole recording system for employee relations cases. Previously the HR Team had been trying to maintain two different systems which led to discrepancies.

- If the employee has a registered disability, absence management cases will now be recorded under 'Capability UHR'. All other absence management cases will be recorded under 'Capability No UHR'.

- Long term sickness absence will now be captured on ESR.

- Unsatisfactory performance during a probationary period will now be captured on ESR.

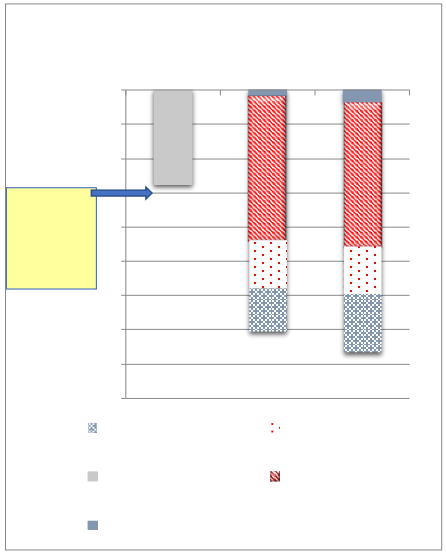
* The average no. of days to close Harassment cases is zero due to the cases still remaining open.

Employee Relations

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jan 2021 - Month 10

KEY METRICS

	M10				YTD (JAN 2021)				Forecast 20/21			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£0.47)	(£0.06)	£0.41		(£0.82)	(£0.30)	£0.52		(£1.92)	(£3.60)	(£1.69)	
Agency Expenditure	(£0.47)	(£0.43)	£0.04		(£3.84)	(£3.61)	£0.23		(£4.78)	(£4.50)	£0.29	
Capital	£2.11	£2.39	(£0.28)		£15.49	£13.19	£2.30		£20.85	£24.42	(£3.58)	
Cash	£56.57	£62.37	£5.80		£56.57	£62.37	£5.80		£28.04	£31.47	£3.44	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95%	93%	-2%		95%	88%	-7%					
CIP	£1.23	£0.64	(£0.59)		£12.31	£4.55	(£7.76)		£14.77	£5.89	(£8.88)	
Use of Resource Metric	3	2			2	2			2	3		



Year to Date Summary

For the second half of the financial year, the Trust has submitted a revised plan to NHS Improvement (NHSI) that reflects the Phase 3 activity plan. Income flows remain largely on a block basis and system funding has been allocated to cover the majority of Covid-19 costs. Year to date the position is a deficit of £0.30m, a favourable variance of £0.52m compared to plan. The M1-6 plan has now been reset to actual expenditure, so the YTD variance represents only 4 months.

- Retrospective funding to cover M1-6 Covid costs has been approved and received. £7.24m of system Covid funding has been allocated for M7-10, with an additional £0.14m provided for Lateral Flow Testing. The Trust has requested a further £1.76m to Covid cover costs outside of the system envelope for testing, vaccinations and research costs.
- Year to date the Trust has incurred costs relating to Covid-19 of £26.70m. M10 costs incurred were £3.20m driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the expansion of the workforce, staff working additional shifts, the segregation of patient pathways, remote management of patients and backfill for increased sickness absence.
- The underlying position excluding Covid-19 costs is a year to date favourable variance of £3.37m, driven by the impact of lower levels of other activity on non-pay costs and staffing vacancies.
- The reported position includes only the M6 impact of the Elective Incentive Scheme (£0.11m). For Months 7, 8 & 10 it is expected that the System will be exempt from the scheme due to high numbers of Covid patients. There remains a risk for Month 9 which is yet to be confirmed and if imposed the penalty is estimated to be £0.57m. In the forecast, any potential future impact of the scheme has also been excluded and remains a financial risk.
- The Trust continues to deliver some efficiency savings. CIP achieved year to date is £4.55m, £7.76m below the original Trust plan. Compared to the Phase 3 Plan, the Trust has delivered £2.59m of savings in 4 months, slightly below the £3.09m described in the revised plan.
- Agency expenditure year to date is £3.61m, £0.23m below the revised planned level.

Key Variances (compared to Phase 3 plan submission)

- Clinical Contract income is largely in line with the Phase 3 plan due to fixed block and top up arrangements, which now includes a fixed monthly allocation to cover Covid-19 expenditure. Most Covid expenditure will have to be managed within that fixed allocation, although there remains an element of Retrospective Covid funding available for Testing, Vaccinations and NHS Nightingale. Income of £1.09m has been assumed to cover testing costs, with a further £0.45m for the vaccination programme and £0.09m for the R&D SIREN (SARS-COV2 Immunity & Reinfection Evaluation) project. In overall terms income is above plan by £2.47m.
- Pay costs are £1.11m below the planned level year to date due to slippage on recruitment to the additional approved posts required to deliver Phase 3 activity plans, offset to some extent by the requirement to account for the future cost of cancelled annual leave that will now have to be carried forward, (annual leave accrual).
- Non-pay operating expenditure is higher than planned by £3.07m. This is due to higher than planned Covid-19 related expenditure, an increase in provisions and some non recurrent legal costs.

Forecast

For Month 7-12 (Phase 3), the Trust is required to manage within the Integrated Care System (ICS) agreed financial envelope. The Trust has been allocated Covid funding on a fair shares basis to cover the remainder of the year and can request access additional central funding to cover costs excluded from the system envelope such as Covid Testing and Vaccinations. The Trust is reporting a forecast deficit of £3.60m, £1.69m higher than planned due to an increase in the required Annual Leave accrual. This is an 'allowable' overspend from an NHS Improvement perspective and has been agreed with our system partners.

- The forecast excludes the potential impact of the Elective Incentive Scheme on the M9-12 position, which based on the current activity forecast could drive a penalty of circa £0.80m.

Total Group Financial Overview as at 31st Jan 2021 - Month 10

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M10

CLINICAL ACTIVITY

	M10 Plan	M10 Actual	Var
Elective	1,710	1,360	(350)
Non-Elective	44,665	39,299	(5,366)
Daycase	22,036	20,967	(1,069)
Outpatient	241,498	250,317	8,820
A&E	110,923	103,447	(7,476)
Other NHS Non-Tariff	948,707	954,352	5,645
Other NHS Tariff	41,347	55,591	14,244
Total	**1,410,885**	**1,425,333**	**14,448**

TOTAL GROUP: INCOME AND EXPENDITURE

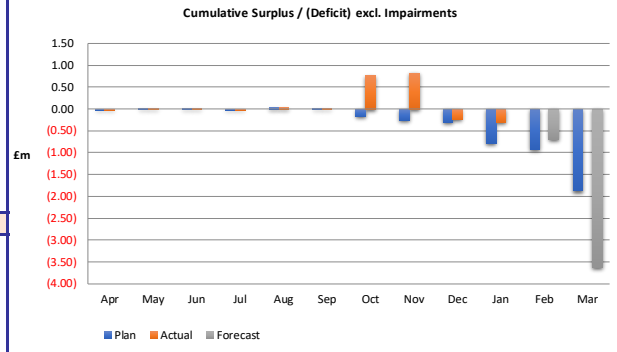
	M10 Plan	M10 Actual	Var
	£m	£m	£m
Elective	£14.76	£14.76	£0.00
Non Elective	£96.09	£96.09	£0.00
Daycase	£25.43	£25.43	£0.00
Outpatients	£38.21	£38.21	£0.00
A & E	£19.49	£19.49	(£0.00)
Other-NHS Clinical	£87.75	£86.18	(£1.58)
CQUIN	£3.16	£3.16	£0.00
Other Income	£39.17	£42.57	£3.40
Total Income	**£324.06**	**£325.88**	**£1.82**
Pay	(£236.98)	(£235.87)	£1.11
Drug Costs	(£34.88)	(£34.33)	£0.55
Clinical Support	(£24.82)	(£24.25)	£0.56
Other Costs	(£54.78)	(£58.97)	(£4.18)
PFI Costs	(£11.20)	(£11.20)	£0.00
Total Expenditure	**(£362.66)**	**(£364.61)**	**(£1.95)**
EBITDA	**(£38.60)**	**(£38.73)**	**(£0.13)**
Non Operating Expenditure	(£20.04)	(£20.09)	(£0.05)
Surplus / (Deficit) Adjusted*	**(£58.64)**	**(£58.82)**	**(£0.18)**
Conditional Funding (MRET/FRF/Top Up)	£57.83	£58.52	£0.69
Surplus / Deficit*	**(£0.82)**	**(£0.30)**	**£0.52**

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

DIVISIONS: INCOME AND EXPENDITURE

	M10 Plan	M10 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£15.18	£17.64	£2.46
Medical	£27.18	£27.67	£0.49
Families & Specialist Services	(£5.74)	(£4.42)	£1.32
Community	(£2.98)	(£1.90)	£1.07
Estates & Facilities	£0.00	£0.00	(£0.00)
Corporate	(£38.31)	(£39.47)	(£1.16)
THIS	£1.26	£1.59	£0.33
PMU	£2.53	£2.95	£0.42
CHS LTD	£0.58	£0.46	(£0.11)
Central Inc/Technical Accounts	(£1.26)	(£3.75)	(£2.49)
Reserves	£0.74	(£1.07)	(£1.81)
Unallocated CIP	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£0.82)**	**(£0.30)**	**£0.52**

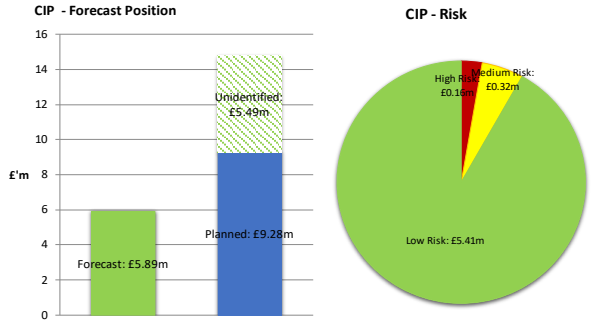
TOTAL GROUP SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date			Year End: Forecast		
	M10 Plan	M10 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£0.82)	(£0.30)	£0.52	(£1.92)	(£3.60)	(£1.69)
Capital	£15.49	£13.19	£2.30	£20.85	£24.42	(£3.58)
Cash	£56.57	£62.37	£5.80	£28.04	£31.47	£3.44
Invoices Paid within 30 days (BPPC)	95%	88%	-7%			
CIP	£12.31	£4.55	(£7.76)	£14.77	£5.89	(£8.88)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	2	2		2	3	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14.77m **Total Forecast £5.89m**

YEAR END 20/21

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	2,245	1,643	(602)
Non-Elective	53,875	46,372	(7,503)
Daycase	28,176	26,333	(1,842)
Outpatient	298,401	310,371	11,969
A&E	133,952	122,930	(11,022)
Other NHS Non- Tariff	1,190,677	1,206,458	15,780
Other NHS Tariff	49,737	69,960	20,223
Total	**1,757,064**	**1,784,067**	**27,003**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£18.01	£18.01	£0.00
Non Elective	£114.89	£114.89	£0.00
Daycase	£30.72	£30.72	£0.00
Outpatients	£46.12	£46.12	£0.00
A & E	£23.16	£23.16	(£0.00)
Other-NHS Clinical	£105.17	£105.18	£0.01
CQUIN	£3.79	£3.79	£0.00
Other Income	£47.57	£50.95	£3.38
Total Income	**£389.43**	**£392.83**	**£3.39**
Pay	(£286.54)	(£287.01)	(£0.47)
Drug Costs	(£41.90)	(£41.47)	£0.42
Clinical Support	(£31.01)	(£30.62)	£0.39
Other Costs	(£64.57)	(£72.69)	(£8.11)
PFI Costs	(£13.44)	(£13.41)	£0.03
Total Expenditure	**(£437.46)**	**(£445.19)**	**(£7.73)**
EBITDA	**(£48.03)**	**(£52.37)**	**(£4.34)**
Non Operating Expenditure	(£24.06)	(£24.10)	(£0.04)
Surplus / (Deficit) Adjusted*	**(£72.08)**	**(£76.46)**	**(£4.38)**
Conditional Funding (MRET/FRF/Top Up)	£70.17	£72.86	£2.70
Surplus / Deficit*	**(£1.92)**	**(£3.60)**	**(£1.69)**

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

DIVISIONS: INCOME AND EXPENDITURE

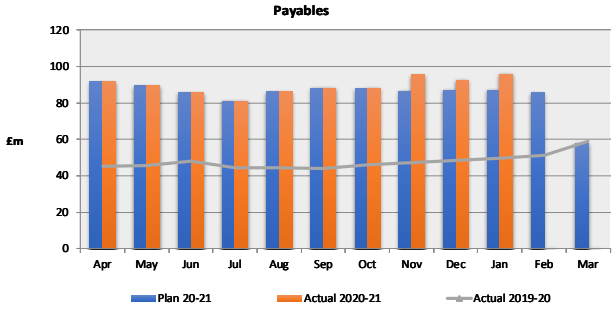
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£17.51	£20.31	£2.80
Medical	£31.43	£31.29	(£0.14)
Families & Specialist Services	(£7.45)	(£5.77)	£1.68
Community	(£3.90)	(£2.48)	£1.42
Estates & Facilities	£0.00	£0.00	(£0.00)
Corporate	(£46.03)	(£47.47)	(£1.44)
THIS	£1.49	£1.51	£0.02
PMU	£3.00	£3.35	£0.35
CHS LTD	£0.71	£0.57	(£0.14)
Central Inc/Technical Accounts	£0.38	(£4.10)	(£4.48)
Reserves	£0.94	(£0.81)	(£1.75)
Unallocated CIP	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£1.92)**	**(£3.60)**	**(£1.69)**

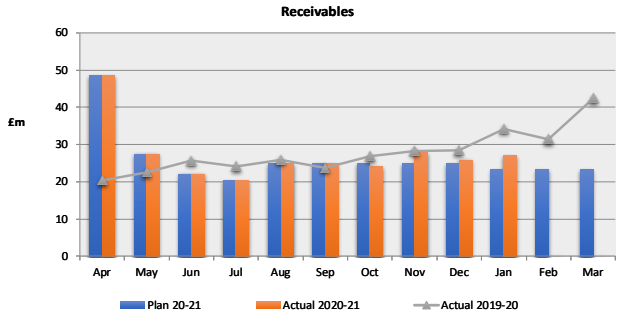
Total Group Financial Overview as at 31st Jan 2021 - Month 10

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

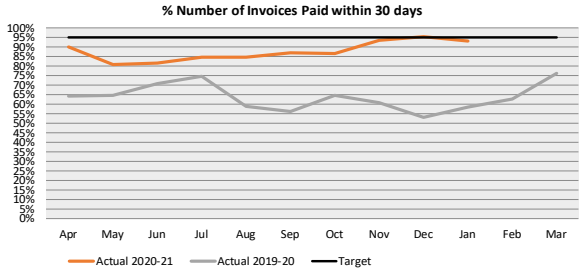
WORKING CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Payables (excl. Current Loans)	(£86.83)	(£95.78)	£8.95	
Receivables	£23.27	£26.97	(£3.70)	



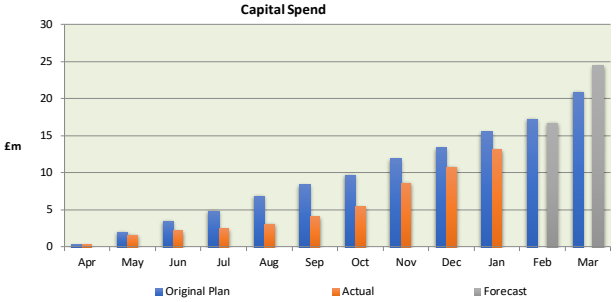


BETTER PAYMENT PRACTICE CODE



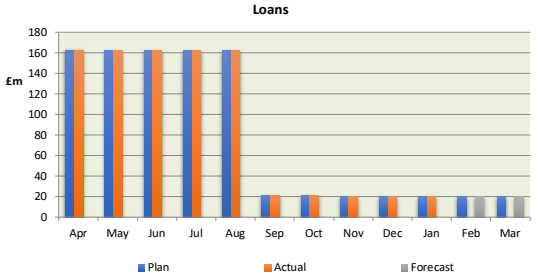
CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Capital	£15.49	£13.19	£2.30	

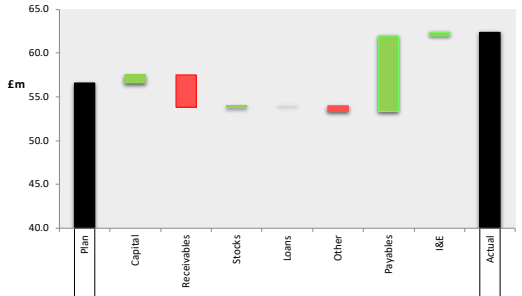


CASH

	M10 Plan £m	M10 Actual £m	Var £m	M10
Cash	£56.57	£62.37	£5.80	
Loans (Cumulative)	£19.88	£19.88	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust is now working to the revised plan for Phase 3 of 2020/21 (M7-12) that was submitted in October. Income flows remain largely on a block basis and system funding has been allocated to cover the majority of Covid-19 costs. Year to date the position is a deficit of £0.30m, a favourable variance of £0.52m compared to plan. The M1-6 plan has now been reset to actual expenditure, so the variance only represents M7-10.
- Clinical Contract income is largely in line with the Phase 3 plan due to fixed block and top up arrangements, including a fixed monthly allocation to cover Covid-19 expenditure. The reported position includes the M6 impact of the Elective Incentive Scheme (£0.11m) For M7, 8 & 10 it is anticipated that the System will be exempt due to Covid activity and the position excludes any potential impact on M9. If this were to be levied the impact of this penalty is estimated to be £0.57m.
- Whilst Outpatient activity remains above the Phase 3 plan Year to date, all other areas of activity are below plan due to increased Covid-19 admissions.
- Year to date the Trust has incurred costs relating to Covid-19 of £26.70m. M10 costs incurred were £3.20m.
- Year to date Capital expenditure is lower than planned at £13.19m against a planned £15.49m.
- Cash balance is £62.27m, £5.80m above the Phase 3 plan: the Trust continues to receive Block and Top Up income one month in advance.

- Year to date CIP schemes have delivered £4.55m of savings, £7.76m lower than the Trust's original 20/21 Target.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 2. This excludes the exceptional adverse impact on the Capital Service Cover Metric of the repayment of Interim revenue and capital support loans, due to changes in the NHS cash regime.

NOTES

- For Month 7-12 (Phase 3), the Trust will be required to manage within the ICS agreed financial envelope. The Trust has been allocated Covid funding on a fair shares basis to cover the remainder of the year and can request access to additional central funding to cover costs excluded from the system envelope such as Covid Testing and Vaccinations.
The Trust is reporting a forecast deficit of £3.60m, £1.69m higher than planned due to an increase in the required Annual Leave accrual. This is an 'allowable' overspend from an NHS Improvement perspective and has been agreed with our system partners.

- The Trust is forecasting delivery of £5.89m savings against a Trust CIP Target for 20/21 of £14.77m.
- The Forecast excludes the potential adverse impact of the Elective Incentive Scheme on the M9-12 position, which based on the current activity forecast could drive a penalty of circa £0.80m.
- The total loan balance at year end is forecast to be £19.88m as planned. All Revenue and Interim Capital Loans (totalling £140.72m) were repaid and replaced by PDC funding during September.
- Capital expenditure is forecast at £24.42m, £3.58m more than the resubmitted 20/21 Capital Plan, due to confirmation of further additional external funding for: Adopt & Adapt, Cyber Security Yorkshire & Humber Care Records and Medical E-Rostering / Job Planning.

RAG KEY: (Excl: UOR)		Actual / Forecast is on plan or an improvement on plan
		Actual / Forecast is worse than planned by <2%
		Actual / Forecast is worse than planned by >2%

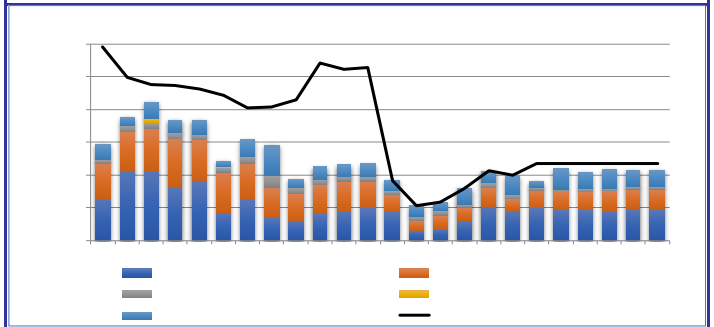
NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per NHSI risk indicator).

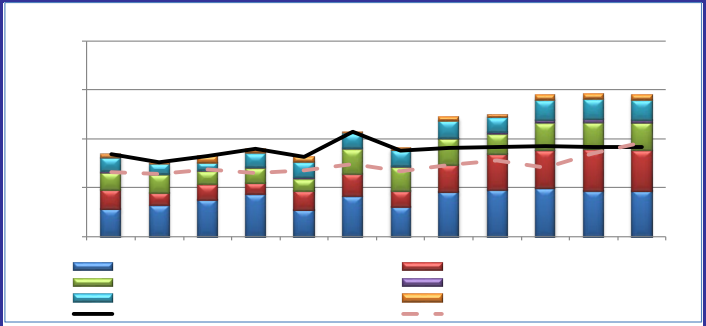
RAG KEY: UOR		All UOR metrics are at the planned level
		Overall UOR as planned, but one or more component metrics are worse than planned
		Overall UOR worse than planned

WORKFORCE

Vacancies

	Sci, Tech & Ther	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	3	96	16	97	15	226
Staff in post (WTE)	729	1,416	635	1,638	1,111	5,529
% Vacancies	0%	6%	2%	6%	1%	4%





Cumulative Agency and Bank Spend	Plan	Actual	Var
	£'m	£'m	£'m
Agency Year to Date	(£3.84)	(£3.61)	£0.23
Agency Forecast	(£4.78)	(£4.50)	£0.29
Bank Year to Date	(£17.63)	(£20.03)	(£2.40)
Bank Forecast	(£21.30)	(£25.83)	(£4.53)

Vacancies
At the end of Month 10 the Trust was carrying 226 vacancies, 4% of the total baseline establishment (excluding Covid / Phase 3 response) and a reduction of 67 vacancies compared to Month 9. Total Staff in Post increased by 38 in month to 5,529. Medical vacancies reduced in month to 2%. Nursing vacancies reduced by 29 to 97 WTE or 6% of establishment. To Note: the establishment has not been adjusted to reflect forecast additional posts for the Phase 3 Covid response, therefore the true vacancy rate is understated.

Agency Expenditure
Total reported agency expenditure year to date is £3.61m; £0.23m below the planned value. The year to date underspend on agency costs is offset by an increase in the use of internal Bank staff.

Forecast agency expenditure is £4.50m, £0.29m below the recently submitted Phase 3 plan.

Bank usage
Expenditure on internal Bank staff year to date is £20.03m, £2.40m higher than planned. £7.18m of these costs relate to the Covid-19 response including: additional medical costs of £4.12m due to changes to rotas, expansion of the workforce, segregation of patient pathways and support to the vaccination programme; and nursing costs of £2.75m due to backfill for higher sickness absence, expanded workforce, plans to release bed capacity and support to the vaccination programme. In month, the increase in bank usage was driven by the hospital site vaccination programme.

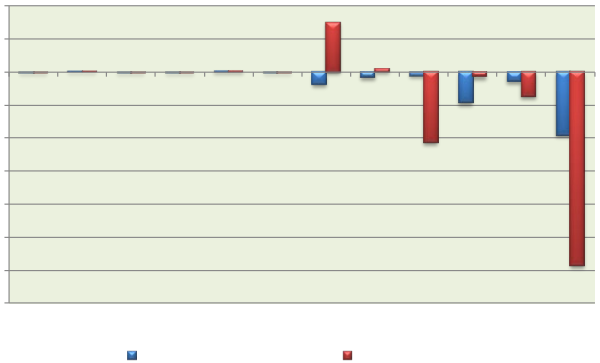
FORECAST

YEAR END 20/21

	Plan £m	Forecast £m	Var £m	
Elective	£18.01	£18.01	£0.00	
Non Elective	£114.89	£114.89	£0.00	
Daycase	£30.72	£30.72	£0.00	
Outpatients	£46.12	£46.12	£0.00	
A & E	£23.16	£23.16	(£0.00)	
Other-NHS Clinical	£105.17	£105.18	£0.01	
CQUIN	£3.79	£3.79	£0.00	
Other Income	£47.57	£50.95	£3.38	
Total Income	**£389.43**	**£392.83**	**£3.39**	
Pay	(£286.54)	(£287.01)	(£0.47)	
Drug Costs	(£41.90)	(£41.47)	£0.42	
Clinical Support	(£31.01)	(£30.62)	£0.39	
Other Costs	(£64.57)	(£72.69)	(£8.11)	
PFI Costs	(£13.44)	(£13.41)	£0.03	
Total Expenditure	**(£437.46)**	**(£445.19)**	**(£7.73)**	
EBITDA	**(£48.03)**	**(£52.37)**	**(£4.34)**	
Non Operating Expenditure	(£24.06)	(£24.10)	(£0.04)	
Surplus / (Deficit) Control Total basis*	**(£72.08)**	**(£76.46)**	**(£4.38)**	
Conditional Funding (MRET/PSF/FRF)	£70.17	£72.86	£2.70	
Surplus / Deficit*	**(£1.92)**	**(£3.60)**	**(£1.69)**	

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

Forecast



Month 7-12 (Phase 3) Financial Plan

The current Block and Top Up arrangements with access to retrospective funding to cover Covid costs have now ended. For Month 7-12 (Phase 3), the Trust will be required to manage within the ICS agreed financial envelope. The Trust has been allocated Covid funding on a fair shares basis to cover the remainder of the year. The plan submitted to the ICS and NHSI assumes an underlying unfunded gap (deficit) of £1.92m as described below:

	£'m	
Technical Accounting Adjustment:	£0.00	*Removed from Plan and Forecast*
Loss of 'Other' Income:	£1.61	
Annual Leave Accrual:	£0.50	
Residual difference between funding and planned expenditure:	-£0.19	
Total Planned Deficit	**£1.92**	

The Trust is now forecasting a £3.60m deficit which is £1.69m more than planned due to an increase in the required Annual Leave accrual. This is an 'allowable' overspend from an NHS Improvement perspective and has been agreed with our system partners. Excluding the Annual leave accrual, the Trust is now confident of achieving the planned position and a combination of the year to date improvement, some expected ongoing slippage on recruitment and an additional funding allocation of £0.81m from the ICSs has allowed the Trust to include in the forecast a £1.5m provision to cover the estimated cost of the 'Flowers' national legal case (relating to back-dated annual leave claims).

Key Assumptions:

- The forecast does not include any potential financial impact for M9-12 as a result of the Elective Incentive Scheme, estimated at circa £0.80m.
- Assumes that all future PPE requirements are provided through National Procurement.
- Assumes that the incremental costs incurred as a result of Covid-19 Testing and the Vaccination programme are recovered in full through additional 'outside of envelope' funding.
- Excludes the potential impact of Brexit on prices / costs.
- Assumes that any additional outsourced activity to the Independent Sector will be recoverable through additional funding.

Risks and Opportunities:

- National funding for Covid Testing has been identified, but the cost per test incurred on existing testing platforms exceeds the recommended value and the approval process for confirming funding in this situation remains unclear.
- Current operational pressures due to Covid-19 may increase the required Annual Leave accrual further compared to the forecast level.
- If the improvement seen in Month 10 continues, there may be the opportunity to reduce the current forecast deficit to some extent.
- The forecast currently excludes any potential benefit if additional funding is released nationally to cover lost income (eg. Car Parking income) or the Annual Leave accrual and Flowers legal case

COVID-19

Revenue Impact of Covid-19 - YTD JAN 2021

Division	Annual Leave Accrual	Covid-19 Direct Costs	Impact on activity	Loss of Income	Total
	£	£	£	£	£
Central & Technical	0	9,259,527	42,208	0	9,301,735
Medicine	0	10,036,134	(252,342)	0	9,783,792
Families & Specialist Services	0	1,481,649	(180,999)	619,370	1,920,020
Calderdale & Huddersfield Solutions Ltd	0	1,244,882	(109,501)	103,000	1,238,381
Corporate Services	0	1,049,571	(48,081)	2,000,430	3,001,920
Community	0	1,139,455	0	30,346	1,169,802
Health Informatics	0	130,740	0	0	130,740
Surgery & Anaesthetics	0	2,357,513	(2,949,394)	0	(591,881)
NHS Nightingale (Hosted Costs)		3,264			3,264
Total costs identified	-	**26,702,735**	**- 3,498,108**	**2,753,146**	**25,957,773**
Retrospective Top Up requested (M1-6)					**14,031,213**
Covid System Top Up (M7-12)					**7,244,000**
Covid funding 'outside of envelope'					**1,759,509**
Total funding					**23,034,722**

Capital Impact of Covid-19 - JAN 2021

Details	Covid-19 Costs
	£
NPEX (PDC received)	330,000
Equipment	444,578
Asset Tracking	105,422
Total costs identified	**880,000**
PDC Confirmed	**844,000**

The Trust has incurred Covid-19 direct costs totalling £26.70m year to date as shown in the table and these have been reported to NHSI in support of the requested 'Retrospective Top Up' (M1-6), Covid system funding provided from M7 and additional funding requested to cover 'outside of envelope costs'. Additional Covid funding totalling £1.62m has been assumed to cover costs for: Covid-19 Testing £1.11m, Covid-19 Vaccination Programme £0.45m and NIHR SIREN £0.09m. This funding is yet to be confirmed and paid. The Trust has also been allocated funding of £0.14m to cover the cost of delivering Lateral Flow Testing.

Key areas of spend are as follows:

Pay - £14.09m

Key area of pay expenditure categorised as within system envelope and therefore covered by Top Up allocations are follows:
- Existing staff to working additional shifts, during both wave 1 and again over the last 3 months as the number of Covid-19 cases have once again increased across the two hospitals.
- Additional costs in community services for bank holiday cover and other additional shifts to support 7 day working.
- Almost 150 students (nursing, therapies and medical) were added to the payroll up until mid August in support of wave 1.
- Changes to medical rotas with additional enhancements paid to junior medical staff.
- The extension of winter initiatives to release bed capacity including the Discharge Lounge and Home First team.
- The facilitation of patient flow and segregation of pathways, particularly in the Emergency Department.
- Backfill for substantive staff who are sick or clinically extremely vulnerable and the cost of paying bank staff who are shielding.

Pay expenditure that requires additional funding as 'outside of envelope' is as follows:
- £0.036m for staff costs to support PCR virus testing using platforms procured prior to Sep 20.
- £0.238m to support the Vaccination programme delivered within the hospital setting.
- £0.005m for NIHR SIREN

Non Pay - £12.61m

Non pay costs categorised as inside of system envelope total £11.24m, including: £5.23m for locally procured PPE, costs related to increased ICU capacity of £1.00m, £1.12m on Covid testing, £1.61m for segregation of patient pathways, £1.05m for decontamination and £0.53m to support remote management of patients.

Non pay expenditure that requires additional funding as outside of envelope is as follows:
- £1.07m for testing kits and associated equipment for PCR virus testing using platforms procured prior to Sep 20.
- £0.20m for the Huddersfield Vaccination Centre at the Johns Smiths Stadium and £0.01m for the Hospital based Vaccination programme.
- £0.09m for NIHR SIREN

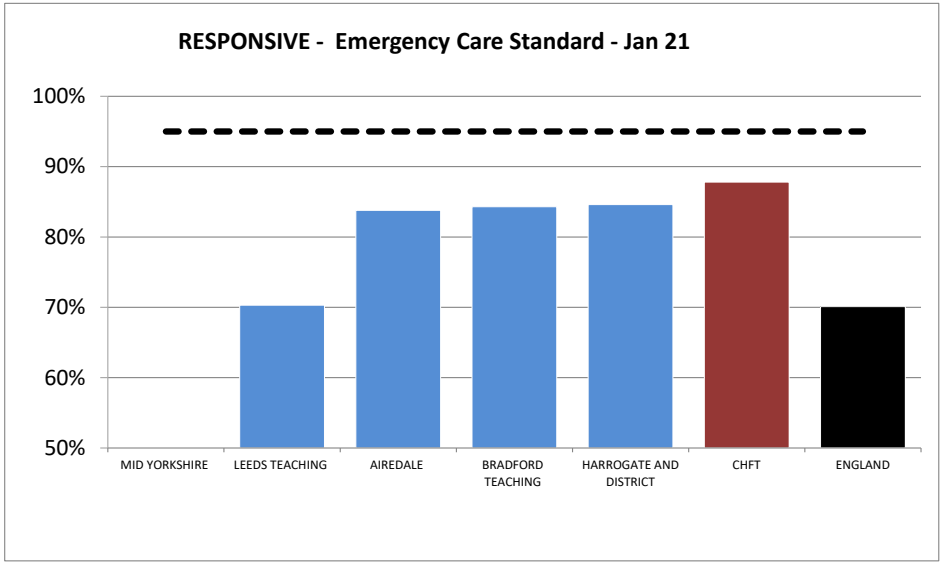
Income Losses

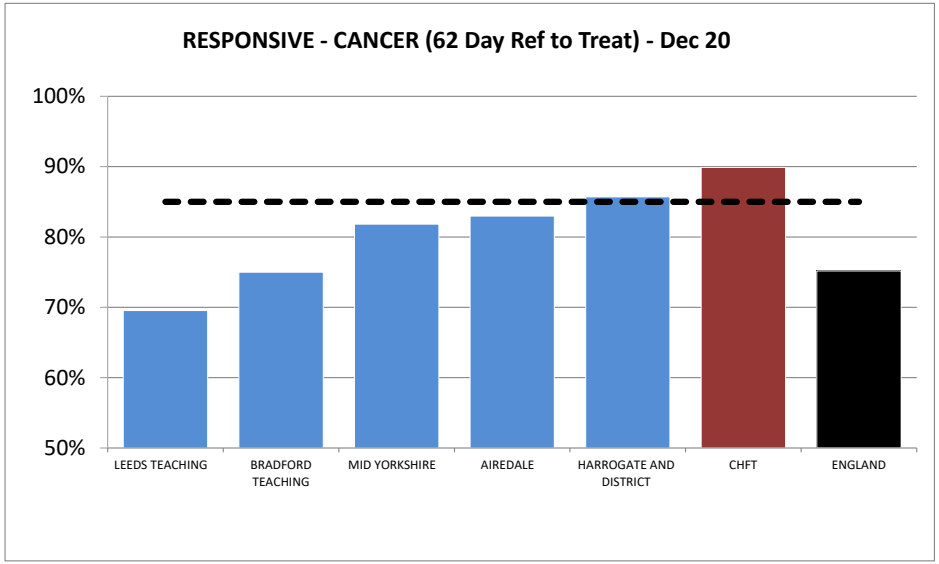
The Trust has lost income totalling £2.75m including: loss of Car Parking Income, (£1.90m which is a combination of income from staff permits and income from patients and visitors), loss of catering income (£0.07m), loss of apprentice levy income (£0.08m from pausing of HCAs apprenticeships delivered internally) and loss of private patient income (£0.62m mainly from Yorkshire Fertility).

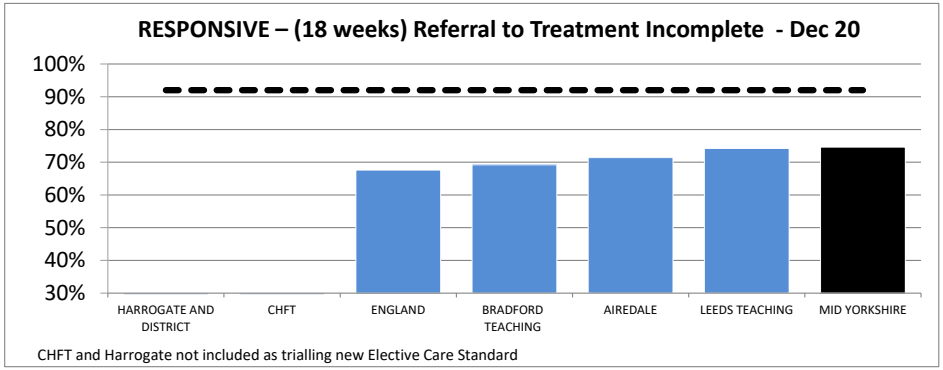
Additional costs have been offset to some extent year to date by the indirect impact of lower than planned costs in non-Covid areas where activity has reduced as a result of the Covid-19 response.

Capital funding for Covid-19 costs has also been requested as shown and the Trust has now had the majority approved as shown.

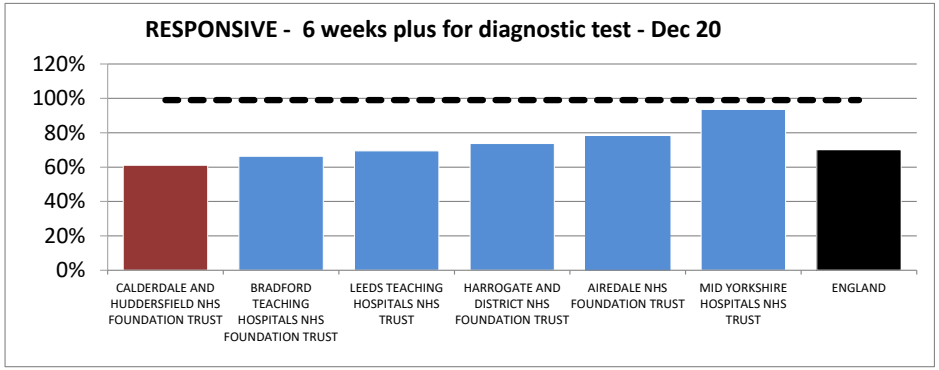
Benchmarking - Selected Measures

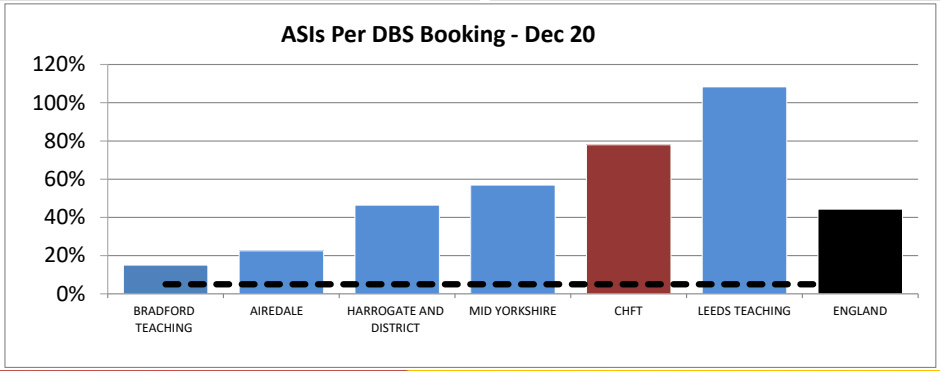






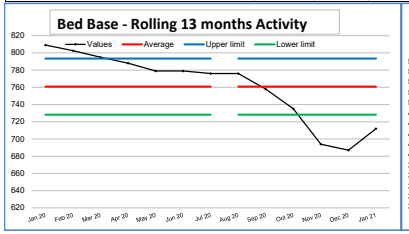
CHFT and Harrogate not included as trialling new Elective Care Standard

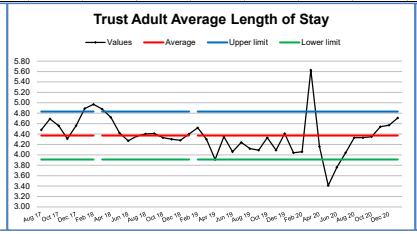


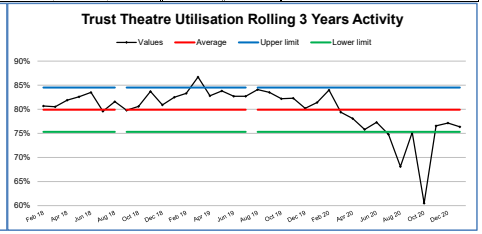


Efficiency & Finance - Key measures

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Performance Range		
Did Not Attend Rates																Green	Amber	Red
First DNA	7.70%	6.94%	7.20%	8.02%	4.46%	3.92%	2.97%	3.28%	3.27%	4.24%	4.35%	5.27%	5.18%	**5.30%**	**4.25%**	<=7%	7.1% - 7.9%	>=8%
Follow up DNA	6.67%	6.21%	6.06%	6.72%	5.58%	4.54%	4.98%	4.63%	5.22%	5.53%	5.24%	5.54%	5.29%	**5.81%**	**5.28%**	<=7%	7.1% - 7.9%	>=8%
Average length of stay																		
Average Length of Stay - Overall	4.26	4.04	4.06	5.63	4.16	3.41	3.76	4.04	4.33	4.33	4.35	4.54	4.57	**4.71**	**4.23**	<=5.19 / <=4.25 from April 20		>=5.30
Average Length of Stay - Elective	2.27	1.94	2.60	2.30	1.44	1.54	2.03	3.69	2.90	2.97	2.23	3.76	2.84	**3.42**	**2.73**	<=2.49 / <=2.30 from April 20		>=2.60
Average Length of Stay - Non Elective	4.50	4.26	4.25	6.03	4.26	3.45	3.81	4.06	4.40	4.42	4.53	4.56	4.62	**4.77**	**4.3**	<=4.62 / <=4.40 from April 20		>=5.50
Average Length of Stay - Non Elective - Excluding Ambulatory	5.64	5.36	5.42	7.28	4.88	4.16	4.54	4.81	5.29	5.37	5.62	5.63	5.8	**5.83**	**5.21**	<=5.56		
Average Length of Stay - Overall - Excluding Ambulatory	5.20	4.96	5.03	6.66	4.75	4.08	4.51	4.77	5.13	5.18	5.26	5.55	5.64	**5.68**	**5.07**	<=5.15 / <=5.10 from April 20		>=5.25
Pre-Op Length of Stay - Elective Patients	0.05	0.04	0.04	0.05	0.07	0.04	0.14	0.24	0.11	0.17	0.04	0.30	0.32	**0.14**	**0.15**	<= 0.02 as per Model Hospital		>0.04
Pre-Op Length of Stay - Non Elective Patients	0.64	0.57	0.59	0.85	0.52	0.48	0.56	0.72	0.69	0.73	0.70	0.65	0.71	**0.65**	**0.65**	<=0.73 as per Model Hospital		
Non Elective with zero LOS (not ambulatory)	8,055	694	640	620	439	581	528	554	501	533	526	471	492	**475**	**5,100**	Not applicable		
Elective Inpatients with zero LOS	907	88	68	73	27	11	16	9	19	25	22	2	2	**7**	**140**	<=75 YTD <=900		>=80
Day Cases																		
Day Case Rate	89.66%	90.53%	89.42%	89.43%	91.94%	94.55%	94.62%	93.56%	92.84%	92.26%	90.61%	96.32%	95.96%	**94.65%**	**93.72%**	>=89.25%	80.1% -89.24%	<=80%
Failed Day Cases	1,483	123	149	116	31	23	30	77	64	80	93	80	92	**117**	**687**	<=120 YTD <=1440		>=125
Beds																		
Beds Open in Month - Plan	801	801	801	801	785	770	770	770	770	770	770	770	770	**793**	**770**	Not applicable		
Beds Open in Month - Actual	795.00	809.10	802.60	795.00	788.00	779.00	779.00	776.00	776.00	758.00	735.00	694.00	687.00	**712**	**712**	Not applicable		
Hospital Bed Days per 1000 population - Adults	40.44	48.65	45.27	40.44	24.91	30.24	32.83	36.83	38.38	38.6	39.51	38.4	38.89	**39.24**	**24.97**	18/19 Baseline		
Emergency Hospital Admissions per 1000 population - Adults	0.08	0.11	0.09	0.08	0.06	0.08	0.08	0.09	0.08	0.08	0.09	0.08	0.08	**0.08**	**0.06**	18/19 Baseline		
Occupied Bed Days							12,604	14,178	14,714	14,834	15,327	14,943	15,166	**15,304**	**137,917**	Not applicable		
Cancellations																		
Clinical Slots not Utilised	8.70%	not available	not available	10.00%	32.30%	32.80%	24.10%	14.30%	11.60%	8.40%	9.10%	11.20%	9.60%	**0.12**	**18.90%**	Not applicable		
Endoscopy Utilisations - Trust level	98.30%	97.20%	99.30%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Endoscopy Utilisations - CRH	99.69%	99.65%	99.64%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Endoscopy Utilisations - HRI	97.22%	95.39%	98.73%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**	>=90%	86% - 89%	<=85%
Hospital Cancellations within 6 Weeks	11,704	not available	not available	8,273	17,022	7,545	3,822	4,368	3,253	3,638	2,820	4,383	4,307	**3,115**	**3,115**	0		>=1
Theatre Utilisation																		
Theatre Utilisation (TT) - Main Theatre - CRH	83.60%	82.10%	84.00%	79.90%	89.16%	82.80%	80.30%	86.50%	80.00%	71.00%	58.50%	78.61%	78.15%	**78.69%**	**79.16%**	>=90%	86% - 89%	<=85%
Theatre Utilisation (TT) - Main Theatre -HRI	87.80%	88.20%	89.30%	82.70%	63.15%	72.30%	90.90%	64.60%	57.00%	63.00%	52.50%	66.29%	not applicable	**not applicable**	**66.70%**	>=90%	86% - 89%	<=85%
Theatre Utilisation (TT) - HRI DSU	73.80%	72.30%	78.50%	73.30%	57.62%	58.70%	62.50%	75.40%	70.00%	82.20%	64.20%	76.84%	76.43%	**75.48%**	**76.20%**	>=88%	85% - 87%	<=84%
Theatre Utilisation (TT) - Trust	82.40%	81.40%	84.00%	79.40%	78.09%	75.80%	77.30%	74.80%	68.10%	75.20%	60.50%	76.55%	77.14%	**76.36%**	**75.45%**	>=90%	84% - 89%	<=83%
% Theatre Scheduled Late Starts > 15 mins - Trust	37.29%	32.71%	36.50%	44.93%	56.76%	55.10%	45.45%	50.98%	65.17%	53.61%	45.18%	33.33%	30.43%	**43.75%**	**49.39%**	Not applicable		
Total Fallow lists - Trust	705	58	52	30	pcation due	**No Reallocation due to COVID**										To be confirmed		
Flow																		
No. of Ambulatory patients	12,405	1,195	1,076	787	434	653	699	655	662	669	749	714	765	**638**	**6,638**	To be confirmed		
Emergency Hospital Discharges	51483	4729	4033	3732	2620	3095	3277	3440	3,278	3,435	3,548	3,394	3,599	**3,308**	**32,994**	<=4200 YTD <=50400		>=4201
Stranded 7 Days	48.07%	47.88%	48.22%	50.70%	37.50%	37.49%	39.58%	42.10%	44.40%	43.69%	42.77%	42.67%	44.87%	**44.17%**	**42.26%**	<=30%	31% - 99%	>=40%
Super Stranded 21 Days	97	104	106	97	24	22	31	40	49	55	53	46	57	**51**	**43**	<= 95	96 - 97	>=98
Average time to start of reablement (days)	6.94	4.60	4.20	4.20	2.00	2.50	2.80	3.10	4.20	4.50	4.20	3.50	4.50	**5.80**	**3.71**	<=5 days	6 - 8 days	>= 9 days
% Catheter Lab Utilisation	89.00%	not available	not available	not available	not available	not available	not available	not available	not available	not available	not available	not available	not available	**not available**	**not available**	No target		







Efficiency & Finance Frailty- Key measures

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Performance Range
Acute Admissions - Aged 75+ Years																Green / Amber / Red
Acute Admissions aged 75+	9,851	947	784	757	581	635	692	741	739	745	866	798	904	not available	6,701	not applicable
Frail* patients admitted aged 75+	3927	437	307	295	188	203	236	226	271	271	270	215	256	not available	2,136	
% patients admitted aged 75+ who are frail**	39%	46%	39%	39%	32%	32%	34%	31%	37%	36%	31%	27%	28%	not available	32%	
Frailty Admissions with LOS < 3 days																
Patients 75+ with a LOS < 3 days	5060	503	408	320	260	327	340	377	362	367	404	347	429	not available	3,213	not applicable
Frail* patients with a LOS < 3 days	1595	184	130	91	81	83	105	83	108	93	98	66	120	not available	837	
% of patients with a LOS < 3 days who are frail**	32%	37%	32%	28%	31%	25%	31%	22%	30%	25%	24%	19%	28%	not available	32%	
Patients 75+ occupied bed days	69085	6267	4940	7011	3409	3005	3781	4561	4,594	4,545	5,121	4,699	5,233	not available	38,948	
Frail* occupied bed days	32362	3536	2358	2926	1074	1170	1425	1872	1,975	2,179	1,962	1,444	1,434	not available	14,535	
Average frail* non-elec IP LOS	42.0	8.09	7.68	9.92	5.71	5.76	6.04	8.28	7.29	8.04	7.3	6.7	5.6	not available	5.7	
Average Frailty Rockwood Score		not available			6	6	6	6	5.90	5.90	6.00	6.00	5.90	not available	5.90	
Re-admitted back to the Frailty Team within 30 days	1035	124	98	93	84	112	72	100	107	97	133	143	113	not available	961	
% Re-admitted back to the Frailty Team within 30 days	20%	18%	17%	18%	17%	20%	14%	17%	18%	17%	20%	22%	19%	not available	18%	

* Data is based on the following Treatment Functions: General Medicine; Endocrinology; Hepatology; Diabetic Medicine; Respiratory; Nephrology; Neurology; Rheumatology; Geriatric Medicine

** The frailty team at Calderdale and Huddersfield Foundation Trust have defined frail patients as being a patient over and including the age of 75 with one of the ICD 10 diagnosis codes described by the Acute Frailty Network (AFN).

Activity - Key measures

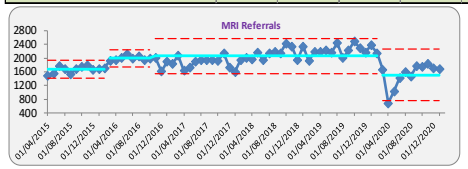
	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	YTD % Change
GP referrals to all outpatients																
02T - NHS CALDERDALE CCG	35,430	2,993	2,421	1,885	679	1,285	2,071	2,271	2,099	2,361	2,307	2,224	1,956	**1,609**	**18,862**	**-40.82%**
03A - NHS GREATER HUDDERSFIELD CCG	32,540	2,721	2,461	1,873	729	1,336	2,115	2,310	2,205	2,385	2,299	2,350	2,035	**1,625**	**19,389**	**-33.48%**
Other	6724	555	470	325	102	122	211	230	221	239	138	62	53	**104**	**1,482**	**-73.76%**
Trust	74,694	6,269	5,352	4,083	1,510	2,743	4,397	4,811	4,525	4,985	4,744	4,636	4,044	**3,338**	**39,733**	**-39.85%**
Trust - % Change on Previous year	0.09%	-4.62%	-2.22%	-37.31%	-78.97%	-60.10%	-29.44%	-33.16%	-30.08%	-28.99%	-36.45%	-25.47%	-20.55%	**-47.05%**	**-39.85%**	
03J - NHS NORTH KIRKLEES CCG	2,533	198	190	119	42	53	100	111	121	114	70	52	43	**23**	**729**	**-66.45%**
02R - NHS BRADFORD DISTRICTS CCG	0	0	0	0	42	30	52	67	72	76	46	37	22	**35**	**479**	**-77.50%**
03R - NHS WAKEFIELD CCG	912	68	58	49	6	10	10	4	8	7	8	6	11	**5**	**75**	**-89.85%**
01D - NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	75	7	7	2	0	0	1	1	1	1	2	1	1	**0**	**8**	**-87.50%**
03C - NHS LEEDS WEST CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
02N - NHS AIREDALE, WHARFEDALE AND CRAVEN CCG	0	**0**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
03G - NHS LEEDS SOUTH AND EAST CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
02V - NHS LEEDS NORTH CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0.00%**
15F - NHS LEEDS CCG	83	7	3	5	0	0	3	7	1	0	0	6	4	**3**	**24**	**-74.19%**
ACTIVITY VARIANCE AGAINST CONTRACT																
Day Case Variance against Contract	-284	-12	121	-760	-2,796	-2,470	-2,578	-2,353	-1,717	-1,917	-1,634	-1,579	-1,370	**-1,580**	**-18,536**	
% Day Case Variance against Contract	-0.74%	-0.33%	3.62%	-20.68%	-80.27%	-74.85%	-67.39%	-59.61%	-66.76%	-50.44%	-42.71%	-43.26%	-42.01%	**-45.47%**	**-57.09%**	
Elective Variance against Contract	-53	-37	39	-76	-364	-365	-406	-346	-225	-237	-243	-396	-327	**-323**	**-2,915**	
% Elective Variance against Contract	-1.06%	-8.10%	9.18%	-16.08%	-79.12%	-83.71%	-80.41%	-70.75%	-75.14%	-54.15%	-47.14%	-80.65%	-76.38%	**-71.12%**	**-70.35%**	
Non-elective Variance against Contract	-962	367	-94	-823	-1,959	-1,201	-997	-1,062	-826	-1,002	-1,124	-1,336	-1,183	**-1,116**	**-10,808**	
% Non-elective Variance against Contract	-1.75%	-3.42%	-3.42%	-3.42%	-38.67%	-24.46%	-20.52%	-20.77%	-24.74%	-20.07%	-21.15%	-25.14%	-21.90%	**-22.05%**	**-23.67%**	
Outpatient Variance against Contract	162	-70	-1,066	-6,806	-18,441	-16,695	-15,365	-13,995	-11,147	-37,538	-15,472	-16,192	-14,664	**-14,985**	**-163,482**	
% Outpatient Variance against Contract	0.07%	-0.30%	-3.62%	-21.48%	-61.92%	-60.29%	-47.95%	-42.62%	-50.13%	-117.41%	-48.26%	-52.69%	-54.18%	**-51.29%**	**-59.83%**	
Accident and Emergency Variance against Contract	3,199	647	538	-2,310	-6,037	-4,326	-3,153	-2,512	-902	-1,655	-2,443	-2,543	-2,994	**-3,072**	**-26,566**	
% Accident and Emergency Variance against Contract	0.58%	5.19%	4.68%	-18.02%	-46.70%	-31.41%	-23.82%	-17.88%	-25.26%	-12.47%	-17.93%	-19.59%	-22.32%	**-24.05%**	**-22.08%**	

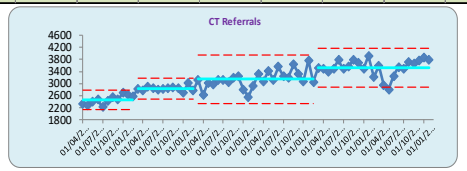
Please note further details on the referral position including commentary is available within the appendix.

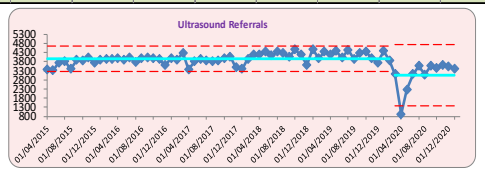
Radiology Summary of Activity of Key Modalities - January 2020

Referrals into Service

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD 20/21	YTD 19/20	Increase	%
MRI	2188	2230	2173	2444	2004	2228	2479	2303	2154	2374	2153	1671	689	1026	1418	1595	1469	1781	1743	1846	1708	1689	14964	22577	-7613	-34%
CT	3497	3380	3498	3785	3481	3572	3790	3683	3482	3911	3212	3599	2949	2807	3249	3545	3489	3717	3665	3762	3862	3786	34831	36079	-1248	-3%
Obstetrics	2288	2481	2247	2581	2400	2329	2480	2276	2287	2394	2175	2301	1909	1951	2235	2244	2076	2271	2236	2161	2296	2255	21634	23763	-2129	-9%
General Radiology	16909	17111	16426	18090	16876	16761	17406	16468	15653	18242	15665	12489	6629	8962	10935	12812	12348	13368	13255	12642	12470	12263	115684	169942	-54258	-32%
Ultrasound	4205	4382	4011	4445	3962	4256	4364	3975	3741	4375	3861	3112	912	2266	3107	3568	3098	3563	3462	3630	3534	3410	30550	41716	-11166	-27%
Total	29087	29584	28355	31345	28723	29146	30519	28705	27317	31296	27066	23172	13088	17012	20944	23764	22480	24700	24361	24041	23870	23403	217663	294077	-76414	-26%





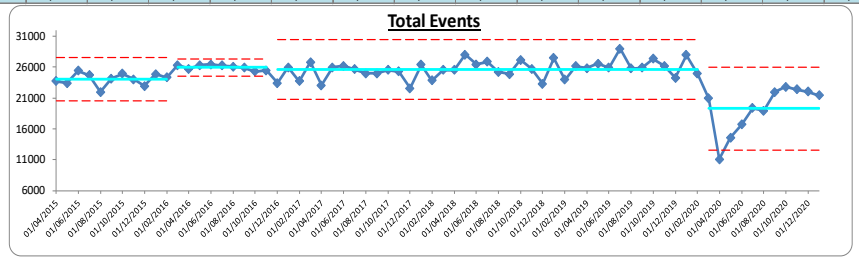


How does this compare to Trust activity Trend?

A&E Activity has decreased by 21.6%, Outpatients decreased by 22.5% and Inpatients (excluding Maternity) decreased by 34.9%

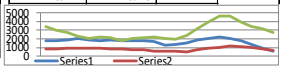
Activity

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD 20/21	YTD 19/20	Increase	%
Total Events	25,856	26,555	25,921	29,002	25,777	25,871	27,344	26,191	24,262	27,950	24,917	20,906	11,080	14,583	16,696	19,353	18,936	21,951	22,807	22,357	22,000	21,444	191,207	264,729	-73,522	-28%
MRI	1900	1778	1905	2041	1874	1992	1990	2132	1849	2068	1974	1832	502	698	822	1190	1201	1517	1812	1918	1828	1785	13273	19529	-6256	-32%
HRI -MRI	675	629	647	682	637	658	698	701	677	690	703	643	221	261	266	329	372	429	495	529	472	492	3866	6694	-2828	-42%
CRH - MRI	463	500	498	558	479	492	582	551	446	533	473	455	160	164	197	226	161	301	364	417	358	321	2669	5102	-2433	-48%
New Scanner - HRI	626	561	643	703	675	752	606	735	621	744	679	579	118	151	232	240	226	348	486	524	503	488	3316	6666	-3350	-50%
CRVAN	127	76	108	90	78	84	92	134	98	92	112	143	0	0	0	0	0	0	0	0	448	478	926	979	-53	-
Other/Unknown	9	12	9	8	5	6	12	11	7	9	7	12	3	122	127	395	442	439	467	448	47	6	2496	88	2408	2736%
CT	3,053	2,925	3,072	3,302	3,009	3,206	3,331	3,132	3,024	3,389	3,187	2,718	1,755	2,576	2,579	2,836	2,911	3,196	3,397	3,378	3,477	3,415	29,520	31,443	-1,923	-6%
General Radiology	15,364	15,664	15,003	17,202	15,071	15,031	15,911	15,148	14,361	16,532	14,381	11,438	5,865	7,941	9,284	10,986	10,914	12,194	12,029	11,622	11,406	10,996	123,496	155,287	-31,791	-20%
Obstetrics	2,098	2,367	2,131	2,392	2,257	2,196	2,316	2,144	2,112	2,242	2,071	2,123	1,786	1,853	2,110	2,067	1,959	2,153	2,087	1,986	2,165	2,093	14,015	22,255	-8,240	-37%
Ultrasound	3,441	3,821	3,810	4,065	3,566	3,446	3,796	3,635	2,916	3,719	3,304	2,795	1,172	1,515	1,901	2,274	1,951	2,891	3,482	3,453	3,124	3,155	24,918	36,215	-11,297	-31%
Total Exams	28,260	29,008	28,480	32,306	28,619	28,405	29,930	28,739	26,521	30,743	27,471	23,073	12,387	16,402	18,715	21,526	21,122	22,355	43,355	24,919	20,343	21,835	222,959	291,011	-68,052	-23%
MRI	1964	1845	1985	2134	1956	2069	2058	2215	1934	2151	2046	1908	515	712	839	1210	1230	1567	1876	1995	1890	1847	13681	20311	-6630	-33%
HRI -MRI	698	654	663	707	667	680	711	729	708	700	719	670	223	273	270	340	380	454	510	545	484	505	3984	6917	-2933	-42%
CRH - MRI	471	513	524	575	495	512	598	572	456	556	486	462	168	168	205	239	169	302	363	429	373	330	2746	5272	-2526	-48%
New Scanner - HRI	653	587	681	751	706	783	643	766	663	790	721	618	121	149	235	251	235	369	520	567	536	520	3503	7023	-3520	-50%
CRVAN	133	78	108	93	81	87	94	137	99	96	113	145	0	0	0	0	0	0	0	0	450	485	935	1006	-71	-
Other/Unknown	9	13	9	8	7	7	12	11	8	9	7	13	3	122	129	380	446	442	483	454	47	7	2513	93	2420	2602%
CT	4,439	4,253	4,498	4,979	4,366	4,719	4,826	4,586	4,363	4,999	4,741	4,167	2,825	4,056	4,108	4,354	4,441	4,921	5,161	5,077	5,280	5,168	45,391	46,028	-637	-1%
General Radiology	15,971	16,342	15,657	18,318	16,062	15,647	16,560	15,785	14,885	17,253	14,974	11,820	5,948	8,068	9,492	11,312	11,293	12,655	12,506	12,053	11,787	11,347	106,461	162,480	-56,019	-34%
Obstetrics	2,107	2,372	2,134	2,398	2,264	2,200	2,320	2,153	2,119	2,248	2,079	2,125	1,791	1,856	2,115	2,072	1,962	0	20,308	1,991	-2,007	0	30,088	22,315	7,773	35%
Ultrasound	3,779	4,196	4,206	4,477	3,971	3,770	4,166	4,000	3,220	4,092	3,631	3,053	1,308	1,710	2,161	2,578	2,196	3,212	3,504	3,803	3,393	3,473	27,338	39,877	-12,539	-31%



Waiting List at Month End

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD 20/21	YTD 19/20	Increase	%
Total number on MRI Waiting List	1774	1803	1878	2044	1845	1761	1913	1779	1780	1755	1671	1295	1335	1527	1867	2042	2192	2092	1786	1409	969	602				
Total number on CT Waiting List	856	873	931	945	973	925	855	845	757	770	614	562	581	553	748	909	1017	1167	1143	1012	829	716				
Total number on US Waiting List	3454	3025	2727	2353	2085	2226	2111	1766	2024	2106	2231	2042	2008	2409	3173	3950	4625	4596	3962	3391	3194	2746				



Number of Exams reported

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD 20/21	YTD 19/20	Increase	%
Internal (Planned)	13589	13823	12320	15530	13995	12592	13511	12221	12550	13959	12956	15532	9098	11411	12777	14472	14221	13578	15627	15319	14404	14497	135404	134090	1314	1%
Insourced (Extras)	253	152	102	283	17	0	0	0	0	0	46	23	0	0	0	0	92	100	137	36	0	0	365	807	-442	-
Locum Radiologist/Sonagropher	288	392	690	1114	217	1161	502	454	512	783	581	479	727	409	579	683	468	791	853	585	687	747	6529	6113	416	7%
Auto Reported	4216	2861	2476	2372	2126	3042	3266	3128	3458	4694	3355	2869	562	1042	2063	3008	1911	4669	4231	3490	3798	3183	27957	31639	-3682	-12%
Outsourced	3278	7511	7279	8759	7481	7409	8055	8310	10180	11003	10037	5418	707	1059	995	1298	1507	2830	3216	4308	4493	3999	24412	79265	-54853	-69%
Total	21624	24739	22867	28058	23836	24204	25334	24113	26700	30439	26975	24321	11094	13921	16414	19461	18199	21968	24064	23738	23382	22426	194667	251914	-57247	-23%

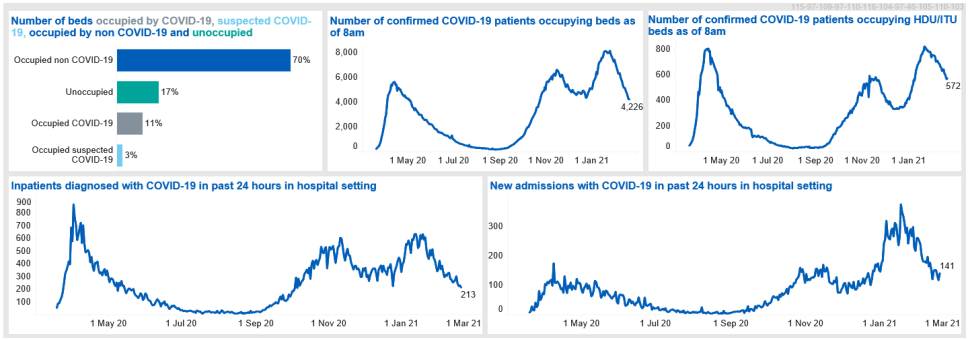
% Outsourced	15%	30%	32%	31%	31%	31%	32%	34%	38%	36%	37%	22%	6%	8%	6%	7%	8%	13%	13%	18%	19%	18%	13%	31%	-19%	
% Insourced/Outsourced	16%	31%	32%	32%	31%	31%	32%	34%	38%	36%	37%	22%	6%	8%	6%	7%	9%	13%	14%	18%	19%	18%	13%	32%	-19%	

Appendices

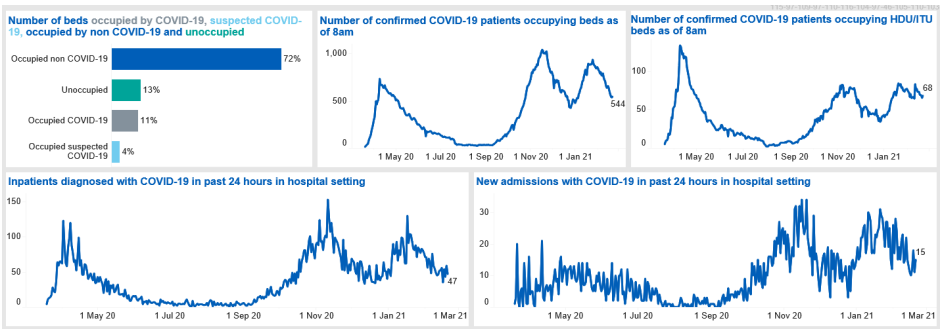
COVID-19 IPR APPENDIX

COVID Metrics across the Region:

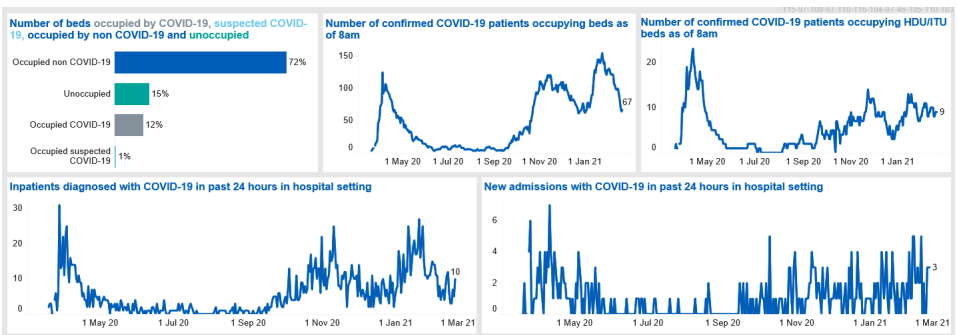
North East and Yorkshire and North West: Peak of Covid19+ inpatients in early April followed by reduction until early September when second wave commenced and Covid19 admissions increased week on week. From mid-November numbers started to fall but with the 3rd wave starting towards the end of December. Occupied beds for Covid19 and suspected Covid19 are at 11% and 3% respectively compared to 15% and 3% respectively last month. Covid19 patients occupying beds passed the peak of the 1st and 2nd wave towards the end of January. With Covid19 patients occupying ICU/HDU beds also passed the peaks experienced in the 1st and 2nd waves towards the end of January.



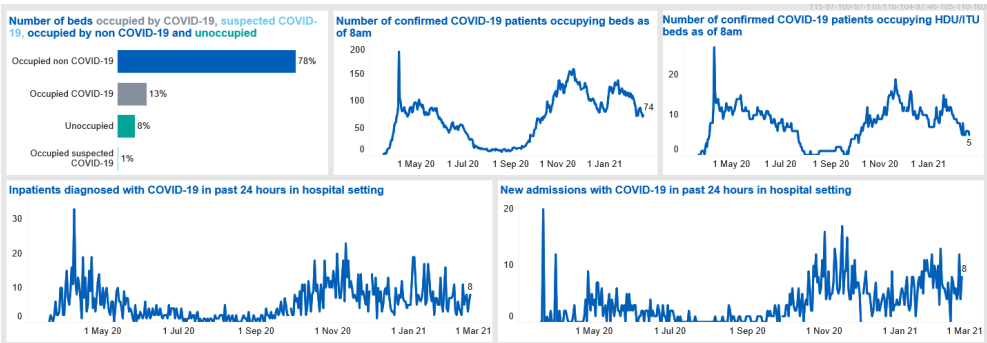
WYAAT: Same pattern as Region above. Covid19 patients occupying critical care beds has not seen as marked a decline as the rest of the region. Occupied beds for Covid19 patients are 11% compared to 12% last month.



CHFT: Pattern for CHFT is similar with the 3rd wave exceeding the peaks of the 1st and 2nd wave for Covid19 patients occupying a bed. There has been a steep decline of Covid19 positive patients occupying a bed from 155 on 25th January to 65 on 22nd February. Covid19 patients occupying critical care beds has not seen as marked a decline as elsewhere in the region.



BTHFT: Bradford reduction in Covid19 cases was flatter since April than the areas above. From mid-September Bradford's second wave was similar to above with Covid19 admissions increasing week on week through to 2nd wave peak at the end of November. There was a gradual decrease until the start of January when there was a 3rd wave. Unlike CHFT the 3rd wave peak at Bradford was not as high as its 1st or 2nd wave. Occupied beds for Covid19 and suspected Covid19 are 13% and 1% respectively compared to 20% and 3% respectively last month. Compared to CHFT Bradford has seen a marked decrease in numbers in critical care since the 25th January.



Beds Occupied Position as at 22nd February across WYAAT – 1-day snapshot

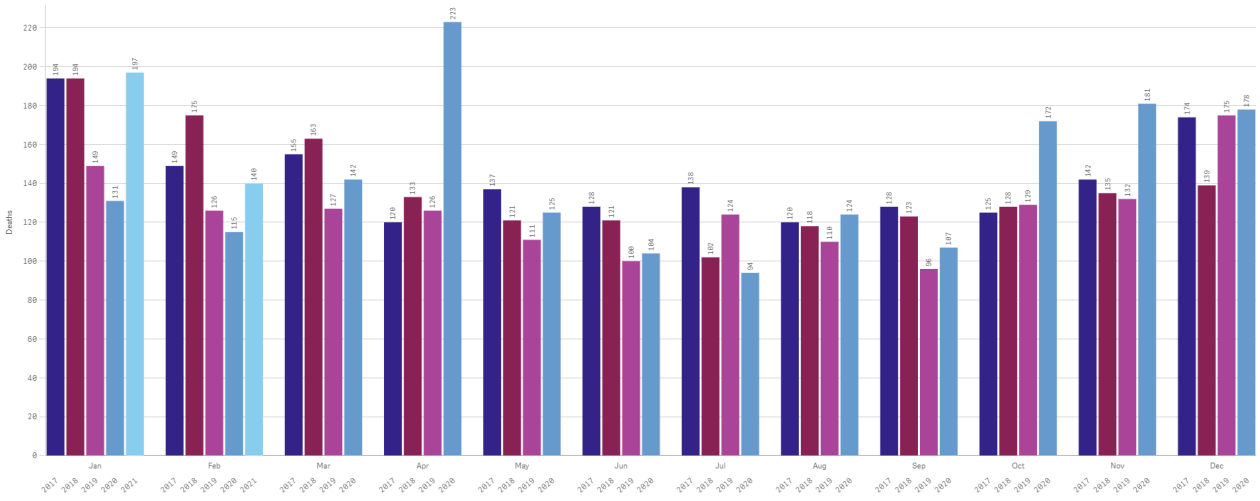
Number of beds (confirmed COVID-19, suspected COVID-19, other patients and unoccupied) reported as of 8am
Bed type:
Click on +/- sign to drill-down/roll-up. Top filters are not applied on this chart.

Region	Organisation				
North East and Yorkshire	Airedale NHS Foundation..	9 (3%)	0 (0%)	295 (84%)	46 (13%)
	Bradford Teaching Hospit..	74 (13%)	4 (1%)	450 (78%)	46 (8%)
	Calderdale and Huddersfi..	67 (12%)	4 (1%)	398 (72%)	82 (15%)
	Harrogate and District N..	51 (15%)	4 (1%)	214 (63%)	72 (21%)
	Leeds Teaching Hospital..	203 (10%)	135 (7%)	1,425 (69%)	290 (14%)
	Mid Yorkshire Hospitals ..	140 (15%)	29 (3%)	681 (75%)	63 (7%)

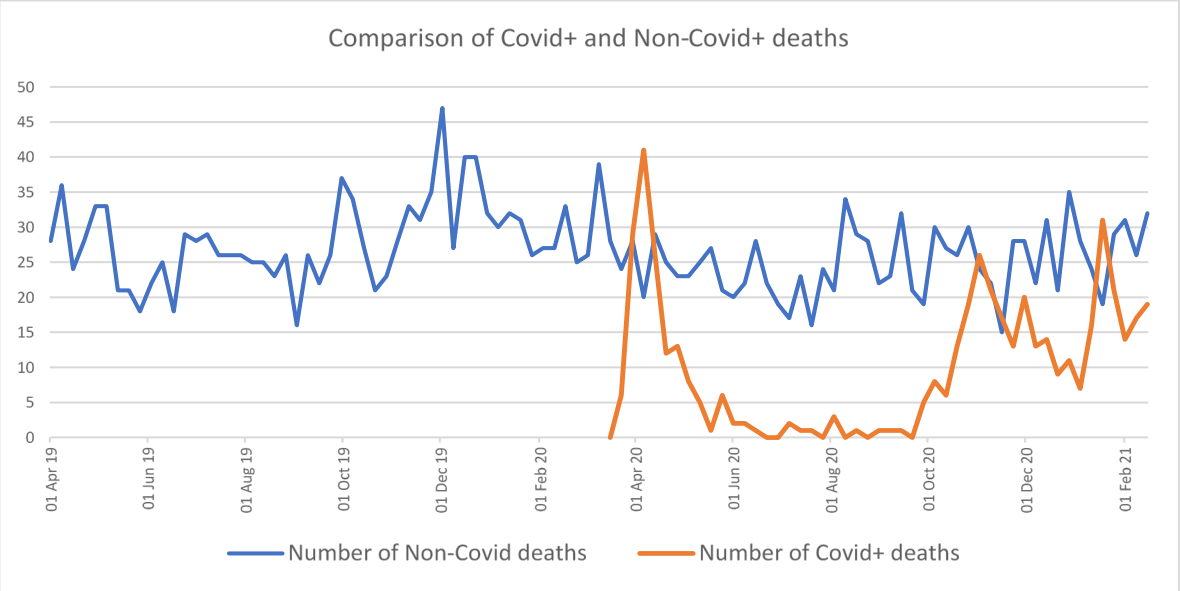
Airedale, Bradford and Mid Yorks have all seen a decrease in the percentage of beds occupied by confirmed Covid19 patients. Harrogate and Leeds have seen a slight increase whilst CHFT remains the same as last month's snapshot. Mid Yorkshire and Harrogate have the highest bed occupancy of confirmed Covid19 patients at 15% with CHFT having the 3rd highest at 12%. Airedale's position is the lowest with 3%. Leeds continue to have the highest bed occupancy of suspected Covid19 patients with 7%. Airedale, Bradford and Mid Yorks have had increased % bed occupancy of non-Covid19 patients since the January snapshot with CHFT, Harrogate and Leeds showing a slight decrease.

CHFT Mortality:

Historical Comparison



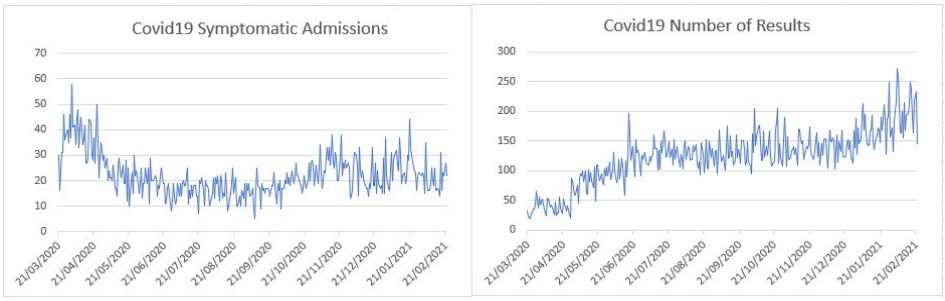
Impact of Covid19 deaths on historical trends seen particularly in April and then less so since May with the lowest number of deaths in July in the last 4 years. Deaths in October and November have been higher than previous 3 years but have not reached levels experienced in April. Deaths in January 2021 are more than those seen in 2019 and 2020 but comparable to 2017 and 2018.



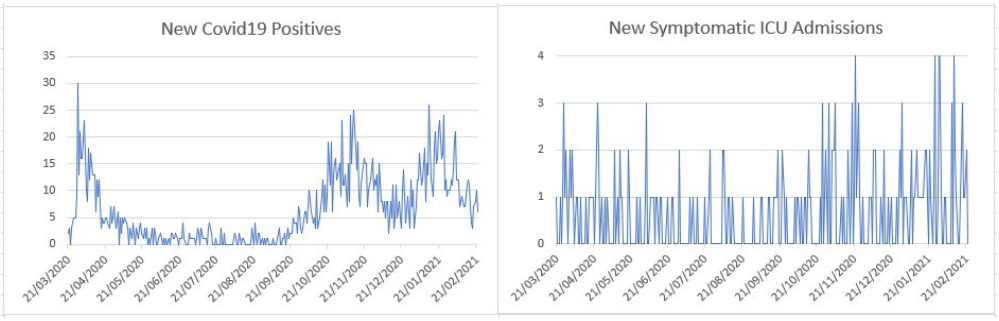
Peak number of Covid19 deaths in early April with a sustained reduction since then to mid/end September when deaths increased during the 2nd wave. There was an overall reduction from 1st week in November until the end of December. From start of January and the 3rd wave there was an increase in Covid19 deaths with a peak of 31 deaths w/c 18th January.

Covid19 Hospitalisation in England Surveillance System (CHESS) was developed by Public Health England (PHE) for monitoring hospitalised COVID-19. The scheme is based on the existing UK Severe Influenza Surveillance Scheme (USISS) that was created following the 2009 influenza pandemic. Objectives of CHESS are to monitor and estimate the impact of Covid19 on the population.

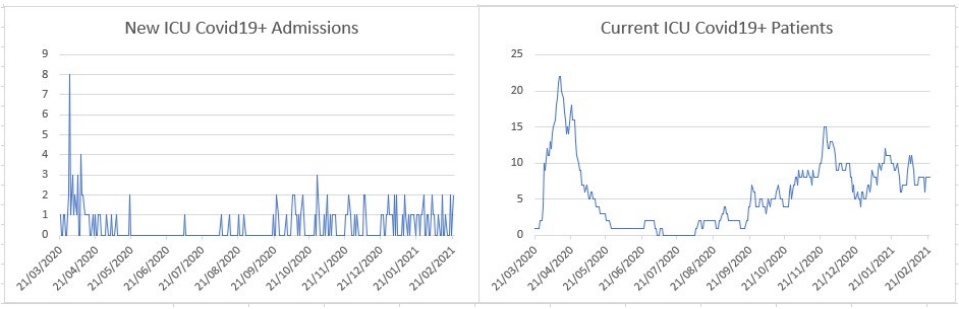
Since a peak in late March/early April there has been an overall reduction in symptomatic admissions to CHFT to a steady state with some daily variation since mid-June. There was gradual increase from mid-October through to mid-November and since the start of December wider daily variation but daily numbers not as high as the first wave. The increase in number of Covid19 results from start of May relates to a change in testing policy to include asymptomatic admissions and this has remained steady from May until start of January when a change in testing policy has resulted in an increase in test results through January and into February.



Since 29th March the trend was a gradual and sustained decrease in new Covid19 inpatients. There was a second wave from mid-September which has continued through October to mid-November. From mid-November towards the end of December there was a gradual decrease in numbers but with the 3rd wave from end of December through January with a gradual decrease in positives since the end of January.



There was a peak of Covid19 patients in ICU from 10th - 12th April and other than a small increase around 22nd April there had been a continual decrease in patients in ICU. There was a gradual increase during August which continued through to end of November when numbers of Covid19 patients in ICU started to fall. There was a gradual increase from 25th December until mid- January when numbers have slowly fallen. The January ICU Covid19 maximum was 12 on 15th.



Appendix - Appointment Slot Issues

ASIs

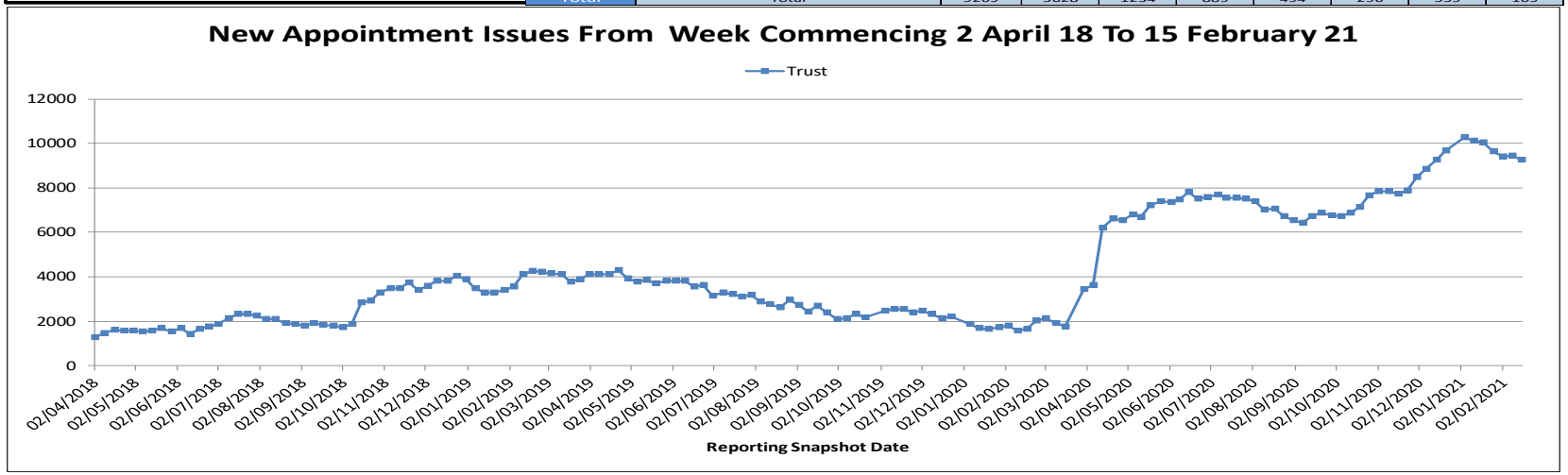
As at 16th February there were 9,269 referrals awaiting appointments.

The top specialties for ASIs backlog are:

Ophthalmology	1467
ENT	1386
Community	1118
MSK	1091
Paediatric ENT	993
Yorkshire Fertility	472
General Surgery	465
Neurology	425
Trauma and Orthopaedics	424
Cardiology	358
Colorectal Surgery	285
Urology	275
Gynaecology	258
Rheumatology	216

1024 patients have been waiting over 6 months, (this was 684 on the last report)

Divison	Specialty	Weeks Waitng							
		Total	0-13	14-17	18-21	22-25	26-29	30-51	52+
FSS	Total	789	564	91	66	36	15	16	1
	Chemical Pathology	1	1	0	0	0	0	0	0
	Paediatric Epilepsy	0	0	0	0	0	0	0	0
	Paediatrics	58	46	7	2	1	2	0	0
	Yorkshire Fertility	472	271	74	64	33	13	16	1
	Gynaecology	258	246	10	0	2	0	0	0
Medicine	Total	1470	1206	122	95	22	13	9	3
	Cardiology	358	273	37	33	8	4	3	0
	Endocrinology	16	13	2	1	0	0	0	0
	Gastroenterology	185	174	3	3	3	0	1	1
	Dermatology	62	61	1	0	0	0	0	0
	Diabetic Medicine	14	14	0	0	0	0	0	0
	General Medicine	3	1	1	0	0	0	1	0
	Geriatric Medicine	12	12	0	0	0	0	0	0
	Hepatology	23	23	0	0	0	0	0	0
	Clinical Haematology	17	16	1	0	0	0	0	0
	Medical Oncology	0	0	0	0	0	0	0	0
	Nephrology	2	2	0	0	0	0	0	0
	Rheumatology	216	137	36	39	3	0	1	0
	Neurology	425	349	40	17	7	9	3	0
	Respiratory Medicine	137	131	1	2	1	0	0	2
Surgery	Total	5877	3359	840	544	277	202	491	164
	Colorectal Surgery	285	219	62	4	0	0	0	0
	Breast Surgery	29	29	0	0	0	0	0	0
	General surgery	465	345	116	1	0	0	3	0
	Ophthalmology	1467	855	234	184	96	47	44	7
	Paediatric Ophthalmology	134	76	16	16	15	0	11	0
	Orthoptics	136	105	7	7	5	1	8	3
	Pain Management	52	43	4	3	1	0	0	1
	Urology	275	231	33	11	0	0	0	0
	Paediatric Urology	39	38	0	0	0	0	1	0
	Audiology	7	7	0	0	0	0	0	0
	ENT	1386	883	260	196	12	7	27	1
	Paediatric ENT	993	127	60	80	96	130	372	128
	Maxillo-Facial Surgery	1	1	0	0	0	0	0	0
	Plastic Surgery	24	22	1	0	0	0	0	1
	Paediatric Plastic Surgery	4	3	0	0	0	1	0	0
	Paediatric Surgery	30	29	1	0	0	0	0	0
	Trauma and Orthopaedics	424	278	43	34	28	3	18	20
	Paediatric Trauma and Orthopaedics	84	26	3	8	24	13	7	3
	Vascular Surgery	42	42	0	0	0	0	0	0
Community	Total	1118	490	178	184	159	65	42	0
	Podiatry	27	23	2	1	1	0	0	0
	MSK	1091	467	176	183	158	65	42	0
Unkown	Total	15	9	3	0	0	1	1	1
	Not CHFT	0	0	0	0	0	0	0	0
	Other CHFT	4	2	2	0	0	0	0	0
	-	11	7	1	0	0	1	1	1
Total	Total	9269	5628	1234	889	494	296	559	169



Appendix - Referrals

•GP Referrals are down 40.5% financial YTD January 2021 compared with January 2020. This is completely understandable following the initial ceasing of all routine referrals during the Covid19 pandemic for a considerable period.

•From April to January 2021, there were 210 working days, exactly the same as the corresponding period for 2019/2020.
•The same working days would indicate no anticipated increase/decrease of GP referrals. Clearly the impact of Covid19 on referral demand has been far more dramatic.
•NHS Calderdale GP referrals have seen a decrease of 41% (13,008) for the year to date and NHS Greater Huddersfield has had a large decrease overall of 33% (9,758).

Detailed Investigation of movement at specialty level has not been considered as a result of the large overall decrease.

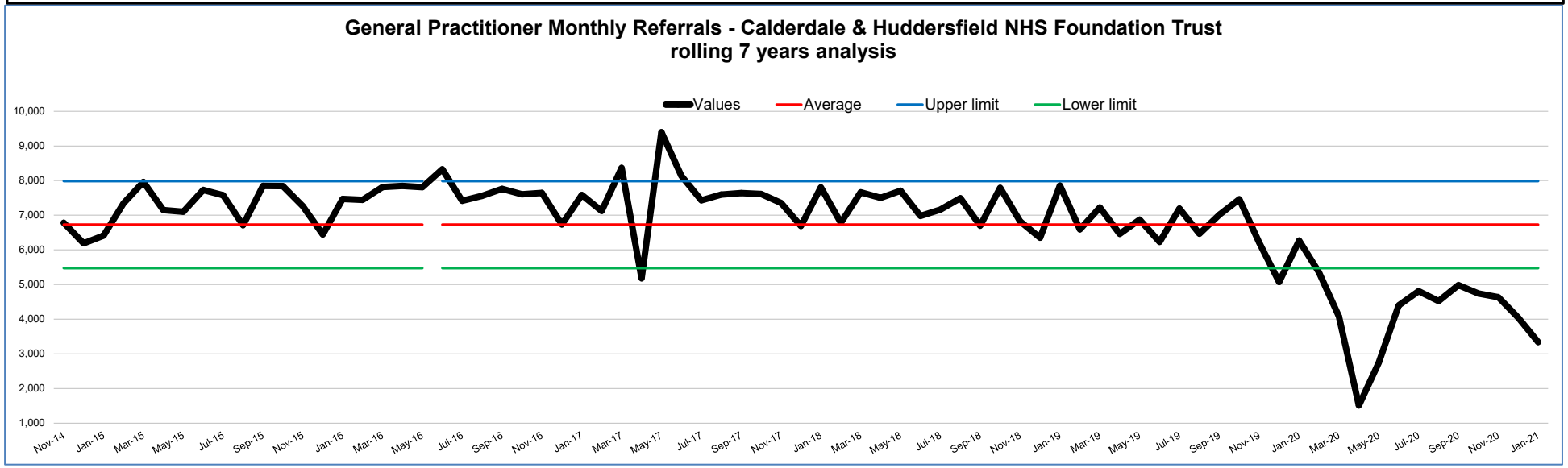
Please note that GP referrals that land on Appointment Slot Issue (ASI) lists as appointments cannot be booked when the referral is made are currently not counted in the referral figures. This explains an element of the decrease in referrals. Referrals do get counted once the ASI is resolved.

Work is ongoing to enable immediate reporting of these ASI related referrals so a complete picture of referral demand is always available.

Other CCGs with contracts with CHFT have all had similar marked reduction in referral volumes

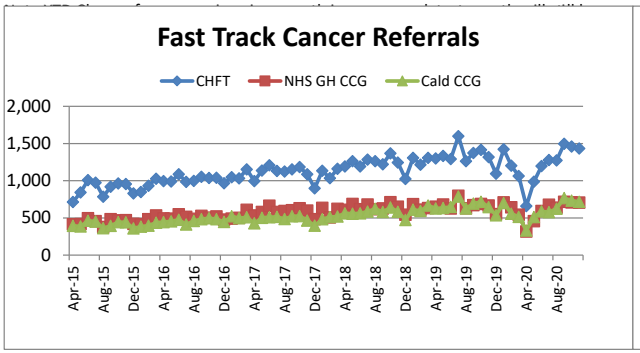
A brief summary is as follows

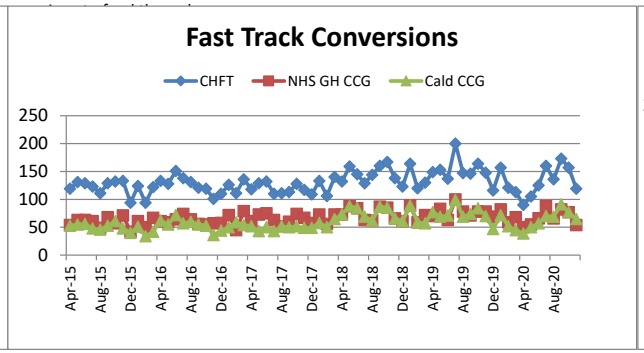
	19/20 YTD	20/21 YTD	Var	% Var
NHS Calderdale	31,870	18,862	-13008	-41%
NHS Greater Huddersfield	29,147	19,389	-9758	-33%
NHS North Kirklees	2,173	729	-1444	-66%
NHS Bradford District	1,739	465	-1274	-73%
NHS Bradford City	390	14	-376	-96%
NHS Wakefield	739	75	-664	-90%
NHS Heywood	64	8	-56	-88%

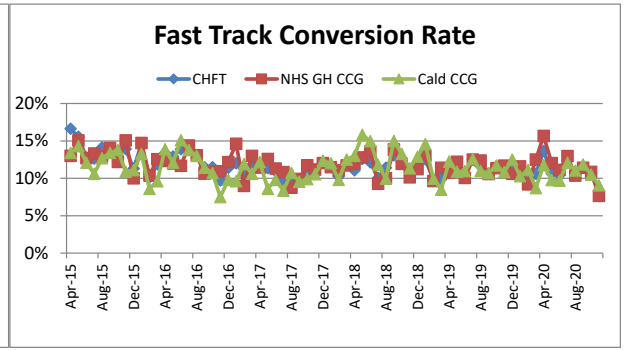


Activity - Key measures

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	YTD % Change
Fast Track Cancer referrals in month and of those referrals numbers that diagnosed with cancer (conversions)																
NHS CALDERDALE CCG Referrals	7,664	702	558	515	332	511	589	580	624	767	733	713	711	in arrears	in arrears	
NHS CALDERDALE CCG Conversions	874	82	62	45	39	50	57	70	69	91	78	72	62	in arrears	in arrears	
NHS CALDERDALE CCG Conversion Rate	11.4%	11.7%	11.1%	8.7%	11.8%	9.8%	9.7%	12.1%	11.1%	11.9%	10.6%	10.1%	8.7%	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Referrals	7,836	707	643	543	317	456	592	677	636	717	710	706	741	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Conversions	929	91	59	68	50	55	65	88	66	82	77	63	60	in arrears	in arrears	
NHS GREATER HUDDERSFIELD CCG Conversion Rate	11.9%	12.9%	9.2%	12.5%	15.8%	12.1%	11.0%	13.0%	10.4%	11.4%	10.9%	8.9%	8.1%	in arrears	in arrears	
Other CCG Referrals	159	12	2	6	10	20	17	21	13	12	18	13	25	in arrears	in arrears	
Other CCG Conversions	16	3	0	0	1	0	3	2	1	0	4	0	0	in arrears	in arrears	
Other CCG Conversion Rate	10.1%	25.0%	0.0%	0.0%	10.0%	0.0%	17.7%	9.5%	7.7%	0.0%	22.2%	0.0%	0.0%	in arrears	in arrears	
CHFT Fast Track Referrals	15,659	1,421	1,203	1,064	659	987	1,198	1,278	1,273	1,496	1,461	1,432	1,477	in arrears	in arrears	
CHFT Fast Track Conversions	1,819	176	121	113	90	105	125	160	136	173	159	135	122	in arrears	in arrears	
CHFT Fast Track Conversion Rate	11.6%	12.4%	10.1%	10.6%	13.7%	10.6%	10.4%	12.5%	10.7%	11.6%	10.9%	9.4%	8.3%	in arrears	in arrears	
% Change on Previous year																

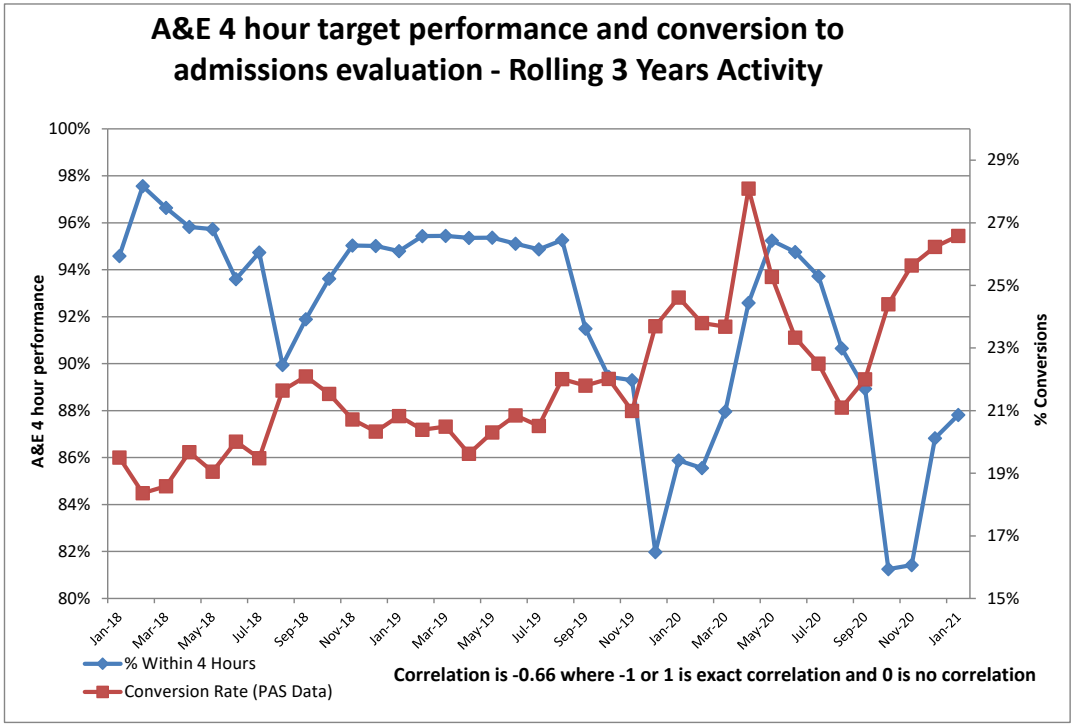






Appendix - A and E Conversion rates and Delayed Transfers

	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	YTD % Change
Analysis of A and E activity including conversions to admission																
A and E Attendances	154,445	13,105	12,017	10,511	6,895	9,445	10,087	11,544	12,129	11,620	11,174	10,434	10,415	**9,703**	**103,446**	-21.6%
A and E 4 hour Breaches	19,339	1,851	1,736	1,266	511	450	529	725	1,134	1,286	2,095	1,939	1,373	**1,182**	**11,224**	-31.3%
Emergency Care Standard 4 hours	87.48%	85.88%	85.55%	87.96%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	**87.82%**	**89.15%**	3.8%
Admissions via Accident and Emergency	34,851	3,146	2,799	2,489	1,937	2,387	2,353	2,597	2,559	2,556	2,727	2,675	2,732	**2,579**	**25,102**	-15.1%
% A and E Attendances that convert to admissions	22.57%	24.01%	23.29%	23.68%	28.09%	25.27%	23.33%	22.50%	21.10%	22.00%	24.40%	25.64%	26.23%	**26.58%**	**24.27%**	-1.4%



Delayed Transfers of Care (Reportable & Not reportable) Snapshot on 15th February 2021	Calderdale	Kirklees	Other	Total
Total number of patients on TOC Pathway	24	26	1	51
Awaiting Completion of Assessment	14	11	1	26
Awaiting Care package in own home	6	7		13
Awaiting Residential home placement	3	2		5
Awaiting public funding		2		2
Awaiting further non-acute NHS Care		3		3
Awaiting community equipment and adaptations				0
Awaiting nursing home placement	1	1		2
Disputes				0
Patient or Family choice				0
Housing - Patients not covered by Care Act				0

Appendix - Cancer - By Tumour Group

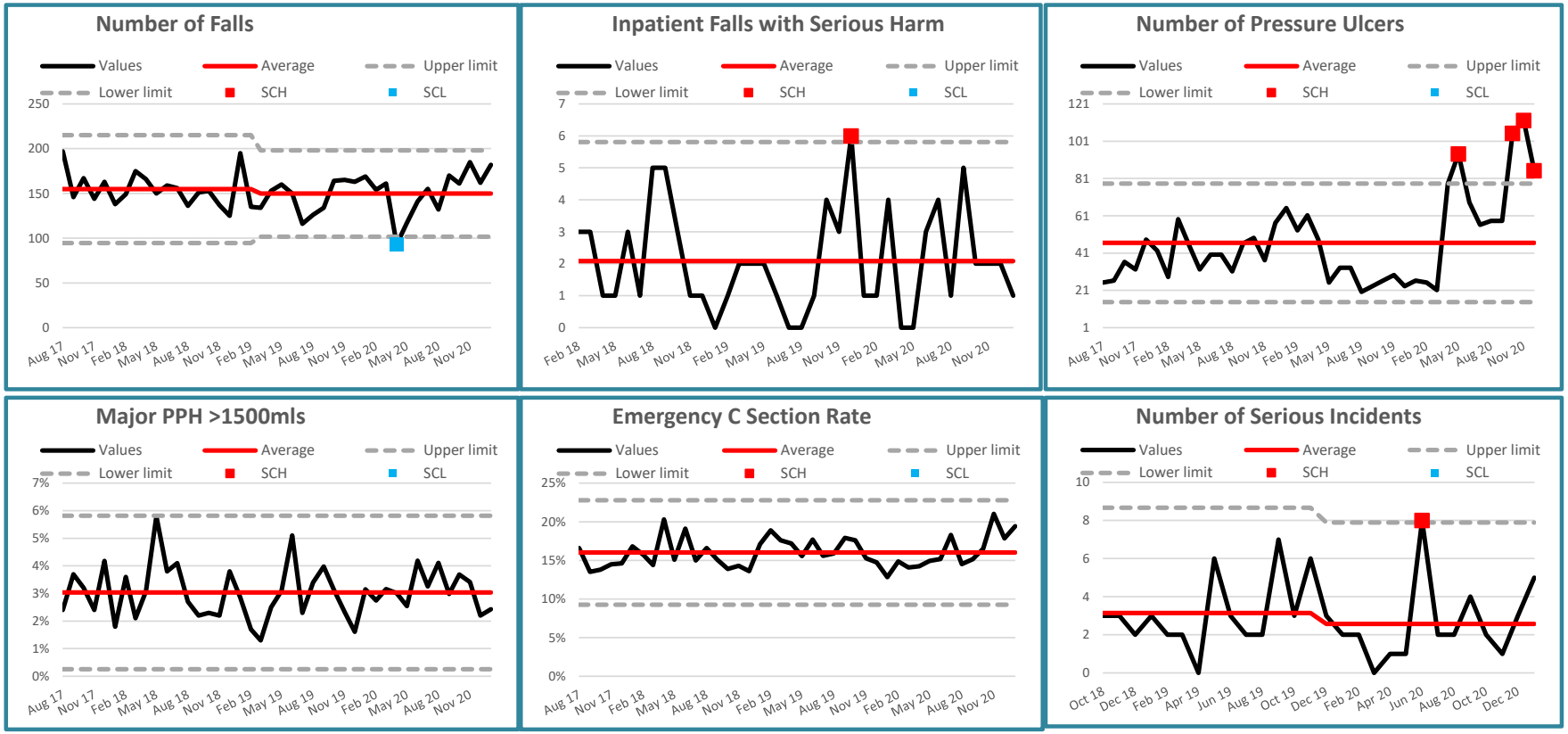
	19/20	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	YTD	Performance Range		
62 Day GP Referral to Treatment																Green	Amber	Red
Breast	99.19%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	88.89%	100.00%	100.00%	100.00%	83.33%	**100.00%**	**97.35%**	>=85%	81% - 84%	<=80%
Gynaecology	91.67%	80.00%	100.00%	100.00%	90.00%	93.33%	100.00%	80.00%	100.00%	66.67%	78.57%	100.00%	100.00%	**66.67%**	**86.21%**	>=85%	81% - 84%	<=80%
Haematology	87.40%	66.67%	100.00%	90.91%	100.00%	100.00%	100.00%	100.00%	91.67%	77.78%	100.00%	88.89%	71.43%	**50.00%**	**85.71%**	>=85%	81% - 84%	<=80%
Head & Neck	56.72%	36.36%	100.00%	60.00%	53.85%	0.00%	45.45%	60.00%	66.67%	40.00%	50.00%	66.67%	80.00%	**75.00%**	**56.52%**	>=85%	81% - 84%	<=80%
Lower GI	83.08%	78.95%	88.89%	100.00%	90.91%	66.67%	46.15%	62.50%	80.00%	100.00%	47.06%	100.00%	88.89%	**81.48%**	**77.71%**	>=85%	81% - 84%	<=80%
Lung	82.26%	91.67%	84.62%	73.08%	100.00%	100.00%	100.00%	85.71%	100.00%	93.33%	90.91%	66.67%	100.00%	**100.00%**	**94.69%**	>=85%	81% - 84%	<=80%
Sarcoma	87.50%	100.00%	none to report	0.00%	none to report	100.00%	none to report	100.00%	none to report	none to report	100.00%	100.00%	100.00%	**0.00%**	**85.71%**	>=85%	81% - 84%	<=80%
Skin	99.76%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.88%	95.24%	**93.33%**	**98.53%**	>=85%	81% - 84%	<=80%
Upper GI	84.81%	75.00%	100.00%	100.00%	75.00%	91.67%	33.33%	100.00%	80.00%	76.47%	85.71%	100.00%	83.33%	**80.00%**	**83.20%**	>=85%	81% - 84%	<=80%
Urology	89.96%	91.53%	93.18%	91.11%	96.30%	80.00%	100.00%	93.75%	94.12%	94.29%	94.59%	100.00%	91.67%	**95.74%**	**95.17%**	>=85%	81% - 84%	<=80%
Others	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	none to report	100.00%	100.00%	none to report	50.00%	0.00%	none to report	**none to report**	**84.21%**	>=85%	81% - 84%	<=80%
Two Week Wait From Referral to Date First Seen																		
Brain	94.70%	100.00%	100.00%	100.00%	80.00%	100.00%	77.78%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**85.71%**	**95.24%**	>=93%	86% - 92%	<=85%
Breast	98.43%	99.50%	100.00%	99.01%	100.00%	100.00%	96.57%	97.81%	99.05%	99.56%	99.57%	96.37%	97.27%	**98.25%**	**98.25%**	>=93%	86% - 92%	<=85%
Childrens	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%	100.00%	**100.00%**	**97.44%**	>=93%	86% - 92%	<=85%
Gynaecology	98.48%	97.30%	100.00%	100.00%	100.00%	97.73%	98.13%	97.64%	100.00%	98.75%	96.50%	100.00%	98.86%	**98.47%**	**98.55%**	>=93%	86% - 92%	<=85%
Haematology	98.59%	90.48%	95.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Head & Neck	99.16%	100.00%	99.17%	97.56%	94.34%	95.93%	96.46%	99.22%	99.13%	92.42%	99.24%	98.10%	99.31%	**94.62%**	**97.07%**	>=93%	86% - 92%	<=85%
Lower GI	99.26%	99.60%	99.63%	100.00%	100.00%	100.00%	100.00%	99.63%	100.00%	99.68%	100.00%	100.00%	100.00%	**100.00%**	**99.93%**	>=93%	86% - 92%	<=85%
Lung	98.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	**96.15%**	**99.13%**	>=93%	86% - 92%	<=85%
Sarcoma	96.48%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	88.89%	100.00%	100.00%	100.00%	100.00%	94.12%	**100.00%**	**97.62%**	>=93%	86% - 92%	<=85%
Skin	98.42%	99.62%	99.53%	98.76%	98.18%	99.50%	99.51%	100.00%	99.60%	96.30%	98.62%	97.78%	99.59%	**99.59%**	**98.86%**	>=93%	86% - 92%	<=85%
Testicular	97.47%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Upper GI	96.87%	96.46%	99.04%	98.18%	89.80%	100.00%	100.00%	100.00%	100.00%	96.58%	99.24%	98.54%	99.32%	**99.12%**	**98.71%**	>=93%	86% - 92%	<=85%
Urology	99.34%	100.00%	100.00%	100.00%	100.00%	98.39%	100.00%	96.88%	100.00%	99.12%	98.29%	97.27%	98.52%	**98.08%**	**98.53%**	>=93%	86% - 92%	<=85%

Appendix 1 - ESR Staff Groups - Roles

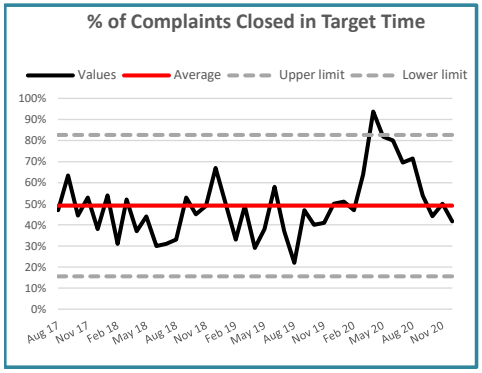
Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals
Chaplain	Assistant	Accountant	Advanced Practitioner
Clinical Director	Assistant Practitioner Nursing	Adviser	Chiropodist/Podiatrist
Manager	Assistant/Associate Practitioner	Analyst	Chiropodist/Podiatrist Manager
Operating Department Practitioner	Counsellor	Architect	Dietitian
Optometrist	Health Care Support Worker	Board Level Director	Dietitian Manager
Pharmacist	Healthcare Assistant	Chair	Dietitian Specialist Practitioner
Physician Associate	Healthcare Science Assistant	Chief Executive	Multi Therapist
Practitioner	Healthcare Science Associate	Clerical Worker	Occupational Therapist
Psychotherapist	Nursery Nurse	Finance Director	Occupational Therapist Manager
Technician	Nursing Associate	Librarian	Orthoptist
	Phlebotomist	Manager	Orthoptist Manager
	Technical Instructor	Medical Secretary	Physiotherapist
	Technician	Non Executive Director	Physiotherapist Manager
	Trainee Healthcare Science Practitioner	Officer	Physiotherapist Specialist Practitioner
	Trainee Healthcare Scientist	Other Executive Director	Radiographer - Diagnostic
	Trainee Nursing Associate	Personal Assistant	Radiographer - Diagnostic, Manager
		Receptionist	Radiographer - Diagnostic, Specialist Practitioner
		Researcher	Speech and Language Therapist
		Secretary	Speech and Language Therapist Manager
		Senior Manager	
		Technician	

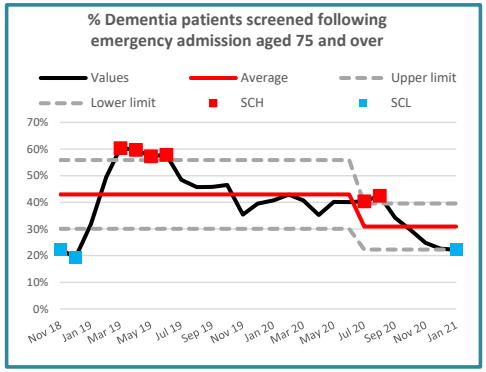
Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Assistant	Healthcare Science Practitioner	Consultant	Advanced Practitioner
Cook	Healthcare Scientist	Foundation Year 1	Community Nurse
Driver	Manager	Foundation Year 2	Community Practitioner
Engineer	Specialist Healthcare Science Practitioner	Specialty Doctor	Director of Nursing
Gardener/Groundsperson	Specialist Healthcare Scientist	Specialty Registrar	Midwife
Housekeeper		Staff Grade	Midwife - Manager
Maintenance Craftsperson		Trust Grade Doctor - Foundation Level	Midwife - Specialist Practitioner
Porter		Trust Grade Doctor - Specialty Registrar	Modern Matron
Supervisor			Nurse Consultant
Support Worker			Nurse Manager
Technician			Sister/Charge Nurse
Telephonist			Specialist Nurse Practitioner
			Staff Nurse

Safe - SPC Charts

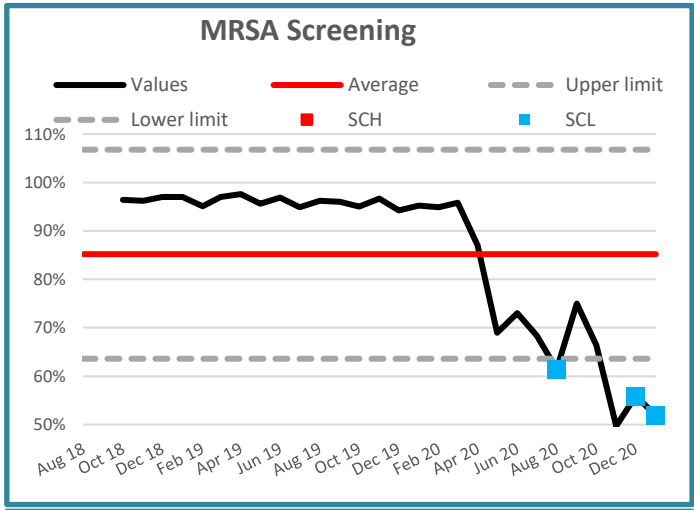


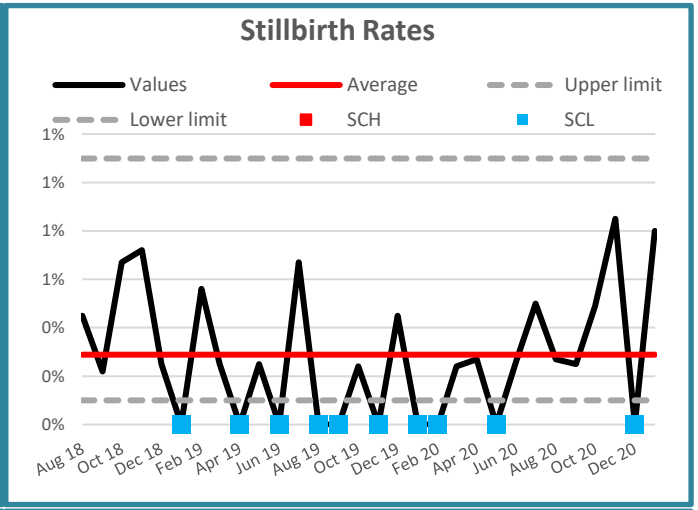
Caring - SPC Charts

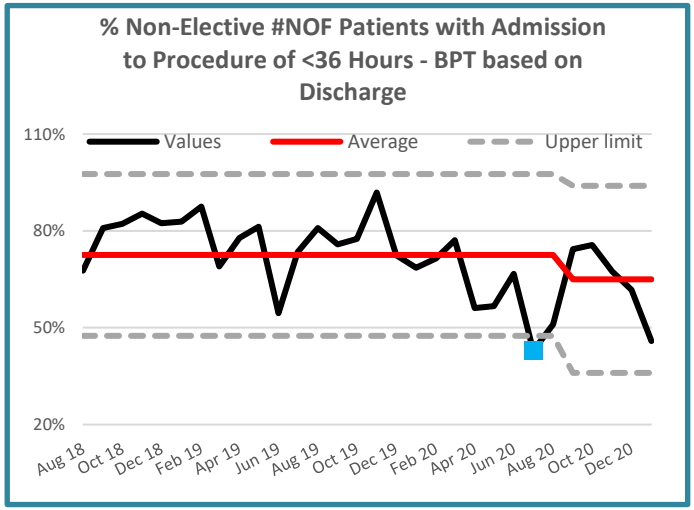


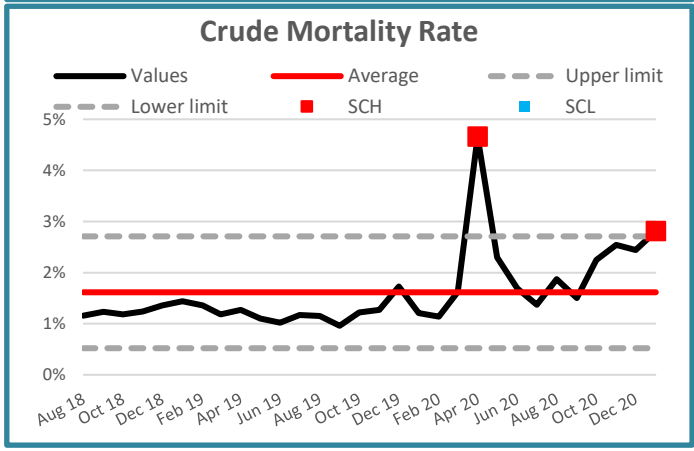


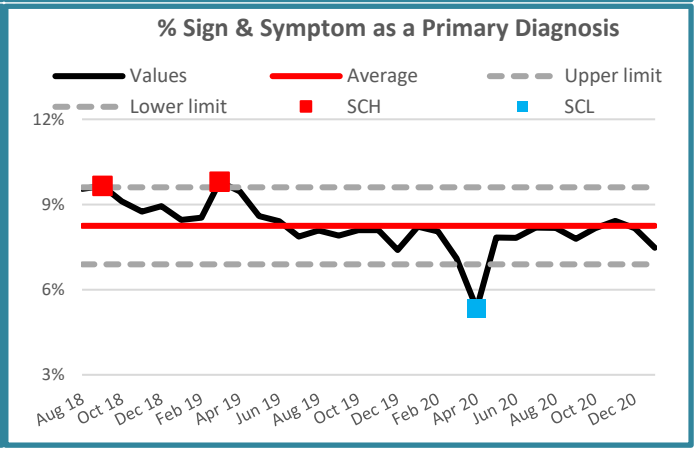
Effective - SPC Charts

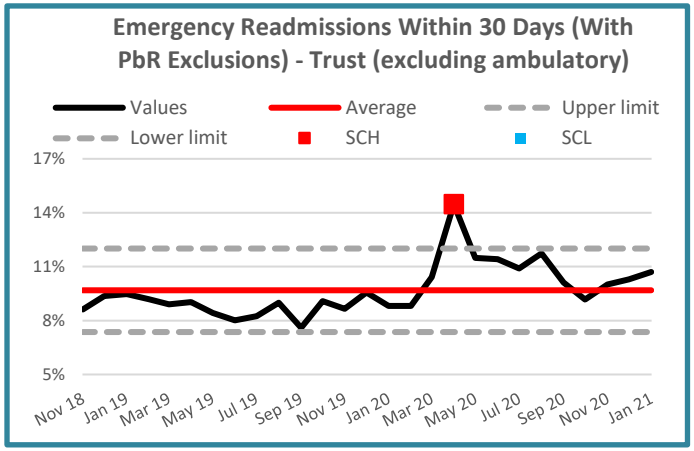




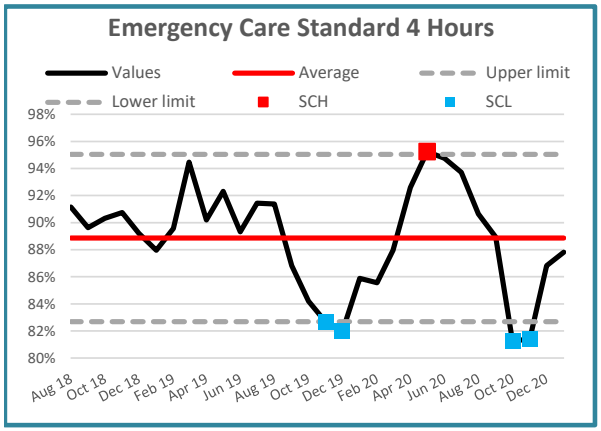


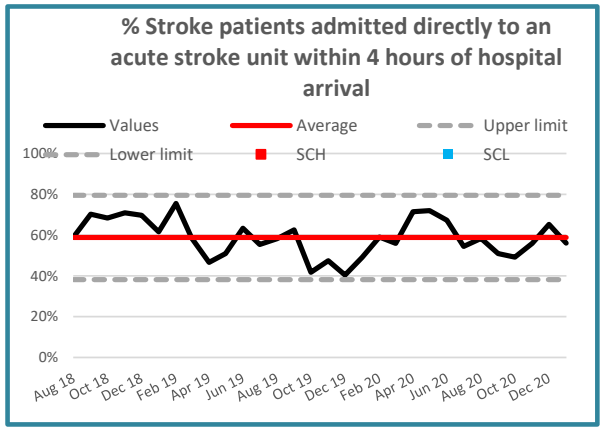


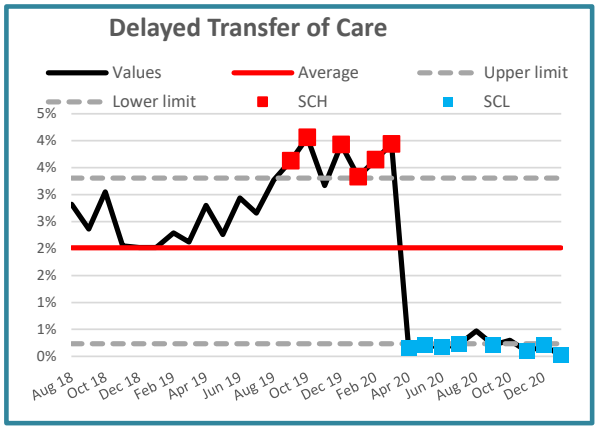


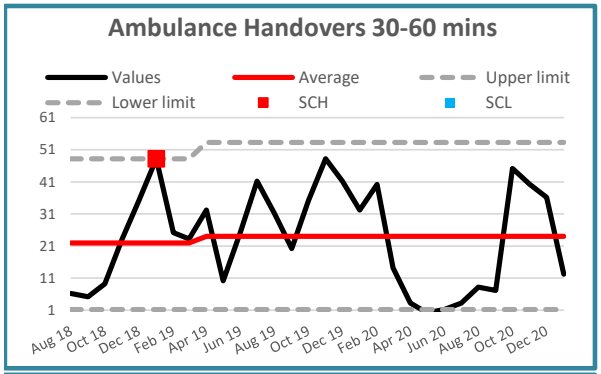


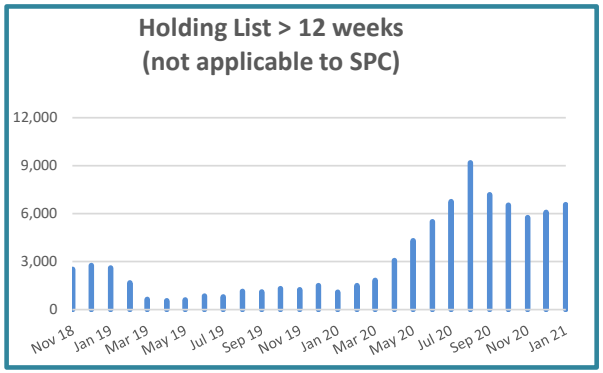
Responsive - SPC Charts

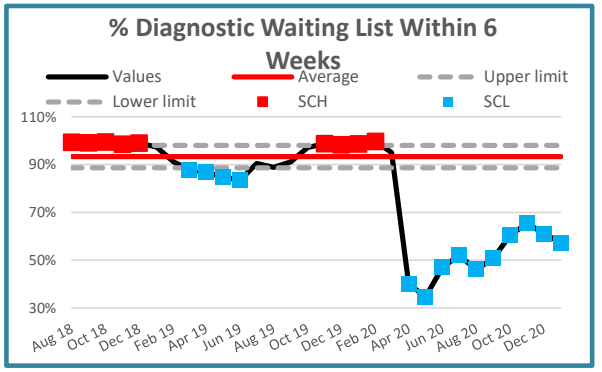


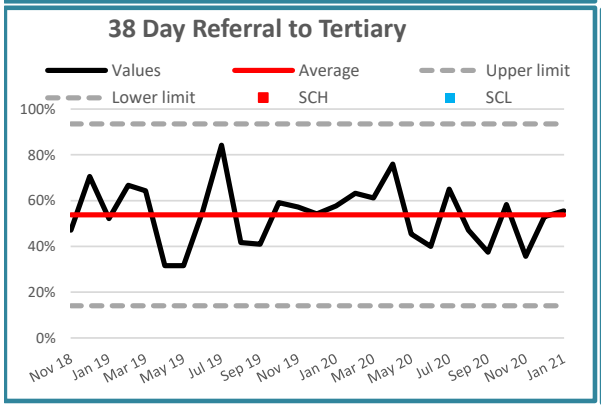


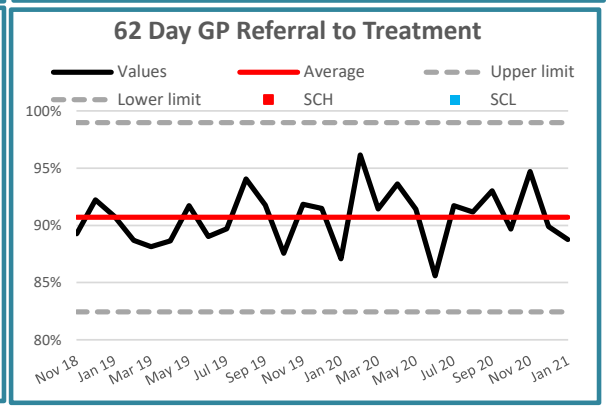












Methodology for calculating the performance score

The "key" targets are all measures included in NHS Improvement's Single Oversight Framework or measures on which the Trust is particularly focussing and are deemed more important.

Standard KPIs and "Key" targets

- Each RAG rating has a score - **red** 0 points; **amber** 2 points; **green** 4 points
- For "Key" targets, scores are weighted more heavily and are multiplied by a factor of 3 - **red** 0 points; **amber** 6 points; **green** 12 points

Calculating Domain Scores

- Add up the scores for each KPI per domain; divide by the maximum total score possible for that domain to get a percentage score.
- Apply the thresholds for the overall domain to get a RAG rating for each domain.
- Thresholds: < 50% is **red**, 50% to < 75% is **amber** and 75% and above is **green.**

Calculating Trust Performance Scores

- Calculate the overall performance score by adding up the scores for all domains; dividing by the maximum total score possible for all domains to get a percentage
- Apply the same thresholds as above to RAG rate the overall score

Glossary of acronyms and abbreviations

- **A&E** - Accident & Emergency
- **ADN** - Associate Director of Nursing
- **AED** - Accident & Emergency Department
- **ASI** - Appointment Slot Issue
- **ASU** - Acute Stroke Unit
- **BPT** - Best Practice Tariff
- **CCG** - Clinical Commissioning Group
- **CCU** - Critical Care Unit
- **CD** - Clinical Director
- **CDiff** - Clostridium Difficile
- **CDS** - Commissioning Data Set
- **CDU** - Clinical Decision Unit
- **CEPOD** - National Confidential Enquiry into Patient Outcome and Death
- **CHPPD** - Care hours per patient day
- **CIP** - Cost Improvement Programme
- **CQC** - Care Quality Commission
- **CQUIN** - Commissioning for Quality and Innovation
- **CRH** - Calderdale Royal Hospital
- **CT** – Computerised tomography
- **DH** - Department of Health
- **DNA** - did not attend
- **DSU** - Decision Support Unit
- **DTOC** - Delayed Transfer of Care
- **EBITDA** - Earnings before interest, tax, depreciation and amortisation
- **ECS** - Emergency Care Standard
- **EEA** - European Economic Area
- **EPR** - Electronic Patient Record
- **ESR** - Electronic Staff Record
- **FFT** - Friends and Family Test
- **FSRR** - Financial Sustainability Risk Rating
- **FSS** - Families and Specialist Services
- **GM** - General Manager
- **GP** - General Practitioner
- **GH** - Greater Huddersfield
- **HAI** - Hospital Acquired Infection
- **HCA** - Healthcare Assistant
- **HDU** - High Dependency Unit
- **HOM** - Head of Maternity
- **HRG** - Healthcare Resource Group
- **HR** - Human Resources
- **HRI** - Huddersfield Royal Infirmary
- **HSMR** - Hospital Standardised Mortality Rate
- **I&E** - Income and Expenditure
- **ICU** - Intensive care unit
- **IT** - Information Technology
- **KPI** - Key Performance Indicator
- **LOS** - Length of Stay
- **LTC** - Long Term Condition
- **MAU** - medical admission unit
- **MRI** - Magnetic resonance imaging
- **MRSA** - Methicillin-Resistant Staphylococcus Aureus
- **MSK** - Musculo-Skeletal
- **MSSA** - Methicillin Susceptible Staphylococcus Aureus
- **NHSE** - NHS England
- **NHSI** - NHS Improvement
- **NICU** - Neonatal Intensive Care Unit
- **NoF** - Neck of Femur
- **OD** - Organisational Development
- **PAS** - Patient Administration System
- **PbR** - Payment by Results
- **PHE** - Public Health England
- **PHSO** - Parliamentary and Health Service Ombudsman
- **PPH** - Postpartum Haemorrhage
- **PRM** - Performance Review Meeting
- **PTL** - Patient Tracking List
- **PU** – Pressure Ulcer
- **QIPP** - Quality, Innovation, Productivity and Prevention
- **RAG** - Red Amber Green
- **RCA** - Root Cause Analysis
- **RN** - Registered Nurse
- **RTT** - Referral to Treatment
- **SACT** - Systemic Anti-Cancer Treatment
- **SAU** - Surgical Admission Unit
- **SH** - Safety Huddle
- **SHMI** - Summary Hospital-level Mortality Indicator
- **SI** - Serious Incident
- **SITREPs** - Situation reports
- **SSNAP** - Sentinel Stroke National Audit Programme
- **SOP** - Standard Operating Protocol
- **SRG** - Systems Resilience Group
- **SUS** - Secondary Uses Service
- **UCLAN** - University of Central Lancashire
- **UTI** - Urinary Tract Infection
- **UoR** – Use of Resources
- **Var** - Variance
- **VTE** - Venous Thromboembolism
- **WLI** - Waiting List Initiative
- **WTE** - Whole Time Equivalent
- **YAS** - Yorkshire Ambulance Service

25. Governance Report

a) Board of Directors Declarations of Interest

b) Fit and Proper Person Self-Declaration Register

c) Board of Directors Terms of Reference

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title of report:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsor:	Owen Williams, Chief Executive
Previous Forums:	None

Purpose of the Report

This paper presents the following governance items to the Board:

a) the formal and updated declaration of interests of members of the Board of Directors via the Declarations of Interest Register which the Trust is required to maintain and the Board is requested to note

b) the compliance position for the Fit and Proper Persons Regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 following an annual update which the Board is requested to note.

The above items are presented to the Board in line with the Trust Constitution, Standing Orders (section 5.2 Register of Interests and 5.3 Fit and Proper Persons Regulations) and the Code of Governance**.**

c) the annual review of the terms of reference of the Board of Directors which describes the role and work of the Board of Directors for approval.

Key Points to Note

a) Board of Directors Declarations of Interest Register

The Board of Directors is committed to openness and transparency in its work and decision-making.

Schedule 7 of the National Health Service Act 2006 and Section 32 of the Trust's Constitution requires all Board directors (including Non-Executive Directors) and any other officers nominated by the Trust to declare interests which are relevant and material to the Board of Directors of which they are a member. A register of these interests must be kept by the Trust.

In addition the Trust has in place a Conflicts of Interest and Standards of Business Conduct Policy which notes the duty to ensure that dealings are conducted to the highest standards of integrity and helps staff and Non-Executive Directors manage conflicts of interest effectively.

On an annual basis the interests of members of decision-makers in the Trust, including the Board members are required to be updated.

The Board of Directors Declarations of Interests Register as at 18 February 2021 is attached at Appendix R1. The Board declarations of interest register is available to the public on the Trust website at the following address: https://www.cht.nhs.uk/publications/

Any changes in interests must be made using the online declarations system as soon as is practicable and notified to the Company Secretary. Changes in interests shall be officially declared at the next Trust Board meeting following the change occurring and be recorded in the minutes.

RECOMMENDATION: The Board is asked to **NOTE** the Board of Directors Declarations of Interests Register as at 18 February 2021.

b) Fit and Proper Person Self-Declaration Register

The fit and proper persons regulation (FPRR) requirements came into effect for all NHS Trusts and Foundation Trusts in November 2014 to ensure greater regulation of NHS Board level Directors. Regulation 5 of the Health and Social Care Act 2008 provides for the CQC to monitor and assess how well Trusts discharge their responsibility to comply with the fit and proper persons requirements for Directors.

The regulation requires NHS Trusts to seek the necessary assurance that all Executive and Non-Executive Directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role. The CQC holds Trusts to account in relation to FPPR through their well-led domain assessments and inspections.

The Board of Directors Fit and Proper Person Self-Declaration Register as at 19 February 2021 is attached at Appendix R2. The following groups of staff are required to complete a Fit and Proper Persons declaration annually:

- Executive Directors (including the Chief Executive)
- Directors
- Non-Executive Directors (including the Chair)
- Deputy Directors (Finance, Medical, Nursing, Operations and Workforce and organisational Development)
- Company Secretary

RECOMMENDATION: The Board is asked to **NOTE** the Fit and Proper Persons Self-Declaration Register and that all current Directors satisfy the Fit and Proper Persons Requirements

c) Board of Directors Terms of Reference

The Board of Directors terms of reference are attached at Appendix R3 which describe the role and work of the Board. An annual review of the terms of reference has taken place. Reference has been added in section 8 to the format of Board meetings noting these may take place virtually. No other material changes are required; however, minor amendments to formatting have been made and these are highlighted in red.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors Terms of Reference.

EQIA – Equality Impact Assessment

An Equality Impact Assessment has been completed on the Conflicts of Interest and Standards of Business Conduct policy to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

The content of this report does not adversely affect people with protected characteristics.

Recommendation

The Board is asked to **NOTE** the following:

- Board of Directors Declarations of Interest Register
- Fit and Proper Persons Self-Declaration Register

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

- Board of Directors Terms of Reference

DECLARATION OF INTERESTS – BOARD OF DIRECTORS
AS AT 16 FEBRUARY 2021

Calderdale and Huddersfield NHS Foundation Trust

Date of Declar-ation	Name	Designation	Directorships, including Non-Executive Directorships held in private companies or public limited companies.	Ownership/ Part Ownership of private companies and businesses	Controlling Share holding	A position of authority in a charity or voluntary organisation in the field of health and social care including membership of Partnership Meetings	Any connection with a voluntary or other organisation contracting for NHS services	Other Employment (paid or non-paid) with a third party
EXECUTIVE DIRECTORS								
09.02.21	Owen Williams	Chief Executive	Nil	Nil	Nil	Member of West Yorkshire Association of Acute Trusts – Committee in Common Chair of the West Yorkshire and Harrogate Capital & Estates Board Co-Chair of the West Yorkshire & Harrogate Flu Board Chair of the National Health Inequalities Expert Advisory Group	Chair of the Local School Committee for Beckfoot Thornton School, Leaventhorpe Lane, Bradford, BD13 3BH	Nil
16.02.21	Dr David Birkenhead	Executive Medical Director	Benson Medical Services	Nil	Nil	Vice-Chair of the WYAAT Pathology Network. Member of the WYAAT Medical Directors Group.		

						Chair of the WYAAT LIMS Procurement Group.		
12.02.21	Ellen Armistead	Director of Nursing	Nil	Nil	Nil	Member of WYATT Chief Nurse group	Nil	Nil
06.02.21	Helen Barker	Chief Operating Officer	Nil	Company Secretary to husband's lighting business which has previously sold to the NHS. No sales to CHFT and not NHS sales in last 36 months. Expert Lighting Direct Ltd.	Nil		Company Secretary of husband's business.	Nil
04.02.21	Gary Boothby	Executive Director of Finance	Director of Pennine Property Partnerships	Nil	Nil	Member of the West Yorkshire Association of Acute Trusts Finance Group Member of Integrated Care System Directors of Finance Forum Member of the Partnership Transformation Board	Nil	Nil
10.02.21	Suzanne Dunkley	Executive Director of Workforce & OD	Nil	Nil	Nil	Nil	Nil	Nil
CHAIR AND NON-EXECUTIVE DIRECTORS								
04.02.21	Philip Lewer	Chair	Nil	Nil	Nil	Member of: West Yorkshire	Nil	Nil

						Association of Acute Trusts (WYAAT) – Committee in Common West Yorkshire NHS Chairs meeting Partnership Transformation Board		
02.02.21	Richard Hopkin	Non-Executive Director	Capri Finance Ltd – own consultancy company.	Nil	Nil	Treasurer (Hon) Community Foundation for Calderdale Finance Director Age UK Wakefield and District		Other project work through consultancy company Capri Finance Limited for the Onside Foundation
10.02.21	Karen Heaton	Non-Executive Director	Nil	Nil	Nil	Nil	University of Manchester – Director of Human Resources Member of Confederation of British Industry (Employment & Skills Board) From 09/19	Nil
08.02.21	Andy Nelson	Non-Executive Director	Non-Executive Director & Strategic Advisor to the Board of The Law Society	Nil	Nil	Nil	Nil	
09.02.21	Peter Wilkinson	Non-Executive Director	Leeds Grand Theatre and Opera House Ltd – independent member of the Board and Trustee. A company limited by guarantee and a registered charity. Non-Executive Director Decipher Consulting UK Ltd. Consultancy business based in Manchester/Macclesfield	PW Advisory Ltd – own consultancy company based in Holmfirth	Nil	Nil	Nil	Nil

15.02.21	Denise Sterling	Non-Executive Director	Nil	Nil	Nil	Nil	Nil	Non paid Trustee, Board of Bradford Diocesan Academies Trust
09.02.21	Alastair Graham	Non-Executive Director	Director and Chair of Calderdale and Huddersfield Solutions Limited	Nil	Nil	Nil	Nil	Nil
ATTENDEES AT BOARD OF DIRECTORS								
16.2.21	Anna Basford	Director of Transformation & Partnerships	Nil	Nil	Nil	Member of WYAAT Directors of Strategy and Chief Operating Officers Group Member of Calderdale Health and Wellbeing Board Member of Calderdale and Huddersfield Partnership Transformation Board	Nil	Nil
12.02.21	Mandy Griffin	Managing Director – Digital Health	Nil	Nil	Nil	Nil	Nil	Nil
23.11.20	Stuart Sugarman	Managing Director – CHS	Nil	Nil	Nil	Nil	Nil	Nil

All the above Board of Directors have confirmed that they continue to comply with the Fit and Proper Person Requirement.

FIT AND PROPER PERSON SELF-DECLARATION REGISTER FEBRUARY 2021

Calderdale and Huddersfield NHS Foundation Trust

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK / RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORSR EGISTER
EXECUTIVE DIRECTORS										
06.02.21	**ARMISTEAD**	Ellen	Executive Director of Nursing/ Deputy CEO	RGN PIN 83G1353E	June 2019	14.10.20	Owen Williams	01.07.19	Clean 10.02.21	Clean 10.02.21
02.02.21	**BARKER**	Helen	Chief Operating Officer	-	13.01.16	23.10.20	Owen Williams	01.01.16	Clean 10.02.21	Clean 10.02.21
02.02.21	**BIRKENHEAD (Dr)**	David	Executive Medical Director	GMC 3280122	29.01.18	16.10.20	Owen Williams	01.12.99	Clean 10.02.21	Clean 10.02.21
04.02.21	**BOOTHBY**	Gary	Executive Director of Finance	Assoc CMA 8659790 CIPFA 41612-CIP	December 2020	02.10.20	Owen Williams	07.03.16	Clean 10.02.21	Clean 10.02.21
10.02.21	**DUNKLEY**	Suzanne	Executive Director of Workforce & OD	FCIP 31049644	December 2020	15.10.20	Owen Williams	01.02.18	Clean 10.02.21	Clean 10.02.21
11.02.21	**WILLIAMS**	Owen	Chief Executive	-	08.07.16	12.02.20	Philip Lewer	14.05.12	Clean 10.02.21	Clean 10.02.21
DIRECTORS & COMPANY SECRETARY										
04.02.21	**BASFORD**	Anna	Director of Transformation & Partnerships	-	28.06.16	09.10.20	Owen Williams	15.7.13	Clean 10.02.21	Clean 10.02.21
12.02.21	**GRIFFIN**	Mandy	Managing Director – Digital Health	-	09.06.20	05.10.20	Owen Williams	19.01.09	Clean 10.02.21	Clean 10.02.21

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
03.02.21	**SUGARMAN**	Stuart	Managing Director - CHS	Solicitor and member of the Law Society	September 2020	June 2020	Alastair Graham	30.09.19	Clean 10.02.21	Clean 10.02.21
04.02.21	**MCCOURT**	Andrea	Company Secretary	-	April 2015	11.09.20	Owen Williams	18.05.15	Clean 10.02.21	Clean 10.02.21
NON-EXECUTIVE DIRECTORS										
02.02.21	**GRAHAM**	Alastair	Non- Executive Director	N/A	December 2017	02.06.20	Philip Lewer	01.12.17	Clean 10.02.21	Clean 10.02.21
10.02.21	**HEATON**	Karen	Non- Executive Director	Member of the Chartered Institute of Personnel and Development (10344496)	12.05.2016	June 2020	Philip Lewer	01.03.16	Clean 10.02.21	Clean 10.02.21
04.02.21	**HOPKIN**	Richard	Non- Executive Director	FCA (membership number 7311370)	14.12.17	08.06.20	Philip Lewer	01.03.16	Clean 10.02.21	Clean 10.02.21
02.02.21	**LEWER**	Philip	Chair	-	April 2018	July 2020	Board / Council of Governors	01.04.18	Clean 10.02.21	Clean 10.02.21
10.02.21	**NELSON**	Andy	Non- Executive Director	-	09.10.17	16.06.20	Philip Lewer	01.10.17	Clean 10.02.21	Clean 10.02.21
10.02.21	**STERLING**	Denise	Non- Executive Director	Health and Care Professionals Council OT10114	October 2019	Objectives agreed for 2020	Philip Lewer	01.01.20	Clean 10.02.21	Clean 10.02.21
08.02.21	**WILKINSON**	Russell Peter	Non- Executive Director	Member of the Royal Institution of Chartered Surveyors (MRICS) Ref No 0085230	September 2019	Objectives agreed for 2020	Philip Lewer	01.01.20	Clean 10.02.21	Clean 10.02.21

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
DEPUTY DIRECTORS										
11.02.21	**ARCHER**	Kirsty	Deputy Director of Finance	Chartered Management Accountant, ACMA (CIMA)	May 2018	07.05.20	Gary Boothby	01.08.08	Clean 10.02.21	Clean 10.02.21
23.02.21	**WALKER**	Bev	Deputy Chief Operating Officer / Lead for the SAFER Transformation Programme	Registered General Nurse 83E0282E	DBS being undertaken currently	21.07.20	Helen Barker	08.11.88	Clean 10.02.21	Clean 10.02.21
11.02.21	**EDDLESTON**	Jason	Deputy Director of Workforce and OD	MCIPD 10327459	Post does not fall within the legal provisions that govern the processing of a DBS standard or enhanced check.	29.07.20	Suzanne Dunkley	08.02.1999	Clean 10.02.21	Clean 10.02.21
04.02.21	**PARKER**	Cornelle	Deputy Medical Director	GMC 3286582	May 2017	04.02.20	Dr Rajprasad Karadi	08.05.17	Clean 10.02.21	Clean 10.02.21
11.02.21	**RUDGE**	Lindsay	Deputy Chief Nurse	RGN 90E0076E	21 June 2019	13.10.20	Ellen Armistead	12.07.93	Clean 10.02.21	Clean 10.02.21

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTITUTION

In accordance with its Constitution, the Trust has a Board of Directors, which comprises both Executive Directors, one of whom is the Chief Executive and Non-Executive Directors, one of whom is the Chair.

As set out in Annex 8 of the Constitution, the Trust has Standing Orders for the Board of Directors which describe the practice and procedures for the business of the Trust. Those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, information for the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees.

2. PURPOSE

The principal purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the Council of Governors and some decisions of the Board of Directors require the approval of the Council of Governors.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients, service users, and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision, strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

4.3. Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:

- Sets, maintains and oversees the implementation of the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Monitors and reviews management performance to ensure the Trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

4.5. Culture

The Board:

- Is responsible for setting values, ensuring they are widely communicated and

that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction;
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation Trust business;
- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:

- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS England/ NHS Improvement from time to time) and appropriate codes of conduct, accountability and openness applicable to foundation Trusts;
- Ensures that the Trust operates in accordance with its Constitution;
- Ensures that all elements of the Trust's licence relating to the Trust's governance arrangements are complied with;
- Ensures the the Trust protects the health and safety of Trust employees and all others to whom it has a duty of care;
- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- Review and approve the Trust's Annual Report and Accounts, including the Quality Report;
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences;
- Ensures that all required returns and disclosures are made to the regulators and complies with all relevant regulatory, legal and code of conduct requirements, including Care Quality Commission fundamental standards for all regulated activities;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation Trust business;
- Agrees the schedule of matters reserved for decision by the Board of Directors;
- Ensures that the statutory duties of the Trust are effectively discharged;
- Acts as a corporate trustee for the Trust's charitable funds.

4.7. Risk management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services;
- Ensures there are appropriately constituted appointment arrangements for

senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining committees of the Board of Directors with delegated powers as prescribed by the Trust's standing orders and/or by the Board of Directors from time to time:

4.9. Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its Governors, members, staff and the local community;
- Meets its engagement obligations in respect of the Council of Governors and members and ensures that governors are equipped with the skills and knowledge they need to undertake their role;
- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly, primarily via the Trust's website;
- Publishes an annual report and annual accounts.

4.10. Finance

The Board:

- Ensures that the Trust operates effectively, efficiently, economically;
- Agrees the Trust's financial objectives and approve the financial plan;
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensures that the Trust achieves the targets and requirements of stakeholders within the available resources;
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and Council of Governors and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Council of Governors.

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chair and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors.

7. ACCOUNTABILITY TO THE COUNCIL OF GOVERNORS'

The Non-Executive Directors are accountable to the Council of Governors' for the performance of the Board of Directors. To execute this accountability effectively, the Non-Executive Directors will need the support of their Executive Director colleagues. A well-functioning accountability relationship will require the Non-Executive Directors to provide Governors with a range of information on how the Board has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the Trust. The Non-Executive Directors will need to encourage questioning and be open to challenge as part of this relationship. The Non-Executives also should ensure that the Board as a whole allows Council of Governors' time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS AND PROCEDURES

The Board of Directors will meet at least six times a calendar year in public on dates agreed with the Chair. Dates of forthcoming meetings held in public shall be posted on the Trust's website. Board meetings may be conducted virtually and, where this is the case, a recording of the Board meeting will be made available on the Trust website as soon as is practically possible after the meeting.

Agendas and papers for forthcoming meetings of the Board to be held in public, and minutes of previous meetings held in public, shall be posted on the Trust's website.

Additional meetings of the Board may be held in private for consideration of confidential business.

Further details on the practice and procedure of the Board of Directors can be found in Annex 8 of the Constitution.

9. QUORUM

Seven directors including not less than three executives, and not less than three Non-Executive Directors shall form a quorum.

If an Executive Director is unable to attend a meeting of the Board, an alternative may be appointed to attend that meeting or part of it, if so requested by the Chair. Any such alternative shall not be counted as part of the required quorum unless they have been formally been appointed by the Board as an Acting Director.

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the Company Secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the Council of Governors and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the Chair and Chief Executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

The Board will review its effectiveness in the following ways:

Review of attendance records
Annual reports from Board Committees
Board of Director Development Sessions
Outputs from any Well-Led Governance Reviews

Date drafted: 25 February 2020

Date approved: 5 March 2020

Review Date: February 2021

26. Annual / Bi-Annual Reports:

a) Public Sector Equality Duty (PSED) Annual Report

To Approve

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 4 March 2021
Meeting:	Public Board of Directors
Title:	Public Sector Equality Duty Annual Report – January to December 2020
Author:	Andrea McCourt, Company Secretary Nikki Hosty, Freedom to Speak Up/Equality, Diversity & Inclusion Manager Rachel White, Assistant Director of Patient Experience
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce & OD
Previous Forums:	Previous Annual Report - Board of Directors, 5 March 2020

Purpose of the Report

To present the annual report as required by the Public Sector Equality Duty. The annual report highlights the activities CHFT have been working on to address the needs of patients and colleagues who fall under the nine protected characteristics as outlined in the Equality Act 2010.

Key Points to Note

The Public Sector Equality Duty Report aims to eliminate discrimination, advance equality of opportunity and foster good relations between people. The duty applies to the public sector, including the NHS and also to others carrying out public functions.

Whilst planned patient and workforce equality and diversity activity for 2020 was impacted by the global COVID 19 pandemic, opportunities arose for CHFT to identify any health inequalities that may impact on our patients and also improved the breadth of our engagement and communication with colleagues.

Actions for 2021 are identified in section 5 of the report.

The launch of CHFT's Empower programme and CHFTs Health and Wellbeing Strategy helped to accelerate the aims and ambitions in the Inclusion Strategy, launched in 2020.

EQIA – Equality Impact Assessment

All equality groups have been consulted on the Equality, Diversity and Inclusion approach we are taking in the Trust. Many colleagues have been involved in the activities delivered for patients and colleagues. We are raising awareness of difference, integrating difference and identifying barriers and removing them for patients and colleagues.

Recommendation

The Board is asked to approve the Public Sector Equality Duty Annual Report for 2020.

Calderdale and Huddersfield
NHS Foundation Trust

Public Sector Equality Duty
Annual Report
January to December 2020

CONTENTS

1 Introduction

2020 saw the greatest challenge that the NHS has ever faced. CHFT's response to the global Covid-19 pandemic focused on the safety of our patients, colleagues and the communities that we serve.

Covid-19s disproportionate impact on some protected characteristics also accelerated our understanding of, and ambition to address, health inequalities. CHFT has therefore used the challenges and opportunities that Covid-19 has brought, to re-emphasise the importance of equality, diversity and inclusion both for our patients, and colleagues.

By adopting differing ways of working, capitalising on digital mechanisms and developing stronger partnerships, CHFT has worked hard to maintain connections with communities, further strengthening our relationships with our patients and their families and friends.

This equality report for the period January to December 2020 provides assurance to the Board that Calderdale and Huddersfield NHS Foundation Trust (CHFT) continues to meet its responsibilities under the Equality Act 2010 and in particular that it meets the requirements of the Public Sector Equality Duty.

The report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the general equality duty. The report also contains the Equality in our Workforce Report, at Appendix 1.

Our purpose is to provide outstanding Compassionate Care to the communities that we serve. We will do that by creating One culture of Care in our Workforce, ensuring that our values and behaviours (our 4 pillars) are embedded in everything we do.

Equality, diversity and inclusion activities and principles are fundamental to the Trust's work to improve the experience and health outcomes for everyone in its care.

This report highlights our approach and work to address any additional needs of those patients or colleagues who identify with a range of protected characteristics. Examples of what we have been doing at CHFT to address these needs are included in the report. The examples are, however, only a sample of the work going on overall to improve services for patients and colleagues from protected groups.

NHS Employers defines Equality, Diversity and Inclusion in the following way:
"Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Inclusion is about an individual's experience within the workplace and in wider society and the extent to which they feel valued and included."

By adopting this definition, we can be clear with both patients and colleagues about what we mean by equality, diversity and inclusion and therefore develop a shared understanding of what we are trying to achieve.

2 The Legal and Compliance Framework

2.1 Equality Act 2010

The Equality Act came into force from October 2010 providing a modern, single, legal framework with clear, streamlined law to more effectively tackle disadvantage and discrimination. On 5 April 2011, the public sector equality duty came into force. The equality duty was created under the Equality Act 2010.

The equality duty consists of a general equality duty, with three main aims (set out in section 149 of the Equality Act 2010) and specific duties for public sector organisations. The Equality Act requires public bodies like CHFT to publish relevant information to demonstrate their compliance with the duty.

The Act applies to service users and Trust employees who identify with the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy or maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The **general equality duty** means that the Trust must have due regard to the need to:

- Eliminate unfair discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups; and
- Foster good relationships between different groups

By:

- Removing or minimising disadvantages suffered by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The **specific duties** are legal requirements designed to help the Trust meet the general equality duty. These require the publication of:

- Annual information to demonstrate our compliance with the general equality duty published on our website by 30 March each year;

- Equality Objectives (which are specific and measurable) published for the first time by 5 April 2012, reviewed annually and re-published at least every four years.

2.2 Care Quality Commission Requirements

The Care Quality Commission (CQC) expects to find evidence that the Trust is actively promoting equality and human rights across all its services and functions. Equality and diversity considerations are specifically addressed as part of its key line of enquiry around a Trust's responsiveness to patient needs. The CQC asks "Are services planned and delivered to meet the needs of people?" and "Do services take account of needs of different people, including those in vulnerable circumstances?" The Trust was rated as 'Good' at the last inspection in April 2018. Due to the pandemic CQC have scaled back the inspection regime in order to concentrate on urgent inspections. The Trust's monitoring has been based on a schedule of engagement meetings and submission of evidence.

3 Our progress in 2020

3.1 Embedding equality, diversity and inclusion

Embedding equality, diversity and inclusion

For the period 2016 to 2020 we identified four priority outcomes (from the 18 outcomes against which we are required to assess and grade ourselves under the EDS2) as follows:

1.2 Individual people's health needs are assessed and met in appropriate and effective ways.

2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.

3.4 When at work, colleagues are free from abuse, harassment, bullying and violence from any source.

4.2 Papers that come before the Board and other major committees identify equality-related impacts including risks and say, how these risks are to be managed.

Some examples of what we have done in 2020 to achieve these outcomes are shown below (it should be noted that this is not an exhaustive list, and these are only examples of the work going on around the Trust).

Key actions and objectives for the year 2021 are identified in section 5 of the report.

To support Executive Directors in the Trust objective of ensuring that Board papers identify equality-related impacts a training session was delivered by the Equality, Diversity and Inclusion Manager.

Using technology to narrow accessibility gaps

During the Covid-19 pandemic the Trust committed to exploring other ways by which patients and relatives could be connected. This led to the formation of the Relatives' Line where a designated relative can contact a dedicated team to provide them with up to date information about the patient's condition. This was twofold – it allowed frontline staff time to care for patients and shielding staff to continue to be part of the workforce. The service has proved to be a great success with positive feedback from relatives who receive information from qualified nurses in a calm and relaxed environment. Alongside this virtual in hospital visiting was also set up which allows face to face calls predominantly for our elderly patients who do not have the ability to be able to instigate such a call using a device of their own.

The Virtual In Hospital Visiting Service has been used for the facilitation of end of life calls using a hand held device to connect members of their family who are unable to visit the hospital either due the current visiting restrictions and associated risk assessments.

Disability

Physical
The need for upgrade of the public toilets in the main entrance on the HRI site was identified in 2019. During 2020 a suitable location at Huddersfield Royal Infirmary was identified for a Changing Places toilet. A detailed bid has been prepared for government funding to support this development. The trust seized 'Go See' opportunities as trust learning approaching other trusts who have already been successful with a bid and implementation.

Dementia care
The Trust has for many years supported and promoted the nationally recognised Butterfly scheme for patients living with dementia. The scheme continues to be promoted alongside ''Johns Campaign' and 'Herbert Protocol'.

During 2020 our engagement support workers continued to provide diversional and therapeutic care for our dementia patients on an individual basis adapting the activities in line with restrictions. The enhanced care and support team have also continued to provide increased 1:1 care for our most vulnerable patients during the acute period of their care and supported patients who were unable to see their families during the Covid restrictions but supported with arranging virtual visits and contacted family members to obtain information to further enhance personalised patient centred care for the individual patient by completion of the see who I am care plan.

Unfortunately, the memory café that had proved such a success in the previous year was closed and the reopened for a short period with themed events on a smaller scale. The memory café is awaiting relocation with plans to extend the service from one to three sessions a week.

Colleagues in the Prevention of Delirium team introduced pocket-sized selfies based on Kate Granger's "Hello my Name Is" initiative. Wearing masks, goggles and or

face shields has made it difficult, so the card is aimed at supporting communications and keeping care personalised.

The successful appointment of a Lead practitioner for Dementia to start early Spring will help promote and embed the local and national improvements identified in the CHFT Dementia Strategy.

The Quest for Quality team in the Community Division are along with colleagues from the Mental Health Trust implementing the CLEAR dementia programme into Care homes across Calderdale. The CLEAR Dementia Care model is designed as a quicker method of assessing and understanding behaviour in dementia, equipping care home staff to respond more effectively. The main premise of the model is that behaviour staff find challenging is the result of unmet need experienced by the person with dementia. The person-centered assessment includes cognition, life story and personality, emotional and physical wellbeing, activity and the environment, and relationships.

Hearing and Visual Impairment

The Trust has worked with the British Sign Language (BSL) interpreting service to set up a suitable platform to enable video consultations during the pandemic. Appointments requiring BSL are taking place using MS Teams and feedback to date is indicating this service is being well received

Following some patient feedback via the Disability Partnership, Calderdale, the Trust has commenced a quality improvement project, working with service users and carers to improve the experience of patients with a visual impairment.

The Audieband system currently used for COVID information at the entrances to the main hospitals and Acre Mill is fully programmable to enable any range of information and messages to be broadcasted to the public as they enter the premises

Covid–19 Response easy read leaflets and information promoting the availability of British Sign Language and signposting to approved national websites are available on the trust website.

Audiology- During the Covid–19 response patients became unable to contact service to order batteries for hearing aids as drop in repair sessions were stood down. An online order form was implemented to allow patients to order which has been positively received by both staff and patients.

Mental Health

All patients that attend Emergency Department (ED) with mental health issues are seen by the Rapid Assessment Interface and Discharge (RAID) team within 2 hours. If they have a prolonged wait within ED they are assessed every 2 hours thereafter to assess their needs. Mental Health patients who have had a prolonged wait have their episode of care reviewed by the ED matron using a proforma looking at care given during their time in the department

A formal assessment tool for high risk patients has been devised and is available on the Electronic patient record (EPR). This is predominantly for the use on the assessment areas for the assessment, initial management, and referral of high-risk patients thus supporting staff to ensure the psychological and emotional needs of patients are met and support robust and safe handover of care.

The Trust has an identified a clinical lead to undertake training with staff regarding safe care and management in the indentation and immediate care of high-risk patients.

The trust's mental health strategy and operations group provides a joint forum between the Trust and the mental health services via the mental health liaison team to facilitate partnership working and sharing of information to drive better practice. A detailed dashboard has been developed to support performance review against key performance indicators. In measuring itself against these key performance measures based on national standards the trust is able to understand how well they are looking after people with mental health needs.

Learning

In response to the pandemic the Trust has worked closely with South West Yorkshire Partnership Foundation Trust to ensure individuals with a learning disability are flagged on the Electronic Patient Record. In addition, people were offered a VIP hospital passport and further supporting information called a 'COVID grab sheet'.

A VIP Passport gives the hospital staff important information about individuals with learning disabilities. This record enables staff to give personalised care to people with reasonable adjustment needs. Over 800 hospital passports were uploaded on to individual's records and over 400 flags set during this time.

The Trust ensured easy read leaflets produced nationally on the Covid pandemic were readily available on both the Trust intranet and internet.

The Trust engaged in the NHS England and Improvement Learning Disability Improvement Standards data collection which took place from October 2020 to January 2021. A total of 100 patient surveys were distributed to adults with a learning disability who used the Trust services over a 12-month period, and 50 staff surveys were also completed. The Trust is waiting the final report due out in 2021.

The Trust has developed a learning disability dashboard on its KP+ electronic platform and can capture all adults known with a learning disability who are flagged on EPR, capturing patient demographics including deprivation of index score.

Currently the dashboard reports all Did not Attend (DNA) clinic appointments which is audited each month. The dashboard will be developed to record emergency department attendances, inpatient attendance, and new referrals to outpatients.

The Trust is working towards ensuring people with a learning disability are high priority on the health inequalities work it is undertaking, especially during the reset work post Covid.

The Treat me well Group unfortunately has not met face to face due to the pandemic. The group is looking forward to meeting again and being part of the transformation work the Trust is undertaking and ensuring the voice of people with a learning disability is listened to.

The Trust continues to remain committed to working with people with a learning disability, their family and carers to shape and redesign its services.

As part of Covid–19 restoration phase, service provision being restored in the trust. And we are looking at learning disability friendly theatre environments and focusing on the patients rather than the specialty they are under and ensuring that they are not delayed any longer than necessary regardless of priority status.

Age

Older

Advanced Care Planning - The Trust, in conjunction with the West Yorkshire and Harrogate Healthcare Partnership, has produced a video with which encourages people to have a conversation about end of life and putting plans in place. Arrangements have been put into place which has enabled bereavement support for relatives.

Frailty Same Day Emergency Care unit (SDEC) - The unit which has moved to a new location near ward 3 at Huddersfield Royal Infirmary provides a multi-disciplinary (MDT) response as soon as a patient presents there. Patients are triaged into the unit after being identified as frail and having the potential to be discharged home the same day with appropriate community support and follow up. It provides a quiet, calm environment where patients are seen by the MDT as soon as they arrive, and a comprehensive geriatric assessment starts. This assessment reviews the condition and their long-term medical conditions, social, mobility, mental health and activities of daily living at home.

Age

Younger

Specialist children & young people roles
A Lead Nurse for Children and Young People, with a portfolio for the Voice of the Child across the Trust has been appointed.

The Trust is looking to support the introduction of a Band 7 Transitional Care nurse post.

The Trust has commenced the process to fund a Registered children’s nurse to support the Paediatric congenital heart disease service.

The Trust has developed guidance for young people admitted with mental health needs including improved risk assessment /care plans. Daily professionals' meetings between CAMHS and the Children's ward to support the young person's pathway has been introduced

Covid-19 initiatives

A drive through clinic (previously clinic based) is in place to ensure that children & young people with diabetes continue to receive a high level of care and remain safe during the global pandemic.

A child friendly display (window of rainbows) on the Paediatric ward is in place to explain to children why staff need to wear masks, along with child friendly information booklets explaining what Covid-19 is about.

The Lead Nurse and the Play and Family Support team worked with NHS England & Improvement to support a virtual Halloween live streaming a short story and recording a film to promote the importance of 'play & distraction' in helping children to feel less anxious when attending hospital for treatment.

The service vision has been co created with children from the Youth Forum and nursing staff - Young Persons Charter.

Young Service Users have been involved with recruitment of key staff e.g. Paediatric Consultant posts.

Distraction packs have been developed for children and younger people who are isolated during their care and treatment.

Race

The Trust worked with The Big Word interpreting service to set up a suitable platform to enable video consultations during the pandemic.

The Trust is reviewing the access to surgery for the BAME population as some reports are showing an in balance of patients being listed for their operations. Early work involves consideration to language barriers, economic aspects and availability of technology when understanding further how this issue can be addressed.

The Trust is engaging with the Pakistani community to look at cancer information needs for newly diagnosed patients. This is being facilitated through NHS England Cancer Improvement Collaborative and will result in the provision of appropriate and timely information designed and deliver in partnership with the community. This work has formed a template for engaging with other BAME communities to support coproduction of other cancer services.

Work is ongoing with menu choices available in 4 main locally spoken languages.

The Trust has in place a Health Inequalities working group to look at a range of issues relating to the IMDs. Working in partnership with local authority the Trust has invested significant time into understanding how the BAME community have been impacted by Covid. The process of clinical prioritisation of those patients where treatment may have been delayed as a result of the pandemic response has been mapped across to all IMD groups. Work is ongoing to understand any differential between in relation to delays and IMD grouping.

Work has commenced to understand the Lived Experience of women and families using maternity services in relation to the BAME population.

The Trust continues to review the demand profile of its BAME population with specific focus on Emergency Department attendances.

Pregnancy/Maternity and Race

Continuity of Carer is a key component of Better Births with an aim of ensuring safe care based on a relationship of mutual trust and respect in line with the woman's decisions. Every woman should have a midwife, who is part of a small team of 4 to 6 midwives based in the community who know the women and family, and can provide continuity throughout the pregnancy, birth and postnatally. It enables the co-ordination of a woman's care, so that a named individual takes responsibility for ensuring all the needs of a woman and her baby are met, at the right time and in the right place. It enables the development of a relationship between the woman and the clinician who cares for her over time and for the specific and personal needs to be responded to without variation.

Within CHFT focus has been given to the implementation of this standard for BAME mothers given the known link between poor perinatal outcomes.

There is an expectation that 35% of women who are 29 weeks pregnant in March 2021 will be booked on to a continuity of carer (COC) pathway. At January 2021 22% of women were booked on to a COC pathway, with a forecast of 24% by the end of March. However, 40% of BAME women were booked onto a COC pathway. There is an expectation that 50% of women would be booked onto a COC pathway by March 2022 and 74% of women from a BAME background by 2024.

Religion/Belief

During 2020 the chaplaincy team have continued to support patients and staff through this difficult year. Providing pastoral support for families through appropriate telephone calls and virtual sessions as visiting was initially prohibited and remains restricted within tight parameters for their loved ones.

Virtual services of worship and prayer took place at Remembrance Day and a Christmas service was well received led by our Chaplain Sue Naughton. There are plans for further services in 2021 to reach a wider audience after its success.

The chaplaincy has also been working on an “End of Life Faith Card” which looks at the religious and cultural needs patients and their carers may have. The card will further enhance End of Life Care and was introduced across the Trust in early 2020.

Marriage and Civil Partnerships

The Trust is committed to delivering compassionate care through inclusion.
We recognise that our patients expect high quality compassionate care. Some may also have additional needs through having a characteristic which is protected under the Equality Act and some may need this consideration because it is the human compassionate thing to do. At times couples may find themselves in hospital at the same time with differing care needs. The Trust is committed to keeping couples together and strive to locate couples together on the same ward where possible.

Pregnancy/Maternity

During the pandemic the Trust worked with partners across local authorities and education to undertake a survey of women’s experiences through Covid and the findings from this survey influenced the development of information leaflets for women about what to expect during Covid.

The trust has provided online birth preparation classes and all other maternity services continued throughout pandemic with use of both virtual and face to face appointments.

In light of national guidance our visiting approach was impact assessed and revised arrangements put in place to support families during birth.

There are seven Better Birth workstreams, one of which is the continuity of carer workstream, which aims to support improving outcomes for all women and babies.

Trusts have the following national targets to achieve:

- 35% of pregnant women will be on a continuity of carer model by March 2021
- Most women (24%) will receive continuity of carer by 2021

It is well known that pregnant women from BAME communities have worse outcomes in pregnancy. Although the target is for 75% of women from BAME communities to receive continuity of carer by 2024, at CHFT work started during 2019 to plan and implement continuity of carer teams for BAME women. Currently this year the trust is predicted to be at 24% of all women and 40% of BAME women. CQC National Maternity Experience Survey action plan (results published Jan 2020) incorporating feedback from the Maternity Voices Partnership.

Maternity Covid-19 survey out in circulation and encouraging women's feedback of their experience of all aspects maternity care including infant feeding support during the pandemic. Results to be fed up nationally to Chief Midwifery Officer for England.

OPD Covid-19 survey results are being reviewed – impact of appointments / treatment being cancelled / postponed and views of video and telephone appointments.

Sex

The privacy and dignity of all our patients remains a priority for us. An existing mixed sex accommodation group policy is in place at trust which will undertake a refresh in 2021. During 2020 it was recognised that in some situations during Covid-19, mixing of the sexes may have been necessary due to the clinical needs of each individual patient i.e. needing critical care. The Trust considers mixing to be an exception and never the norm. In order to manage the privacy and dignity needs during times of extraordinary circumstance further specific processes were developed. Key measures that are currently in place are as follows:

- Standard Operating Procedures
- Monitoring and recording
- Understanding triggers
- Dignity screens

Gender Reassignment

Our group policy takes into account how we care for, and support service users who may be going through a transgender process. In 2019 work was commenced to train and support ward staff via ward managers how to care for our transgender communities, unfortunately this work was paused during 2020 in light of the Covid–19 response. The Trust intends to recommence this training programme at the earliest possible opportunity during 2021.

Sexual Orientation

Recognising the significant impact that Covid–19 has had on our communities and the vulnerabilities that younger people may experience at the point of realising their sexuality, the safeguarding team has undertaken training to raise awareness with staff around the importance of creating safe spaces and culture that enable people to discuss sexual safety and sexuality.

Commitment to Carers

The Equality Act will protect people who by association with someone who has a protected characteristic may be at risk of discrimination, e.g. protecting carers who are caring for a disabled child or relative. They will be protected by virtue of their association to that person.

Considered in the Trust as a 10th protected characteristic group, a Carers workstream has been established as part of the Trust's 'Experience, Participation and Equalities programme'. The objective is to deliver against corporate priorities and national policy with the ultimate aim of transforming carers experiences of care at the trust. Initial priorities include:

- Introducing processes for early recognition of carers
- Developing a charter to agree the role of recognised carers e.g. inclusion of the carer in the patient's journey and the provision of services such as free parking / discounted meals
- Exploring a means of recognising carers e.g.
- Go see work to identify good practice from other Trusts and Carer services

3.2 EDS (Equality Delivery System)

EDS is a framework that helps the Trust, in discussion with local partners including local people, review and improve performance for people with protected characteristics. During 2019 in collaboration with CCGs and other local partners an engaging, interactive and informative event discussing initiatives such as Project Search, Youth Forum, End of Life Care for different cultures and Learning Disability transition of care occurred. This approach was well received by our communities and the plan for 2020 was to repeat this successful engagement approach. However, in light of Covid–19 response this engagement activity will now happen late summer / early autumn 2021.

2020 saw the Trust working with NHS England and Improvement to refresh the framework and the reporting approach to be taken in the future.

3.3. Learning from Experiences & Personalised Care Planning

Observe and Act - Project work commenced in 2020 to introduce ‘Observe and Act’ within the trust. This ‘through the patient eyes’ observation / improvement tool is to be utilised virtually as part of the focussed support framework approach. This module will be predominately supported/ delivered by volunteers, governors, members and non-executive directors. One of the key elements of this module relates to observing how our patients and carers with accessibility, inclusion and diversity needs are cared for. Key findings at each observation then drives local improvement at ward level in the trust.

Making Complaints Count - Following an internal review and external audits an improvement collaborative has been convened. A key objective for the collaborative is to ensure the service is accessible to all. In order to inform this project work existing complaints data has been reviewed against ethnicity and health deprivation data. A service survey has been developed and internal work to strengthen our data capture system has been undertaken. By capturing very specific data in this way we are able to more fully understand the needs of our diverse communities.

Covid-19 Response & Winter Volunteering – Following public concerns raised and submission of a successful bid to NHS England and Improvement a project is now underway which is currently project led by redeployed staff . The aim of the project is to:

- step back up the front of house service,
- patient belonging drop off service,
- discharge / community support service,
- and job marketing support for the volunteers who are keen to be employed by the Trust.

A key aim as part of the subsequent recruitment drive is to target specific community groups in order ensure that our volunteers are more fully representative of the communities we serve and for the trust to support volunteers keen to utilise this as an opportunity to step into the NHS job market.

Learning from Survey Insights - CQC National Maternity Experience Survey action plan (results published Jan 2020) incorporating feedback from the Maternity Voices Partnership.

Maternity Covid-19 survey out in circulation encouraged women's feedback of their experience of all aspects maternity care including infant feeding support during the pandemic. Results of this local survey have been fed up nationally to the Chief Midwifery Officer for England.

The Outpatients Department Covid-19 survey revealed significant insight around the impact of appointments / treatment being cancelled / postponed and views of video and telephone appointments

Web App for FFT feedback is on trial on the Children's Ward.

A short survey was developed in order to monitor progress with National children and young people's action plan.

Personalised Care

2020 has seen the comprehensive introduction of Personalised Care and Support Planning across services supporting cancer patients. This takes into consideration what really matters to individuals and their families receiving care at Calderdale and Huddersfield NHS Foundation Trust. The Macmillan eHNA (electronic Holistic Needs Assessment) platform supports the development of focussed care plans, developed in partnership with the patient that set out responsibilities for health and social care staff as well as responsibilities for the patients. These care plans are shared across relevant health and social care platforms to support continuity of care.

Personalised Care and Support planning online training has been developed for staff to improve the quality of conversations and HNAs to focus on true personalised care. The training was developed for cancer teams but can be used more widely to support the Personalised Care and Support Planning.

Virtual Visiting and Relatives line was introduced very quickly into the trust in response to the Covid–19 pandemic. Significant positive feedback has been received in relation to both of these initiatives.

3.3 Engagement Activities

As a Foundation Trust, CHFT has a Council of Governors (CoG), which is actively engaged through divisional reference groups and corporate sub-groups with members and service users about quality improvement and service change.

During 2020 we have reviewed the make-up of the CoG focusing specifically on diversity. Going forward we are taking a number of steps to broaden the diversity of our CoG in the areas of youth, ethnicity, LGBTQ+ and disability.

The Trust has a large public membership which is compared with its local population to assess whether it is representative of the diverse communities that we serve. The data (see below) shows that we continue to have under representation in three sectors of our communities, namely younger people, males and those with an ethnic group of Asian/Asian British:

	Members	% of total members	Eligible membership*	% of eligible membership
Age (years)				
17-21	33	0.5%	51927	8.2%
22+	7594	99.5%	571194	90.2%
Ethnicity				
White	6503	85.3%	529668	83.3%
Mixed	160	2.1%	9659	1.5%
Asian or Asian British	709	9.3%	79829	12.6%
Black or Black British	216	2.8%	10162	1.6%
Other	39	0.5%	3935	0.6%
Gender				
Female	5003	65.6%	325492	51.4%
Male	2623	34.4%	307761	48.6%
Transgender	1	0.01%	Not available	Not available

* 2011 Census Data

Totals approximate as not all Trust members declare their age or ethnicity

These groups have been given special focus during recruitment activities in 2020, although activities have been hampered to an extent due to the Covid-19 pandemic restrictions.

The Trust continues to focus on efforts to engage with as wide a range of service users and stakeholders as possible. During 2020 we have made progress against the priorities in our Membership and Engagement strategy (despite the restrictions mentioned above). Specifically, we have:

- Identified specific areas within our communities that have a high BAME population and targeted organisations/groups within those areas to encourage membership;

- Promoted membership and the governor role at the University of Huddersfield via its Pakistani Student Society, its BAME staff network and its BAME Ambassador Scheme;

- Established links with a number of organisations which either have a high BAME membership, or existing links with BAME communities including:

    - The Ahmadiyya Muslim Community
    - Locala
    - Healthwatch

- Made initial enquiries about becoming involved in a project between Global Diversity Positive Action (GDPA) and the University of Huddersfield looking at health/economic outcomes. Global Diversity is a Huddersfield-based charity that supports socially excluded people to improve their lives through digital technology and community action. It was set up in 2014 to provide support, guidance, functional and employability skills for young people who were NEETs (not in education employment or training).

4 Strengthening Equality, Diversity and Inclusion – Workforce

4.1 Why Equality, Diversity and Inclusion was even more important to us in 2020

The period from March to December 2020 was significantly impacted by CHFTs response to Covid-19.

However, rather than pausing the activities identified in our Inclusion Strategy, CHFT took the opportunity to progress several high level activities that have improved our approach to Equality, Diversity and Inclusion.

The Trust's vision is to provide compassionate care to the populations of Calderdale and Kirklees. To do this we adopted 'One Culture of Care', focusing on caring for ourselves and each other so that we can offer outstanding care to our patients.

During 2020, 'One Culture of Care' became a crucial element in our response to Covid-19.

Our Covid Health and Wellbeing Strategy was launched as soon as the nation went into lockdown in March 2020. At its helm was a 'friendly ear' service, focused on mental health - which disproportionately affects BAME people and LGBTQ groups. In designing the Health and Wellbeing Strategy it was important to understand the different needs of our workforce and what compassionate care looked like to them. By understanding our colleagues' different needs, we were then able to adapt our wellbeing services to better suit them.

Our BAME colleagues played an important part in our communications during 2020. Not just as colleagues of CHFT, but as citizens of the communities they serve, our colleagues delivered important messages about the Covid vaccination programme and raising awareness of the symptoms of Covid-19.

4.2 The benefits of Equality, Diversity and Inclusion

We aim to create an inclusive culture where all employees feel engaged, valued and included. Leadership will be inclusive and compassionate in order that colleagues feel supported by their line managers. Greater accountability and engagement from senior managers in the equality, diversity and inclusion (EDI) agenda, taking ownership of the issues affecting different diverse groups of staff.

A diverse and inclusive work environment will help CHFT better understand and meet different patient expectations and improve their experience. As ~80% of our workforce live in the communities CHFT serves, harnessing the insight and views of our colleagues also enabled us to understand the needs of our communities. Moving forward, it will also help us to attract and retain a whole range of people from different walks of life, with different experiences.

This plan embraces our values and vision (our four pillars) , and explains what we are working towards, our goals, commitments and activities, as well as mechanisms and timescales for reporting our progress.

Our approach will be to 'seek to understand' and to 'stand in the shoes' of our colleagues to better understand their needs and differences.

Our Inclusion Strategy identifies 4 key aims:

- We will have a workforce that champions and celebrates our diverse communities. Our board and senior clinical and non clinical teams will be fully inclusive
- We will support current and future colleagues and enable them to make the most of their skills and talents
- We will engage a whole range of colleagues to create an inclusive culture where all staff feel engaged and valued
- We will engage and work with our partner organisations to share best practice, learn from one another, build relationships and work together for the benefit of colleagues and the communities we serve

4.3 Equality and Diversity Training

We will provide a high quality service for all of our patients and be an employer of choice in the local area.

We will fulfil our legal obligation under the Equality Act 2010 to provide services and employment in a manner that eliminates discrimination, advances equality and fosters good relationships between protected groups.

Our Equality, Diversity and Inclusion (ED&I) education approach aims to raise awareness of equality and inclusion via peer to peer communications and support.

Equality and diversity training is mandatory for all employees. Compliance rates are monitored by Executive Board as part of the Weekly Essential Safety Training paper.

Colleagues are required to repeat their equality and diversity training every three years and essential safety training compliance is closely monitored at a divisional level by HR Business Partner colleagues.

Our Leadership Development Programme, mandatory for all people managers but also open to all colleagues across CHFT has a focus on Inclusion. As the programme is online, colleagues will be able to learn at a time and in a way that suits them.

4.4 Equality, Diversity & Inclusion Activity

Our journey into Health Inequalities
Throughout 2020, the disparity of outcome for protected groups infected with Covid-19 was evident. Analysing patient data confirmed that BAME patients have longer waiting time for care, are less likely to Trust health organisations and suffer greater incidents of multiple deprivation (IMD). Men, and older patients also suffered poorer outcomes from Covid-19.

From a workforce point of view, initial queries were made into the health inequalities that may be suffered by our colleagues. This has offered CHFT the opportunity to become curious and interested in our workforce data.

An exercise carried out with our Executive team looked at the IMD standing of our Executives and Directors for the area in which they grew up, and the area in which they now lived.

A further exercise carried out into an identified Ward has also made us more curious about the health inequalities of our colleagues, with the aim of understanding disproportionate outcomes in recruitment, promotion, engagement and absence.

BAME Network
Our BAME Network continues to offer a powerful insight into the needs and views of our BAME colleagues. Meeting regularly with the Chief Executive, the group informs and responds to key workforce activity. In particular in 2020, the BAME Network was pivotal in defining our approach to Health and Wellbeing Risk Assessments.

Our BAME network is chaired by a colleague of our partner organisation, Calderdale and Huddersfield Solutions.

Black History Month
CHFT celebrated black history month with a strong and innovative campaign that made CHFTs position on racism clear. A series of events took place to celebrate black history by using famous quotes and stories.

Health and Wellbeing Risk Assessments and strategy
Early on in the pandemic, all hospital Trusts were asked to carry out physical risk assessments with their staff. It was clear that the virus had a disproportionate impact on certain protected groups – sex (male) ethnicity and age. The requirement was to carry out physical risk assessments with all BAME colleagues. In consultation with our BAME Network, CHFT took a broader and more wide ranging approach to

Health and Wellbeing Risk Assessments, with BAME colleagues feeding back that they did not wish to be the only people subject to risk assessments. Our Health and Wellbeing Risk Assessments were designed to not only cover physical risk, but mental health risk and also personal circumstances. This allowed us to respond to colleagues needs whilst also understanding more about the needs of all protected groups.

Colleague Disability Network
2020 saw the creation of our disability network. The disability network brings together colleagues from across CHFT to identify improvements for our colleagues. This includes improvement to the built environment, our policies and procedures and our understanding of the different needs of our disabled colleagues. Meeting regularly, the network is chaired by a colleague.

LGBTQ Network
Our LGBTQ network has grown further and meets regularly to discuss the needs of our gay, lesbian, bisexual, transgender and queer colleagues. Celebrating LGBTQ month, CHFT flew the rainbow flag at both locations and developed a series of activities to cement our support and celebration of our colleagues. The network is chaired by a colleague of CHFT.

Empower Programme
In October 2020, CHFT launched the 'Empower Programme' open to all colleagues to improve their confidence and help overcome barriers to advancement and promotion. Championed by our Deputy Medical Director, the programme offers CHFT colleagues an opportunity to develop new skills and to understand more about what CHFT can do to improve the success of colleagues developing at CHFT.

Leadership Development Programme open to all
Our Leadership Development Programme, launched in July 2020, is open to all colleagues and is mandatory for all people managers. Included in the programme is a strong emphasis on inclusion, with dedicated sessions to help colleagues understand the impact of their actions on protected groups, and how we can all become a champion for equality, diversity and inclusion.

West Yorkshire & Harrogate report into the impact of COVID 19
In June 2020, Public Health England (PHE) published their findings into a review of the disparities in risk outcomes of COVID 19. To build on this review, West Yorkshire and Harrogate (WY&H) Health and Care Partnerships launched a further review into the impact of COVID 19 on health inequalities and support needed for Black, Asian and Minority Ethnic (BAME) communities and staff.

The review was independently commissioned, and was chaired by Professor Dame Donna Kinnair, Chief Executive and General Secretary of the Royal College of Nursing (RCN.)

The review was co-produced by leaders from the NHS, Local Government and the Voluntary and Community Sector (VCS) with the report findings launched in October 2020.

CHFT participated in this review and was supported by our Chief Executive, Owen Williams.

CHFTs progress against the actions identified in the review can be found below:

Recommendation	**CHFT progress and support**
Improving access to safe work for BAME people in WY&H	~17% of CHFTs workforce is from a BAME background – higher than the local community average in Calderdale (10.3%) but lower than the community average in Kirklees (20.9%) All CHFT roles are subject to equality of opportunity CHFT's Health and Wellbeing Risk Assessment was co-produced with our BAME network. It covers physical and mental health risk as well as any personal circumstances which may impact on the risk to colleagues of COVID 19 CHFT ran a local anti-racism campaign as part of Black History month 2020 Equality, Diversity and Inclusion role created and recruited to in 2019 offering support to our BAME network and colleagues Five year Inclusion Strategy launched 2020 Positive action recruitment for a Colleague Engagement Advisor conducted successfully in 2020 BAME Community Engagement colleagues appointed February 2021
Ensuring partnership leadership is reflective of the communities it serves	15.4 % of the Board of CHFT is BAME CHFT's leadership behaviours developed as part of our COVID Health and Wellbeing Strategy Disciplinary and grievances are reviewed and monitored as part of our WRES data 2 x Board appointments have adopted an inclusive approach to ensure that we attract BAME candidates with the skills and experience to fulfil the roles successfully CHFT's new recruitment strategy to launch July 2021, including positive statements for candidates thinking about choosing CHFT for their employer

Diverse range of FTSU Ambassadors, Inclusion Champions and Wellbeing Ambassadors

CHFT has a wide range of Ambassadors to ensure that all colleagues feel confident to approach them and to share their ideas and thoughts.

International Womens Day Event

The aim of the session is to celebrate women and their achievements. The theme focussed on Empowerment and how we can channel our energies into taking accountability for achieving our aspirations. We hosted a range of internal and external speakers and at this face to face session approx. 60 diverse colleagues from different divisions / grades across the Trust attended the session. The event also enabled the Trust to launch its Empower (Inclusive Personal Development) Programme. Feedback from the event highlighted colleagues left feeling energised, inspired and committed to making a difference.

Wellbeing Hour/Wellbeing Ambassadors

The Trust has over 100 local wellbeing ambassadors who promote all things wellbeing within their local area. One of the main responsibilities of a wellbeing ambassador is supporting the implementation of the wellbeing hour. All colleagues in the Trust can take one-hour wellbeing time per week to support 'self care' and 'take time out' to relax and reflect'.

Equality Impact Assessments

The Equality Impact Assessment process was modernised in 2020 and supports an evidence-based approach designed to help CHFT ensure that our policies, practices, events and decision-making processes are fair and do not present barriers to participation or disadvantage any protected groups from participation. This covers both strategic and operational activities.

The EIA will help to ensure that:

• we understand the potential effects of the policy by assessing the impacts on different groups both external and internal
• any adverse impacts are identified, and actions identified to remove or mitigate them
• decisions are transparent and based on evidence with clear reasoning.

National Inclusion Week

The theme of National Inclusion Week 2020 was Each One, Reach One, were we celebrated everyday inclusion in all its forms! Sharing, promoting, and inspiring colleagues to demonstrate One Culture of Care, where we care for each other the same way we care for our patients, every day.

Overseas Community

We launched our Overseas Colleague Community Network last year. A chance for overseas colleagues to share what is on their mind, ask for help and support and generally meet other colleagues, network and share experiences. This network is sponsored by a Clinical Director.

5 Conclusions/Looking ahead to 2021

We will help colleagues feel confident and competent when caring for or dealing with people with any of the protected characteristics, and to ensure that equality and diversity considerations are an everyday, intrinsic part of being a valued Trust colleague and of delivering excellent, compassionate care.

In 2021 the Trust will focus on the Health Inequalities experienced by our patients and colleagues as a powerful next step in our Inclusion journey.

Key Objectives for the Trust during 2021 - 2025 are as follows:

- Development of a mechanism for systematic involvement of BAME communities from community groupings with known health inequalities

- Development of a transformation programme: Focus On: addressing inequalities in health, participation and experiences for patients and carers

- Development of a learning portal for staff. Focus On: Learning from complaints and incidents.

- Develop a deep understanding of complaints service access inequalities by strengthening relevant monitoring and reporting to drive improvements and engaging with service users on specific complaints service codesign projects

6 Contacts and Enquiries

If you have any questions or comments on this report, or would like to receive it in alternative formats, e.g. large print, braille, languages other than English, please contact Nikki Hosty at Nicola.Hosty@cht.nhs.uk

APPENDIX 1

EQUALITY IN OUR WORKFORCE REPORT

1. Introduction

Equality and diversity related to the workforce is led by the Director of Workforce and Organisational Development. This report provides information about equality in the Trust's workforce. It is based on data that is held about the workforce as at 31 December 2020. In accordance with the Equality Act 2010, we have a duty to "publish information relating to persons who share a relevant protected characteristic who are its employees."

The Trust published its Workforce Race Equality Standard (WRES) in October 2020. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES became operational from 1 April 2015. The standard has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for BAME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust also published its Workforce Disability Equality Standard (WDES) in October 2020. Again, the WDES is a national equality standard for employment against which all NHS organisations are assessed.

2. Staff profile

The staff profile shown in the graphs below are based on a 'snapshot' of all the staff working for the Trust as at 31 December 2020 against the same date in the previous four financial years.

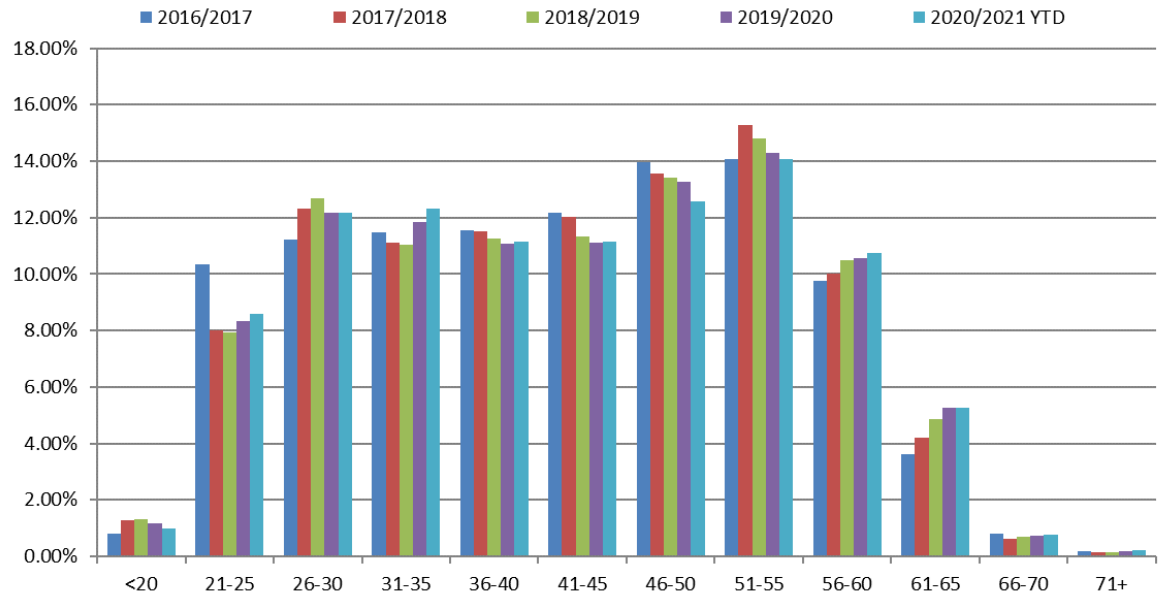
Following good practice in data protection and to ensure personal privacy, some categories have been combined. This helps to protect the anonymity of staff.

We have analysed the Trust's workforce information from the last four years using key equality and diversity indicators to try and identify any significant trends in the data. The categories used are:

- Age
- Disability
- Ethnicity
- Gender
- Religious Belief
- Sexual Orientation

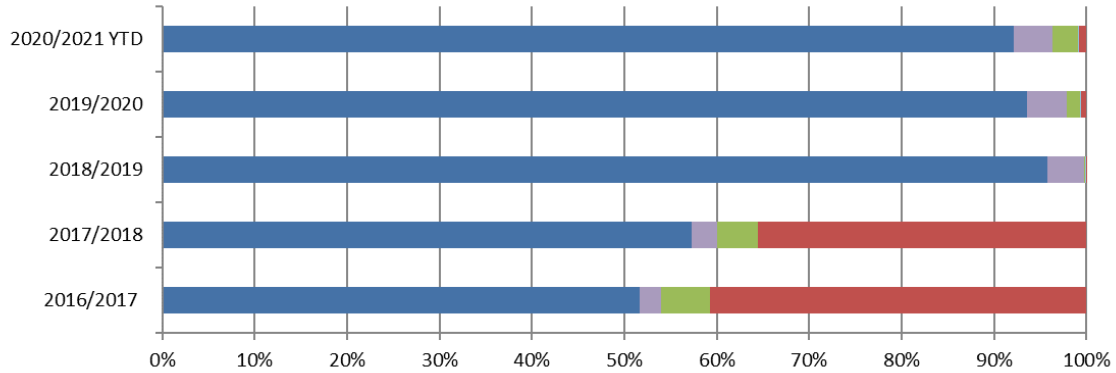
Age Profile

The highest proportion of Trust employees (14.09%) are in the age bracket 51-55.



Disability

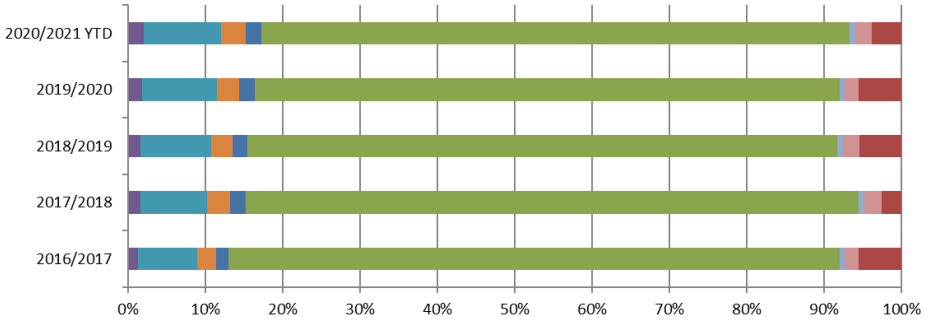
Information on the profile of the Trust's workforce in terms of disability is not sufficiently clear in order to provide a valid analysis of the data. Data quality has improved over the last 5 years, with a significant data quality exercise taking place in 2018; however detail level data on type of disability is currently not available. This are reviewed on an on-going basis and continuous improvements made.



	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021 YTD
No	51.70%	57.30%	95.75%	93.61%	92.20%
Yes	2.30%	2.80%	4.05%	4.26%	4.13%
Not Declared	5.30%	4.44%	0.07%	1.48%	2.79%
Prefer not to say	0.00%	0.00%	0.07%	0.05%	0.05%
Unknown	40.70%	35.52%	0.07%	0.60%	0.83%

Ethnicity

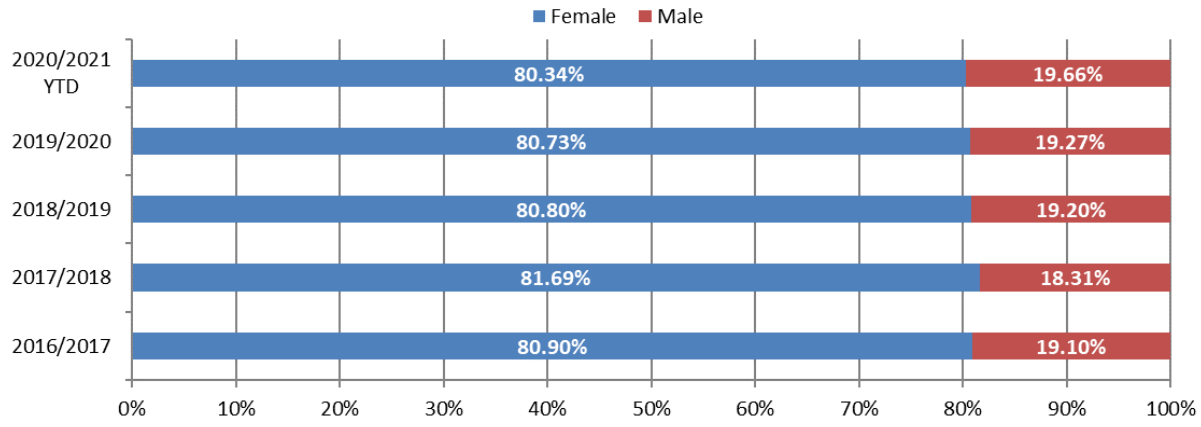
The ethnicity profile of the Trust has seen gradual increases within the Asian and 'Any Other' ethnic groups, however the largest profile remains White - British (76.06%).



	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021 YTD
Any other ethnic group (including Chinese)	1.30%	1.54%	1.61%	1.79%	2.04%
Asian and Asian British	7.60%	8.65%	9.15%	9.71%	9.95%
Black and Black British	2.50%	3.00%	2.79%	2.91%	3.21%
Mixed Race (dual heritage)	1.60%	2.06%	1.89%	1.98%	2.04%
White - British	79.00%	79.20%	76.30%	75.61%	76.06%
White - Irish	0.70%	0.75%	0.70%	0.67%	0.78%
White (not British or Irish - includes White unspecified)	1.80%	2.23%	2.13%	1.84%	2.06%
Not Known	5.50%	2.57%	5.43%	5.50%	3.86%

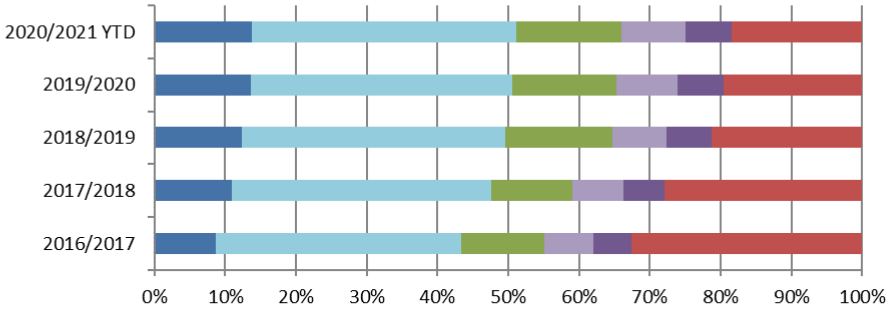
Gender

The gender split in the Trust has not shown much change over the reporting period, with the proportion of men significantly lower than the national workforce average. However, the health and social care sector traditionally employs more women than men.



Religion & Belief

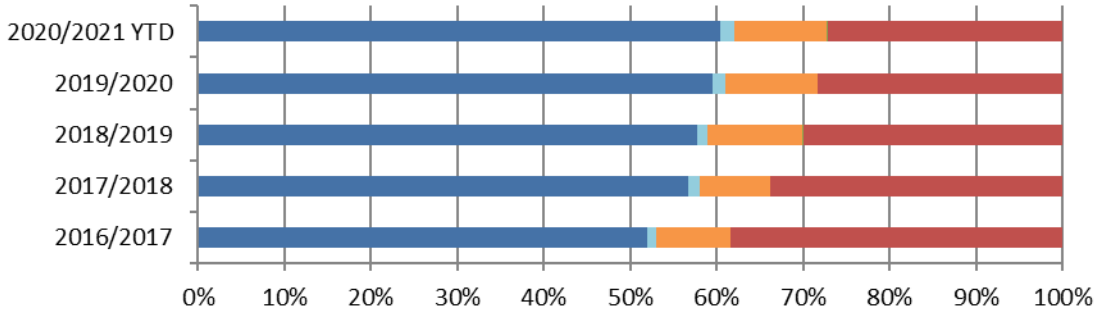
Data quality has continued to improve; however, at the time of reporting 18% of the workforce has not recorded their religious belief.



	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021 YTD
Atheism	9%	11%	12%	14%	14%
Christianity	35%	37%	37%	37%	37%
I do not wish to disclose my religion/belief	12%	11%	15%	15%	15%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	7%	7%	8%	9%	9%
Other	5%	6%	6%	7%	6%
Not Known	33%	28%	21%	20%	18%

Sexual Orientation

Data quality on Sexual Orientation has continued to improve. At the time of reporting 30.47% of the workforce has an unknown sexual orientation, a decrease of 1.19% from the end of the prior year.



	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021 YTD
Heterosexual	56.86%	61.69%	64.77%	66.60%	67.63%
Lesbian, Gay or Bisexual	1.16%	1.51%	1.46%	1.66%	1.78%
Other Sexual Orientation	0.00%	0.00%	0.00%	0.02%	0.03%
I do not wish to disclose	9.38%	8.81%	12.31%	11.97%	11.95%
Undecided	0.00%	0.00%	0.07%	0.07%	0.08%
Not Known	41.98%	36.80%	33.70%	31.66%	30.47%

3. Staff joining the Trust

This section shows demographic data for the recruitment of staff and has been broken down using equality and diversity indicators. All information in this section is sourced from Trac, an online recruitment tool used by Calderdale and Huddersfield NHS Foundation Trust.

The charts below reflect all recruitment activity for the period 1 January 2020 to 31 December 2020, and provide a breakdown (%) of applicants, applicants shortlisted and applicants recruited.

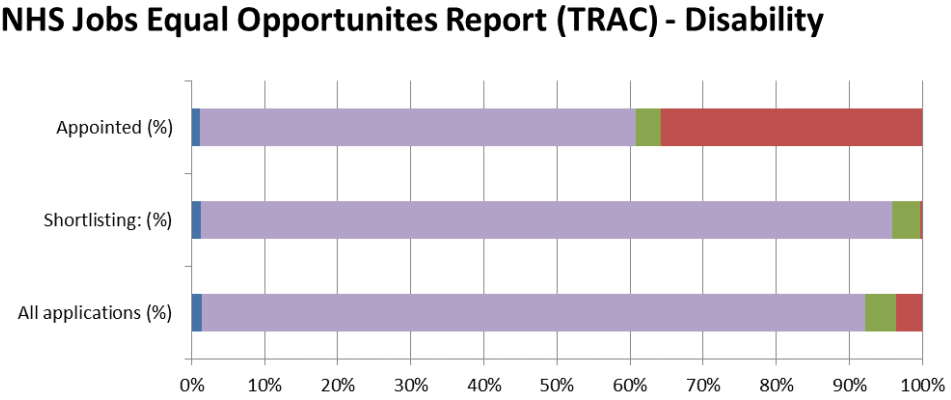
Age Profile

The majority of applications (27.10%) come from the 25-29 age group. This group is also the most likely to be shortlisted (27.49%) and appointed (21.70%).

Age Group	Applications	%	Shortlisted	%	Appointed	%
Under 20	454	3.30%	302	3.42%	38	3.23%
20 - 24	2198	15.90%	1534	17.37%	174	14.81%
25 - 29	3739	27.10%	2428	27.49%	255	21.70%
30 - 34	2498	18.10%	1604	18.16%	212	18.04%
35 - 39	1416	10.30%	923	10.45%	142	12.09%
40 - 44	986	7.20%	614	6.95%	91	7.74%
45 - 49	909	6.60%	544	6.16%	75	6.38%
50 - 54	784	5.70%	469	5.31%	71	6.04%
55 - 59	551	4.00%	293	3.32%	74	6.30%
60 - 64	207	1.50%	102	1.15%	36	3.06%
65+	37	0.30%	20	0.23%	7	0.60%

Disability

4.10% of applicants, 3.80% of those shortlisted and 3.50% of appointed staff declared themselves as disabled.

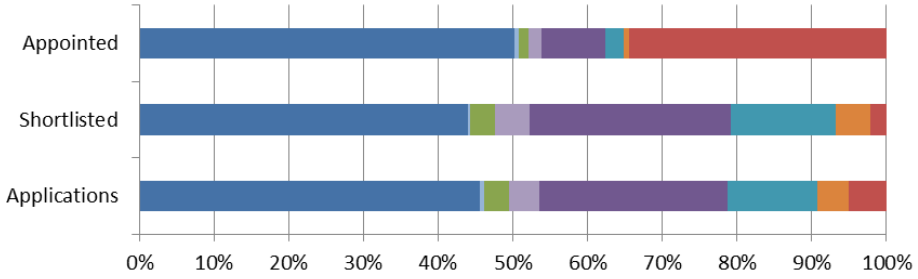


	All applications (%)	Shortlisting: (%)	Appointed (%)
I do not wish to disclose whether or not I have a disability	1.3%	1.28%	1.11%
No	90.9%	94.65%	59.66%
Yes	4.1%	3.81%	3.49%
Not stated	3.6%	0.26%	35.74%

Ethnicity

The majority of applications (45.7%), applicants shortlisted (44.1%) and applicants recruited (50%) identify as 'White – British'. 25.2% of applicants identify as 'Asian & Asian British' however this group only accounts for 8.5% of those successfully appointed.

NHS Jobs Equal Opportunities Report (TRAC) - Ethnicity

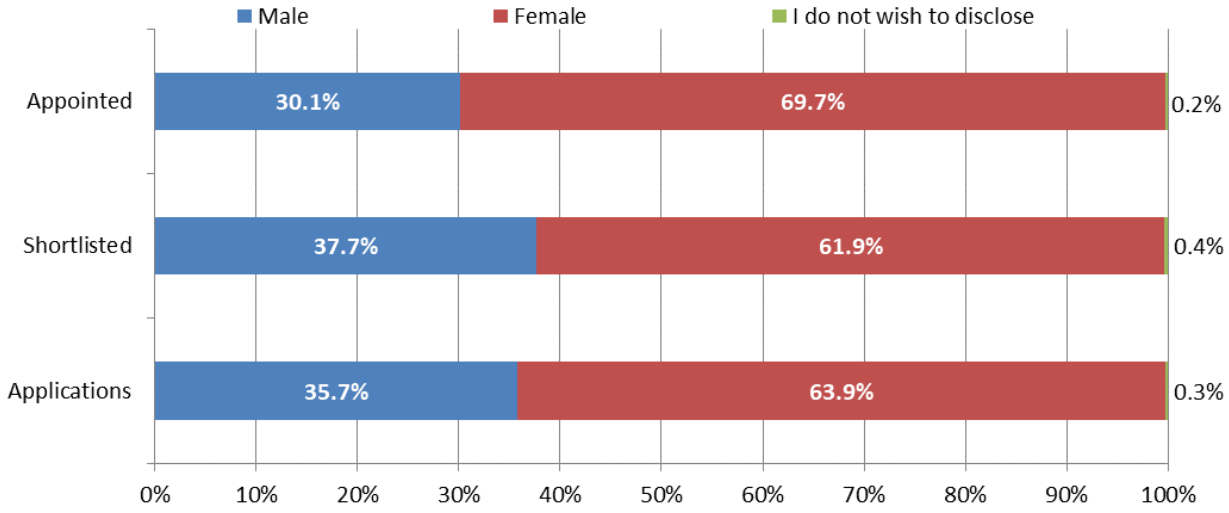


	Applications	Shortlisted	Appointed
WHITE - British	45.7%	44.1%	50.0%
WHITE - Irish	0.5%	0.3%	0.6%
WHITE - Any other white background	3.4%	3.4%	1.4%
Mixed Race	4.1%	4.6%	1.7%
Asian & Asian British	25.2%	27.1%	8.5%
Black & Black British	12.0%	14.1%	2.4%
Any other group (Including Chinese)	4.2%	4.7%	0.7%
Undisclosed	5.1%	2.1%	34.4%

Gender

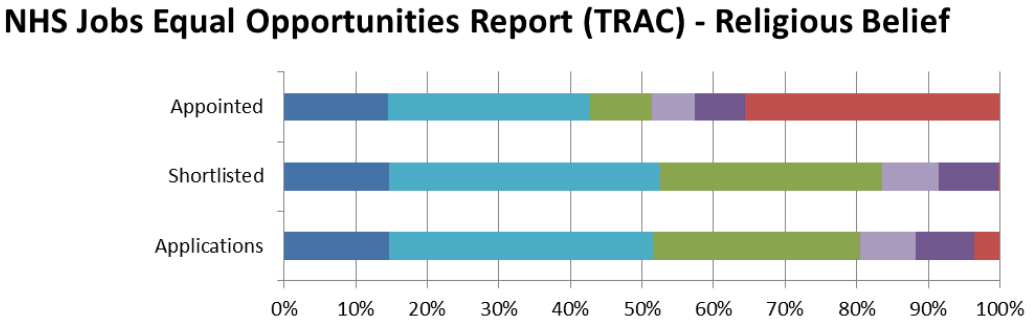
The majority of applications, applicants shortlisted and applicants recruited are female.

NHS Jobs Equal Opportunites Report (TRAC) - Gender



Religion & Belief

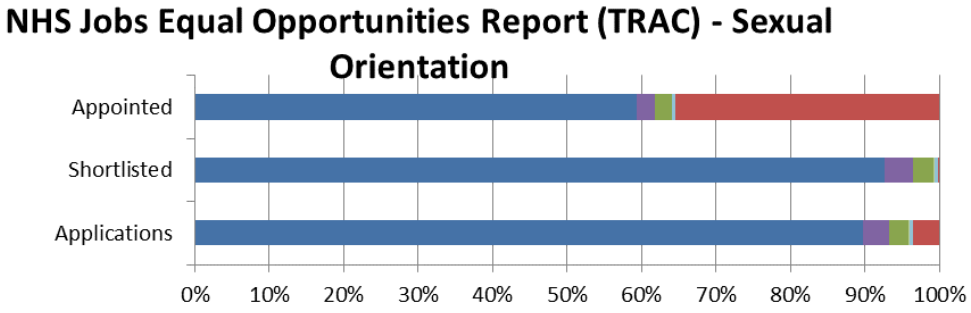
The majority of applicants (36.9%), applicants shortlisted (37.9%) and applicants recruited (28.2%) identify as Christian.



	Applications	Shortlisted	Appointed
Atheism	14.7%	14.7%	14.6%
Christianity	36.9%	37.9%	28.2%
Non Christian Religions	28.9%	31.0%	8.7%
Other	7.8%	7.9%	6.0%
I do not wish to disclose my religion/belief	8.1%	8.3%	7.0%
Not stated	3.6%	0.2%	35.6%

Sexual Orientation

The majority of applications, applicants shortlisted and applicants recruited identify as heterosexual.



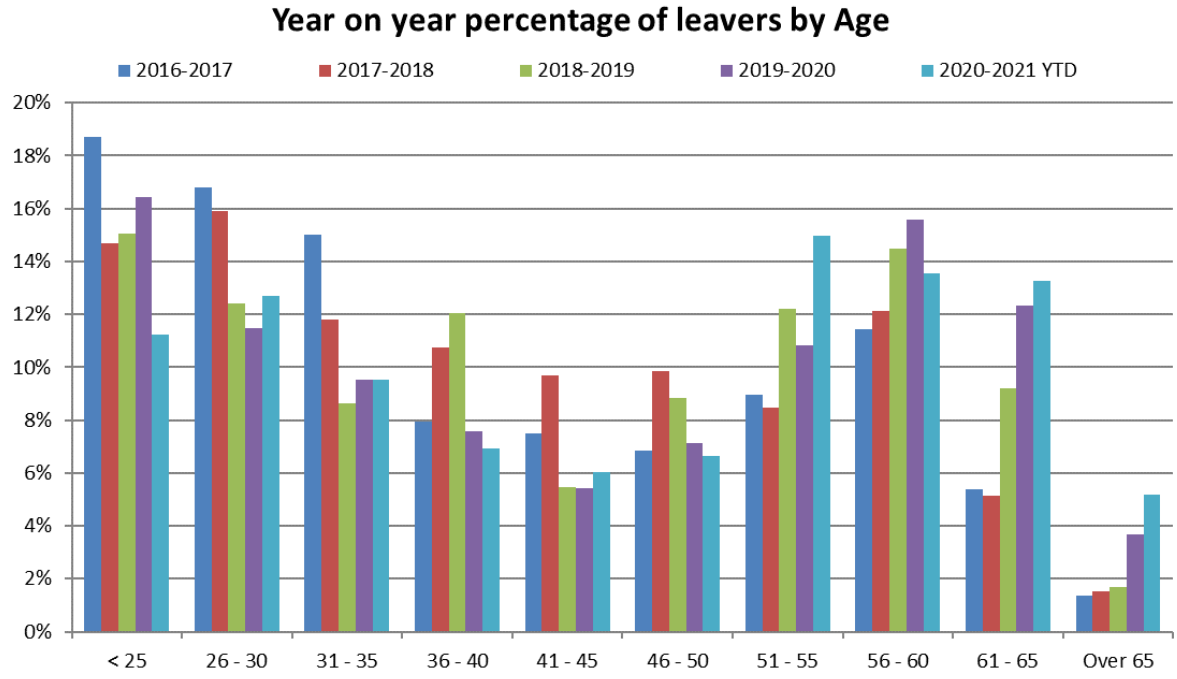
	Applications	Shortlisted	Appointed
Heterosexual or Straight	89.8%	92.7%	59.3%
Lesbian, Gay or Bisexual	3.6%	3.8%	2.6%
I do not wish to describe my sexual orientation.	2.6%	2.6%	2.2%
Other sexual orientation not listed	0.2%	0.2%	0.1%
Undecided	0.4%	0.4%	0.3%
Undisclosed	3.6%	0.2%	35.5%

4. Staff leaving the Trust

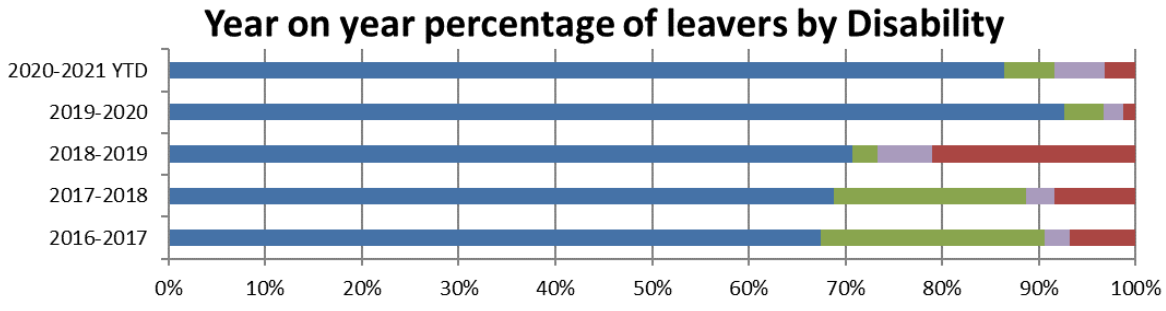
This section shows data regarding staff that left the Trust between 1 April 2016 and 31 December 2020; broken down using the equality and diversity indicators.

Age Profile

During the current year to date turnover is highest amongst staff aged 51-55 (14.99%) closely followed by the 56-60 (13.54%) and 61-65 (13.26%) age groups.

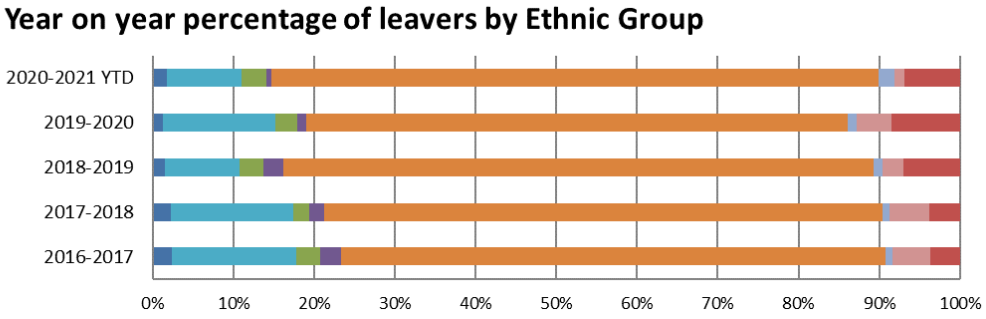


Disability



	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021 YTD
No	67.38%	68.79%	70.68%	92.64%	86.46%
Yes	23.09%	19.85%	2.63%	4.11%	5.19%
Not Declared	2.58%	3.03%	5.64%	1.95%	5.19%
Not Known	6.84%	8.33%	21.05%	1.30%	3.17%

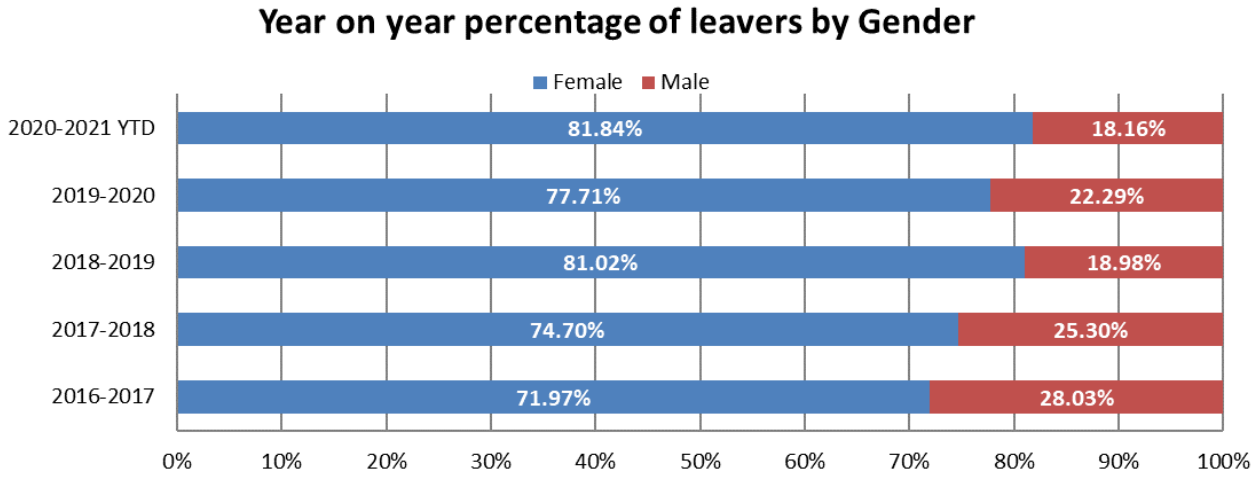
Ethnicity



	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021 YTD
Any other ethnic group (including Chinese)	2.35%	2.27%	1.50%	1.30%	1.73%
Asian and Asian British	15.47%	15.15%	9.21%	13.85%	9.22%
Black and Black British	2.91%	1.97%	3.01%	2.81%	3.17%
Mixed race (dual heritage)	2.58%	1.82%	2.44%	1.08%	0.58%
White - British	67.49%	69.24%	73.12%	67.10%	75.22%
White - Irish	0.90%	0.76%	1.13%	1.08%	2.02%
White (not British or Irish - includes White unspecified)	4.60%	5.00%	2.63%	4.33%	1.15%
Not Known	3.70%	3.79%	6.95%	8.44%	6.92%

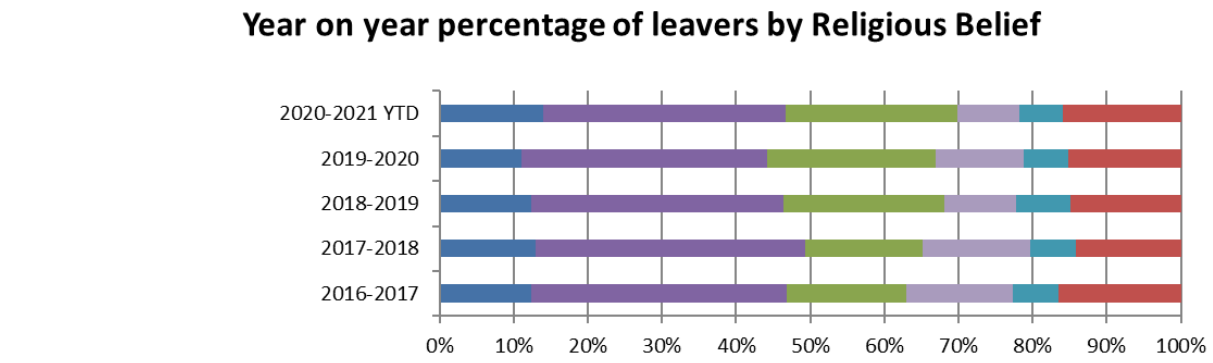
Gender

81.84% of leavers are female employees, however with the Trust employing a significantly higher amount of female employees this is expected.



Religion & Belief

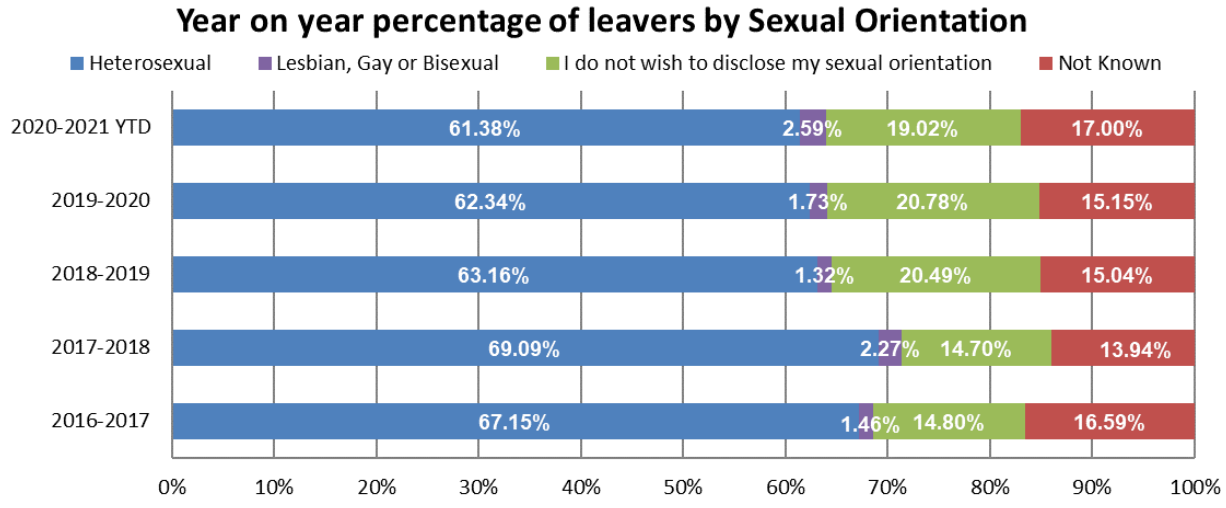
As with 2019-20, the majority of leavers in 2020-21 are Christians (32.75%).



	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021 YTD
Atheism	12.33%	12.88%	12.41%	11.04%	13.91%
Christianity	34.42%	36.36%	34.02%	33.12%	32.75%
I do not wish to disclose my religion/belief	16.14%	15.91%	21.62%	22.73%	23.19%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	14.46%	14.55%	9.77%	11.90%	8.41%
Other	6.17%	6.21%	7.33%	6.06%	5.80%
Not Known	16.48%	14.09%	14.85%	15.15%	15.94%

Sexual Orientation

The majority of leavers in 2019-20 are Heterosexual (61.38%) The percentage of leavers with an unknown sexual orientation has increased from 15.15% to 17%.



5. Staff profile by pay

The data below is a 'snapshot view' of the pay levels for all Trust employees as at 31 December 2020. This section looks at the organisation pay and measures this against the key equality and workforce indicators.

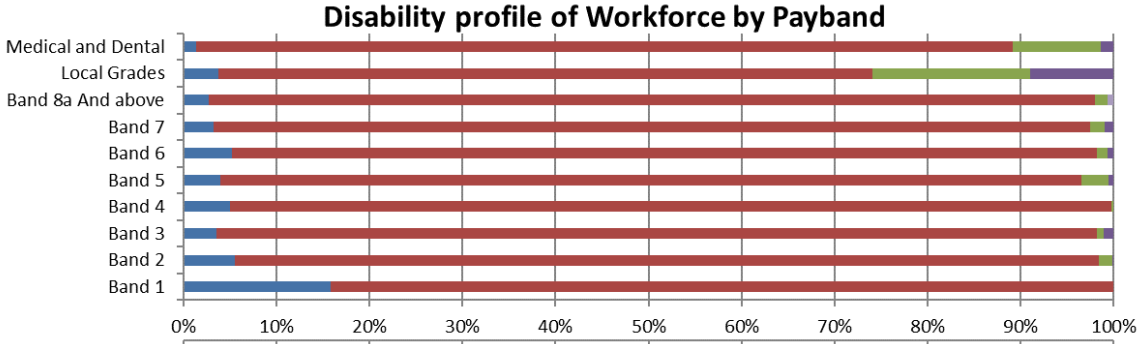
Age Profile

The most common pay band in the Trust is Agenda for Change band 5 with 21.69% of colleagues in this band. Band 2 comes in a close second with 21.44% of staff in this band. Within Band 5 the largest majority (16.36%) of people are in the age band 26-30.

Age Band	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Other	Medical and Dental
<25	0.00%	9.86%	13.21%	5.56%	15.05%	3.85%	0.19%	0.00%	41.80%	8.54%
26 - 30	0.00%	9.20%	12.32%	7.94%	16.36%	12.04%	10.90%	2.73%	8.99%	18.90%
31 - 35	5.26%	9.93%	11.07%	9.79%	12.87%	17.11%	10.71%	9.56%	6.35%	15.40%
36 - 40	5.26%	9.12%	9.11%	8.99%	9.96%	14.47%	14.72%	13.65%	7.41%	12.96%
41 - 45	0.00%	7.43%	10.18%	12.43%	10.98%	12.55%	12.62%	18.77%	4.76%	13.57%
46 - 50	26.32%	11.48%	12.32%	13.49%	10.47%	13.16%	17.97%	18.09%	8.99%	11.74%
51 - 55	26.32%	15.16%	12.68%	20.11%	10.40%	15.18%	19.50%	24.23%	8.47%	9.60%
56 - 60	26.32%	15.53%	11.43%	16.67%	8.87%	8.00%	10.52%	9.90%	6.35%	6.10%
61 - 65	5.26%	10.60%	6.43%	4.50%	4.29%	3.34%	2.10%	2.05%	5.29%	2.13%
Over 65	5.26%	1.69%	1.25%	0.53%	0.73%	0.30%	0.76%	1.02%	1.59%	1.07%

Disability

Information on the profile of the Trust's workforce in terms of disability has improved over the last 5 years and from work completed for the WDES submission. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Yes	15.79%	5.52%	3.57%	5.03%	4.00%	5.16%	3.25%	2.73%	3.70%	1.37%
No	84.21%	92.86%	94.64%	94.71%	92.51%	93.02%	94.26%	95.22%	70.37%	87.80%
Not Declared	0.00%	1.47%	0.71%	0.26%	2.91%	1.11%	1.53%	1.37%	16.93%	9.45%
Prefer Not To Answer	0.00%	0.00%	0.00%	0.00%	0.00%	0.10%	0.00%	0.68%	0.00%	0.00%
Unspecified	0.00%	0.15%	1.07%	0.00%	0.58%	0.61%	0.96%	0.00%	8.99%	1.37%
Not Known	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

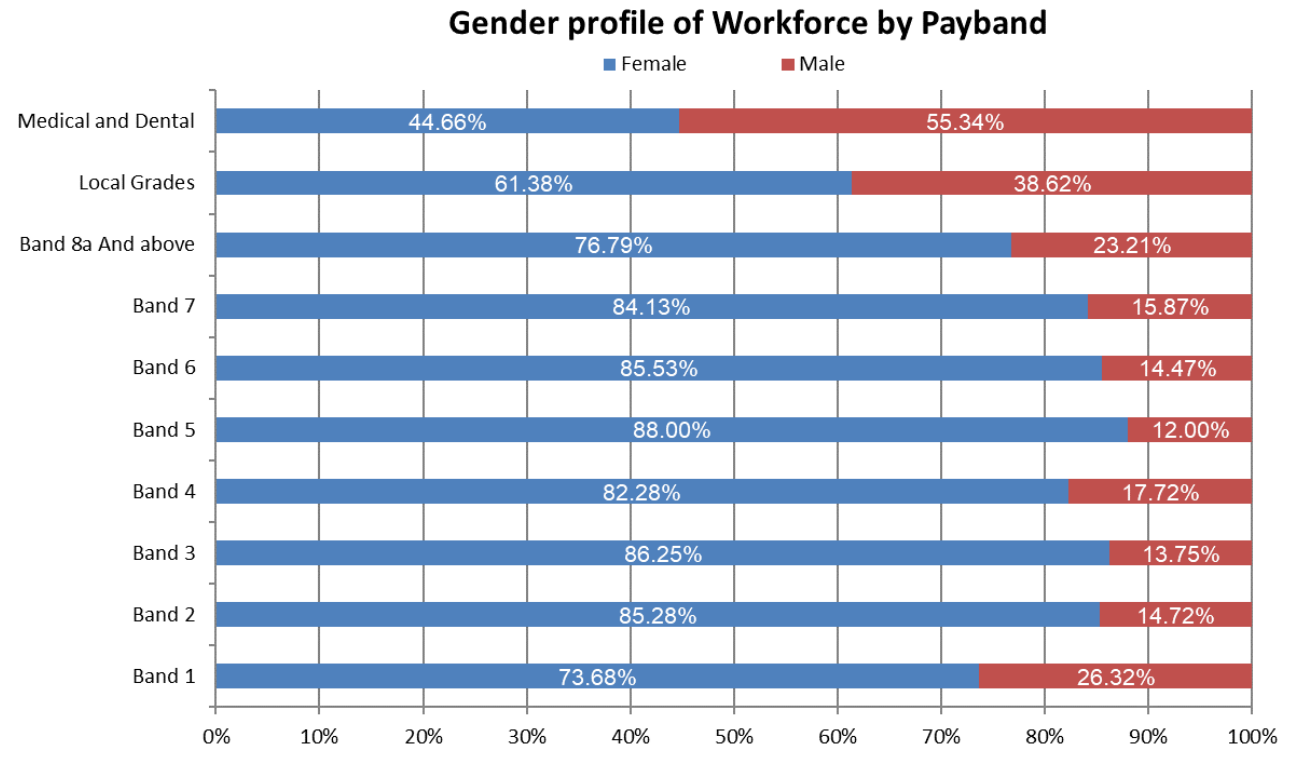
Ethnicity

Over all the Agenda for Change pay scales, the majority of colleagues are White British. Medical and Dental have a more even split between White and other ethnic backgrounds, with a large proportion of those being Asian/Asian British.

Ethnicity	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Any other ethnic group (including Chinese)	0.00%	1.25%	0.18%	0.53%	2.91%	1.11%	0.38%	0.34%	0.00%	8.54%
Asian and Asian British	5.26%	6.33%	7.14%	3.70%	12.07%	5.67%	5.54%	3.41%	7.41%	34.76%
Black and Black British	15.79%	4.64%	1.61%	2.12%	4.29%	1.82%	1.53%	0.68%	4.23%	3.66%
Mixed race (dual heritage)	0.00%	2.50%	2.32%	2.65%	1.75%	1.32%	1.72%	1.71%	2.12%	3.20%
Not Known	10.53%	4.86%	3.04%	2.91%	3.78%	2.83%	1.91%	2.05%	5.82%	7.01%
White - British	63.16%	77.48%	84.11%	86.51%	71.64%	85.02%	87.57%	89.08%	79.37%	37.50%
White (not British or Irish - includes White unspecified)	5.26%	2.06%	1.07%	1.06%	2.40%	1.32%	0.76%	2.05%	1.06%	5.03%
White - Irish	0.00%	0.88%	0.54%	0.53%	1.16%	0.91%	0.57%	0.68%	0.00%	0.30%

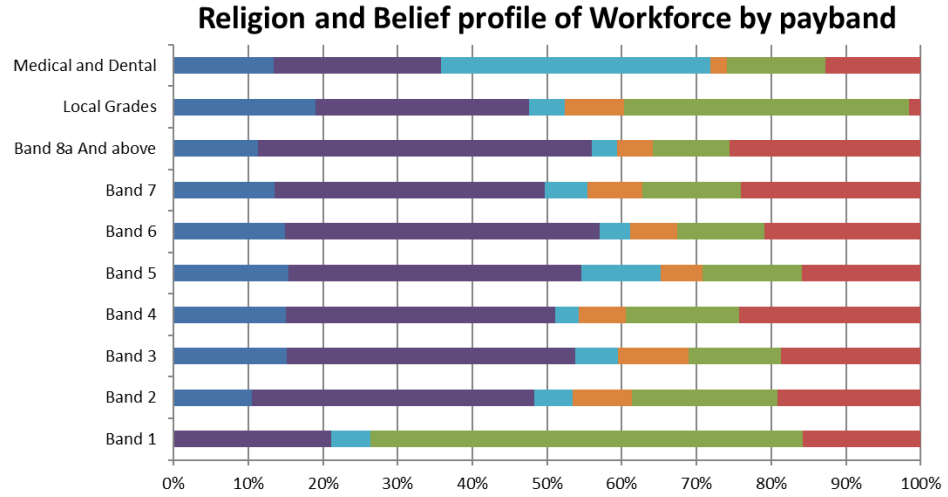
Gender

Men are over-represented in the Medical and Dental pay band (55.34%) compared with the workforce profile, where the majority of colleagues are female (80.34%)



Religion & Belief

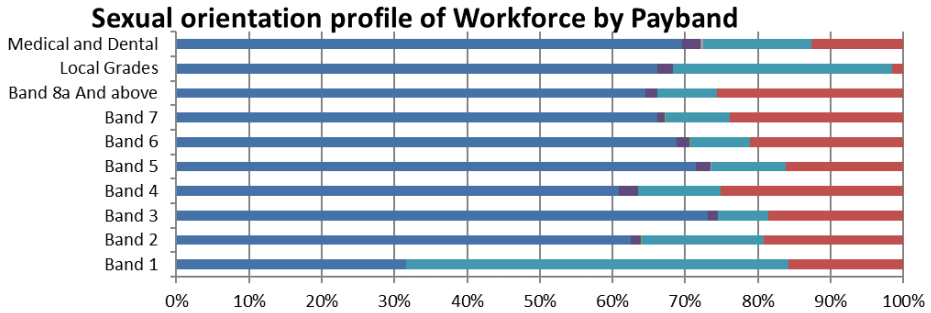
Progress is been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Atheism	0.00%	10.52%	15.18%	15.08%	15.35%	14.88%	13.58%	11.26%	19.05%	13.41%
Christianity	21.05%	37.82%	38.57%	35.98%	39.27%	42.11%	36.14%	44.71%	28.57%	22.41%
Non Christian religion (Buddisnm, Hinduism, Islam, Judaism, Sikhism)	5.26%	5.08%	5.71%	3.17%	10.55%	4.15%	5.74%	3.41%	4.76%	35.98%
Other	0.00%	7.95%	9.46%	6.35%	5.60%	6.28%	7.27%	4.78%	7.94%	2.29%
I do not wish to disclose my religion/belief	57.89%	19.43%	12.32%	15.08%	13.31%	11.64%	13.19%	10.24%	38.10%	13.11%
Not Known	15.79%	19.21%	18.75%	24.34%	15.93%	20.95%	24.09%	25.60%	1.59%	12.80%

Sexual Orientation

Heterosexual is the predominant selection across the majority of pay bands. There is still a relatively high proportion of each pay band who do not which to disclose their sexual orientation (the most significant being in Band 1 (52.63%).



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Heterosexual	31.58%	62.55%	73.04%	60.85%	71.49%	68.83%	66.16%	64.51%	66.14%	69.51%
Lesbian, Gay or Bisexual	0.00%	1.40%	1.43%	2.65%	1.96%	1.72%	0.96%	1.71%	2.12%	2.59%
Undecided	0.00%	0.07%	0.00%	0.00%	0.07%	0.10%	0.19%	0.00%	0.00%	0.15%
Other sexual orientation not listed	0.00%	0.00%	0.00%	0.00%	0.07%	0.00%	0.00%	0.00%	0.00%	0.15%
I do not wish to disclose my sexual orientation	52.63%	16.78%	6.96%	11.38%	10.18%	8.30%	8.80%	8.19%	30.16%	14.94%
Not Known	15.79%	19.21%	18.57%	25.13%	16.22%	21.05%	23.90%	25.60%	1.59%	12.65%

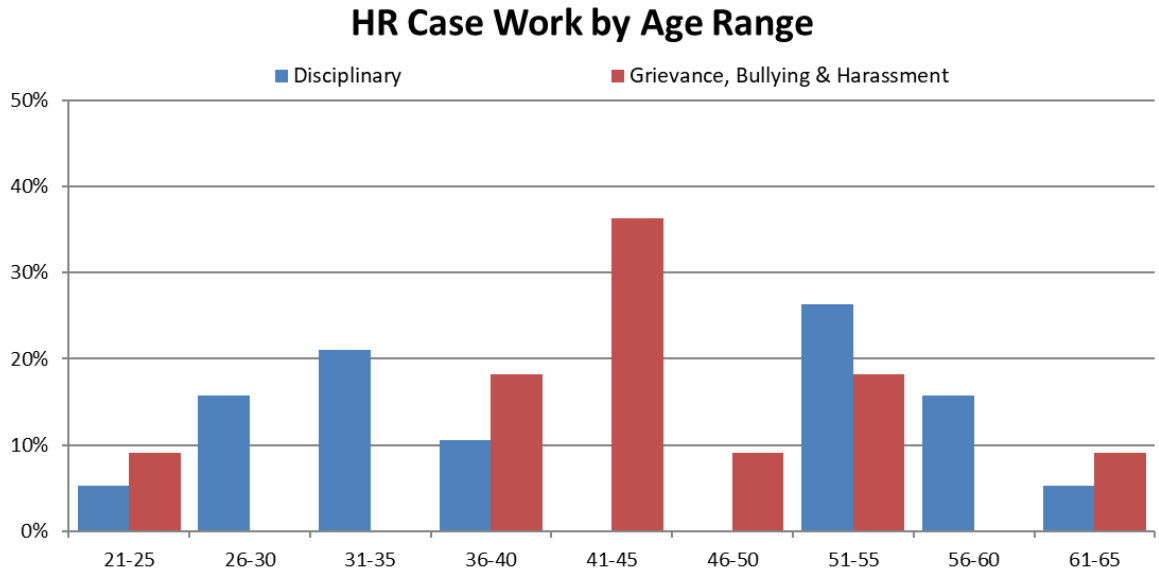
6. Disciplinary, grievance and bullying and harassment

Overall, between January 2020 and December 2020 there were:

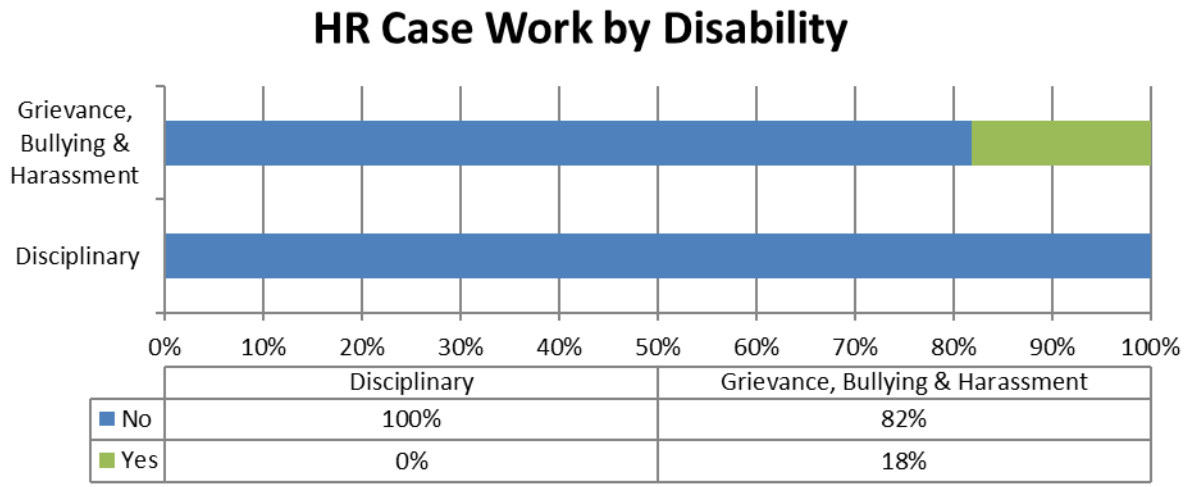
- 19 disciplinary investigations
- 8 grievance investigations
- 3 bullying and harassment investigations

To ensure anonymity of the data, bullying, harassment, and grievance cases have been combined for reporting purposes. This section looks at the number employee relation cases and measures this against the key equality and workforce indicators.

Age Profile

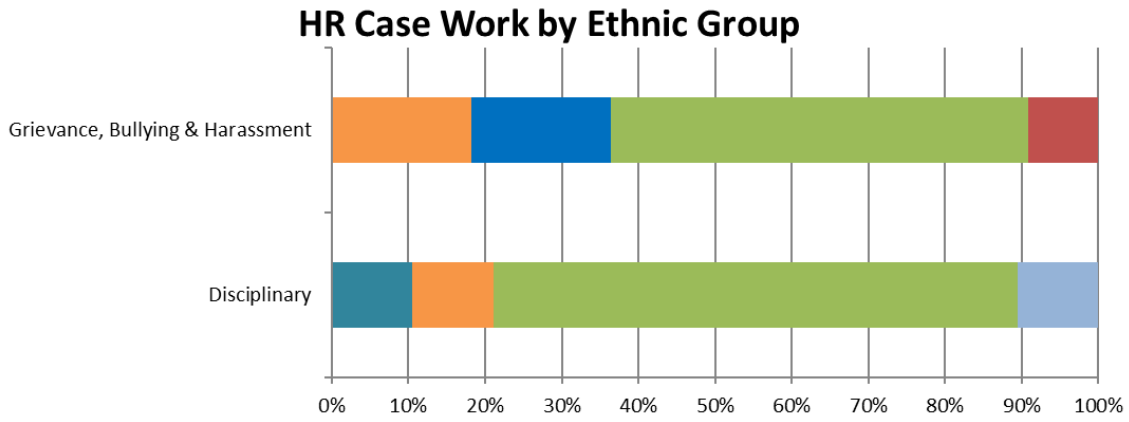


Disability



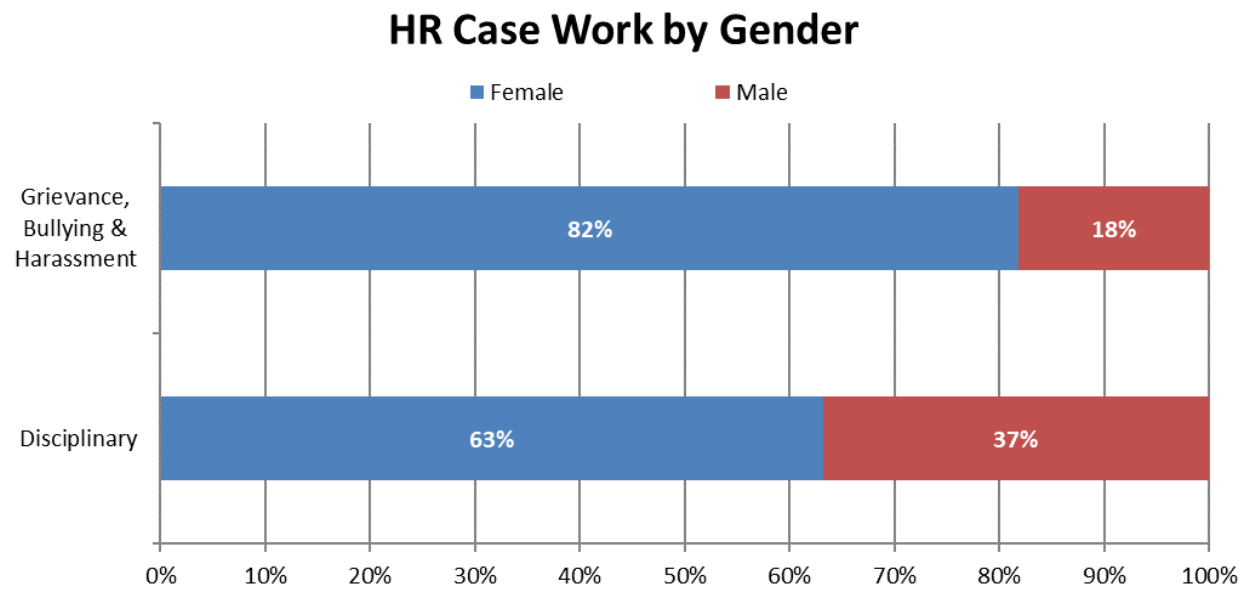
	Disciplinary	Grievance, Bullying & Harassment
No	100%	82%
Yes	0%	18%

Ethnicity

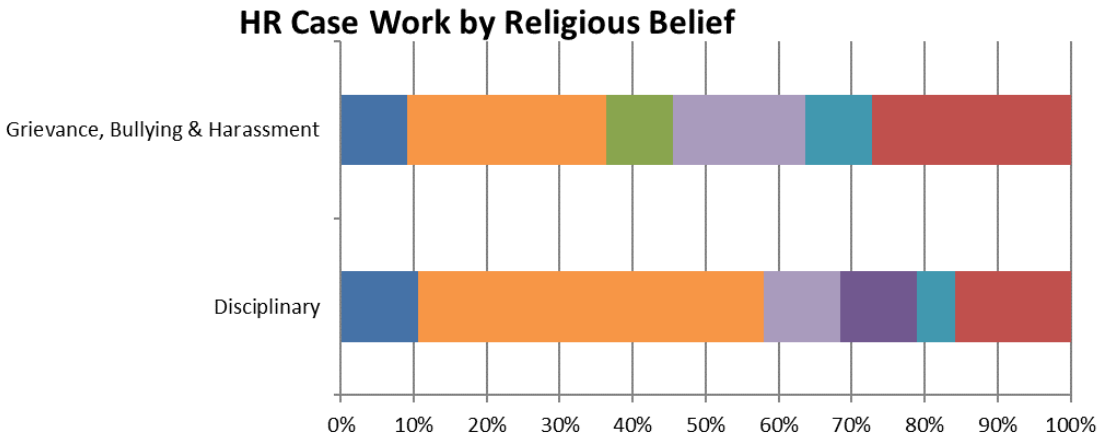


	Disciplinary	Grievance, Bullying & Harassment
Any other ethnic group (including Chinese)	0%	0%
Asian and Asian British	11%	0%
Black and Black British	11%	18%
Mixed Race (dual heritage)	0%	18%
White - British	68%	55%
White - Irish	11%	0%
White (not British or Irish - includes White unspecified)	0%	0%
Not Known	0%	9%

Gender

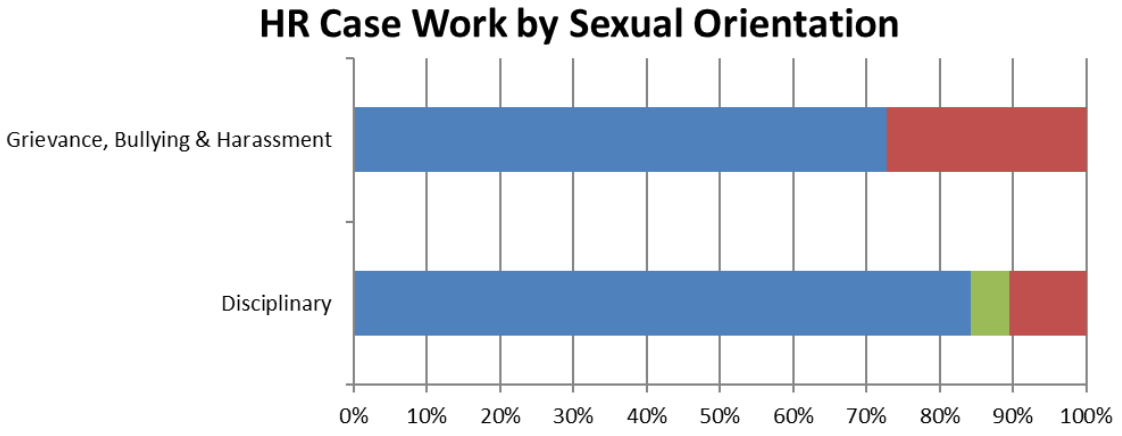


Religion & Belief



	Disciplinary	Grievance, Bullying & Harassment
Atheism	11%	9%
Christianity	47%	27%
Hinduism	0%	9%
I do not wish to disclose my religion/belief	11%	18%
Islam	11%	0%
Other	5%	9%
Unknown	16%	27%

Sexual Orientation



	Disciplinary	Grievance, Bullying & Harassment
Heterosexual or Straight	84%	73%
Not stated (person asked but declined to provide a response)	5%	0%
Unknown	11%	27%

7. Policies and programmes in place to address equality issues

The Trust continually reviews its policy framework in order to ensure that it is meeting its legal obligations and providing a supportive workplace environment for all of its employees. The Trust policies apply to all employees regardless of gender, ethnicity, disability and sexual orientation.

An Equality, Diversity and Inclusion lead has been appointed by the Trust to ensure that the Trust board and all staff understand their collective and individual responsibilities and ensure compliance within the legal framework.

The Trust strives to widen participation into apprenticeship opportunities through ensuring the scheme continues to support people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation into the employment market. CHFT is a lead employer for Calderdale Project Search, an initiative to support young people with learning disabilities to gain valuable work experience. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting health and wellbeing. In most cases, completion of an apprenticeship at CHFT leads to a substantive position and therefore the opportunity to further develop and progress via advanced and higher apprenticeships.

Work is progressing within the Trust to ensure that we have accurate information about the workforce. This involves encouraging all colleagues to update their personal information via ESR Employee Self Service. The focus in early 2019 was on Disability Status in line with the Workforce Disability Equality Standard (WDES) which is a set of specific measures that will enable the Trust to compare the experiences of disabled and non-disabled staff.

The Trust is committed to interviewing all applicants with a disability who meet the minimum criteria for a job vacancy and considering them on their abilities; to ensuring there is a mechanism in place to discuss the development of disabled employees; to making every effort when employees become disabled to make sure they stay in employment and, to taking action to ensure that all employees develop the appropriate level of disability awareness needed.

The Trust published its annual Workforce Race Equality Standard (WRES) in September 2020. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The standard has nine indicators and has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for Black, Asian and Minority Ethnic (BAME) staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust is rolling out a unique and innovative programme, which allows all participants to learn from each other. The aim of the Inclusive Mentoring Programme is to support colleagues from Black, Asian and Minority Ethnic (BAME) groups by providing development opportunities and to offer support and advice on career progression.

As part of the Trust's BAME network, the Trust is committed to ensuring that a BAME representative is allocated to all interview panels for Bands 6, 7 and 8a posts to ensure equity and transparency during the selection process.

As a Trust our aim is to engage colleagues in a whole range of Diversity & Inclusion activities in order to bring our staff together, learn from one another and enhance levels of awareness around all types of difference. This year we have taken part in a Candy Dance challenge, implemented the LGBTQ pledge where colleagues sign up to wear a visible symbol of support for LGBT patients, colleagues, friends and family, and have attended local Pride events at Hebden Bridge and Halifax. We launched our Colleague Disability Action Group: engaging colleagues in identifying barriers and providing recommendations for change. Our BAME forum goes from strength to strength with the Mayor of Huddersfield attending one of the sessions and we launched our Inclusion Facebook page 'CHuFT about Inclusion' and held a number of activities during National Inclusion Week ranging from 'Let's Talk about Race', Introduction to Sign Language and Transgender Awareness workshops.

8. Improving workforce equality data

In 2020, we have:

- Improved the quality of diversity information stored within the Electronic Staff Record (ESR).
- Encouraged colleagues to update their personal information via ESR Self Service.
- The Trust continued to support and recruit staff using the apprenticeship scheme.
- Published the Workforce Race Equality Standard (WRES) in August 2020 and the Workforce Disability Equality Standard (WDES) in September 2020.

27. Update from sub-committees and receipt of minutes and papers - In the Review Room

- Finance and Performance Committee meetings held 11.01.21 and 01.02.21
- Quality Committee meeting held 30.12.20 and 25.01.21
- Workforce Committee meeting held 08.02.21
- Covid-19 Oversight Committee meeting held 26.01.21
- Audit and Risk Committee meeting held 26.01.21
- Council of Governors meeting held 28.01.21

28. Items for Review Room

- CHS Managing Directors Update
- Council of Governors Election Timetable

29. Date and time of next meeting

Thursday 6 May 2021, 9:00 am

Via: Microsoft Teams

To Note

Presented by Philip Lewer