Public Board of Directors

Schedule	Thursday 1 July 2021, 9:00 — 12:00 BST
Venue	Microsoft Teams
Organiser	Jacqueline Ryden

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1. Welcome and Introductions:

To Note

Presented by Philip Lewer

2. Apologies for absence:

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Note

4. Minutes of the previous meeting held on 6 May 2021

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 6 May 2021 at 9:00 am via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships	
Mandy Griffin	Managing Director, Digital Health	
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd	
Andrea McCourt	Company Secretary	
Amber Fox	Corporate Governance Manager	
Neeraj Bhasin	Vascular Surgeon and Trust Clinical Lead for GIRFT	item 60/21
Asifa Ali	Research and Innovation Lead and GIRFT Programme Support	item 60/21
Nicola Bailey	Transformation Programme Manager / GIRFT Programme Manager	item 60/21
Clare Vickers	Regional Head of Nursing and GIRFT Nursing Lead	item 60/21
Nicola Hosty	Assistant Director of Human Resources	item 65/21
Jonathan Hammond	Director of Operations - Service Planning	item 65/21
Clare Simpson	Operations Manager - Service Planning	item 65/21
Leanne Grice	Clinical Educator – Education	item 65/21
Rachel Newburn	Project Manager, THIS	item 65/21
Mike Lucraft	Clinical System Support Administrator	item 65/21
Joanne Fortune	Physiotherapist – Rehabilitation	item 65/21
Rosaleen Sunderland	Therapy Assistant – Rehabilitation	item 65/21
Sally Grose	Occupational Therapist – Rehabilitation	item 65/21
Chris Roberts	General Manager - Service Planning	item 65/21
Andrew Hardy	Consultant - Respiratory Medicine	item 65/21
Vanessa Dickinson	Matron - Service Planning	item 65/21
Andre Mitchell	Colleague Engagement Advisor	item 65/21
Robert Dadzie	Environment Manager – Estates **(for item 64/21)**	
Anu Rajgopal	Guardian of Safe Working Hours **(for item 67/21)**	

OBSERVERS

Alison Schofield	Public Elected Governor
Lynn Moore	Public Elected Governor

53/21 Welcome and Introductions

The Chair welcomed Neeraj Bhasin, Asifa Ali, Nicola Bailey and Clare Vickers to the meeting who were in attendance to present a staff story on the 'Getting it Right First Time' Programme.

The Chair informed the Board a number of colleagues will be joining for the Workforce and Organisational Development Strategy and Staff Survey results agenda item.

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

54/21 Apologies for absence

Apologies were received from publicly elected governors Stephen Baines, Veronica Woollin, Sheila Taylor and Christine Mills.

55/21 Declaration of Interests

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

56/21 Minutes of the previous meeting held on 4 March 2021

The minutes of the previous meeting held on 4 March 2021 were approved as a correct record.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 4 March 2021.

57/21 Action log and matters arising

The action log was reviewed with all actions complete.

58/21 Chair's Report

The Chair reported he is working across West Yorkshire and he is the current chair of the West Yorkshire Association of Acute Trusts. The Chair has attended sessions arranged by NHS Providers on the White Paper *"Integration and Innovation: working together to improve health and social care for all"* and currently attends monthly reference groups for the development of the Integrated Care System (ICS). The Chair meets with the leaders of the local authorities at the start of their municipal year and other NHS Trust Chairs across West Yorkshire.

The Chair informed the Board that Richard Hopkin has agreed to be the Well-Being Guardian.

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

59/21 Chief Executive's Report

The Chief Executive asked to formally record the Board of Directors thanks to our non-surgical oncology colleagues who have been working very hard with Mid-Yorkshire Hospitals Trust (MYHT) colleagues to ensure we look after MYHT cancer patients.

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

60/21 Staff Story - Getting it Right First Time (GIRFT) Annual Update

Neeraj Bhasin, the Trust's clinical lead for 'Getting it Right First Time' (GIRFT) Programme in CHFT presented the annual update and introduced Asifa, Clare and Nicola who together make up the Trust core GIRFT team.

Neeraj explained GIRFT is a significant national clinical quality improvement programme which is fully embedded nationally with government backing. GIRFT is a clinically led peer review with multi-professional involvement. The aims of the GIRFT Programme are to:

- Improve the quality of care through reducing unwarranted variation
- Improve patient outcomes and experience
- Cost improvement though the focus is on patient and clinical services

The key points to note were:

- Benchmarking of GIRFT takes place locally, regionally and nationally
- CHFT are working collaboratively with the GIRFT national team on the process designed at CHFT to create a national exemplar toolkit that will be launched nationally as the way to introduce GIRFT into an organisation
- Regionally, CHFT has liaised with two Trusts to help embed GIRFT into their organisation
- Lots of engagement has taken place within CHFT to embed the process and a total of 26 deep dives into specialties have taken place across 3 Divisions which has seen numerous positive service and patient care developments
- Future work includes the national report that has been received on improving the management of adult Covid-19 patients in secondary care. Whilst co-ordinating a response to this, CHFT had already implemented several the recommendations that came through in the report
- CHFT have now become fast followers for the National Consultant Information Programme which is a digital portal at consultant level of individualised benchmarking data which will be rolled out to 8 surgical specialties
- GIRFT action plan will be incorporated into the CQC assurance process.

The Director of Workforce and OD congratulated the team on being a national exemplar and fast follower which has been very successful. She asked if there was an opportunity to blend the Trust's 3 R's (result, reality and response) improvement methodology with the GIRFT methodology. Neeraj responded that they are very similar processes, a GIRFT deep dive is almost a 3 R's Working Together Get Results and GIRFT could form a facet of this work.

AG stated it is heartening to see how GIRFT is embedded at both organisational and national level. He asked how the patient voice is reflected through the GIRFT process. Neeraj responded that GIRFT is a metrics driven process which includes patient satisfaction studies, friends and family test (FFT) metrics for each specialty and patient reflections on how they receive information.

Nicola Bailey added in addition to metrics driven information and FFT data packs, through the engagement and action planning stage, they use local intelligence from the teams to incorporate the patient voice at different levels which can influence and inform the improvement actions using this evidence, e.g. feedback from patients on what doesn't work for them.

The Managing Director for Digital Health asked from a digital perspective if there is any learning from GIRFT to improve data quality regionally and nationally. Neeraj explained coding is essential and a clinical coder attends every deep dive and the link with THIS is strengthened. He explained coding may differ by Trust and standardising coding is important so that benchmarking and comparison is more accurate and effective. He added that regional visits take place and more services are undertaken across the Integrated Care System patch. Neeraj explained they have a GIRFT digital portal which updates information quarterly with the aim to get monthly data through direct linkage with the theatre management systems. There was a discussion about how CHFT could influence and drive the agenda on data quality by specialty or ICS level.

AN asked for examples of where the process has seen improved patient outcomes. Asifa provided examples where direct patient impact has been seen in stroke, cardiology, urology and radiology services, for example for stroke a new workforce model was implemented to support a stroke assessment bed in A&E at Calderdale which has led to 1 hour scans and enables direct admission to the stroke unit, with a similar process being worked up at HRI.

RH stated it is useful to hear specific examples which demonstrate the real benefits of the great programme and we should continue to facilitate the communication of these through Board Committees and other forums.

Clare Vickers explained the nursing engagement within GIRFT has excellent attendance from the clinical nurse specialists and the team are looking at more engagement from nurses in all areas, e.g. wards and outpatients.

The Chair thanked Neeraj and the GIRFT team for all their hard work embedding GIRFT into the organisation and their work nationally.

OUTCOME: The Board **NOTED** the staff story on the 'Getting it Right First Time' Programme.

61/21 Health Inequalities Group

The Director of Nursing presented the minutes of the Health Inequalities Group meeting held on 23 March 2021 and reported that health inequalities was brought in to focus during Covid-19. In recognition of the importance the Board places on health inequalities and disproportionate impact, a health inequalities group has been set up to provide oversight of key workstreams which is chaired by Peter Wilkinson.

NHS England/Improvement (NHS E/I)I have made the agenda clear in relation to health inequalities which is being driven by the Chief Executive.

The key points to note were:

- Director of Transformation and Partnerships leads on the wider strategic community response and quality impact assessment, driving forward Business Better than Usual
- Chief Operating Officer leads on the clinical prioritisation and recovery plan
- Director of Nursing leads on the lived experience of external users with the focus starting on maternity
- Assistant Director of Workforce, Nikki Hosty is leading on the workforce agenda.

Next steps include:

- A formal report on the group's workplan to the July Board of Directors meeting
- A session on health inequalities scheduled for the joint Council of Governors and Board of Directors informal workshop next week
- Deep dive is scheduled at the June Board of Directors Development Workshop to ensure clarity on what success will look like in 12 months' time

PW added that a few meetings have taken place so far with lots of energy and enthusiasm. The meeting is focusing on the four areas described above, each led by a Director. He added that is has been impressive work to date.

The Chief Operating Officer explained in terms of prioritisation, focus is on the agreed priorities linked to health inequalities as part of the recovery framework. The Chief Operating Officer has shared the presentation nationally. Feedback from these national presentations are that the Trust's commitment to learning disability is evident and the

Board is commended for its bold and clear position statement that the recovery response be undertaken using a health inequalities lens.

The Chief Executive stated health inequalities is now a standing agenda item at the Board. He reported that West Yorkshire Acute Trusts and all other Trusts presented their position on backlog and waiting lists and it was disheartening to see the pattern of which groups of patients could be at a disadvantage, which is seen across other Trusts in the West Yorkshire region. The Chief Executive reported there is a learning disability awareness week in June and suggested some connectivity to the work the Trust are doing.

KH was very supportive of this and hopes it will make some progress.

Neeraj Bhasin provided an update on two business better than usual projects taking place which included:

- Social responsibility project – access to healthcare in disadvantaged individuals, a network has been developed in Calderdale and the next steps are looking at developing a network in Kirklees
- Working with the A&E department to make attendances into a more stable continuity of care working with Greenwood PCN collaboratively with Integrated Care System colleagues in an effort to reduce health inequalities.

The Chair thanked all colleagues who are actively involved in this work.

OUTCOME: The Board **NOTED** the Health Inequalities minutes and that a health inequalities report will be received at future Board meetings.

62/21 Annual Plan 2021/22

The Director of Finance presented the recovery framework and annual plan for 2021/22 which was deferred this year. The operational plan is linked to reducing inequalities.

The recovery framework, including the executive summary, was approved at the Finance and Performance Committee. This is a framework that will evolve over the next few months.

The key points to note were:

- New terminology, H1 means the first six months (half) of the year and H2 means the latter half of the year
- Detailed plans have been submitted for H1, not H2
- More clarity is needed on the funding regime for H2
- Set a balanced plan for H1
- The combined impact of these decisions in H1 2021/22 drives a requirement for a £3m efficiency in H1 to deliver a balanced budget, the Trust delivered £6m in efficiency last year
- Within the annual plan budgets have been set with budget holders with greater focus on budgetary control for 21/22
- Plan supported £4.5m of Covid expenditure pressures (out of an original £8m set aside)
- The balance of £3.5m remains held but will be redirected to elective activity recovery actions (Stage 3)
- £2.8m funding for developments was accepted to progress to business case stage for consideration at Commercial Investment Strategy Committee which is on top of the £2.2m of developments approved last year
- £5m of new ways of working and improvements – subject to business cases to the commercial investment group with KPI's identified
- Planning to deliver more activity within the first 6 months than the planning guidelines trajectory

- Additional funding becomes available if more activity is delivered
- There is potentially a further £2m of elective recovery fund income which is not built into the plans currently
- Agreed small financial risk for H1 now on the risk register
- There is significant financial challenge for H2 from October onwards as less funding appears to be available
- H2 requires a further £14m for efficiencies which is a greater scale than ever before and is consistent across West Yorkshire and this is driven by reduced funding support after September based on the current guidance
- H2 financial plan has a score of 20 on the risk register which was agreed at the Finance and Performance Committee on 5 May 2021

AN asked if there was an independent sector element to this. The Director of Finance explained it was agreed prior to understanding what the financial framework looked like and a sum has been committed to working with the independent sector however activity cannot all be delivered on in the first three months. The Trust are still working through other options to increase activity e.g. LLP partnership with orthopaedic colleagues and additional waiting list initiative work. There is further challenge with clinical colleagues around Covid and social distancing.

AN queried why a higher level of activity was not planned for April to September. The Director of Finance explained the volume of work undertaken last year from an outpatient point of view was 167,000 of outpatient interventions compared to 190,000 in a normal year. The Chief Operating Officer added it was a conscious decision to agree a core activity level and build up from it. The national GIRFT team attended the WYAAT meeting and provided clarity on the standardisation and theatre length which will help productivity.

The Medical Director explained the impact of Covid remains as the guidance around managing Covid infections and preventing the spread remains the same in terms of bed spacing, social distancing and low, medium and high groups. He explained there is still a relatively high rate of Covid in West Yorkshire; however, the number of patients has reduced significantly. There is an ongoing challenge in terms of efficiency.

AG recognised the huge challenge to deliver and achieve the savings and asked how the Trust will get the commitment from key staff to achieve this. The Director of Finance explained the scale of the challenge has not yet been communicated and there is nervousness around funding and the Covid restrictions in how the Trust operates.

OUTCOME: The Board **APPROVED** the Recovery Framework and Annual Plan for 2021/22 and **APPROVED** the financial risk on the risk register for H1.

63/21 Month 12 Financial Summary

The Director of Finance presented the month 12 financial summary and highlighted the key points below:

- Control total basis delivered surplus of 360k in year, a favourable variance of £2.27m compared to plan – this is the second year in a row the Trust have delivered a surplus
- The Trust has incurred costs relating to Covid-19 of £33.54m
- External audit is working with the Trust on the accounts which will be presented to the Audit and Risk Committee in June 2021
- Accounts will show a deficit due to several technical items that fall below our control total
- Agency expenditure year to date is £4.51m, £0.28m below the revised planned level
- Underspent on capital due to externally funded schemes
- Good cash position linked to changes in the Cash regime

- Better Payment Practice code achievement
- Over 05% of invoices were paid within the due date
- CIP achieved for the year was £6M without much focus on delivery in year
- Use of Resources delivered a score of 2

OUTCOME: The Board **NOTED** the information provided in the Month 12 finance report and the financial position for the Trust as at 31 March 2021.

64/21 CHFT Green Plan (Climate Change)

The Managing Director for CHS presented the CHFT Green Plan. The key points to note were:

- Vision is on the climate and sustainability agenda
- Plan approved by the Transformation Programme Board
- Progress will be reviewed by the Board and the Green Planning Committee Chaired by Andy Nelson
- Discussion with partners such as local councils are interested in learning what the Trust has done e.g. waste, transport etc.

The Managing Director for CHS thanked Rob Dadzie, Environment Manager and Andy Nelson who have developed this agenda.

Robert Dadzie, Environment Manager explained the Green Plan comes with an ambitious action plan with 10 key themes which are integrated with the Trusts key plans. The Green Plan is a mandatory document with significant reduction in carbon emissions across 5 years, working with the energy consultant to verify the data and estimate a baseline.

Leaders have been identified on the sustainability action plan and support needed to monitor delivery. A travel plan has been produced and approved as part of the reconfiguration.

AN suggested the Trust need to avoid this becoming a separate action plan which is progressing and needs to be evolved.

The Director of Transformation and Partnerships added the importance of this plan has been apparent over recent months and longer term with regard to the reconfiguration work. She explained partner organisations have been positive on the scope and ambition and the Director of Transformation and Partnerships has been asked to inform key partner organisations of the outcomes at the Board meeting so that the CHFT Green Plan can be shared more widely.

The Chief Executive welcomed the work of colleagues that initiated this and endorsed the suggestion for the Board to incorporate sustainability into the standing report and cover sheet. He highlighted that additional training was required for the Board to learn how to embed the 'Equality Impact Assessment' into the cover sheet and training will be required to understand how it may apply.

The Environment Manager explained they received a proposal for carbon literature training which can be rolled out to the Trust to help understand how this may be embedded for Board papers and report writers. The Environment Manager added there is also a requirement to embed sustainability into Business Cases and a discussion has taken place with the Associate Director of Finance and a draft paper will be shared to take this forward.

The Managing Director for CHS explained he is working with West Yorkshire colleagues as sustainability lead and is putting in a bid for funding for additional training.

The Chief Operating Officer highlighted the importance of recognising who needs to attend the training as many colleagues are involved in writing Board papers. She suggested the Board are mindful that there may be elements of this which have a financial consequence. The Chief Operating Officer asked if ISS are included as they deliver lots of services as she felt the plan was more focused on HRI and asked if community teams are included e.g. travel for community colleagues. The Managing Director for CHS confirmed the membership of the Green Planning Committee is being broadened to include unions, local authority, and ISS. The intention of the plan is on energy consumption across the Trust and is not HRI focused.

KH shared her support to include this in Board paper as it is important to understand the impact of sustainability on any decisions made. She was also supportive of the Green Champions which are key to taking this forward and making ownership across the Trust.

AG stated the plan included ensuring all new builds achieve the 'good' rating as a minimum and thought the required rating was 'very good'. The Environment Manager confirmed the rating should state 'very good' at a minimum with an aspiration of 'excellent'.
Action: Environment Manager to update the target of new builds in the Green Plan

DS stated it is an excellent piece of work and highlighted the importance of using every opportunity to communicate and promote the plan to integrate into work. She pointed out there was no lead in the action plan for sustainable care models and asked that this was addressed as soon as possible. The Environment Manager confirmed the actions to address this will be picked up and explained this is a working document which will be added to as progress is made.

RH highlighted the minimum recycling target of 40% has already been achieved by the Trust and asked if this was an ambitious enough target. The Environment Manager explained an order has been placed to increase recycle bins at the Trust which were delivered this week and will be rolled out. The target of 40% is the NHS target set by NHS E/ I. He reported that some Trusts have achieved higher and the minimum is 40% with an aim to achieve more. RH suggested a more aggressive target is set for the Trust.
Action: Environment Manager to review the recycling target of the Trust set at the minimum of 40%

AN explained there was a proposal at the Green Planning Committee about how the Green Plan is shared and the Director of Workforce and OD suggested linking with the organisations the Trust work with by using 'The Cupboard'.

The Company Secretary asked if there was an indicative timeframe for incorporating sustainability into the Board front sheets, subject to the training. The Managing Director for CHS with keep the Company Secretary up to date on the training.
Action: MD for CHS to inform the Company Secretary when the sustainability training is available for Executives and key staff and will be incorporated into Board papers

OUTCOME: The Board **APPROVED** the CHFT Green Plan, **NOTED** the requirements within the accompanying Sustainability Action Plan and **APPROVED** the proposed amendments to Board papers, subject to training.

65/21 Workforce and Organisational Development Strategy including Staff Survey Results and Action Plan

Nikki Hosty, Assistant Director of Human Resources introduced the Workforce and Organisational Development Strategy which includes seven themes and the staff survey results and explained the alignment to the NHS People Plan is vital. A recent review

highlighted keeping the content fresh is crucial and also highlighted a number of gaps where a plan has been developed.

The staff survey results from Picker have been shared with Directors, Workforce Committee and the Executive Board. The data highlights a 50% response rate which is higher than the benchmark and the overall staff engagement score has improved by 1%.

The key points to note were:

- Organisation takes positive action on health and wellbeing, 10% increase from 22% to 32%
- Adequate equipment and materials to do my work has increased from 49% in to 58%
- I am not looking to leave this organisation rose from 58% in 2019 to 62% in 2020

The Assistant Director of Human Resources invited a number of colleagues to share the work that has undertaken on the staff survey results.

Johnathan Hammond, Director of Operations for Medicine who joined the Trust October 2020 explained the Medical Division Engagement Plan was shared which highlighted what the Trust are good at and the areas for improvement. The Division set some key actions which were presented to the weekly Executive Board developed by Divisional Management Teams. Lessons learned were shared from Directorates who had scored well. A Divisional Communication and Governance Strategy is being developed and implemented and Ian Kilroy is rolling out further training for areas with higher rates of violence.

Chris Roberts, General Manager for Integrated Medical Specialties (IMS) highlighted the following key points from the staff survey action plan:

- One culture of care came through in ward support throughout the pandemic from Nephrology and Rheumatology who stepped down activity to support the pandemic
- Embedded development and improvements within the urology team implementing a consultant of the week / Neurologist of the week rota
- Maintaining morale amongst staff has been difficult and IMS have been as visible as possible during the pandemic
- The lowlights included challenges relating to shielding during Covid, the longer term impact of fatigue amongst staff and the impact on morale and Neurology team engagement which has started to improve engagement with the rota
- The key actions from the staff survey results for IMS were shared

Rosaline Sunderland and Joanne Fortune, Physiotherapists and wellbeing champions who embrace one culture of care shared the work they had undertaken during the pandemic. They created a baby board, positivity tree, kindness calendar and star of the month to celebrate what had gone well. The team built together a positivity jigsaw during a socially distanced meeting which improved morale. Rosaline explained how they use their wellbeing hour on the Stroke Unit by using a whiteboard to share and promote ideas to inspire colleagues to try something different to reduce and manage stress. The team are organising a walking group and a tea trolley.

Leanne Grice, Clinical Educator shared the pastoral support that has been provided to learners which focused on health and wellbeing which included dedicated wellbeing sessions on MS Teams, introducing a ‘CHuFT Board’ to help increase staff morale, creating health and wellbeing packs for colleagues and introducing a quarterly team book club and celebratory team event.

Mike Lucraft, Chair of the colleague Disability Action Group explained how the life of colleagues has been changed and how the forum is used to collate and pass on information to disabled colleagues. This knowledge can be used to perceive how the

patient sees and interacts with care providers. This forum is for colleagues to air their issues and suggestions for real improvement through in house learning events. Anyone is welcome to join the group. There is a private safe place for colleagues to meet through Teams or the existing Cupboard. The Disability Action Group is here to make a difference and ensure one culture of care is applied to disabled colleagues.

Rachel Newburn, Project Manager for THIS explained she is chair of the LGBTQ forum with 25 members in the group. They are looking to increase membership by promoting the network. This forum gives colleagues a safe space and means of support. The forum are looking to develop the intranet to include terminology and hold learning at work events through shared experiences. It is recognised that staff may come to the network to support colleagues or family. This forum promotes one culture of care and the Trust as an inclusive employer and provides a great experience for colleagues.

Andre Mitchell, Colleague Engagement Advisor explained how CHFT supported him when applying for the Empower programme and was appointed to the position.

Sally Grose, Occupational Therapist explained how she used her clinical skills as an occupational therapist to support a colleague back to work following a period of sickness. She helps colleagues develop the coping strategies required to return to work and is very passionate about caring for each other.

KH thanked all colleagues who contributed today and recognised that staff have been working under very difficult conditions and still achieved a remarkable staff survey result. She recognised the longer term fatigue issue for staff and highlighted there has been lots of good practice during this time that can help towards the future.

RH stated he is the Non-Executive Director appointed as Wellbeing Guardian and is looking forward to working with the Assistant Director of Workforce, Director of Workforce and OD and the team to start this piece of work.

The Chair thanked the Assistant Director of Workforce and all colleagues in attendance for their inspiring examples of the work undertaken from the staff survey results. The Chair looks forward to the progress reported at a future Board meeting.

OUTCOME: The Board **NOTED** the update on the Workforce Strategy/2020 and Staff Survey results.

66/21 Director of Infection Prevention Control (DIPC) Report

The Medical Director presented the Director of Infection Prevention Control report which covers the period from December 2020 to March 2021 and is similar to previous years. The key points to note were:

- Infection control team and microbiologists focused on managing covid-19 safely throughout the pandemic
- Guidance on managing Covid-19 changed very frequently which was managed by Anu Rajgopal and her team
- Hospital onset covid infections (HOCI) in the report relate to October to March 2021 and there is now greater control over this, an outbreak recently only involved 2 patients

The Chief Executive acknowledged the hard work undertaken by Andrea Dauris, Associate Director of Quality and Safety on PPE. He added that the PPE group has now been stood down which suggests how far the Trust has travelled. The Chief Executive reminded colleagues to remain vigilant as the national guidance changes and any signs of slippage needs to be recognised. A Board conversation will need to take place once the requirement of social distancing is removed.

OUTCOME: The Board **NOTED** the performance against the key Director of Infection Prevention Control targets and **APPROVED** the report.

67/21 Guardian of Safe Working Hours Q4 Report

Anu Rajgopal, Guardian of Safe Working Hours presented the Q4 report. The key points to note were included in the presentation and included information on exception reports, areas of unfilled locum shifts (Medicine), good engagement with the junior doctor's forum and equality impact. The flexibility of junior doctors with rotas was noted. Anu informed the Board the Guardian of Safe Working Hours annual report was available in the review room.

The Medical Director personally thanked Anu for all her hard work focusing on this piece of work and the improved engagement as a result with this group.

OUTCOME: The Board **NOTED** the Q4 Guardian of Safe Working Hours Report and **NOTED** that the Annual Report was circulated and available in the Review Room.

68/21 Health and Safety Policy

The Director of Workforce and OD presented the Health and Safety Policy which has previously been approved at the Health and Safety Committee and the Audit and Risk Committee.

The changes to the policy include reference to the five year strategy which will be brought to the Board on 1 July 2021 and Andy Nelson is the critical friend on this. The changes also include reference to the four pillars, staff wellbeing and a 'statement of intent' included in the policy.

OUTCOME: The Board **APPROVED** the updated Health and Safety Policy.

69/21 Quality Report

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

- CHFT led the John Smiths Stadium Vaccination Centre and were commended for the strong partnership working by the CQC
- No guidance from NHSI/E yet on Use of Resources
- Lots of work has taken place on the risk mitigation from the outstanding action from the previous CQC inspections on emergency cover within ED
- Focus Support Framework – local CQC style inspections have been put on hold with the introduction of the Observe and Act model
- There is an improving picture around CAS Alerts
- Continuing challenge around pressure ulcers – steady increase in community and work is ongoing to understand this better
- Complaints – challenges continue in terms of response levels and more work to do in closing outstanding actions
- The number of incidents resulting in severe harm or death is starting to decline largely due to a significant reduction in the number of HOCI incidents
- A regular report into Board and a monthly report into Quality Committee with a maternity focus on Ockenden, which highlights obstetric staffing issues
- Excellent 1-1 performance on labour KPI's and safety indicators
- Quality priorities in the coming year include recognition and timely treatment for sepsis, reducing hospital acquired infections including Covid-19 and reducing waiting times for individuals attending the Emergency Department

AN highlighted there has been more traction on complaints and suggested more trend data around complaints and legal would be helpful in future reports. AN asked if a deep dive on falls had taken place. The Director of Nursing confirmed two deep dives take place at the Quality Committee for each focused priority with the relevant lead providing an update. There was a challenge to set targets on falls and raise awareness and more work is needed around risk assessment and documentation. The trend data was reviewed by Denise Sterling, Doriann Bailey and the Director of Nursing who agreed to include more trend data in future reports.

RH highlighted the deterioration in month for pressure ulcers and asked if there were reasons behind this. The Director of Nursing responded the Trust are starting to see a reduction in the pressure ulcers per 1,000 bed days and other Trusts are experiencing the same. There was a steady increase in community looking at the data which could relate to deconditioning at home. A few pressure ulcers are related to incontinence which may relate to frailty. The Chief Operating Officer added the deconditioning is being seen in the Emergency Department (ED) which is also impacting on the ability to avoid admission. The Director of Nursing added there is renewed focus around pressure ulcers working closely with Judy Harper, Tissue Viability Specialist.

PW highlighted the recommendation by the Royal College of Emergency Medicine to meet 16 hours of consultant presence in ED. The Director of Nursing explained the Trust will not meet the 16 hours consultant presence in the department as there is still a gap due to a national shortage of ED consultants. This is also further challenged by having a two site model however mitigating actions are in place.

The Managing Director for Digital Health fed back on conversations with the Chief Executive about the complaints process and Datix system. She is researching NHS wide to improve and look at interoperability and EPR to help inform incidents. A conversation has taken place with Professor Felicity Astin at the Huddersfield University who has been made aware of funding that could become available for Trusts to improve their complaints process. This is being worked through and will be brought back to the Executive team to improve the process and patient experience.

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

70/21 High Level Risk Register

The Director of Nursing presented the high level risk register which has previously been through the Risk Group and Quality Committee. The Director of Nursing thanked the Company Secretary for her contribution to the report. The key points to note were:

- 6 new risks on the high level risk register – 4 of which are new risks
- 3 risks where the scores have reduced
- 1 risk where the score has increased
- All risks are discussed at Divisional Level and the Risk Group which has good Divisional representation
- 3 risks that were not reviewed in March will be picked up at the next Risk Group
- Evidence of a dynamic risk register with clear movement

OUTCOME: The Board **NOTED** the current risks on the high level risk register and **APPROVED** the high level risk register.

71/21 Integrated Performance Report – March 2021

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

- Positive end of the year with no red domains throughout the year of the pandemic
- Areas of concern – complaints, stroke, summary hospital-level mortality indicator (SHMI), backlogs as part of recovery and ED is very busy with significantly high attendances
- Success – cancer continues to be strong, approach in clinical prioritisation, follow up outpatient cohort are being clinically validated, positive approach to understanding patients at a higher risk from a performance perspective

OUTCOME: The Board **NOTED** the Integrated Performance Report and current level of performance for March 2021 and **NOTED** the ongoing activity across the Trust.

72/21 Approval of the new Performance Accountability Framework

The Chief Operating Officer presented the new performance accountability framework which is a refresh from 2015. This has been widely consulted with Executives and reflects recommendations from the Aqua well-led review.

The current framework has been in place for 5 years and significantly contributed to the Trust's position nationally in relation to performance where it is one of the highest achievers across the regulatory standards and contributed to the movement from 'Requires Improvement' to 'Good' following the last CQC inspection. The Trust has continued to perform at the highest level in terms of its key metrics throughout the COVID pandemic and will endeavour to take this standard of excellence through the next stage of recovery and sustainability.

The framework was approved the Finance and Performance Committee on 5 May 2021

AN highlighted the other bodies referenced in section 6 'Roles and Responsibilities' and asked if the same can be reflected in the performance report, e.g. HPS. He suggested there will be a challenge on triangulation of activity e.g. how ED drives other measures. The Chief Operating Officer explained this is built in a formal group of deputies who complete the work on the Integrated Performance Report together with activity being part of this conversation.

OUTCOME: The Board **APPROVED** the new Performance Accountability Framework.

73/21 Governance Report

The Company Secretary presented the governance items for approval and noting in May 2021. There are four items for approval.

a) Changes to the Trust's Constitution and Standing Orders of the Council of Governors

The Company Secretary highlighted the three material changes to the constitution which are the removal of the reserve register for governors, the introduction of a 'Rest of England' constituency to widen membership across the area and that governors who have completed their term can re-stand for election after a 2 year gap.

The Company Secretary highlighted the changes to the Standing Orders of the Council of Governors which included confirmation that a governor who has been terminated is not eligible to re-stand for a period of 2 years from the date of removal from office.

The changes to both the Trust's Constitution and Standing Orders of the Council of Governors were approved by the Council of Governors on 22 April 2021.

OUTCOME: The Board **APPROVED** the changes the Trust's Constitution and Standing Orders of the Council of Governors.

b) Compliance with Licence Conditions

The Company Secretary explained the self-certification schedules for 2020/21 relate to governance and compliance with the NHS Provider licence. Compliance with condition FT4 (8), systems and processes for good governance and condition G6(3), effective systems to ensure compliance with the conditions of the NHS provider licence, was confirmed. For condition S7 (CoS7(3) relating to continuity of service and availability of resources for the next 12 months the Trust has declared that it has a reasonable expectation that the required resources will be available (declaration 3b) with an explanatory narrative from the Director of Finance.

OUTCOME: The Board **APPROVED** the content of the self-certification documents for the signature of declarations.

c) Delegation of 2020/21 annual accounts and annual report approval to the Audit and Risk Committee

The Company Secretary explained the proposal which was supported by the Audit and Risk Committee is for the Board to delegate approval of the sign off processes to the Audit and Risk Committee at the meeting arranged on 10 June 2021.

OUTCOME: The Board **APPROVED** the delegation of authority to the Audit and Risk Committee to approve on behalf of the Board, at its meeting of 10 June 2021, the 2020/21 audited annual accounts and annual report.

d) External Development Review of Leadership and Governance

The Company Secretary reported the well-led development review of governance had now been completed and further discussion will take place at a Board Development session in June 2021.

OUTCOME: The Board is **NOTED** the completion of the external well-led development governance review.

e) Board of Directors Attendance Register – for the Annual Report and Accounts 2020/21

The Board of Directors attendance register was shared which will be published in the Annual Report and Accounts in June 2021. The Board are asked to advise of any discrepancies.

OUTCOME: The Board **NOTED** the Board of Directors Attendance Register which will be published in the Annual Report and Accounts 2020/21 and advise of any discrepancies.

f) Standing Orders/Standing Financial Instructions and Scheme of Delegation

The Audit and Risk Committee on 26 January 2021 agreed changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation. These changes were presented to the Board for approval.

OUTCOME: The Board **APPROVED** the changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

g) Board of Directors Workplan 2021/22

The Board of Directors workplan for 2021/22 was shared for information.

OUTCOME: The Board **NOTED** the Board Workplan for 2021/22 and will advise the Corporate Governance Manager should there be any further items or amendments to the workplan.

h) Use of Trust Seal

The Trust Seal has not been used since the last report to the Board on 5 November 2020.

OUTCOME: The Board **NOTED** that there has been no use of the Trust Seal since the last meeting on 5 November 2020.

i) Council of Governors – Staff Vacancies and Election Timetable

The Company Secretary reported the process of elections to the Council of Governors is underway and there are 12 public governor vacancies and 4 staff governor vacancies.

OUTCOME: The Board **NOTED** the staff governor vacancies and timeline for governor elections.

74/21 Review of Sub-Committee Terms of Reference

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

- Finance and Performance Committee Terms of Reference
- Transformation Programme Board Terms of Reference

OUTCOME: The Board **APPROVED** the terms of reference for the Finance and Performance Committee and Transformation Programme Board.

75/21 Board Sub-Committee Chair Highlight Reports

The following Chair Highlight reports were received which will be on every agenda following a recommendation from the AqUA review.

- Finance and Performance Committee
- Workforce Committee
- Quality Committee
- Covid-19 Oversight Committee
- Audit and Risk Committee

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

76/21 Update from sub-committees and receipt of minutes and papers

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

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

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

77/21 Items for Review Room

- Calderdale and Huddersfield Solutions Ltd – Managing Director Update March 2021
- Guardian of Safe Working Hours Annual Report

OUTCOME: The Board **RECEIVED** the Calderdale and Huddersfield Solutions Limited (CHS) Managing Director Update for March 2021.

78/21 Any Other Business

There was no other business.

Date and time of next meeting
Date: Thursday 1 July 2021
Time: 9:00 – 12:30 pm
Venue: Microsoft Teams

The Chair closed the meeting at approximately 12.03 pm.

5. Action Log and Matters Arising

For Comment

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 06.05.21

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
06.05.21 64/21	Environment Manager to update the target of new builds in the Green Plan to 'very good' at a minimum with an aspiration of 'excellent' Environment Manager to review the recycling target of the Trust set at the minimum of 40% which has already been achieved and set a more ambitious target MD, CHS to inform the Company Secretary when the sustainability training is available for the Board to incorporate the change into Board papers	SS/RD				

6. Chair’s Report

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

Presented by Owen Williams

Transforming and Improving Patient Care

8. Staff / Patient Story - Gathering Place

Jayne Duffy, Community Matron - District Nursing

To Note

9. Health Inequalities Update

To Note

Presented by Ellen Armistead, Helen Barker and Suzanne Dunkley

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title:	Health Inequalities Progress Report
Authors:	Ellen Armistead, Director of Nursing / Deputy CEO Anna Basford, Director of Transformation and Partnerships Helen Barker, Chief Operating Officer Suzanne Dunkley, Director of Workforce and OD
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy CEO
Previous Forums:	Health Inequalities Group

Purpose of the Report

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

Key Points to Note

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

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

In response to the expectation around strengthening leadership and accountability the issue h as been discussed in a number of forums. A Health Inequalities Working Group has been est ablished to oversee progress and activity.

External environment: how we connect with our communities: A refreshed assessment of the EQIA and QIA impact of the proposed service changes and estate developments at CRH a nd HRI has been undertaken. Trust colleagues have continued to work with partners in relatio n to the Calderdale Action Plan to reduce the impact of Covid 19 impact on our BAME commu nities. The Trust has asked the Social Value Portal (SVP) to support the Trust in measuring an d reporting the delivery of social value.

The lived experience, initial focus on maternity services: At the end of May 51% of women from a BAME background have been booked onto a Continuity of Carer pathway. A of discovery interviews have been commenced to gain an insight into how it feels to be cared for by CHFT. undertaking some anonymous interviews with staff to gain insight into the

challenges of caring for service users from vulnerable groups and different ethnic backgrounds.

Using our data to inform stabilisation and reset: 76% of adult patients with a learning disability have received treatment and those who remain have an individual treatment plan agreed. Trajectories have been established for all specialties, these are reviewed weekly and areas of concern are highlighted and investigated. All surgical waiting lists remains compliant at 100% for clinical prioritisation. Weekly briefings to the Leadership teams also continue and meetings with Consultants have been used as an opportunity to remind colleagues of our agreed priorities.

Diverse and Inclusive workforce: There have been a number of initiatives developed and progressed that including appointment to the post of Black & Minority Ethnic Community Enga gement Role. A Board Development session was held in June. The session covered the opportunity for CHFT to become an anchor institution and how it can add social value.

EQIA – Equality Impact Assessment

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

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

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

Recommendation

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

HEALTH INEQUALITIES PROGRESS REPORT

1. Introduction

Health Inequalities are defined as:

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

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

2. Background and Context

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

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

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

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

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

3 Strengthening Leadership and Accountability

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

The Trust Board have received a number of updates in relation to Health Inequalities in both public sessions and Board Development.

A development session was held with the Board of Governors covering the reality of the widening health gap nationally and locally as well as an update on the main workstreams.

Health Inequalities is a regular agenda item on a number of trust wide leadership forums.

A Health Inequalities Clinical Reference Group has been established to inform and drive the stabilisation and reset agenda.

The Trust is viewed as an exemplar in the way it is addressing health inequalities and has attracted a number of enquiries from peer organisations.

4 Workstream Updates

External environment: how we connect with our communities.

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.

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

Partnership Working: Trust colleagues have continued to work with partners in relation to the Calderdale Action Plan to reduce the impact of Covid 19 impact on our BAME communities. Meetings of a steering group with system partner representation have been held and an update on progress will be provided to the Calderdale Health and Wellbeing Board in October 2021. The Trust has continued to work with system partners and communities to understand and develop actions that could support a reduction in inequalities experienced by people that are frequent attenders at A&E, homeless, asylum seekers or refugees.

Service Planning and Social Value: The Trust has asked the Social Value Portal (SVP) to support the Trust in measuring and reporting the delivery of social value. The SVP will provide a nationally approved methodology for measuring social value in terms of economic, social and environmental impact of the Trust's £196m planned estate investment

at CRH and HRI. For example describing how contractors and their supply chain will generate wider economic and social benefits for local communities such as creation of new jobs, increasing apprenticeships, community engagement and reduction in carbon emissions. The Social Value assessment will be based on a local needs analysis and target actions to support a reduction in health inequalities experienced by our local communities. The report will be provided by the end of July.

The lived experience, initial focus on 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. There is also a direct relationship between higher levels of socio-economic deprivation and higher stillbirth and neonatal mortality rates

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

Continuity of Carer: Work continues to achieve the targets for continuity of carer. While this is a very challenging target to achieve at the end of May 51% of women from a BAME background have been booked onto a pathway.

Service User Experience: As part of the Trusts response to improving the service for women and families from BAME and vulnerable groups the service has commenced a series of discovery interviews to gain an insight into how it feels to be cared for by CHFT. A staff member from a BAME background has been enlisted to support the interview process. Following the completion of the discovery interviews the aim will be to develop an action plan to address any gaps in service provision and have the findings published in relevant professional journals.

Culturally Competent Care: Given the link with clinical outcomes and service user engagement the service is undertaking some anonymous interviews with staff to gain insight into the challenges of caring for service users from vulnerable groups and different ethnic backgrounds. One completed the aim would be to use the findings to define a programme of learning and development and have this published alongside of the service user discovery interviews.

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

Using our data to inform stabilisation and reset

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 disabilities: 76% of adult patients with a learning disability have received treatment and those who remain have an individual treatment plan agreed. All children on the surgical waiting list who also have a learning disability have been validated and are now receiving dates for their treatment. We continue to work with partners to ensure that priority access to theatres is also provided for patient on their waiting list who have a learning disability.

Outside of the surgical waiting list work has progressed on the criteria for children with a learning disability and the importance of accurately recording this in relation to patients with complex needs. This work is being led by the Clinical Director for Children's services with a checklist for use across all Consultants in development.

The Task & Finish group continues to meet with current priority focus on the appointment of a project manager to support the development of FastTrack type pathway for all patients with a learning disability and the deployment of care navigators to support this

Waiting list management: Trajectories have been established for all specialties, these are reviewed weekly and areas of concern are highlighted and investigated. All surgical waiting lists remains compliant at 100% for clinical prioritisation and the priorities established by the Board continue to be monitored for adherence

Early discussions have commenced on the development of a CHFT specific prioritisation matrix that combines the Royal College Clinical Prioritisation score with a local holistic needs score that better reflects the Health Inequalities agenda.

Awareness sessions continue to be delivered, all administrative staff have been invited to these with good uptake and feedback that this has been helpful in understanding some of the changed focus in recovery. Weekly briefings to the Leadership teams also continue and meetings with Consultants have been used as an opportunity to remind colleagues of our agreed priorities and the associated rationale; some of these are being followed up with individuals.

An audit of patients who declined treatment is underway with early outputs currently being analysed and options to improve access being considered

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

A key element of tackling health inequalities is the development of a diverse and inclusive workforce, reflective of the local community.

There have been a number of initiatives developed and progressed that includes:

- Appointment to the post of Black & Minority Ethnic Community Engagement Role with the purpose to build an effective 2 way communication channel between BAME Colleagues & the community.
- Overseas Network developed – meet bimonthly with a newsletter in the pipeline
- 6 x Equality Groups (Disability / LGBTQ / BAME / Armed Forces / Women's Voices / Long Covid (With Mental Health & Menopause group being planned

- Leadership Development Platform – module being developed on health inequalities
- Empower programme – last module 'Pay it Forward' asking delegates to reach out to their local community
- Access to free wellbeing support to all our colleagues

Anchor Institution: A Board Development session was held in June. The session covered the opportunity for CHFT to become an anchor institution and how it can add social value. Anchor institutions contribute to local economy and society across five key themes: Employment; Capital and Estate; Place based working; Procurement and purchasing and Environment and sustainability. The Board agreed several actions to progress, including using Local Authorities measurements tools for social value.

5 Summary

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

Ellen Armistead,

Executive Director of Nursing/Deputy CEO

July 2021

TACKLING HEALTH INEQUALITIES IN CHFT

Workstreams

External Environment: Connecting with our Communities

Business Better Than Usual

- Long Term Conditions, working with Greenwood PCN, Huddersfield
- 'Social Responsibility' in Calderdale - Access for Disadvantaged Groups - Homeless, Refugees, Asylum Seekers etc (extending to Huddersfield)
- Longer term strategy for tackling health inequalities

Impact Assessments for Service Change

Process now incorporates Equality Impact Assessments

Reconfiguration

- Continuous process for assessing EQIA/QIA
- Deliver Social Value from investments

Calderdale BAME Action Plan

Support the delivery of the Action Plan developed following extensive community engagement to understand the differential impacts the pandemic has had on BAME communities

Digital Inclusion

- Digital access includes translation & interpreters
- Work with partners to develop digital inclusion strategies
- Develop joint action plans to reduce risk of digital exclusion

Year 1 Milestones

- ✓ Demonstrate Social Value added targeted at reducing health inequalities
- ✓ Positive feedback from communities on access to services
- ✓ Agreed co-produced digital inclusion strategies

Lived Experience: Maternity

Communication & Health Literacy	Training & Awareness	Organisation of Care	Smoking Cessation	Obesity & Diabetes
Language & accessibility of information	Cultural competence and training	Continuity & personalisation	Information & education	Information & education

Year 1 Milestones

- ✓ >60 Black and Asian on CoC pathway
- ✓ >50% Quintile 1 on CoC pathway
- ✓ 'You said , we did' - Reduction in complaints from areas of deprivation | Welcome signs in key languages | Evaluation of GDM animation in English/Urdu and Polish
- ✓ Improvement in awareness measured through survey
- ✓ Publish paper on why women smoke in pregnancy/local support needs | Implementation of care bundle | 10% increase in quit rate

Using our Data to inform stabilisation & reset

Reviewing Waiting List Data

Reviewing the waiting list data to look holistically at patient groups & 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

Learning Disability

Programme has been developed with the Matron for Learning Disabilities. High priority assigned to patients with a learning disability

Ethnicity/IMD

IMD and ethnicity data is being used to ensure equity of access for BAME/non-BAME patients and by IMD

Clinical Reference Groups

Focus on understanding variation, developing modelling to support delivery and engagement with wider workforce

Year 1 Milestones

- ✓ All patients with a learning disability are known to the service and have an individual prioritisation plan
- ✓ Care navigators are in place to support the pathways of patients with a Learning Disability
- ✓ Positive feedback from patients with a LD & their families about the timeliness of their journey
- ✓ No differential waiting times between BAME & Non BAME patients on waiting list
- ✓ An agreed holistic needs based matrix for prioritisation

Diverse & Inclusive Workforce

Health & Wellbeing

Colleague risk assessments

Colleague Voice

Equality Groups

Transformation & Recovery

Review of programmes & plans to ensure equality of opportunity for BAME groups

Independent Discrimination Panels

Preview all cases of racial discrimination in disciplinaries & complaints prior to progress through formal stages

Recruitment & Advertising Strategies

To include bold and ambitious statements for equality of opportunity

Talent Management

Strategy to include specific targets to achieve a reflective ethnic balance in all roles above band 6 within the next 5 years

Mental Health

Strategy review to ensure health inequalities are addressed

Specialist Mental Health training support into ED to focus on the needs of MH service users from BAME groups

Year 1 Milestones

- ✓ Outputs & measures from WRES /WRDES
- ✓ Board that matches the make up of our workforce and communities we serve
- ✓ % of Managers Band 6+ from each protected group
- ✓ % of all groups accessing wellbeing offer
- ✓ Staff survey results by protected group
- ✓ Diverse candidate pools - % of candidates attracted, shortlisted and appointed

10. 2020/21 Strategic Objectives Progress Report

To Note

Presented by Anna Basford

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title of report:	2020-21 Strategic Plan – Progress Report (period ending June 2021)
Author:	Anna Basford
Sponsor:	Owen Williams
Previous Forums:	None

Purpose of the Report

Provide an update on progress made against the 2020/21 strategic plan for period ending June 2021.

Key Points to Note

This report highlights that of the 19 deliverables:

0	are rated red
5	are rated amber
12	are rated green
2	have been fully completed

EQIA – Equality Impact Assessment

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

Recommendation

The Board of Directors is asked to **NOTE** the assessment of progress against the 2020/21 strategic plan.

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

Purpose of Report

The purpose of this report is to provide an update on progress made against the four goals described in the Trust's 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
5	are rated amber
12	are rated green
2	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'.	**AMBER** off track – with plan	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. Quarterly updates on the progress of this work have been provided to Trust Board sub-committees (i.e. Transformation Programme Board, Quality Committee, Finance & Performance Committee and WOD Committee). The last report in March highlighted that of the 12 themes: 4 were rated amber, and 8 were rated green. There are agreed processes in place for on-going support and review of the programme. A further quarterly update report will be provided to Trust Board sub-committees in July.	**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 development plans was undertaken in March. The planning application for development of a new A&E at HRI was submitted to Kirklees Council in June and the programme is on track to submit planning applications for the hospital expansion and new car park at CRH to Calderdale Council in July. The	**Lead: AB** Transformation Programme Board NHSE/I

		Reconfiguration OBC and HRI FBC are planned to be completed by Autumn 2021.	
Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire.	**GREEN** on track	The clinical strategy describes the Trust position on service development across West Yorkshire. A refresh of the clinical strategy has been completed and an updated strategy submitted for approval by the Trust Board on 1st July 2021.	**Lead: DB** Weekly Executive Board Quality Committee Trust Board
Trust Board approval of a 5-year digital strategy supported by an agreed programme of work and milestones.	**GREEN** on track	The 5-year Digital strategy was approved by the Trust BOD on 2nd July 2020. The key programmes are in flight and progress • Scan4 safety Project – 20/21 programme delivered to budget and 21/22 programme under development. Closed loop and safety elements for HIMSS 6 accreditation are being developed into an action plan with a target assessment date of September 21 • 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. Letter of agreement with NHSX approved and milestones agreed for 21/22 • 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. Work was delayed but has now started to accommodate face to face meetings rather than virtual Others to be agreed • Infrastructure Strategy – Engaged with external agency to develop strategy through to business case. Work with UK Cloud has commenced Strategy and Business Case will be completed by March • Information strategy – Gap analysis complete through HIMSS Standards trust score 4 and will develop the strategy using this analysis.	**Lead: MG** Divisional digital boards Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.

		• 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. Mental Health trust SWYPFT can now use community view to see trust EPR.	
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 with a range of colleagues (e.g., Patients, Doctors, Nurses, Therapists, Medical Secretaries) 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. CHFT, 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 has been incorporated into a Health Inequalities dashboard where we can then look at it in relation to: • Patients with a learning disability • By ethnicity • By Index of Multiple Derivation • By their Frailty score By reviewing the waiting list data in this way we have been able to look more holistically at patient groups and individuals and prioritise treatment taking account of additional risks factors. The two areas currently in focus	**Lead OW** Weekly Executive Board Board of Directors Learning Improvement Review Board Health Inequalities Oversight Group (England)

		are patients with a learning disability and patients from a BAME background. It should be noted that the Trust is not doing this work in isolation and is deeply involved in influencing and partnering with other organisations to reduce health inequalities at place and neighbourhood levels; across the acute collaboration of WYAAT and as a part of the West Yorkshire & Harrogate Partnership's 10 big ambitions.	
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	Although hospitalisations remain low in comparison to this time last year, Kirklees and Calderdale have seen an increase in the number of Covid-19 infections in the past few weeks. There are increasing numbers of the Delta variant infection in our local communities. We are continuing to work with all partners and communities to support increased population uptake of the Covid-19 vaccine. The Trust is ensuring social distancing measures remain in place, so all patients and colleagues feel safe in our hospitals. We are placing priority on reducing the backlog of patients that have had their care and treatments delayed due to the pandemic and to ensure that our recovery plans will support a reduction in health inequalities.	**Lead: OW** Weekly Executive Board Trust Board
Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating.	**AMBER** off track – with plan	During the pandemic the process for internal assessment (ward accreditation/ Focussed Support Framework) was suspended. During this time the quality directorate have worked with the divisions and developed a new style accreditation Journey to Outstanding (J20). This has been tested and the roll out has commenced.	**Lead: EA** Quality Committee Weekly Executive Board

		The CQC have undertaken 3 service level assessment with the Trust in line with their pandemic response to inspections. We have had favourable feedback from CQC, but the assessments do not have ratings attached to them. Work in line with well-led continues. The amber progress rating reflects the gap in assurance around external validation as a result of CQC rating activity and the level of embeddedness of the J2O.	
Involve patients and the public to influence decisions about their personal care and improve patient experience by: • responding to the needs of people from protected characteristics groups • implementing "Time to Care". • achieving patient safety metrics	**GREEN** on track	Work continues on a range of activities around patient engagement. Observe and Act has been introduced and plans in place for the schedule of assessments. These align to our J20 programme. The Health Inequalities group are overseeing the work plan in relation to the lived experiences that involves some discovery interviews commencing in maternity services. • LD has had an increased focus across the organisation.	**Lead: EA** Quality Committee Weekly Executive Board
Develop an outcome-based performance framework and deliver against key metrics.	**BLUE** completed	Performance and Accountability framework completed to plan and approved at Board of Directors. IPR updated to include a specific recovery section and an increased focus on outcome metrics which will continue to develop through 21/22	**Lead: HB** Integrated Board Report Weekly Executive Board Audit and Risk Committee Finance and Performance Committee
Deliver the actions in the Trust's 2020/21 Health and Safety Plan.	**GREEN** on track	Significant progress has been made in developing Health and Safety Sub Committees and the Trusts 5-year Health and Safety Strategy will be presented to Board in July.	**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 a focus on recruitment and retention in our people strategy, a 3-year recruitment strategy, a 3-year apprenticeship strategy, a 5-year equality, diversity, and inclusion strategy and Covid and non-Covid specific redeployment processes. Additionally:- • all job descriptions and adverts have flexible working options as standard, encouraging diversity of applications • we have increased cohorts of Trainee Nurse Associate and Health Care Assistant apprentice • we are progressing recruitment to Enhanced Care Support Worker roles which enhance our therapeutic care to patients • we are participating in the NHS England/Improvement sponsored international recruitment programme for qualified nurses • we are participants in the nationally sponsored Health Care Support Worker recruitment programme • we continue to be successful in recruiting to Consultant level posts in the medical workforce	**Lead: SD** Workforce Committee
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	**Lead: SD** Workforce Committee

		• 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 • a significant investment has been made by the Trust to establish a 'widening participation' team in the Workforce and OD Directorate. This will enable an increased focus on ensuring that people in our local communities have access to healthcare employment opportunities and to pre-employment skills development support.	
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. A full review of the content is to be conducted in 2021/2022 with a relaunch to be scheduled. New material is added to the programme as it becomes available and new leadership modules are in development (for example, collaborative health system working). A leadership Hot House event was held on 7 June 2021 with 70 participants focusing attention on the skills/attributes required in our leader's post-pandemic. This will inform the development of our leadership and management development programmes.	**Lead: SD** Workforce Committee
Develop an approach to inclusive recruitment panels and assessment processes	**AMBER** **off track with plan**	The NHS People Plan emphasises the importance of improvement work in relation to equality and diversity and recruitment. It makes specific reference to an	**Lead: SD** Workforce Committee

to ensure a senior management team that reflects the diversity of the workforce. (SD)		‘overhaul of recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.’ A review of how current inclusive recruitment is operating completed in February 2021 highlighted there are areas for development. The engagement and recruitment teams are working with our established equality network groups to improve processes, expand membership on panels, increase interview training and enhance decision making linked to our 4 pillars. Refreshed training will be implemented at the end of June 2021. It is anticipated that activity will ensure compliance by September 2021.	
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	145 Wellbeing Ambassadors are now in place. 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. Wellbeing Advisers operating as part of the Engagement Team based in the Workforce and OD Directorate are aligned to service areas to ensure maximum health and wellbeing support. The implementation of the wellbeing hour continues. A Non-Executive Director (Richard Hopkin) has been appointed as our Board level Wellbeing Guardian. The 2020 national staff survey results show a significant increase in our health and wellbeing score. In response to a question about the organisation taking positive action on health and wellbeing a 10% improvement in responses occurred, from 22% in 2019 to 32% in 2020.	**Lead: SD** Workforce Committee
Goal: Sustainability			

Deliverable	Progress rating	Progress summary	Assurance route
Deliver the 20/21 regulator approved financial plan. (GB)	**GREEN** on track	The Trust is forecasting to deliver the Board approved H1 plan agreed within the ICS for 2021/22. The plan requires a £3m efficiency which is being identified and assumes additional income is received for delivering additional recovery activity over and above the original plan. A plan for H2 has yet to be agreed along with a financial framework for H2 that is still to be issued.	**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 is presented monthly at Finance and Performance committee. This shows improvement from when our assessment took place. Whilst the metric is no longer being collected by NHSIE we have continued to monitor. For H1 of 2021/22 the financial framework is known, and we forecast to deliver the improved score. For H2, the framework is yet to be agreed. Unless further funds are identified, a deficit is likely which would impact the metric. A report was published to F&P in June 2021 that demonstrated progress against other KLOE and progress against all CQC / Our actions identified.	**Lead: GB** Reported to Finance & Performance Committee Quality Committee Monthly regulator discussions
Trust Board approval of a 10-year sustainability plan to support reduction in the Trust's carbon footprint.	**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 national consultation and has confirmed support for proposed	**Lead: AB** Plans reviewed by Board and WYAAT Committee in Common System Leadership Meetings with NHSE and ICS

		changes in the legislative footing of Integrated Care Systems in 2022. The Trust has updated its Clinical Strategy (subject to approval at Trust Board on 1st July) that provides information of how the Trust can support the resilience of service delivery by working in partnership across West Yorkshire.	

11. Clinical Services Strategy 2021-25

To Approve

Presented by David Birkenhead

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title of report:	Clinical Services Strategy 2021-25
Authors:	Anna Basford, Rob Moisey, Mark Davies
Sponsor:	David Birkenhead, Executive Medical Director
Previous Forums:	Weekly Executive Board 10th June 2021

Purpose of the Report

This report provides a refresh of the clinical services strategy that was agreed in 2019 to incorporate key learning over the past two years. This has been informed by significant engagement with colleagues and partner organisations during 2020-21.

Key Points to Note

The clinical services strategy aligns with the Trust's wider strategic plans and highlights the commitment of CHFT to:

- Provide the most effective clinical care for patients to achieve a reduction in health inequalities and optimal health outcomes;
- Deliver the best possible service configuration and collaborative working arrangements that will improve service resilience and patient outcomes;
- Support and opportunities for clinical skills learning, development and research.

EQIA – Equality Impact Assessment

The Clinical Services Strategy describes the key areas of work (themes) the Trust will progress to deliver the most effective clinical care and outcomes for patients that will achieve a reduction in health inequalities. The assessed impact across all Health Inequality domains is positive.

Recommendation

The Board of Directors is asked to **APPROVE** the refreshed Clinical Services Strategy 2021-2025.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Clinical Services Strategy 2021-2025

June 2021

compassionate care

Content:

1. Introduction

Calderdale and Huddersfield NHS Foundation Trust (CHFT) is an integrated Trust providing hospital services and community health care for the populations of Greater Huddersfield and Calderdale.

In June 2019 the Trust agreed a clinical service strategy setting out plans for the development of clinical services at Calderdale and Huddersfield NHS Foundation Trust over the next five years.

Since then the COVID-19 pandemic has necessitated many changes across the health and social care system. Despite these challenges positive learning has emerged, and we want to ensure that this informs future service delivery models to embed and sustain the examples of positive transformation.

One of the most important areas of learning to emerge is the increased understanding that we are part of a bigger system. We need to work in partnership at local and regional level to ensure the very best services for the populations we serve.

This report builds on and provides a refresh of the clinical strategy that was agreed in 2019 to incorporate key learning over the past two years. This has been informed by significant engagement with colleagues and partner organisations during 2020-21. For example during 2020 over 185 CHFT colleagues, 9 health and care partner organisations, and 1,377 patients and members of the public have shared their thoughts with us about key learning of their experiences during the pandemic. Alongside this, specific meetings have taken place with every clinical specialty in the Trust to review and update the clinical strategy agreed in 2019.

This refreshed clinical strategy sets out CHFT ambitions of how we can strengthen patient care, and support colleagues to deliver the most effective clinical services. This will contribute to increased service resilience in our local health and care system in Greater Huddersfield, Calderdale and across West Yorkshire.

2. Purpose of the Clinical Strategy

This clinical strategy sits alongside several other Trust strategy documents. This includes for example: the 10 Year Strategy, the Digital Strategy, the Green Plan, our Service Reconfiguration Plans, the Quality Plan, the Research and Development Strategy, and the Workforce and Organisational Development Plan.

The NHS long term plan was published in 2019 and describes ambitions over the next ten years to ensure the NHS is fit for the future with improvements to be delivered in the following key areas:

- Improving out-of-hospital care (primary and community services);
- Strengthening the NHS contribution to prevention and reducing health inequalities;
- Reducing pressure on emergency hospital services;
- Delivering person-centred care;
- Delivering digitally enabled primary and outpatient care;
- Focusing on population health and local partnerships with Integrated Care Systems having a central role in the delivery of the Plan.

CHFT's clinical strategy aligns with these wider strategic plans and its purpose is to highlight the commitment of the Trust to:

- Provide the most effective and 'state of the art' modern clinical care for patients to achieve optimal health outcomes for people;
- Deliver the most effective service configuration and collaborative working arrangements that will improve service resilience and patient outcomes;
- Provide colleagues with support and opportunities for clinical skills learning, development and research.

3. About the Trust

3.1 Our Vision and Strategic Plans

The Trust's Vision is that - ***"Together we will deliver outstanding compassionate care to the communities we serve"***

This vision is underpinned by four fundamental or 'Pillars' of behaviour that guide all Trust colleagues in the way they work. This aims to ensure that we continue to involve and work closely with patients, members of the public and colleagues to ensure that:

- We put the patient first

- We ‘go see’ (learning from others)
- We work together to get results
- We do the must dos (ensuring regulatory and statutory compliance)

‘Work Together To Get Results’ has been embedded across the Trust and this is the improvement method and approach colleagues consistently use to transform the way we work and create an environment where the ideas of colleagues, partners and the public are taken on board and the patient comes first.

The Trust’s aim is to deliver one culture of care which means that we care for our colleagues in the same way that we care for our patients - ensuring colleague well-being remains a priority. The Trust’s 10 - Year Strategic Plan on a Page was approved by the Trust Board in 2020 and is shown below.

10 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			
The result	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Sustainability
Our response	Patients and public are able to shape decisions about service developments and their personal care.	We will have achieved and sustained a CQC rating of outstanding.	The Trust will be widely known as one of the best places to work through an embedded one culture of care.	We will be financially sustainable and an exemplar for use of resources.
	We will have an optimal configuration of services and demonstrated improved outcomes for local people.	We will consistently achieve all relevant patient performance targets as featured in the NHS Long Term and ICS plans.	We will foster an open learning culture that focuses on, and demonstrates lessons learnt and sharing best practice.	The Trust will have significantly reduced its carbon footprint.
	Patients and colleagues will be digitally enabled to access and provide care wherever this is needed.	We will be fully compliant with health and safety standards and be faithful to our constitution.	We will have a workforce of the right shape, size and flexibility to deliver care that meets the needs of patients.	
	Working with partners we will regularly use population health data to address health inequalities.		As an anchor institution we will have a workforce that champions, reflects and celebrates our diverse communities.	

3.2 The Health Needs of the Population We Serve

The resident population of Huddersfield and Calderdale is approximately 458,000. People in Calderdale and Huddersfield are living longer lives than in the past, however, more people are likely to have multiple long-term conditions thereby increasing demands on the health and social care system. As a result, there is a growing population of people older than 65 with the younger population remaining stable thereby leading to an increase in the dependency ratio. These patients have more complex health needs, placing greater demands on healthcare services. Our population is very varied and diverse and there are also significant areas of deprivation resulting in a significant difference in life expectancy of approximately 7.5 years from the most to least deprived areas, with an even greater variance in the number of years lived in good health of approximately 11 years. In Kirklees 21% of the population is from an ethnic minority background whilst in Calderdale

approximately 10%, the largest minority ethnic groups across both authorities are Asian/Asian British comprising 15% and 8% of the population respectively.

The COVID-19 pandemic has affected every child, adult, family and community in Calderdale and Huddersfield, with some of the biggest impacts seen for the most disadvantaged and people from BAME communities. More than 2,000 patients with Covid have been treated and discharged from our hospitals – but we know some people continue to experience long term health impacts. Management of the pandemic has unfortunately resulted in the development of significant planned care backlogs at CHFT. Providing treatment for people that have had their care delayed is a top priority for the Trust. We will use Health Inequalities data to complement clinical prioritisation to inform our system's post Covid-19 recovery to minimise the risk of treatment delays widening health inequalities in our communities.

3.3 Our Services and Estate

CHFT provides acute and community health services. Hospital services are provided at Calderdale Royal Hospital (CRH) and at Huddersfield Royal Infirmary (HRI). The distance between the two hospitals is just over five miles. The Trust provides community health services in the Calderdale area.

The Trust employs circa 6,300 members of staff (headcount) who deliver compassionate care at CRH and HRI as well as in community sites, health centres and in patients' homes. In a typical year the Trust delivers treatment and care for 71,248 inpatients and 49,204 day-case patients, delivers 436,143 outpatient appointments, and has 156,923 patient attendances in the accident and emergency departments. The annual planned operating expenditure for 2021/22 is £452m.

Both hospitals currently provide accident and emergency services, outpatient and day-case services, acute inpatient medical services and intensive care for adults. Some services are delivered at one site only (e.g. stroke and trauma).

We know that care should not be about very long stays in hospital and Increasingly, hospitals are providing treatments as day cases. Many services such as specialist nursing which were once provided only in a hospital can now be delivered in the local community and in people's homes. The pandemic has accelerated implementation of digital and service delivery options that mean many people can now more conveniently access the care and support they need closer to home.

Work to develop safe and sustainable models of hospital and community care in Calderdale and Huddersfield has been underway since 2012. Several independent reviews have recommended that changes to the current dual site hospital service configuration are needed to improve patient safety and outcomes. In 2019 the Trust's Strategic Outline Case describing plans for reconfiguration of services across the two hospital sites and investment in our estate was approved by NHS England and the Department of Health and Social Care (DHSC). An allocation of £196.5m of public capital funding was announced to enable implementation. The approved service model will sustainably

address quality, operational and workforce challenges and deliver benefits for patients and colleagues. Acute and emergency services will be consolidated at CRH and planned care at HRI, both hospitals will continue to provide Accident and Emergency services.

West Yorkshire and Harrogate Health and Care Partnership, the Integrated Care System (ICS), has confirmed that the planned service reconfiguration and estate developments across CRH and HRI: fits with the overall strategy for the development of better health and care services for West Yorkshire and Harrogate as a whole and this is the West Yorkshire and Harrogate ICS's highest priority for public capital investment. The plans will support the longer-term resilience of acute and emergency service provision and have critical importance in ensuring the overall resilience of hospital service provision across West Yorkshire.

3.4 Overview of Our Quality and Performance

CHFT has an excellent track record in the delivery of safe and timely access for patients across all pathways. Prior to the Pandemic it was one of the top-rated Trusts across the key regulatory standards (e.g. Referral to Treatment Times (RTT), Emergency Care Standard (ECS) and Cancer waiting time less than 62 Days) and has a Good CQC rating. The Trust's ambition is to achieve a CQC rating of Outstanding.

Whilst CHFT and the wider system has always performed well significant planned care backlogs have developed as a consequence of managing the pandemic, that will take many months to eliminate. Recovery plans have been developed and the Trust is committed to ensuring the delivery of these plans will reduce Health Inequalities.

3.5 Our Digital Health Strategy

CHFT is one of the most digitally advanced Trusts in the UK. CHFT has committed to be innovative in its use of digital technology to deliver more consistent care, improve access to clinical records by both health care professionals and patients and improve patient outcomes. This commitment has resulted in CHFT moving to the top of the national Clinical Digital Maturity Index (CDMI).

The Trust's development of digital technology is enabling:

- clinicians and patients to access patient information, anywhere, anytime
- providing in-built decision support to clinicians and issuing automated safety alerts (for example in relation to over-prescribing)
- providing alerts for deteriorating patients
- use of advanced information systems to support the efficient use of our theatre capacity
- delivering high levels of inter-operability so that different healthcare providers can see each other's records supporting the safe transfer of patients between hospitals and community services and the provision of integrated care.

3.6 Working in Partnership

The Trust is a member of the West Yorkshire and Harrogate Health and Care Partnership (Integrated Care System - ICS) which is the second largest ICS in the country covering a population of 2.6 million people and a budget of over £5 billion. The purpose of the partnership is to deliver the best possible health and care for everyone living in the areas of: Calderdale; Kirklees; Bradford District and Craven; Leeds; Wakefield; Harrogate. The Partnership is made up of care providers, commissioners, voluntary organisations and Councils working closely together to plan health and care.

The Trust plays a major role in the West Yorkshire Association of Acute Trusts (WYAAT) established in 2016 as an acute collaborative provider network comprising six local Trusts which are engaged in a number of provider to provider arrangements. The vision of WYAAT is to create a region-wide efficient and sustainable healthcare system that embraces the latest thinking and best practice consistently delivering the highest quality care and outcomes for patients. The purpose of the collaborative programme is to reduce variation and deliver sustainable services to a standardised model which are efficient and of high quality.

In Calderdale and Kirklees CHFT works closely with local system partners and is supporting the development of local Integrated Care Partnerships and Provider Networks.

4. Our Clinical Strategy

4.1 Overview of Key Themes

Patient Centred Care	*We will ensure that patients (and their carers) are involved in decisions and care is personalised to support and meet their needs.*
Reduce Health Inequalities	*We will work with partners and communities and use population health data to understand and take action that will reduce health inequalities.*
Digitally Enabled	*We will ensure that data and decision support tools are available at the fingertips of our doctors, nurses and therapists to drive safety, quality improvement, and research. We will also use data to gain insight into the way people access services and use this to inform how we can make care more personalised and relevant to individual patients and communities to reduce health inequalities.*
Eliminating Unwarranted Variation	*We will continue to embed the "Getting it Right First Time" (GIRFT) programme at CHFT. This programme has been highly successful and CHFT is a recognised national thought-leader. The programme is clinically led and involves doctors, nurses and therapists in peer review to identify and reduce unwarranted variation in working practices and apply evidence-based practice to their clinical care to achieve improvements in clinical quality.*
Research & Development	*We will build on our strong track record of research (in particular our award-winning work on the Covid-19 Recovery Trials) to make the Trust a national exemplar for applying research findings to clinical practice and in improving the health of our population.*
Care Closer to Home	*We will work with patients and our partners to develop clinical and diagnostic services closer to people's homes. This will include new pathways of care and optimising the use of digital technology to enable access to specialist advice and support in the community.*
Service Reconfiguration	*We will invest at CRH to expand the hospital providing additional wards, theatres and a new emergency department including a special paediatric A&E. At HRI investment will enable the build of a new A&E department and the adaptation of existing buildings. These developments will provide 'state of the art' healthcare facilities and enable essential clinical adjacencies to improve quality and safety.*

Regional Networks	*We will collaborate with partners across West Yorkshire and Harrogate to improve the resilience of acute hospital services, patient safety and clinical outcomes through the establishment of speciality clinical networks and centres of excellence.*
One Culture of Care	*We will work together to create an organisation that is known for one culture of care that means we care for colleagues in the same way we care for our patients. This will also help us ensure that colleagues are able to develop as professionals throughout their career at the Trust, with opportunities for gaining new skills and taking on new roles and responsibilities.*

4.2 Clinical Strategy Themes in More Detail

4.2.1 Patient Centred Care

The Trust's aim is to ensure that service delivery is patient centred and personalised. This will be informed by the systematic involvement of patients, carers and local populations in the continuous improvement to the quality of our services.

Our priorities are:

- to ensure the Trust supports and enables the integrated and seamless provision of primary, secondary, mental health and social care services to meet the holistic needs of patients and carers;
- ensure that our services are sensitive to the cultural needs of our patients and reduce health inequalities;
- to provide personalised care planning and support people to live well;
- to ensure that physical and mental health are given equal priority in the care of our patients;
- to deliver the same high standards and quality of service 7 days a week;
- to learn from deaths and ensure we provide the best end of life care;
- to ensure that our patients do not spend unnecessary time in hospital and avoid unnecessary admissions;
- to maintain and improve where possible our nationally reportable performance metrics, particularly in relation to Cancer and Emergency Care;

We will do this by:

- demonstrating visible leadership;

- engaging our patients and their families in the continuous development and improvement of our services;
- engaging with minority groups both within CHFT and our communities;
- engaging our staff in service improvement using Work Together Get Results;
- learning from other organisations - 'Go See';
- maintaining a continuous drive for improvement, being innovative in our approach and continuing to engage in national quality improvement collaboratives including NHS Quest and the NHS Improvement Quality, Service Improvement and Redesign Programme;
- Continuing to develop our approach to frail patients, developing in partnership additional community based support;
- ensuring compliance with NICE and other national guidance;
- learning and improving from our successes, mistakes and complaints and responding in a timely manner;
- implementing the Medical Examiner role;
- continue to focus on the training and education of our clinical staff and to be a centre of excellence in this regard.

This will result in:

- us putting the Patient First;
- the Trust being recognised for the delivery of "outstanding" care by our regulators and achieving a CQC rating of Outstanding;
- the Trust demonstrating pro-active actions taken to support reduction in health inequalities;
- the Trust being recognised by our patients and their families for delivering effective and responsive care with an improvement in our Friends and Family results and being the place of choice for their healthcare needs;
- our SHMI/HSMR mortality metrics will remain within the expected range;
- a reduction in our formal complaints;
- a reduction in clinical incidents;
- a reduction in Hospital Admissions and Delayed Transfers of Care;
- CHFT seen as an employer of choice and a reduction in the number of vacant clinical posts.

4.2.2 Reduce Health Inequalities

The Trust is committed to lead and contribute to work across Calderdale and Greater Huddersfield that will reduce health inequalities experienced by our population. This includes understanding and taking actions to reduce inequalities experienced by people caused by deprivation, mental health conditions, learning disabilities and for Black, Asian and Minority Ethnic Communities.

Our priorities are:

- strengthening community relationships and listening to the views of local groups and communities about their experience of accessing healthcare to develop actions that can be taken to meet their specific needs;
- ensuring our procurement processes and estate investment plans target and reach out to the most vulnerable groups and communities that currently experience inequality with the aim of supporting job creation, training placements, in-reach to colleges / schools, and apprenticeships;
- improving the lived experience, with initial focus on families accessing our maternity service and Continuity of Carer (CoC). Our aim is to ensure that the proportion of Black and Asian women and those from the most deprived neighbourhoods on CoC pathways meets and preferably exceeds the proportion in the population as a whole;
- Using Health Inequalities data to complement clinical prioritisation and our system's post Covid-19 Recovery Framework for both planned and unplanned care. We are using real time data analysis of patient waiting lists in relation to index of multiple deprivation, ethnicity, and other protected characteristics to prioritise patient care as part of elective recovery plans;
- Ensuring we have a workforce that reflects our local population at all levels, delivering a workforce and organisational development programme around Health Inequalities, diversity and inclusion.

We will do this by:

- involving and listening to local people;
- engaging minority groups within our workforce and communities;
- working in partnership with organisations across our local health and care system;
- using health population data to understand inequalities in access and experience of care and enable us to target actions to reduce inequalities;
- providing training for all colleagues in relation to health inequalities and cultural awareness;
- ensuring we have inclusive recruitment panels and assessment processes to ensure a senior leadership team that reflects the diversity of our population.

This will result in:

- an inclusive workforce that reflects the diversity of the communities we serve;
- positive feedback and confidence of local people and communities in the services provided by CHFT;
- positive feedback from CHFT colleagues;

- reduction in complaints;
- improved health outcomes and equity of access to services for people;
- services that are culturally competent and designed to meet individual needs;
- demonstrating the Trust has created wider social value as an "anchor institution" through creation of job opportunities, apprenticeships, skills and training that contribute to a reduction in health inequalities in our local population.

4.2.3 Digitally Enabled

The Trust has implemented one of the most advanced digital infrastructures in the country, integrating the live primary and secondary care record. We will continue to work to include Social care records in this regard. This enables an exciting platform for shared pathways and innovative technical alternatives for patients to access care, breaking through organisational boundaries to create effective and safe continuity of care for patients at all times.

Our Priorities are:

- to use digital technologies to improve the quality and reliability of clinical care offered to our patients;
- to use Health Inequalities data to complement clinical prioritisation for both planned and unplanned care;
- to make available to our staff an integrated healthcare system that is easy to use and access;
- to create straightforward Digital access to NHS services and help patients and their carers manage their health;
- to facilitate the use of remote consultations;
- to use digital and data capabilities to support timely and effective transfers of care from and to our communities;
- to use digital technologies to support the early discharge of patients;
- to facilitate the efficient working of our staff;
- to reduce the number of standalone IT systems that need to be accessed to ensure all relevant clinical information is available from a single information source;
- to protect patient's privacy and give them control over their medical record;
- to use our digital journey to support evolving digital maturity at place and community;
- to ensure that NHS systems and NHS data are secure through implementation of security, monitoring systems and staff education.

We will do this by:

- enabling clinicians to access and interact with 'real-time' patient records and care plans wherever they are. The Trust's aim is to ensure that staff and patients have access to the right information and data, at the right time, to optimise the delivery of effective, safe, high quality care;
- supporting clinical practice with automated safety alerts;
- providing alerts for deteriorating patients;
- supporting the provision of data to national audit systems;
- enabling transformation of out-patient services and the provision of virtual clinics so patients do not have to make unnecessary visits to hospital;
- developing digital health solutions such as telecare, telehealth, tele-monitoring and direct booking of appointments;
- using video conferencing and other messaging systems;
- using predictive techniques to support local health systems to plan care for populations;
- using real time data analysis of patient waiting lists in relation to index of multiple deprivation, ethnicity, and other protected characteristics. This analysis is being used to prioritise patient care as part of elective recovery plans. In particular to take action to ensure that people with Learning Disability or from BAME communities do not wait longer for care than other patients;
- using intuitive tools to capture data as a by-product of care in ways that empower clinicians and reduce the administration burden;
- using decision support and artificial intelligence (AI) to help clinicians in applying best practice, eliminate unwarranted variation across the whole pathway of care, and support patients in managing their health and condition;
- enabling interoperability across laboratory information management systems so that patient diagnostic test results can be accessed at any hospital the patient attends – this will improve the safety and quality of care;
- being innovative and implement technology that will allow remote patient monitoring and facilitate early discharge;
- supporting remote home monitoring to enable patients and their carers to self-manage their condition out of hospital;
- to mandate and rigorously enforce technology standards (as described in The Future of Healthcare) to ensure data is interoperable and accessible.

This will result in:

- all relevant clinical information being available within a single software package;
- a reduced reliance on face to face Patient – Clinician interactions resulting in increased efficiency and greater patient satisfaction;
- improved and timelier clinical information being available to our Patients;

- clear and appropriate information being made available to healthcare partners, improving the reliability of clinical care and reducing the need for duplication;
- a reduction in the need for staff to travel between sites to attend meeting;
- the facilitation of remote and flexible working;
- the Trust being recognised as a digital exemplar and test bed for new technologies, providing a national repository of information and expertise;
- improved quality and safety of patient care and better working lives for clinical staff.
- reduced length of hospital stay;
- achievement of the digital practical next steps that are described in the *NHS Long Term Plan.*

4.2.4 Eliminating Unwarranted Variation

GIRFT is a national programme that aims to improve the quality of care in the NHS by identifying and reducing unwarranted variations in services and working practices. This involves clinically led review of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved. GIRFT involves the Trust receiving a visit from other clinicians to look at the information available, review the service delivered, share best practice and discuss the challenges faced in that specialty.

Since 2017 CHFT has undertaken 26 speciality reviews and in each review clinical colleagues have identified actions that have been implemented to improve quality and safety of care. CHFT has been recognised at a national level for leading the way in GIRFT implementation.

Our Priorities are:

- to support all specialities to undertake GIRFT reviews and embed processes and actions;
- to implement GIRFT reviews that have been developed to improve the management of adult COVID-19 patients in secondary care;
- to strengthen multi-disciplinary input to reviews and in particular nurse involvement;
- to develop and share a national toolkit and methods that will enable more colleagues locally and in other Trusts to engage in GIRFT;
- to use GIRFT benchmarks and best practice approach to optimise efficiency, increase focus on day case activity (elective and non elective), and ensure optimal use of estate to maximise patient activity;
- to implement the National Consultant Information Programme that will provide a Digital Portal of individualised benchmark data across 8 surgical specialties.

We will do this by:

- continued active engagement with clinical specialities and colleagues sharing easy to access learning through videos and webinars;
- involving and supporting specialist and consultant nursing colleagues to lead reviews;
- appropriately encouraging the use of individualised benchmark data in appraisals, governance and research.

This will result in:

- elimination or reduction in unwarranted clinical variation;
- improved patient safety, experience of care and clinical outcomes;
- development of clinical skills in leading service improvement;
- enhanced multi-disciplinary working and engagement.

4.2.5 Research and Development

Research is an important part of our Trusts commitment to continuously improve and offer the best care options for our patients. Research is fundamental in providing our patients the opportunity to try new treatments and therapies by offering the choice to participate in cutting edge research at their local Trust.

Our vision is to work with our partners at the leading edge of healthcare, realising the research potential in all areas of our organisation for the benefit of our patients and staff. Our aspiration is for all clinical specialties to be engaged in high quality research and that our patients and staff have the opportunity to participate. Organisations that take part in research have better patient outcomes and creates a research culture leading to evidence-based practice.

Our Priorities are:

- to develop a dedicated research hub to expand our research capability, capacity and delivery.
- expanding our commercial research portfolio of studies;
- to increase our number of clinical staff as Principal and Chief Investigators;
- to increase the number of patients able to access and participate in clinical trials;
- to forge greater collaboration with our academic and industry partners to generate successful research grants.

We will do this by:

- Providing a bespoke research hub with a robust infrastructure to deliver research
- Widening the research base by setting up research in new clinical specialities.
- Placing emphasis on research when appointing to new clinical posts.

- Re-investing research income for continuous research improvement.
- Meeting high level objectives for performance and delivery thereby growing our reputation as a centre for excellence.
- Pro-actively engaging with academia and industry partners to explore opportunities for research and joint appointments as part of the hub model.

This will result in:

- Greater access and opportunity for our patients to participate in research studies.
- Offering cutting-edge treatments, therapy and access to novel trial drugs for our patients.
- Attract and retain high quality and expert staff.
- Attracting new research sponsors by creating a strong base for delivery via the hub model.
- The Trusts reputation and performance as a centre for research excellence.
- Improved measurable outcomes for all our patients.

4.2.6 Care Closer to Home

The Trust is working with networks of GP practices to serve and design care for 'localities' of 30,000-50,000 people. This involves working with health and social care partners to share resources and deliver holistic person-centred care that will reduce the need for hospital admissions and attendances.

Our Priorities are:

- to work with partners to enable the full integration of community health services and social care provision based around GP practices;
- to make it easier for people to access care when closer to home, with a consistent and high-quality experience for patients as they move between different parts of the integrated system;
- to improve urgent and emergency care to reflect the delivery expectations of the NHS 10 Year Plan;
- to reduce the need for people to attend hospital for a traditional 'face-to- face' outpatient appointments;
- to work with our partners to support increasingly preventative and anticipatory health and care offers for our local communities.

We will do this by:

- continuing to work with health and social care partners to develop and improve pathways of care particularly in relation to Frailty, non-admitted AED attenders, adult and children, High Intensity

Users, Mental Health, Same Day Emergency Care services, End of Life care, and respiratory services;

- working with our own Community Division to be an exemplar for care in the community and adopt innovative practice;
- promoting self-care and access to alternate support out of hospital;
- increasing the use of technology to offer virtual consultations and review;
- reducing the number of appointments each patient needs to attend by offering one-stop clinic models combining diagnostics and management in the same visit or by implementing patient initiated follow up models;
- positive patient and carer feedback on their experience of services;
- delivering care in the most appropriate setting and by the most appropriate person e.g. therapy led, or nurse led appointments.

This will result in:

- seamless provision of services and support for patients and carers;
- integrated health and social care provision making the best use of available resources and skills;
- reduction in non-elective admissions to hospital;
- reduction in the number of people delayed in hospital;
- positive feedback from patients and carers on their experience of services.

4.2.7 Service Reconfiguration

There is a compelling clinical case for change to develop a safe and sustainable model of hospital and community services in Calderdale and Huddersfield. Over several years, the Trust has worked with partners to develop plans for the reconfiguration of services across the two hospital sites and the Secretary of State for Health and Social Care has confirmed £196 million of capital funding is available to implement the changes. The plans for these changes are described in the Trust's Strategic Outline Case.

Our Priorities are:

- to achieve compliance with Royal College of Emergency Medicine workforce recommendations and the standards for Children and Young People in Emergency Care settings with regards to having ready access to paediatric specialist trained staff;
- to achieve compliance with Guidelines for the Provision of Intensive Care Services 2015 (GPICS) standards;
- to strengthen clinical rotas and enable specialised rotas to be provided;

- to provide models of service that are attractive to staff and will improve recruitment and retention reducing the Trust's reliance on locum and agency staff (particularly in Emergency Medicine, Gastroenterology, Urology, Radiology, Dermatology, Rheumatology, Ophthalmology, Critical Care, and Acute Medicine);
- to provide models of service that support community pathways of care and the recruitment of colleagues providing care in community settings;
- to separate unplanned inpatient care from planned services to make it easier to run efficient surgical services.

We will do this by:

- investing in both our hospitals to provide 'state of the art' healthcare facilities that will enable essential clinical adjacencies to improve quality and safety;

- Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) will both provide 24/7 consultant-led A&E services and a range of day-case, outpatient and diagnostic services;
- A&E at CRH will receive all blue light emergency ambulances for patients that have serious life-threatening conditions and all patients likely to require hospital admission;
- A&E at HRI will receive self-presenting patients. All patients requiring acute inpatient admission will be transferred by ambulance from HRI to CRH;
- Critical care services, emergency surgical and paediatric surgical services will be provided at CRH;
- physician-led inpatient care will be provided at HRI. This is for people who do not require the most acute clinical inpatient healthcare but do require extra support whilst arrangements are made to meet their future needs;
- midwifery led maternity services will be provided on both hospital sites. Consultant led obstetrics and neo-natal care will be provided at CRH;
- paediatric emergency care and all inpatient paediatric services will be provided at CRH;
- planned surgery and care will be provided at HRI. Patients that require complex surgery or it is known that they will require critical care after surgery will be treated at CRH;
- working with partners in the community to deliver integrated community services covering the 3 key care stages in the community of anticipatory, intermediate and urgent response.

This will result in:

- improved clinical quality and safety of services;
- improved efficiency of service delivery;
- improved staff recruitment, retention and wellbeing;
- improved compliance with statutory, regulatory and accepted best practice;
- make the best use of the available hospital estate.

The plans for these changes are described in the Trust's Strategic Outline Case.

4.2.8 One Culture of Care

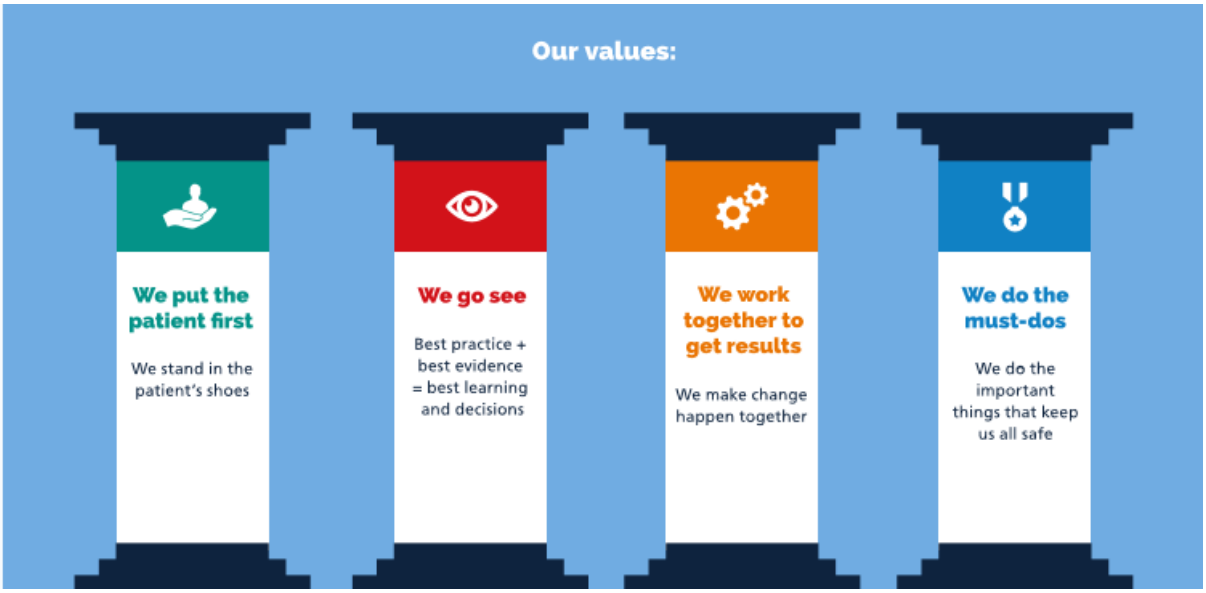
The Trust will create an organisation that is known for one culture of care. This means we care for colleagues in the same way we care for our patients. We will become the employer of choice across our health care communities and facilitate our staff to deliver exceptional clinical care.

The strategy is made up of 7 important priorities:

- equality, diversity and inclusion;
- talent management;
- health and wellbeing;
- working together to improve;
- workforce design;
- corporate social responsibility;
- colleague engagement.

We will do this by:

- using the Trust's four key behaviours which guide all Trust employees in the way they work:



- using "The Cupboard, "our Organisational Development strategy at CHFT;
- designing our workforce not just for now, but for the future using the Calderdale Framework to look at what skills and roles are needed in an area or team;

- introducing new roles and develop those already in place including further development to our Physician and Nurse Associate workforce;
- being innovative in our approach to workforce redesign making best use of the skilled healthcare professionals available to us;
- continuing to work closely with Universities, other local education providers and Health Education England to develop new courses and training for staff;
- working hard to support out volunteers recognising their contribution to the Trust.

This will result in:

- having the right people in the right numbers with the rights skills in the right place;
- a diverse and inclusive workforce making the best skills and knowledge of our exceptional staff;
- a workforce where all are felt to be important and whose opinions and ideas are valued
- an improvement to our staff survey metrics;
- CHFT being an employer of choice.

4.2.9 Clinical Networks and Centres of Excellence

The Trust's aim is to continue to provide a wide range of hospital services for the local Calderdale and Huddersfield population. Some hospital services face growing demand and there are sustainability challenges that need to be addressed. It is also recognised that some complex or rare conditions are better managed in centres of excellence and this can result in better outcomes for patients.

Reviews of current service provision across the West Yorkshire Association of Acute Trusts (WYAAT) has shown that there is opportunity for CHFT to play a role in the delivery of specialist services to support the regional provision of acute hospital services. Furthermore, the planned reconfiguration of services within CHFT and the associated funding provision and investment could provide cost effective solutions for the West Yorkshire ICS.

CHFT has a track record of working in partnership with clinical teams across West Yorkshire and Harrogate to improve the resilience of services and drive the highest standards of care. We will continue to develop and accelerate this approach and work. The Trust's strong track record of performance (consistently one of the top performing Trust's in England) and the development and use of digital technology at CHFT means the Trust is also well placed to make a positive contribution to the establishment of clinical speciality networks across West Yorkshire and Harrogate and/or to host the delivery of services (centre of excellence) serving a wider population.

Further detail of the Trust's analysis of clinical service provision highlights where there may be opportunity to work in clinical networks or to host services. These include the potential for CHFT to provide a centre of excellence delivery model for the following specialist services;

- Bariatric Surgery
- Primary Percutaneous Coronary Intervention (PPCI)
- Non- Surgical Medical Oncology service provision and the hosting of network services
- Hyper acute stroke services and the hosting of network services
- Revision joint surgery and ambulatory day case arthroplasty
- Development of Respiratory Medicine to include, for example centres of excellence for sleep, complex asthma and idiopathic pulmonary fibrosis
- Development of Community Diagnostic network Hub and Spoke models

5. Our Ambitions to develop Clinical Networks and Centres of Excellence

<table>
<tr><td colspan="2">COMMUNITY SERVICES</td></tr>
<tr><td colspan="2">• Community services will support transformation through key programmes of work such as Business Better than Usual (BBTU), Care Closer to Home, Urgent Care Response, and Community and Place Based Provider Collaboration and Provision.

• Across Calderdale and Huddersfield, community services will work in partnership with the third and voluntary sectors to provide care closer to home, tailored to the individual's requirements and delivered when they need those services.

• Local communities will be supported to stay healthy, be responsible for their own lifestyle choices and be absolutely central to decision making on their care provision and by extension how local services are configured. Delivery of this will be continually evidenced through a transparent quality improvement framework and validated by independent evaluation (i.e. CQC, GIRFT, NHS Benchmarking).

• Community services will support the development of Primary Care Network (PCN) based services for example First Contact Practitioners (FCPs) and wider anticipatory roles.

• Community services will develop sustainable community and specialist nursing workforce models to meet care closer to home and NHS Long Term Plan out of hospital care strategies.</td></tr>
<tr><td colspan="2">MEDICINE SERVICES</td></tr>
<tr><td>Cardiology</td><td>• In 2017 cardiology services were consolidated to a single site model at CRH. This has improved the quality and continuity of care for patients and enabled increased day case provision and</td></tr>
</table>

	earlier discharge of patients reducing length of stay. The vision is to further improve adjacencies across the departmental services. • Community services in Calderdale were increased to support reducing admissions and early supported discharge • LTHT provides tertiary cardiology services and there is need for additional capacity to meet demand for the provision of primary PCI. • CHFT has ambitions to be designated as a second centre in West Yorkshire for the provision of primary Percutaneous Coronary Intervention (PCI).
Respiratory	• Following the consolidation of respiratory services on a single site model at CRH, an enhanced care area for respiratory patients with high acuity e.g. requiring NIV and improved care and continuity for these patients has been developed. The aspiration is to progress this to Level 2 Unit – HDU/Respiratory Care Unit and expand the sleep service. • Lung cancer service improvement across the ICS, including increased screening, is a priority for the Cancer Alliance • There are opportunities to strengthen community provision for respiratory patients including the development of pathways for Asthma • LTHT provides tertiary respiratory services. • CHFT is interested in the development of local sleep service (patents currently travel to Leeds)
Nephrology	• Specialised nephrology services are currently provided at BTHT and LTHT with renal dialysis units provided at CRH and HRI. • CHFT is working in partnership with LTHT on local Nephrology appointments to improve the quality of care the Trust can provide to medical and surgical inpatients and ensure local provision of outpatients at CHFT. Two consultants are in post and we are now looking to develop a joint nurse post to support low clearance patients having recently established a specific low clearance clinic at CHFT. • An Acute Kidney Injury Nurse has been in post for a year and is continuing to develop the role.
Diabetes and Endocrinology	• CHFT has a strong model for the provision of diabetes and endocrinology services. • Significant work has been undertaken to improve care for inpatients with diabetes. Diabetes UK has identified CHFT in the new NaDIA-harms audit as one of the few trusts with the systems in place to collect data on inpatient harms in an effective way and highlighted that CHFT's use of point of care testing to streamline workload is something all diabetes inpatient teams should be replicating. A member of CHFT staff is the Diabetes UK Clinical Champion and part of a group of leading diabetes professionals who are shaping national policy in diabetes inpatient care. • The diabetes outpatient transformation programme includes the establishment of virtual consultations for adolescents and app self-management. • Increased support for Primary care to provide specialist care closer to home. • The Trust is interested in becoming a centre of excellence for Diabetes and sharing best practice across West Yorkshire and Harrogate and supporting clinical networks.
Gastroenterology	• The Trust provides gastroenterology services including the provision of complex endoscopic procedures. The ambition is to extend the use of recently introduced Trans Nasal Endoscopies. • Outpatient services have been redesigned to enable Consultant led review of referrals and for advice to be provided to primary care, or patients referred 'straight to test' reducing unnecessary appointments. • CHFT is interested in the potential future development of clinical networks for acute and elective pathways • An increase in the decontamination resource will support developments in endoscopic procedures.

Haematology	• CHFT is interested in the potential future development of clinical networks to strengthen service sustainability and sub-specialisation. • To develop clinical adjacencies with oncology for a co-located inpatient ward area with direct admission.
Medical Oncology	• CHFT has a strong medical oncology service with a full establishment of Consultants and provides Inpatient and Outpatient services with a 24/7 on-call specialist rota. • CHFT is interested in expanding inpatient provision and hosting a clinical network of day case, outpatient and community services to strengthen service sustainability across West Yorkshire and Harrogate. • In late 2020 MYHT experienced workforce shortages that CHFT have been supporting. In March 2021 these were further exacerbated requiring an increased and more sustained level of support. To mitigate immediate patient safety risks CHFT is providing interim services for Breast and Lung Medical Oncology patients that are resident in North Kirklees that would otherwise have been referred to MYHT. The Trust is also supporting a process across the West Yorkshire ICS to determine a longer-term sustainable model for oncology services in West Yorkshire and Harrogate. • Continue to develop the collaborative working with Community based services to improve continuity of care from hospital. • To develop clinical adjacencies with haematology , for a co-located inpatient ward area with direct admission.
Stroke	• CHFT will continue to be one of 4 Trusts across West Yorkshire and Harrogate providing hyper-acute stroke services (HASU) within the newly established stroke network. • CHFT is increasing its use of community services for the care of stroke patients supporting further Early Supported Discharge and enhancements to community rehabilitation services. • The Trust has a strong service and will continue to achieve an overall rating of 'A' in the National Sentinel Audit. • LTHT provides tertiary services (thrombectomy). • Develop the provision of rehabilitation in the community.
Neurology	• The Trust provides outpatient Neurology only and are currently closed to out of area referrals. • The Trust does not provide neurorehabilitation. • To develop the Neurophysiology Service provision to provide a Sleep Service, Home EEG Video telemetry (Home VT).
Care of the Elderly	• In 2017 care of the elderly services were consolidated to a single site model at HRI. As part of the planned reconfiguration of hospital services the single site model will be developed on the CRH site with an ambulatory unit to be collocated with the Acute wards/unit. • CHFT has an aspiration to deliver a 24/7 Frailty service and be a centre of excellence in frailty services across acute and community care. • The elderly care consultants now provide a 7-day service. Nationally only 38% of Acute Trusts provide this service. This has improved patient assessments and aided earlier discharges. It has also resulted in an increase in applications for elderly care consultant posts at CHFT with 3 successful recruitments since reconfiguration. The aspiration is to develop this further into a Perioperative Older People's Service. • The creation of Rapid Access clinics.
Dermatology	• In Calderdale there are several GPs that have achieved accreditation for providing an extended role in dermatology however the Trust is unable to progress this due to lack of consultant supervision.

	• The Trust has appointed locum consultant who is close to completed CESR with a view to becoming substantive • The Trust has appointed 1.2WTE specialty doctors. This now puts the department in a stronger position to support GP's in the future. • The Trust is interested in the development of a clinical network model to improve workforce sustainability of services and is currently in discussion with MYHT regarding this.
Rheumatology	• The Trust provides rheumatology out-patient services. • LTHT provides tertiary services. • The Trust's Rheumatology services are piloting the development of Patient Initiated Follow Up (PIFU) pathways to support to support the management of patient follow up demand, alongside the development of a pharmacist role within Rheumatology initially with a view to integrating this role in other specialties as appropriate.
Emergency Medicine	• As part of the planned reconfiguration of services at CHFT Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) will both provide 24/7 consultant-led A&E services, the A&E at CRH will receive all blue light emergency ambulances for patients that have serious life-threatening conditions and all patients likely to require hospital admission, the A&E at HRI will receive self-presenting patients. • Develop the service to provide Senior Review on presentation. • Explore the opportunities to take ED to the patient. • Increase working from home opportunities.
FAMILY AND SPECIALIST SERVICES (FSS)	
Maternity	• Improve the adjacencies of Women's services with antenatal, post-natal, transitional care and gynae patients closely located. • Maintain Birth Centre co-located but independent and separate access. In line with Better Births offer 4 different locations: Home, Stand Alone Midwifery Unit; Co-Located Midwifery Unit & Consultant Led Unit. • Develop Maternity Hubs in the community. • Create a second maternity theatre.
Paediatrics	• Paediatric medical inpatient services are currently provided at CRH and paediatric surgery is provided at HRI. Neonatal services are provided at CRH • The future reconfiguration of CHFT services will consolidate paediatric inpatient medical and surgical services. A paediatric emergency centre will be established at CRH. • As part of the planned reconfiguration the aim is provide a separate Paediatric ED providing 24 hour cover with co-located Paediatric Assessment Unit (PAU) providing approx. 18 hour cover (separate to ward) • Neonatal Unit co located with Maternity Unit and closely aligned to community services. • Transitional Care Ward • Develop Rapid Access Clinics.
Gynaecology	• CHFT provides outpatient and inpatient services. The Trust could offer additional capacity across West Yorkshire. • Cancer services are provided at LTHT. • Provide Hysteroscopy and Colposcopy as outpatients/daycase on one site.
SURGERY	

Orthopaedics	• To provide acute orthopaedic surgery on a single site supported by acute paediatric and medical teams. Planned procedures to be developed on a planned care, "green", site. • To develop an orthogeriatric led fracture neck of femur model of care supported by Orthopaedic Surgery in-reach. • To create a same day emergency care model. • CHFT has the potential to increase elective activity that could support access across West Yorkshire and repatriate activity currently sub-contracted to private sector providers. • Some procedures are not carried out in sufficient volume in any individual Trust in West Yorkshire reflecting the increases in sub-specialisation; CHFT would actively participate in any network solutions that consolidate low volume procedures and aspires to host one or more of such centres of excellence. CHFT would wish to work to develop a networked specialist joint revision service, and the development of an Ambulatory Arthroplasty Unit.
Upper GI, Colorectal & Acute Surgery	• The Trust provides acute Upper GI and Colorectal services across a network of Trusts with LTHT and BHFT as the cancer centres in West Yorkshire and Harrogate. • CHFT has an award winning 24/7 Consultant delivered Acute Surgery service. • Ambition to further expand the surgical Same Day Emergency Care services (SDEC). • Build on the direct-to-test model for colorectal surgery outpatient referrals and increase the provision of Lower GI through Daycase and a Day Treatment Unit taking 70% capacity • Strengthen Enhanced recovery and support pre-habilitation. • Develop the Endoscopy service with aspirations for a separate decontamination unit.
Bariatric Surgery	• CHFT has developed Bariatric Surgery services and has a strong track record of performance (e.g. 1-day LOS for 90% patients, providing the only senior bariatric training post in Yorkshire, optimised lists delivering 3 cases per list, specialist on call cover 24/7). • The Trust is unique in being compliant with the agreed West Yorkshire service specification • Virtual consultations have enabled people outside of the area to access bariatric pathways without the need to travel onerous journeys. Pre and post-surgical care is provided in this way to patients from Chorley and South Ribble. • The Trust aspires to be the centre of excellence for Bariatric Surgery
Plastics	• The Trust provides outpatient and day case plastic surgery services. • Cancer pathways support is provided to dermatology and Breast services with inpatients and acute services provided by BTHFT. • Aspiration to develop a Skin Cancer Suite with Dermatologists to offer a One stop clinic • Ambition to ensure co-location of plastic and breast surgery services.
ENT	• The Trust provides outpatient and inpatient services for routine, emergency and cancer referrals. • Complex Head and Neck Cancer services are provided at BTHFT and LTHT. • The clinical aspiration is to convert more elective admissions to daycase. • There is need to integrate the Audiology patient information system into EPR.
Oral and Maxillo-Facial	• Maxillofacial services are provided on an Outreach basis by BTHFT with a small cohort of very complex procedures undertaken in LTHT. • Oral surgery is a CHFT service provided by Specialty Doctors. CHFT provide support to community services for paediatric dentistry and dental services for patients with Special Needs.
Ophthalmology	• CHFT provides outpatient and inpatient services.

	• Significant work has been undertaken to redesign service pathways and this includes the development of multi-disciplinary team working that includes specialist nurses and orthoptists. • Outpatient pathways have been redesigned and include clinical triage of all referrals and development of electronic referrals from Optometrists • Subspecialisation pressures are increasing for both elective and non-elective activity across West Yorkshire. • CHFT is interested in the potential future development of clinical networks to strengthen service sustainability and sub-specialisation.
Breast	• CHFT provides outpatient and inpatient services. • CHFT outpatient services are a one stop facility currently delivered on 2 sites but variation in capacity and demand remains a challenge. • The Trust aim is to centralise all breast outpatient/diagnostic activity onto a single site.
Urology	• Urology patient and inpatient care is provided at CHFT. • LTHT, BTHFT and MYHT provide specialist cancer care. • A Urology one stop clinic has been implemented at CHFT and has reduced patient's pathways from referral to treatment at the tertiary centre from 62 days to 28 days, with first local treatments initiated on days 19-22. • Urology non-elective workload is high with workforce establishment not sufficient to provide 24/7 direct input. • The Trust is interested in working a clinical network to support the delivery of urology services across West Yorkshire with priority being on the out of hours services.
Vascular	• CHFT delivers vascular services through a network service delivered across West Yorkshire with shared management, governance and finance. • Outpatient and day case vascular surgery are provided at CHFT. • Acute vascular arterial surgery and inpatient services are provided at Leeds and Bradford.
SUPPORT SERVICES	
Pathology	• CHFT is working in partnership with Leeds Teaching Hospitals Trust and Mid-Yorkshire Hospitals Trust to develop a hub and spoke model for the provision of pathology services. • CHFT has worked with partners to submit a proposal to establish a Calderdale, Kirklees and Wakefield network model for the provision of community diagnostic services that will include community-based hub and spoke sites.
Radiology	• CHFT is working with Trust's across WYAAT to develop future models of service delivery that will be enabled using digital technology and shared information systems. • CHFT has worked with partners to submit a proposal to establish a Calderdale, Kirklees and Wakefield network model for the provision of community diagnostic services that will include community-based hub and spoke sites • The Trust is interested in developing collaborative / shared service model arrangements to strengthen the provision of interventional radiology. • The Trust is interested in working a clinical network to support the sustainable delivery of Radiology services across West Yorkshire and increased requirement for subspecialisation. • The development of Rapid Diagnostic centres are a key element of the 10-year plan and CHFT would wish to explore the opportunities of hosting such a facility.
Pharmacy	• The Trust has worked with other Trusts across WYAAT to explore the option of establishing a central store in West Yorkshire. The business case for this has demonstrated this is not a viable option going forward.

	• The Trust is currently reviewing local contracts for the provision of outpatient pharmacy services and there may be potential benefits of a collaborative procurement for these services with other Trusts and for this to be hosted via CHFT Calderdale Health Solutions (wholly owned subsidiary). • The Trust is exploring the implementation of pharmacy robots and automation.
Endoscopy	• The Trust runs Endoscopy services from both CRH & HRI and has invested in decontamination equipment. • The Trust hosts the Bowel cancer screening service for Calderdale and Kirklees. • CHFT are fully JAG compliant receiving praise by the accreditation team.
Adult Critical care	• Adult Critical care is provided on 2 sites with staffing used flexibly to support variations in capacity and demand. • CHFT will be centralising and expanding critical care capacity onto a single site through reconfiguration. • Outreach services are in place in hours with handover to the HOOP service out of hours; further opportunities to strengthen this are being explored.
Anaesthetics	• Anaesthetic services are provided at both HRI and CRH. This ensures a 24 hour / 7-day presence of middle grade Anaesthetists, and Consultant staff on-site for a proportion of each day with 24/7 on call responsibility. • This existing level of anaesthetic cover will continue to be provided following the reconfiguration of services across the two hospitals.

12. 5 Year Digital Strategy Annual Review

To Note

Presented by Mandy Griffin

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title:	5 Year Digital Strategy Annual Review
Author:	Mandy Griffin, Managing Director - Digital Health
Sponsoring Director:	Mandy Griffin, Managing Director - Digital Health
Previous Forums:	Weekly Executive Board and Finance and Performance Committee

Purpose of the Report

The CHFT Digital strategy was approved by the Board of Directors in July 2020. In creating the digital strategy we engaged with over 300 stakeholders through workshop sessions, digital hothouses and one to one interview's. This was with both Internal and external colleagues.

This is the first annual review of the 5year Digital Strategy. We are really proud of what has been achieved and the update will hopefully provide the Board and colleagues significant assurance on the Digital Health teams ability to deliver what was agreed and how they will continue to lay the foundations to ensure that CHFT is continually recognised as one of the most digitally advanced Trusts in the country, putting the patient first in all we do enabling our workforce and healthcare professions to provide the best possible patient experience.

Our vision continues to be about "delivering outstanding compassionate care to the communities we serve" with digital being the key enabler in supporting clinical and non-clinical colleagues to provide care to all our patients. It is fundamentally important that the Digital Strategy continues to align with "one culture of care" in that we support patients and colleagues on their own digital journey.

Whilst we have successfully delivered many projects there is further work to still to do in making sure our digital solutions are fully adopted by Trust colleagues. Digital needs to become mainstream for everyone and we need everyone to become an ambassador for digital in their own right.

Our Digital Strategy priorities remain in place we will aim to continue to:

- improve the reliability and quality of clinical care to support early discharge of patients
- improve adoption/optimisation of current systems
- make available an integrated care system
- give patients control over their care
- ensure our corporate divisions are digitally enabled to support clinical care
- support the sustainability agenda

Key Points to Note

The key messages from 2020/21 are:

COVID Response

- Coronavirus pandemic has driven us to accelerate our digital programmes and, in some cases, change the focus however the flexibility in the strategy has allowed us to do that successfully.
- The digital team focus rightly shifted to support the response to the pandemic. Including the deployment in keeping our patients connected.
- Our digital support teams/functions were a key enabler around changing the way we work internally and externally keeping our workforce colleagues safe as well as our patients safe, mobilising over 2000 colleagues to work from home in less than two weeks.
- Having an electronic patient record (EPR) and the access to real time data provided us with information/data that aided better decision making from admission through to discharge, we have been able to track hospital status as well as forecast the future status.
- We have built monitoring tools to protect patient data from inappropriate access
- We continue to develop our analytical capability and reporting tools through Knowledge Portal+ with the ambition to become the Business Intelligence centre of excellence.
- Data has also allowed us to address the all-important health inequalities agenda.
- CHFT has led the way around the health inequalities piece including the focus on learning disabilities. This piece of work has been recognised nationally
- An MPage was developed to prioritise patients by clinical need not just waiting times further enhancing our ability to respond to the ever-growing backlogs as we move through recovery.
- We connected 169 labs from across the NHS to our NPex solution to support COVID testing and accelerate turnaround times

Interoperability

- We are now integrated with our community partners and social care across Calderdale

Organisation/Division	Available datasets viewable
Systm1 GP Greater Hudds CCG Calderdale CCG	EMIS GP Data via GP Connect Cerner EPR (15 key fields) S1 Community Data (Calderdale – CHFT Community)
EMIS GP Greater Hudds CCG Calderdale CCG	S1 GP Data via GP Connect Cerner EPR (15 key fields)
Cerner EPR CHFT	S1 GP Data (GH CCG and C CCG) EMIS GP Data (GH CCG and C CCG) Palliative Care (EPACCS) from the GP record GH CCG & C CCG, both S1 & EMIS Adult Social Care Data from Calderdale Council CIS system (10 key datasets) In Progress – SWYPFT Mental Health data – DSA in place, request with TPP
S1 Community Module CHFT	Cerner EPR S1 GP Data (GHCCG & CCCG) EMIS GP Data (10 key data sets) In progress - Adult Social Care Data from Calderdale Council CIS In progress – SWYPFT Mental Health data – DSA in place
S1 Community MH SWYPFT	In Progress – Cerner EPR, DSA in place. Work is currently with Cerner to enable

Integration

- Integration has presented us with complex challenges over the last 12 months.
- The reliance on suppliers and skilled resources around some of the complexity of the technology has meant progress has been slow.
- The changing of different operating systems has given compatibility issues (windows 7 vs Windows 10).
- Current integration projects are Medisoft (Ophthalmology), Ascribe/EMIS, (Pharmacy) and K2 Athena (Maternity). All making progress but not complete.

Projects/Programmes…

- Our investment commitment for digital for 2021 was £4.6m. This was delivered however some changes to programmes and projects were necessary to make sure we didn't lose any of the funding.
- The funding streams came from various sources mainly the Digital Aspirant and Scan for Safety Programmes (£3m)
- The Digital Aspirant funding has enabled the refresh of hardware in our datacentres, supply of new laptops, the deployment of voice recognition, the procurement of an e-consent solution, a programme of pharmacy integration solutions and improvements all part of the 5year strategy and road map.
- The Scan for Safety funding has resulted in the delivery of the asset tracking that was initially deployed to track COVID critical equipment now over 3000 devices are connected, we have active temperature monitoring and have investment in over 400 Zebra Devices supporting our ambition of having a multi-use single device.
- Outside of these programmes there has been multiple digital programmes around EPR including a significant upgrade, windows 10 upgrade and office 365
- We are making progress in areas such as Endoscopy where we have removed unnecessary paper. We now need to focus in the solutions/systems we use and how we integrate with EPR
- Cardiology have hugely benefitted from ECG management solution we are working with stakeholders to build a business case for future consideration. In parallel the ICS is doing a detailed review of current state and requirements for cardiology as a system.
- We are building an options appraisal on how we use our patient portal and have developed a whitepaper on outpatients as a way of challenging Cerner to improve process. We are leading this piece of work nationally.

Digital Governance

- The governance as described in the strategy is in place and working
- Division Digital Boards are now embedded and the right conversations are happening within the divisions on a more local level.
- Investment decisions are supported by robust business cases and key stakeholders from across the trust.
- All business cases are now approved and monitored through the Commercial Investment and strategy Group.

Reconfiguration

- We have continued to invest in technical and transformational support and have appointed a Digital Transformation and innovation Director and an Assistant Chief Technology Officer to support the reconfiguration programmes.
- All the work undertaken within the projects is supporting the trust in becoming digitally ready for reconfiguration.

Infra-structure strategy

- An external agency, UKcloud, have been commissioned to develop a strategy and business case and will be completed in July 2021 this will be shared with the Board in September 2021

Health Information and Management System Society (HIMSS)

- Level 6 has been a long-term ambition for the Trust, over the last year we have conducted the gap analysis for the following adoption models:
- Electronic Medical Record Adoption Model (EMRAM) – 5
- Infrastructure Adoption Model (INFAM) – 4
- Analytics Maturity Cumulative Capabilities – (AMAM) rated 4
- We are looking to achieve a HIMSS Level 6 EMRAM in Autumn 2021 with a focus on closed loop technologies which is the ultimate safety prize.

Optimisation Plan

- The optimisation planned has been delayed however we have commissioned an external agency to conduct an in-depth analysis that will contribute to developing a plan
- There is much to do in this space we need to ensure we maximise the potential of all our current systems, training and education will be the focus for 2021/22.

Integrated Care System (ICS) Collaborations

- We are the digital Lead for the Regional Laboratory Information Management System (LIMS) and Enterprise Integrated Clinical Environment solution (ICE).
- Digital lead for Scan for Safety and inventory management.
- We are heavily involved in conversations with Digital as a Place for Calderdale/Kirklees Digital Boards. This will continue to ensure that we acknowledge our place as anchor organisation digitally and capitalise on opportunities to share data through our interoperability agenda

Digital Inclusion

- Striving to take steps in promoting digital inclusivity as part of the wider work on Health Equalities is critically important this will continue to be a focus of the Digital Strategy. In some ways the pandemic has allowed us to implement technology that has enabled us to connect with patients, relatives and our workforce, it has introduced a way of working that will become the norm. But there is more to do to ensure we expand our reach across the whole system and patient populations

Moving forward….

As we move forward we will keep pushing the progress on all our digital programmes through to completion, we will challenge our suppliers and look to secure skilled capability in order to keep CHFT in pole position when it comes to Digital Maturity and national influence. We will continue to take advantage of the wealth of data that can help address the issues across our patients populations.

EQIA – Equality Impact Assessment

The Digital Strategy aims to promote inclusivity as part of the wider work on Health inequalities.

CHFT are national leaders in this space and will continue to work locally, regionally and nationally on addressing health inequalities including but not exclusively learning disabilities using our data and technological capabilities to understand our patient populations.

We want to continue to push the boundaries of interoperability using the Health Information Exchange and Medical interoperability Gateway software by ensuring data sharing agreements are in place so we can ensure information is available at the point of care so those patients that don't have digital access to the information can get the appropriate care and information when meeting their health care professional.

CHFT have a Digital Strategy that supports optimisation making sure people are fully adopting the technology we have. The technology does often work however engagement with workforce/people/patients is critical and we need to make sure this is ongoing under the umbrella of "one culture of care" and digital ways of working. We have and will continue to support engagement sessions around the Digital Strategy including patients, relatives and workforce colleagues so they can continue to contribute to our strategy. Digital needs to be seen as mainstream not as an add on "people first-then technology".

Recommendation

The Board is asked to **ACKNOWLEDGE** the good progress that has been made against the commitments laid out in the Trust 5 year Digital Strategy for 2020/21.

Sustainability

13. 2021/22 Budget Book

To Approve

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1 July 2021
Meeting:	Public Board of Directors
Title:	Budget Book 2021-22
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance
Previous Forums:	

Purpose of the Report

To provide the Board with a formal record of the budget for 2021-22.

Key Points to Note

2021/22 Financial Plan - Overview

The Trust's financial plan for 2021/22 is for a break-even position.

National Position

National planning guidance only covers the first half of the financial year, described as H1 (Apr-Sep 21). The submission deadline for System and Provider plans was extended until June 2021 (draft submission May 2021). Plans were based on a rollover of the financial framework in operation in Months 7-12 20/21 and funding envelopes were set at ICS level. West Yorkshire Integrated Care System agreed to allocate funding to organisations on the same methodology as 20/21. Guidance and funding envelopes for H2 are not yet available.

An Elective Recovery Fund is in place to support the system to return to 19/20 activity levels and work through any waiting lists. Access to funding is based on the System exceeding activity thresholds on a monthly trajectory. Funding is based on overall system performance, but will proportionally flow to those Trusts that exceed these trajectories.

Commissioner block funding arrangements continue for 21/22, with an adjustment for the Vascular service transfer to Bradford. System Top up funding has been confirmed for H1, including continued support for Covid-19 costs.

2021/22 Financial Improvement Trajectory

The Trust's internal plan for the full year assumes that funding will return to the Pre-Covid regime for H2 and that deficit support will be provided as per the 5 year plan issued in 2019. The 5 year plan assumed an improvement trajectory that would gradually reduce reliance on Financial Recovery Funding. Funding assumed for H2 is £12.19m, a reduction compared to H1 System Top Up funding and this drives an increased efficiency requirement for H2 in order to deliver a break-even position. This is an assumption for planning and budget setting purposes as National funding envelopes have not yet been confirmed.

Staged Planning Process for 21/22

A staged planning approach was agreed by Board to reflect the operational uncertainly:

Stage 1 Set baseline budgets and Covid reserve
Baseline budgets - agreed at Board March 2021, including £2.2m pre-approved developments.
Covid reserve – reviewed and reduced from £8m to £4.5m based on exit plans. Balance of £3.5m held as Recovery Reserve.

Stage 2 Agree developments
£2.8m funding ringfenced subject to Business Cases through Commercial Investment Strategy Committee.

Stage 3 Plan for elective recovery
Currently both income and expenditure linked to recovery plans are excluded from the budget. Recovery plans have been worked up based on existing internal capacity plus independent sector and should be contained within available funding.

Efficiency Requirement

The Trust has a £3m efficiency requirement for H1 which equates to a transactional level of savings. For context £5.8m efficiency was delivered through 20/21 in spite of Covid-19. There may also be non-recurrent opportunities from slippage and recovery productivity.

For H2 the efficiency requirement is significantly more challenging based on current assumptions: £14.2m efficiency requirement. However, the funding framework for H2 is yet to be confirmed and this may provide additional funding compared to the current planning assumptions.

Attachment: Budget Book 2021-22

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 **APPROVE** the Budget Book for 2021/22.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

BUDGET BOOK
2021-22

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21/22 Plan (CHFT Group): Income & Expenditure

Income & Expenditure	19/20 Actual	20/21 Actual	21/22 Plan (Excl. Efficiency)	21/22 Efficiency	21/22 Total Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income	373.31	422.23	401.95	0.00	401.95
Other Income[1]	51.39	57.71	51.02	0.25	51.27
TOTAL INCOME	424.70	479.94	452.96	0.25	453.21
Medical	(74.28)	(84.45)	(81.09)	0.00	(81.09)
Nursing	(76.40)	(83.29)	(85.84)	0.00	(85.84)
Sci Tech & Ther	(32.50)	(35.04)	(36.50)	0.00	(36.50)
Support to clinical staff	(40.14)	(45.08)	(44.87)	0.19	(44.68)
Any Other Spend[1]	(1.85)	(1.61)	(3.93)	10.81	6.88
Managers and infrastructure support	(36.11)	(40.87)	(42.89)	0.00	(42.89)
PAY EXPENDITURE	(261.29)	(290.35)	(295.11)	11.00	(284.11)
Drugs	(40.32)	(40.96)	(41.98)	(0.09)	(42.06)
Clinical Supplies & Services	(29.50)	(30.47)	(31.62)	0.00	(31.62)
Other Costs	(69.21)	(91.09)	(72.35)	6.07	(66.28)
NON PAY EXPENDITURE	(139.03)	(162.52)	(145.95)	5.99	(139.96)
TOTAL EXPENSES	(400.31)	(452.87)	(441.06)	16.99	(424.08)
EBITDA	**24.39**	**27.07**	**11.90**	**17.24**	**29.14**
Non Operating Expenditure	(24.73)	(36.47)	(29.48)	0.00	(29.48)
TOTAL SURPLUS/(DEFICIT)	**(0.34)**	**(9.40)**	**(17.58)**	**17.24**	**(0.34)**
Less: Items excluded from Control Total[2]	0.39	9.75	0.34	0.00	0.34
TOTAL SURPLUS/(DEFICIT) on a Control Total Basis	**0.05**	**0.36**	**(17.23)**	**17.24**	**0.00**

Overview:

- 21/22 Budget excludes any funding from the Elective Recovery Fund.
- 21/22 Budget excludes both the funding and expenditure for any Covid costs that are considered to be outside of system envelope (eg Testing and Vaccinations).
- Efficiency requirement for 21/22 is estimated to be £17.24m: £3m in H1 and £14.24m in H2.
- Position includes inflation, approved pressures and any developments that are either approved or expected to be supported (held in Reserves).

[1] Excludes notional income and expenditure relating to 6.3% pension contributions paid by NHS England in 19/20 and 20/21

[2] Donated Asset Income, Donated Asset Depreciation, Donated Consumables and Impairments

21/22 Plan (CHFT Group): Statement of Financial Position

Statement of Financial Position	20/21 Budget As at 31 Mar 21 £'m	20/21 Actual As at 31 Mar 21 £'m	21/22 Plan As at 31 Mar 22 £'m
Non Current Assets			
Property, Plant & Equipment	110.46	109.95	116.07
On B/S PFI assets	65.53	61.71	59.98
Investment in Joint Venture	6.56	3.91	3.91
Other	4.12	3.99	3.99
	186.67	179.56	183.94
Current Assets			
Inventories	6.51	7.46	7.46
Receivables	29.74	19.75	19.75
Other	3.49	5.13	5.13
Cash	3.99	48.22	37.07
	43.73	80.56	69.40
Current Liabilities			
Loans	(2.21)	(2.21)	(1.21)
Deferred Income	(3.30)	(4.68)	(4.68)
Payables	(44.69)	(63.85)	(51.76)
Provisions	(2.55)	(6.43)	(6.43)
PFI Leases	(3.02)	(3.02)	(0.75)
	(55.77)	(80.19)	(64.83)
Non Current Liabilities			
Loans	(18.56)	(17.67)	(16.46)
PFI Leases	(67.90)	(67.89)	(67.14)
Provisions	(1.49)	(1.18)	(1.18)
Other	(1.06)	(0.99)	(0.99)
	(88.99)	(87.73)	(85.77)
TOTAL ASSETS EMPLOYED	**85.63**	**92.19**	**102.74**
Taxpayers Equity			
Public Dividend Capital	262.39	281.00	291.90
Income & Exp Reserve	(182.08)	(191.54)	(191.88)
Revaluation Reserve	5.32	2.72	2.72
TOTAL TAXPAYERS EQUITY	**85.63**	**92.19**	**102.74**

Key Assumptions:

- No asset valuation adjustments are assumed.
- Expected changes to accounting standards for Leases have been deferred until 22/23.

21/22 Plan (CHFT Group): Statement of Cash Flow

Statement of Cash Flow	20/21 Budget £'m	20/21 Actual £'m	21/22 Plan £'m
Surplus/(deficit) from Operations	**0.46**	**(9.40)**	**(0.34)**
non-cash flows in operating surplus/(deficit)			
Non-cash donations/grants credited to income	(0.08)	(0.20)	(0.08)
Depreciation and amortisation	10.61	11.01	14.33
Other operating non-cash (income)/ expenses	14.61	10.50	15.16
Impairments	0.00	12.67	0.00
Gain on disposal of assets	(0.46)		0.00
	24.68	**33.98**	**29.41**
Operating Cash flows before movements in working capital	**25.14**	**24.58**	**29.07**
Movement in working capital	**6.05**	**33.55**	**(4.80)**
Net cash inflow/(outflow) from operating activities	31.19	58.13	24.27
Net cash inflow/(outflow() from investing activities			
Capital Expenditure	(16.11)	(24.55)	(18.99)
Proceeds on disposal of property, plant and equipment	1.40	1.14	0.28
Increase/(decrease) in Capital Creditors	(2.80)	4.73	(8.00)
Other cash flows from investing activities	0.14	0.04	0.14
	(17.37)	**(18.63)**	**(26.58)**
Net cash inflow/(outflow) before financing	**13.82**	**39.51**	**(2.30)**
Net cash inflow/(outflow) from financing activities			
Public Dividend Capital Received	139.98	158.59	10.90
Drawdown of Loans	0.00	0.00	0.00
PDC Dividends paid	(2.58)	(1.33)	(1.59)
Repayment of Loans	(141.93)	(142.93)	(2.21)
Financing	(14.59)	(14.68)	(15.95)
Non-Current Movements	0.00	(0.23)	0.00
	(19.12)	**(0.57)**	**(8.85)**
Net increase/(decrease) in cash	**(5.30)**	**38.93**	**(11.15)**
Opening cash	9.29	9.29	48.22
Closing cash	**3.99**	**48.22**	**37.07**

Key Assumptions:

- Capital Plan totals £18.99m, including £10.90m assumed to be externally funded:
  * £1.50m PDC funding for Wireless Network Refresh
  * £3.15m PDC funding for Backlog Maintenance
  * £1.04m PDC funding for Scan4Safety
  * £0.13m PDC funding for diagnostic equipment
  * £0.08m PDC funding for Yorkshire Imaging Collaberative.
  * £5.00m of the £197m SOC case – for Reconfiguration of Services at HRI
- Cash balances as at 31st March 21 were higher than planned due to high levels of accrued expenditure, both Capital and Revenue, including the Annual Leave Accrual - it is assumed that these payments will catch up during 21/22 and reducing the total cash balance.

21/22 Plan by Division: Income & Expenditure

Division	20/21 Contribution Actual £'m	21/22 Income Plan £'m	21/22 Pay Plan £'m	21/22 Non Pay Plan £'m	21/22 Contribution Plan £'m
Medical Division	31.38	5.96	(78.12)	(28.47)	(100.63)
Surgical Division	20.84	2.38	(67.08)	(18.78)	(83.47)
Families & Specialist Services	(5.73)	7.47	(63.13)	(27.26)	(82.92)
Community Division	(0.30)	2.78	(25.48)	(2.26)	(24.96)
Corporate Division	(50.19)	(2.23)	(20.26)	(28.68)	(51.17)
Estates & Facilities	0.00	0.00	0.00	0.00	0.00
Health Informatics	1.45	19.59	(9.89)	(7.54)	2.16
PMU	3.40	14.61	(2.47)	(9.11)	3.02
CHS LTD*	0.15	59.98	(10.59)	(48.58)	0.81
Central Inc/ Technical Accounts*	(0.59)	381.94	(4.15)	(61.08)	316.72
Trust Reserves	(0.06)	23.57	(2.95)	(0.17)	20.44
Surplus / (Deficit)*	**0.36**	**516.04**	**(284.11)**	**(231.92)**	**0.00**
LESS Inter-company payments	**(0.00)**	**(62.83)**	**0.00**	**62.83**	**0.00**
GROUP Surplus / (Deficit)	**0.36**	**453.21**	**(284.11)**	**(169.10)**	**0.00**

* Includes inter-company transactions

Notes:

• The planned income and expenditure totals shown above include inter-company payments of £62.83m between the Trust and its subsidiary company (CHS Ltd). These payments are excluded when reporting the Income & Expenditure position for the Group (as required by NHS Improvement).

21/22 Plan: Activity & Income

Activity	20/21 Budget	20/21 Actual [1]	21/22 Plan (Excl. CIP)	21/22 CIP	21/22 Total Plan
	Spells	Spells	Spells	Spells	Spells
NHS Clinical Income					
Elective	5,574	1,704	3,880	0	3,880
Non Elective	60,676	46,717	57,088	0	57,088
Daycase	43,418	20,401	46,367	0	46,367
Outpatients	368,867	156,157	405,096	0	405,096
A & E	158,159	125,522	154,885	0	154,885
Other-NHS Clinical	1,967,305	1,450,732	1,751,023	0	1,751,023
TOTAL SPELLS	2,603,999	1,801,233	2,418,339	0	2,418,339

Income	20/21 Budget	20/21 Actual	21/22 Plan (Excl. CIP)	21/22 CIP	21/22 Total Plan
	£'m	£'m	£'m	£'m	£'m
NHS Clinical Income					
Elective	18.01	18.01	11.44	0.00	11.44
Non Elective	114.89	114.89	113.53	0.00	113.53
Daycase	30.72	30.72	25.34	0.00	25.34
Outpatients	46.12	46.12	34.99	0.00	34.99
A & E	23.16	23.16	23.42	0.00	23.42
Other-NHS Clinical	111.23	113.53	139.39	0.00	139.39
CQUIN	3.79	3.79	3.39	0.00	3.39
Other Income	61.74	57.71	51.02	0.25	51.27
TOTAL INCOME	409.67	407.93	402.51	0.25	402.76
Top Up / Conditional Income:					
MRET	6.15	0.00	3.07		3.07
Financial Recovery Fund (FRF)	27.48	0.00	12.19		12.19
System Top Up	0.00	41.95	22.18		22.18
Growth funding		1.72	1.74		1.74
Restrospective Top Up / Covid-19 funding		28.34	11.27		11.27
TOTAL INCOME (INCL.CONDITIONAL FUNDING)	443.29	479.94	452.96	0.25	453.21

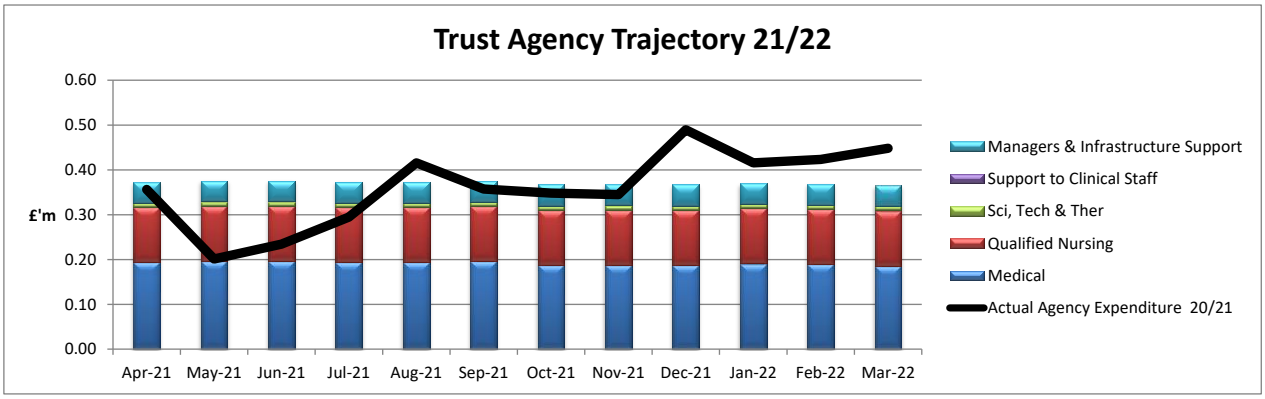
Key Assumptions:

- Block contract arrangements continue for H1.
- H1 funding envelope confirmed and includes fixed system funding allocation for ongoing Covid-19 costs.
- System funding envelope not yet confirmd for H2. H2 budget assumes return to previous financial regime based on Financial Improvement Trajectory with Financial Recovery Funding.
- Excludes funding from Elective Recovery Fund.
- Excludes funding for costs that are 'Outside of System Envelope' e.g, Covid-19 testing and Vaccinations
- Includes re-categorisation of some activity from 'Other NHS Clinical' into the 'Outpatient' point of delivery (Non face to face, Ward Attenders and MSK)

21/22 Plan: Agency Trajectory

Agency Trajectory 21/22	Apr-21 £'m	May-21 £'m	Jun-21 £'m	Jul-21 £'m	Aug-21 £'m	Sep-21 £'m	Oct-21 £'m	Nov-21 £'m	Dec-21 £'m	Jan-22 £'m	Feb-22 £'m	Mar-22 £'m	Total £'m
Medical	0.19	0.20	0.20	0.19	0.19	0.20	0.19	0.19	0.19	0.19	0.19	0.19	2.30
Qualified Nursing	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	0.12	1.48
Sci, Tech & Ther	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.11
Support to Clinical Staff	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
Managers & Infrastructure Support	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.57
Total	0.37	0.38	0.38	0.37	0.37	0.38	0.37	0.37	0.37	0.37	0.37	0.37	4.46

Actual Agency Expenditure 20/21	0.36	0.20	0.23	0.29	0.42	0.36	0.35	0.34	0.49	0.42	0.42	0.45	4.33



Key Assumptions:

- No NHS Improvement agency ceiling has been set for 21/22.

21/22 Plan: Reserves

Reserves Summary	21/22 Plan £'m	Notes
Uncommitted Reserves		
Contingency Reserve	1.00	Assumed as Pay in Plan
Winter Contingency Reserve	0.50	Assumed as Pay in Plan
Winter / Growth Reserve	0.04	20/21 c/f
	1.54	
Planning Gap		
Unidentified CIP - H1	(2.27)	Savings Gap to £3m requirement
Unidentified CIP - H2	(13.52)	Estimated pending confirmation of funding arrangements
	(15.79)	
Committed Reserves		
Covid-19 Reserve	4.50	Expenditure plans approved through Business Planning
Recovery Reserve	3.50	Recovery plans confirmed Jun 21
Clinical Excellence Awards	0.90	21/22 awards yet to be paid
Approved Business Cases / funding	1.30	To be transferred to Divisions once costs are incurred
Reconfiguration	0.34	To be transferred to Divisions once costs are incurred
Pressures / Developments not yet approved	2.08	To be transferred to Divisions once approval confirmed
	12.62	
TOTAL RESERVES	**(1.64)**	

Key Assumptions:

• Covid-19 Reserve in place to offset any costs incurred in Divisions, but budget not allocated. Costs will be monitored closely and reported on a monthly basis.

• CIP has not yet been fully identified: of the £17.24m total, £15.79m is unidentified. This will need to be transacted as plans progress and will result in changes to Divisional control totals.

21/22 Plan: Capital

Scheme Category	Capital Schemes	21/22 Plan £'m
IT	Wireless Network Refresh	1.06
	Clinical Systems	0.59
	Hardware	0.09
		1.74
Built Environment	Backlog Maintenance	0.00
	Car Parking	1.50
	Learning Centre	0.40
		1.90
Other	Equipment Replacement	2.22
	PFI lifecycle costs	0.26
	MRI	1.97
		4.45
Total Internally Funded		**8.09**
Funded by Public Dividend Capital (DHSC)	Wireless Network Refresh	1.50
	Yorkshire Imaging Collaberative	0.08
	Scan4Safety	1.04
	Backlog Maintenance	3.15
	Equipment - diagnostics	0.13
	Reconfiguration of Services	5.00
TOTAL CAPITAL EXPENDITURE		**18.99**

Key Assumptions:

• Internally generated funds from Depreciation (£14.3), are also required to cover the cost of repayments on the PFI (£3.3m) and Capital Loans (£2.2m), leaving £8.8m available for Capital Expenditure, of which £8.1m has been committed as shown above.

• Internally generated funds from depreciation are planned to be supplemented by income from asset sales of £0.28m.

21/22 Plan: Investments

Category	Description	21/22 Plan £'000
Covid-19 Reserve	Approved Covid-19 expenditure - held in Reserves	**4,498**
Recovery Reserve	Held in Reserves	**3,500**
Divisional Pressures	FAMILIES & SPECIALIST SERVICES	104
	MEDICAL DIVISION	362
	CALDERDALE & HUDDERSFIELD SOLUTIONS LTD	535
	CORPORATE SERVICES	780
	SURGERY & ANAESTHETICS	222
	HEALTH INFORMATICS	1,649
	COMMUNITY DIVISION	260
	PMU	600
	Non Operating Costs	2,273
		6,784
Developments	HEALTH INFORMATICS	33
	SURGERY & ANAESTHETICS	414
	MEDICAL DIVISION	608
	PMU	197
	CORPORATE SERVICES	411
	FAMILIES & SPECIALIST SERVICES	502
	COMMUNITY DIVISION	316
	CALDERDALE & HUDDERSFIELD SOLUTIONS LTD	122
	Reconfiguration	506
	Business Case required - Held in Reserves pending approval	2,451
		5,560
Activity	Net impact of changes to Vascular Service	138
		138
TOTAL INVESTMENTS		**20,480**

14. Month 2 Financial Summary

For Assurance

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1 July 2021
Meeting:	Public Board of Directors
Title:	Month 2 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 the Board with a summary of the financial position as reported at the end of Month 2 (May 2021).

Key Points to Note

Year to Date Summary

Year to date the Trust has delivered a surplus of £3.28m, a favourable variance of £2.94m compared to plan. This favourable variance is driven by a combination of: slippage on developments, vacancies, lower than planned recovery costs and higher than planned Elective Recovery Funding (ERF).

- Planning for the financial year ending 31st March 22 has once again been split into two halves, H1 (Half 1) and H2 (Half 2). Guidance for the second half of the year has not yet been released, but the Trust does now have a plan for H1 which aims to deliver a break-even position.
- Funding for H1 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure.
- For H1, the Trust has been allocated £22.19m of System Top Up funding, £11.27m of System Covid funding and £1.74m of Growth funding, a total Top Up of £35.20m to be received equally across the first 6 months of the year.
- In addition the Trust will have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and year to date has accounted for £2.02m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing and 3rd Year Student Nurse contracts.
- In total the Trust has incurred costs relating to Covid-19 of £4.14m. Costs were driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the segregation of patient pathways (particularly within the Emergency Department), staff working additional shifts and 3rd Year Student Nurses.
- These costs have been offset to some extent by an underspend on activity reset, slippage on new developments and lower than planned recovery costs.
- For H1 the Trust has an efficiency savings target of £3m, which is expected to be delivered but largely on a non-recurrent basis.

- Agency expenditure year to date is £0.87m, £0.12m higher than the value planned by the Trust. However, an Agency expenditure ceiling has not yet been allocated by NHS Improvement for this financial year.
- Clinical activity is higher than planned year to date across Elective, Day-case and Outpatients points of delivery and is above the required threshold to secure Elective Recovery Funding (ERF). The Trust has assumed £2.55m of additional ERF in support of recovery as advised by Integrated Care System (ICS).

Key Variances

- Income year to date is £3.76m higher than planned due to ERF of £2.55m and £2.02m of additional income accounted for to offset Covid-19 costs, funding for which has been requested from NHS Improvement. This is offset to some extent by lower than planned commercial income.
- Pay costs are £0.21m above the planned level year to date, although this includes £0.75m of Covid-19 costs that are outside of envelope and therefore offset by additional income and £0.16m of Recovery costs that are offset by ERF. There remain some higher than expected pay pressures, particularly in Medical Division, where Emergency Department segregation and some enhanced staffing models on Wards and in Critical Care continue to drive higher costs. These costs have been offset by slippage on new developments, activity related underspends in Surgical Division and vacancies in Outpatients and Community Division.
- Non-pay operating expenditure was also higher than planned by £0.71m, this is due to Covid-19 related expenditure of £1.27m for vaccinations costs and Covid-19 testing that are outside of envelope and £0.91m of recovery costs. The underlying position was a £1.46m underspend largely related to lower than planned drugs and consumables costs.

H1 (Apr-Sep) Forecast

The Trust is forecasting a break-even position as planned at the end of this reporting period (H1). The underspend in the year to date position is not expected to continue into future months. Recovery costs will increase over the next 4 months, and the associated ERF funding will be harder to achieve as the threshold for delivery increases.

Attachment: Month 2 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 2 Finance Report and note the financial position for the Trust as at 31 May 2021.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st May 2021 - Month 2

KEY METRICS

	M2				YTD (MAY 2021)				Forecast 21/22			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	£0.27	£2.66	£2.39		£0.34	£3.28	£2.94		£0.00	£0.00	(£0.00)	
Agency Expenditure	(£0.38)	(£0.37)	£0.01		(£0.75)	(£0.87)	(£0.12)		(£4.46)	(£4.71)	£0.25	
Capital	£0.18	£0.00	£0.18		£0.38	£0.17	£0.21		£18.99	£18.99	(£0.00)	
Cash	£44.44	£47.06	£2.62		£44.44	£47.06	£2.62		£37.07	£36.63	(£0.43)	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95%	94%	-1%		95%	93%	-2%					
CIP	£0.51	£0.57	£0.06		£1.02	£1.04	£0.01		£17.23	£17.22	(£0.00)	
Use of Resource Metric	3	1			3	2			3	2		

Year to Date Summary

Year to date the Trust has delivered a surplus of £3.28m, a favourable variance of £2.94m compared to plan. This favourable variance is driven by a combination of: slippage on developments, vacancies, lower than planned recovery costs and higher than planned Elective Recovery Funding (ERF).

- Planning for the financial year ending 31st March 22 has once again been split into two halves, H1 (Half 1) and H2 (Half 2). Guidance for the second half of the year has not yet been released, but the Trust does now have a plan for H1 which aims to deliver a break-even position.
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Key Variances

- Income year to date is £3.76m higher than planned due to ERF of £2.55m and £2.02m of additional income accounted for to offset Covid-19 costs, funding for which has been requested from NHS Improvement. This is offset to some extent by lower than planned commercial income.
- Pay costs are £0.21m above the planned level year to date, although this includes £0.75m of Covid-19 costs that are outside of envelope and therefore offset by additional income and £0.16m of Recovery costs that are offset by ERF. There remain some higher than expected pay pressures, particularly in Medical Division, where Emergency Department segregation and some enhanced staffing models on Wards and in Critical Care continue to drive higher costs. These costs have been offset by slippage on new developments, activity related underspends in Surgical Division and vacancies in Outpatients and Community Division.
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H1 (Apr-Sep) Forecast

The Trust is forecasting a break-even position as planned at the end of this reporting period (H1). The underspend in the year to date position is not expected to continue into future months. Recovery costs will increase over the next 4 months, and the associated ERF funding will be harder to achieve as the threshold for delivery increases.

Total Group Financial Overview as at 31st May 2021 - Month 2

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M2

CLINICAL ACTIVITY

	M2 Plan	M2 Actual	Var
Elective	534	624	90
Non-Elective	9,882	8,774	(1,108)
Daycase	6,852	7,161	309
Outpatient	59,774	62,463	2,689
A&E	26,451	28,399	1,948
Other NHS Non-Tariff	252,910	270,094	17,184
Other NHS Tariff	14,518	14,769	252
Total	**370,920**	**392,284**	**21,364**

TOTAL GROUP: INCOME AND EXPENDITURE

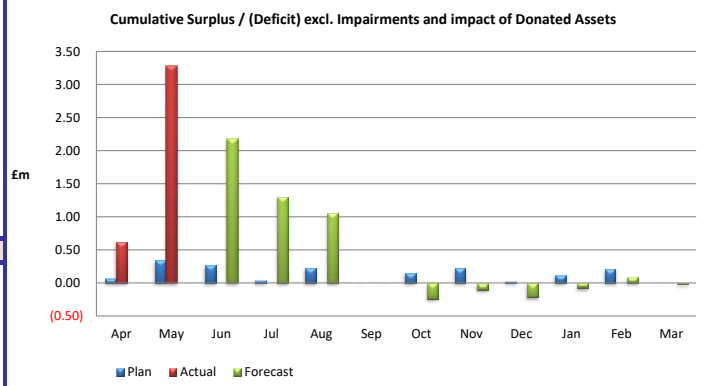
	M2 Plan	M2 Actual	Var
	£m	£m	£m
Elective	£1.61	£1.61	£0.00
Non Elective	£19.19	£19.19	£0.00
Daycase	£3.90	£3.90	£0.00
Outpatients	£3.40	£3.40	£0.00
A & E	£4.08	£4.08	£0.00
Other-NHS Clinical	£28.63	£33.37	£4.75
CQUIN	£0.55	£0.55	£0.00
Other Income	£8.41	£7.42	(£0.99)
Total Income	**£69.76**	**£73.51**	**£3.76**
Pay	(£48.15)	(£48.37)	(£0.21)
Drug Costs	(£6.76)	(£6.23)	£0.53
Clinical Support	(£5.10)	(£5.83)	(£0.73)
Other Costs	(£9.82)	(£10.33)	(£0.51)
PFI Costs	(£2.17)	(£2.17)	£0.00
Total Expenditure	**(£72.01)**	**(£72.93)**	**(£0.92)**
EBITDA	**(£2.25)**	**£0.59**	**£2.84**
Non Operating Expenditure	(£4.80)	(£4.70)	£0.10
Surplus / (Deficit) Adjusted*	**(£7.05)**	**(£4.11)**	**£2.94**
Conditional Funding (MRET/FRF/Top Up)	£7.40	£7.40	£0.00
Surplus / Deficit*	**£0.34**	**£3.28**	**£2.94**

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

DIVISIONS: INCOME AND EXPENDITURE

	M2 Plan	M2 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£13.69)	(£13.92)	(£0.23)
Medical	(£16.51)	(£17.91)	(£1.40)
Families & Specialist Services	(£13.86)	(£13.28)	£0.58
Community	(£4.15)	(£4.15)	£0.01
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£8.50)	(£8.82)	(£0.32)
THIS	£0.39	£0.47	£0.08
PMU	£0.50	£0.35	(£0.15)
CHS LTD	£0.13	£0.16	£0.02
Central Inc/Technical Accounts	£58.42	£57.98	(£0.44)
Reserves	(£2.39)	£2.40	£4.79
Surplus / (Deficit)	**£0.34**	**£3.28**	**£2.94**

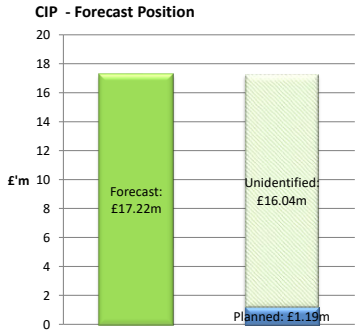
TOTAL GROUP SURPLUS / (DEFICIT)

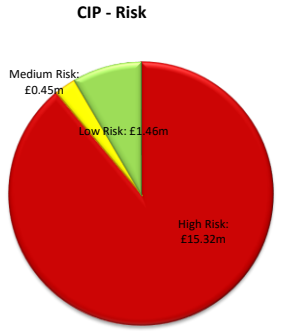


KEY METRICS

	Year To Date			Year End: Forecast			
	M2 Plan	M2 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	£0.34	£3.28	£2.94	£0.00	£0.00	(£0.00)	
Capital	£0.38	£0.17	£0.21	£18.99	£18.99	(£0.00)	
Cash	£44.44	£47.06	£2.62	£37.07	£36.63	(£0.43)	
Invoices Paid within 30 days (BPPC)	95%	93%	-2%				
CIP	£1.02	£1.04	£0.01	£17.23	£17.22	(£0.00)	
	Plan	Actual		Plan	Forecast		
Use of Resource Metric	3	2		3	2		

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£17.23m**

Total Forecast **£17.22m**

YEAR END 21/22

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	3,790	3,880	90
Non-Elective	58,196	57,088	(1,108)
Daycase	46,367	46,675	309
Outpatient	402,979	405,668	2,689
A&E	154,885	156,833	1,948
Other NHS Non- Tariff	1,637,434	1,654,618	17,184
Other NHS Tariff	94,178	94,430	252
Total	**2,397,829**	**2,419,193**	**21,364**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£11.44	£11.44	£0.00
Non Elective	£113.53	£113.53	£0.00
Daycase	£25.34	£25.34	£0.00
Outpatients	£25.27	£25.27	£0.00
A & E	£23.42	£23.42	£0.00
Other-NHS Clinical	£162.11	£175.20	£13.09
CQUIN	£3.39	£3.39	£0.00
Other Income	£51.18	£48.93	(£2.25)
Total Income	**£415.68**	**£426.52**	**£10.84**
Pay	(£284.11)	(£288.33)	(£4.22)
Drug Costs	(£42.06)	(£41.62)	£0.43
Clinical Support	(£31.62)	(£35.65)	(£4.03)
Other Costs	(£53.25)	(£56.85)	(£3.60)
PFI Costs	(£13.03)	(£13.46)	(£0.43)
Total Expenditure	**(£424.08)**	**(£435.90)**	**(£11.83)**
EBITDA	**(£8.39)**	**(£9.38)**	**(£0.99)**
Non Operating Expenditure	(£29.05)	(£28.06)	£0.99
Surplus / (Deficit) Adjusted*	**(£37.45)**	**(£37.45)**	**(£0.00)**
Conditional Funding (MRET/FRF/Top Up)	£37.45	£37.45	£0.00
Surplus / Deficit*	**£0.00**	**£0.00**	**(£0.00)**

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

DIVISIONS: INCOME AND EXPENDITURE

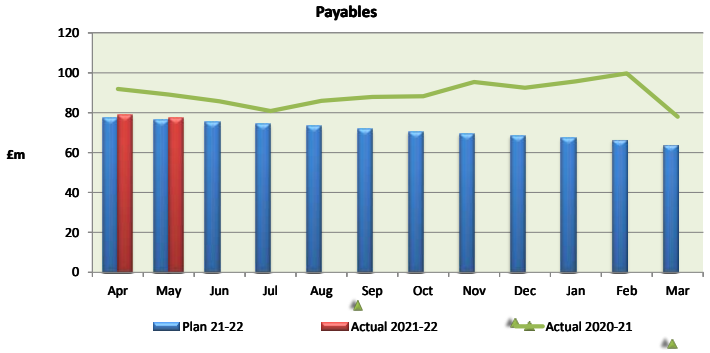
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£83.47)	(£83.70)	(£0.23)
Medical	(£100.63)	(£102.03)	(£1.40)
Families & Specialist Services	(£82.92)	(£82.34)	£0.58
Community	(£24.96)	(£24.95)	£0.01
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£51.17)	(£51.49)	(£0.32)
THIS	£2.16	£2.16	(£0.00)
PMU	£3.02	£3.02	£0.00
CHS LTD	£0.81	£0.80	(£0.01)
Central Inc/Technical Accounts	£334.77	£334.34	(£0.43)
Reserves	£2.39	£4.19	£1.81
Surplus / (Deficit)	**£0.00**	**£0.00**	**(£0.00)**

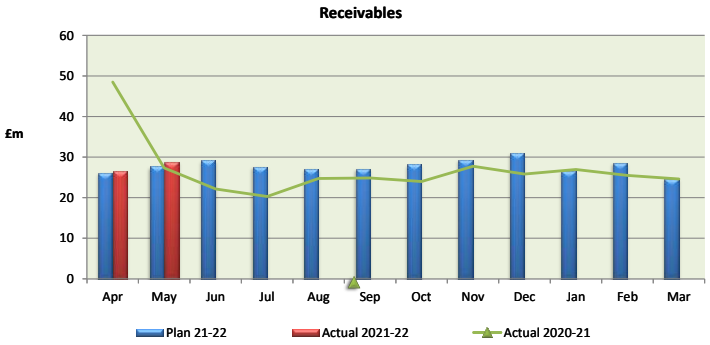
Total Group Financial Overview as at 31st May 2021 - Month 2

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

WORKING CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Payables (excl. Current Loans)	(£76.28)	(£77.48)	£1.20	
Receivables	£27.71	£28.78	(£1.07)	





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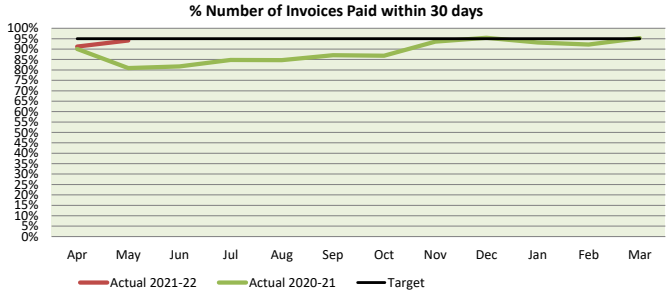
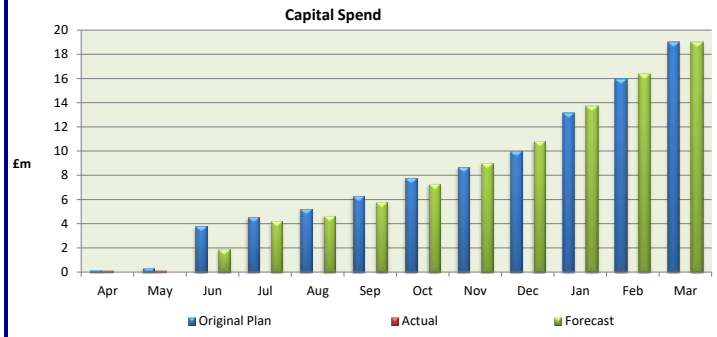


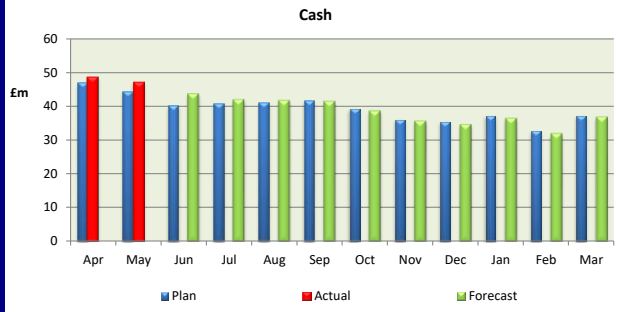
CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Capital	£0.38	£0.17	£0.21	

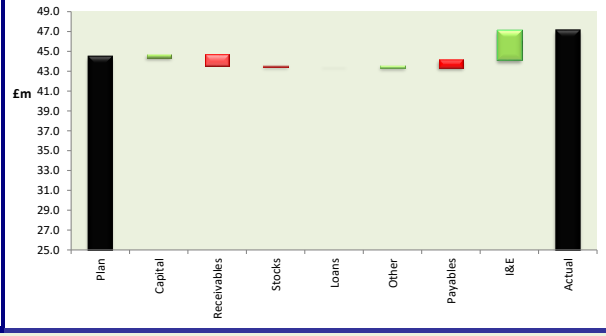


CASH

	M2 Plan £m	M2 Actual £m	Var £m	M2
Cash	£44.44	£47.06	£2.62	
Loans (Cumulative)	£18.77	£18.77	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date, the Trust has delivered a surplus of £3.28m, a favourable variance of £2.94m compared to plan. This favourable variance is driven by a combination of slippage on developments, vacancies , lower than planned recovery costs and higher than planned Elective Recovery Funding (ERF).
- Funding for H1 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H1, the Trust has been allocated £22.19m of System Top Up funding, £11.27m of System Covid funding and £1.74m of Growth funding, a total Top Up of £35.20m to be received equally across the first 6 months of the year.
- With the exception of Non-Elective, all activity points of delivery are above the planed level year to date, exceeding the Elective Recovery Fund thresholds and confirming the Trust's eligibility for additional funding. ERF funding is reliant on the performance of the whole Integrated Care System, but so far this is on track.
- The Trust has incurred costs relating to Covid-19 of £4.14m, of which £2.02m are considered as 'outside of system envelope' and for which additional funding is available.
- Capital expenditure is lower than planned at £0.17m against a planned £0.38m.
- CIP delivered year to date is £1.04m, £0.02m above the planned level.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 3.

NOTES

- The Trust is forecasting to deliver a break-even position at both H1 (Apr-Sep) and for the full financial year.
- Planning for the financial year ending 31st March 22 has once again been split into two halves, H1 (Half 1) and H2 (Half 2). Guidance for the second half of the year has not yet been released, but the Trust does now have an agreed plan for H1 which aims to deliver a break-even position.
- The forecast assumes that recovery costs incurred will be funded through the ERF, currently forecast for H1 at £5.51m
- The total loan balance is £18.77m as planned. No further loans are planned for this financial year.
- The Trust has a cash balance of £47.06m, £2.62m higher than planned.
- The estimated efficiency target for the year is £17.23m of which only £3m is required to be found in H1. This target may change when funding arrangements for H2 are confirmed.
- The Trust is forecasting to spend £18.99m on Capital programmes in this financial year, in line with the planned value.

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

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

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

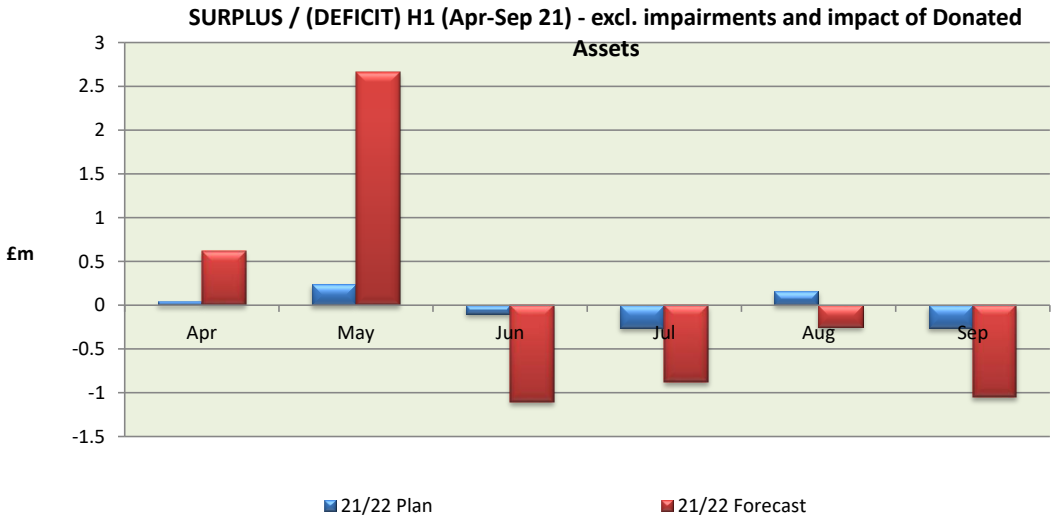
H1 (Apr-Sep) FORECAST POSITION 21/22

H1 Forecast (30 Sep 21)

Statement of Comprehensive Income	Plan £m	Actual £m	Var £m	
Income	£263.60	£273.30	£9.70	
Pay expenditure	(£144.32)	(£147.62)	(£3.30)	
Non Pay Expenditure	(£105.18)	(£111.62)	(£6.44)	
Non Operating Costs	(£14.27)	(£14.27)	(£0.00)	
Total Trust Surplus / (Deficit)	**(£0.17)**	**(£0.21)**	**(£0.04)**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	£0.00	£0.00	
Donated Asset depreciation	£0.21	£0.21	(£0.00)	
Donated Asset income (including Covid equipment)	(£0.04)	£0.00	£0.04	
Net impact of donated consumables (PPE etc)	£0.00	£0.00	£0.00	
Adjusted Financial Performance	**£0.00**	**£0.00**	**(£0.00)**	

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

MONTHLY SURPLUS / (DEFICIT)



Forecast for H1 (Apr-Sep 21)

- The Trust is forecasting a break-even position as planned at the end of this reporting period (H1). The underspend in the year to date position is not expected to continue into future months. Recovery costs will increase over the next 4 months, and the associated ERF funding will be harder to achieve as the threshold for delivery increases.

Forecast Assumptions:

- £5.4m recovery costs required to deliver the agreed final activity plan submitted to the ICS in May 21.
- Assumes a further £2.4m expenditure to cover Independent Sector arrangements that are currently under discussion.
- Elective Recovery Funding (ERF) of £5.51m is assumed in the forecast - this is the planned level plus the year to date favourable variance.
- Covid-19 costs are managed within the approved £4.5m reserve, set aside for this purpose.

COVID-19 & Recovery

Covid-19 Expenditure YTD May 21	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	45	0	45
COVID-19 virus testing - rt-PCR virus testing	106	640	746
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	459	1	460
COVID-19 - Vaccination Programme - Vaccine centres	0	621	621
Remote management of patients	85	89	174
Support for stay at home models	9	-1	8
Plans to release bed capacity	8	0	8
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	170	40	210
Segregation of patient pathways	1,129	150	1,278
Enhanced PTS	0	46	46
Existing workforce additional shifts	86	39	125
Decontamination	0	56	56
Backfill for higher sickness absence	36	0	36
PPE - locally procured	0	6	6
Internal and external communication costs	0	1	1
Sick pay at full pay (all staff types)	2	0	2
NIHR SIREN	5	1	6
COVID-19 - International quarantine costs	0	5	5
COVID-19 - Deployment of final year student nurses	182	0	182
Total	**2,322**	**1,692**	**4,014**

Recovery Costs YTD May-21	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	0	709	709
Additional Staffing - Medical	68	0	68
Additional Staffing - Nursing	39	0	39
Additional Staffing - Other	26	0	26
Non Pay	0	204	204
Enhanced Payment Model - Medical	20	0	20
Enhanced Payment Model - Nursing	7	0	7
Total	**159**	**913**	**1,072**

Covid-19 Costs

Year to date the Trust has incurred £4.01m of expenditure relating to Covid-19. Planned Covid costs year to date were £1.50m, but this plan does not include Covid-19 costs that are outside of System envelope and for which funding can be claimed retrospectively. These costs are highlighted in the table to the left and total £2.02m year to date **The underlying overspend on Covid was therefore £0.49m** and was driven by the continuation of some enhanced workforce models on wards and in ICU and a continuation of Emergency Department segregation. However, at this early stage of the year, this pressure has been offset by underspends on consumables and drugs linked to elective and daycase activity which remains lower than historic levels.

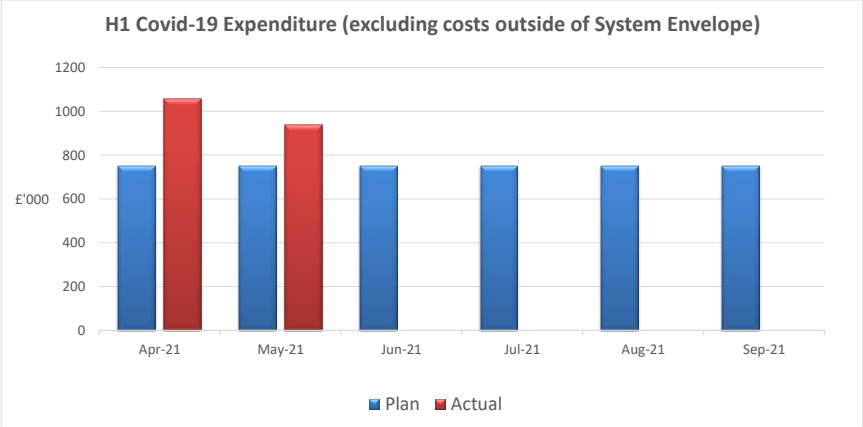
Covid-19 Funding

The Trust has been allocated block funding by the ICS to cover any Covid-19 costs totalling £3.76m year to date. In addition the Trust will be requesting retrospective Covid-19 funding of £2.02m to cover costs relating to Vaccinations, Covid-19 Testing and 3rd year student nurses.

Recovery

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

- Year to date Recovery costs are £1.07m.
- The majority of the costs incurred related to use of the Independent Sector for outsourcing. The Trust has agreed contracts with Optegra, BMI and Spire.
- Elective Recovery Fund (ERF) Funding is allocated at System level and will only be paid if the Integrated Care System (ICS) as a whole exceeds activity thresholds.
- The ICS has confirmed that the Trust is eligible to receive additional funding via the Elective Recovery Fund as the thresholds agreed for April and May activity have been exceeded. £2.55m of income has been assumed in the year to date position, £1.02m more than planned.



COMFORT BREAK – 10 MINUTES

A Workforce for the Future

15. Staff Survey Progress against actions

To Note

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title:	National Staff Survey 2020 – Progress against actions
Author:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee, February 2021, CHFT Board, June 2021, Divisional Performance Management Reviews April, May, June 2021

Purpose of the Report

To provide the Board with assurance that the actions arising from the National Staff Survey 2 020 are being progressed and clear next steps have been identified.

Key Points to Note

- CHFT increased responses to the annual National Survey by 4% in 2020 to 50.1% from 46% in 2019
- CHFT saw an overall improvement in its scored by 1%
- Significant improvement was recorded in scores for questions related to Health and Wellbeing, Safety, working for CHFT and care provided
- There were reductions in scores for questions related to involvement and team effectiveness
- Feedback from the 2019 score led to an approach focused on key themes for the Trust and Division, with more Divisional ownership for activities under each theme identified
- All Divisions have chosen to develop staff survey plans for each Directorate
- Progress against actions under each key theme are monitored through WOD Workforce Monitoring Meetings, Workforce Committee, Divisional Senior Management Team meetings, Performance Review Meetings with progress updates provided to Board
- Further work is required to identify and progress Divisional activity in relation to Inclusion; to align priorities with actions arising from the recent Well Led Aqua review and to prepare a communications campaign in the run up to the 2021 survey which launches in September 2021
- CHFT is required to run quarterly staff 'pulse' surveys from July 2021

EQIA – Equality Impact Assessment

The National Staff Survey results are broken down by each protected characteristic. As part of our analysis of results, improvement is monitored both by theme and protected characteristic.

A new diverse Engagement team, reformed in order to respond to workforce priorities arising throughout our response to COVID, will focus on key activities that will improve engagement across CHFT, paying particular attention to any areas for improvement that are related to a protected group. Aligning staff survey engagement priorities with outcomes from our 6 equality groups, and with actions identified by our Community Engagement Advisor, CHFT will develop an holistic overview of issues impacting on all groups of colleagues working at CHFT and living in the communities it serves.

The Workforce Intelligence team has developed a data report that enables CHFT to look at the IMD of its workforce, as well as its patients. As this work becomes more sophisticated, it can be mapped against workforce data based on protected characteristic to identify the activities that will have most impact on all our colleagues, helping us to make CHFT even more informed about its workforce and their needs. This in turn will enable us to make CHFT an even better place to work.
Recommendation
The Board of Directors is asked to **NOTE** the progress made against the 5 key themes identified from the results of the National Staff Survey 2020.

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NHS
Calderdale and Huddersfield
NHS Foundation Trust

Staff Survey 2020

Progress update July 2021

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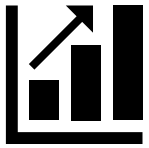
National Staff Survey 2020 - Overview

Improvements in scores to questions related to Health and Wellbeing, care provided, safety and CHFT as a good place to work

Scores in relation to involvement and team effectiveness declined

EDI positive from an ethnicity pov, more work to &do to engage disabled and LGBTQ+ colleagues



Response rate 50.1%

Overall improvement of 1% in our scores

Priority areas by theme and more direct ownership of colleague engagement through Divisions

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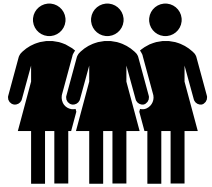
CHFT Staff Survey 2020
Trust wide priorities

- Wellbeing
- Leadership Development
- Development for all
- Inclusion
- Involvement



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Tracking progress

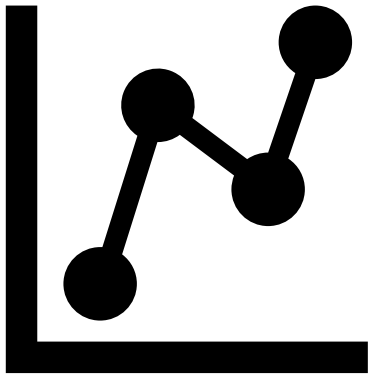
Directorate staff survey plans reviewed monthly within Division

Trust staff survey progress reviewed monthly at Workforce Monitoring Meeting

Divisional staff survey progress reported at monthly Performance Review Meetings

Progress against agreed priorities for the Trust and Division reviewed at Workforce Committee

Progress against agreed priorities for the Trust and Division presented to Board



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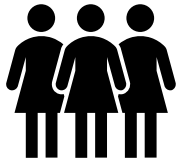
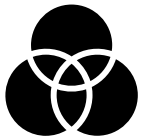
Overall Trust progress

145 Wellbeing Ambassadors appointed, working closely with Calderdale & Kirklees Place



Leadership Development Hot House held 7th June 2021, relaunch leadership development platform July 2021, participating in a Team Engagement Diagnostic pilot with 6 other UK trusts from July 2021

Empower feedback excellent, season one will end October 2021 – plan to introduce Season 2 in October 21 (3 cohorts / places for 30 people). Self help resources added to The Cupboard, working on career pathway, talent and succession mechanisms for launch late September 2021



6 equality groups at CHFT. Post pandemic, colleagues now wish to have a safe place to share 'lived experiences'. Pride Month, Windrush day. BAME Community Engagement Advisor in post and will be focussing on networks, health inequalities and racism strategy

Involvement – all about 'Team CHFT' – Engagement teams currently working closely with local divisional teams to understand what makes them feel rewarded and valued –relaunch of CHuFT and Celebrating success in July 2021. Colleagues participating in EQIA, Inclusive Recruitment, Equality Groups

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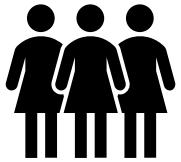
Surgical Division progress

Focus on wellbeing with proactive wellbeing activities and sessions provided with support of Wellbeing Advisor; implementation of wellbeing hour



Standard objective for all people managers re Leadership Development and Return to Work Interviews

Listening Events held across the Division; teams in need given specialist support to improve; new recruitment social media platform through TikTok #chftrecruit

Each Directorate has a 1 year and 5 year engagement plan

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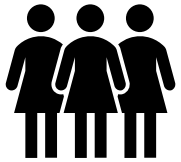
Medical Division progress

Focus on wellbeing with wellbeing plans incorporated into Divisional agendas



Specific programme for Management team developed with programme of key events and learning forums

Thank you and debrief events held across the Division; focus on ED with a more holistic view of the service; Friday News well established and received; reconfiguration involvement events held across Division

Each Directorate has a 1 year engagement plan

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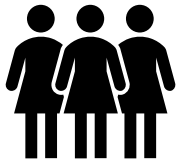
FSS Division progress

Focus on clinical team engagement; WTGR sessions continued; wellbeing fund re-established



New DD and CD appointments in radiology, paeds and pharm used as a catalyst to further improve engagement; divisional newsletter planned

Lessons learned exercises with focus on engagement through COVID; staff survey champions network developed;

Each Directorate has an engagement plan

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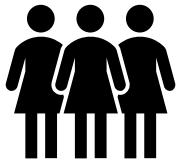
Community Division progress

Wellbeing hour consistently implemented across Division; Wellbeing integral to every team meeting



Thank you cards and Star Awards consistently and constantly awarded

Debrief events for all colleagues involved in near misses; focused communication and involvement plans in place for each directorate; equipment audit completed with colleagues to ensure they have the right tools for the job

Each Directorate has an engagement plan

Next steps

- More Divisional focus on Inclusion activity
- Align priorities in Staff Survey action plan with Aqua review priorities (talent management, management development, and leadership at all levels)
- July ‘pulse survey’ review
- Communications plan to prepare for Staff Survey 2021 (launches September 2021)

Keeping the Base Safe

16. Director of Infection Prevention Control (DIPC) Annual Report

To Note

Presented by David Birkenhead

Date of Meeting:	Thursday 1 July 2021
Meeting:	Public Board of Directors
Title:	Director of Infection Prevention and Control (DIPC) Annual Report
Author:	Jean Robinson, Matron Lead IPC Lindsay Rudge, Deputy Director of Nursing Anu Rajgopal, Consultant Microbiologist
Sponsoring Director:	David Birkenhead, Executive Medical Director, Director of Infection Prevention and Control
Previous Forums:	None

Purpose of the Report

To provide the Board of Directors an annual report of the position of performance and of Healthcare Associated Infections (HCAIs) for 2020-21.

Key Points to Note

- There was 1 trust apportioned Meticillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia reported against a ceiling target of zero.
- There were 49 trust apportioned *Clostridium difficile* toxin (CDI) positive cases this year against a ceiling target of 40. All were subject to a Root Cause Analyses (RCA) – 16 of these cases were identified as potentially avoidable. Learning from the RCAs is fed into a Trust-wide action plan and divisional actions plans, to minimise the risk of patients acquiring CDI.
- There were 16 CHFT-attributed Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemias.
- The Trust reported 29 *Escherichia coli* bacteraemias which is comparable to previous year's performance.
- A cluster of 3 Serratia line infections was identified on ICU at CRH, this was managed as an outbreak in line with Trust Policy.
- A cluster of 3 MRSA colonisation was identified on SCBU and managed as an outbreak in line with Trust policy.
- There were 5 wards affected (either closed or restricted) with viral gastroenteritis, resulting in a total of 87 bed days lost in comparison to 89 bed days lost during 2019/20.
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of compliance with the Hand Hygiene Policy for the year was 78% compared to 89% the previous year.
- The Trust participated in the mandatory orthopaedic surgical site infection surveillance (SSIS) programme.
- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust intranet and internet sites. Three policies have been approved at Executive Board during 2019/20.
- ANTT continues to be a priority with overall Trust compliance at 88.14% by the end of March 2021.
- COVID-19 pandemic – the IPC team supported all relevant COVID-19 workstreams over the pandemic and drafted internal CHFT procedures to help maintain services at CHFT in-

line with national IPC recommendations.

- Hospital-acquired COVID infections and outbreaks were managed in accordance with NHSE recommendations. We had 35 COVID-19 outbreaks over the last year which involved 89 patients and 75 staff.
- COVID19 PCR and POCT-led improvement in turnaround times and early diagnosis, improved management.
- The IPC team has worked with PHE and partner organisations in supporting outbreaks outside of CHFT.

EQIA – Equality Impact Assessment

This report relates performance information relating to Infection Prevention and Control. With the exception of COVID it is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. Whilst IPC guidelines apply to all patients and visitors COVID has had a greater impact on the elderly and some members of the BAME community, the restrictions placed to control nosocomial infection therefore have had a greater impact on those communities.

Recommendation

The Board is asked to **NOTE** the assurances in the 2020/21 Annual Infection Prevention Control report that:

- there were effective systems in place for infection prevention control (IPC) during the year;
- the performance against key IPC targets in 2020/21 and areas for improvement for 2021/22;
- the IPC team response to the Covid-19 pandemic.

Calderdale and Huddersfield
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2020-21

Executive Summary

The Trust has a statutory responsibly to be complaint with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (updated 2015) and the Care Quality Commission (CQC) guidance. Compliance is demonstrated through a self-assessed Healthcare Associated Infection (HCAI) programme of work and audit for 2019/20 that includes the 10 criteria identified in the code.

Evolving clinical practice, expanding services, emerging infections, antimicrobial resistance and an increase in vulnerable populations present new challenges for which a constant review of policies and procedures is essential.

This year has been unprecedented one of exceptional challenge related to Infection Prevention and Control, COVID 19 has consumed considerable time and energy the Trust has demonstrated a timely and unified response to protect both patients and staff.

This report demonstrates the continued commitment of the Trust to IPC and details the activities of the Infection Prevention and Control Team (IPCT) during the period of April 2020 to March 2021. The Director of Infection Prevention and Control (DIPC) who is also the Executive Medical Director leads the IPCT and reports directly to the Chief Executive.

Key points:

- There was 1 trust apportioned Meticillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia reported against a ceiling target of zero.
- There were 49 trust apportioned *Clostridium difficile* toxin (CDI) positive cases this year against a ceiling target of 40. All were subject to a Root Cause Analyses (RCA) – 16 of these cases were identified as potentially avoidable. Learning from the RCAs is fed into a Trust-wide action plan and divisional actions plans, to minimise the risk of patients acquiring CDI.
- There were 16 CHFT-attributed Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia.
- The Trust reported 29 *Escherichia coli* bacteraemia which is a comparable previous year's performance.
- Serratia marcesens outbreak on CRH ICU over April-May'20-see attached summary sent to CQC.
- We had 35 COVID-19 outbreaks over the last year
- A cluster of 3 MRSA colonisation was identified on SCBU and managed as an outbreak in line with Trust policy.
- There were 5 wards affected (either closed or restricted) with viral gastroenteritis, resulting in a total of 87 bed days lost in comparison to 89 bed days lost during 2019/20.

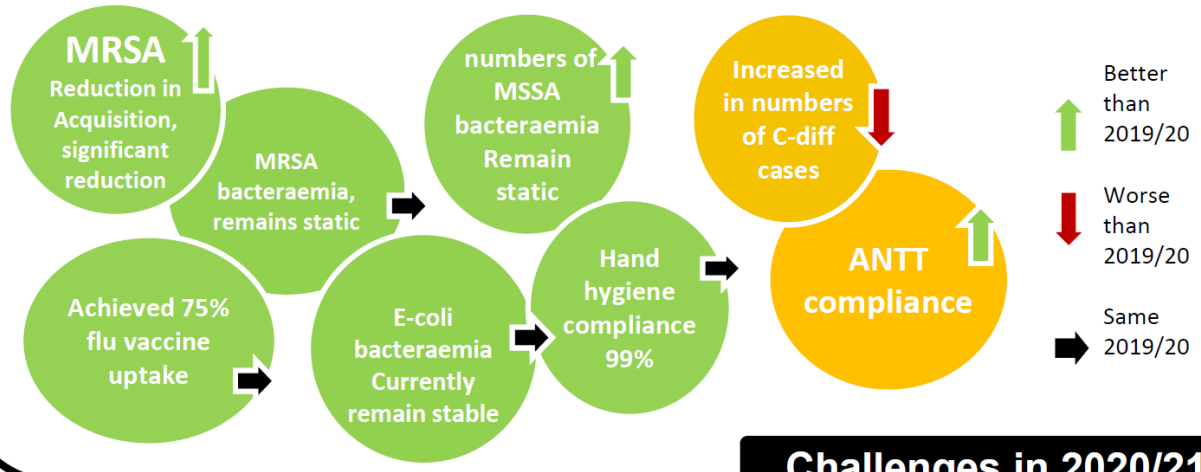
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of compliance with the Hand Hygiene Policy for the year was 78% compared to 89% the previous year.
- The Trust participated in the mandatory orthopaedic surgical site infection surveillance (SSIS) programme.
- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust intranet and internet sites. Three policies have been approved at Executive Board during 2019/20.
- ANTT continues to be a priority with overall Trust compliance at 88.14% by the end of March 2021.
- COVID-19 pandemic – the IPC team supported all relevant COVID-19 workstreams over the pandemic and drafted internal CHFT procedures to help maintain services at CHFT in-line with national IPC recommendations.
- COVID19 PCR and POCT-led improvement in turnaround times and early diagnosis, improved management.
- The IPC team has worked with PHE and partner organisations in supporting outbreaks outside of CHFT.

Infection Prevention & Control April 2020-March 2021 highlight report

RESULT: safe, evidence based practice with reduction health associated infections.

REALITY 2020/21 with comparison to 2019/20

What we did well: What could be better: What needs significant improvement



Challenges in 2020/21

- Increased cases of Clostridium difficile.
- Outbreaks of COVID (patients and staff)
- Outbreak of Serratia in NICU
- Management of Covid Outbreaks
- Ongoing response to the Covid-19 Pandemic.
- ANTT Drs compliance.
- FFP3 FIT testing & PPE
- Rapidly changing National IPC Guidance

Key achievements for 2020/21

- reduction in E-coli bacteraemia maintained
- PCR introduced for COVID testing
- Integrated working with divisions
- All Policies reviewed within timeframe
- Significant reduction MRSA acquisition
- Sanity maintained within IPCT
- Coordinated hospital wide response to Covid
- FFP3 FIT testing
- In-patient Covid testing strategy

Data overview for 2020/21

MRSA	MRSA (HAI)	CDIFF	ECOLI:	MSSA:	KLEB:	PSEUDO:	Hand Hygiene	FLO:
1 Post 2 Pre	12	CDIFF – 38 COHA – 12 Preventable – 16 Unpreventable – 33 Pending - 1	29	16	10	2	99.47%	IP – 91.16% Theatres – 93.77% Community – 94.41%

Contents

1. Infection Control Arrangements

The Director of Infection Prevention and Control (DIPC) leads the Infection Prevention and Control Team (IPCT), and is supported by the Assistant DIPC, the Matron Lead for IPC and the Infection Prevention and Control Doctor (IPCD).

Assurance pertaining to IPC is received and scrutinised by the Infection Control Committee, chaired by the IPCD, who then reports to the Quality Committee and to the DIPC directly. The Quality Committee and DIPC report to the Executive Board and the Board of Directors.

In addition to the onsite day service, the IPC Team provide an on-call advice service which has been particularly challenging over the last 12 months.

Additional staffing was sourced (1 WTE Band 4 as of October 2020) to support the ongoing roll out of Fit testing and PPE.

Full details of the Infection Control arrangements are available in the Trust Policy: Section A – Infection Prevention and Control Arrangements - s*ee Appendix 1.*

The Director of Infection Prevention and Control (DIPC) has presented the Trust Board with the following agenda items on IPC during 20/21:

- The annual DIPC report 2019/20 – endorsed.
- Quarterly DIPC reports – endorsed.
- Quarterly Infection Control Committee minutes highlighting outbreaks and areas of concern and providing assurance around infection control practice across the organisation.
- Monthly Trust MRSA bacteraemia trajectory progress and areas of concern.
- Monthly Trust Clostridium *difficile* trajectory progress and areas of concern.
- Monthly Trust MSSA and E-coli bacteraemia figures.
- A narrative of any underperformance against target indicators is provided in the integrated board report, detailing actions being taken to mitigate risks and to support improvement to deliver against targets.
- IPC board assurance framework self-assessment

The IPCT has a proactive approach with the emphasis on being visible, particularly on in-patient areas, so expert advice and support can be accessed**.**

The team also has a wider quality remit which includes attendance at corporate/divisional/partnership meetings, involvement in tender processes for services and procurement of equipment.

The IPCT was also involved in the review of various national guidelines including along with CHS colleagues the National Specifications for Cleanliness in the NHS.

The IPC Board assurance document has been updated and reviewed in line with guidance e alongside a review of the Health and Safety review of acute providers and the CQC framework and key lines of enquiry. The IPC BAF will be reviewed monthly in the recovery oversight and co-ordination group.

The table below shows the current position across all 3 areas of recommendations from the above.

Infection Prevention & Control Action Plan – 16.06.21				
Guidance	Fully Compliant	Partially Compliant	In Progress	Total Requirements
IPC Board Assurance Framework Recommendations - *February 2021 Guidance*	96	8	3	107
CQC Infection Prevention & Control Transitional Monitoring Approach (TMA	37	1	1	39
Health & Safety Executive (HSE) Recommendations	31	5	0	36

Infection Control Budget 2020/21

The Infection Control Team has a budget of £570,731.00, of this £55628.00 is for non-pay including licensing of ICNet surveillance IT system which during the reporting period has been upgraded phase, training expenses and other non-pay items. The Matron Lead is both the budget holder and budget manager. Excess costs associated with outbreaks including the COVID pandemic are funded separately from within the Trust.

2. Mandatory reporting of Healthcare Associated Infections (HCAI)

Mandatory reports are made to Public Health England (PHE) of the following organisms causing the stated infection.

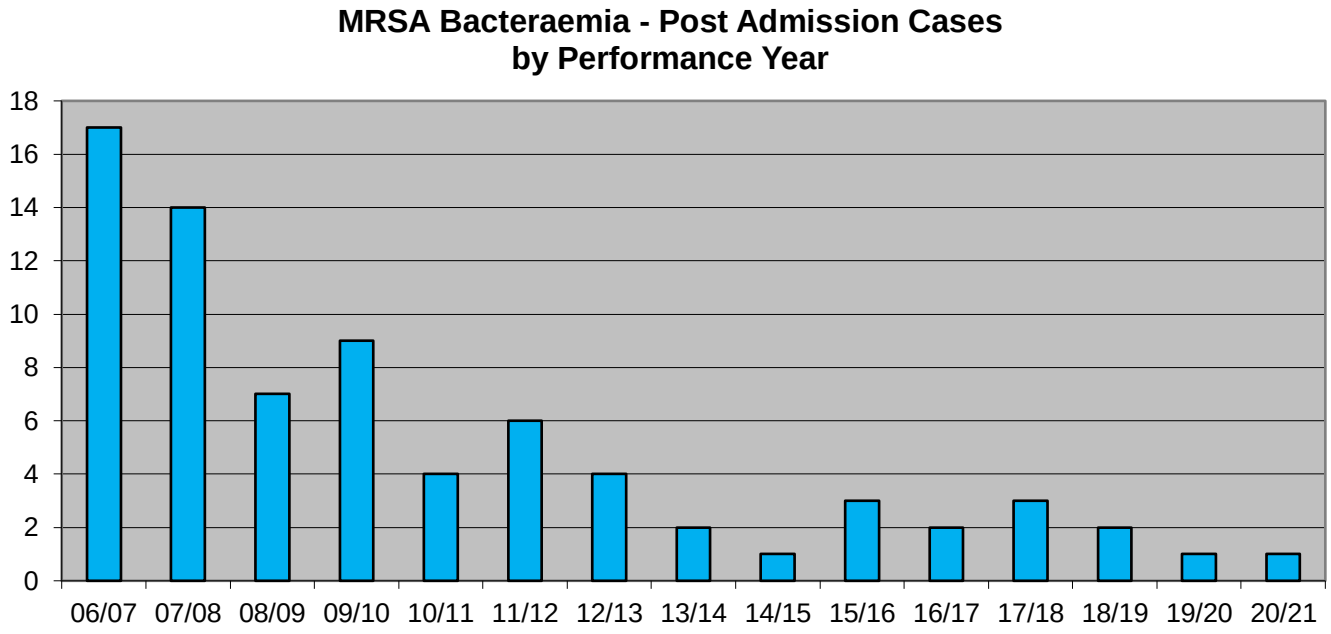
- *Staphylococcus aureus* bacteraemia (MRSA and MSSA)
- *Escherichia coli* bloodstream infections
- *Clostridium difficile* toxin positive infections diagnosed 48 hours after admission and COHAs.

- Orthopaedic Surgical Site Infection Surveillance (minimum 3 month period per annum)

Surgical site Infection Surveillance:- It is a mandatory requirement for acute trusts to participate in the collection of surgical site infections for a minimum of one orthopaedic category over one surveillance period each financial year this was completed from 1st October to 31st December 2020. During this quarter we had 5 infections in 75 operations of Repair of neck of femur. Relatively low numbers of operations are performed per quarter and 5 infections will take CHFT over the national infection rate of 1%. The Orthopaedic team were informed, and an action plan is being developed with involvement from the IPCT. Further surveillance will be undertaken once actions are complete.

Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia

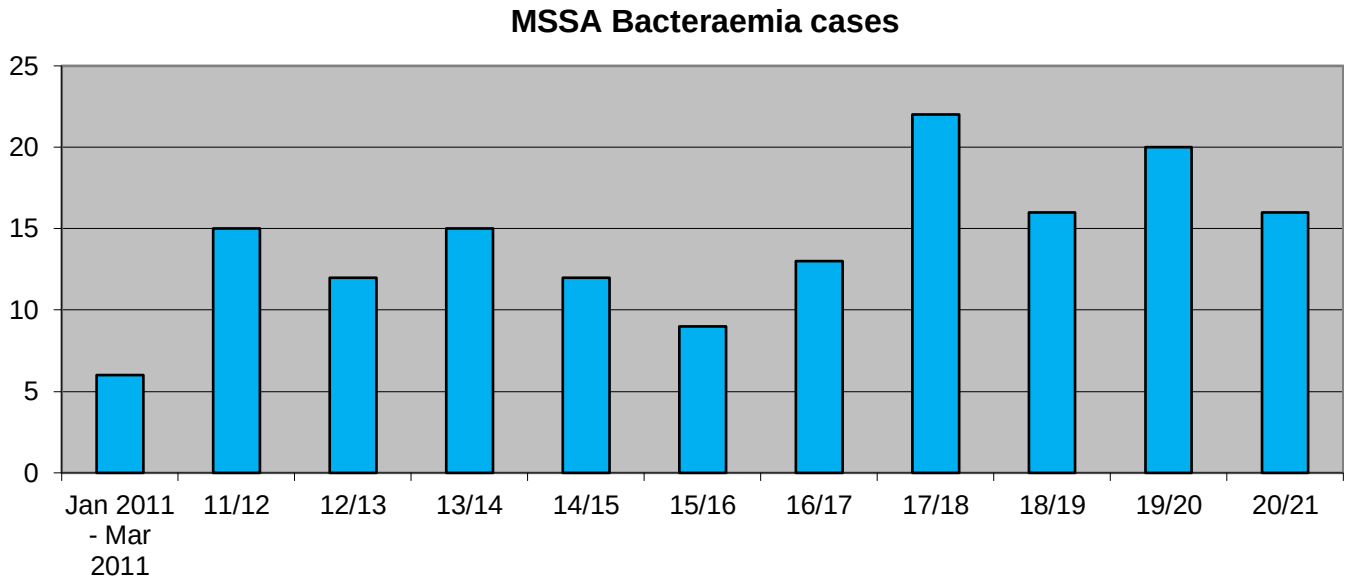
The total number of Trust-apportioned MRSA bacteraemia (blood stream infection) cases for the 2020/21 was 1 against a ceiling of zero, The Trust ensures that these have a Post Infection Review (PIR) to identify if there were any lapses in care to aid prevention of further cases; this case was deemed as non-preventable.



Meticillin-sensitive Staphylococcus aureus

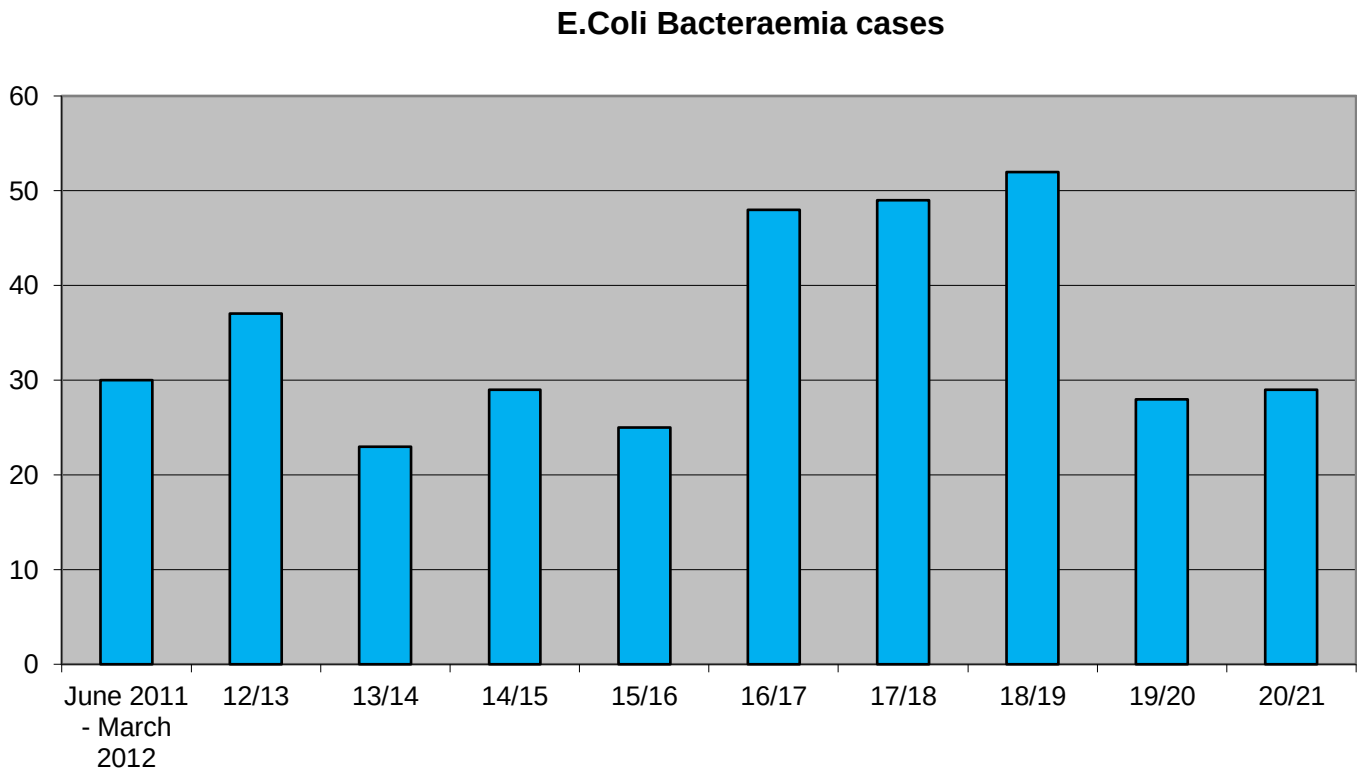
MSSA (Meticillin-sensitive *Staphylococcus aureus)* bloodstream infections are reported nationally although there are no mandated reduction targets set. 16 Trust apportioned cases were reported during 2020/21.

The chart below shows the number of post admission MSSA bacteraemia.



E.coli Bloodstream Infections

There is aspirational national objective for the reduction of *E.coli* bloodstream infections for 50% reduction by 2024. During the reporting period with a total of 29 cases in 2020/21, which is comparable to the previous year.



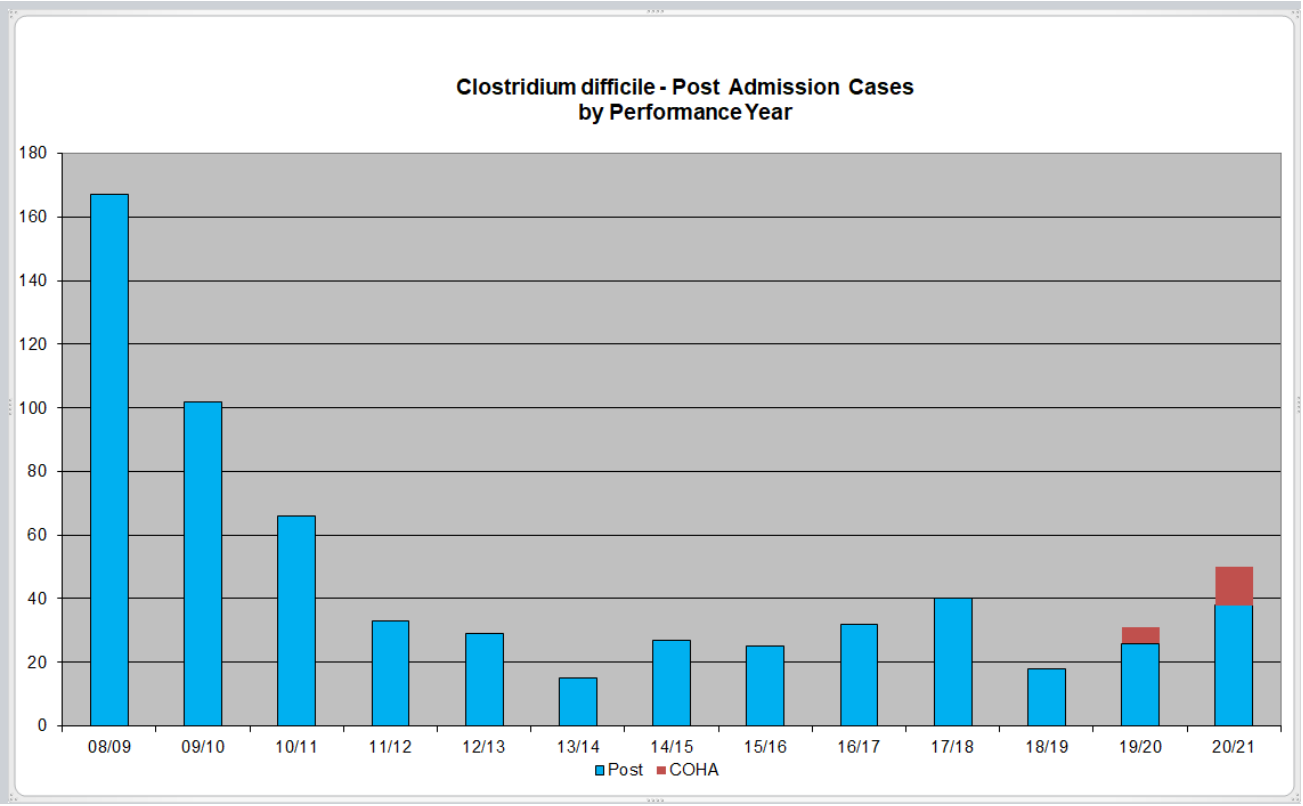
Clostridium *difficile* Infections

Due to the pandemic no national objectives were set but Trust was asked to use the previous year's ceiling of 40 cases: At the year end, we had 49 cases in total demonstrating an increase in cases from the previous year. All cases underwent an investigation following which 16 were deemed to have lapses in care.

Key themes from the C. difficile cases identified at post-infection review are:

- Delay in taking samples
- Delay in Isolation
- Repeat testing if negative
- Antibiotic prescribing issues

Improvement work regarding these will form part of the HAI action plan.



3. Serious Incidents and Outbreaks

The following incidents occurred in 2020/21 related to infection prevention and control:-

- Three babies screened MRSA positive on SCBU from 23/12/20 to 30/12/20, all the babies are colonised. The 3 samples belong to the same cluster genetically which would suggest recent transmission event on SCBU/NICU. Outbreak control measures were put in place including isolation of babies and deep cleaning of the environment. No further cases were identified, and babies continue to be routinely

screened twice weekly. This was investigated according to Trust guidelines and involved PHE.

- Four central line infections, one exit site infection and one hospital-acquired pneumonia due to *Serratia marcescens* on CRH ICU. These infections occurred between the period of 13th April-7th May 2020. A further isolate of *S.marcescens* was isolated from a gloved hand on environmental swabbing. All isolates are identical on molecular typing. Outbreak control measures were implemented with local PHE input. No further cases were identified.

COVID-19 pandemic background:-

Containment phase; January 2020 – February 2020:- The national response to COVID-19 was the led by NHSE/I and PHE. The Trust was actively engaged under the leadership of the DIPC/Chief Nurse/Chief Operating Officer, and Incident Management Team (IMT) was established that included key stakeholders.

The IPCT liaised with clinical colleagues in all emergency access areas to support and advise on: -

- The identification of potential isolation facilities across all emergency access areas, to manage cases of suspected COVID-19 who needed to be assessed.
- The initial installation and management of assessment PODs for testing members of the public who were suspected to have COVID-19
- Guidelines and training for staff on the use of Personal Protective Equipment (PPE) that were made available on the Trust IPC website.
- Identifying and supporting COVID-19 cohort wards and supporting and training staff.

Pandemic phase March onwards:-

As the situation rapidly moved into the pandemic phase the response was expanded and led by the IMT, the Trust contingency plans included: - escalation plans for additional capacity to manage patients who presented to be tested, review of potential isolation facilities and extending the programme for training staff to use enhanced PPE.

Several specific actions in response to the pandemic were undertaken by the IPCT these are summarised below:-

Implementation of National Guidance: - As the pandemic evolved there was rapidly changing national guidance from PHE supplemented by additional guidance from professional bodies. The IPCT interpreted national guidance to produce local Standards Operating Procedures (SOPS) for clinical staff including guidance on isolation/cohorting/collection and transport of high consequence infectious diseases samples.

A proactive external review from NHSE/I was undertaken, and reassurance provided to the organisation. Self-assessment against the Covid Board Assurance Framework was

completed in October 2020 and reviewed again in March 2021, this is an ongoing process and is monitored via the Quality Committee.

GIRFT (Getting it right first time) - IPC responded to the pandemic to ensure patient safety was paramount in our response this included the following:-

- Regional IPC input at DIPC meetings chaired by NHSE/I IPC Lead and CCG/Acute Trust IPC meetings (CHPAG).
- SOPs for COVID risk pathways developed in-line with national IPC guidance included the entire patient journey from triage to final ward placement.
- Patients segregated based on their COVID19 risk pathway. Staff segregated where possible.
- In-house COVID PCR testing with rapid turnaround times, supported safe patient movement and cohorting.
- SOPs developed to effectively manage COVID exposures and staff roles/responsibilities clarified.
- Outbreaks and HOCIs identified rapidly and outbreak policy initiated when required.
- IPC input into daily tactical meetings helped support patient movement and segregation throughout the pandemic.
- IPC collaboration with Trust health informatics and the EPR team helped provide timely data on COVID positives and HOCIs to inform patient segregation and cohorting plans and institute any rapid changes when required.
- Visiting restrictions where implemented in line with national guidance.

There was close liaison with the microbiology laboratory to support in-house COVID PCR testing which helped improve the turnaround time of results substantially.

The IPCT consistently updated advice on PPE undertaking risk assessments and developing strategies to rise to the challenges of shortages in the national provision of PPE.

The IPCT provided expert advice and support to strategic and operational meetings that was incorporated into polices and daily communications. In additional, they also supported clinical teams from a wide range of specialities throughout each stage of the pandemic.

Training and education were key and the IPCT delivered bespoke presentation on the emerging coronavirus and the use of PPE; The team produced educational materials including video on donning and doffing PPE, posters and frequently asked question (FAQS) these resources were available on the trust intranet.

A rapid vaccine rollout was established for CHFT and the local healthcare economy using hospital hubs at both CRH and HRI. This commenced in early January 2021 and delivered over 49000 doses of vaccine.

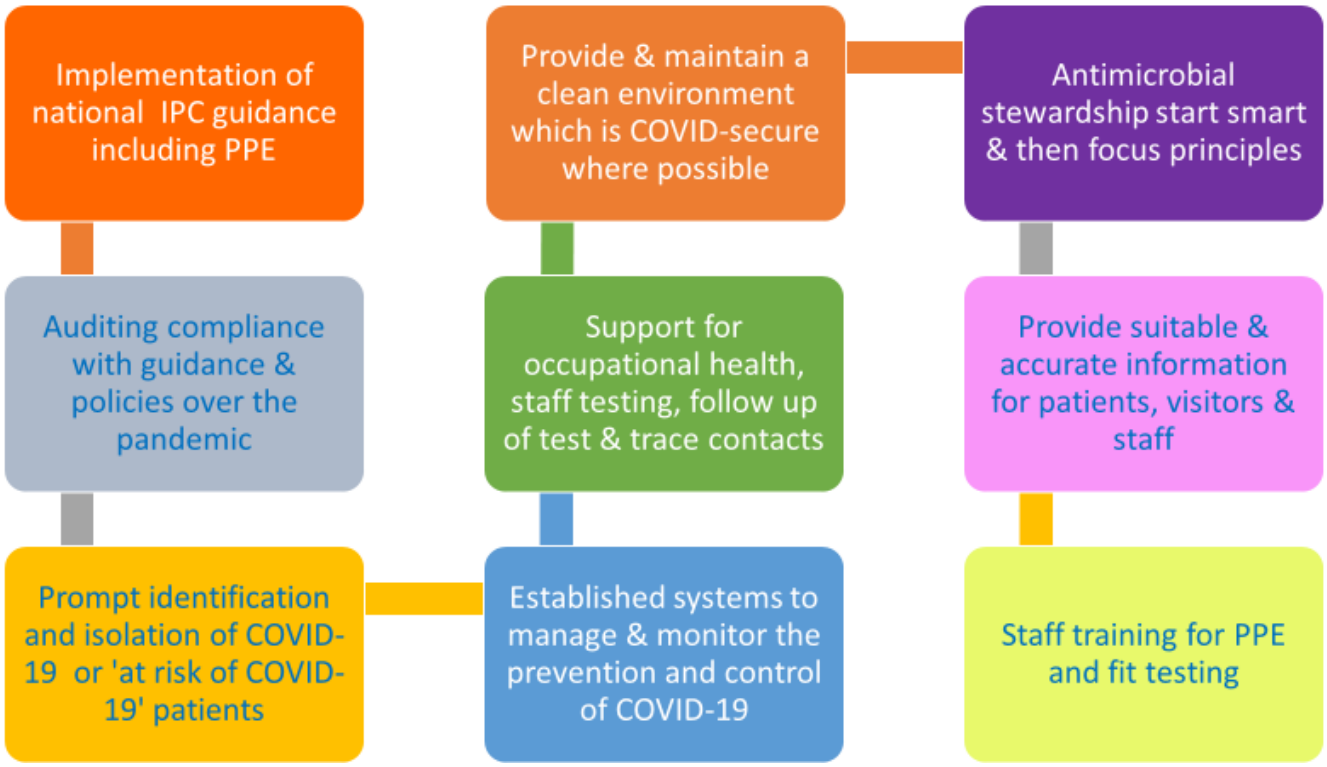
COVID Outbreaks: - There have been 35 outbreaks involving 89 patients and 75 staff during the reporting period all of which are now closed; All outbreaks are managed in line with COVID outbreak management guidelines and are monitored for 28 days. Common themes identified includes: -

- Environmental issues especially difficult with maintaining social distancing for both patients and staff
- Shared toilet facilities: - mitigation in place following CAS alert in December to increase frequency of toilet cleaning.
- Staff break and changing areas – social distancing not maintained, and area not always appropriately cleaned
- Mobile patients with cognitive impairment
- Multiple bed moves
- Breaches in PPE
- Staff not recognising early or minor symptoms of COVID and then attending work.

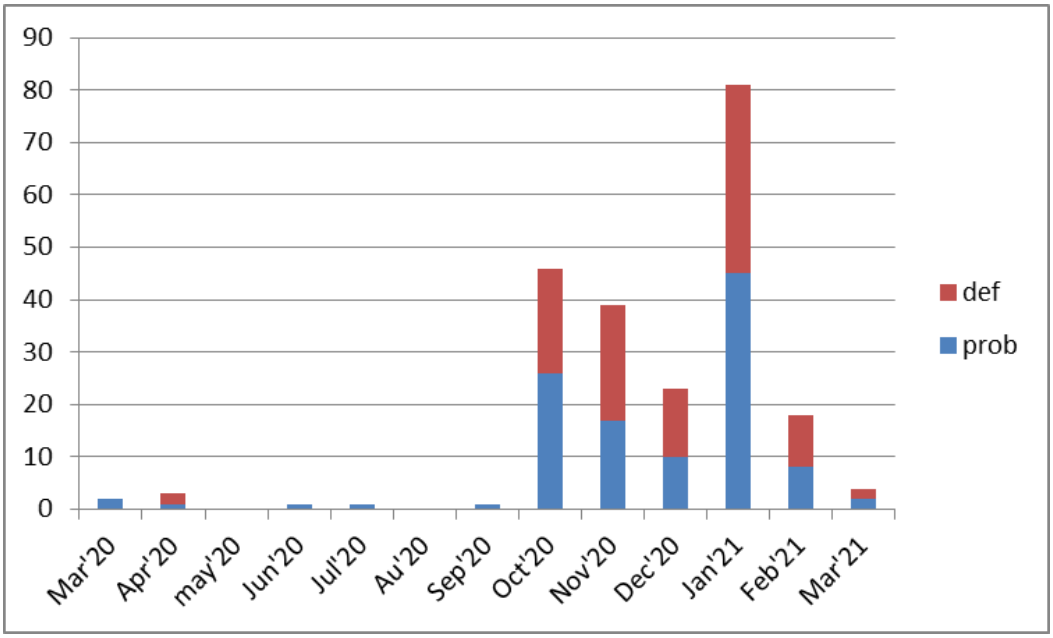
IPC response to the COVID-19 Pandemic:-

The COVID-19 pandemic has been managed and monitored via the Incident Management Team (IMT). IPC is represented at the following: - PPE Group; Tactical group and IMT; Social Distancing; Patient Experience; Staff exposure; Clinical Reference Group; plus, other clinical areas to support ongoing plans. A weekly COVID IPC work-stream was established in July'21 to provide assurance that appropriate arrangements are in place to manage and monitor the prevention and control of infection which fed directly into IMT. This was escalated to a daily COVID IPC Gold meeting in January'21 and was a standing agenda item for the Trust COVID IMT.

See below graphical demonstration of the role of IPC over the pandemic.



Healthcare – Associated COVID Infections (HOCI's)



The definitions of HOCI were confirmed in June'20 from NHSE and all probable and definite cases have been reported via the Trust incident reporting system (Datix) at CHFT. We had a total of 126 cases, majority of which were reported in December'20 and January'21 (104 of 126). A significant number of these HOCIIs resulted in outbreaks. As a result of the impact of national lockdown and the successful initiation of the COVID vaccination programme, there was a decreased prevalence of COVID and this is mirrored in the sharp fall in HOCIs in the Trust from February'21.

All probable and definite HOCIs are investigated at CHFT following a process agreed with the divisions and the risk team. Any immediate learning is also discussed at the IPC gold meetings and communicated where relevant.

Actions from HOCIs and outbreaks have been implemented and may have contributed to the decrease in HOCIs. These include an expanded in-patient COVID testing strategy (both laboratory, point of care test and lateral flow tests) and a dedicated swabbing team, cohort wards for COVID positive patients and COVID contacts, use of air scrubbers and opening windows to improve ventilation, installation of segregation curtains, daily senior medical review of positive patient placements on speciality wards, 1;1 requisition for mobile patients with cognitive impairment, supporting in-patient mask use and bedside hand hygiene, enhanced cleaning and time to clean standard operating procedure.

Communication: - IPC have supported communication in the following ways:-

- IPC team established the Trust COVID intranet page for staff to access relevant IPC guidance and SOPs including PPE donning doffing videos and patient and staff COVID testing strategies.
- All new information/guidance was communicated via COVID IMT, work streams, daily tactical meetings, and workforce briefings.
- IPC red border emails communicated any Trust-wide essential messages rapidly.
- IPC team worked closely with the Trust communications and other relevant work streams to support campaigns on IPC must-do's, COVID signage, PPE compliance, patient/visitor information, Influenza and COVID vaccination, work force well-being and social distancing.

4. Preventing Healthcare Associated Infections – Divisional Reports

Division of Medicine

The Division of Medicine has continued to progress its control agenda to support the Trust action plan. The Medical Divisions lead for IPC has delivered key messages to the division re specific areas of infection control practice and management with particular emphasis on training compliance for all staff groups and to ensure that we learn from experience.

We have had 27 cases of C-difficile within the Medical Division 10 which were potentially preventable and 17 unpreventable.

We have done a full multi-disciplinary review MDT of C difficile cases and have highlighted several areas of learning:

- Delay in obtaining a stool specimen
- Not all antimicrobial prescribing is compliant with Trust policies.
- Delay in isolation – wards awaiting specimen results before isolation of the symptomatic patients.

Work continues to improve compliance with the above issues within the Division. There have been continued challenges to comply with side room isolation requirements for all our patients however proactive management from wards and teams have worked hard to minimise risks for our patients. The division have had 2 wards with all side rooms one with 10 side rooms and new a purpose-built ward with 15 side rooms. Additional challenges

have been faced with side rooms with the Covid-19 pandemic and aerosol generating procedures.

The Division has taken action to improve the performance levels of nurses and medical staff who undertake ANTT procedures to ensure that they are trained to do so correctly. This is monitored closely each month at the Patient Safety and Quality Board. Infection prevention and control remains a fundamental part of the matron's role and as such they play a key role in improving standards at ward level with strong partnership working with the ward sister. An independent FLO audit is also carried out by the IPCT on a quarterly basis for all in-patient wards.

During the last 12 months the Division has made many changes to both its inpatient bed base and outpatient areas due to the Covid-19 pandemic. As mentioned previously we had a purpose built ward which was all side rooms and accommodated another ward which again was all side rooms. All our wards were risk assessed against the trust IPC pathways and signage clearly indicated which pathway each ward was i.e. green, amber or red. Most wards were operating within the medium pathway. Bed bases have also been changed either increased or decreased to accommodate the rising and subsequent lowering of Covid-19 cases. Weekly Covid-19 assurance checks have been completed by the matrons and Leadership walk rounds have been undertaken by the divisional management team. The Medical Divisions lead for IPC has been an integral part of the IPC gold command and has ensured that key messages have been delivered to the division and that actions have been carried forward to ensure all our patients have been safe.

Division of Surgery

Surgical division - Within the last year, undoubtedly COVID cases have had a significant impact on services. Within the surgical division this has largely been in critical care however the escalation of beds had an impact on surgical services as they were reduced to redeploy staff to critical care. Large scale training was required in the use of enhanced PPE and IPC was at the forefront of everything for the protection of staff and patients. Several line infections occurred at CRH ICU and there was a focus on back to basics IPC and addressing the lack of bare below the elbow which sessional enhanced PPE and long-sleeved gowns had created.

Across surgical wards Hospital acquired COVID Infections were reported, closely monitored and actions implemented.

Green low risk pathways have now been created within theatres and surgical wards to move towards business as usual and recommence elective theatre safely for both patients and staff.

FLO audits have the addition of COVID assurance audits and within surgery remain around 92-94%, estates repairs factor in some of lower scores, particularly floor and wall repairs.

Hand Hygiene surveillance has been above 97% across the division, there is evidence within audits that staff are challenged with non- compliance and poor practice.

The year- end position for the division assigned Clostridium difficile cases is 11, of those 5 were considered preventable. Following a deep dive there is learning around antibiotic prescribing and timely sampling. If a sample is taken, then the patient should be isolated, or the reason why should be documented if this isn't possible.

There have been 6 MRSA HAI within division, there have been no reported MRSA bacteraemia's.

ANTT training is, 87% overall but 68% for the medical staff, this is being addressed with a new focus for increasing ANTT assessors to include medical staff and a strict approach to non-compliance.

Division of Families and Specialist Services (FSS)

Families and Specialist Services Division have maintained a good performance in 2020/21. Within the last 12 months there were 4 cases in the neonatal unit of HAI Methicillin–resistant staphylococcus (MRSA), 3 cases were reviewed through an outbreak investigation, and the investigation was unable to determine how the transmission occurred. There was 1 case Klebsiella pneumonia but no cases of E-coli infections or Clostridium difficile(C-diff).

The Infection control clinical lead links have been instrumental in keeping the base safe, with regular updates and feedback to individual teams. The nursing and midwifery leaders have focussed on compliance with all mandatory training including all aspects of Infection prevention that are discussed at the forums and team meetings. Overall compliance for both ANTT (90.48%, 1.4.21) and Infection control level II (94.51%, 8.4.21) are good, however we continue to target specific groups that are low in compliance at every opportunity including training sessions on audit days.

The FLO audits show compliance of 93.2% and hand hygiene at 99% over the last 12 months and we continue to use 'fresh eyes' when Matrons complete FLO's in colleagues areas when requested.

In maternity services the campaign to vaccinate pregnant women against influenza has had another successful year in 2020/21. Uptake of flu vaccination by pregnant women across Calderdale and Huddersfield exceeded the national and regional averages. Greater Huddersfield had the highest uptake by pregnant women across the region for the first time.

The maternity flu campaign aims:-

- To promote flu vaccination and increase the uptake of flu immunisation by pregnant women booked to birth with Calderdale and Huddersfield NHS.
- To offer flu immunisation at a time/place convenient to the woman including acute hospital sites or at the woman's own GP surgery/local pharmacy.
- To prevent maternal and neonatal mortality and morbidity caused by influenza
- To provide Flu Vaccination Training to Registered Midwives and Nurses who will administer vaccines to pregnant women, delivered jointly with Occupational Health.

- To provide Immunisation Awareness Training and annual updates for Midwives and Maternity Support Workers (MSW)/Health Care Assistants (HCA) who promote flu and pertussis immunisation to pregnant women.

Women with high risk pregnancies attending antenatal clinics at HRI/CRH were offered flu vaccinations at their appointments and 126 vaccines were given on site. Uptake across Calderdale and Huddersfield is shown below.

Percentage uptake of flu vaccine by pregnant women	**2020/21**
ENGLAND	43.5
WEST YORKSHIRE AND HARROGATE HCP STP	45.2
NHS CALDERDALE CCG	**47.7**
NHS GREATER HUDDERSFIELD CCG	**49.8**
NHS NORTH KIRKLEES CCG	39.5
NHS WAKEFIELD CCG	46.4
NHS LEEDS CCG	48.6
NHS BRADFORD DISTRICT AND CRAVEN CCG	40.5

Community

The Community Healthcare division have effectively managed all IPC requirements in the wake of the Covid19 pandemic throughout a very difficult 12 months.

The biggest challenge for staff has been the response required from them to support Covid outbreaks in care homes across the Community. This not only involved a timely response to the symptomatic residents but supporting care home staff with IPC requirements including resident testing and vaccination programmes.

Other challenges have been the extra time required for the donning and doffing of PPE and finding appropriate places for this to be carried out which has been particularly challenging in a Community environment.

As a division compliance to guidelines has been excellent despite challenges with estate as social distancing requirement has meant significant changes in daily operational working patterns. Compliance has been monitored effectively through leadership assurance visits providing visible support to staff and enabling risk assessment and the prevention of any ICP breach.

5. Occupational Health

Influenza – staff immunisation campaign 2020 - 21

The NHS staff target uptake for 2020 – 21 was 100% offer, with an expectation for a minimum of 80% of frontline healthcare workers to have had their flu vaccine by 28th February 2021. The flu campaign was planned with the context of Covid pandemic backdrop and was delivered within Covid safe parameters of practice. It was viewed as a pilot run to deliver Covid vaccines when they became available.

Over 100 peer immunisers areas were trained to deliver vaccines to the staff in their own work areas; and several vaccine clinics were held by appointment in various locations to facilitate staff who did not have immediate access to an immuniser.
Uptake reports were reported into the organisation through Knowledge Portal which provided a real time uptake data, and nationally reported through ImmForm.

The final uptake of frontline healthcare workers reported to the Department of Health was 80% This is similar to the uptake from the previous year.

Coronavirus Occupational Health (OH) activity

The OH Service took a key role in undertaking individual risk assessments for staff allocation during the peaks of Covid pandemic, and in speaking with staff who reported Covid symptoms, arranging PCR swabs and feeding back with recommendations on the outcomes, including track and trace and staff isolation where needed. The OH service supported the IPC team and managers in workplace outbreaks, providing timeline details for any positive staff cases.

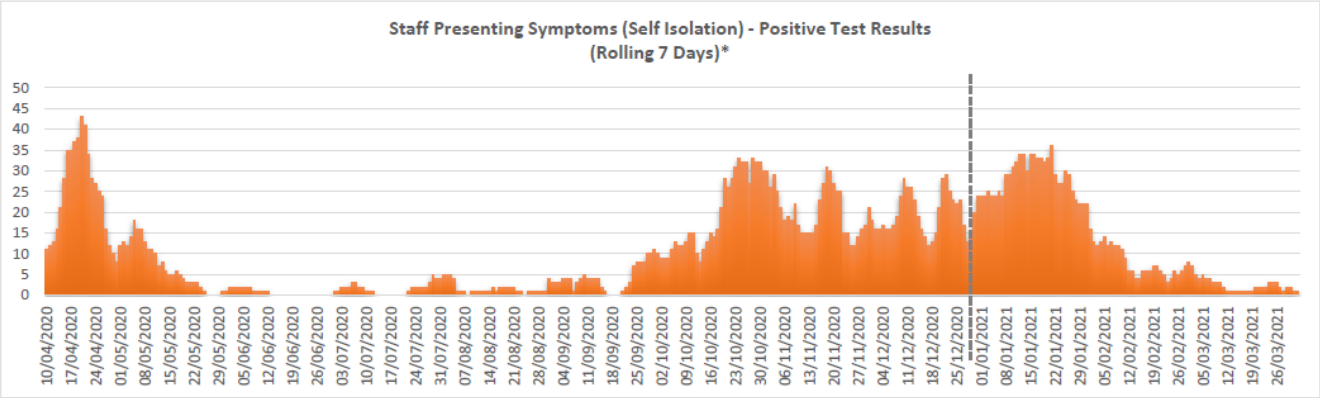
4387 staff/household members have been tested since 03-April-2020
2447 colleagues have been able to end their isolation early and return to work

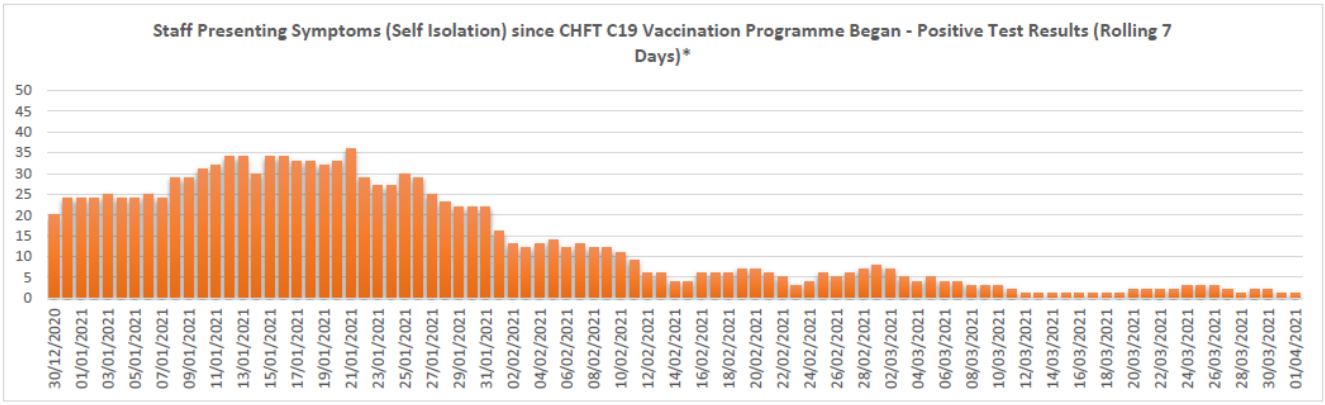
Covid Immunisations

The OH service supported the set up; training and running of two Covid immunisation clinics at CHFT, which provided approximately 50 thousand vaccines to healthcare workers in Calderdale and Kirklees areas. Many of the immunisers trained are continuing to support the national vaccine sites

Staff absence due to Covid infection and isolations has significantly reduced due to the roll out of vaccines to staff as shown in the following graphs.

Covid vaccination uptake for CHFT staff peaked at 82% first dose vaccine; and currently at 78.5% first dose and 75.2% second dose. The declines are due to staff leavers, and new starters to CHFT have had the question of past Covid vaccine asked on pre-employment screening. A process is in place to report past vaccinations through ESR, and unimmunised staff are directed to the national campaign.





EPP Worker checks / assurance

New starter immunisations for EPP Workers has continued throughout Covid outbreaks and all new EPP Workers were appropriately screened at pre-employment checks

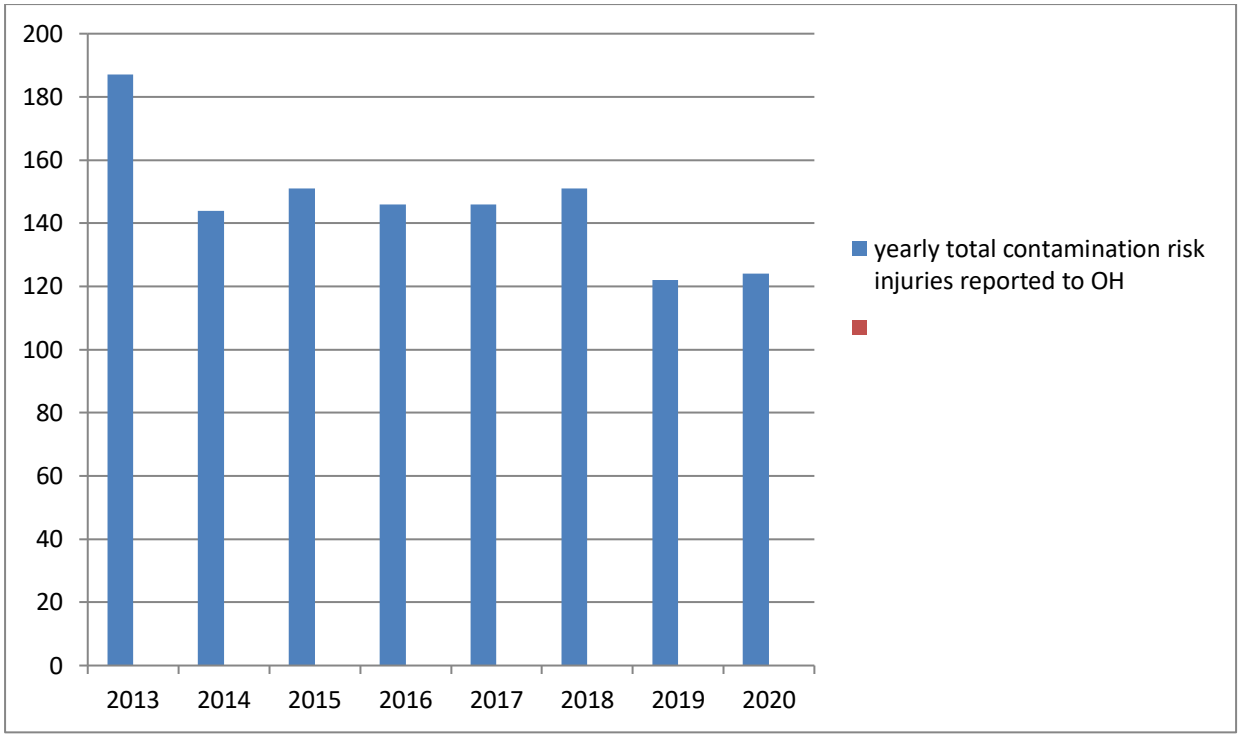
Routine Immunisations for staff

Routine immunisations other than for high risk areas was suspended during peak pandemic activity.

A review of outstanding immunisations is underway with catch-up clinics planned for June 2021.

Contamination Risk Injuries

An **Injuries** quarterly report is presented to the ICC in OH data for contamination injuries. A new “Sharps” group has been formed to investigate any patterns of incidents and make practice improvements. Currently no trends have been identified, however increased PPE has shown a reducing number of splash injuries, but an increase in sharps injury. Overall cases remain consistent over the 2020 period and are reduced in the first quarter of 2021.



6. Antimicrobial Prescribing

Antimicrobials Overview

Table showing Total Antimicrobial DDDs/1000 admissions per quarter.

		Q1 average	Q2 average	Q3 average	Q4 average	Average of quarterly values YTD	% change on previous financial year
Financial Year 2018-19	CHFT	4746.7	4725.1	4694.9	4771.8	4722.2	-42.5
	NHS Yorkshire and Humber	5186.4	5044.6	5340.6	5333.3	5190.5	2.1
	England Average	5316.8	5096.9	5310.3	5272.6	5241.3	-3.5
Financial Year 2019-20	CHFT	4676.1	4449.9	4817.0	4849.3	4647.7	-1.6
	NHS Yorkshire and Humber	5200.2	5155.3	5454.0	5460.3	5269.9	1.5
	England Average	5279.6	5140.0	5339.9	5495.9	5253.2	0.2
Financial Year 2020-21	CHFT	6508.12	5039.102	5251.91	4915.02	5428.5	16.8
	NHS Yorkshire and Humber	6957.538	5342.729	5454.718	5248.792	5750.9	9.1
	England Average	6223	4932	5038	5288	5370.3	2.2

Consumption:

Average quarterly values demonstrate an increase in overall consumption for 2020/21 versus 2019/20. There was a significant peak in antibiotic consumption in quarter 1 around the time of the first COVID- 19 peak. CHFT antibiotic usage is now above the national average however it is still below the regional average.

There have been changes to laboratory antibiotic testing and reporting which has seen increased time to final susceptibility results and increased dosing/frequency for some organism-antibiotic combinations.

Work is ongoing to try and reduce antibiotic use, including antibiotic ward rounds, proposed changes to EPR and working with specialties to improve sampling and ensuring the correct antibiotics are started on admission.

CQUINs

Currently on hold due to COVID 19 guidance.

Gentamicin Improvement Work

- A Gentamicin Stakeholder Group was set up to try and reduce the risk of errors with Gentamicin. There were representatives from surgical clinicians, the renal team, nursing staff, phlebotomy, hospital out of hours team, microbiology consultants, pharmacy, IT and the EPR team.
- Following discussions with the relevant groups, it was decided to change the Gentamicin guidelines to stop using it as the first line agent in patients that are felt to have a higher risk of toxicity (Patients ≥65 years or CrCl < 60ml/min).
- The duration of Gentamicin was restricted to 7 days unless microbiology approves longer use.
- A new Gentamicin Training package was created, consisting of a slide package with audio and some assessment questions at the end. The users receive feedback via email. It is available on the trust intranet and also on the Junior Doctor Induction App.
- A training session on Gentamicin was given to the phlebotomists.
- There is work ongoing to create a Gentamicin Dashboard.

Antibiotic Ward rounds

- Focus on prescribing in COVID-19, especially for Community Acquired Pneumonia CAP during the pandemic. Review of procalcitonin results and respiratory sampling. Realtime feedback delivered. Currently on hold with attention now on focussed reviews of piperacillin/tazobactam and IV cephalosporin prescribing (x2 weekly).
- In Dec 20, the EPR team set up a task list which identified patients who have been on antibiotics for over 7 days. These patients are reviewed with twice weekly and any patients that are felt to require further review are discussed with the clinical team.

Guidelines

- All guidelines are reviewed and updated where needed every 3 years. In addition to this, new guidelines have been written for antibiotic use in obstetric patients and a protocol has been written for PCT use in COVID-19 patients (currently under review). European Committee on Antimicrobial Susceptibility Testing (EUCAST) changes implemented by CHFT microbiology laboratory has led to increases in dose +/- frequency of some antibiotics on the empirical guidelines.

Audit Work

- Procalcitonin audit – Cycle one completed and the audit report won trust audit prize. A poster was created and accepted at national conference in March 2021.
- Point Prevalence Survey across the trust was completed in August 2020. Specialities collected their own data which was analysed by the Antimicrobial Team (AMT) and the results were fed back to the Speciality teams. AMT collated feedback, common themes and action plans. The plan is to repeat a trust-wide PPS audit every 6 months.
- Restricted Antimicrobial Audit was completed in November 2020 during Antibiotic Awareness week. 83.78% (n=93) prescriptions followed either Trust treatment guidelines or were approved by microbiologist.
- Carbapenem use in ICU patients

Antibiotic Awareness Week

- Antibiotic Awareness Week November 2020 events were restricted due to COVID-19 so the focus was on a virtual campaign:
    - Social Media Campaign – A daily message regarding Antibiotic Use from various clinicians and members of the Antimicrobial Management team.
    - Guest editorial in the CHFT News from our Antimicrobial lead
    - Screensavers promoting Antimicrobial Stewardship were displayed on the Trust computers
    - The restricted antimicrobial audit (mentioned above) was completed and timely feedback was given to the prescribers on the ward where interventions were required.

Education

- The AMT have delivered antimicrobial stewardship training to FY1 doctor, physician associate, pharmacy, podiatry student and phlebotomy colleagues.
- Continued participation in Junior doctor inductions (longer timeslot secured for 2021).

Proactive working

- We have increased the number of consultant champions appointed to improve engagement with AMT.

- Plan to develop an antimicrobial dashboard still ongoing (Currently with THIS to progress).
- Plans to make changes to the Electronic Patient Record (EPR) system when prescribing antimicrobials to improve antimicrobial stewardship.
    - To include a mandatory stop date for antimicrobials
    - To have a mandatory review form for antibiotics 48-72 hours after prescribing.
    - To have a free text option for antibiotic indication

  Eprescribe currently forecasting September 2021 for starting the project work.

7. Decontamination

The Decontamination contract novated to Calderdale Huddersfield Solutions (CHS) in 2020, SLA remains in place for Decontamination manager from AGH Solutions 1 day per week, as well as Head of Medical Engineering and Decontamination Services being qualified as Decontamination Manager.

The updated Decontamination Policy has been agreed and will be escalated for ratification to Health and Safety Committee.

The Decontamination contract to be continued with BBraun, for a further 5 years, which will take us to 2027, during that time the Pathfinder group are to scope options for the future. BBraun – achieved all agreed KPIs, due to COVID-19 pandemic regular meetings are on hold, these are to be rescheduled for 2021.

The Pathfinder Project Board and Joint Management Board have restarted.

During the reporting time period external audits of both Endoscopy units were undertaken by the external authorised Engineers with excellent results for both sites. A Gap analysis was performed and Standard Operating Procedures were updated. All observations identified have been dealt with, and there are no outstanding actions or revisits required.

Decontamination Units at both sites have raised concerns regarding the high ambient temperature within these areas, Estates maintenance have been informed, air cooling systems to be purchased.

The Decontamination Committee transferred chair to the Managing Director of CHS and Deputy Chair to Head of Medical Engineering and Decontamination Services CHS, bi-monthly meetings scheduled.

8. Cleaning Services

The Trust cleaning services are provided by CHS (CHFT Partner) at HRI and ISS (PFI partner) at CRH.

As part of the monitoring arrangements both companies self-monitor the performance of cleaning services against key performance indicators. These are reported to the Trust on a

monthly basis for analysis and challenged where appropriate by the Service performance team and via escalation to the IPCT.

In addition, the standard of cleanliness is monitored fortnightly by the ward/dept manager as part of the FLO (frontline ownership) audits which forms part of the assurance framework.

The past year has proved challenging as a result of the Covid19 Pandemic and as such in addition to delivering a high quality patient focussed service, Cleaning Services have been required to become more reactive and work flexibly in order to meet the needs of the Trust.

Additional cleaning resource has been provided on Covid19 wards to ensure IPC guidelines and expectations were achieved

Optimised touch point cleaning of communal toilets in “in patient” areas was introduced, 7 days per week to try and slow transmission

Increased curtain changes were carried out in high risk areas

CHS were tasked with the deep Clean / HPV service of a Calderdale care home following its closure due to a Covid19 outbreak

Support with several ward moves at short notice with deep cleans carried out once Covid19 wards reverted to their original speciality

Instantaneous response to ad hoc deep cleans following outbreaks on ward areas and non-clinical areas.

9. Estates

The IPCT continue to advise and support estates with refurbishments within the Trust. This has required attendance at key design and planning meeting and the review of plans to ensure they meet minimum build standards.

Water sampling for *Legionella* and Pseudomonas was undertaken in accordance with L8 and health technical Memoranda (HTM-04). Any remedial action was successfully undertaken on outlets that did not meet the required standard.

Annual performance and verification checks were undertaken on all critical ventilation systems including theatres revalidation.

Testing and validation was carried out on the mechanical ventilation systems to ensure that there were sufficient air changes to allow Aerosol Generating Procedures in suspected COVID positive patients to take place safely and to calculate the necessary fallow time. .

Ventilation re balancing took place, to increase fresh air in treatment / procedure rooms which were deemed higher risk and priority. Lifecycle replacement of ventilation plant also

took place in line with the annual capital plan. This covered Outpatients, maxillofacial and the emergency department.

Funding was secured, which allowed the full refurbishment of an existing ward. This become a 15 bed, fully single en-suite room, Isolation ward. The unit was designed and built to provide 10 air changes per hour to each room (see below).

Ward 18 Refurbishment

PROJECT BACKGROUND

Investment in increasing side room capacity at Huddersfield Royal Infirmary in support of the ability to isolate Covid positive patients, accommodating increased numbers through the winter period and aiding patient flow through A&E was essential.

An Infection control benefit of being able to isolate these patients particularly where aerosol generating procedures are being administered was highlighted.

A modular build was considered however the existing estates carries significant back-log maintenance which created an opportunity to lower the back log burden and increase the patient experience with high quality finishes.

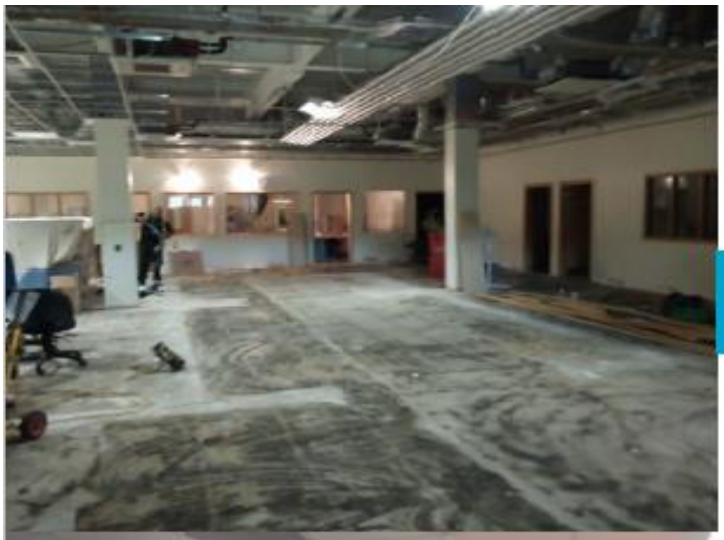
Without this facility to adequately isolate patients the trust would not have the ability to receive all non elective patients causing pressure on the wider system. If patients were accepted into non isolated facilities there is an increased risk of infection spread which could indude out of hospital risk

WHAT WE DID

The project delivered a 15-bed isolation ward, with spacious ensuite bedrooms, within a 12-week programme. The ward includes a comfortable staff room with a coffee machine and TV, separate staff WCs, a ward office, and two nurses' touchdown points. There is also a fully enclosed reception area, two store rooms, a separate utility rooms. The new ward provides additional capacity to respond to the COVID 19 pandemic.

In addition, a new air handling unit has been installed with dedicated ventilation to the side rooms, providing up to ten air changes per hour. Improvements have also been made to the fire compliance of the existing building by completing a full survey of fire stopping within ward 18 and then rectifying any existing penetrations through fire walls that were not compliant.

The refurbishment at Broadstreet Plaza was completed which is now the bases for the



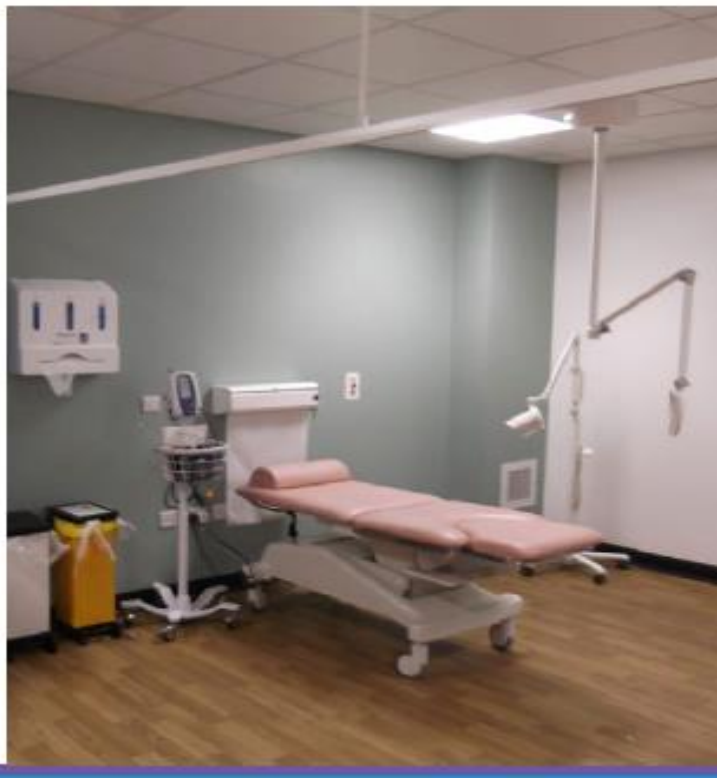
NHS
Calderdale and Huddersfield
NHS Foundation Trust

WHAT WE DID

CHS established a clear brief with the stakeholders; the clinic staff, support and office staff, infection prevention, fire officer and estates team; with regards to what was needed to function as an improved department and deliver an ongoing excellent service for the Yorkshire fertility clinic and support teams.

CHFT estates and AFL Architects engaged closely with the stakeholders in terms of schedule of accommodations, equipment needs, arrangement and layout of rooms taking on board both patient and staff safety.

This was undertaken via a series of design team meetings, initially starting with the HTM and HBN defined rooms and layouts, these were followed by a revised design and further review. This process allowed the design to be refined specifically to the users needs and anticipated future requirements.



RESULT

The result was an excellent facility that has received praise from both internal and external stakeholders on the overall design and quality of finish.

The clinic now has an increased capacity, able to treat a greater number of patients than the previous facility.

High quality | Delivered on time | Improved care pathway | Delivered to budget

Yorkshire Fertility Clinic.

10. Infection Prevention and Control Policies

All core policies as required by the Hygiene Code 2008 have been reviewed and have been published on the Trust Intranet and Internet. The following policies have been approved at Executive Board during 2019/20:

Section C	Standard Precaution
Section D	Meningococcal Infection
Section E	Major Outbreak
Section F	Decontamination
Section G	Aseptic Technique
Section H	Hand Hygiene

11. Education and Training

Since the COVID pandemic was declared face to face training has been kept to a minimal ensuring social distancing is maintained. Level 2 IPC training is now delivered by e-learning and will remain so going forward with bitesize and bespoke training session arranged as required.

In addition to this education is provided on a one to one basis during routine clinical visits by the IPCNs and in response to patient specific clinical enquiries from wards and departments.

The IPCT also support Aseptic Non Touch Technique (ANTT) training, supporting compliance and safety metrics and zero harm; the Trust overall compliance at the end of March 2021 reported 88.14%.

Comprehensive Infection prevention training for the Junior doctor's induction day, including the assessment of ANTT.

The IPCT has led FIT testing for FFP3 masks throughout the year and a strategy for delivering this is a more sustainable way is being reviewed, this includes the provision of personal issue reusable masks for those staff working in high risk areas.

The IPCT keeps update to date with current national policies and guidance and attending any relevant study days or conferences.

12. Conclusion

Infection prevention and control is the responsibility of all Trust employees and the IPCT does not work in isolation. The successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels

within the organisation. A number of key risks and challenges exist and the focus on COVID19 control has had and will continue to have an impact on other aspects of infection control activity. Clearly COVID19 control is extremely important but the need to prevent and maintain control of other types of infections must not be overlooked.

The IPC Team should be commended for their continued enthusiasm and commitment to ensuring safety of our patients, visitors, and staff.

Appendix 1:

Link to the Infection Prevention and Control Arrangements Policy:

http://www.cht.nhs.uk/services/clinical-services/infection-prevention-and-control/infection-control-policies/

17. Learning from Deaths Annual Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title:	Learning from Deaths 2020/21 Annual Report
Authors:	Dr Cornelle Parker, 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 mortality review process
- To provide a review of mortality associated with Covid-19 during 2020/21

Key Points to Note

Learning from Deaths Annual Report 2020/21

- Hospital Standardised Mortality (HSMR) remains a positive outlier with CHFT performing in the top 5% of Trusts.
- Our Summary Hospital-level Mortality (SHMI) has deteriorated over the year but remains within expected limits.
- Whilst our Inpatient SHMI is in a positive position the Out of Hospital SHMI is consistently over the 100 target.
- 542 Level 1 Initial Screening Reviews took place covering 31% of deaths against a target of 50%
- 121 Level 2 Structured Judgement Reviews (SJR's) took place

Improvements have been noted in timely senior review however clear clinical leadership for clinical decision was highlighted as a concern.

EQIA – Equality Impact Assessment

Deaths of those with learning disabilities aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities will be reported externally and reviewed, regardless of the cause of death or place of death. This process runs alongside our internal mortality reviews and does not replace out internal process. All deaths are reviewed internally using a SJR. These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group.

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

Maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of

residence. These cases are also reported on Datix to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports are presented to the Mortality Surveillance Group.

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

Recommendation

The Board is asked to **APPROVE** the Learning from Deaths Annual Report and the following recommendations:

1. To support the additional actions scrutinising Standardised Hospital Mortality Index (SHMI) including the establishment of the Care of the Acutely Ill Patient (CAIP) quality improvement programme

2. To support the requirement of the Medical Examiners' Office to review deaths within the community. We will begin to scrutinise community deaths by the end of Q3, aiming to be at 50% capacity by the end of Q4 (2021/22)

3. A target of 50% of all in-patient deaths to be subject to Initial Screening Review by June 2022. Deaths in Elderly and Respiratory specialities account for half of inpatient adult deaths. The Mortality Surveillance Group (MSG) have asked the mortality leads and clinical directors for these areas to develop a plan of action to address the deficit in reviews for 2020/21

Learning from Deaths Annual Report 2020/21

Executive Summary

- This report covers the period April 2020 to March 2021 spanning the first year of the COVID-19 global pandemic. Of note, Hospital Standardised Mortality Ratio (HSMR) and Standardised Hospital Mortality Index (SHMI) both exclude COVID-19 deaths

- Trust in-hospital mortality metrics remain favourable. Assurance is provided by our HSMR being a positive national outlier ie top 5% (latest release 90.06), a better than average in-hospital SHMI (latest release 96.06) and stable crude mortality benchmarking

- SHMI remains in the expected range (latest release 103.17) but has been trending adversely since Jan 2020 on a backdrop of a rising national SHMI (currently 101.15). This deteriorating position is driven by a high Out-of-Hospital SHMI (116.78) reflecting deaths within 30 days of hospital discharge

- Detailed analysis of the Out-of-Hospital SHMI has excluded a number of potential confounding variables, including palliative care coding, patient acuity on discharge as measured by NEWS 2 score, frailty on discharge. Further analysis is underway examining health inequalities.

- The Care of the Acutely Ill Patient (CAIP) Programme has been initiated as a quality improvement approach to focus on themes that have emerged from Learning from Death reviews and monthly mortality alerts from Healthcare Evaluation Data (HED)

- The Medical Examiner Service is now established with scrutiny of all in-patient deaths. Benefits include improvement in the quality of death certification, support offered to all bereaved relatives and improved communication with the Coroner's Office

- 542 Level 1 Initial Screening Reviews took place covering 31% of deaths against a target of 50%. This is a similar proportion to 2019/20 when 32% of deaths were reviewed and although still below target it should be noted that during the COVID-19 pandemic, completion of ISRs was temporarily suspended for several months

- 121 Level 2 Structured Judgement Reviews (SJR's) took place. The SJR process was not suspended during the COVID-19 outbreak

- 20 SJR's were requested in patients who died of Hospital Onset COVID-19 Infection (HOCI). 17 of these have been completed. No significant quality of care concerns have been identified to date

- As a consequence of increased medical staffing to acute areas during the COVID-19 pandemic, improvements have been noted in frequency and timeliness of senior medical review, however in some cases this has also impacted on continuity of patient care

Learning from Deaths Annual Report 2020/21

During 2020/21 there were a total of 1789 adult inpatient deaths at CHFT between April 2020 and March 2021. This time period encompasses the first 12 months of the COVID-19 global pandemic and includes 486 recorded COVID-19 deaths.

Figure 1 shows the annual declining trend in deaths at CHFT since 2008/09 up until the COVID-19 pandemic which has seen in increase in mortality.

Figure 1. Annual Mortality

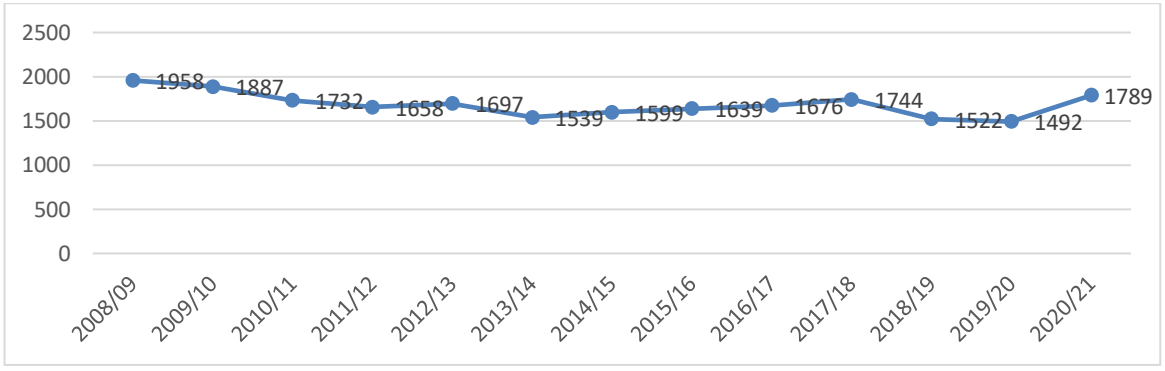


Figure 2 illustrates COVID-19 bed occupancy across Yorkshire, Humber and the North East indicating the surges in COVID-related admissions and the timing of the 3 waves which relates closely to mortality peaks at CHFT shown in Figure 3.

Figure 2. Number of beds occupied by confirmed COVID-19 cases

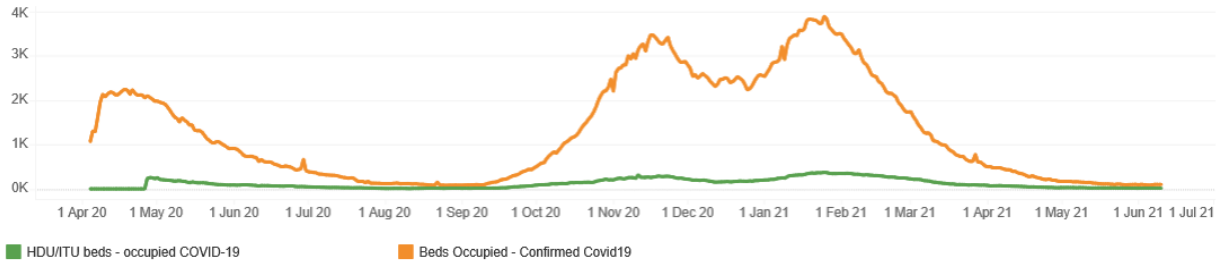
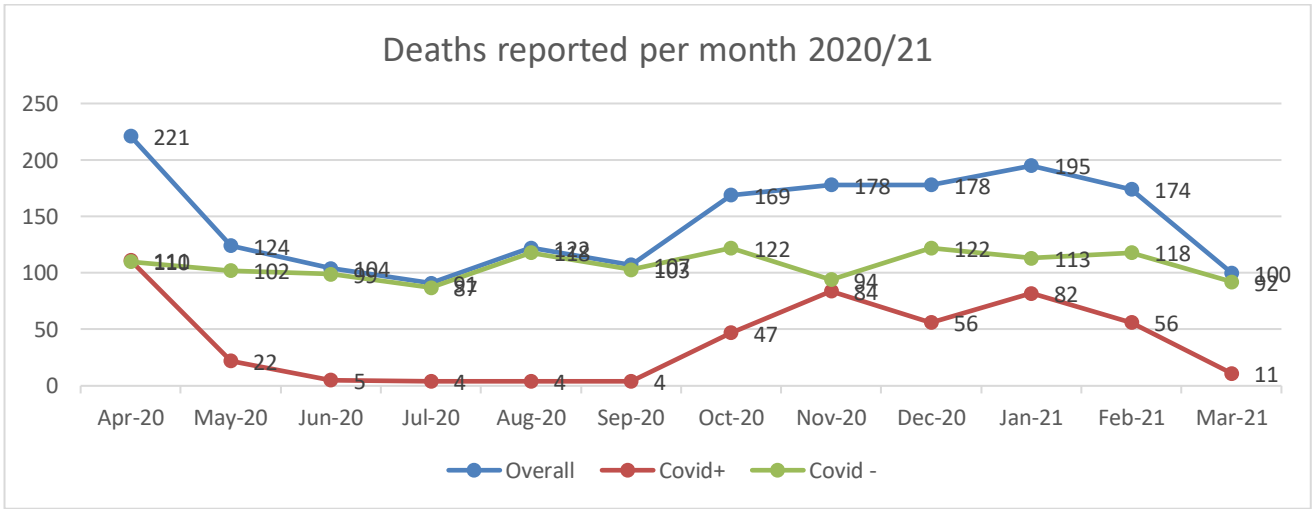


Figure 3. Deaths reported per month 20/21



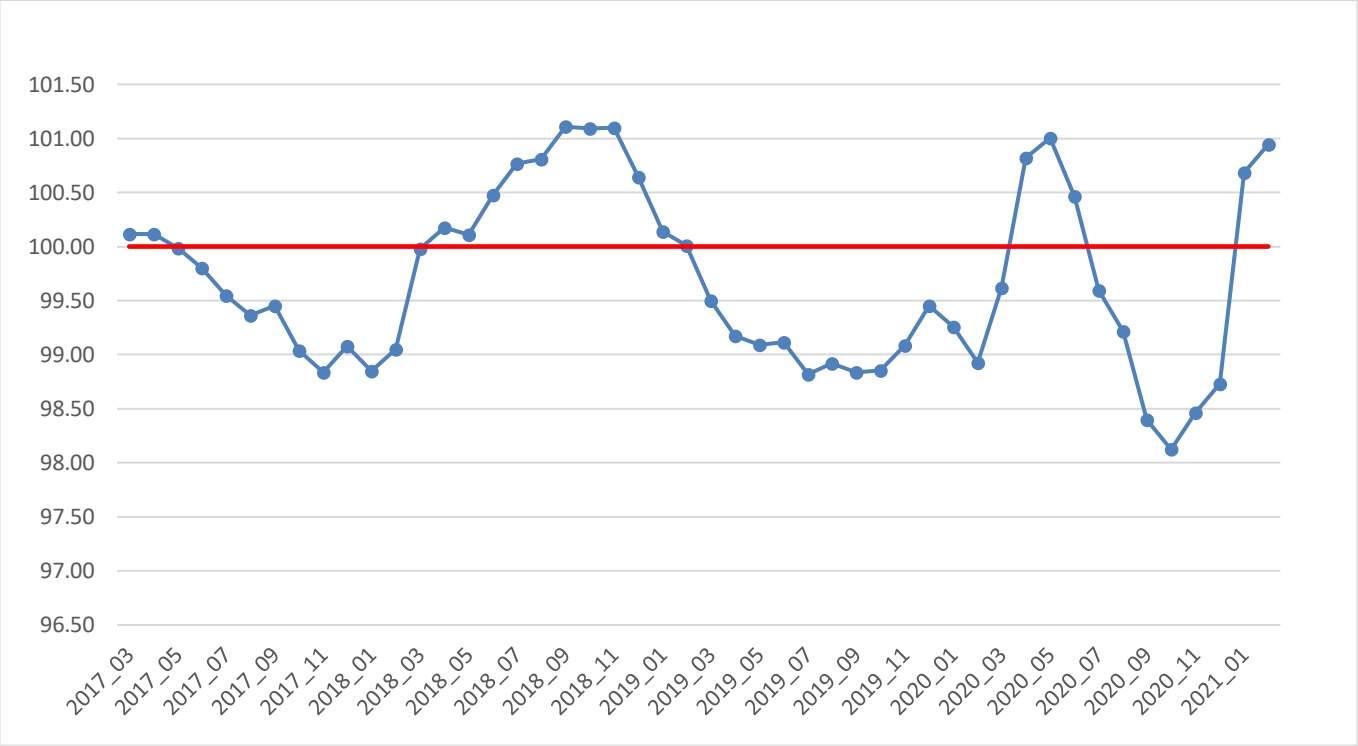
Mortality statistics

HSMR

The HSMR (Hospital Standardised Mortality Ratio) compares how many hospital inpatients die, with how many we would have predicted to die given their age, gender, area-level deprivation, diagnoses and co-morbidities.

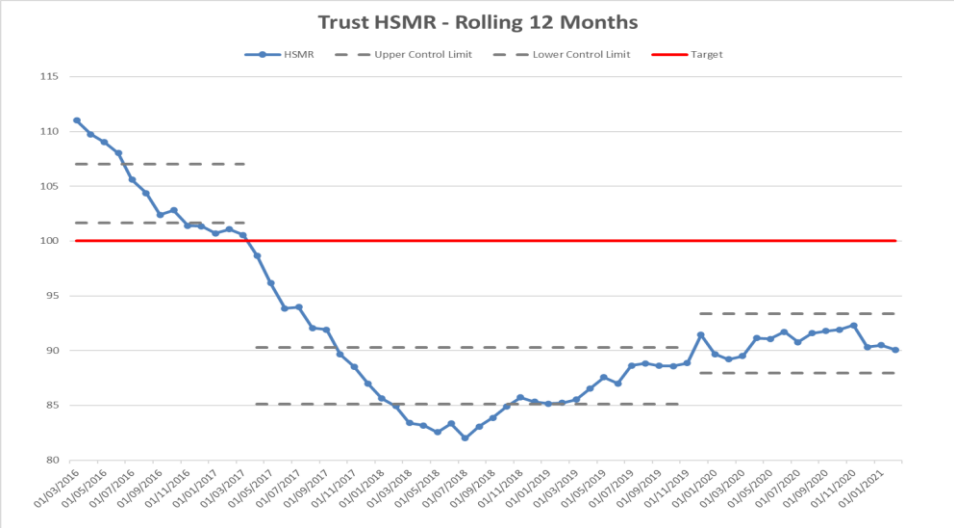
The national HSMR figure rose significantly above the 100 mark in April to June 2020 and again in January and February 2021 during the COVID-19 pandemic (Figure 4). Prior to this increase the national figure had been stable for 12 months around 99. The latest (March 2020 to Feb 2021) has the national HSMR at **100.95**

Figure 4. National 12 month rolling HSMR



The Trust's HSMR position has been consistently below the expected target of 100 since April 2017 (Figure 5).

Figure 5. Trust HSMR - Rolling 12 months



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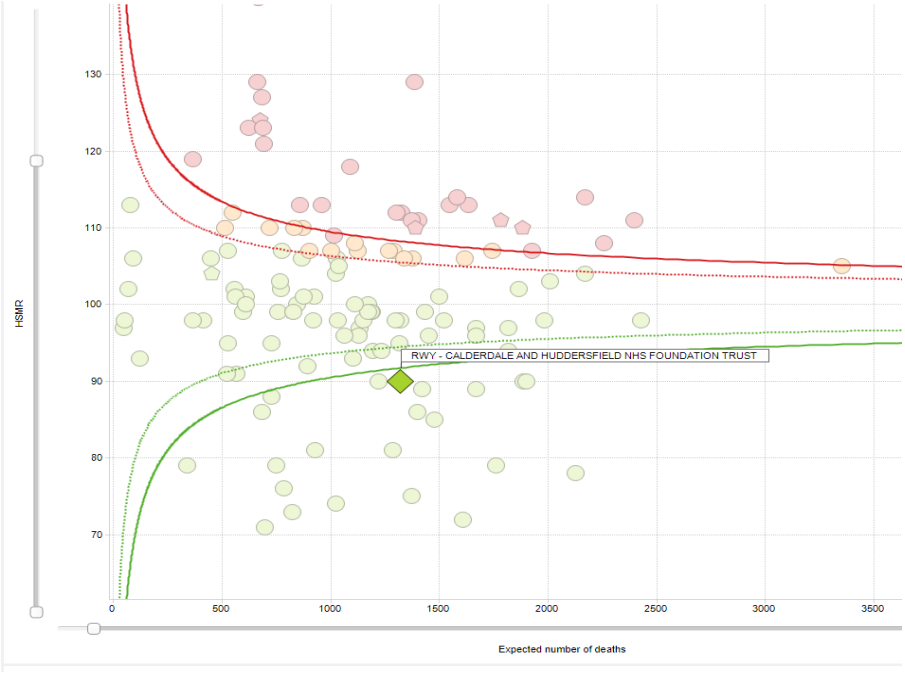
The Trust's current HSMR (as at May release) is 90.06 which positions CHFT as a positive outlier nationally (top 5%) as shown in the Poisson funnel plot in Figure 6.

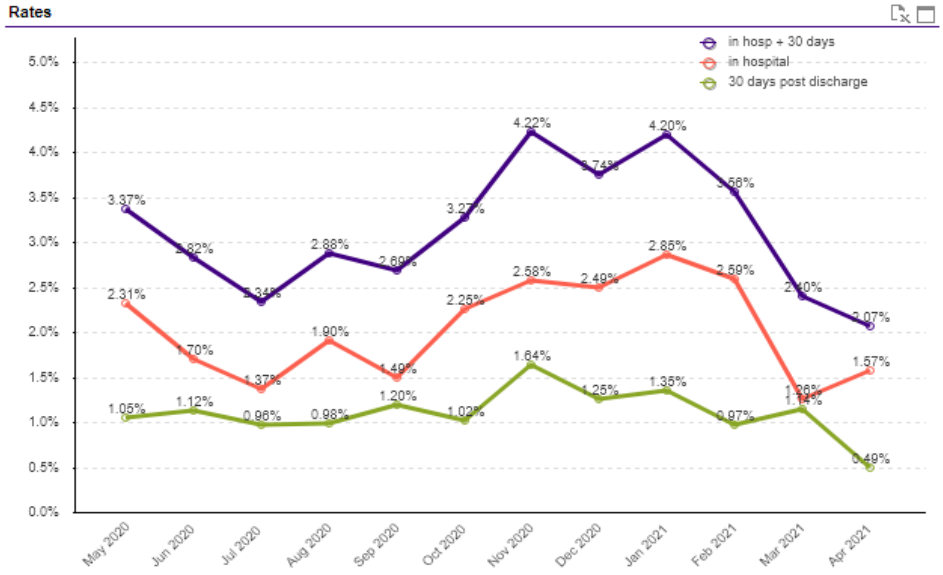
Figure 6.



Crude Mortality

Crude mortality further triangulates our current in-patient mortality position**.** This is calculated from observed/expected deaths with no adjustments (figure 7).

Figure 7. Crude mortality 2020/2021

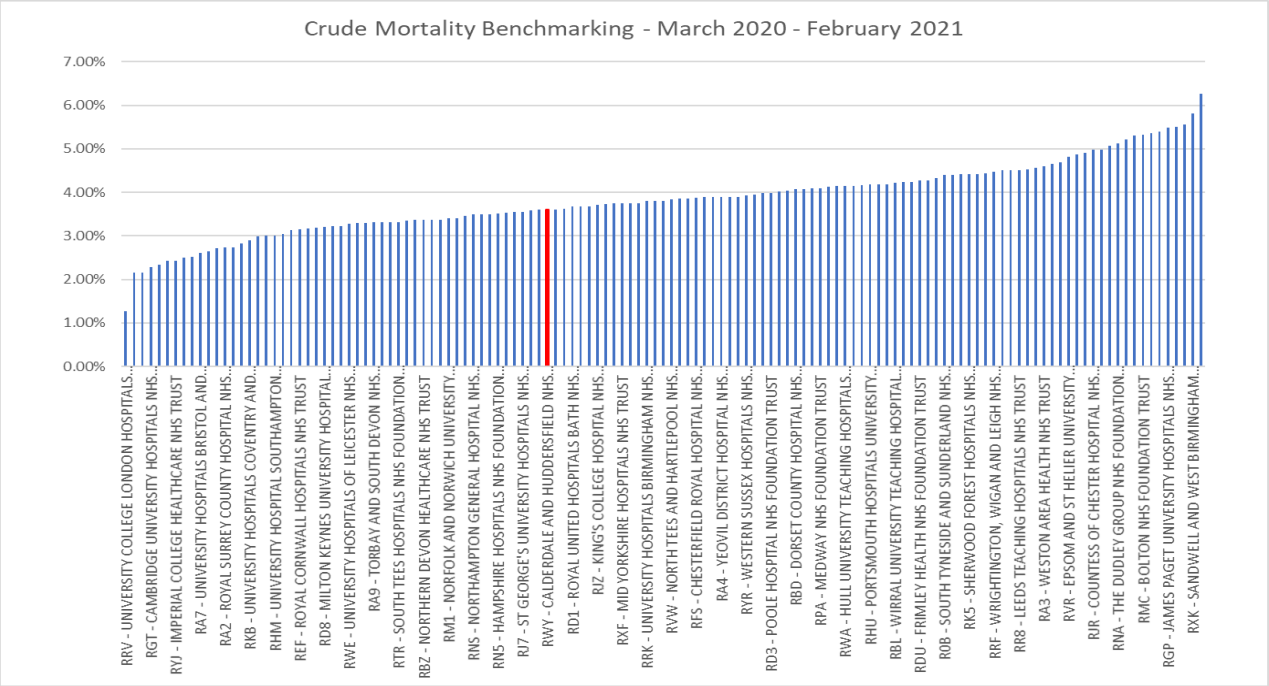


Looking at the rolling 12 months figure (May 20 – April 21) crude mortality is 2.01% (1,697 deaths). This is a decrease from the previous rolling 12-month period (April 20 – March 21), 2.22% (1,787 deaths).

Crude mortality can be impacted by number of episodes, as has been the case in recent months, when these have fallen across the country. As such, it then helps to look at crude mortality benchmarking.

Figure 8 shows the Trust currently benchmarks 52nd out of 132 trusts, a position that has remained stable over the last 12 months.

Figure 8. Crude Mortality Benchmarking Mar 2020 - February 2021



SHMI

The SHMI (Summary Hospital-level Mortality Indicator) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die, on the basis of average England figures given the characteristics of the patients treated there.

SHMI = Observed Deaths/Expected Deaths

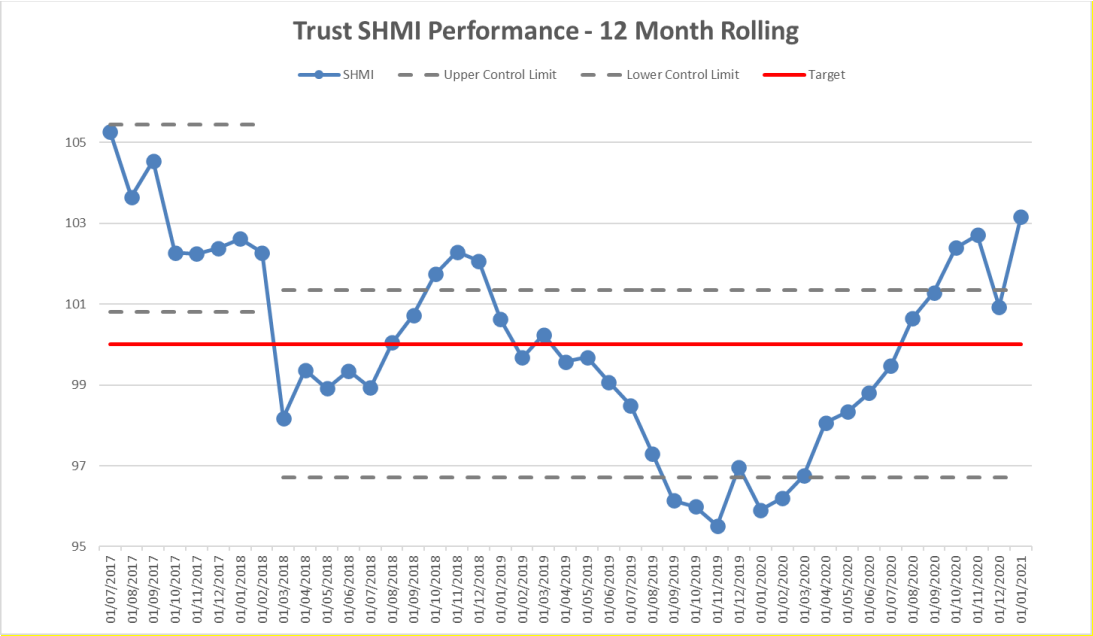
Any episodes with COVID-19 diagnostic codes are excluded from the SHMI, including any patients who died within 30 days of admission where COVID-19 is included on the death certificate.

For the SHMI a death is attributed to a trust if the patient dies in hospital or within 30 days of discharge.

SHMI does adjust for age, gender, current and underlying medical condition or birthweight (perinatal diagnosis group only). SHMI does not adjust for severity of condition, palliative care coding or deprivation score.

SHMI is not a direct measure of quality of care. The expected number of deaths for each trust is not an actual count of patients but is a statistical construct which estimates the number of deaths that may be expected at the trust on the basis of average England figures and the characteristics of the patients treated there.

Figure 9. Trust SHMI Performance – 12 month rolling



The Trust's overall (12 month rolling) SHMI in the May 2021 release (Feb 20 – Jan 21) is **103.17**. The expected number of deaths for this 12-month period was **1925**. The observed number of deaths at CHFT during this time period was **1986**. This is a negative variance of **61** deaths.

It is important to recognise that the difference between the number of observed deaths and the number of expected deaths cannot be interpreted as the number of avoidable deaths for the trust. Whether or not a death could have been prevented can only be investigated by a detailed case-note review.

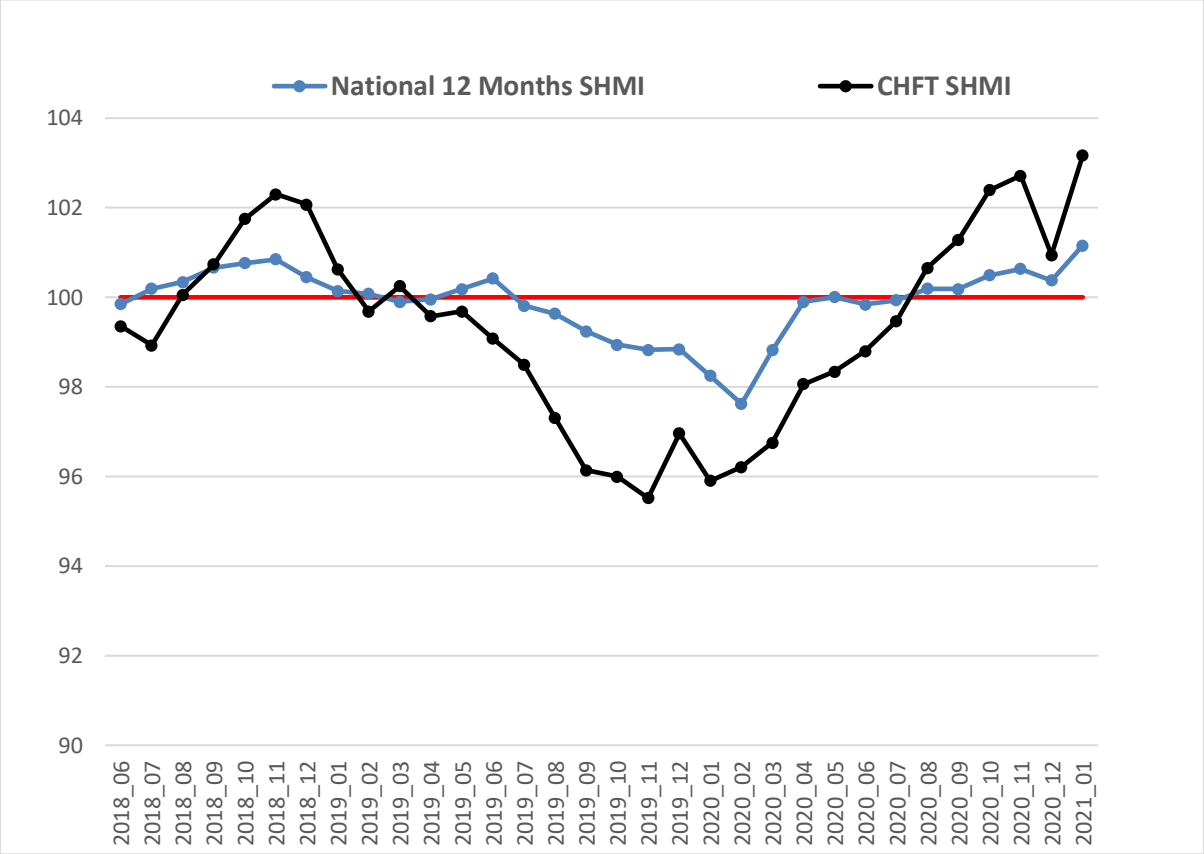
Whilst the trust's SHMI continues to show a rising trend, the trust remains within the 'as expected' range, illustrated in the national Poisson funnel plot below.

Figure 10.

The national SHMI figure rose in April 2020 above the 100 mark and has remained there for the preceding 9 data releases, with the latest data release peaking at 101.15 ie given COVID-19 cases are excluded, there is a rising trend nationally in non-COVID-19 deaths for reasons that are unclear. Figure 11 maps CHFT SHMI against the national SHMI and it can be seen that the trend pattern is very similar notwithstanding the CHFT figures exceed

those nationally from Aug 2020. This suggests that national trends in SHMI significantly contribute to the variation in CHFT SHMI.

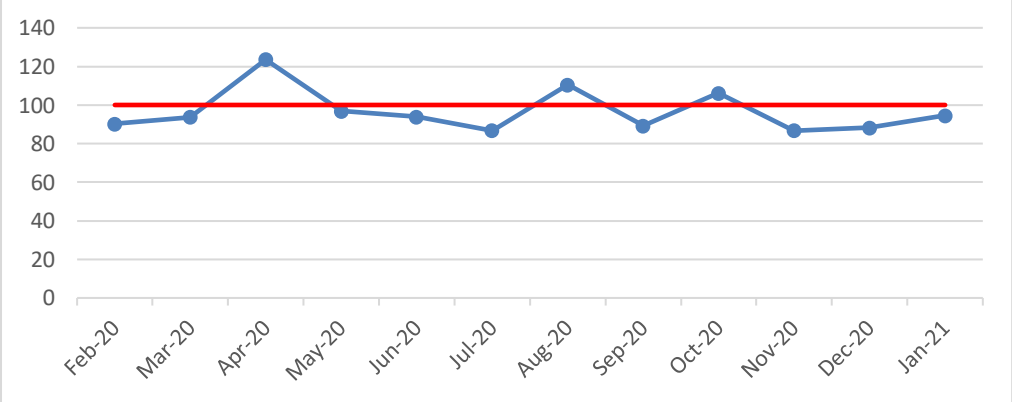
Figure 11. National vs CHFT SHMI trend



The Trust ranks 67th out of 124 Trusts nationally. In 2018/19 the Trust's overall rank was 58th and in 2019/20 this was 43rd.

The SHMI can be broken down further to deaths that have occurred in hospital and those that occurred within 30 days of discharge.

Figure 12. Trust In-Hospital SHMI

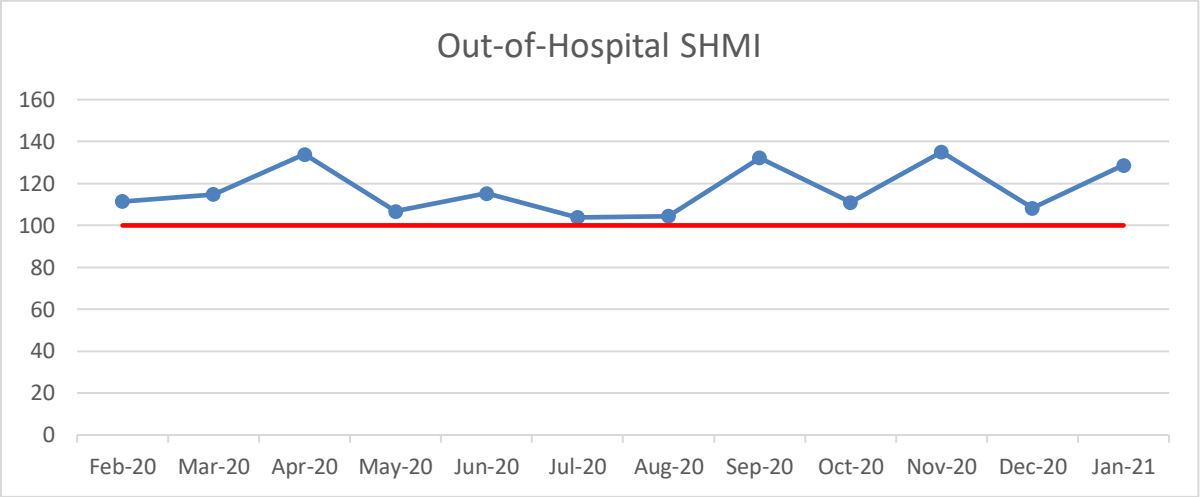


The Trust's (12 month rolling) In-Hospital SHMI in the May 2021 release (February 2020 – January 2021) is **96.06**.

The expected number of in hospital deaths for this 12-month period was **1266.94**. The observed number of deaths at CHFT during this time period was **1217**. This is a positive variance of **50** deaths.

The trust's In-Hospital SHMI ranks it 37th out of 124 – an improvement of 2 ranks from the previous report. This puts the Trust in the second quartile nationally which is a favourable position and agrees with the HSMR and crude mortality findings.

Figure 13. Out-of-Hospital SHMI



The Trust's (12 month rolling) Out-of-Hospital SHMI in the May 2021 release (February 2020 – January 2021) is **116.78**. The CHFT Out-of-Hospital SHMI is consistently above 100. The trust's Out-of-Hospital SHMI ranks it 99th out of 124 Trusts putting it in the lower quartile.

The expected number of Out-of-Hospital deaths for this 12-month period was **658.48**. The observed number of deaths at CHFT during this time period was **769**. This is a negative variance of **111** deaths.

As the SHMI is a function of observed/expected deaths we have looked more closely at these 2 elements and we found there is some variation in expected deaths. The calculation to determine expected deaths is based on the preceding 36 months of data, which includes 18 months pre-dating the COVID-19 pandemic. We are therefore, in large part, basing data for expected deaths during the pandemic on pre-pandemic data when something very different may be impacting mortality risk during the pandemic, even when COVID-19 cases are excluded.

Regional SHMI Benchmarking

It is important to note that NHS Digital advise the SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts according to their SHMI. If 2 trusts have the same SHMI banding, it cannot be concluded that the trust with the lower SHMI value has better mortality outcomes.

The information below is therefore included for local context rather than direct comparison.

Table 1. SHMI local acute providers

Trust	*Overall SHMI*	*Number of total discharges*	*Expected*	*Observed*	*Obs. - Exp.*	*In-hospital SHMI*	*Out-of-Hospital SHMI*	*In-Hospital Rank*	*Out-of-Hospital Rank*	*Overall Rank*
YORK TEACHING HOSPITAL	94.94	73178	2604.92	2473	-132	86.8	109.84	14	72	25
HARROGATE AND DISTRICT	95.47	21331	751.02	717	-34	89.01	107.54	17	64	31
CALDERDALE AND HUDDERSFIELD	103.17	52196	1925.04	1986	61	96.06	116.78	37	99	67
BRADFORD TEACHING HOSPITALS T	105.83	66106	1356	1435	79	97.51	122.5	46	108	86
BARNSLEY HOSPITAL	106.3	34822	1184.38	1259	75	103.47	111.45	81	78	88
LEEDS TEACHING HOSPITALS	107.47	89261	3092.11	3323	231	110.21	102.16	106	52	95
MID YORKSHIRE HOSPITALS	111.05	69674	2135.16	2371	236	104.62	124.03	85	111	105
DONCASTER AND BASSETLAW TEACHING HOSPITALS	112.02	53704	1896.93	2125	228	111.59	112.81	107	85	107
HULL UNIVERSITY TEACHING HOSPITALS	115.14	61090	2385.84	2747	361	117.69	110.56	119	75	118

Actions scrutinising SHMI and improving quality of care in the acutely ill patient

Following monthly analysis of the available mortality statistics, the Mortality Surveillance Group has initiated a number of actions to further our understanding:

- Detailed analysis has excluded a number of potential confounding variables, including patient acuity on discharge as measured by NEWS 2 score, frailty on discharge (using a basket of HED surrogate clinical codes) and overall accuracy of clinical coding. We are examining in more detail accuracy of palliative care coding in patients being discharged from CHFT with referral to community palliative care teams

- **Discharge acuity workstream into Care of the Acutely Ill Patient –** developing metrics for discharge acuity and how this may assist our understanding of the Trust's Out-of-Hospital SHMI

- **Health inequalities** – in contrast to HSMR, SHMI methodology does not adjust for deprivation. According to NHS Digital this is because adjusting for deprivation might create the impression that a higher death rate for those who are more deprived is acceptable. Patient records are assigned to 1 of 5 deprivation groups (called quintiles) using the Index of Multiple Deprivation (IMD). Contextual indicators on the percentage of provider spells and deaths reported in the SHMI belonging to each deprivation quintile are produced to support the interpretation of the SHMI.

In Figure 14 Feb 2020-Jan 2021 it can be seen at CHFT that hospital spells and mortality are higher in the lowest quintile i.e. patients with the greatest levels of deprivation. Initial analysis (Figure 15) suggest this distribution is unchanged when compared with Feb 2019-Jan 2020 so is not contributing to the rising trend. This is undergoing further analysis.

Figure 14. Deprivation quintiles for provider spells and mortality at CHFT Feb 2020 - Jan 2021

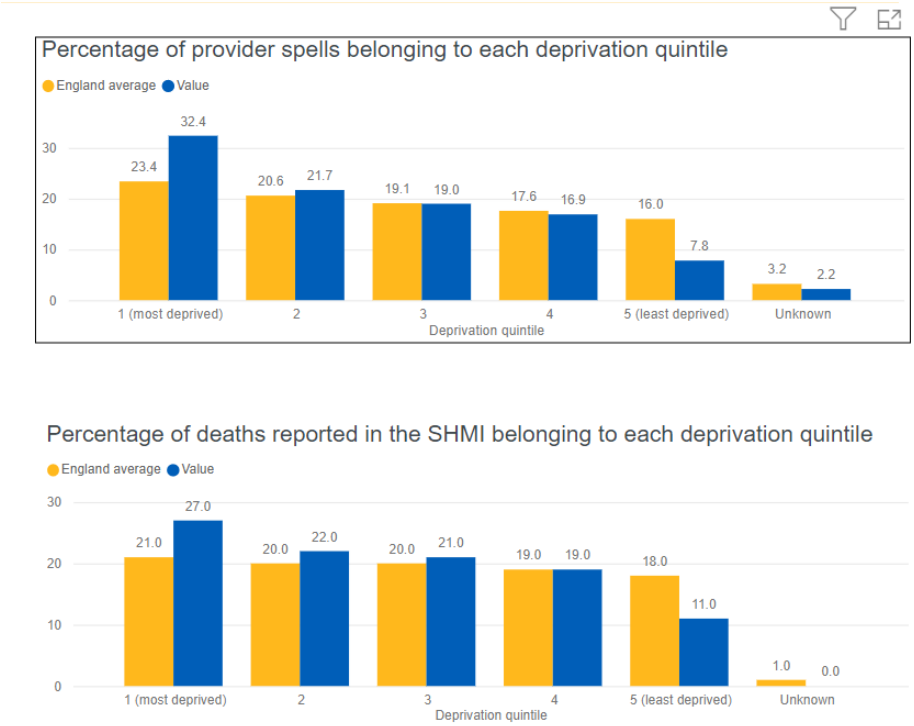
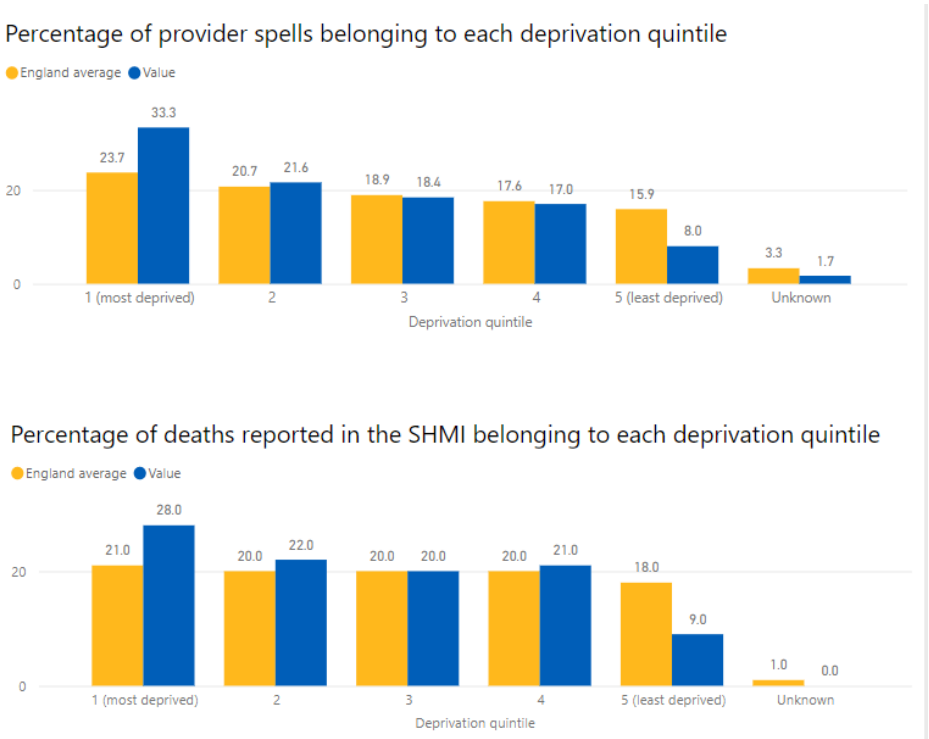


Figure 15. Deprivation quintiles for provider spells and mortality at CHFT Feb 2019 - Jan 2020



- **External Review of SHMI -** The Trust have asked Prof Mohammed Mohammed, Professor of Healthcare Quality and Effectiveness, University of Bradford to conduct a review of the CHFT Out-of-Hospital SHMI to assist us in understanding why this upward trend continues.

- **Discussions with public health around community mortality in care homes –** Leading up to, and throughout the pandemic, a greater proportion of our patients have not been discharged to their usual places of residence. In particular, more have been discharged to care homes. We will need to examine this further to establish if and how this links with a greater incidence of non-COVID-19 deaths.

- **Improved mortality alerts process –** the Mortality Surveillance Group have initiated a monthly alert review meeting following the publication of the latest mortality data and alerts. This includes an initial review of patient level data by the coding team to ensure correct coding and then the team agrees the need for clinical input from the relevant speciality and the need for SJR reviews.

  In April, the Trust met with our account manager at Healthcare Evaluation Data (HED) to understand how we can better utilise the information within the system to understand our mortality and assist with horizon scanning. From May 2021, as well as SHMI, HSMR and CUSUM (amber HSMR) alerts the Trust are now receiving SHMI Diagnostic Group (early warnings for potential outliers of SHMI groups) and SHMI VLAD (3-month) alerts. The VLAD module is a tool to highlight SHMI diagnostic groups that are either on a positive/improving trajectory or a declining trajectory. It quickly visualises any of the 142 SHMI diagnostic groups, looking at the "estimated lives gained/lost" over a 12-month period. It also clearly identifies upper and lower control limits on each VLAD chart.

- **Case reviews of out-of-hospital deaths –** early review of cases of those patients dying within 30 days of discharge from CHFT within Calderdale and Kirklees footprint has not revealed any significant quality of care issues. This scrutiny will be expanded and consideration given to COVID-related factors such as access to healthcare.

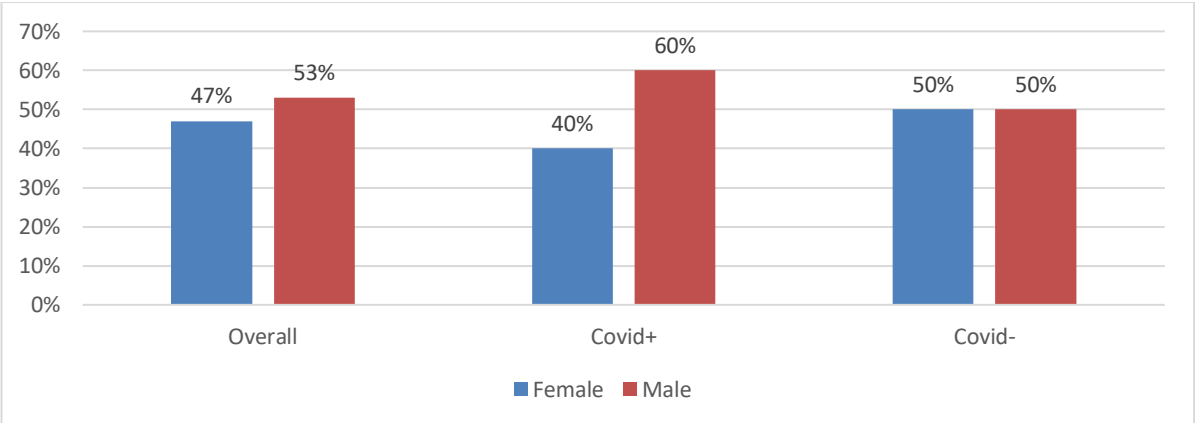
- **Medical Examiner Community Certification review –** in advance of the progression of Medical Examiner scrutiny to include all community deaths, we will be developing the process through earlier scrutiny of the accuracy of completion of the Medical Certificate of Cause of Death in a sample of those patients who died within 30 days of discharge from CHFT.

Demography

The following section describes demographic characteristics for 2020/21 deaths

Gender

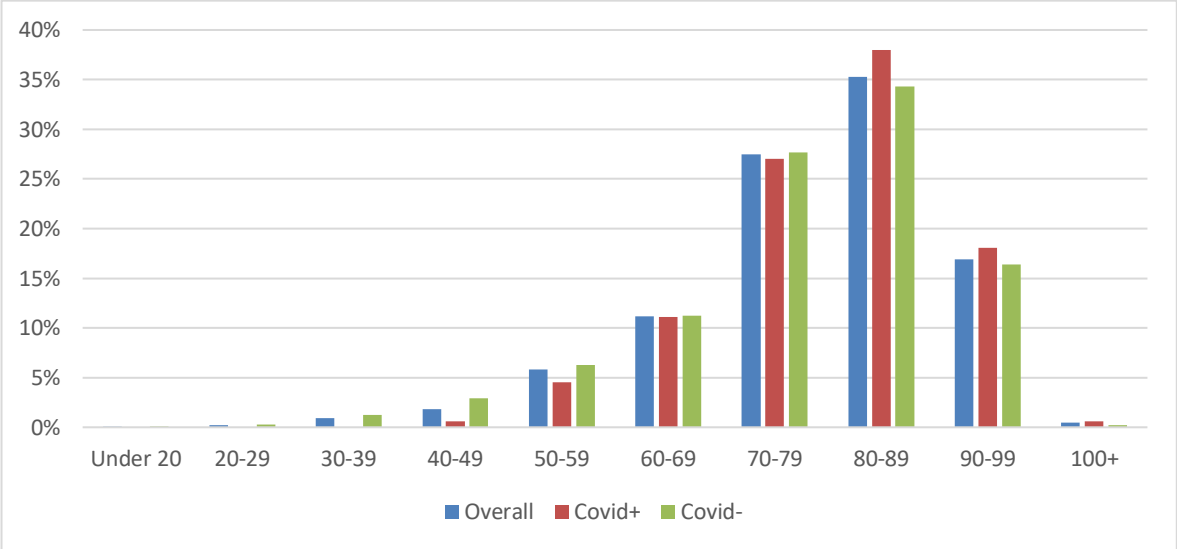
Figure 16. Gender distribution



In CHFT male patients account for a higher percentage of COVID-19 deaths compared with non-COVID-19 mortality, a pattern that has been observed nationally.

Age

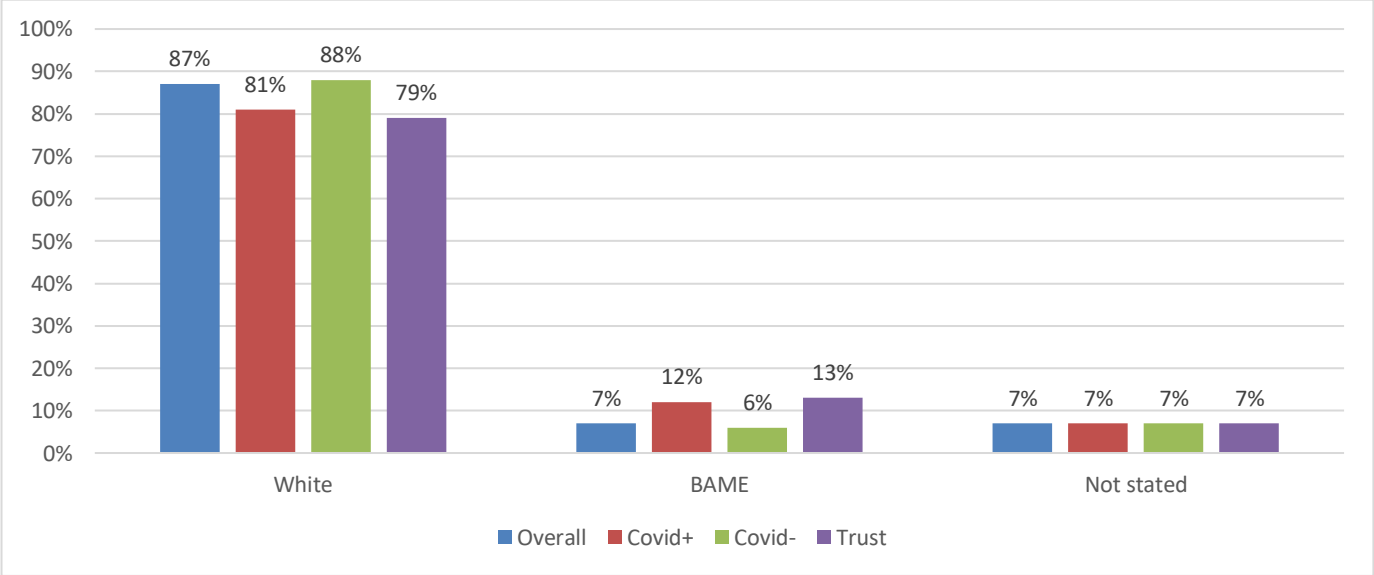
Figure 17. Age range



The difference in age range distribution between COVID-19 and non COVID-19 deaths is not statistically significant. No COVID-19 deaths occurred in patient's under 40 and there was a slightly higher proportion of COVID-19 deaths in the over 80's.

Ethnicity

Figure 18. Ethnicity distribution

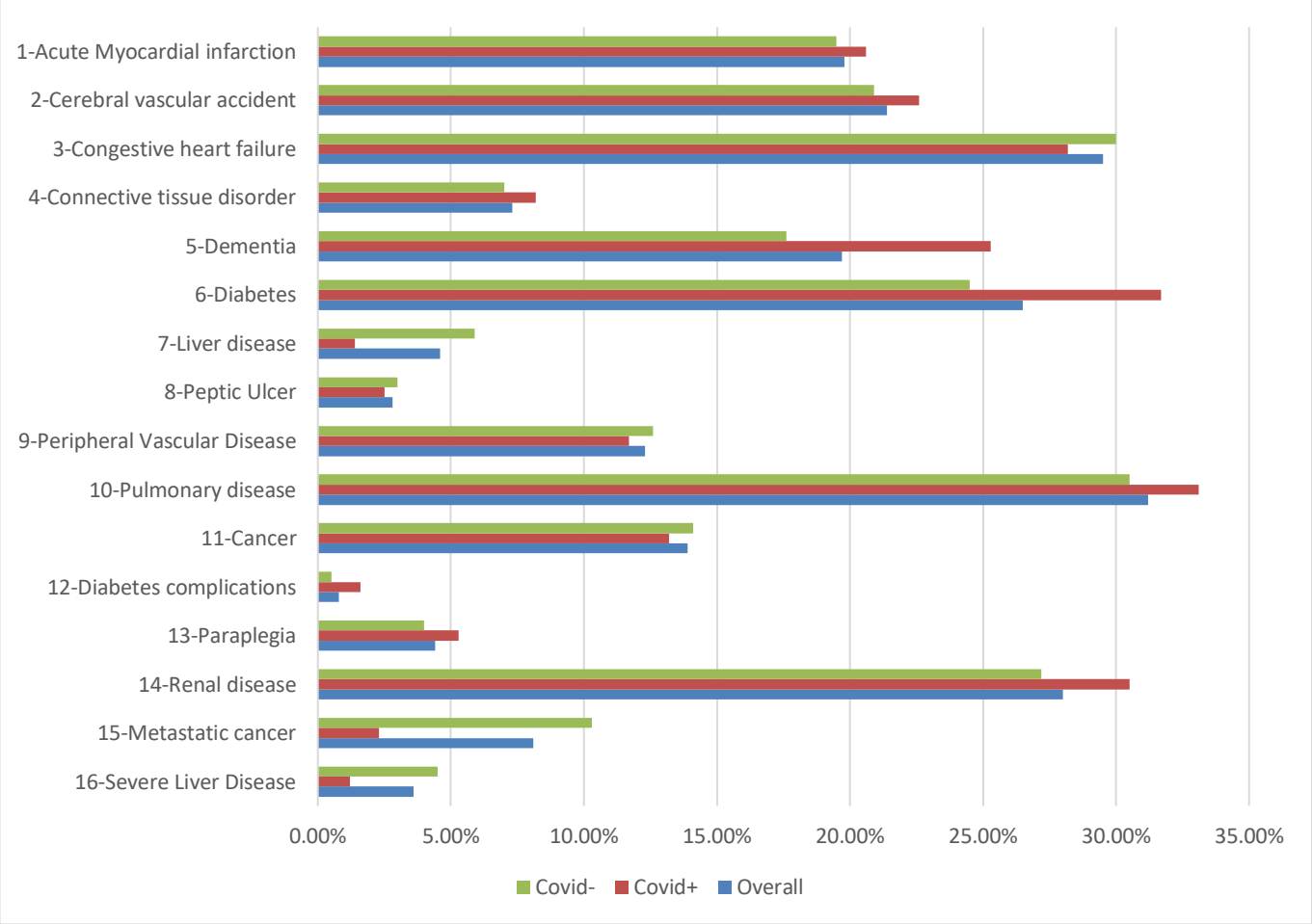


Conclusion: Data from the Knowledge Portal shows that for all patient contacts at CHFT across inpatient and outpatient settings, the ethnic breakdown of CHFT treated patients is 79% White,13% BAME and 7% recorded as not stated (Trust figures). The mortality data above shows that the percentage of COVID-19 deaths for people in the BAME ethnicity grouping was higher than the overall death figure, similar to the national picture.

Comorbidities

Figure 19 shows the percentage of inpatients who died in 2020/21 with each of the diagnoses incorporated in the Charlson comorbidity index.

Figure 19. Recorded co-morbidities in 2020/21 deaths



Conclusion:

- Most patients, both COVID-19 and non COVID-19 had multiple comorbidities
- Only 9% of 2020/21 overall mortality deaths occurred in patients who were recorded as having no identified comorbidities. This was 7% for COVID-19 patients.
- The most notable difference between COVID-19 and non COVID-19 patients is the higher proportion of COVID-19 patients diagnosed with Dementia and Diabetes.

Mortality reviews

Learning from the deaths of people in our care can help us improve the quality of the care we provide to patients and their families and identify where we could do more.

A CQC review in December 2016, *'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England'* found some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.

Each Trust should at a minimum ensure there is:

- Meaningful engagement and support of bereaved families and carers
- The introduction of structured case record reviews when reviewing patient deaths.

CHFT response:

- In 2020 the Medical Examiner's Office was established. The medical examiner team review all Trust inpatient deaths and engage with and offer support to all families and carers
- The Trust's case record review consists of 2 levels –Initial Screening Reviews (ISRs) and second level Structure Judgement Reviews (SJRs).

Medical Examiner Office

The Medical Examiner (ME) service has been established during the past 12 months and continues to evolve. This development is an indirect result of learning from the Harold Shipman case, aimed at providing more robust and timely scrutiny of the circumstances and cause of death for every patient who does not otherwise require referral to the coroner.

Originally intended to be funded by the monies historically received as fees for the completion of cremation forms, the pandemic has had a major impact on that activity, and as such there has been a change with central funding now from the Department of Health and Social Care according to the number of deaths dealt with by an individual acute organisation.

At CHFT there are 1500-1700 deaths annually giving a staffing allocation of 7 Medical Examiners and 2 WTE Medical Examiner's Officers (MEO's).

The Lead Medical Examiner was appointed just before the first wave of the pandemic struck in 2020, and due to this their official start was delayed until the beginning of July. Thereafter began the task of setting up the service, initially with the recruitment of the MEOs (November 2020) and the MEs (December 2020).

The process of scrutiny commenced in mid-December following a nationally agreed exemplar process. Learning from the trial allowed us to rapidly evolve to being able to scrutinise almost all deaths within the organisation by the end of Q4 2020/21.

The process itself revolves around an ME being allocated to independently scrutinise the case notes for a deceased patient, and subsequently having a conversation with a representative of the clinical team responsible for their care. In most cases, the outcome of that interaction is an agreed cause of death, and a Medical Certificate of Cause of Death (MCCD) can be released so that the bereaved family can arrange registration. The ME then contacts the family to explain the cause of death to them and ascertain whether they have any concerns surrounding the circumstances of the death.

In a small number of cases, there are concerns identified during scrutiny which mean a referral to the coroner is necessary, and the ME service will offer guidance on this as appropriate.

It has always been the goal to roll the service out into the community. We will begin to scrutinise community deaths by the end of Q3, aiming to be at 50% capacity by the end of Q4 (2021/22)

To achieve this, it is anticipated that we will need to double our team to a total of 4 WTE MEOs and 14 MEs, recruiting from within the trust and also from our colleagues within General Practice.

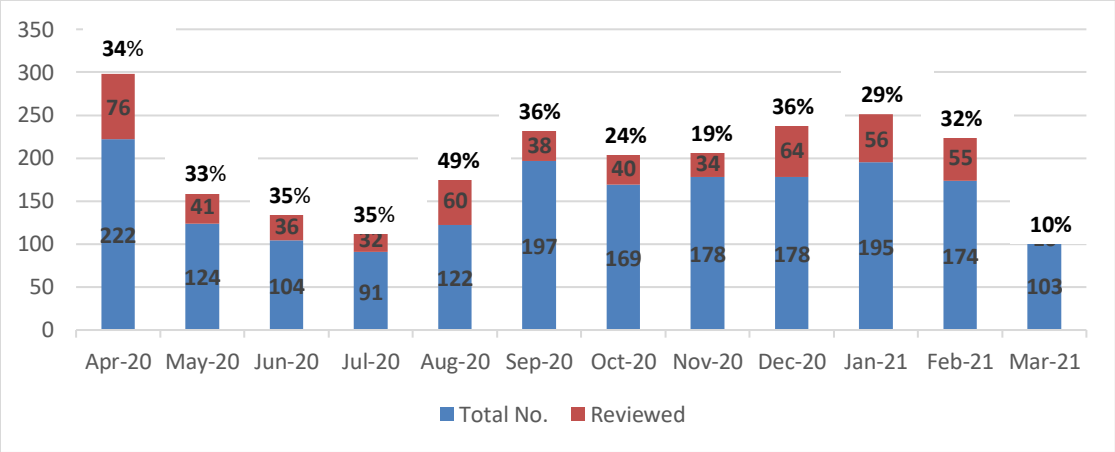
From feedback, we have learnt that bereaved relatives value the opportunity to discuss cause of death with an ME, and readily appreciate the independence of the service if they have any concerns. Although it is too early to fully appreciate the impact, it is hoped that such an interaction will resolve unanswered questions and reduce the number of complaints.

Initial Screening Reviews (ISR)

The online initial screening review tool focuses primarily on initial assessment, ongoing care and end of life management. Reviewers are asked to provide their judgement on the overall quality of care. On a monthly basis the specialities are informed of their mortalities and are asked to complete ISRs.

Of the 1789 identified deaths that occurred in 2020/21, 1767 were adult inpatient deaths. Of these 542 (31%) have been reviewed using the initial screening tool (ISR). This process aimed to achieve an initial review of 50% of all CHFT adult inpatient deaths. This target has not been met. It is similar proportion to 2019/20 when 32% of deaths were reviewed.

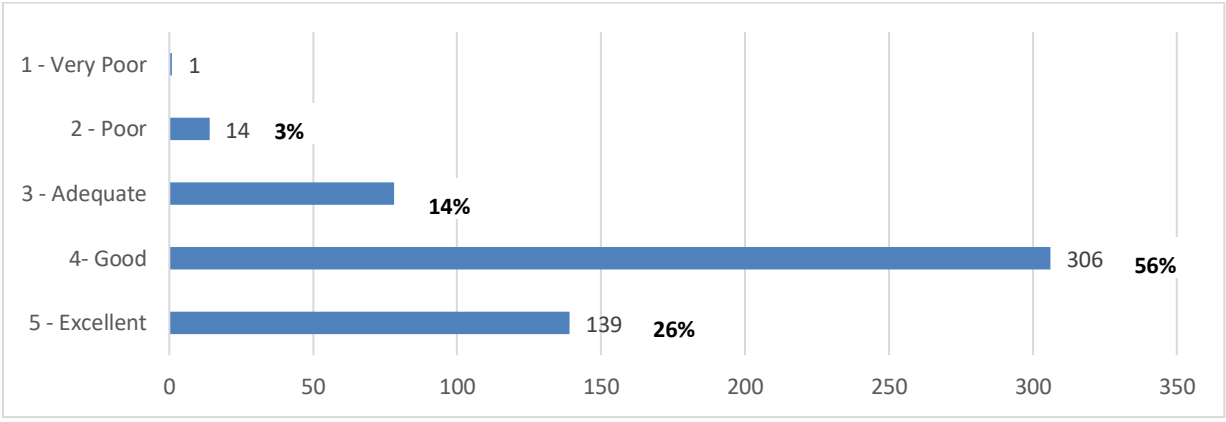
Figure 20. Number of adult inpatient deaths reviewed by ISR by month



Of note there is a lag between death and completion of review. During the COVID-19 Pandemic completion of ISRs was temporarily suspended for several months. We anticipate the numbers of completed reviews will increase as COVID-19 pressure on services decrease.

In the 542 cases reviewed the quality of care was assessed as follows:

Figure 21. Quality of Care Score distribution for 542 completed ISR's



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

Speciality-focused Initial Screening Reviews

In Q3 of 18/19 the Trust made the decision to support speciality specific reviews. The LfD team recognises that whilst the COVID pandemic has impacted the number of reviews completed, the monthly average is below the expected level in several areas.

The table below indicated the performance of each speciality using the following scale:

	Target Achieved
	Above 40% but below 50%
	Below 40%

Table 2

Speciality	Total		Percentage reviewed
	Total	Reviewed	
Critical care	148	113	76%
Oncology	26	14	54%
Acute Medicine	307	167	54%
Stroke	113	55	49%
Surgery	80	38	48%
Gastroenterology	84	38	45%
Orthopaedics	33	14	42%
Cardiology	63	26	41%
Endocrinology	26	8	31%
Elderly	568	37	7%
Haematology	18	1	6%
Respiratory	248	10	4%

There are 2 areas that are impacting on the Trust's overall position. Deaths in Elderly and Respiratory specialities account for 46% of ALL inpatient Adult deaths. We recognise that these 2 specialities have been heavily affected by the pressures of the pandemic, the MSG have asked the mortality leads and clinical directors for these areas to develop a plan of action to address the deficit in reviews for 2020/21.

In addition to adult inpatient services, mortality reviews also take place in the Emergency Department, Maternity, Paediatrics and Calderdale Community (30 days post-discharge) using other specific review processes.

Each speciality is requested to present the findings from their reviews at the Mortality Surveillance Group (MSG) annually. The LfD team have developed a standardised presentation template to ensure applicable information is captured. MSG meetings were suspended between Sep 2020 and Feb 2021 during the second and third COVID-19 waves but a programme to ensure all specialities are reviewed over the next 12 months is now in place.

Structured Judgement Reviews (SJR's)

SJR is a standardised case note review methodology. SJR blends traditional, clinical judgement based, review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, including feeding back to members of the multi-professional team examples of excellent care and to score care for each phase.

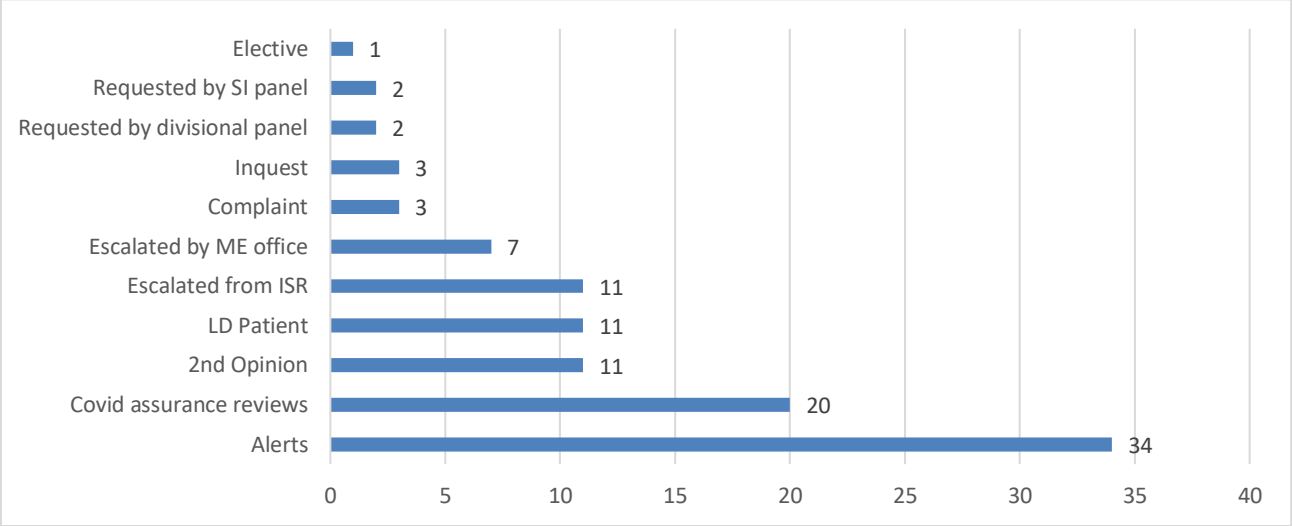
The identified phases of care are:

- Admission and initial care - first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/procedure care

- End-of-life care (or discharge care)
- Assessment of care overall

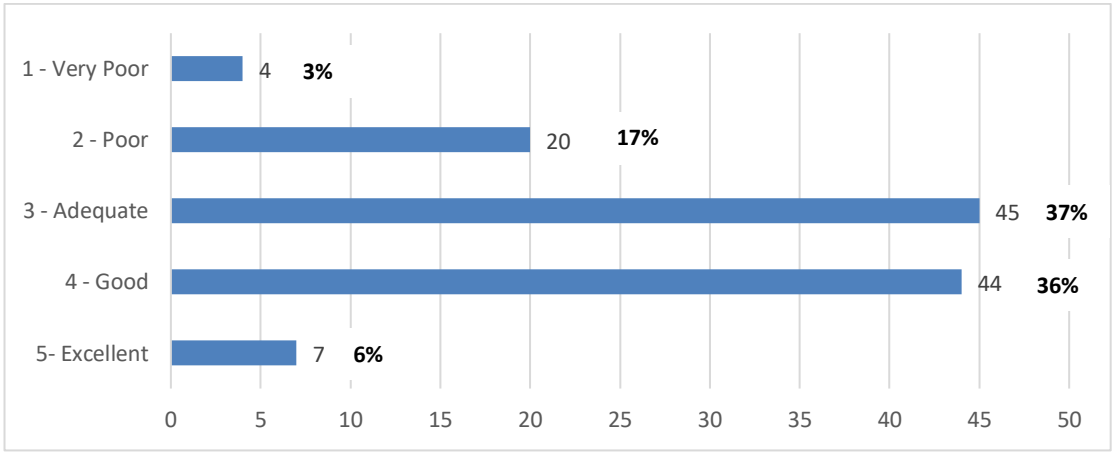
In 2020/21 121 SJRs were completed. The chart below shows the rationale for these SJRs. This includes assurance reviews requested by the Mortality Surveillance Group following the decision for specialities to review their own deaths.

Figure 22. Indication for SJR's requested in 2020/21



As with the ISR's the SJRs give an overall care score. Figure 23 gives the breakdown of quality care scores for completed SJRs in 2020/21.

Figure 23. Quality Care Score distribution for 121 completed SJRs



- All SJR reviews, irrespective of care score, are shared with the relevant division
- All cases given a care score of Poor or Very Poor are subject to a 2nd opinion SJR
- Following 2nd opinion SJRs any cases agreed as a care score of 1 or 2 are reported as Orange incidents onto Datix if they have not already been reported by division
- If there is a discrepancy of more than 1 between SJR scores, the 2 reviewers are requested to discuss the case to reach a common score.

- If an agreement is not achieved then escalation takes place to the Deputy Medical Director for arbitration as the Trust mortality lead

Learning Disabilities

- In 2020/21 11 SJRs were completed for patients with learning disabilities. All Learning Disability deaths are also reported to LeDeR (Learning Disabilities Mortality Review) a national programme created to improve the quality of health and social care for people with a learning disability, by the CHFT Learning Disabilities Matron. There were no significant concerns raised regarding the quality or disparity of care received at CHFT by patients with Learning Disabilities. It was noted that there could be earlier identification of Next of Kin for Learning disability patients.

Thematic analysis of Structured Judgement Reviews (SJR's)

Positive themes

- As a result of increasing senior staffing during the pandemic response, there was greater consultant presence at the acute front end ensured early senior review which historically has been raised as an area of concern in SJRs
- MDT involvement – Reviewers highlighted the good use of MDT approach and the benefits of this approach for the patient
- Good use of the palliative care team to support patients in the dying phase
- Good well-documented communication with patient's relatives and carers despite the visiting restrictions in place with the pandemic.
- Well documented identification of ceilings of care

Areas for improvement

- A theme from 2020/21 emerged that care may have been technically good and all policies and guidelines adhered to but patients were often seen by different senior doctors each day, impacting on continuity of care. This occurred as a result of the staffing measures implemented to enhance early senior medical review during the pandemic. To ensure greater frequency and promptness of senior medical review, issues sometimes surfaced regarding continuity of care
- Failure to recognise existing conditions/comorbidities early in admission – recognition of the acutely unwell patient
- Standard of documentation – overuse of abbreviations and annotation which could lead to misinterpretation and confusion, rationale for clinical decisions not recorded
- Communication – between staff and teams

Learning from Death Actions

Care of the Acutely Ill Patient (CAIP) Programme

The CAIP Programme has been introduced, chaired by the Deputy Medical Director as a quality improvement initiative to focus on themes that have been highlighted through Learning from Death reviews and monthly mortality alerts from Healthcare Evaluation Data (HED). Work stream leads have been identified and outcome measures for each work stream are being agreed.
The 5 workstreams are:

- Sepsis (Quality Priority) and the Deteriorating Patient
- Stroke
- Acute Kidney Injury
- Discharge acuity
- Coding

New reviewers

During 2020/21 the LfD team have recruited 2 new SJR reviewers. It had been highlighted by the surgical division that there were concerns regarding SJR reviewers' understanding of surgical pathways therefore the LfD team are delighted to welcome Rob Adair, Consultant General Surgeon to the SJR team alongside Anneka Biswas, Consultant in Respiratory Medicine.

SJR training

The Yorkshire and the Humber Allied Health Science Network's Improvement Academy have offered a half day SJR Training session. This training will support our newer reviewers and serve as a refresher for our existing reviewers. This will support consistency in our reviews and promote good identification of broader learning.

HOCI (Hospital Onset COVID-19 Infection)

The Trust has agreed a governance approach to HOCI incidents. The Medical Examiner Team reviewed all HOCI incidents where the patient has died within 28 days of a positive specimen result and where COVID-19 was stated on the death certificate. Of the 88 patients who died within 28 days of a positive specimen result, COVID-19 was stated on the death certificate in 73 cases.

The Medical Examiner Team categorised these cases as:

Died OF	Where COVID-19 is considered the cause of death
Died WITH	Where the patient died of other causes but had COVID-19 at the time of their death, and therefore this is recorded on the death certificate
UNCERTAIN	Where the patient had comorbidities and had a positive COVID-19 specimen result and it is unclear what impact that COVID-19 had, or did not have, on contributing to death.

Structured Judgement reviews were conducted on 20 deaths that were categorised as 'Died OF' COVID. The SJR process was not used to assess if IPC processes had been followed or review the circumstances of the infection. The reviews were to ascertain if there were any other care quality concerns associated with the patients' care.

To date 17 of the 20 cases have been reviewed. In 5 of the cases care was judged as 4 - Good, 9 cases as 3 – Adequate and 3 cases as 2 – Poor.

For the 3 cases judged as Poor 2nd opinion SJRs were completed. In 2 cases the 2nd opinion SJR returned a care score of 3 – Adequate. In 1 case the 2nd opinion returned a care score of 4 – Good, as this was a difference of more than 1 the LfD team requested the reviewers discuss to see if they could agree a score. In this case they agreed upon 3 Adequate.

Therefore no major care concerns have been identified thus far and overall themes reflect those identified for other SJR reviews over this period. Further details of the HOCI SJR reviews will be incorporated into a paper for the Trust Quality Committee.

Recommendations

1. To support the additional actions scrutinising Standardised Hospital Mortality Index (SHMI) including the establishment of the Care of the Acutely Ill Patient (CAIP) quality improvement programme

2. To support the requirement of the Medical Examiners' Office to review deaths within the community. We will begin to scrutinise community deaths by the end of Q3, aiming to be at 50% capacity by the end of Q4 (2021/22)

3. A target of 50% of all in-patient deaths to be subject to Initial Screening Review by June 2022. Deaths in Elderly and Respiratory specialities account for half of inpatient adult deaths. The Mortality Surveillance Group (MSG) have asked the mortality leads and clinical directors for these areas to develop a plan of action to address the deficit in reviews for 2020/21

18. Fire Safety Annual Report

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title:	Fire Annual Report 2020/21
Author:	Keith Rawnsley, Fire Safety Officer
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Fire Committee

Purpose of the Report

To provide the Board of Directors with an overview of the activities of the Fire Committee in 2020/21.

Key Points to Note

The Trust has continued to make good progress over the last 12 months in terms of fire safety; with a Fire Strategy in place, supported by an updated Fire Policy and work programme, agreed in response to the external review commissioned as part of the strategy development.

The Trust had an established Fire Committee with Terms of Reference that were reviewed and updated in 2020/21. The key change being the inclusion of the Trust Risk Manager on the Committee and formal reporting into the Trust's Health and Safety Committee.

Operationally, 2020/21 has been a challenging but successful year, with the need to respond quickly to the Covid-19 pandemic, which posed risks in relation to estate configuration, Oxygen usage and staff redeployment.

Despite the pandemic, estates work has continued in line with the agreed capital programme, with all fire works completed to plan. This included the introduction of Dry Risers at HRI, the Trust's interim mitigation for further compartmentation, which remains limited due to estate occupancy.

Fire safety advice, support and training are provided by the Fire Safety Officer who resides within the Corporate Operations Team. For further assurance, the Trust commissions independent advice from a formally appointed authorising Fire Engineer AE (Fire) as required by HTM 05. In 2020/21, a trainee Fire Officer has been appointed to both provide capacity for input to the Trust reconfiguration programme by the Fire Officer, but also to ensure resilience in relation to succession planning.

EQIA – Equality Impact Assessment

This is a report of the annual activities of the Fire Committee, these activities individually have a QIA & EQIA as required.

Recommendation
The Board is asked to **NOTE** the contents of the report.

CHFT Annual Fire Safety Report
1st April 2020 – 31st March 2021

1. Introduction

This report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2020/2021 in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (RRO) and the Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety in parallel with the Trust agreed priorities.

2. Executive Summary

The Trust has continued to make good progress over the last 12 months in terms of fire safety; with a Fire Strategy in place supported by an updated Fire Policy and work programme agreed in response to the external review commissioned as part of the strategy development.

The Trust had an established Fire Committee with Terms of Reference that were reviewed and updated in 2020/21. The key change being the inclusion of the Trust Risk Manager on the Committee and formal reporting into the Trust's Health and Safety Committee.

Operationally, 2020/21 has been a challenging but successful year, with the need to respond quickly to the Covid-19 pandemic, which posed risks in relation to estate configuration, Oxygen usage and staff redeployment.

Despite the pandemic, estates work has continued in line with the agreed capital programme, with all fire works completed to plan. This included the introduction of Dry Risers at HRI, the Trust's interim mitigation for further compartmentation, which remains limited due to estate occupancy.

Fire safety advice, support and training are provided by the Fire Safety Officer who resides within the Corporate Operations Team. For further assurance, the Trust commissions independent advice from a formally appointed authorising Fire Engineer AE (Fire) as required by HTM 05. In 2020/21, a trainee Fire Officer has been appointed to both provide capacity for input to the Trust reconfiguration programme by the Fire Officer, but also to ensure resilience in relation to succession planning.

3. Estate activity

3.1 At HRI the fire detection upgrade program has resulted in an improved detection system making good progress towards a compliant system. Work this year has focused on replacing old interfaces (a devices which causes something to happen, such as closing fire doors or dampers). Work on relabeling the devices and the graphics package. In addition, progress has been made to ensure the door locks with swipe card access are programmed to the fire alarm system.

At CRH, the fire alarm system is being upgraded via the life cycle program. Work commenced in the main hospital in patient areas and has now reached the Trust HQ block. Blocks G and H (Pathology)

are due to be replaced this coming year.

3.2 The Trust commissioned, through Calderdale and Huddersfield Solutions Limited (CHS), a fire compartmentation scheme, repairing / replacing non-conformities in the 90/60-minute compartmentation fire barriers and doors across Huddersfield Royal Infirmary. A good proportion of the 60-minute compartmentation has been completed at HRI.

This does not address all issues in relation to sub-compartmentation as this would require the decant of ward space over a prolonged period, which cannot be safely accommodated due to ongoing demand for beds as activity remains high. A programme to install Dry Risers to Tower blocks 1 and 2 at HRI was agreed and supported by the Fire Service; this has been completed in 2020/21. These allow the fire service to pump water to the floor level quickly, so in the event of a fire, they can extinguish it much quicker than before. These are not a permanent solution but provide sufficient interim mitigation

Compartmentation at Calderdale Royal Hospital did not require intervention.

3.3 Ward 18 at HRI underwent a full refurbishment to establish an Isolation ward. This was national funded with exceptionally tight delivery timescales. It was a significant undertaking and was fully supported by the Fire Officer to ensure we maximized the benefits of the refurbishment in old estate and any existing fire weaknesses were removed.

3.4 Broad Street was repurposed to provide clinic capacity for Yorkshire Fertility, which, in turn, provides capacity for the replacement MRI Scanner. Both schemes have had input from the Fire Officer to ensure compliance with regulation.

3.5 A facility at Elland for The Health Informatics Service was commissioned, which facilitated the closure of Oak House and Acre House and also allowed the relocation of the loan store at Salterhebble. Space was identified within the building that could provide off-site storage from other Trust premises including HRI & CRH. A lift was installed to support this and significant equipment is now stored safely in the building. This has made a huge impact to the areas this has been transferred from, with lower volumes of clutter and a reduced fire risk.

3.6 Oxygen enrichment was a major challenge during the pandemic due to the amount of oxygen being delivered to patients with Covid. Very few wards have mechanical ventilation and windows are not usually opened in the winter months. Daily monitoring and on occasions, twice daily checks were carried out. High readings have been recorded (above 23%) but action was taken quickly to reduce this level. An Oxygen group was established, reporting daily into Tactical, overseeing the monitoring and agreeing corrective actions if required. There were very few escalations reflecting the close working between clinical staff and the Fire officer and any actions required were immediately implemented and risk reduced.

4. Reporting

4.1 Fire Risk Assessments

Fire Risk assessments (FRA) are a legal requirement and have been carried out for CHFT premises; these are done on a rolling program. These are reviewed by the Fire Committee and agreed actions are monitored for implementation. This is an area that requires closer scrutiny in 2021/22 to ensure actions are completed to agreed milestones.

The main areas for improvement were fire compartmentation at HRI as previously highlighted and actioned / mitigated along with storage, mitigated through the Elland development.

Fire doors, particularly in community premises, were a concern and the replacement programme continues with priority in 2021/22 being community buildings.

4.2 Fire and Fire Alarms

There have not been any major fires within the Trust this year; there was a small fire in the Dales. However, this is run by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).

4.3 False Alarms

The Trust is required to monitor fire alarm activations to ensure they are kept to a reasonable level and determine the reason for the activation and actions to prevent a reoccurrence.

Table 1 Fire Alarms Statistics:

Huddersfield				Calderdale			
Year	**Actuations**	**Fire**	**False Alarms**	**Year**	**Actuations**	**Fire**	**False Alarms**
2020/21	37	0	33	2020/21	11	0	11
2019/20	26	0	24	2019/20	21	1	20
2018/19	46	1	38	2018/19	21	0	21
2017/18	76	0	76	2017/18	37	0	37
2016/17	35	0	35	2016/17	33	2	31
2015/16	36	2	34	2015/16	62	2	60
2014/15	53	4	49	2014/15	100	0	100
2013/14	67	5	40	2013/14	95	2	93

There was 1 activation in the PMU (Pharmacy Manufacturing Unit) which resulted in an unwanted Fire signal. There was also a further 2 activations, 1 in Acre Mills and 1 in Acre Mill OPD.

In addition to these, there were also 6 activations within the Dales at CRH, 1 of which was a fire, this was

extinguished by staff.

Previous years are shown above to show how actuations and unwanted fire signals have decreased in certain areas. CRH's statistics continue to decrease in all areas, where HRI's actuations have increased this year. This increase has been due to the incorrect use of toasters (16 activations, HPV use 6 activations and contractor fault 2 activations).

An unwanted fire signal (UFS) is a fire alarm where the fire service attend site and there is no fire. West Yorkshire Fire and Rescue Authority can charge organisations £450 for each UFS. Their objective is to reduce the number of UFS thus ensuring fire tenders / appliances are available for actual fire calls. CHFT's Fire Officer and Authorised Engineer continue to work closely with the Fire Authority, Estates and Facilities, Engie and ISS to ensure, where possible, we manage UFS internally and are not charged.

5. Training

5.1 Fire training was delivered this year non-face-to-face reflecting the requirement to reduce social contact and keep colleagues safe from infection. This was accessed via the ESR, steps were taken to cover those members of staff who are not Trust staff, such as ISS and Leeds Teaching Hospital staff (Renal and Security).

In addition, were high risk, some evacuation training was carried out, particularly in areas where high volumes of staff had been deployed to e.g. ICU to ensure all colleagues were conversant with the fire response arrangements.

Fire warden numbers have remained high and training support has been provided as required rather than specific training reflecting some stability of wardens and the impact of the pandemic. This has been particularly important as, with increased numbers of staff working from home, there was an impact on some departments, both from buildings not being covered by fire wardens as they are at home, and their own personal safety (home fire safety). Additional checks have been carried out and, where gaps were noted, contact was made with managers of these areas to address these gaps.

Reflecting the ongoing pandemic and the expectation that non-face-to-face contacts remain at a minimum, a new fire training programme has been developed and uploaded to ESR. This is a more comprehensive programme covering hospital premises, premises where Trust staff work and the home environment. All elements that are included in the Fire strategy. This has been favorably reviewed.

5.2 Annual fire training this year was achieved by staff reading an amended version of the booklet and a figure of 91.65% was achieved.

Table 3 Fire Training Statistics

Year	Fire Safety Training	Fire Warden Training
2020/21	5500	221
2019/20	5612	693
2018/19	5465	334
2017/18	5630	270
2016/17	4452	151
2015/16	4171	1089
2014/15	4976	1042
2013/14	2460	826

The numbers above account for just Trust and CHS staff, with a further 800 staff trained in Fire Safety, from areas such as ISS, Engie, Renal, Locala, Social Services, League of Friends, etc.

5.3 Fire Response Team Training - reduced due to Covid, but security at HRI have had additional training on the dry risers.

5.4 Trust Induction Training – induction training is carried out, either by online training or by using teams dependent on who the induction is for.

6. Governance

The Authorising Engineer (AE) for Fire fulfills his role by undertaking the fire risk assessments for the Trust; by doing this, it enables him to have a good overview of how the Trust is progressing with fire safety. The Trust Fire Officer is in regular contact with the Trust AE.

The Trust Fire Committee has an overview of the Trust Fire Safety roles and responsibilities. There are, when needed, site specific fire meetings that look at each site's Fire risks and resolves and rectifies these.

During Covid there was specific Covid Fire Risk Register Management by the Fire Committee.

The Trust's Fire Committee reports back to the Trust's Health and Safety Committee.

7. Fire Strategy

The Trust commissioned MottMacDonald to undertake an estate review in regard to Fire and to develop a Fire strategy. Both elements concluded with a Fire Strategy signed off by the Board of Directors in March 2021 and the associated Fire Policy ratified by Executive Board in May 2021.

The Fire strategy and associated action plan has informed the capital programme and will be used to support reconfiguration planning. There will also be a need to ensure that future plans have the ability to incorporate external decisions in relation to regulations, particularly in the wake of the

Grenfell fire and subsequent inquiry.

Reflecting the increased workload in relation to ongoing Fire management and the requirement to support the reconfiguration planning, additional capacity was approved, and a trainee Fire Officer is now in post.

8. West Yorkshire Fire and Rescue Service / Building Control

There is a sustained and open dialogue between the Trust Fire Officer, the AE Fire and the Fire Service, both in terms of building work and in conjunction with building control. We also liaise with operational crews for site visits and training by allowing use of our premises where appropriate. Site visits have unfortunately reduced due to availability of fire crews and Covid restrictions.

19. Quality Report

- Maternity Services Update

To Note

Presented by Ellen Armistead

Date of Meeting:	Thursday 1 July 2021
Meeting:	Public Board of Directors
Title:	Quality Report (Reporting period April 2021 to May 2021)
Author:	Doriann Bailey, Assistant Director for Patient Safety
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Quality Committee

Purpose of the Report

The purpose of this report is to provide the Trust with ongoing oversight of the Quality agenda and the emerging issues for consideration.

It is to ensure that the Board of Directors are provided with a level of assurance around key quality and patient experience outcomes and confirmation that during the COVID pandemic and that as the Trusts seeks to plan the recovery response to the 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 and Quality Priorities Report.

Care Quality Commission (CQC)

- There is an improved position for the 'Must Do' action related to financial performance to ensure services are sustainable in the future. This action is a long-term action which continues to progress a further update is scheduled to be reviewed at the CQC & Compliance Group.
- There has been a closure of the three 'Should Do' actions which include:
  - SD3: measure the outcomes of mental health patients in order to identify opportunities to improve care
  - SD6: The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards
  - SD9: The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.
- The CQC' new strategy - *A New Strategy for the Changing World of Health and Social Care,* which was launched in May 2021, the four themes in CQCs strategy which are:
  - People and communities
  - Smarter regulation
  - Safety through learning
  - Accelerating improvement

  Within the strategy there are 12 outcomes that are then linked to the four themes.

- The ward assurance tool based on the CQC Focused Support Framework has transitioned to the Journey to Outstanding (J2O) framework. The revised format includes a 360-degree review of safety, quality and experience which includes the Trust's Observe and act. A pilot has been completed and the full lunch will commence from July 2021.

Central Alert Systems

- To note the current position and actions being undertaken for the Central Alert System (CAS) indicators which has 3 overdue alerts and 1 alert in progress.

Dementia Screening

- The note the Trust overall compliance for dementia training which exceeds the target of 95% and the planned work for the newly appointed Dementia Lead which will focus on dementia screening and will work closely with the medical teams to increase compliance with screening which remains significantly below the 90% target.

Experience, Participation, Equalities Highlight report

- The first report for the Divisional Patient Experience and Caring Group and the various initiatives and improvements over the reporting period, which includes the progress for the various work streams and the ongoing plans for the next reporting period.

Complaints

- To note the Trusts improved position in relation to complaints performance. The number of complaints received is showing an increase of 10% during April and May and an increase in activity within the PALS service.

Legal

- To receive the legal report outlining the Trust position for the reporting period. Initial plans are in place to include a legal component in the planned Clinical Directors (CD) on boarding training sessions. A 'Go See' opportunity arising from the getting it right first time (GIRFT) programme is presenting further learning opportunities for the Trust which will be explored further in the next period.

Incidents

- To note the summary of patient safety incidents and learning for the organisation including 4 serious incident reports submitted to the Clinical Commissioning Group.
- A delayed never event was reported and is currently under investigation which related to a retained foreign object post procedure. Actions have been put in place following review of the incident.

Medicine Safety

- To note the priority work streams, the progress to date including use of electronic CD registers and Active temperature systems. Both systems are due to go live in the next two months, and training will be required to be supported.

Maternity

- To receive the monthly maternity governance assurances in response to the Ockenden review which confirms submission of evidence assurance against the seven immediate and essential actions of the Ockenden Report.
- The Trust response to the **Enhanced Safety** action which requires that "*All maternity Serious Incidents are shared with Trust Boards at least monthly, and the Local Maternity*

System, in addition to reporting, as required to the Healthcare Safety Investigation Branch"

- To note that the first Perinatal Quality Surveillance Meeting was held on the 25th May 2021 and that the meeting gives the assurances required the Board Commissioners and Local Maternity System.
- The note the requirements for the Trust as it relates to compliance against the Continuity of Carer ambitions to be in place by March 2022.
- The Trust reported three stillbirths in May which were all antenatal intrauterine deaths; no neonatal deaths have been reported

Healthcare Safety Investigation Branch (HSIB)

- There are currently six open cases at varying stages of investigation. The learning identified from these cases can be summarised under the following themes:
  - Failure to recognise and follow guidelines regarding smaller/larger than expected foetus
  - Midwives not taking advantage of the 'fresh eyes' review
  - Failure to recognise high risk pregnancies e.g., mother that present who are smokers, obese and taking the appropriate action
  - Missed opportunities for the assessment of better pain relief when woman in labour

Maternity Staffing

- To note the current percentage of 1:1 care in relation to NICE guidance on safe midwifery staffing and the provision of 1:1 care reported on the maternity services dashboard. There is proactive recruitment via the Local Maternity System into the Midwifery vacancies within the service and recruitment of trust grade doctors to support Obstetric staffing due to gaps in the deanery training rotas.

Quality Priorities

- To note the updates and the Trusts response to the Quality Account Priorities and the Focussed Quality Priorities for 2021 / 2022:

  <u>Quality Account priorities</u>
  - Recognition and timely treatment of Sepsis
  - Reduce number of Hospital Acquired Infections including Covid 19
  - Reduce waiting times for individuals attending the ED

  <u>Focussed Quality Priorities</u>
  - Falls resulting in harm
  - End of Life
  - Clinical documentation
  - Clinical Prioritisation
  - Nutrition and Hydration
  - Pressure Ulcers
  - Making Complaints Count

  All Quality Account Priorities and the Focussed Quality Priorities for 2021 / 2022 have been shared and discussed at divisional Performance Review Meetings with the focus that the quality priorities form an integral part of the divisional quality agenda and strategy. The robust reporting schedule will enable assurances of improvements which will be reported to the Quality Committee and Board.

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. The Board is asked to receive the monthly Maternity report which has been presented at the Quality Committee.

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.

The Trust Quality Board paper seeks to brief the Board on the developments and progress against the Quality Strategy and improvement work underway.

This report provides assurances that as a Trust we are working towards the Outstanding CQC rating, the question for any Trust committee should be one of 'Am I assured and am I confident that we know where the risks lie'. Through the transparent reporting and the robustness of the reports we seek to give the Board the clarity required.

This report provides an update on assurances against several quality measures for the last quarter and the plans for the new financial year 2021/2022 to include the progress report for the new Quality Account Priorities and the Focussed Quality Account Priorities for 2021/2022.

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 has and continues to recognise the challenges that has been placed upon the Trust during the COVID -19 Pandemic and acknowledges the hard work from all staff as we sought to keep all our patients safe and continue to provide high levels of care. As we come out of the Pandemic and embark on our recovery programme it is more than ever important that as a Trust, we are sighted on the quality agenda and any associated risks.

2. Care Quality Commission (CQC) workstreams

During April 2021 and May 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.

2.1 2020 / 2021 CQC Exceptions Action Plan – Update on 'Must Do' and 'Should Do' Actions

Of the outstanding actions from the 2018 CQC inspection, the Trust now has one action to complete.

In brief the one 'must do' action is not yet embedded in the Trust and remains incomplete pending further consideration of the quality and financial position of the Trust as set out below. During the April 2021 and May 2021 CQC and Compliance Groups, a further three 'should do' actions were closed and detailed below.

Standards Subjects:	Current position	Risk(s) identified	Forthcoming action for the next two months	Assurance
There is 1 MD that remains open as follows:				
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.	N/A	This action is a long-term action which continues to progress a further update is scheduled to be reviewed at the CQC and Compliance Group.	**Substantial assurance**
There are 3 SD are now closed as follows:				
SD3 - The Trust should develop processes to measure the outcomes of mental health patients in order to identify opportunities to improve care	**SD6** - The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	**SD9** - The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.		**CLOSED**

2.2 CQC Engagement Meetings

Regular review meetings between CQC and CHFT have continued to take place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services. These review meetings are scheduled to continue monthly. The engagement conversations have been structured using CQCs approach to regulation during the pandemic including the Emergency Support Framework and Transitional Monitoring Approach.

2.3 Focused Support Framework / Journey 2 Outstanding Review

During April substantial work was undertaken to revise and update the Focus Support Framework, the review toolkit has been updated to reflect CQC's Core Service Frameworks. The review has been rebranded with the plan to launch as the 'Journey 2 Outstanding' Review.

The Journey 2 Outstanding Review (J2O) has been developed with the aim to provide a 360-degree evaluation of the ward environment, workforce, patient safety and patient experience. The Patient Experience is assessed using the Observe and Act Framework the findings from both elements of the review are reported as one under the name Journey 2 Outstanding.

The aim of the J2O Review is to provide Ward Managers and their teams the opportunity to demonstrate the Safe and Compassionate Care which is delivered to patients across the Trust every day.

The framework is also designed to identify where extra support may be needed to support services on their Journey 2 Outstanding.

2.4 The Toolkit

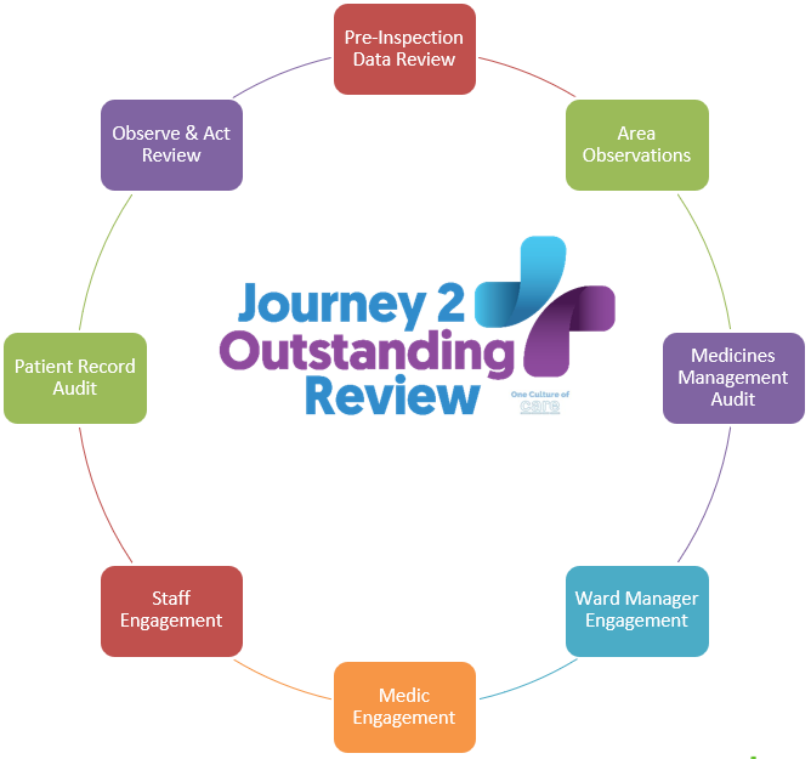
The review is carried out by a team of CHFT colleagues from medical, nursing, and non-clinical backgrounds. Each colleague will be responsible for undertaking a section of the J2O Review Toolkit as set out in figure 1.

The review will run over a full week to ensure flexibility for both the ward area and the team. There will be two reviews will be carried out across the Trust per month and the areas will be decided on intelligence from the Senior Leadership Team.

The area observations and the medicines sections of the review will be unannounced to the Ward Manager and Team.

Each section of the Toolkit will be completed as part of the review and will form the overall final summary report to the Ward Team.

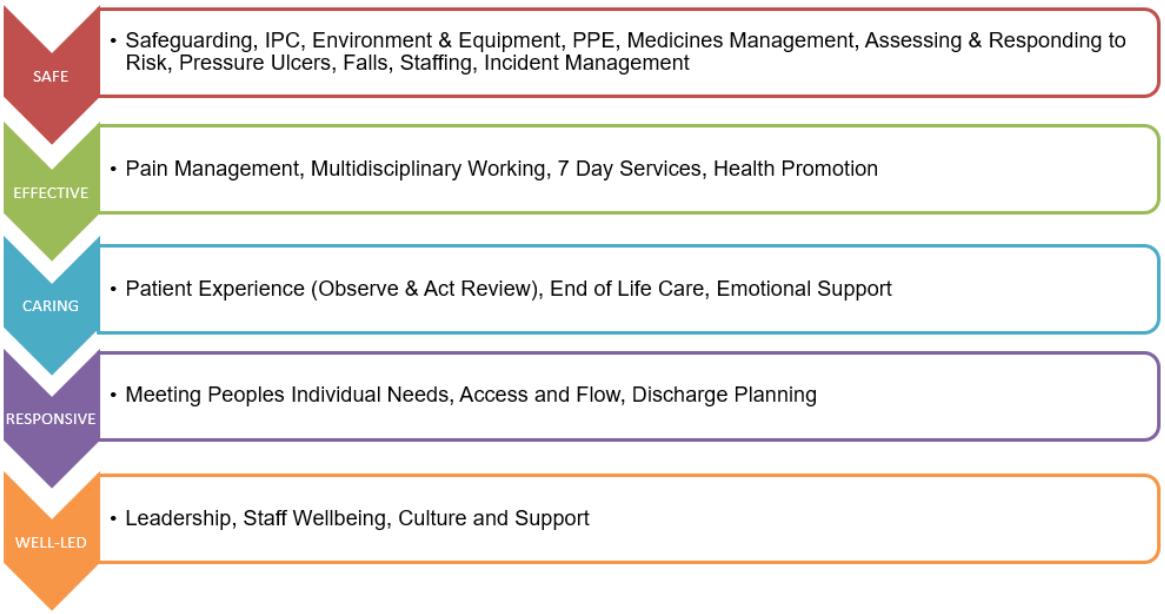
Figure 1:



2.5 Key Themes

Some of the key themes running throughout the review are detailed in figure 2.

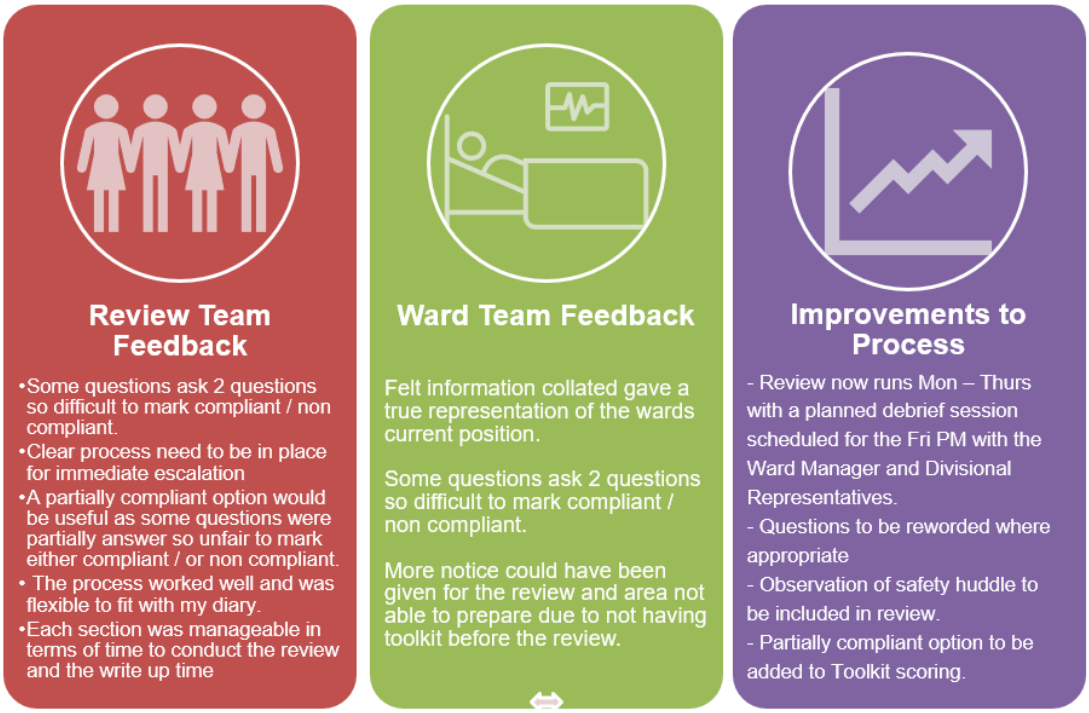
Figure 2



2.6 Pilot Review

In May 2021, a pilot review was run on Ward 8B at Calderdale Royal Hospital. The overall feedback was that the process worked well, and the review captured a true representation of the ward area. Further developments have now been carried out based on feedback from colleagues to ensure it is reflective of our work together to get results improvement framework.

Figure 3

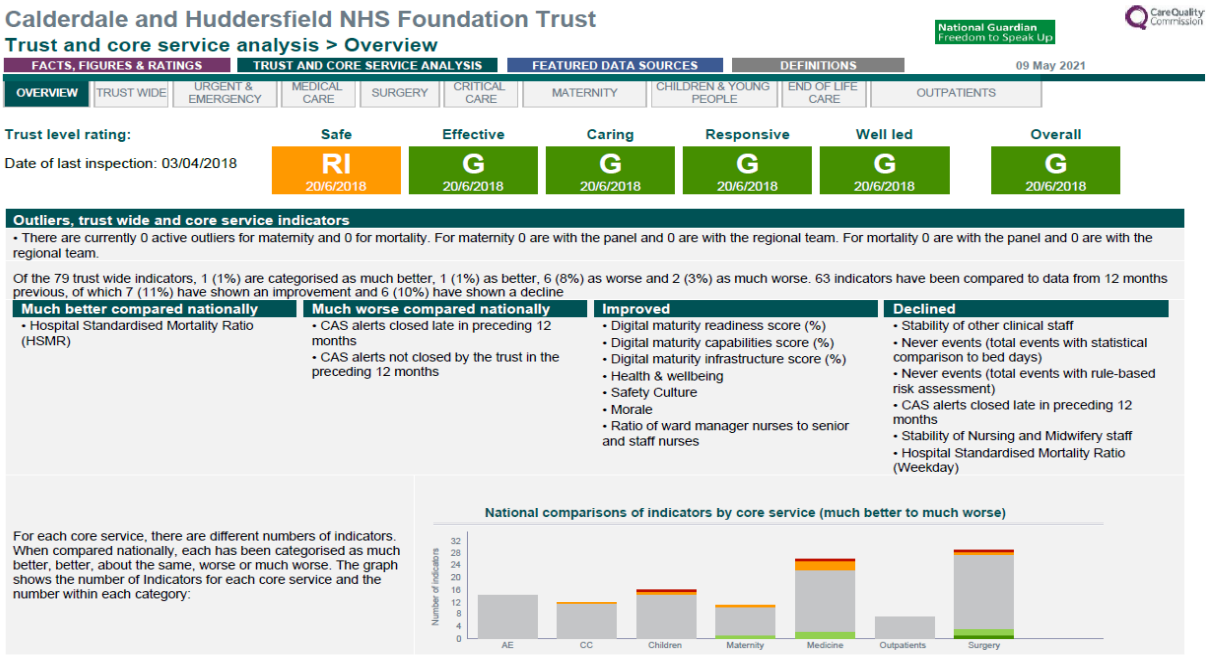


A second pilot review is planned to take place week commencing 14th June 2021 with a planned launch from July 2021.

2.7 CQC Insight Report

The most recent CQC Insight Report was published in May 2021 with the previous report been published in March 2021. The insight report indicators and outliers continue to be monitored via the CQC and Compliance Group.

2.8 CHFT Performance Summary

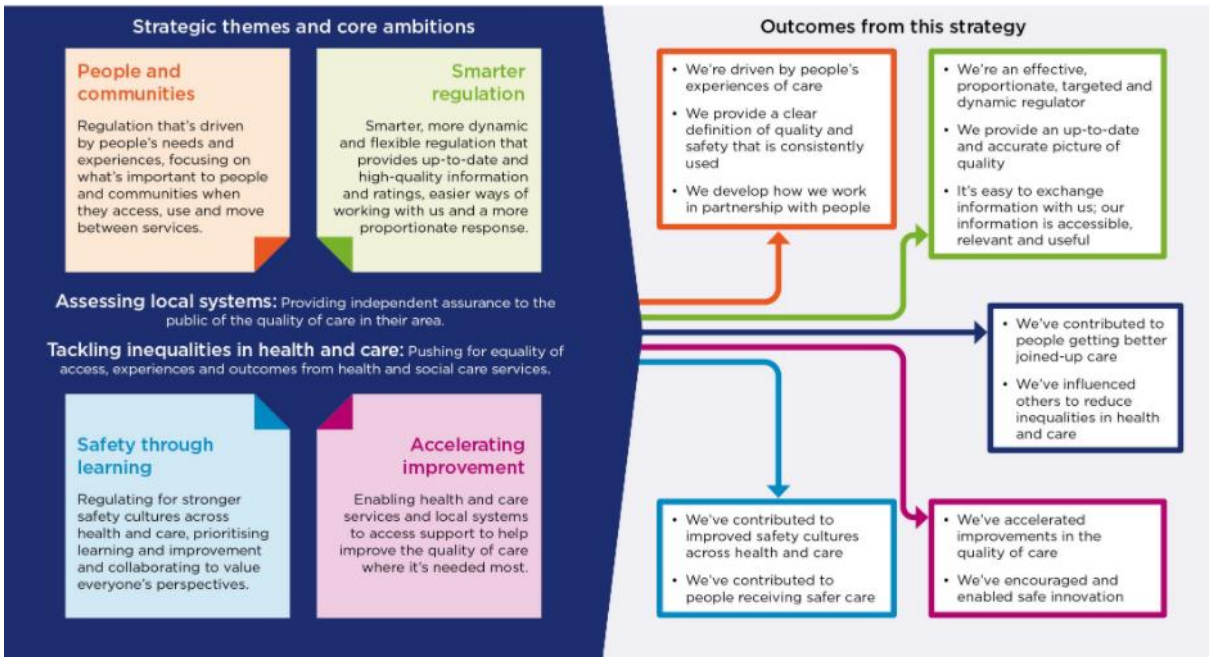


2.9 CQC Strategy

On 27 May 2021 CQC launched their new strategy.

Figure 4 sets out the four main strategic themes and two core ambitions which run through the full strategy as well as the 12 main outcomes.

Figure 4



2.10 CQC priorities for Year 1

The CQCs priorities for year one in launching the strategy are:

- Develop how they monitor risk and test a new assessment framework
- Use Insight from this to drive improvement using their independent voice – supported by the development of a new provider portal and mobile friendly website
- Carry out further research and engagement to develop their collaborative work on safety and improvement
- Explore their approach to assessing how local systems understand the need of people in their area, especially those who face the most barriers in accessing good care and those with the poorest outcomes

Future CQC preparation within the Trust will be guided by the new strategy.

2.11 Central Alerts System Update

Please see table below for the current status and progress of the Central Alert System (CAS) Patient Safety Alerts.

Central Alerts System Patient Safety Alert Update

CAS Alert Title	Current Status	Update	Risk(s) identified	Forthcoming action for the next two months
2020NatPSA/2020/001/NHSPS Ligature and ligature point risk assessment tools and policies	Overdue	30 April 2021: Further task and finish group meeting to take place to finalise the last action of this alert in relation to the Policy, and confirmation needed that a trust wide risk in relation to ligature cutting devices has been written. **June 2021:** Working Group convened for Thursday, 1 July 2021 to close this alert.	• Challenges of securing ligature cutters for the Emergency trolley • Procure the fit for purpose ligature cutters • The inability to respond to an emergency where a ligature needs to be removed.	• Purchase of Ligature cutters • Risk to be placed onto the Trust wide risk register
NatPSA-2020-005-NHSPS Steroid emergency card to support early recognition and treatment of adrenal crisis in adults	Overdue	Three of four actions complete **June 2021:** Received at Trust PSQB in May, with further meeting held on 18 May 2021 to discuss progress with lead.	Although steroid cards are in place to ensure robustness, further exploration of the alert being implemented into EPR is being reviewed.	Task and finish group to be convened (Tuesday, 29 June 2021) to assess the final action relating to changes to the prescribing module on EPR.
NatPSA-2020-006-NHSPS Foreign body aspiration during intubation, advanced airway management or ventilation	Overdue	Two of four actions complete **3 June 2021:** Update received at Trust PSQB, with a request for response in relation to the two outstanding actions on implementation of protocols and review of other equipment used for intubation which includes small loose components. This alert remains open.		Ongoing

NatPSA-2020-008-NHSPS Deterioration due to rapid offload of pleural effusion fluid from chest drains	Overdue	One of two actions now complete. 3 June 2021: Update received at Trust PSQB, with request for paper chest observation chart to be used until electronic form can be uploaded onto EPR. This alert remains open.		Ongoing
NatPSA-2020-002-NHSPS Urgent assessment / treatment following ingestion of 'super strong' magnets	Ongoing	One of four actions complete June 2021: Alert circulated to Trust PSQB, Divisional Directors, Clinical Directors, Directors of Operation, Associate Directors of Nursing, General Managers and Quality Governance Leads for all divisions on 20 May 2021. One action has now been completed by Radiology, with their guidelines updated to reflect the alert.		A Task and Finish Group is convened to include representative from the Emergency Department, General Surgery, Radiology and Paediatrics.

3. Dementia Screening

Reporting Period: May 2021

Subject standard	Update	Risk(s) identified	Forthcoming action for the next two months	Assurance
National Driver Dementia screen Target 90%	Medicine 29.78% Surgery 20.41% FSS 100%	There is a risk that the whiteboard functionality on EPR will not increase compliance.	▪ The band 7 will focus on dementia screening and will work closely with the medical teams to increase compliance. ▪ Development of the whiteboard on EPR ▪ Increased compliance for doctors undertaking Dementia Screening via the EPR	**Limited Assurance**
National Driver - Dementia training Target 95%	Overall compliance for Dementia training across the Trust is 98.10%.	Not applicable	A full review of how person-centred dementia training can take place across the Trust.	**Substantial assurance**
Local Driver - Person centred dementia care training	This training has always been delivered face to face in small groups of up to 10 people. During the COVID pandemic this training stopped and has now been evaluated so the training can now be re-established in small groups socially distanced	Inability to deliver training to staff to enable them to identify dementia patients and deliver high quality care	▪ Training to be arranged for small socially distanced groups	**Limited Assurance**
Local Driver - Delirium and Depression screening Target 90%	This is a new indicator; Data will be presented in the next report	The Trust is unable to screen for Dementia due to the low levels of depression screening	The development of the quality project for delirium Depression, delirium, and dementia to be accessed on EPR.	**Limited Assurance**

4. Patient Experience, Participation and Equalities Programme

Reporting Period: April and May 2021

In response to the pandemic, CHFT stood down the Patient Experience and Caring Group (PECG) meeting to free up clinical staff. This is the first report following the PECG meeting being stood back up.

4.1 Divisional Highlights

In addition to the Trust wide priorities (reported above), various initiatives and improvements, reported to the Patient Experience and Caring Group, have been delivered operating through Divisional teams and Corporate services

Experience:

- Seeking and sharing feedback: Facebook pages for maternity (Better Births) and paediatrics (Feedback Fridays) are used to encourage feedback and showcase the excellent experiences reported by those using the service; An audit of the Gynaecology Clinical Nurse Specialist provided positive patient feedback about the service provided
- Colleagues in the Emergency Department are working with the University of Huddersfield to produce a video about being kind and putting themselves in the patients and relatives' shoes. Will be used to support training
- As part of the restart work attention is being given to the identification of children waiting for surgery who have a learning disability to agree a process for the prioritisation for treatment
- Children's ward linked with University of Huddersfield re improvements for Noise at Night relating specifically to children and young people – an educational package has been developed to share with staff across the units
- The Ascitic Drain service on Ward 17 now running seven days per week delivered by a group of ward staff who have been specially trained, improving access for patients and reducing delays.
- In order to improve a patient's journey through the ED weekly cross specialty, multi-disciplinary meetings held to review breeches and identify efficiencies / opportunities, e.g. Diagnostic colleagues re support with imaging.
- Ward 12 given funding for a 24-hour helpline providing cancer patients direct access to the ward 12 (avoid ED and Acute floor), the ward will be redesigned to accommodate an assessment area for this.
- Acute Floor HRI conducting weekly Datix reviews to review incidents and initiate early actions / communication / learning

Equalities:

- District Nurses changed clinic location of wound clinic for vulnerable patients (including homeless) to enable easier access and increase attendance rate, therefore improving healing
- Equality impact assessments developed re changes within the FFS division as part of the Reconfiguration programme, e.g. Rainbow Child Development services
- Continuity of Carer Maternity team cross site focusing on BAME/areas of deprivation

Participation:

- Direct feedback from young people and families regarding services used to raise the profile of the 'child's voice' to support key improvements presented to WEB and Capital investment Group

Experience, Participation, Equalities – Bi-monthly highlight report April / May 2021

Workstream	Progress this period	RAG	Next Period
Strategy, Policy & Programme	• Completed the 2020/21 strategic priorities and end of year reporting requirements • Agreed restart of the Patient Experience and Caring Group, Divisional briefings re extended scope to enable review of membership		• First meeting of the Patient Experience & Caring Group held, scheduled to meet every 2 months • Presentation of the Experience, Participation and Equalities strategy shared at the meeting – finalise as word document
Equality	• **Ethnic Diversity Index (EDI):** Completed work to map complaints to EDI • **Equality Delivery System (EDS):** Planning underway for the EDS community events • **Impact Assessments:** Collaborative approach to the delivery of an awareness event re EQIA and QIA (PMO / Transformation / WOD / Quality Directorate • **BAME:** Approach to systematically involving our BAME communities approved at Patient Experience & Caring Group; Connection made with CHFT BAME engagement officer		• **Ethnic Diversity Index (EDI):** Undertake further analysis of EDI to test assumptions arising from the T&F project; Conduct further analysis of EDI in relation to maternity complaints • **BAME:** Identification of community groups where active links can be developed on a regular basis
Experience	• **Commitment to carers (unpaid):** As no individual lead identified a proposal approved by PE&CG to deliver this project via a collaborative group with shared responsibility – from services such as dementia, LD, stroke • **Making complaints count:** Agreed as focused quality priority 2021/22; Interim 3 Rs session held as 'stocktake' • **Winter and Covid Volunteering programme:** Mini team recruited to progress the 2 projects; Increasing numbers recruited to Front of House volunteer role; Supporting processes for ward helper (induction and training) formalised		• **Commitment to carers (unpaid):** Establish collaborative group • **Making complaints count:** Report Q1 quality priority; Take forward actions from 3Rs stocktake - closing action plans, process improvements and fine tuning performance reporting • **Winter and Covid Volunteering programme:** The ward volunteer helper role to be tested on SAU
Participation	• **Improving the experience of patients with visual impairment:** Established a joint project with Disability Partnership Calderdale, Halifax Society for the Blind and Kirklees Visual Impairment Network; Engaged with service users		• **Improving the experience of patients with visual impairment:** Project group to review the feedback and agree priority for first QI activity

Experience, Participation, Equalities – Highlight Report April / May 2021

Workstream	Progress this period	RAG	Next Period
Participation	**Observe and Act (O&A):** National programme adopted as patient experience framework for CHFT; Embracing digital technology with the engagement of a virtual observer's team; CHFT trainer delivered further training to expand non clinical team of observers to support the ongoing delivery of the programme. **Engagement opportunities:** Making connections with Calderdale CCG Engagement Co-ordinator and Involving People Network		**Observe and Act:** • Further engagement with NHSEI and the national team to contribute towards further development of the O&A framework in response to pilot work in 2 Trusts; Ensure O&A framework is integrated as the patient experience module of the Journey to Outstanding ward assurance toolkit; Utilise the feedback from patient experience and estates issues to contribute to the CHFT reconfiguration agenda; Non-Exec Director lead for Quality has opportunity to share learning with NHS Providers
Enhancing our business better than usual and continuous quality improvement	• **Friends and Family Test:** The re-start of FFT remains challenging in some services – in particular maternity and community response rates remain very low • **Chaplaincy:** Review of service commenced against the NHS Chaplaincy guidelines 2015. • **Every story matters:** Developed a process for receiving 'stories' in the organisation– consent form, information sheet and process map – approved by Patient Experience & Caring Group • **Learning lessons to improve patient experience:** A process for populating 'Impact Narratives / Stories' using various sources of insight (e.g. FFT / Complaints / Incidents) – approved by Patient Experience & Caring Group		• **Friends and Family Test:** Standardised reporting format for Divisional PSQBs to be finalised; Agree performance targets for each service • **Chaplaincy:** Progress the position papers for CHFT chaplaincy services to support further service developments and quality improvement initiatives; Seek approval for Band 7 Lead Chaplain. • **Every story matters:** Every story matters T&F group to kick start the process and establish future panel meetings • **Learning lessons to improve patient experience:** A task and finish group to be established to firmly establish the process & required ways of working

Assurance RAG rating : Substantial , Reasonable , Limited, Full Assurance

Risk/ Issue	Risk Owner	Action	Progress
Due to work on COVID-19 and limited delivery capacity in divisions . Activity & project work has been prioritised. This situation will persist during the reset and recovery phase	Rachel White	The programme plans are under further review / prioritisation by the Patient Experience & Caring Group	A revised programme plan is in progress. But further adjustments can be expected

5. Patient Advice and Complaints Service (PACS)

Reporting Period: April and May 2021

CHFT views any complaint as an extension of our service user's care and the Trust is committed to moving towards a user centric service. Effective processes and procedures for handling concerns, feedback, stories, compliments, and complaints is pivotal to organisational learning success.

5.1 Key Objectives

The Patient Advice and Complaint team's main objectives are:

Objective	Current level of assurance	Comments
1. Working with the divisions effectively to deliver strong complaints performance and user centric service	**LIMITED Assurance**	Progress but with some potentially significant concerns regarding delays in completing actions
2. Making Complaints Count & Working Together to Get Results: Delivering on collaborative action plan/ quality priority	**REASONABLE Assurance**	Good progress.

5.2 Progress against key objectives

Performance

Complaints and Patient Advice and Liaison Service (PALS) Performance Summary

	April	May
Complaints received	30	27
Complaints closed	19	19
Complaints closed outside of target timeframe	0	2
% of complaints closed within target timeframe	100%	89.5%
Complaints reopened *1	4	1
*1 Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix		
PALS contacts received	182	206
Compliments received	37	46
PHSO complaints received	4	2
PHSO complaints closed	1	1
Complaints under investigation with PHSO	12	13

Response performance improved to 95% (aggregated across April and May) as the divisional and corporate teams worked with patients and families to agree response timescales and provide detailed progress updates. The corresponding figure for February and March was 55%.

There has been an approximate 10% increase in the number of complaints received during the April to May period. There is currently no agreed metric to establish the complexity of complaints (the number of issues as opposed to, for example, the seriousness of the allegations). However, there are anecdotal concerns from both the divisional and corporate teams regarding the increasing complexity of complaints being received.

More complaints were opened (57) than closed (38) during the period. This has confirmed the following:

- an emphasis on seeking to ensure the information gathered during the complaint investigation is robust and communicated effectively
- and the need to undertake essential quality improvement work with a particular focus on process improvements.

There has been a notable increase in PALS contacts between the two-month period but remains at a similar level to the previous two months.

There has been a 20% reduction in the number of overdue actions (300) compared to the February to March 2021 reporting period (378). While this is positive, work is ongoing within the divisions to address the backlog in actions as quickly as possible.

5.3 Making Complaints Count Collaborative

Further meetings of the Making Complaints Count (MCC) steering and operational groups have taken place. Work has been focussed on process improvements.

Please refer to the quality priority report (page 55) for further detail of progress against the prioritised Parliamentary and Health Service Ombudsman (PHSO) standards and regulations

6. Legal Services

This report covers the period 1 April 2021 – 31 May 2021

Calderdale and Huddersfield NHS Foundation Trust ("the Trust") is committed to:

1. Promoting the highest possible standards of care for patients in an environment that is safe and effective for staff & visitors.
2. Dealing with claims that arise in a competent and consistent manner, in a culture of openness between the parties to facilitate early resolution, and thereby minimise the financial loss to the Trust/ NHS Resolution (NHS R).
3. Using learning arising from claims and inquest investigations to promote improvements to the quality of care provided to patients. Service Performance / Activity Data

Exception reporting	Forward Plan
▪ Recruitment for Head of Legal Services in process. ▪ Interim Head of Services is currently in post.	▪ Over the next two months the team will be focussed on the development of an annual plan to lend further structure / support to the team.
Clinical Negligence	**Employers' and Public Liability (EL/PL) Claims**
▪ 173 active clinical negligence claims ▪ 15 new clinical negligence claims were received. ▪ 12 clinical negligence claims were concluded. ▪ Damages totalled £785,048	▪ 25 active EL/PL claims ▪ 2 EL/PL claims were received ▪ 2 EL/PL claims were concluded ▪ Damages totalled £0
Lost Property	**Inquests**
▪ 16 active lost property claims ▪ 11 lost property claims were received ▪ 16 lost property claims were concluded £5,353,70 paid in respect of lost property claims	▪ 147 active inquests ▪ 13 inquests were opened ▪ • 5 inquest files were closed

Organisational learning
Initial plans are in place to include a legal component in the planned Clinical Directors (CD) on boarding training sessions. A 'Go See' opportunity arising from the getting it right first time (GIRFT) programme is presenting further learning opportunities for the Trust which will be explored further in the next period. The Quality report will contain further details relating to service developments and forward plans

7. Incidents

Below is a summary of patient safety incidents and incidents with severe harm or death, for the year April 2020 to May 2021, and number of serious incidents (SIs) reported by month.

Following review, the number of incidents resulting in severe harm or death during the period reported has been amended to reflect the current position, post investigation.

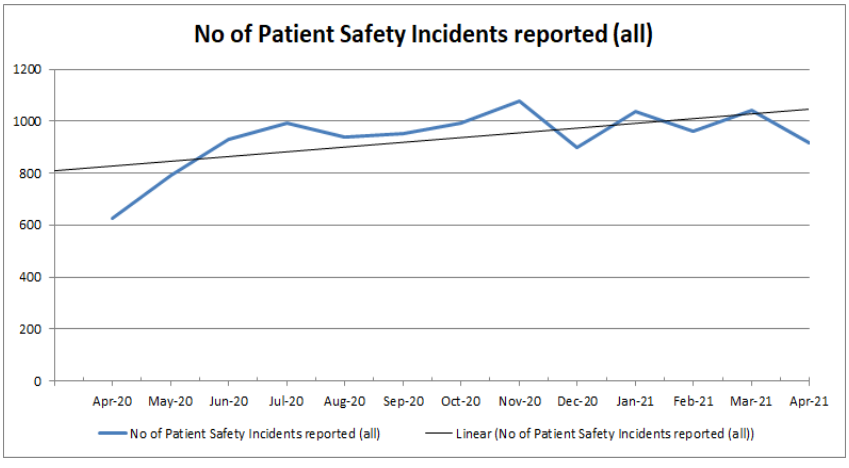
Month reported	Number of Patient Safety Incidents reported (all)	Number of Patient Safety Incidents of severe harm or death	Serious Incidents by the month externally reported on StEIS
April 2020	625	2	1
May 2020	790	3	1
June 2020	931	6	9
July 2020	994	2	2
Aug 2020	937	2	2
Sept 2020	954	5	4
Oct 2020	992	6	2
Nov 2020	1079	25	1
Dec 2020	900	13	3
Jan 2021	1037	32	5
Feb 2021	961	16	2
Mar 2021	1042	6	2
April 2021	918	6	4
May 2021	1006	6	2

7.1 Never Events

A delayed never event was reported and is currently under investigation which related to a retained foreign object post procedure. Actions have been put in place following review of the incident.

7.2 Summary of Progress with Serious Incident Actions

- Work continues across divisions to manage outstanding actions, to include the development of a robust process to ensure all action owners are aware of their actions and that they are responded to in a timely manner. There has been a significant reduction in the numbers of open actions which are overdue by six months.
- A new Patient Safety Incident Framework is being introduced into the NHS from the Summer of 2021 and this will have an impact on the Trust's current serious incident policy and processes. A gap analysis will be undertaken and reported to a later Quality Committee meeting.
- A total of six StEIS (Strategic Executive Information System) incidents were reported; four for April and two in May, of which three were diagnostic related incidents.



7.3 Learning from Safety Incidents

Serious incident reports submitted to the Clinical Commissioning Group (CCG) in April 2021 and May 2021 are as follows:

Incident Summary	Learning Need and Organisational Learning
Patient death and delayed diagnosis of HIV	Two key points of organisational learning emerged: • The importance of adhering to data protection principles and practices. In particular, individual logins should be kept confidential and not shared amongst staff. The Trust has ongoing work to raise the importance of data protection e.g. learning page on the intranet and screensaver on computers • The importance of listening and responding well to patients concerns. The Trust has set out its commitment to putting the patient first and working together to get desired results. This includes the need to work together with our patients and families to achieve a collective desired outcome.
Loss of consciousness following a fall.	Three key points of organisational learning emerged: 1. The importance of keeping the estate maintained to secure the health and safety of people under our care. In particular the need for regular checks of bed rails prior to use. 2. The importance of adhering to the current fall assessment process and procedures that are designed to keep our staff and learners safe. This includes: • Adhering to appropriate measures in relation to delegated authority. • Accurate falls risk assessments at the point of admission and transfer to another ward. 3. The importance of regular post fall observations in line with the appropriate support tools to aid clinical decision making e.g. Glasgow Coma Score
Re admission via Emergency Department following recent discharge from the Trust	One key point of organisational learning emerged: 1. The importance of the Trust fostering colleague to colleagues learning from their incident learning experiences. This learning needs to be delivered in a way that informs improved clinical practice in others and deliberately develops an additional layer of clinical curiosity that ensures all diagnostic options are explored.

Communication crossover in relation to medication therapy following admission to hospital with sepsis.	One key point of organisational learning emerged: 1. The importance of caring for and supervisory check-ins with our clinical colleagues especially during time of organisational pressure and in the early few weeks for our new clinicians. In addition, our clinical colleagues need to be encouraged to ask for support if they are feeling under pressure and feel their safe practice is at risk of compromise.

8. Medicines Safety

The Medication Safety and Compliance group (MSCG) continues to raise awareness of the importance of safe storage, prescribing and administration of medication.

The priority MSCG work streams are:

- Development of an electronic recording solution for controlled drugs (CD) registers to improve our CD documentation and compliance with legislative requirements
- Phase one of installation of electronic medication storage cabinets. This first phase is for installing the required cabinets in our Emergency Departments to ensure we have robust storage facilities, reduce risk of medication error selection, medication diversion and free up nursing time to care
- Go live for active temperature monitoring for medication stored in fridges and then expansion of system to include ambient temperature monitoring
- Review of Internal Audit's recent Portable Medicines Trolley audit (CH/22/2021) results and add action plan to be included in MSCG agenda for monitoring / assurance of completion of required actions. Final version of audit to be reviewed at next MSCG meeting

Main concerns / escalations:

- Training requirements of ward staff for use of electronic CD registers and Active temperature systems. Both systems due to go live in the next two months and will require release of ward staff to complete training.

Support / decision required

- There is no clear process established for any future staff annual exposure occupational testing for Entonox and Nitrous Oxide exposure. Recommend that this is monitored by the Health and Safety Group and led by Occupational Health who can then update staff records accordingly rather than the Medication Safety and Compliance Group.

Subject standard	Update	Risk(s) identified	Forthcoming action for the next two months	Assurance
Non-compliance of the medicines management 'must do's Ongoing objective requiring continual monitoring	Bi-annual pharmacy audits continues which highlights both areas of good practice and areas for improvement. Medicines Management nurse working closely with Trust Web designer to produce an electronic annual medicines management audit tool for ward managers to complete. Trials of audit tool currently being completed in three areas.	Audits only give a snap shot of routine practice **Mitigation** Ad hoc spot checks to be undertaken by pharmacy team and senior nurses to ensure required standards are consistently met	Trial of electronic audit system and feedback from users Any issues identified to be highlighted to web team Roll out to all ward managers to complete annual audit electronically by October 2021	**REASONABLE ASSURANCE**
Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100% compliant. Repeated audits continue to show poor compliance. Go live for Active temperature monitoring system set for completion by 31st August 2021	Temperature assets placed in clinical areas for monitoring ambient temperatures to identify any potential areas of non-compliance before system go live. Standard Operating Procedure for how to access and update active temp system shared with Digital Operations board and Nursing and Midwifery Committee for approval	Staff have turned off current' traditional' fridge thermometer alarms which can results in no audible alarm when fridge door left open Once live with ambient temperature monitoring there is a financial risk for any areas' temperature that is consistently above 25 degrees Celsius as they may need air conditioning installing and increased cost further to destruction of medication Staff may tamper with new temperature devices	Training of ward and pharmacy staff on the Stanley Active temperature monitoring system	**REASONABLE ASSURANCE**

		Mitigation Pharmacy audits continue to check 'traditional' fridge monitor alarm correctly switched on and daily monitoring of temperatures is recorded		
To improve medical gas training to ensure compliant with HTM requirements	New oxygen group as a subgroup of medical gas group. Remit is to review medical gas and oxygen training and ensure both cylinder device training and clinical oxygen therapy training compliance is clearly available to divisions	Not all clinical staff may be up to date with training **Mitigation** Completion of Datix reports when any incidents relating to medical gases including poor practice occur	Current training to be reviewed and updated. Date for completion tbc by oxygen group	**LIMITED ASSURANCE**
Requirements for areas administering Entonox and nitrous oxide to complete annual occupational exposure checks	Site visits completed by Peritus. Compliance report produced for HRI. Awaiting CRH report. HRI report showed no major concerns.	Not all staff using gas were tested (just a sample) and exposure levels were dependent on amount of Nitrous oxide/ Entonox being used during the clinical session. The test may have been completed on a day of 'light' exposure/ low gas use **Mitigation** Good ventilation in Nitrous Oxide / Entonox areas Repeat testing in 12 months	Review of CRH audit results. This includes labour ward, a high use area.	**REASONABLE ASSURANCE**

9. Maternity

9.1 Ockenden Report

Maternity services have been advised that evidence is to be submitted against the seven Immediate and Essential Actions of the Ockenden Report by end June 2021. The team are currently collating the evidence and will meet the submission deadline.

The first Perinatal Quality Surveillance Meeting was held on the 25th May 2021 with attendance from CHFT maternity safety champions Clinical Commissioning Groups (CCGs) and Local Maternity System (LMS) colleagues. The meeting was productive with suggestions for areas to be added to the agenda for subsequent meetings.

The meeting gives assurances that CHFT maternity services are able to provide assurance to the Board, Commissioners and Local Maternity System and that there are systems and processes in place to monitor performance and outcomes in maternity services to ensure the highest standard of safety and care is maintained.

On the 6th May 2021 maternity services submitted a bid for funding from the additional £95.6 million NHSEI made available to support sustained improvement in maternity services. The submission criteria were closely aligned to midwifery staffing and the requirement for a current Birth Rate Plus (maternity staffing tool) report. NHSEI have requested additional information from all providers to support the funding submission requests with a deadline extended to the 7th June 2021.

In response to the requirement for the **Enhanced Safety** action work has commenced with the LMS in a Trust response to the requirement that "*All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB "*

The purpose of this is to enable the LMS to have oversight, and peer review of, local investigations into Serious Incidents in West Yorkshire and Harrogate region.

9.2 Better Births

On the 25th March 2021, NHS England / Improvement, the Maternity and Neonatal transformation priorities was released with a commitment to women receiving Continuity of Carer. There is a recognition of the potential barriers which includes inadequate staffing and ensuring that the model is based on a team approach with a named Obstetrician attached. Within the document there are nine objectives, but particularly relating to Continuity of Care are the following:

CHFT to put in place the building blocks by March 2022 so that **Continuity of Carer** is the default model of care offered to all women by March 2023, specifically to:

a) Undertake a Birth-rate Plus assessment to understand the current midwifery workforce required and follow this through with recruitment.

b) Co-design a plan by July 2021 with local midwives, obstetricians, and service users for implementation of continuity of carer teams in compliance with national principles and standards and phased alongside the fulfilment of required staffing levels. This plan should also take into account the need for maternity staff to be supported to recover from the challenges of the pandemic.

c) Prioritise those most likely to experience poorer outcomes first, including ensuring most women from Black, Asian and mixed ethnicity backgrounds and also from the most deprived areas are placed by on a continuity of carer pathway by March 2022.

d) Develop an enhanced model of continuity of carer which provides for extra midwifery time for women from the most deprived areas for implementation from April 2022.
Maternity is on track to complete the first deadline (b). Workforce planning is currently being undertaken

9.3 Perinatal Mortality Review Tool (PMRT) / NHS Resolution Early Notification Scheme (ENS)

The PMRT tool was established nationally in 2012 to ensure that there should be a comprehensive and robust review of all perinatal deaths from 22+0 days gestation until 28 days after birth*; excluding termination of pregnancy and those with a birth weight <500g (but organisations should aspire to include these also). The reviews are conducted using a standardised nationally accepted web-based tool that includes a system for grading quality of care linked to outcomes. A multidisciplinary group review each case and input from families is encouraged.

9.4 Stillbirth / Late Fetal Loss

Three stillbirths occurred in May 2021.

All three cases were antenatal intrauterine deaths. Two of the cases have been reviewed at Divisional Orange Panel and no areas of concern have been identified with either case.

The third case has been reviewed at FSS Divisional Orange Panel and will be shared with colleagues in the Medical Division for their review and investigation.

9.5 Neonatal Deaths

No neonatal deaths have been reported

9.6 Healthcare Safety Investigation Branch (HSIB)

As of 30th May 2021, CHFT had 11 completed cases, two cases have been rejected by HSIB as they did not meet the COVID-19 criteria for HSIB investigation. There are currently six open cases at varying stages of investigation. The most recent referral was an incident from the 30th April 2021 in which a baby received therapeutic cooling. The learning identified from these cases can be summarised under the following themes.

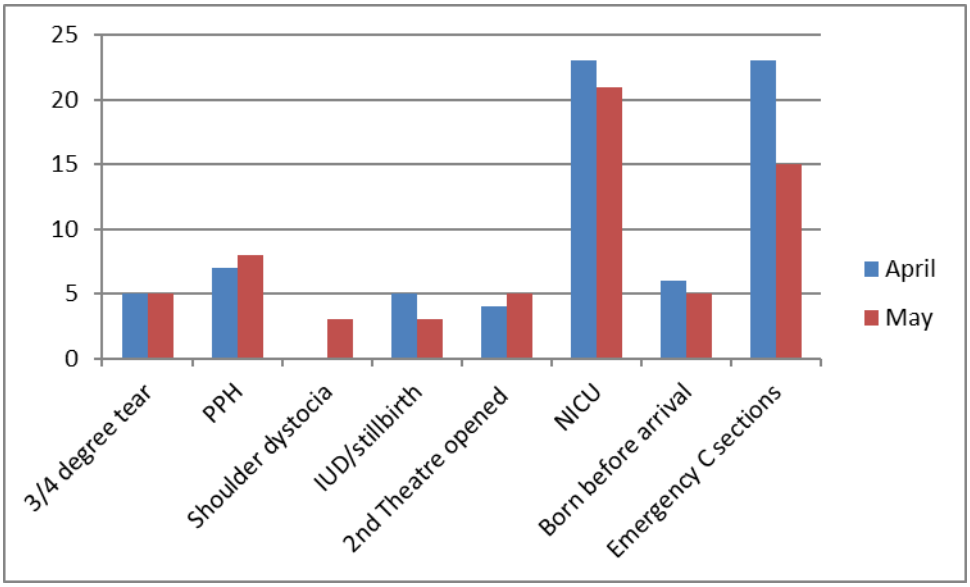
- Failure to recognise and follow guidelines regarding smaller/larger than expected foetus
- Midwives not taking advantage of the 'fresh eyes' review
- Failure to recognise high risk pregnancies e.g., mother that present who are smokers, obese and taking the appropriate action
- Missed opportunities for the assessment of better pain relief when woman in labour

9.7 Maternity Incentive Scheme

In March 2021 NHS resolution revised the 10 safety actions and extended the submission date to the 15th July 2021 in view of the ongoing COVID-19 pandemic. CHFT maternity service continues to work towards full compliance with all 10 safety actions.

9.8 Maternity Incidents

Maternity incidents are reviewed at weekly maternity governance multi-disciplinary team (MDT) meeting. All incidents are reported via Datix and coded as maternity incidents.



9.9 Maternity Complaints

Maternity services currently have three open complaints under investigation and within timescale.

9.10 Maternity Staffing

In 2015, NICE produced its guidance on safe midwifery staffing and the provision of 1:1 care is a recognised recommendation within the guidance and as such is reported on the maternity services dashboard.

	December 2020	January 2021	February 2021	March 2021	April 2021	YTD 2021- 2022
1:1 Care in labour	100%	100%	99.7%	99.7%	98.9%	98.9%

Unfortunately, this metric is not recorded on the regional dashboard, so it is not possible to benchmark CHFT against other services.

Midwifery has 13 whole time equivalent (WTE) vacancies with plans in place to recruit to these positions via the central recruitment of newly qualified midwives in place across the Local Maternity System (LMS). Interviews are currently being undertaken.

Obstetric staffing is more challenging with gaps in the middle grade rota as a result of deanery gaps in the obstetric training rota. This has been mitigated by the recruitment of trust grade doctors and is reflected on the Directorate risk register.

9.11 User feedback

Following the 12th April 2021 mandate from the Secretary of State for Health, for the full introduction of support for pregnant women accessing maternity services visiting for one hour per day, has been reintroduced to the antenatal / postnatal ward areas, along with a birth partner supporting women attending all antenatal and ultrasound clinic appointments on CHFT premises.

With the introduction of freely available lateral flow tests, we do advise women and their partners to take up the offer of twice weekly lateral flow tests cognisant of the fact that this cohort of adults has not yet become eligible for the national covid vaccination programme. However, if women and their partners elect not to lateral flow test, then their access to maternity services is not restricted.

Maternity services have sadly been made aware that the successful recruit to the chair of the Maternity Voices Partnership has reconsidered their position and will not be taking up the post. However, we continue to meet regularly with the current chair who is a member of the maternity services health inequalities workstream.

Quality Priority updates

Set out below is the first report in relation to the Quality Account Priorities for 2021/2022. The report details each priority and the measures to be monitored and reported into the Quality Committee this coming year.

Quality Account Priorities

CQC Domain: Effectiveness	CQC Domain: Safety	CQC Domain: Experience
Recognition and timely treatment of Sepsis	**Reduce the number of Hospital Acquired Infections including COVID-19**	**Reduce waiting times for individuals in the Emergency Department (ED)**

Focussed Quality Priorities

CQC Domain: Caring	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Responsive	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Effective
Reducing the number of Falls resulting in harm	**End of Life Care**	**Increase the quality of clinical documentation across CHFT**	**Clinical Prioritisation (Deferred care pathways)**	**Nutrition and Hydration for in-patient adult and paediatric patients**	**Reduction in the number of CHFT acquired pressure ulcers**	**Making complaints count: Implementation of the national regulations & PHSO standards (phased introduction)**

10. Recognition and timely treatment of Sepsis

We will this year undertake quality improvements to:

- Improve the recognition and timely treatment of Sepsis

What do we aim to achieve?	Update – June 2021	Progress rating
QP1. Increase our concordance with the administration of intravenous antibiotics in the emergency depts. within 60 minutes of recognition of sepsis to 80% for the severely septic patient. This will be measured by using the Red Flag Criteria for severe sepsis recognition. Concordance is captured by the timing from the earliest suspected sepsis alert to the administration of the first intravenous antibiotic through the electronic patient record system.	**April 21- 81.7%** **May 21- 76.7%** The above percentages are based on all patients with suspected sepsis in the Emergency Department (ED) at both sites. We are soon to report the Red Flag Sepsis data following meeting with Informatics and specific criteria being set. **Update** • (ED) consultant monitoring non-compliant patients and feeding back issues at the ED handovers for learning and action. Compliance from this clinical audit indicates ED performance at 85-90% • Consultant also updating ED specific sepsis training presentation for clinicians. • Sepsis Nurse requested to attend ED Quality Improvement (QI) Forum. • Sepsis trollies purchased and in use at both sites. • Macoset device being trialled in HRI ED to assist speed in mixing Pip Tazocin. • Sepsis nurse training the ED health care assistants about NEWS 2/sepsis. • ED clinical educator addressing sepsis on Registered Nurse (RN) induction. **Risks identified** • Flow issues through the EDs have been noted to effect administering of intra venous antibiotics within 60 minutes. • Consistent use of sepsis trollies within Department remains an issue. • Macoset device supply delay for onward trial. **Actions** • ED consultant to monitor that suspected sepsis patients are categorised as level 2 and seen in rapid assessment where appropriate. • ED Consultant to report results of noncompliant patients in ED monthly plus feedback issues to ED clinicians. • Sepsis Nurse to oversee and support consistent use of sepsis trollies. • Sepsis Nurse to follow up request for further Macoset devices so audit of usage versus Pip Tazocin doses can commence.	**Reasonable Assurance**

What do we aim to achieve?	Update – June 2021	Progress rating
QP2. Compliance of all elements of the sepsis 6 (BUFALO) to be improved to 50%		
	April 2021 **May 2021**	**Reasonable**
Blood cultures	78.7%. 81.7%	**Reasonable**
Urine output	66.7% 60.9%	**Limited**
Fluids	97.2% 95.5%	**Substantial**
Antibiotics	99.1% 97.4%	**Substantial**
Lactate	Unable to add Lactate to EPR	**N/A**
Oxygen	64.8% 63.5%	**Limited**
Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.	**Update** Oxygen data now being reported on compliance if received oxygen or the patient's oxygen saturation is between the target of 92-98% or 88-92% (risk of hypercapnic respiratory failure). No significant improvement noted, agreed to wait for next month's data results and audit 20 non-compliant patients to check if any issues/learning points within the data pull from the electronic patient record (EPR). Sepsis care bundle addressed on training and through communication channels (Trust News, Sepsis Press, Sepsis Teams Channel, Training, poster drops, ward meetings). No date available for Lactate adding to EPR. Sepsis nurse working to improve recording of blood cultures as compliance variable- focussing on the front-end areas. **Risks identified** • Blood cultures not consistently recorded on EPR. • Urine output pulling through to Nerve centre. • Oxygen compliance (with new measures) has not improved as expected. • Awaiting Lactate to be added to EPR.	

What do we aim to achieve?	Update – June 2021	Progress rating
	Actions • The operational lead to contact Chief Clinical Information Officer regarding Arterial Blood Gases and Venous Blood Gases being pulled through to EPR. • Sepsis nurse auditing 20 non-compliant patients for oxygen to pull out any issues. • Sepsis Nurse to continue working with front end areas regarding improving the recording of blood cultures on EPR. • Urine output being addressed by separate working group.	
QP3. Establish sepsis skills training as part of essential safety training and achieve 40% concordance for eligible staff in year 1. This will be measured by training compliance records extracted from ESR and Lead Sepsis Nurse presentations.	**Update** Training application form for ESR and combined sepsis presentation for clinicians/registered nurses approved by Sepsis Collaborative Members. 250 RN have received sepsis training, there are currently 9 clinician sepsis champions and 45 RN champions. Sepsis nurse meeting with Divisional Matrons to deliver sepsis updates. Junior doctor induction- EPR sepsis power plan is in the handbook with video link to training presentation. EPR team asked to raise the importance of viewing the slides during the Induction programme. Business intelligence have now provided the training numbers: • Consultants (except Obstetrics and Gynaecology) 250 • Foundation years (except Obstetrics and Gynaecology) 82 • Core Trainees (except Obstetrics and Gynaecology) 31 • Specialist Trainees (except Obstetrics and Gynaecology) 69 • Physician Associate 21 • Trust Grade Doctor – Foundation Level – 10 • Trust Grade Doctor – Specialty Registrar - 48 • Clinician Total **511** • Registered Nursing Total 765	**Limited Assurance**

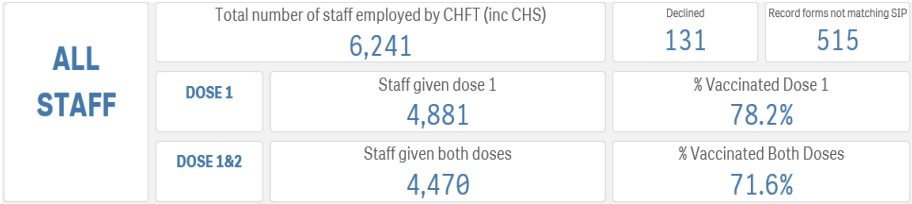
What do we aim to achieve?	Update – June 2021	Progress rating
	Risks identified • Sepsis recognition and treatment not currently part of essential safety training. **Action** • PM to submit training application form with Presentation to Executive board and Nursing Midwifery Committee for approval. • PM to continue delivering face to face and Teams sepsis training.	

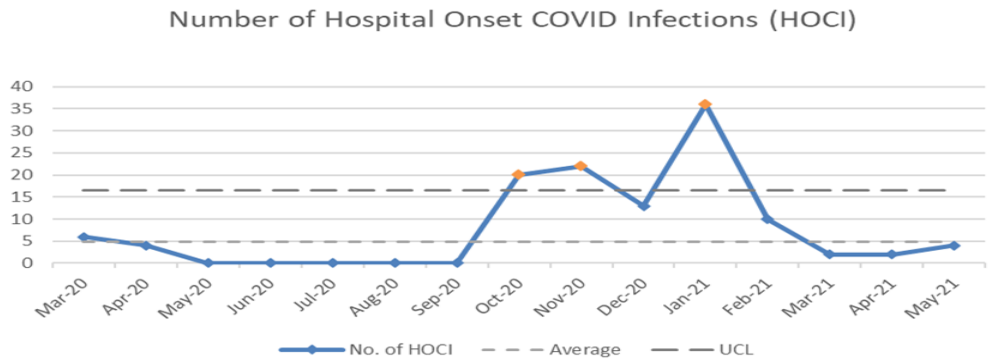
11. Reduce number of Hospital Acquired Infections including COVID-19

We will this year undertake quality improvements to:

- Reduce the number of Hospital Acquired Infections including COVID-19

What do we aim to achieve?	Update	Progress rating
QP1. Through the testing workstream we will ensure that all CHFT patient and colleague testing strategies are compliant with National and Local guidance. This will be measured by performance against patient testing regimes and colleague lateral flow device (LFD) testing.	CHFT are compliant with the minimal national patient testing regime and also include based on review of testing additional tests are undertaken as part of our local guidance Lateral Flow Device (LFD) testing is in place as per national guidance We have seen a decrease in reported testing and through leadership briefing and the MUST Do we encourage colleagues to undertake LFD testing	**Substantial assurance**
QP2. Support a system wide approach to Covid-19 vaccination programme through CHFT vaccine centres and support to the national programme	Using the Joint Committee on Vaccination and Immunisation (JCVI), prioritisation criteria vaccines were offered to all Health and Social care workers, Clinically Extremely Vulnerable staff, and patients including patient's carers across CHFT, Calderdale & Kirklees. CHFT delivered vaccines to our own staff (including CHS, ISS and HPS) plus staff from partner organisations including Locala, Local Care Direct, Mental Health Trust, three Local Hospices, two Private Hospitals and numerous voluntary organisations including local Mountain Rescue Teams, Mental Health/Well Being Charities and Food Banks	**Substantial assurance**
2a Establish specialised vaccine clinics for people with Learning Disabilities (LD)	Specialised clinics have been established to support people with a learning disability to receive their vaccines. First clinic took place on 13th March with a 83% The second clinic on 15th May with a 100% success rate.	**Substantial assurance**

What do we aim to achieve?	Update	Progress rating
2b Establish clinics for people with allergies	Specialised clinics for patients with multiple allergies and/or previous anaphylaxis were undertaken, again outside of the routine clinics, supported by a Consultant Anaesthetist, senior nursing, and administration staff. A total of 17 allergy patients have been through the clinics. The final allergy clinic session is planned for 28 June 2021 for the administration of second doses. All future allergy referrals for the whole of West Yorkshire where there is the need to administer the vaccine in an acute setting will be managed at Airedale Hospital.	**Substantial assurance**
2c Through our community teams support the vaccine programme across Calderdale	The community healthcare division has proactively supported the vaccination programmes across Calderdale place	**Substantial assurance**
2d Through our partnerships support the vaccine programme across Kirklees	CHFT have remained an active partner on the Executive Partnership meeting for Kirklees and have contributed both in leadership activities and resource support to the programme	**Substantial assurance**
This will be measured as a narrative against the indicators and numbers of people vaccinated where data is available.		**Substantial assurance**

What do we aim to achieve?	Update	Progress rating
QP3. Reduce the number of preventable Clostridium Difficile infections This will be measured by ensuring we do not exceed the threshold of 40 cases set in 20/21 (awaiting national guidance 21/22 target)	A 'deep dive' of the 49 C-diff cases from 2020/2021 was undertaken in May 2021; key learning was identified, and an action plan has been developed which is being led by the Infection Control Doctor/Consultant Microbiologist. Awaiting National healthcare associated infections (HCAI) objectives. Q1 performance is showing an improved position	**Substantial assurance**
QP4. Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection (HOCI) This will be measured by the rate of HOCI each month.	COVID patient pathways are in place to minimise the risk. Any HOCIs identified are reported immediately and a rapid RCA completed. HOCIs are currently reported weekly to Infection Prevention and Control (IPC) Gold and monthly to IPC Performance Board. Every action counts tools are being used to support alongside the updated IPC guidance There is currently one outbreak open in which there are three HOCI cases. Lessons learnt from HOCI are shared to support organisational learning. The IPC Board Assurance Framework (BAF) is reviewed within the governance structures. 	Substantial assurance

12. Reduce waiting times for individuals in the Emergency Department

We will this year undertake quality improvements to:

- Reduce waiting times for individuals attending the Emergency Department

What do we aim to achieve?	Current update	Progress rating
QP1. Implement and monitor effectiveness of the standard operating procedure to prevent any 12-hour breaches within the ED department This will be measured by: • Number of (NHSE/I) reportable 12-hour breaches	Presented to DQB in June that new reporting mechanism (on discharge) implemented April 2021 ensures that all length of stay (LOS) in the ED are captured and reported accurately	**Reasonable Assurance**
• Internal standard: Number of patients who waited >12 hour within the department from time of arrival	Zero tolerance as reportable. There were two patients over 12-hour breaches last month discharged home non-reportable.	**Limited assurance**
• Training delivered for on call teams to support implementation of the SOP	Surge and escalation document in use ensuring wide communication between all on call elements and tactical leads	**Limited assurance**
QP2. To align reporting systems with Cerner and the DATIX incident reporting system. This will be measured by • Establishment of >12hr DTA breach report from Cerner that matches incident reporting	New datix format for 12-hour LOS implemented by risk	**Substantial assurance**
QP3. Improved documentation of Intentional care rounds to ensure patients are receiving effective pressure area care, nutrition and hydration. This will be measured through: • No of colleagues who undertake training for intentional care rounds	Documentation audit in place to provide assurance to lead nurses that standards are met. Requires further monitoring to establish success	**Reasonable Assurance**
• Monthly audit of patient cases to review compliance with clinical documentation	Care is reviewed via datix	**Reasonable Assurance**

Focused Quality Priority updates

Set out below is the first report in relation to the Trust Focussed Priorities for 2021/22. The report details each priority and the measures to be monitored and reported into the Quality committee this coming year.

13. Reducing the number of falls resulting in harm

We will this year undertake quality improvements to:

- Reduce the number of inpatient falls and those resulting in harm by 10%, by the end of 2021 / 2022

What do we aim to achieve?	Current update	Progress rating	Next steps
Reduce the total number of falls. Reduce number of harm falls by 10%	Number of harm falls plateaued to two harm falls each month for last three months. Total Number of falls on downward trajectory since January. Have reduced harm falls by four since 2019 – 2020 from 22 - 18. However, this may not be a true picture due to COVID-19 pandemic. Number of total falls has gradually increased since 2020 as outlined in graphs below.	**Reasonable assurance**	
Slip trip policy to include measurable falls assessment risk target	Slips, trips, and falls policy updated to include time frame for falls assessment on admission and transfer for patients over age 65 to new ward to be completed within two hours. Post falls review algorithm completed, being reviewed in falls collaborative on 27/5/21 then will be updated in policy accordingly.	**Reasonable assurance**	Falls policy to be updated to include algorithm
Implement audits to check progress against targets	Lying and standing blood pressure taken on admission on ward 6 – plan to roll out to other wards in June/July. Currently ward 6 are at approximately 46% compliance. Lying and standing blood pressure target straightforward to audit, support is needed to audit medication review and mobility review (as need to go through patient notes and is time intensive).	**Reasonable assurance**	Two hour falls assessment to be audited.
Implement Learning from Serious Incidents (SIs)	Learning disseminated through falls collaborative and divisional Patient Safety and Quality Board (PSQB) meetings: • Need to implement bite sized learning and disseminate • develop falls link practitioner role to support learning through the Falls collaborative. • Helen Hodgson (Matron) and Lauren Green (LG) (Dementia Lead) meeting 18th June to develop the learning outcomes from recent SI's. • LG is gathering data and information from other Trusts to support implementation of changes in this organisation.	**Limited assurance**	• To develop a falls team within the Trust. • Aiming to have information gathered from Go See & reported on by July 2021.

14. End of Life Care

We will this year undertake quality improvements to:

- Ensure the needs of both the patient and their families/carers does not vary in quality because of an individual's characteristics by ensuring care provision is individualised, timely and relevant.
- Ensure improved resources for relatives and carers relating to breaking bad news relating to End of Life (EoL) care

What do we aim to achieve?	Current update	Progress rating
QP1. Implement a 7-day service across community services Measure impact of 7 day working across the Key Performance Indicators EoL dashboards	7-day service commenced within Calderdale community SPCT in April/May this year. Dashboard to be approved	**Reasonable Assurance**
QP2. Implement a 7-day service within the in-patient areas Measure impact of 7 day working across the Key Performance Indicators EoL dashboards	Due to current sickness levels in palliative care the move to a 7-day specialist palliative care (SPCT) service has been paused. Modelling has suggested that the current workforce could support a 7-day service, however, due to documented and evidenced concerns a business case for an enhanced SPCT model has been developed and will be submitted in July 2021.	**Limited Assurance**
QP3. Improve access to ePaCCs for patients within Frailty service This will be measured through an audit of records every quarter	Improve access to ePaCCs - The network is working towards a digital platform which will allow YAS to see ePaCCs when they attend the scene. There is work ongoing to pull through ePaCCs data to EPR. There is also work ongoing to trial social care to have access in care homes so everyone will have the ability to see ePaCCs. In the acute trust the advance care planning facilitator is training staff to use system one so ward areas can view ePPaCCs. This work has just recommenced as the resource for this was deployed into the frailty workforce during COVID. As part of this project the plan will be enhance the nursing and AHP knowledge and confidence, so they are skilled to have end of life conversations sooner, bring about advance care planning sooner and document in the write place. Audit to be undertaken Q2	**Reasonable Assurance**

What do we aim to achieve?	Current update	Progress rating
QP4. Introduce a standard(s) that will improve a person's experience pre and post bereavement delivered by the ward teams This will be measured by qualitative narrative quarterly by EoL care facilitator.	The bereavement service as highlighted in QP5 will act on negative and positive person's experience gained from the bereavement telephone service. Currently the Educational Facilitator and assistant work with wards and groups to improve overall care but specific areas are targeted based on feedback from the bereavement service where necessary. A business case has been prepared and will be submitted to support the maintenance of the bereavement service as 'business better than usual' moving forward. The bereavement service will feed back person narrative and improvements to the End of Life Care Steering Group quarterly in a 'you said, we did' style report.	**Reasonable Assurance**
QP5. Review the Bereaved relatives telephone support service This will be measured by a qualitative and quantitative review of the service established during the pandemic	Ongoing review of the bereavement support service. We now have the bereavement service as part of the Datix reporting to enable us to look at trends and implement changes. Writing a business case to look for substantive funding for this service – building back better than usual. Overwhelming positive feedback from the relatives we speak to. Q2 will establish data capture of number of calls undertaken as a percentage of people who died within in-patient areas.	**Reasonable Assurance**
QP6. Review Visitors guidance in line with national guidance and monitor compliance This will be measured by a Quarterly audit of the guidance in relation to EoL patients	Visiting adhered to national guidance. Further local safety issues were taken into consideration when needed. Two general visiting audits were completed in the last quarter 20/21 which highlighted improvements in compliance. From an end of life point of view regular audits are completed as part of the bereavement telephone service. Improvements and complements are fed back into the system through the actions resulting from QP4 above.	**Substantial assurance**

15. Clinical Documentation

We will this year undertake quality improvements to:

- Measure this piece of work is to ensure that the clinical record gives an accurate picture of the patients diagnoses, the care provided to that individual, that it reflects the standards laid down by the Trust and that information is recorded consistently.

What do we aim to achieve?	Current Update	Progress rating
QP1. Optimise the Clinical Record 1a. Complete the in-depth analysis	Company identified – stuck in the procurement process at the moment.	**Limited Assurance**
1b. Benchmark	Subject to the outcome of the in-depth analysis	**Reasonable Assurance**
1c. Set local standards	Subject to the outcome of the benchmarking	**Reasonable Assurance**
QP2. Trial the use of the Digital White Board Identify areas to trial over a 4-week period - implement the white boards identifying data that can be pulled and measured to determine progress and future planning.	Trial period commenced – end date 15th June 21.	**Substantial assurance**
QP3. Carry out a full review of the Ward Assurance within the KP+. 3a. Look at current data captured with service users	This will be reviewed by the SME's and Ward Managers following the Work Together Get Results (WTGR) piece. Work to commence July 2021	**Reasonable Assurance**
3b. Assess whether data relevant	Full review of data to be carried out regarding not only relevance, but also how staff can make it more meaningful to them in addressing shortfalls	**Reasonable Assurance**
3c. Agree metrics for collection	Metrics already agreed upon – review of data being extracted	**Substantial assurance**
QP4. Ensure Ward Managers and Matrons own their own ward data using KP+ 4a. Ensure that all Ward Managers and Matrons have access to KP+	Staff groups contacted already – awaiting feedback. Aim to complete this by end of June 2021.	**Reasonable Assurance**
4b. Provide training in the use of KP+ for Ward Managers and Matrons	This was carried out in November 2020 but plan to revisit once access is granted for staff.	**Substantial assurance**
4c. Embed review of KP+ into daily practice	This will be an action from the WTGR – start end of July 2021.	**Reasonable Assurance**

What do we aim to achieve?	Current Update	Progress rating
QP5. Audit clinical records using an audit tool. Audit 5 sets of records per week by Ward Manager reporting and act upon findings.	Audit to be carried out by Matrons – one per month per each of their wards – to start end of July 2021.	**Reasonable Assurance**
QP6. Identify and establish a project team that can drive the improvement of data entry into EPR across the Trust. 6a. Identify the team	This will include Associate Director of Nursing, Matron and Ward Managers across the Trust.	**Substantial assurance**
6b. Identify outcomes wanting to achieve	Working Together Get Results sessions arranged – face to face to ensure optimum engagement obtained. Sessions planned for end of June and beginning of July. This will include several groups of mixed role to enable full appreciation of challenges	**Reasonable Assurance**
6c. Agree defined goals and action plan that reflects this	Outcome of the WTGR will determine the action plan – aim for this to be available by the end of July 2021	**Reasonable Assurance**
QP7. Ensure training in the use of EPR reflects the standards laid down by the Trust and that it reflects training needs of the staff 7a. Support the Training team to ensure training meets the needs of the service user – fully aligned to roles and responsibilities	Task and Finish Group set up 2/12 ago to review the training plans for medical, nursing and HCA groups as a priority. Some representation from nursing but not medical teams – seeking support from them.	**Reasonable Assurance**
7b. Encourage Training Team to explore ways in which service users can be supported e.g. online, face to face, digitally	This is being reviewed within THIS. Initial plans e-Learning developer starting in post on 21.06.21 with an immediate action to create e-Learning modules for medical, nursing and HCA roles for August 2021.	**Reasonable Assurance**

16. Clinical Prioritisation

We will this year undertake quality improvements to:

- Maintain a clear and comprehensive understanding of deferred care pathways as a result of COVID 19

What do we aim to achieve?	Current update	Progress rating
QP1. Ensure recovery plans assess and align the impact of health inequalities for people accessing services. This will be measured by: • Number of patients within the backlog assessed by using health inequality determinants within data sets	The Board of Directors have agreed clear Health Inequalities priorities Capacity and capability are being built to ensure we fully understand the Health Inequality agenda. This is clinical, operational and informatics. A Clinical Reference Group on Health Inequalities has been established and meeting regularly to steer this element of recovery Work has commenced looking at health inequalities data and how this will be used to compliment clinical prioritisation and our post COVID-19 delivery model for both planned and unplanned care. This includes IMD, ethnicity and learning disability	**Reasonable Assurance**
QP2. Monitor compliance with agreed clinical prioritisation process this will be measured by: • using the KP+ data set established monthly through the Integrated Performance Report (IPR)	Trajectories have been developed to monitor delivery of the Board priorities Monitoring undertaken weekly at Divisional level to ensure early investigation of variance and corrective action Further assurance through Performance Review Meetings and IPR	**Substantial assurance**
QP3. The 'Buddy' system is in place for each specialty where it was agreed. This will be measured by monitoring process in place at speciality level	The buddy system is being reviewed to align with national requirement to implement Patient Initiated Follow Up. This is being developed through the Outpatient Transformation Board	**Substantial assurance**
QP4. Measure any Harm as a result of delayed pathways • monitoring of incidents & complaints related to backlogs and establish key themes for learning	All colleagues reminded to complete Datix for any concerns and will be managed in line with Trust Risk management procedures This, along with complaints data, will be reviewed with a clear focus on identifying themes for learning.	**Substantial assurance**

What do we aim to achieve?	Current update	Progress rating
QP5. Establish Learning disability pathway This will be measured through the KP+ portal for Learning Disability	The Trust is prioritising patients with a Learning disability who are treated as a priority regardless of their clinical prioritisation status. To date, 76% of patients have now received treatment. A new pathway from referral is being developed to ensure ongoing prioritisation of patients with a Learning Disability	**Substantial assurance**

17. Nutrition and Hydration for in-patient adult and paediatric patients

We will this year undertake quality improvements to:

- The delivery of safe and high-quality nutrition and hydration care for all in-patients at CHFT.

What do we aim to achieve?	Current update	Progress rating	Next period
1. A minimum of 90% of staff required to complete Malnutrition Universal Screening Tool (MUST) training will be compliant	96.2% trust wide position May data	**Substantial assurance**	To maintain the target
2. A minimum of 90% of staff required to complete Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) training will be compliant	Progress from 0% - 71.4% Trust wide position as at May 2021, this training package started in March 2021.	**Reasonable assurance**	To have 90% of staff trained by the next reporting period
3. 100% of adult in-patients will have a MUST assessment within 24 hours of admission & weekly thereafter	May data 16.3% compliance **Mitigation** - Safety huddle inclusion within clinical areas as a prompt for completion of the assessments by clinical staff Inclusion within Journey to Outstanding clinical area reviews. **Actions** - The nutritional specialist nurses and dieticians have undertaken some partnership working with Bradford colleagues to review the mandated fields within the MUST assessment to aid with automated calculation of the MUST following completion of 3 mandated fields. The aim is that this will help to improve compliance.	**Limited assurance**	Work Together to Get Results (WTGR) improvement work planned for clinical documentation to include work on nutrition and hydration risk assessment and compliance monitoring.
4. Trust aspiration to achieve 100% of paediatric in-patients having a STAMP assessment within 24 hours of admission & weekly thereafter	Data collated on nutritional dashboard to be set to enable the Trust to pull of the live data. Requested for this to be included on ward assurance dashboard on Knowledge Portal+ in June 2021	**Reasonable assurance**	Work with IT analysis for the development of the dashboard. To report data for paediatric in-patients having a STAMP assessment within 24 hours of admission

What do we aim to achieve?	Current update	Progress rating	Next period
5. 100% of adult in-patients with a MUST score of 2 or above will be referred to the dietetic service	May data - 2.3% compliance In partnership with Bradford colleagues, if the MUST calculated score is of 2 or above an automatic referral will be populated to the dietetic team who will screen the patients records and determine appropriate action linking with ward areas appropriately. This aims to capture a more accurate number of our patients requiring nutritional support from the dietetic team and not be reliant on a separate referral process, as is the system at the current time. This proposed work will be shared with the Digital health group in the near future.	**Limited assurance**	To monitor compliance and report back through the Nutrition and Hydration group and the Quality Committee
6. 100% of paediatric in-patients with a STAMP score of 4 or above will be referred for nutritional support (i.e., dietician, nutritional support team or consultant)	Data not currently collated on dashboard. Requested for this to be included on the dashboard 3.6.21	**Reasonable assurance**	Work with IT analysis for the development of the dashboard. To report data for paediatric in-patients with a STAMP score of 4 or above and referred for nutritional support
7. A minimum of 90% of staff from wards that are regular users or high users of nasogastric tube feeds will be compliant with nasogastric training	Divisional reporting via dashboard and monitoring monthly compliance. Initial training and ongoing management undertaken by Nutritional specialist nurses via simulation session. Update training undertaken every 3 years is undertaken through online training package and self-assessment and verification sign off by ward leader and confirming e mail sent through to nutritional specialist nurse (NSN) who collates the data. Areas with lower than 80% offered in reach training/support by NSN	**Limited assurance**	Target high use areas for training to include train the trainer to improve compliance.
8. Nasogastric and STAMP training will be added to the ESR platform	Nasogastric training compliance currently undertaken via a manual process. NSN trained to input data.	**Limited assurance**	To get STAMP training on the ESR platform

What do we aim to achieve?	Current update	Progress rating	Next period
to enable monitoring by ward managers & matrons	Nasogastric tube insertion and ongoing management for clinical staff is an essential skill in some clinical areas only, due to patient pathways therefore all staff groups cannot maintain competencies safely, this would require selective ward areas compliance to be identified through ESR. 3.6.21 update ESR compliance is based on the target audiences on position not on an individual level. It has to be everyone in that position as they do the same job. Option: To try to put through the EST proforma and ask it to be set up as an EST role specific course. This action will provide compliance if you identify that target audience. But if it gets agreed, the target audience will need to be everyone not i.e., 3/7 nurses on e.g., Ward 5. It has to be the full 7 nurses. 3.6.21 STAMP training has been requested via EST process to be reported.		
9. Meal service will be safe, organised, and well led on all wards at CHFT	Divisional action plans and observation of service delivery in ward areas. Patient feedback collated by ISS and CHS catering depts. Feedback through patient discussions and complaints/incidents Leadership observations at ward level	**Reasonable assurance**	Observation of mealtimes during Observe and Act framework, practice will be monitored through this process and shared at ward level. Proposal for matrons and ward managers to observe and get involve in meals services.
10. The red tray/lid and jug lid alert system will be used consistently and appropriately on all adult in-patient wards	Trust wide initiative not consistently utilised in all ward areas. HRI site A recent review of red trays has resulted in catering department purchasing further trays and reviewing condition of existing supply.	**Reasonable assurance**	Question to be included within Observe and Act observation tool to monitor local compliance (Theme D. Food and drink)

What do we aim to achieve?	Current update	Progress rating	Next period
	CRH site utilise a red plate lid system for alert due to the meal delivery system, this is reliant on ward staff identifying a requirement for the lid when ordering the meals.		
11. CHFT guidelines, policies, strategies, pathways, decision making tools will reflect current NHS guidelines & NICE guidance	CHFT Policies and guidance is reviewed against current NHS guidelines & NICE guidance via the nutrition operational meeting. Includes: • Nutrition and hydration policy (including allergen management) • Food hygiene policy • Parenteral nutrition policy	**Substantial assurance**	Reviews to be undertaken as new guidance released and via CHFT policy review process
12. The ward assurance indicators for nutrition and hydration will be reviewed for appropriateness and accurate affiliation with CHFT's nutritional policies, guideline etc.	Ward assurance documentation indicators reflect the current guidance within the current Nutrition and Hydration policy.	**Reasonable assurance**	Further actions for discussion of ward assurance indicators at Working to get results (WTGR) session planned for June / July 2021
13. A staff education plan to be developed and actioned to ensure staff know when a fluid balance chart is indicated and understand the importance of monitoring and recording correctly within EPR	Current position • No generic education plan in place • No existing CHFT HCA competencies for nutrition and hydration. • Trust compliance with clinical recording of fluid balance on EPR, May 21.4% compliance. **Risks** Inaccurate monitoring and recording of fluid balance chart on EPR impacting on patient's clinical outcome and patient experience.	**Limited assurance**	• Educational Lead to be identified to develop an education plan. • NVQ team to devise HCA competencies. • Review process of indication/recording/monitoring requirement through WTGR workshop.

What do we aim to achieve?	Current update	Progress rating	Next period
	Mitigations • Clinical based actions-requests via medical team with clear guidance as to rationale for Fluid balance charts. • Accuracy of monitoring/compliance through ward assurance documentation		
14. Theme D (Food & Drink) of Observe & Act reports to be monitored at monthly Nutrition Operational group meetings for information, discussion, and potential shared learning	Pilot areas completed utilising Observe and Act framework completed.	**Reasonable assurance**	To be included on monthly Operational group meetings agenda as an item for discussion and shared learning.
15. A CHFT Food & Drink strategy to be developed to sit alongside the comprehensive CHFT Nutrition and Hydration policy (recommendation of the 2014 Hospital Food Standard panel report DoH)	Strategy to be developed with identified Clinical lead	**Limited assurance**	To identify a Clinical Lead

18. Reduction in the number of CHFT acquired pressure ulcers

We will this year undertake quality improvements to:

- Reduce the occurrence of pressure ulcers and improve healing rates for existing pressure ulcers. In doing so we can reduce harm and spend, while improving the quality of healthcare experience of our most vulnerable patients.

What do we aim to achieve?	Current Update – June 2021	Progress rating	Next period
Reduction in the Incidence* of hospital-acquired pressure ulcers by 10%. This will be measured by incident data	There has been a 12.5% decrease in the incidence of hospital acquired pressure ulcers from March to April 2021. May data still being validated.	**Substantial assurance**	Continue to monitor and validate May Data
Reduction in the incidence* of hospital acquired medical device related pressure ulcers by 20%. This will be measured by incident data	There has been a 66% decrease in the incidence of hospital acquired medical device related pressure ulcers. May data still being validated.	**Substantial assurance**	Continue to monitor and validate May Data
Reduction in the incidence* of hospital-acquired heel pressure ulcers by 20%. This will be measured by incident data	There has been a 27% decrease in the number of hospital acquired pressure ulcers from March to April 2021. May data still being validated.	**Substantial assurance**	Continue to monitor and validate May Data
Reduction in the number of Orange harm pressure ulcers by 50%	There was no reduction in Orange pressure ulcer harms from March to April 2021 (10 orange harms in each month).	**Limited assurance**	Actions in place to address lapses in care identified in RCAs.
No Red serious pressure ulcer incidents	No red incidents in April and May 2021.	**Substantial assurance**	
~~100% compliance with monthly observational audit of ward safety huddles~~	J2O Review to include observational audits covering pressure ulcer prevention elements	**Not applicable**	This indicator to be removed from the QP

What do we aim to achieve?	Current Update – June 2021	Progress rating	Next period
95% or more of patients in hospital will have a pressure ulcer risk assessment within 6 hours of admission to Trust / transfer to ward. This will be measured by ward assurance	33.7% of patients received a risk assessment. Risk for missed or late implementation of preventative interventions.	**Limited assurance**	Actions in place to undertake focused work on selected wards. Key focus for Pressure Ulcer Collaborative.
95% or more of at-risk patients in hospital will have a sskin bundle identified and completed. This will be measured by ward assurance	Data incomplete. Actions in place with EPR and Informatics team to address data extraction difficulties. sskin bundles are in use across the Trust but EPR design requires review. **Risk** Acknowledged that sskin bundles can show gaps in care which poses risk for pressure ulcer development.	**Limited assurance**	Key focus for Pressure Ulcer Collaborative.
95% or more of at-risk patients in hospital will have a pressure ulcer care plan initiated. This will be measured by ward assurance	All patients with a Waterlow of 10 > had a pressure ulcer prevention care plan initiated.	**Substantial assurance**	Actions underway to improve documentation within care plans to evidence care delivered.
95% or more of patients will have a completed Waterlow pressure ulcer risk assessment within 7 days of admission to District Nursing caseload. This applies to patients who have been on caseload for more than 28 days. This will be measured by SystmOne audit.	Data to follow.	**Not applicable**	
~~95% or more of patients on District Nursing caseload with a Waterlow score of 10 or more will have a~~	Measure removed as risk of data being unreliable due to way clinicians combine results of Waterlow score with clinical judgement to inform pressure ulcer risk. Not all patients with a	**Not applicable**	This indicator to be removed from the QP

What do we aim to achieve?	Current Update – June 2021	Progress rating	Next period
~~pressure ulcer prevention care plan implemented. This will be measured by SystmOne audit.~~	score of 10 > will require a care plan. This practice aligns to NICE guidance.		
95% of relevant staff (RNs, Nursing Associates and HCAs) will have completed React To Red Pressure or equivalent Pressure Ulcer training in last 2 years. This will be measured by Essential Safety Training (EST) compliance data	83% of staff have completed React To Red Training. Additional virtual and ward-based training has been provided on pressure ulcer prevention to support staff.	**Reasonable assurance**	Actions in place to work with selected ward to address compliance.

19. Making complaints count: Implementation of the national regulations and Parliamentary and Health Service Ombudsman (PHSO) standards (phased introduction)

Our focus for this quality priority is to:

Demonstrate an incremental improvement / compliance over the year against the national regulations and standards. Our implementation success measure will be a shift change in the assurance from red to green over the year. Improvements will be noted via performance reporting and within this bi-monthly report.

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
QP1. Through the MCCC strategic, operational group and tactical meetings we will ensure that CHFT is compliant with National regulations. This will be measured by aligned performance reporting			
QP1. Robust performance reporting against the national regs & PHSO standards /governance: National Targets • Acknowledgement of the complaint within 3 working days	• Weekly performance reporting has been revised in order to align more closely with the national regs and standards • Phase One Improvement plans and activity – to be focussed on process improvements • Weekly and monthly performance reporting ongoing • Weekly tactical meetings allow for a deep dive approach in the review of individual cases and their management • Realtime dashboard on Datix has been built for the divisions	**Reasonable Assurance**	• Fine tuning of the performance reporting to meet all stakeholders needs – additional narrative • IPR metrics require revision to align more closely to the standards.
QP2. Support a trust wide user led approach to making complaints count by focussing improvements on the following key draft PHSO standards that the MCCC has self-assessed as having limited assurance. Progress will be measured by self-assessment by the collaborative against the standards and recognised achievements / outputs against the MCCC WTGR improvement plan			
1.1. Staff know how they can deliver a just and learning culture in their role	• Making complaints count Collaborative (MCCC) operating framework and reporting schedule is in place – staff engagement. • Staff engagement - A learning /joint responsibility as a trust culture is being	**Reasonable Assurance**	• Briefing under development to lend further clarity around the MCCC roles and responsibilities. • Weekly tactical meetings to build in decision making process - which complex complaints require consideration at the Friday pm panel meetings • Ongoing comms/ engagement, training & support to embed the new approach & processes into practice

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
	deliberately built by the head of PACS and the Assistant Director – Patient Experience operating through the various forums to help move the Trust away from the previous 'them and us' thinking. • Focus on closing the learning reporting loop – Datix actions • Development of a process that will enable learning from stories (impact stories) to be incorporated within current trust reporting arrangements • Development of a page within the Datix complaint module to support the front end of the complaints process – risk assessment & proposed management plan • Development of a revised response report template arrangement / approach and Standard operating procedure (SOP)		
1.5. Seek feedback from those who raise complaints (as well as staff involved) on their experience	• Service user survey developed • 3Rs session held with MCCC staff	**Reasonable Assurance**	• Take forward findings from 3Rs as specific actions
2.7. Every stage of concerns / complaints meets the needs of minority and vulnerable groups and makes reasonable adjustments where required.	• Health inequalities task and finish project - IMD data / analysis indicates BAME communities are accessing the service above the current %population figures • Equality monitoring data is now captured as part of the service user survey and at the point of access into the service • Access to reasonable adjustment services are in place e.g., language line	**Reasonable Assurance**	• Further analysis of data is required • Further IMD T&F project – focus on maternity
2.9. Staff make sure they respond to concerns and complaints at the earliest opportunity - clear timeframes given	• Service has moved to negotiated timelines in partnership with families – Datix updated to reflect revised timelines	**Reasonable Assurance**	

PHSO / Reg Standard Focus for the priority - What do we aim to achieve?	Current update	Progress rating	Next Period
3.1. Staff are properly trained and have the appropriate level of experience and authority	• Patient experience and quality support leads – action learning set approach in place • Investigation training programme is ongoing • Complaint Electronic Staff Record (ESR) learning module in place	**Reasonable Assurance**	• Conclude the work to build a 'complaints' element into the CD programme • Scoping / mapping of current investigators to be undertaken • Quality check of draft responses to identify which ones require additional / focussed support – further work required to work up an agreed process
3.2. Staff have the appropriate resources, support, and protected time	• Resources & support – please see above updates	**Reasonable Assurance**	• As above
3.3. Assign complaints to staff who have had no prior involvement or who have no actual or perceived conflict of interest.	• Careful consideration is given to complex complaints of sensitive nature on a case by case basis and where needed an investigator not involved / perceived conflict of interest is assigned • No specific action / focus as yet but need to move to a trust position of single list of investigators / sharing responsibility across all divisions – to be paused until next year	**Reasonable Assurance**	• In light of reset and recovery work underway. No planned action until next year • Build thinking into front end management plan

Risk/ Issue	Owner	Action	Progress
Ongoing workforce challenges are creating delivery capacity concerns	Rachel White	• Additional flexible support has been requested and additional recruitment has concluded • Risk assessment to expedite recruitment process	Substantive head of PACS will in post at the end of this month

Conclusion

- The Trust to commence the J2O programme of assurance visits across the Trust further to the pilot
- The Trust to work with the CQC engagement manager for the implementation for the strategy.
- Dementia screening to continue to work on the improvements to achieve substantial assurance status
- The complaints data suggest that there has been an increase in the number of complaints received.
- Work for SI continues within the divisions for the management of outstanding actions
- Medicine management continues to provide reasonable assurances for the “Must Do’s”, Training and temperature monitoring audits
- CHFT Maternity services continues to demonstrate compliance against the requirements as outlined in the Ockenden Report.

Recommendations

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

The Board is asked to receive the monthly Maternity report which has been presented to the Quality Committee.

Appendix 1 – Report BRAG rating assurance table

RAG RATING	Evidence of fulfilling RAG rating
WHITE	• Not yet started
Substantial assurance	• Progressing to time, evidence of progress • Full assurance provided over the effectiveness of controls. • No action required • This would normally be triggered when performance is currently meeting the target or on track to meet the target. • No significant issues are being flagged up and actions to progress performance are in place.
Reasonable Assurance	• Evidence available at the time of assessment shows that the outcome is mostly met or there is insufficient evidence to demonstrate the outcome is met. • Impact on people who use services, visitors or staff is low. • Action required is minimal • Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed at this moment but should improve. • There are a set of actions in place that is expected to result in performance coming closer to meeting the target by the end of the target or reporting period. • Delayed, with evidence of actions to get back on track.
Limited assurance	• Evidence available at the time shows that the outcome is not being met or there is no available evidence that the outcome is met. Impact on people who use services, visitors or staff is high/significant. Action is required quickly • Cause for concern. No progress towards completion. Needs evidence of action being taken • Close monitoring or significant action required. This would normally be triggered by any combination of the following: • Performance is currently not meeting the target or set to miss the target by a significant amount. • Actions in place are not believed to be enough to bring performance fully back on track before the end of the target or reporting period. • The issue requires further attention or action
Full assurance	• Completed with documented evidence • Evidence of compliance with standards or action plans to achieve compliance.

20. Integrated Performance Report – May 2021

To Note

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title:	QUALITY & PERFORMANCE REPORT
Author:	Peter Keogh, Assistant Director of Performance Kirsty Archer, Deputy Director of Finance Cornelle Parker, Deputy Medical Director Lindsay Rudge, Deputy Chief Nurse Jason Eddleston, Deputy Director of Workforce and OD Bev Walker, Deputy Chief Operating Officer
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee

Purpose of the Report

To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of May 2021.

Key Points to Note

Trust performance for May 2021 was 71.1% which is a slight deterioration on the April position with the key changes being within Stroke and Cancer 28-day faster diagnosis.

The **SAFE** domain is green and improving with only 2 KPIs off plan. **EFFECTIVE** domain is also green but #Neck of Femur access has remained challenging as more cautious pathways for some patients most vulnerable during the pandemic meant it was clinically viewed as safer to wait than to have rapid surgery. The **CARING** domain is now green with Complaints closed achieving 100% for the first time. In our endeavours to become fully compliant with the national regulations and PHSO standards and move towards a more person centric service; negotiated timescales working the families are now in place. For FFT we have looked at the national position where we compare well and set ourselves local targets. This position will be reviewed on a quarterly basis. Dementia screening still needs a more focussed recovery plan. The **RESPONSIVE** domain is the most challenging as it contains the main planned access indicators with a mixed picture so remains amber with 3 of the 4 stroke indicators deteriorating in month after a good April. **WORKFORCE** remains amber with KPIs consistent with April. **FINANCE** is amber with Agency Expenditure and Capital missing target. We have not been set an agency expenditure ceiling by NHSI this year, so the metric is monitoring against our internal (quite ambitious) plan.

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

The Board of Directors is asked to **NOTE** the narrative and contents of the report and the overall performance score for May 2021.

Calderdale and Huddersfield NHS Foundation Trust

Performance
May 2021

Background

Calderdale and Huddersfield Foundation Trust has an excellent track record in the delivery of safe and timely access for patients across all pathways. Prior to the Pandemic it was one of the top-rated Trusts across the key regulatory standards and has a Good CQC rating.

CHFT continues to perform well against its key metrics during this challenging period. Excellent Cancer performance has been maintained throughout Covid and compares well to all organisations nationally. We have seen unprecedented numbers of attendances at the Emergency Departments (ED) over the last 3 months with peaks at both hospital sites in May, but we have still managed to maintain performance at just below 90%.

Recovery

We are now working within our Elective Recovery Framework and beginning to refocus our capacity to those patients who are waiting to access care following the disruption of our elective programme.

This has meant more focus on prioritisation, health equality and the wider patient experience with a reduction in variation within and across specialties.

We are now in a position where we need to consider our response to the ongoing Covid-19 prevalence alongside the delayed access to treatment for patients on our waiting lists.

Here are some examples of the workstreams that have been developed during the last 3 months.

- Weekly Modelling Clinical Reference Group
- Tracking of trajectories weekly
- Ongoing clinical validation
- Deep dive by specialty
- Escalation to system leaders
- Separating new additions from upgrades in reporting
- Personal treatment plan for over 104/52 waiters
- Health inequalities development sessions
- Self-assessment against new GIRFT standards
- Looking at further options for additionality
- Reviewing current Waiting List Initiative options
- New insourcing/outsourcing team formed from CCG staff
- System agreement to seek and utilise all outsourcing options
- Increased scheduling capacity
- Access to Theatres based on principles of recovery framework
- Theatre efficiency programme relaunch
- Establishment of specialty theatre groups with clinical leadership
- Recruitment and retention programme for Theatre including Anaesthetic Consultant leadership
- Reviewing patients listed where little evidence base for procedure with a view to remove
- Virtual ‘Go Sees’ taking place

We have made some real progress around individual groups of patients including patients with a learning disability (LD). 81% of adult LD patients have now been treated whilst all LD children on a waiting list have been identified and treatment planning has commenced.

We must also note that we have seen higher levels of patients waiting and with a longer length of wait than other Trusts in West Yorkshire and as a result we have looked into each specialty in greater detail to try and understand the reasons for these differences. The position is largely determined by our choices over the last year in terms of opening to referrals, carrying on with cancer activity and limiting elective activity.

We have seen an increasing volume of P2 additions, new patients and upgrades with more patients added to the waiting list weekly than removed. Also there is currently no 'Any Qualified Provider' capacity in GH or Calderdale and we are seeing significant volumes of staff sickness and vacancies in Theatre.

Quality, Workforce and Finance

We have looked at our main headlines from a Trust overview perspective and considered the impact that these areas are having on service performance.

Sickness absence is comparatively good when assessed against our West Yorkshire neighbours and beyond across North East and Yorkshire. Short term sickness absence is below our 1.5% (rolling 12-month and in-month), long term absence is above the 2.5% target (rolling 12-month and in-month). There are a number of service hot spots that require attention where absence is much higher than our 4% target. Vacancies have increased since April 2021 although turnover remains stable. and we have already seen the impact of this on our Recovery programme. Staff stress and fatigue is a risk to our Recovery programme.

Skill-mix within nursing is leading to colleagues recording safe care red flags across a number of wards where the planned RN care hours are not achieved.

There has been a significant and continued increase in demand for both our emergency departments which is creating pressure at the front door with increased risks relating to social distancing and infection control measures. We are continuing to see high costs in the ED associated with partial segregation and increased attendances.

Across ED we have seen the increase in attendances but the percentage converting to inpatients has reduced. We have had specific clinician feedback around patients presenting with increased acuity and complexity as a result of not accessing services and deconditioning during the Covid period whilst on the back of this we still have the same bed base. The increase in falls requires further analysis within this context.

For our Stroke patients gaining access to a Stroke bed within 4 hours has deteriorated and the issues are multifaceted, from patients stepping down from stroke being unable to be discharged in a timely way to one of the CT scanners at CRH being out of operation for some time during May which impacted on both timeliness of patient scans and subsequent time of admission into the Stroke bed base. Although the Stroke assessment bed continues to be operational in the ED 24/7 there have been significant challenges in staffing this overnight with consultant cover. There has been an increase in the numbers of patients with a length of stay of over 50 days and the complexity of their needs has been noted with an unusually high number of younger patients (< 60) being in this category. On the back of this Community services have been struggling with reablement and packages of care exacerbating the problem.

Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and LTC management. Further work is required to embed the use of acuity and complexity models within the Community to fully evidence this demand.

For Cancer although our performance has been excellent, we are now starting to see a step change increase in referrals which will naturally have an impact on the front end of the pathway around diagnostics capacity.

As noted in our Recovery programme we are facing challenges with increasing capacity due to the staffing issues referenced above and waiting list initiatives not having the full desired impact. In these early months the elective activity performance has exceeded the NHSI thresholds for receipt of Elective Recovery Funding (ERF). The challenge is to increase this performance to positively impact backlogs.

Trust in-hospital mortality metrics remain favourable. Assurance is provided by our HSMR being a positive national outlier i.e. top 5%, a better than average in-hospital SHMI and stable crude mortality benchmarking. SHMI remains in the expected range but has been trending adversely since January 2020 on a backdrop of a rising national SHMI. This deteriorating position is driven by a high Out-of-Hospital SHMI, reflecting deaths within 30 days of hospital discharge. Detailed analysis of the Out-of-Hospital SHMI has excluded a number of potential confounding variables, including palliative care coding, patient acuity on discharge as measured by NEWS 2 score and frailty on discharge. The Care of the Acutely Ill Patient (CAIP) Programme has been initiated as a quality improvement approach to focus on themes that have emerged from Learning from Death reviews and monthly mortality alerts from Healthcare Evaluation Data (HED).

Overall, we have a positive financial position in the year to date, the Trust has delivered a surplus of £3.28m, a favourable variance of £2.94m compared to plan. This favourable variance is driven by a combination of vacancies, lower than planned recovery costs and most significantly higher than planned Elective Recovery Funding (ERF). This benefit is offset in part by pressures in staffing in ED, as noted above, driving additional costs of bank and agency staffing. The underspend in the year to date position is not expected to continue into future months. Recovery costs will increase over the next 4 months, and the associated ERF will be harder to achieve as the threshold for delivery increases.

Next Steps

Deputy Directors will continue to meet monthly to review the KPIs and associated detail in the Trust level Integrated Performance Report and assess the position in each domain and highlight where there could be a cause and effect on another domain.

A paper will be provided to Trust Board on a bi-monthly basis.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

May 2021

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Performance Summary

May 2021

OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
FFT Inpatients FFT Outpatients FFT A&E FFT Community	FFT Maternity
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

May's Performance Score is at 71.1% which is a slight deterioration on the April position with the key changes being within Stroke and Cancer 28 day faster diagnosis.

The **SAFE** domain is green and improving with only 2 KPIs off plan. **EFFECTIVE** domain is also green but #Neck of Femur access has remained challenging as more cautious pathways for some patients most vulnerable during the pandemic meant it was clinically viewed as safer to wait than to have rapid surgery. The **CARING** domain is now green with Complaints closed achieving 100% for the first time. In our endeavours to become fully compliant with the national regulations and PHSO standards and move towards a more person centric service; negotiated timescales working with the families are now in place. For FFT we have looked at the national position where we compare well and set ourselves local targets. This position will be reviewed on a quarterly basis. Dementia screening still needs a more focussed recovery plan. The **RESPONSIVE** domain is the most challenging as it contains the main planned access indicators with a mixed picture so remains amber with 3 of the 4 stroke indicators deteriorating in month after a good April. **WORKFORCE** remains amber with KPIs consistent with April. **FINANCE** is amber with Agency Expenditure and Capital missing target. We have not been set an agency expenditure ceiling by NHSI this year, so the metric is monitoring against our internal (quite ambitious) plan.

Key Indicators

	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	YTD	Performance Range		
SAFE																	Green	Amber	Red
Never Events	2	0	1	1	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=1
CARING																	Green	Amber	Red
% Complaints closed within target timeframe	60.07%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	63.0%	52.9%	60.00%	100.00%	**in arrears**	**100.00%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	91.09%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.63%	93.46%	88.32%	96.82%	96.75%	**in arrears**	**96.75%**	>=90%	80% - 89.9%	<80%
Friends and Family Test Outpatients Survey - % Positive Responses	93.27%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.37%	93.10%	93.28%	92.38%	92.45%	**in arrears**	**92.45%**	>=90%	80% - 89.9%	<80%
Friends and Family Test A & E Survey - % Positive Responses	90.16%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	90.38%	90.91%	89.37%	90.48%	85.13%	**in arrears**	**85.13%**	>=90%	80% - 89.9%	<80%
Friends & Family Test (Maternity) - % Positive Responses	98.86%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	98.00%	100.00%	100.00%	91.89%	85.71%	**in arrears**	**85.71%**	>=80%	70% - 79.9%	<70%
Friends and Family Test Community Survey - % Positive Responses	100.00%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	100.00%	100.00%	100.00%	100.00%	96.70%	**in arrears**		>=90%	80% - 89.9%	<80%
EFFECTIVE																	Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	6	1	1	2	2	0	0	0	0	0	0	0	0	0	**0**	**0**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.94	98.4	98.68	99.05	99.74	100.88	101.31	102.27	102.71	100.94	104.11					**104.11**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	90.49	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98	90.32	90.49	89.45				**89.45**	<=100	101 - 109	>=111
RESPONSIVE																	Green	Amber	Red
Emergency Care Standard 4 hours	88.81%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	87.82%	86.48%	87.83%	88.22%	**86.70%**	**87.42%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	65.30%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	56.06%	25.42%	38.60%	61.02%	**49.06%**	**55.36%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.74%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	98.55%	98.80%	98.76%	98.26%	**99.02%**	**98.63%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.86%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	97.35%	96.45%	97.34%	98.28%	**98.00%**	**98.15%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.08%	99.42%	97.37%	98.26%	97.83%	97.69%	100.00%	98.67%	96.23%	96.71%	96.82%	98.55%	99.22%	99.45%	**99.32%**	**99.39%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	90.99%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	73.91%	92.31%	100.00%	97.14%	**100.00%**	**98.53%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.15%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	100.00%	98.04%	100.00%	**100.00%**	**100.00%**	>=98%		<=97%
38 Day Referral to Tertiary	54.64%	76.00%	45.45%	40.00%	65.00%	47.06%	39.13%	58.33%	35.71%	50.00%	43.75%	61.54%	91.67%	60.00%	**80.00%**	**70.00%**	>=85%		<=84%
62 Day GP Referral to Treatment	91.47%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.76%	90.00%	90.10%	87.58%	95.65%	93.07%	**88.46%**	**90.89%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	63.98%	72.22%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	85.19%	83.33%	73.91%	100.00%	72.22%	**55.56%**	**66.67%**	>=90%		<=89%
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	79.84%	70.98%	85.89%	73.70%	80.21%	83.19%	82.94%	82.52%	80.91%	81.48%	71.76%	82.50%	80.21%	72.68%	**67.10%**	**70.06%**	>=75%		<=70%
WORKFORCE																	Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	4.52%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	4.59%	4.52%	4.37%	4.35%	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	3.07%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	3.07%	3.07%	3.01%	2.99%	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.45%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	1.52%	1.45%	1.36%	1.35%	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.90%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	94.85%	94.68%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	95.15%									95.15%	95.15%	95.15%	95.15%			-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	41.05%															-	>=95%	>=90%	<90%
FINANCE																	Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	(0.00)	0.00	0.00	0.00	0.00	0.00	0.95	0.16	-1.00	0.41	0.58	1.18	0.55	**2.39**	**2.94**			

SWOT Analysis

Strengths

- Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities.
- Continue to deliver recovery activity greater than plan.
- Continue to support Mid Yorkshire Hospital Trust with Non-Surgical Oncology services and building resilience within the CHFT Team.
- The joint Neurology post with Leeds has now had the job plan signed off by Leeds and so we will be moving towards going out for advert.
- Thank you sessions with colleagues continue - these are an opportunity to recognise colleagues and thank them for all the work done throughout the pandemic.
- Continued take up of the Health and Wellbeing offer.
- Ongoing focus on clinical validation and prioritisation.
- Agreed Recovery Framework.

Weaknesses

- High volumes of planned care backlogs.
- There has been an anecdotal increase in the number of colleague absences due to caring for school children who are isolating due to the increased community prevalence in Covid. The data on this is currently being pulled together in order to quantify the impact.
- Not consistently listing patients for surgery in line with Trust agreed criteria.
- Backlog in Endoscopy with high volume of patients waiting more than 6 weeks for routine appointments.
- There have been gaps with matrons due to redeployment, promotion and sickness.

Opportunities

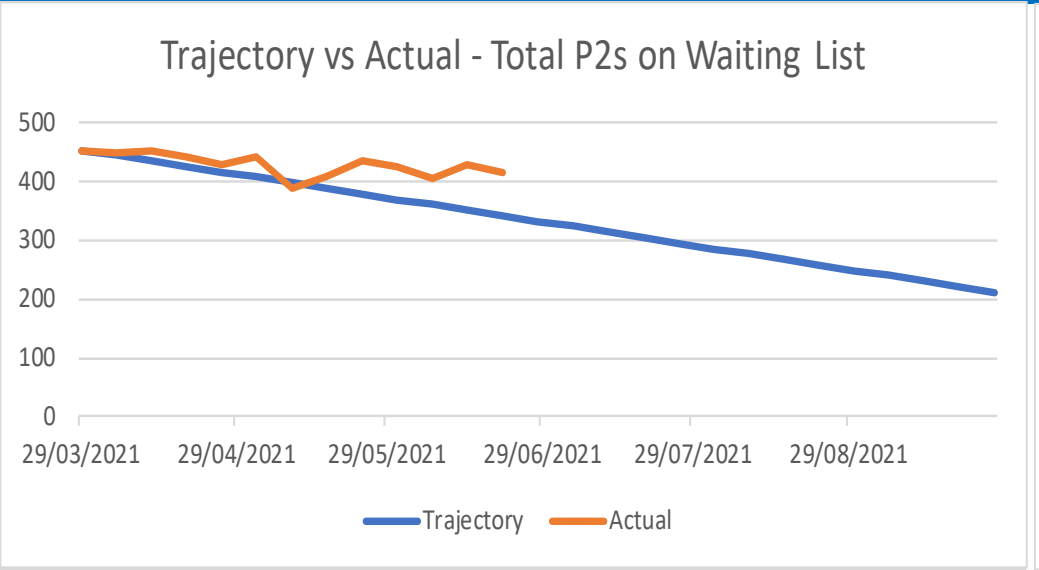
- Work together Get results sessions between services and Execs.
- Several new Clinical Director appointments.
- The relaunch of the SAFER programme has been initiated and will pull together existing workstreams and new ones identified as part of Business Better Than Usual.
- Waiting List Initiative programme to support recovery.
- Further expansion of Programme Management Team.
- Non-Surgical Oncology.
- Community Division and development of Integrated Care Provider partnerships.
- Development of onsite Urgent Care Offer.
- Elective Recovery Funds to be received.
- System leadership escalation and focus on additional recovery options for additionality.

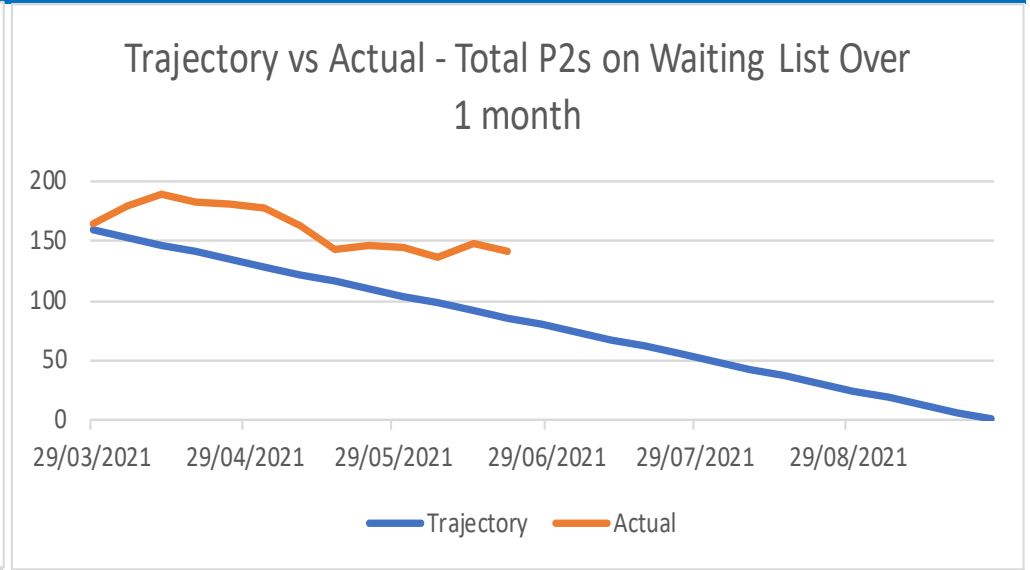
Threats

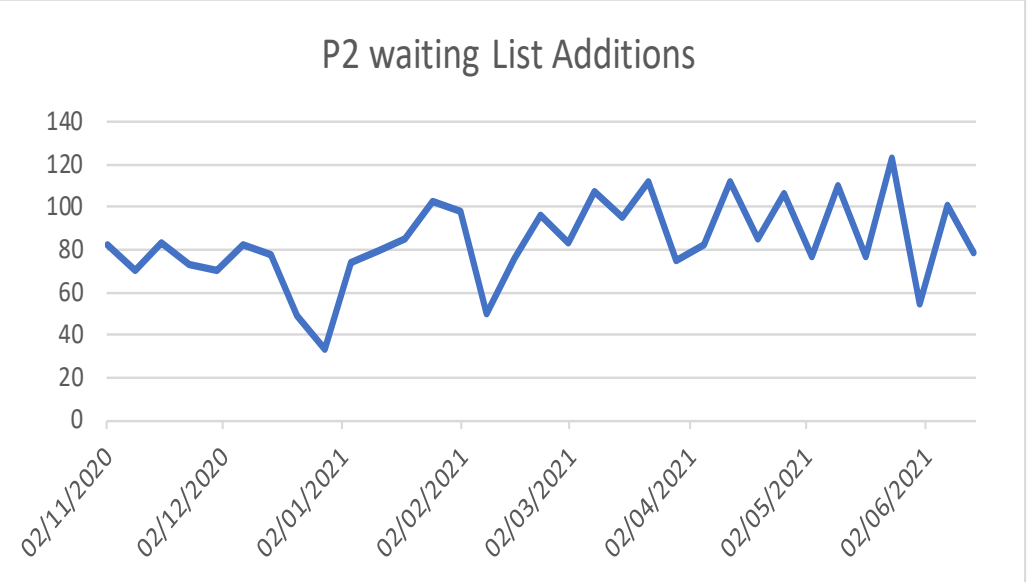
- There has been a significant and continued increase in demand for both our emergency departments which is creating pressure at the front door.
- Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and LTC management.
- We are continuing to see high costs in the ED associated with partial segregation and increased attendances.
- Patients presenting with increased acuity and complexity as a result of not accessing services and deconditioning during the Covid period.
- Staff fatigue.
- Further Covid surges - Expected Paediatric Medical surge (from August 2021) likely to impact elective activity.
- Winter pressures - Planning has been initiated. Final sign-off in August will enable plans to be put in place and to allow discussion with Community colleagues.
- Limited uptake to date of enhanced payments scheme to support recovery.
- Increasing patient complaints due to prolonged waiting.
- Positive ongoing clinical review of waiting lists is increasingly expediting patients to Priority 2 impacting on trajectory.

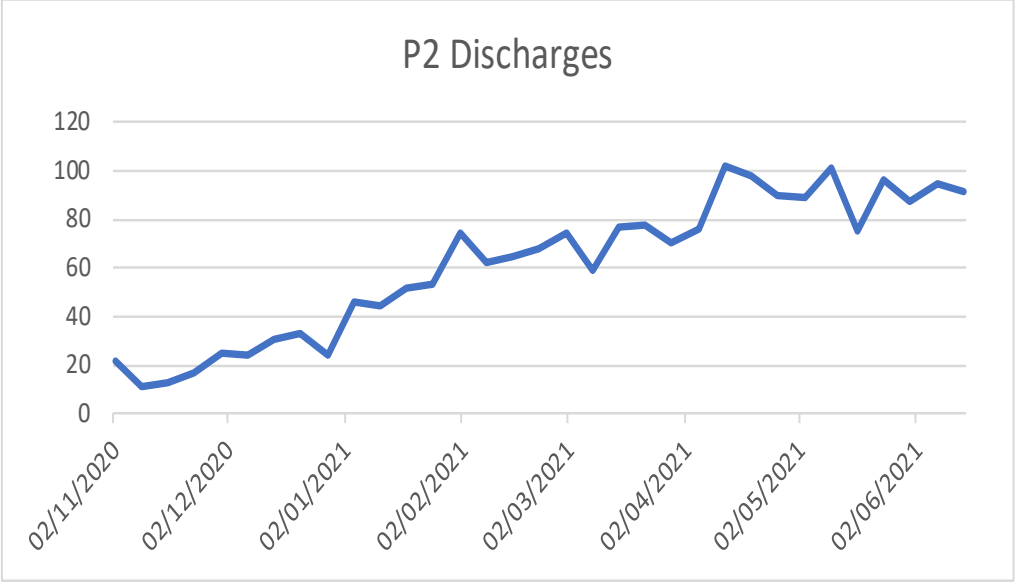
Recovery

INPATIENT WAITING LIST - P2



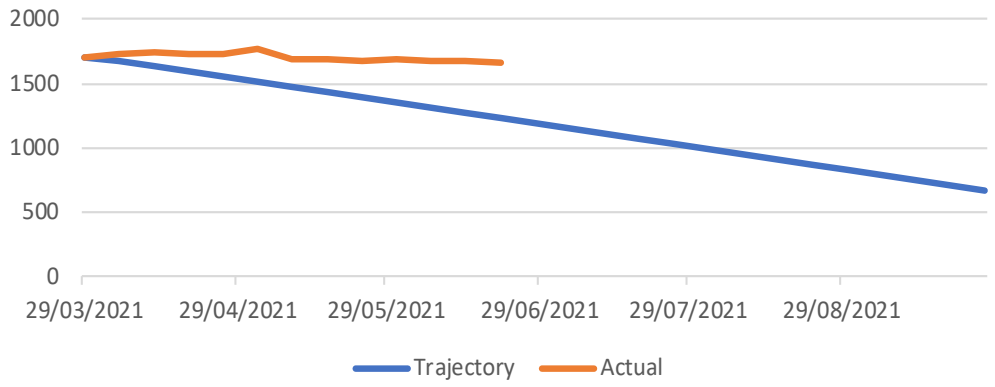




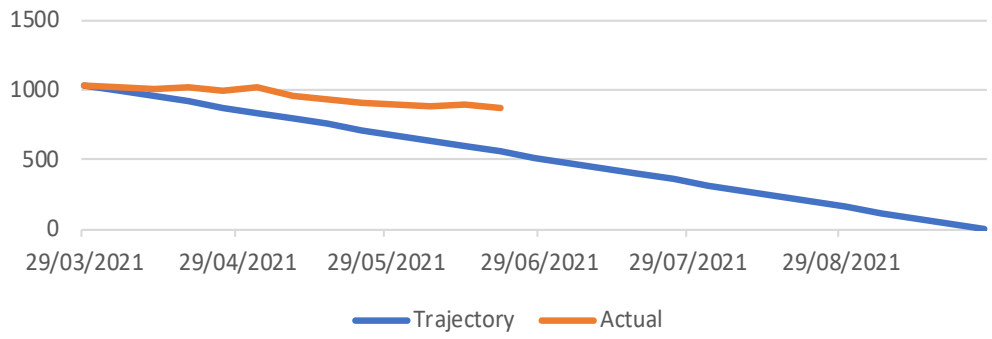


INPATIENT WAITING LIST - P3

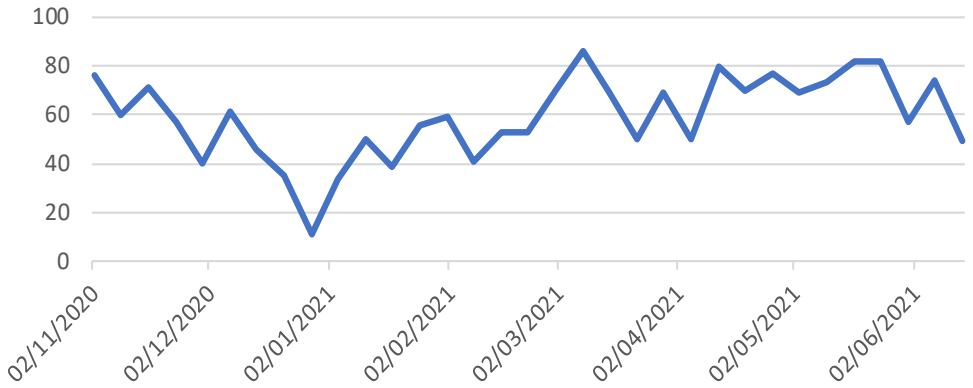
Trajectory vs Actual - Total P3s on Waiting List



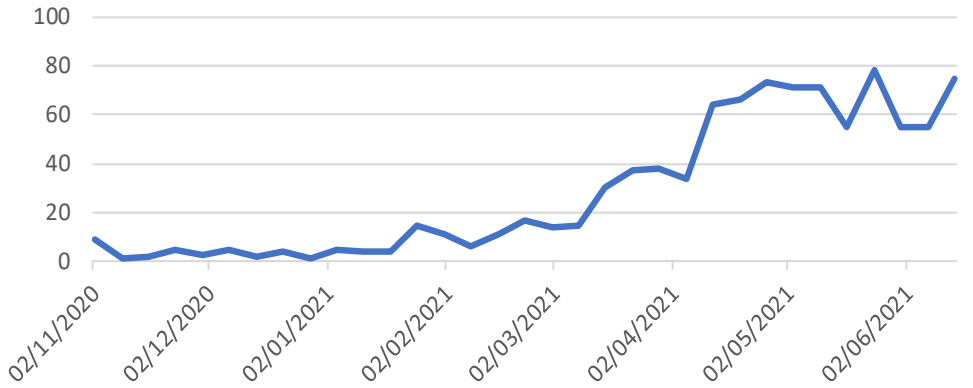
Trajectory vs Actual - Total P3s on Waiting List Over 3 months



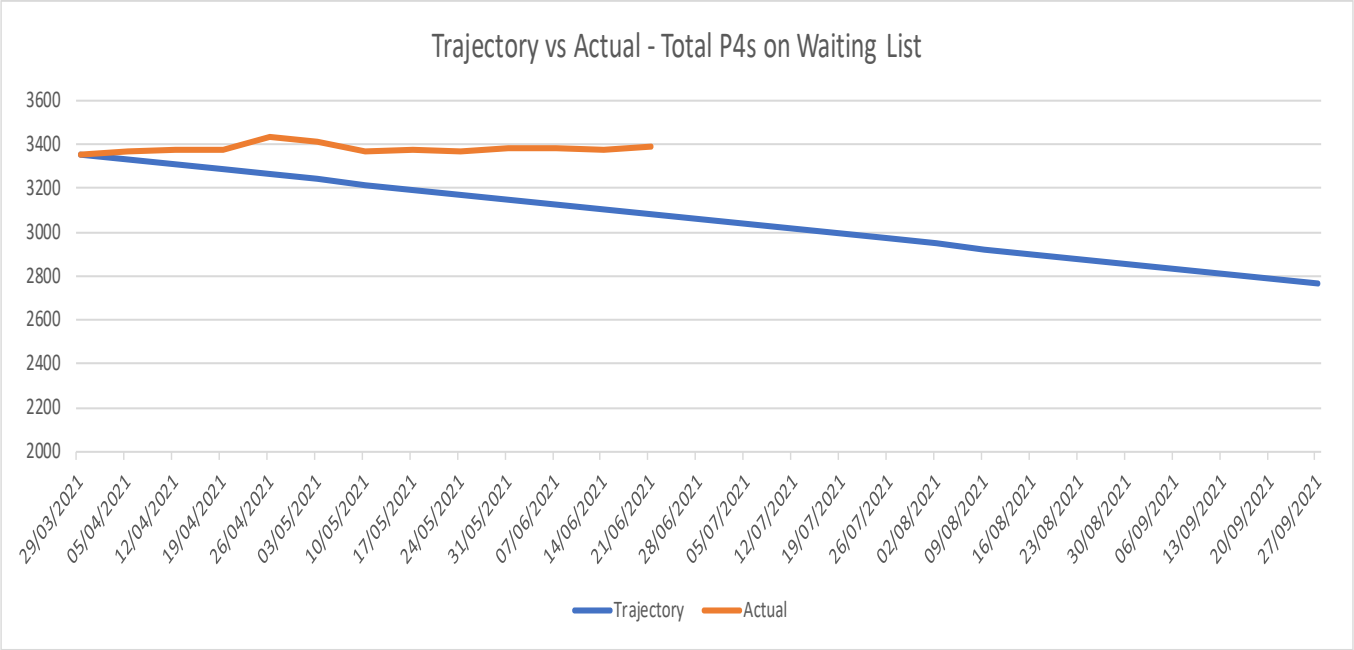
P3 waiting List Additions

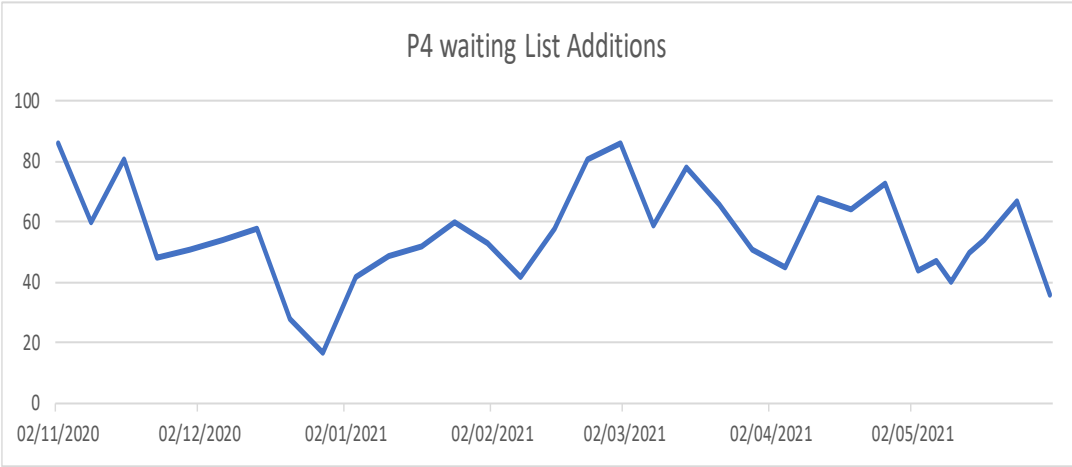


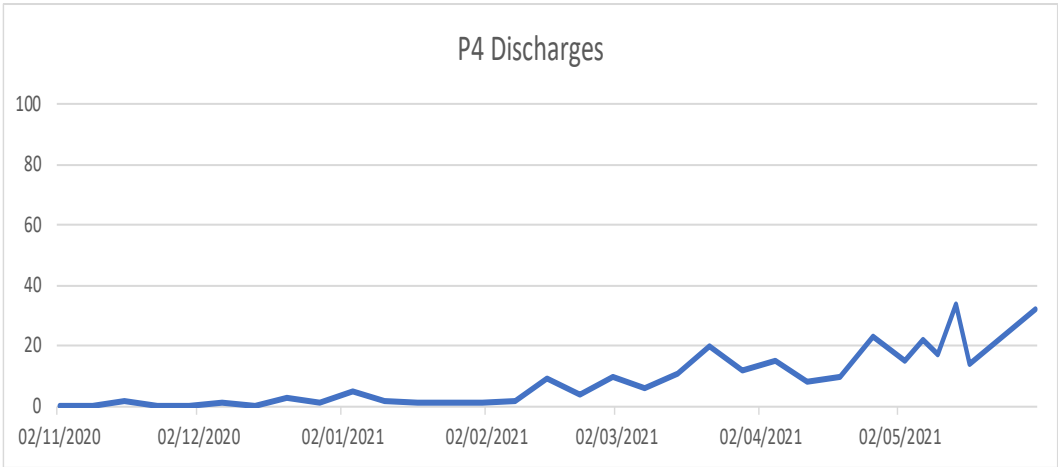
P3 Discharges



INPATIENT WAITING LIST - P4

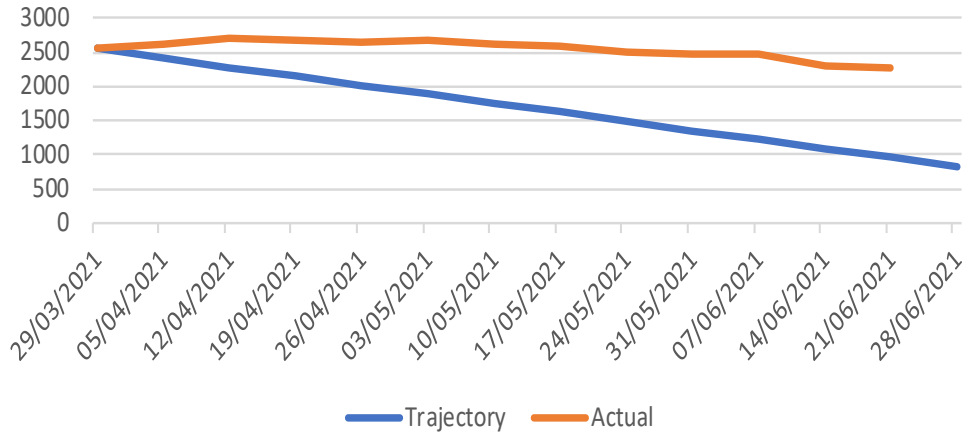




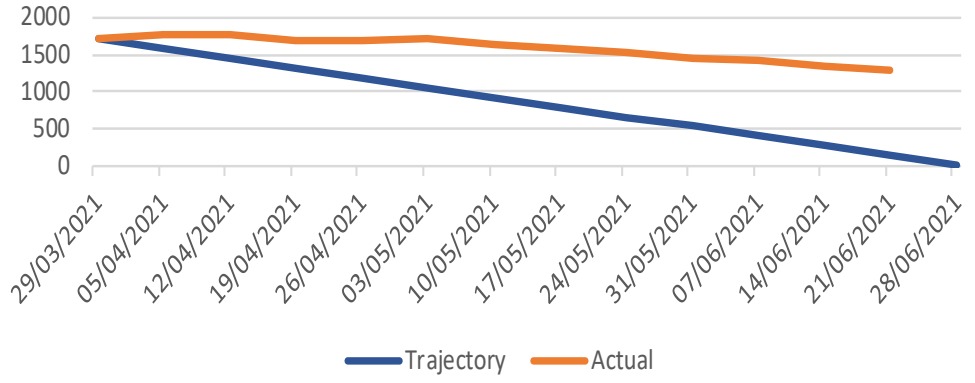


Endoscopy Waiting List

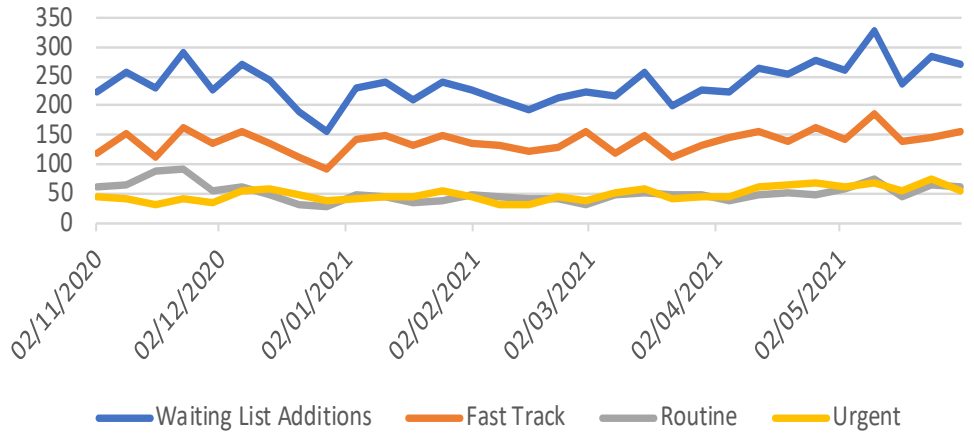
Trajectory vs Actual - Total Endoscopy Waiting List



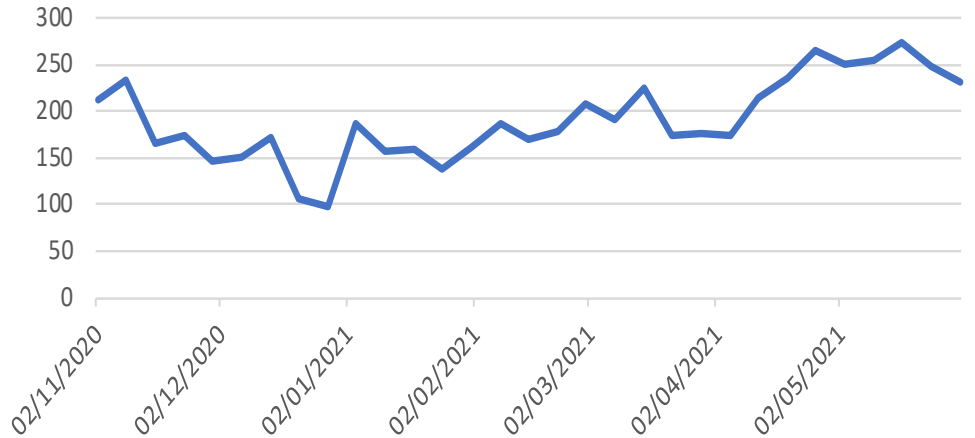
Trajectory vs Actual - Total Endoscopy Waiting List - Over 6 Weeks



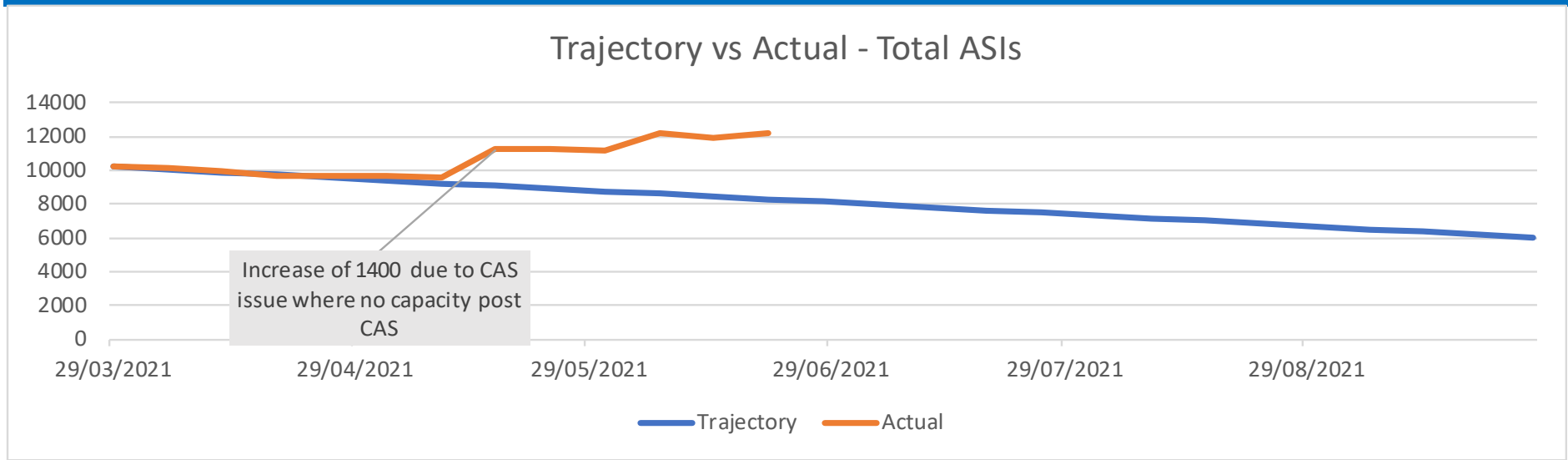
Endoscopy Additions

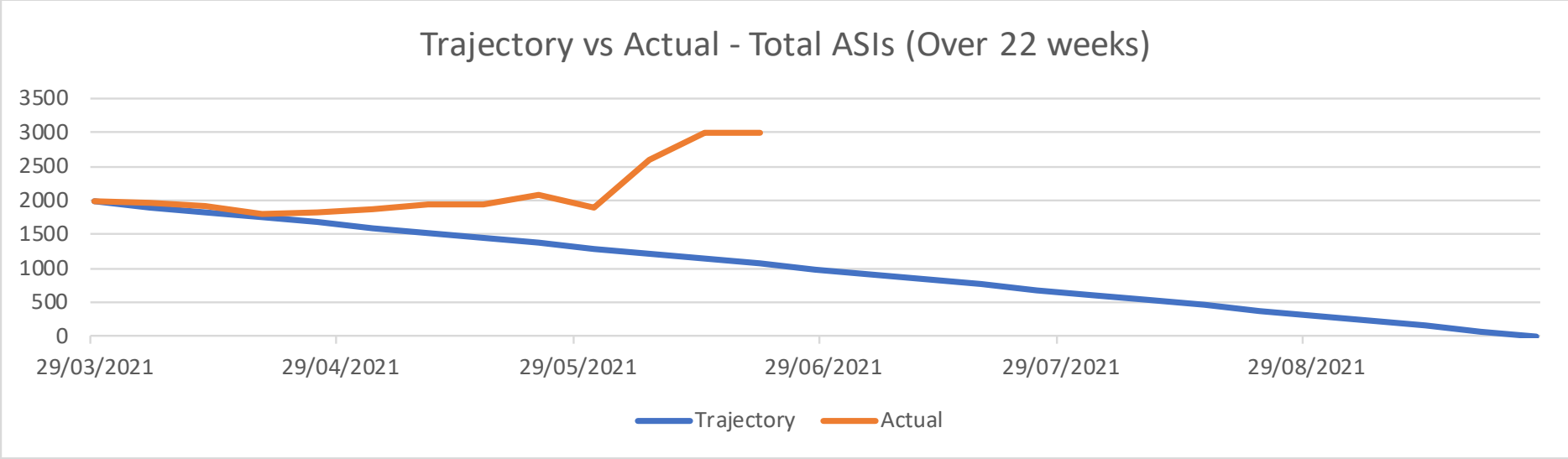


Endoscopy Discharges

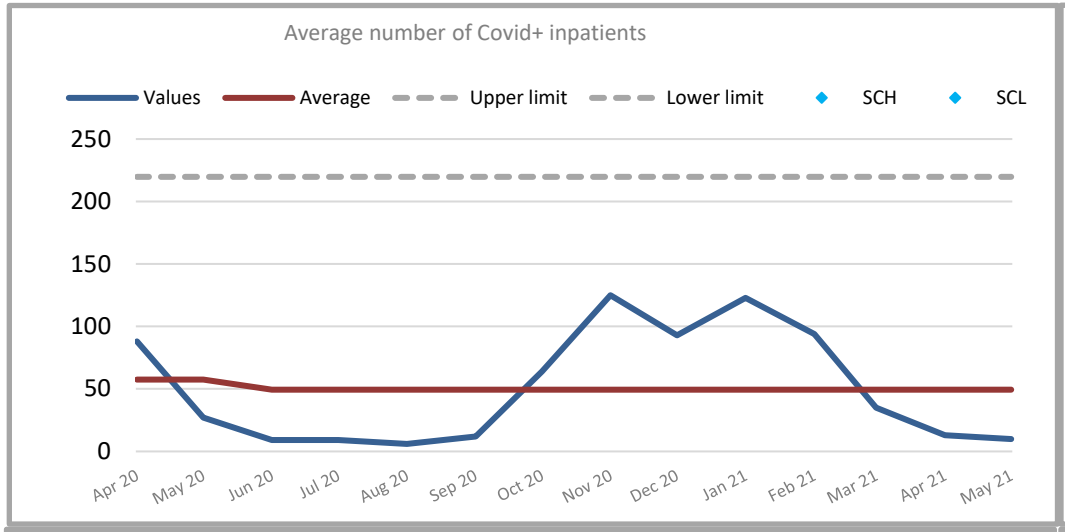


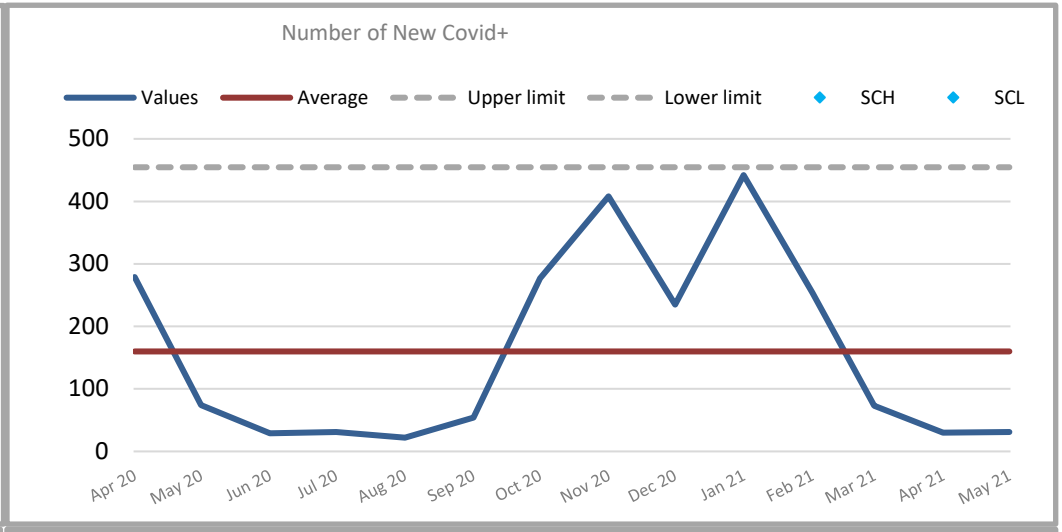
ASIs

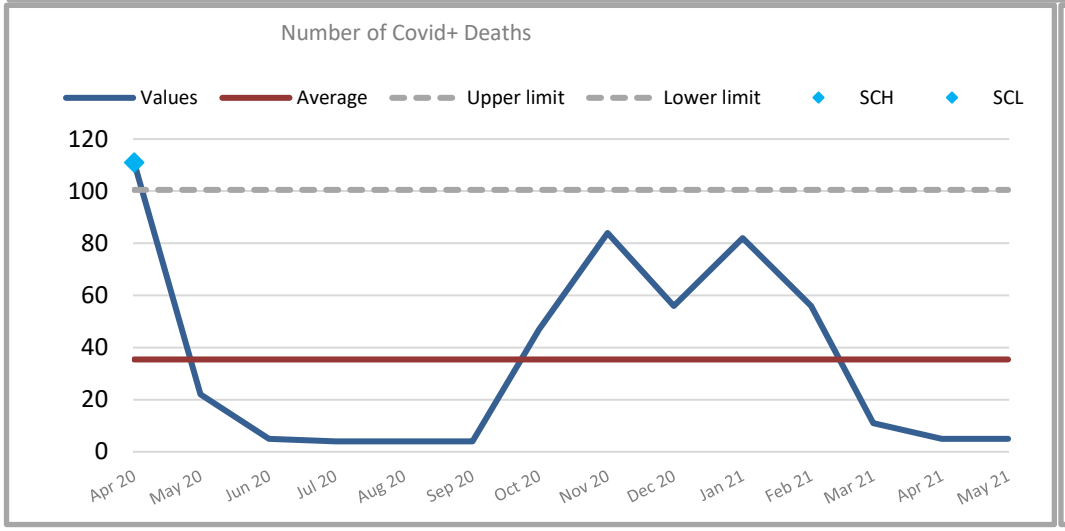

Trajectory vs Actual - Total ASIs
14000
12000
10000
8000
6000
4000
2000
0
Increase of 1400 due to CAS issue where no capacity post CAS
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
Trajectory
Actual

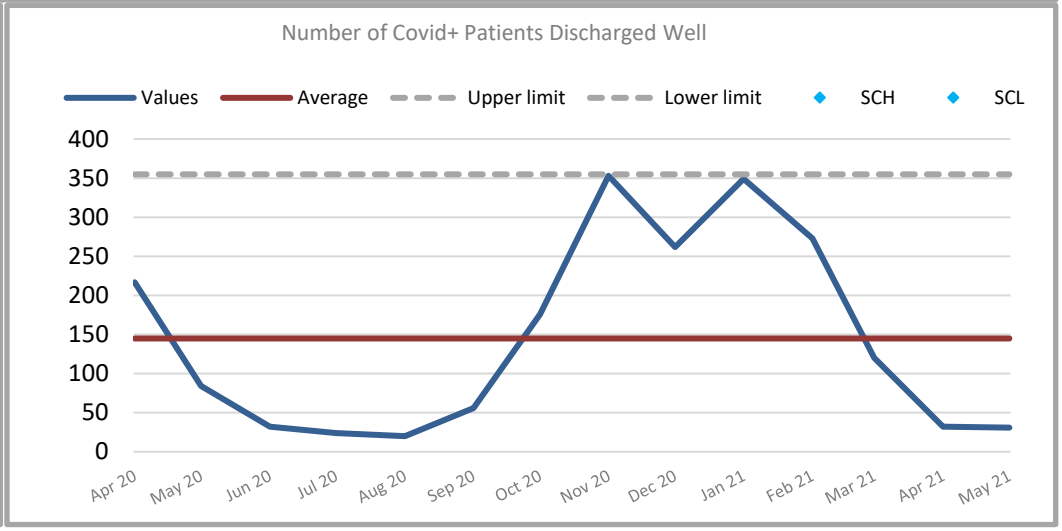

Trajectory vs Actual - Total ASIs (Over 22 weeks)
3500
3000
2500
2000
1500
1000
500
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
Trajectory
Actual

Covid-19 - SPC Charts

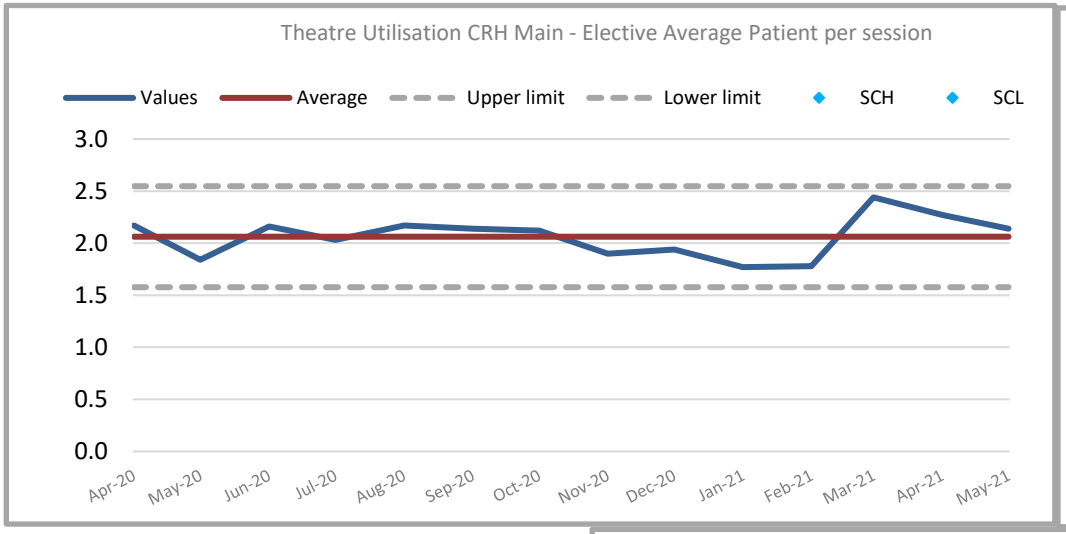


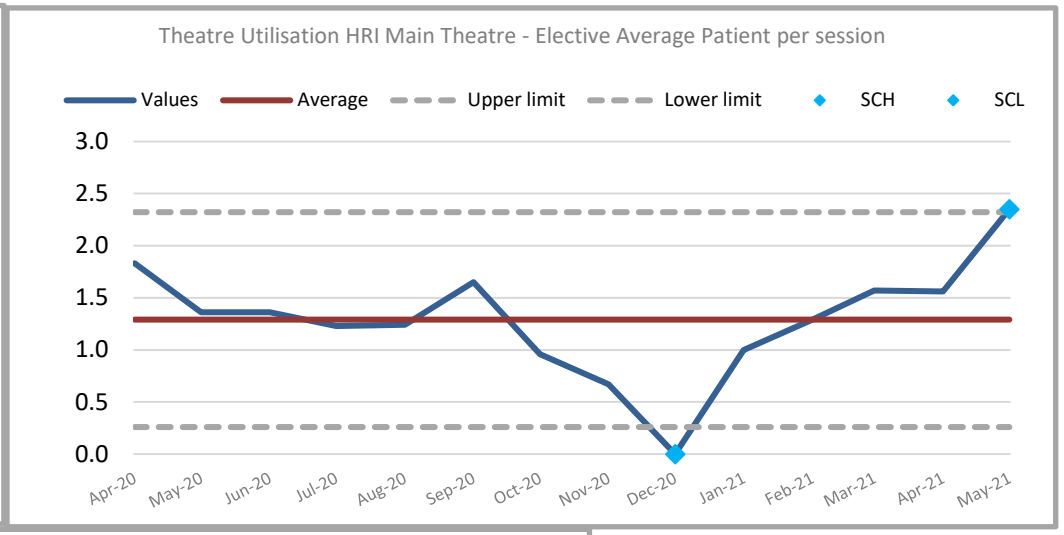


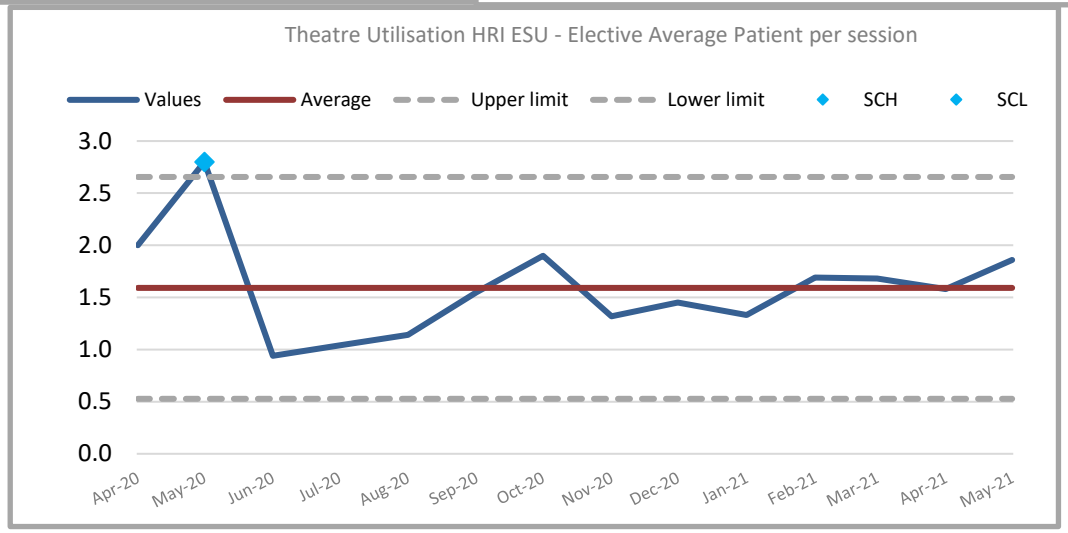




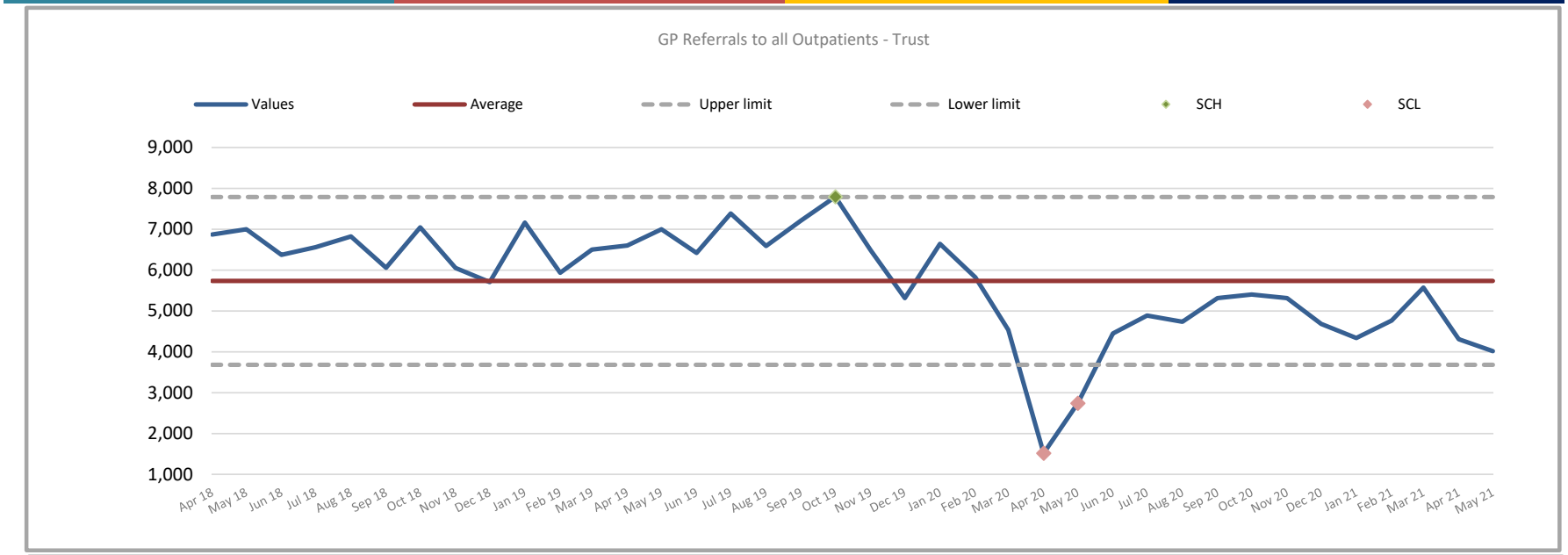
Theatres - SPC Charts

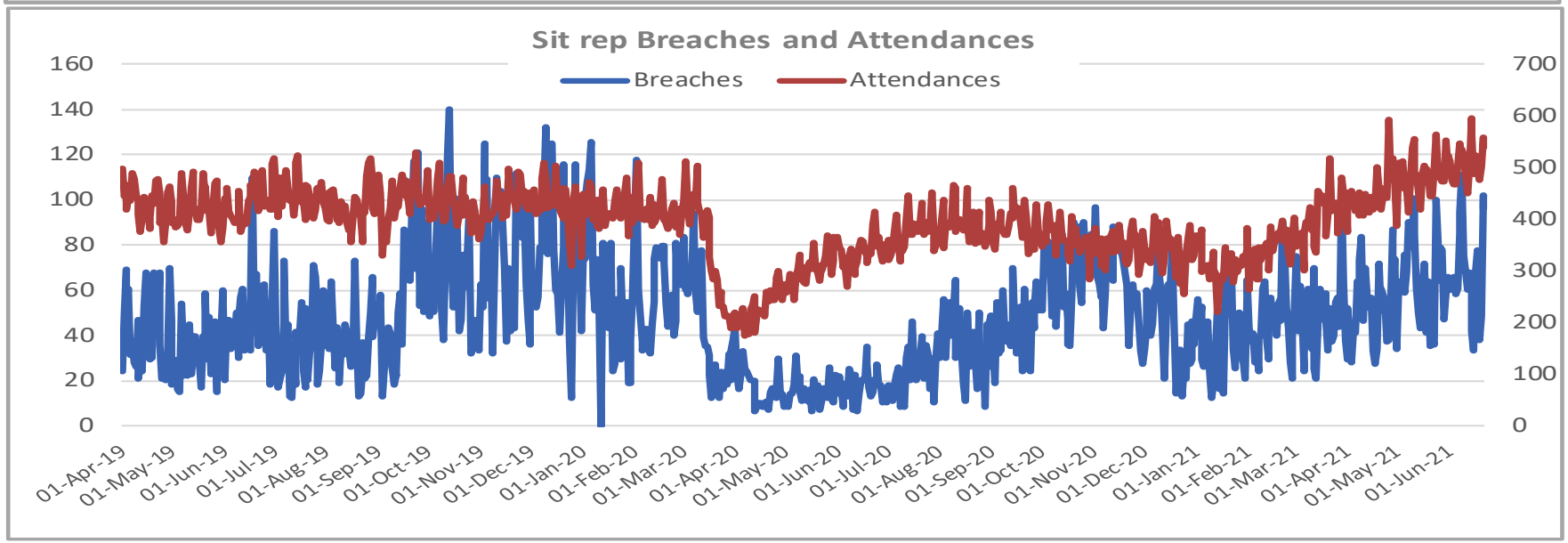






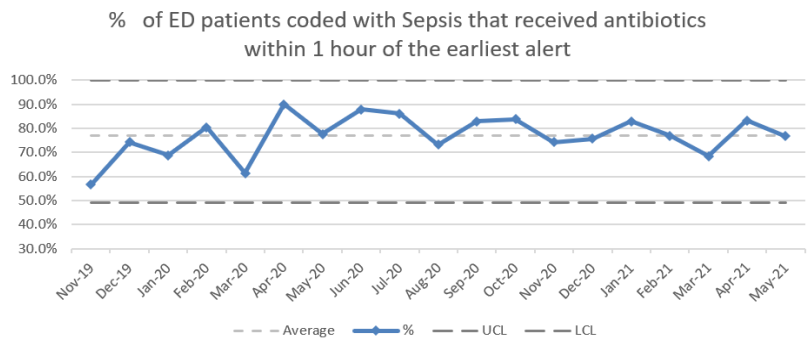
Capacity and Demand

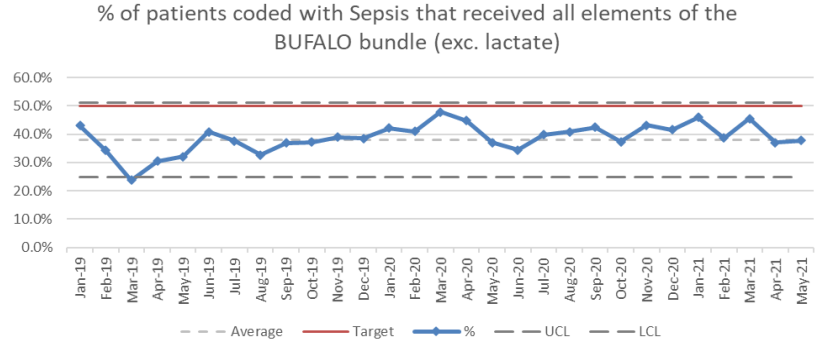




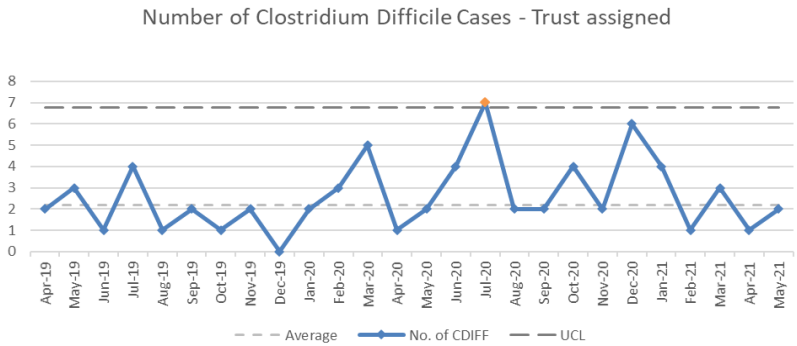
Quality Priorities - Quality Account Priorities

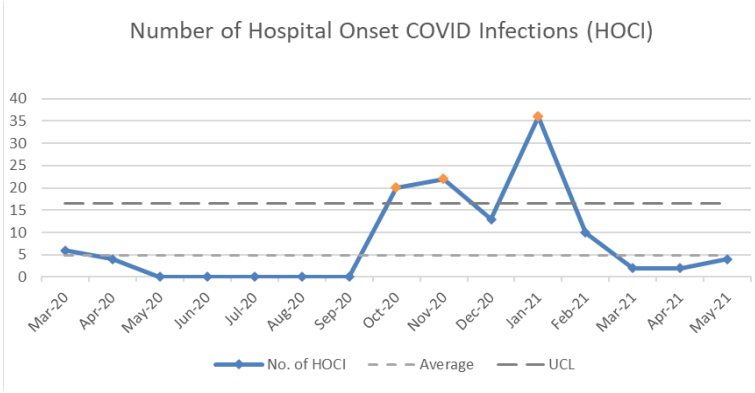
1. Recognition and timely treatment of Sepsis



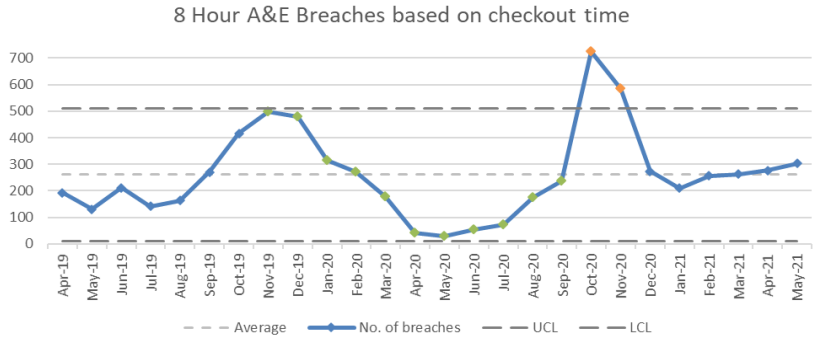


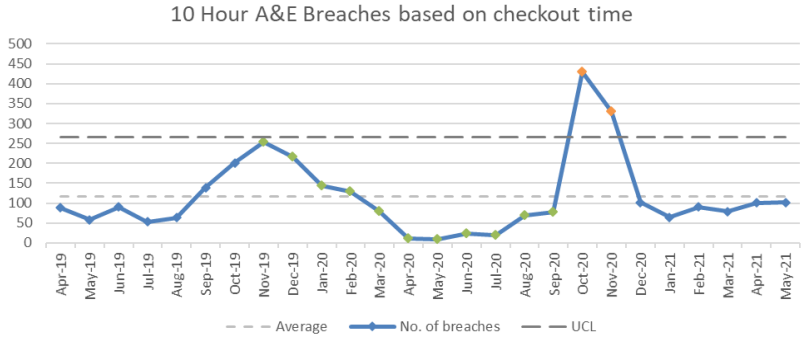
2. Reduce number of Hospital Acquired Infections including Covid 19





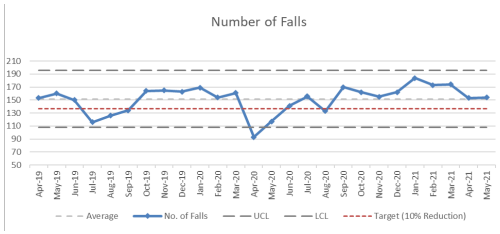
3. Reduce waiting times for individuals attending the ED



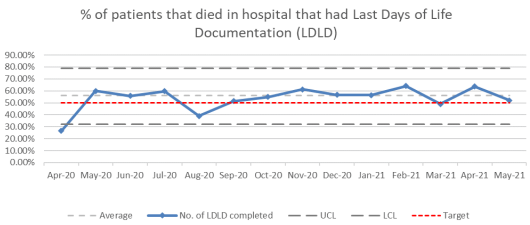


Quality Priorities - Focussed Quality Priorities

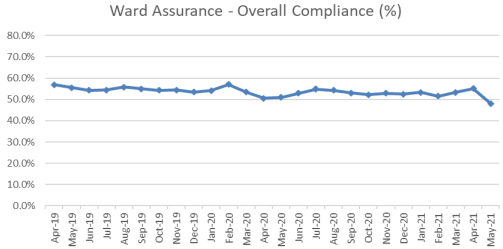
1. Falls Resulting in Harm



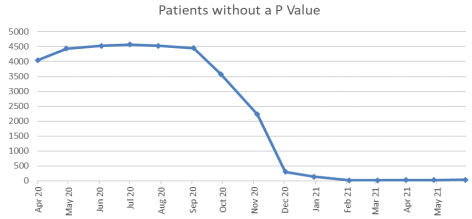
2. End of Life Care



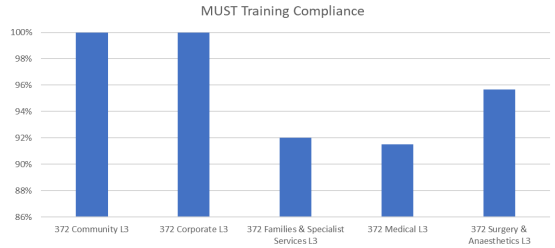
3. Clinical Documentation

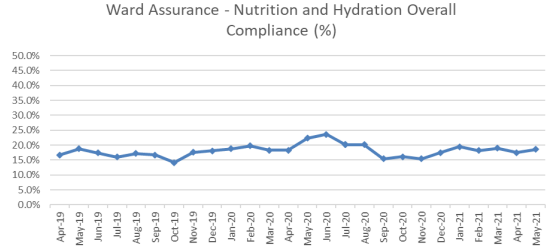


4. Clinical Prioritisation (Deferred care pathways)



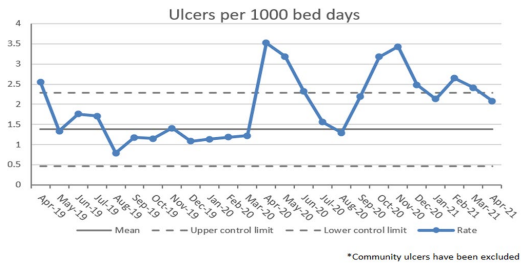
5. Nutrition and Hydration

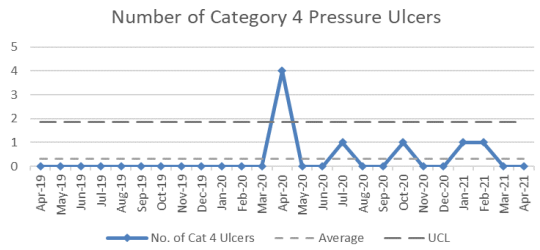




6. Pressure Ulcers

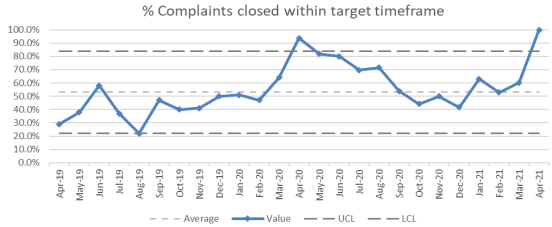
(Reported a month in areas)





7. Making Complaints Count

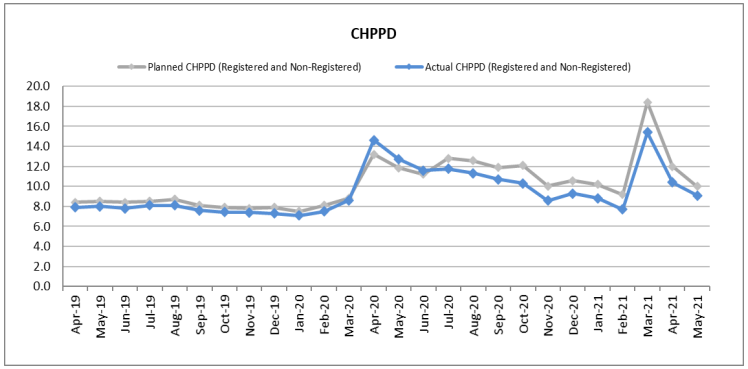
(Reported a month in areas)



Hard Truths: Safe Staffing Levels

TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

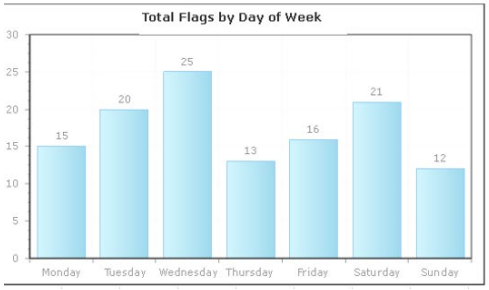
	Mar-21	Apr-21	May-21
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	83.7%	82.5%	94.3%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	84.7%	97.6%	91.6%
PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	18.4	12.0	10.0
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	15.4	10.4	9.1

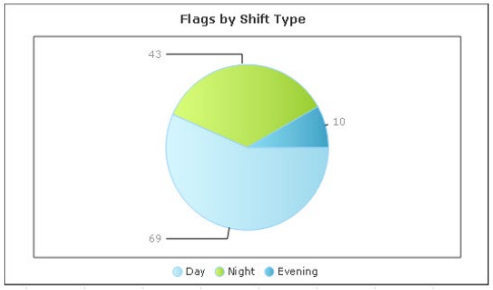


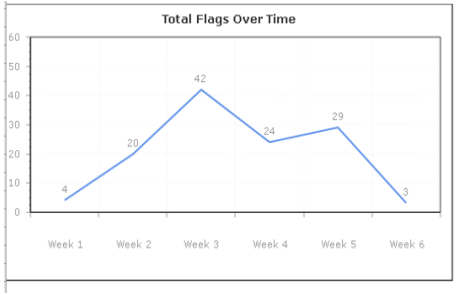
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

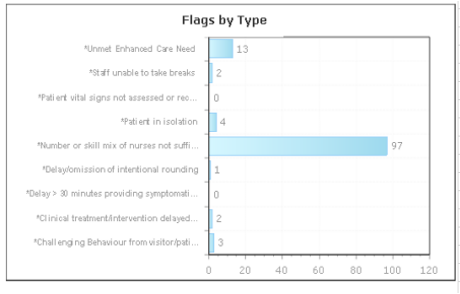
A review of May 2021 data indicates that the combined RN and non-registered clinical staff metrics resulted in 22 clinical of the 26 clinical areas having less than the planned CHPPD. A review of the nurse sensitive indicators does not indicate a direct correlation between the CHPPD position and the number of falls and pressures ulcers reported. However across these two areas, the numbers reported are less than previous months across the divisions of Medicine and Surgery. Areas with CHPPD greater than planned are attributable to 1:1 enhanced care requirements.

STAFFING RED FLAG INCIDENTS





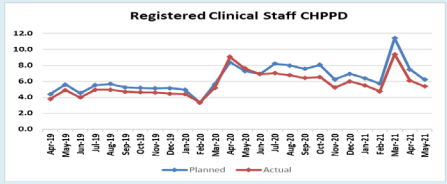
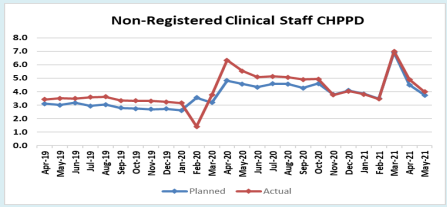
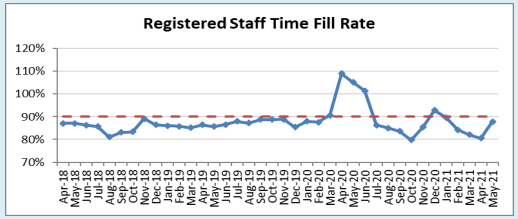
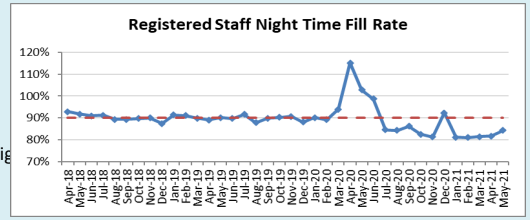
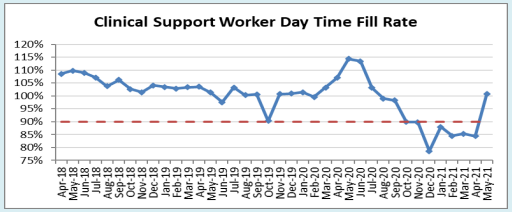
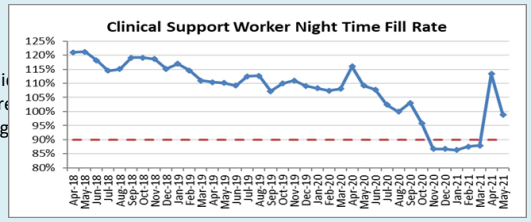




A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and review monthly through the Nursing workforce strategy group. There has been a focused piece of work with matrons and ward managers to support a shared understanding of the use of the red flag process which has been supported by the development of a frequently asked questions document.

122 red flags during the month of May, of which 97 were categorised as the number of skill-mix of nurses were not sufficient which has been a trend seen in recent months. As part of the escalation process these are also reviewed with the twice daily staffing meetings where actions are taken to mitigate the risk associated with the escalation. This decision making will be informed following an assessment of the clinical area by the matron and supported with professional judgement.

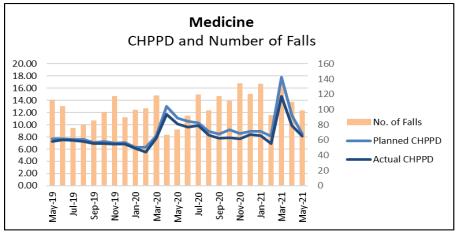
Hard Truths: Safe Staffing Levels (2)

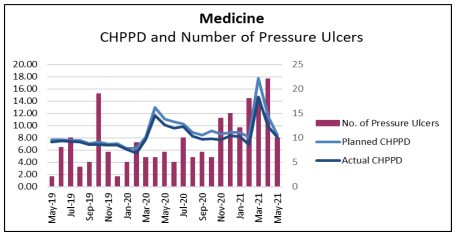
	Aggregate Position	Trend	Result
CARE HOURS PER PATIENT DAY (CHPPD) BY STAFF TYPE			
Registered Clinical Staff Monthly hours (day and night combined) divided by average patient count at midnight	CHPPD was 6.2 for planned and 5.4 for actual for Registered Clinical Staff		Overall there is a shortfall of 0.8 CHPPD against an overall requirement of 6.2. CHPPD alongside professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas. A suite of nurse sensitive indicators have also been incorporated into this section of the report to monitor for any correlations alongside the CHPPD in line with national recommendations. For those indicators reported against there has been a reduction in the number of falls and pressure reported for the month of May.
Non Registered Clinical Staff Monthly hours (day and night combined) divided by average patient count at midnight	CHPPD was 3.7 for planned and 4 for actual for Non-Registered Clinical Staff		Overall there is an increase in the CHPPD of 0.3 for non-registered clinical staff, which is reflective of the national campaign to achieve a zero vacancy position (achieved April 2021). Reflecting the fill rate position below of both workforce groups. This will also be a skill-mix response to mitigate the risk to meet the needs of patients.
FILL RATES BY STAFF AND SHIFT TYPE			
Registered Clinical Staff Day Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.	87.86% of expected Registered Clinical Staff hours were achieved for day shifts.		
Registered Staff Night Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.	84.29% of expected Registered Clinical Staff hours were achieved for nig shifts.		
Non Registered Clinical Staff Day Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.	100.72% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.		
Non Registered Clinical Staff Night Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.	98.81% of expected Non-Registered Clini Staff hours were achieved for nig shifts.		

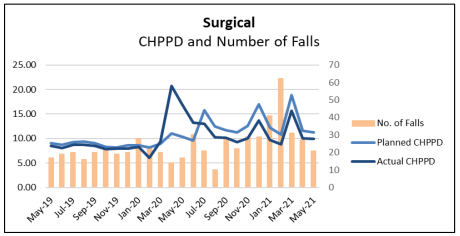
Hard Truths: Safe Staffing Levels (3)

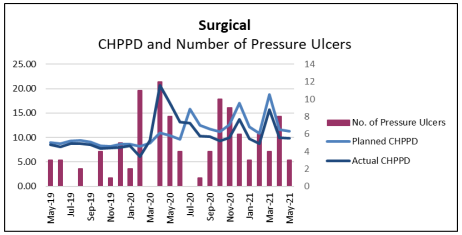
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

Ward	Average Fill Rates				Care Hours Per Patient Day		Nursing Quality Indicators					Safecare	
	DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month in Areas)	Falls	Staffing Red Flags	Ward Assurance	Number of red shifts	Number of amber shifts
Medicine	**90.9%**	**103.8%**	**83.7%**	**105.5%**	**8.5**	**8.1**	**0**	**10**	**98**	**50**	**60%**	**722**	**144**
CRH ACUTE FLOOR	99.4%	94.9%	98.6%	96.5%	8.5	8.3		1	23		66.6%	82	20
HRI ACUTE FLOOR	87.7%	89.2%	94.2%	89.7%	8.8	8.0		1	15	4	58.7%	80	20
RESPIRATORY FLOOR	68.8%	93.2%	69.1%	94.4%	12.6	10.0		2	10	7	56.8%	2	4
WARD 4D	80.5%	108.5%	96.8%	78.4%	10.4	9.4			5	1	53.7%	10	2
WARD 5	73.4%	123.8%	90.1%	145.8%	7.0	7.5		1	5	11	56.8%	46	14
WARD 6	81.4%	87.4%	100.0%	106.7%	4.3	3.9			18	10	61.3%	34	14
WARD 6C	88.7%	136.1%	101.2%	148.3%	6.5	7.5			3		52.3%	116	8
WARD 6AB	88.7%	136.1%	101.2%	148.3%	6.3	7.3				6	56.9%	46	12
WARD CCU	82.1%	77.8%	93.4%	-	8.9	7.9			3	1	56.7%	38	10
STROKE FLOOR	198.2%	152.8%	87.1%	111.3%	8.7	12.3			8		54.5%	12	6
WARD 12	77.2%	100.0%	74.1%	100.1%	8.9	7.6				1	56.5%	14	10
WARD 17	73.9%	93.6%	72.4%	106.5%	7.1	5.8				2	51.2%	126	6
WARD 18	50.0%	99.8%	54.8%	96.8%	14.8	11.0			4		59.7%	26	10
WARD 20	84.5%	91.7%	78.6%	109.4%	6.9	6.3		5	4	7	64.2%	90	8
Surgical	**86.1%**	**97.0%**	**84.3%**	**86.3%**	**11.3**	**9.9**	**0**	**3**	**22**	**3**	**67.1%**	**180**	**53**
WARD 21	79.5%	100.0%	72.5%	91.7%	8.2	7.0			3	1	63.6%	18	8
WARD 22	97.8%	98.0%	90.7%	103.2%	6.7	6.5		1	5		68.4%	47	16
ICU	83.3%	81.8%	85.0%	57.1%	38.9	31.3		1	1		75.2%	23	4
WARD 8B	100.0%	122.5%	100.0%	69.4%	8.4	8.3					63.3%	23	4
WARD 8D	70.5%	81.0%	67.7%	-	24.2	17.3			1		61.2%	2	2
WARD 10	76.9%	103.7%	80.0%	84.0%	13.8	11.8					77.5%	10	2
WARD 19	86.5%	97.8%	88.4%	111.8%	7.7	7.3		1	10	2	67.5%	26	10
SAU HRI	95.8%	102.7%	85.2%	111.2%	7.2	6.9			2		61.5%	31	7
FSS	**86.3%**	**84.3%**	**86.7%**	**88.1%**	**13.3**	**11.5**	**0**	**0**	**0**	**2**	**19.9%**	**0**	**0**
WARD LDRP	85.8%	89.7%	84.9%	93.6%	25.8	22.3					18.0%		
WARD NICU	88.7%	55.9%	90.9%	80.2%	13.5	11.7					40.4%		
WARD 3ABCD	81.5%	82.3%	81.2%	79.4%	24.0	19.5				2	22.4%		
WARD 4ABC	92.2%	93.4%	97.3%	93.5%	5.1	4.8					18.1%		
TRUST	**87.86%**	**100.72%**	**84.29%**	**98.81%**	**10.0**	**9.1**							









Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments.

On-going activity:

1. A revised dashboard has been approved as part of the Hard Truths section of the IPR which closely aligns the workforce position to an agreed suite of nurse sensitive indicators.
2. The Nursing and Midwifery Workforce Steering Group has been re-established with new terms of reference.
3. A section on Knowledge Portal Plus has been developed to support triangulation of the workforce position to the agreed suite of nurse sensitive indicators and has been supported with a staff engagement and training exercise.
4. An Associate Director of Nursing with Corporate Nursing has been established, which includes Nursing/Midwifery Workforce and Education within their portfolio.
5. A review of the current Nursing and Midwifery workforce plans is underway and supported by Workforce Business Intelligence.
6. International recruitment projects continue to progress with an aspiration to recruit a further 70 international nurses for 2021/2022. The pausing on India has impacted on this programme, awaiting further update.

21. Health and Safety Update and Strategy

To Approve

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title:	Health and Safety Report Update
Author:	Richard Hill, Head of Health and Safety
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	Health and Safety Committees 2021

Purpose of the Report

To provide the Board with an overview of the health and safety activities during 2020/2021 and the progress against the Health and Safety action plan.

Key Points to Note

A summary of the main activities and updates for the 12-month reporting period to 31st March 2021, and progress against the action plan monitored at the Health and Safety Committee to date.

EQIA – Equality Impact Assessment

All Health and Safety guidance and advice is provided in language that is appropriate for all colleagues, including those who are neuro diverse. Throughout COVID, place based risk assessments have been designed to be clear, easy to read and understand. Work is underway to identify all reportable Health and Safety data by protected characteristic break down, including RIDDOR reportable incidents, violence and aggression incidents, slips trips and falls, sharps injuries. This work will be complete by 2nd July 2021. The Health and Wellbeing Risk assessment enables CHFT to breakdown heightened levels of stress and or anxiety by protected characteristic.

Recommendation

The Board of Directors is asked to note the progress made against the action plan presented and receive the Health and Safety Update.

BOARD OF DIRECTORS

1 JULY 2021

HEALTH AND SAFETY UPDATE

1. Introduction

This paper presents progress against actions identified in the Health and Safety Annual Plan 2021 and the external audit conducted by Quadriga in 2019. In addition to progressing the actions identified above, work has also been undertaken to implement and maintain COVID compliance, with support and guidance provided to colleagues and partners throughout CHFTs COVID Response and Recovery. Support has also been provided to Huddersfield Pharmacy Specials to improve their health and safety compliance. Accident prevention groups have been established and a special focus has been given to Community Division compliance.

Finally, work has been undertaken to develop a CHFT 5-year Health and Safety Strategy, using the NHS Workplace Health and Standard as a guide. The draft Health and Safety Strategy will be added, after being presented at the next Health and Safety Committee before ratification at the Board in September 2021.

2. CHFT Health & Safety Action Plan (April 2020/ March 2021)

Progress against the CHFT Health and Safety Annual Plan is identified in Appendix (A).

3. Quadriga Health & Safety Review Update

In 2019 Quadriga Ltd were appointed to carry out a review of the policies status, including aspects of governance arrangements in place. The review generated 15 recommendations and work has taken place to address each of them. Since the last review 3 more items have been completed. Remaining actions will be completed by November 2021. The action plan is at Appendix B.

4. COVID-19 Compliance

The Trust has implemented measures to provide a secure environment for colleagues and patients. The Incident Management Team introduced a social distancing group, PPE group meeting and IPC Gold meetings. The output from these meetings have helped strengthen the Trust's Environmental COVID Risk Assessment which has been updated and republished to all colleagues. Spot checking of conditions continue across the Trust to ensure standards remain in place, including occupancy levels, PPE wearing and social distancing. The Trust Health and Wellbeing Risk Assessment has also been developed to include three 'lite' assessments for colleagues.

5. Huddersfield Pharmacy Specials

Since the last update to the Board in January 2021, significant progress has been made in the development of policies, procedures, and risk assessments. The development of training is outstanding but will be finished by September 2021.

6. Accident Preventative Initiatives

We have placed a focus upon the most common risks, which are highlighted in the DATIX results and are slips, trips, and falls injuries and sharps related injuries. Action has been taken to set-up compliance groups to help monitor and manage the risks. Further information below.

(a) Falls Injuries – collaborative work has taken place with the Falls Collaborative Group. A review has now taken place of their 'Management of Falls Policy', this has resulted in widening the focus of it, towards including non-clinical matters, floorplate inspections and coordination with Albany, CHS Ltd under landlord obligation health and safety requirements.

(b) Sharps Injuries – since the last update a group has been set-up to help monitor DATIX incidents and put in plans to manage the risk. The group includes representation from clinical and non-clinical departments and continues to function successfully.

7. Community Division

The Community Division has been given extra attention to ensure compliance continues to be in the right place. The Division is unique by the fact that its services are remote to the main hospital setting which is reflected by the extra attention given. In the last 2 months a Community Compliance Group has been set-up with input from SME's in fire safety, security, safety, environmental compliance. The group continues to work at pace to take forward compliance.

8. NHS Workplace Health and Safety Standards

The NHS Workplace Health and Safety standards were published to all NHS Trusts in 2013 and provide simple and straightforward guidance to achieve compliance. There are 30 standards with each standard is accompanied by guidance on how to meet the requirements of legislation and a safer environment for patients and colleagues. We have set-up Lead Persons to support the Head of Health and Safety drive forward the development and implementation of these. The objective is to have the Standards as the 'management system of choice' and independently audited with certification of compliance.

Appendix C identifies the stages of development towards final implementation of the standards.

Appendix A

Progress Against the CHFT Health and Safety Annual Plan (April 2020/ March 2021)

			Target for completion					
Ref	**Action**	**Progress**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**
1.0	A review of the CHFT Health and Safety Policy which includes a review of the roles, responsibilities, and arrangements across the organisation with a focus also upon developing a 'statement of intent' which highlights commitment for a safe environment by the CEO.	The revised policy is now displayed on the Intranet. The 1-page 'statement of intent' is now to be displayed on notice boards		X				
2.0	To produce a CHFT slips, trips, and falls policy which will place focus upon managing the risk of injuries by non-patient movement across the hospital and community hubs	A pragmatic decision has been agreed to review the Falls Collaborative Policy by including non-clinical references into it. The revision will be shared with the H/S Committee on the 23rd June 2020 and final approval,	X					
3.0	To develop the risk assessment process as a stand-alone document and to introduce a new risk assessment template	A re-think upon this based on achieving better oversight of completion oversight, on-line risk assessment form to be designed which will have 100% central oversight when completed by staff members from the Head of Health and Safety.			X			
4.0	To review the staff incident report and change into a quarterly report, with reference to the top 3 staff causes of incidents (slips, trips and falls / moving and handling / sharps reduction	Each subject is now a standing agenda item at all H/S Committee Meetings	**Completed**					

			Target for completion					
Ref	**Action**	**Progress**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**
5.0	To support the PPE and Social Distancing Groups in the development of COVID secure measures	An environmental risk assessment has been produced and shared across all staff in the Trust. The social distancing notices on all entry doors has been refreshed, relevant policy has been produced to support COVID secure measures.	**Completed**					
6.0	To support the wellbeing of staff working from home and using a display screen, workstation set-up	On-line guidance has been produced and shared with all home-workers. The guidance is to help individuals reduce the risk of ergonomic related posture.	**Completed**					
7.0	To collaborate with partner organisations which provide support services to ensure there is equal understanding of health and safety measures for staff and patients.	Attendance takes place at each of the partner health and safety meetings which allows for alignment of thinking and understanding on subject related matters.	**Completed**					
8.0	To help carry out COVID secure walkarounds so measures are in place to help protect staff and patients	The first round of walkarounds has taken place and these continue at pace.						
9.0	To review and reconvene the sharps reduction group, including a reset of the terms of reference	A sharps reduction injury group has now been set-up with meetings taking place to review DATIX incidents and actions	**Completed**					

Appendix B

Quadriga Health and Safety Review

	Action	Tasks	Target Date	Progress/Action to progress
1	**Review of Health and Safety Arrangements**	a. Assess and review health and safety governance arrangements between CHFT and CHS	N/A	**Complete** Robust governance structures in place between CHFT and CHS.
		b. Advertise and appoint Trust Health and Safety Manager	N/A	**Complete** Richard Hill in post Sept 20.
		c. Review Trust Health and Safety Policy to create clarity on roles and responsibility within CHFT (referencing relevant support from CHS) stating how competent support is provided at strategic level.	N/A	**Complete** The policy has now been approved and uploaded to the Intranet policy pages
2.	**Review of Risk Assessments**	a. Introduce Risk Assessment Policy / Protocol	June 2021	The Risk Assessment Policy/Protocol is to be changed and become an appendix to the Risk Management Policy. This will avoid unnecessary duplication of content between each version.
		b. Review Risk Assessment scoring matrix	n/a	**Completed** Scoring matrix to remain as is following discussions with Risk. This is because to alter the scoring matrix would interfere with the entire scoring matrix within the risk management policy, used by other departments.
		c. Review effectiveness of Risk Assessment Training	N/A	FB Update - Face to face training suspended by the Trust. CHS SLA only covers CHFT Induction Training not CHFT RA training

3	**Develop Specific Risk Related policies**	a. Review and, where appropriate, create individual policies on specific risk areas namely: - • Dangerous Substances and Explosive Atmosphere Regs (2002) • Control of Noise at Work Regs (2005) • Control of vibration at Works Regs (2005 • Control of Electromagnetic Fields at Work Regs (2006)	n/a	**Completed** A position statement written by the Head of Health and Safety on rejection of the requirements. **DSEAR** – equal measures already in place. **Noise** – not applicable to current clinical and non-clinical activities **Vibration** – tools used in theatre/plaster room no vibration risk **Electromagnetic fields** – consultation with Furgus Dunn (IRS Ltd) = no risk within the Trust but could apply to CHS operations
4	**Ensure compliance with Construction (Design & Management) Regs 2015**	a) CHFT to clarify appointments in writing including the HTM roles and responsibilities and CDM 2015 appointments.	July 2021	**ONGOING** CHS SLA to include both HTM arrangements and CDM arrangements.
		b) HTM roles clearly defined in letters of appointment and acceptance letters at both CRH & HRI including respective AP structures	n/a	**Completed** All HTM appointment letters / acceptance letters in order and available for audit.
		c) CDM 2015 Principal Contractor and Principal De-signer appointments will be project specific on a case by case basis. Clearly defined in H&S construction phase plans for all such minor works	July 2021	**ONGOING** CHS SLA being updated to reflect CDM arrangements
5.	**Ensure compliance with the Fire Safety (Regulatory Reform) Order and supporting HTM 05**	a. Appoint Director with overall responsibility for Fire Safety	n/a	**Completed**
		b. Review Fire Safety Service Level Agreement between CHFT and CHS.	n/a	**Completed** CHS SLA with Fire Committee approved.
		c. Review Trust Fire Policy ensuring clarity on roles, responsibilities, and arrangements with CHS and clarity on training requirements.	n/a	**Completed** Fire Policy Agreed at Fire Committee
		d. Develop 5-year Fire Strategy considering capital works / reconfiguration and compartmentation.	n/a	**Completed** Fire Strategy Agreed

6	**Reduce the number of Needle-stick, Sharps and Splash incidents.**	a. Update Health & Safety Committee terms of reference incorporating the role and responsibility of Divisional Reps	n/a	**Completed** TORS discussed at Oct H&S Committee and approved at Dec meeting. Lead sourced for this group To be escalated to Audit & Risk Committee for approval. Not required.
		b. Measure the number of incidents on a quarterly basis.	n/a	**Completed** Quarterly report provided which is aligned with Occ. Health data. Shared at Oct 20 H&S Committee
		c. Develop and share innovative learning across Trust	n/a	**Complete** Forms part of 6a; H&S Committee Sub-Group TORs agreed and sent to new chair. Meetings to commence
7	**Provide a robust COSHH management system Trust wide**	a. Carry out a review of current COSHH system within Trust recognising:- • Number of Super users • Number of Staff Trained • Up to date COSHH folders available • Knowledge of colleagues in Divisions	July 2021	**ONGOING** COSHH Lead to be identified and agreed. Meeting planned with Lis Street in May 2021
8	**Monitor reporting of Slips, Trips & Falls**	a. Monitor the number of incidents on a quarterly basis.	n/a	**Completed** Slips trips and falls (non-clinical) is now integrated into the Falls Collaborative Group as a standing agenda item with representation by the Head of Health and Safety and Contracts Performance Manager. Data stats will continue to report into health and safety committee meeting
		b. Encourage accurate reporting and learning via Datix		**Completed** Learning to be established from Sub-Group. Quarterly reports to be discussed at Trust Health and Safety Committee

9	**Review Health and Safety Training**	a. Monitoring mandatory 3 yearly training	November 2021	**ONGOING** The national skills framework has been studied and a paper produced, shared with the health and safety committee meeting February 2021. Next steps are work on the recommendations of that paper, which will take place later in 2021 as part of the NHS Workplace Health and Safety Standards implementation
		b. Measure numbers of colleagues receiving risk assessment training	n/a	**Completed** Paper shared with Oct H&S Committee. As 2c
		c. Reviewing effectiveness of risk assessment training	n/a	**Completed** Paper shared with Oct H&S Committee. As 2c
10	**Wards / Departments to achieve Medical Devices training target**	a. Monitor and report medical device training statistics at health and safety committee	n/a	**Completed** Regular reports feature at Health & Safety Committee
		b. Escalate areas of concern to Audit & Risk Committee	n/a	**Completed** SOAP template designed for escalation of Health and Safety Committee issues to Audit and Risk
11.	**CHS & CHFT Risk Registers**	a. Cross reference CHS and CHFT applicable risks	n/a	**Completed** Agenda Item at Joint Liaison Committee and TORs
		a. Ensure Joint Liaison Committee (CHS/CHFT) periodically review whether risk controls in place are considered acceptable and are actually working.	n/a	**Completed** Risk controls reviewed and challenged at regular intervals
		a. Where risks are registered as falling into the significant risk category on either CHS or CHFT register, and are reported to the JLC Committee, that the immediate actions being taken to mitigate the risk are also outlined in the same report. This should be supplemented by the planned timescale for implementation.	n/a	**Completed** action plans considered at JLC.

12.	**Improvement of reporting arrangements of RIDDORs incidents to HSE**	a. Review RIDDOR reporting arrangements for interfacing with the Health and Safety Executive and submitting reports under RIDDOR to the HSE	September 2021	This is planned for 2021 to increase awareness of RIDDOR reporting requirements across the Trust. Will be part of the NHS Workplace Health and Safety Standards project
		b. Monitor and report RIDDOR incident and trends at health and safety committee	n/a	**Completed** RIDDOR incidents included in incident reporting

Appendix C

NHS Workplace Health and Safety Standards

Ref	Title	Lead Person	Review of Policy content	Development of Policy	Implementation of Policies
			Jan-March 2021	**June-December 2021**	**Jan-March 2021**
1.0	Incident Reporting Compliance	Naheed Razziq	Completed		
2.0	Occupational Health Compliance	Christine Bouckley	Completed		
3.0	Slips, Trips and Falls Compliance	Helen Hodgson	Completed	Completed	Planned
4.0	Radiology Compliance	Claire Gruszka	Completed		
5.0	Musculoskeletal Disorders, Moving and Handling Compliance	Mandy Tanyan	Completed		
6.0	Electrical Profiling Beds Compliance	Mandy Tanyan	Completed		
7.0	Violence and Aggression/Challenging Behaviour	Ian Kilroy	Completed		
9.0	Management of Work-Related Stress Compliance	Nicola Hosty	Planned		

Ref	Title	Lead Person	Review of Policy content	Development of Policy	Implementation of Policies
			Jan-March 2021	**June-December 2021**	**Jan-March 2021**
10.0	Management of Bullying & Harassment Prevention Compliance	TBC	Planned		
11.0	Hazardous Substances Compliance	TBC	Planned		
12.0	Management of Sharps Compliance	Maria Ferris	Completed		
13.0	Work Equipment Compliance	Rob Ross	Completed		
14.0	Display Screen Equipment Compliance	Diane Marshal	Planned		
15.0	Legionella Compliance	Ian Rawson	Completed		
16.0	Asbestos Compliance	Ian Rawson	Completed		
17.0	Room Temperature Conditions Compliance	Ian Rawson	Planned		
18.0	Transport Compliance	Ian Rawson	Completed		
19.0	Electricity Compliance	Ian Rawson	Completed		
23.0	Competency	Richard Hill	Completed		

Ref	Title	Lead Person	Review of Policy content	Development of Policy	Implementation of Policies
			Jan-March 2021	**June-December 2021**	**Jan-March 2021**
24.0	Risk Profiling Assessment	Richard Hill	Completed		
25.0	Measuring Compliance Performance	Richard Hill	Completed		
26.0	Lessons Learnt	Richard Hill	Completed		
27.0	Policy Planning	Richard Hill	Completed		
28.0	Roles and Responsibilities	Richard Hill	Completed		
29.0	Cooperation and Communication	Richard Hill	Completed		
30.0	First Aid	Richard Hill	Completed		

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 1st July 2021
Meeting:	Public Board of Directors
Title:	Health and Safety 5 Year Strategy
Author:	Richard Hill, Head of Health and Safety
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	Health and Safety Committee - June 2021

Purpose of the Report

To provide the Board with a 5-year health and safety strategy paper for discussion.

Key Points to Note

This paper presents to the Board for approval a 5-year health and safety strategy (via a powerpoint presentation) which includes the development of a structured health and safety management system by the adoption of the NHS Health and Safety Workplace Standards. The Health and Safety Policy is attached for information.

EQIA – Equality Impact Assessment

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in the use of the 5-year health and safety strategy no individual is discriminated against by reason of their gender, race, disability, age, sexual orientation, religion or religious/ philosophical belief or marital status, alternatively promoting efforts through the strategy towards inclusion and reducing health inequalities.

Recommendation

The Board of Directors is asked to **APPROVE** the content of the 5-year strategy.

One Culture of care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Health and Safety Strategy

2021-2026

Introduction

- We have more than 6,000 brilliant colleagues who deliver compassionate care across multiple sites including two hospital sites, community sites, health centres and of course in patients' homes.
- We want everyone who works for us or with us, receives care from us or visits us to be safe
- Providing an environment that protects the health and safety of those colleagues as well as our patients, their families and visitors, contractors, and partner organisations is everyone's responsibility under the Health and Safety at Work etc. Act 1974
- But this strategy isn't just about law – its about who we are as a Trust, and the values and behaviours we hold dear to our hearts – the very behaviours that make us unique
- One culture of care is all about caring for ourselves and each other in the same way we care for our patients. There is no better way to demonstrate how we care than to keep each other safe.

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What's in our Health and Safety Strategy?

1. The aim of our Health and Safety Strategy, alongside our Health and Safety Policy
2. The 6 key elements of our Health and Safety Strategy
3. How our Health and Safety Strategy aligns with our 4 pillars and One Culture of Care
4. Inclusion and Health Inequalities
5. Continuous improvement and learning from COVID
6. The NHS workplace Safety Standards
7. The key activities that will be undertaken in the next 5 years
8. How our governance structure will be used to assure the Board of progress against our objectives

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What is the aim of our Health and Safety Strategy?

- The aim of our Health and Safety strategy is to identify, communicate and embed the overarching principles and activities that will create a safe environment in which to work, receive care and visit
- The strategy does not replace our Health and safety policy or associated action plan - our Health and Safety policy is a more formal detailed document that sets out how we will respond to known risks and issues and identifies national legislation by which we must abide

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Health and Safety Strategy – 6 key elements

- We will champion the rules and legislation that keep us, our colleagues patients visitors and partner safe, making Health and Safety everyone's business
- Health and Safety actions and priorities will be planned, delivered and monitored in line with our 4 pillars and One Culture of Care
- We will assess any Health Inequalities in our approach and ensure that plans, activities and communications are inclusive
- We will adopt a strong lessons learned and continuous improvement approach, with particular emphasis on our learning through COVID
- We will use the NHS Workplace Safety Standards as a framework for our activity
- We will use our internal governance processes to provide assurance to the Board

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Championing the rules and legislation that keeps us safe

- Our training, communications and ‘must dos’ will be delivered through accessible, innovative, fun and effective channels and platforms
- We will relaunch our Health and Safety Training and continually refresh our Must Dos
- We will develop and communicate patient and colleagues stories about the importance of health and safety Must dos

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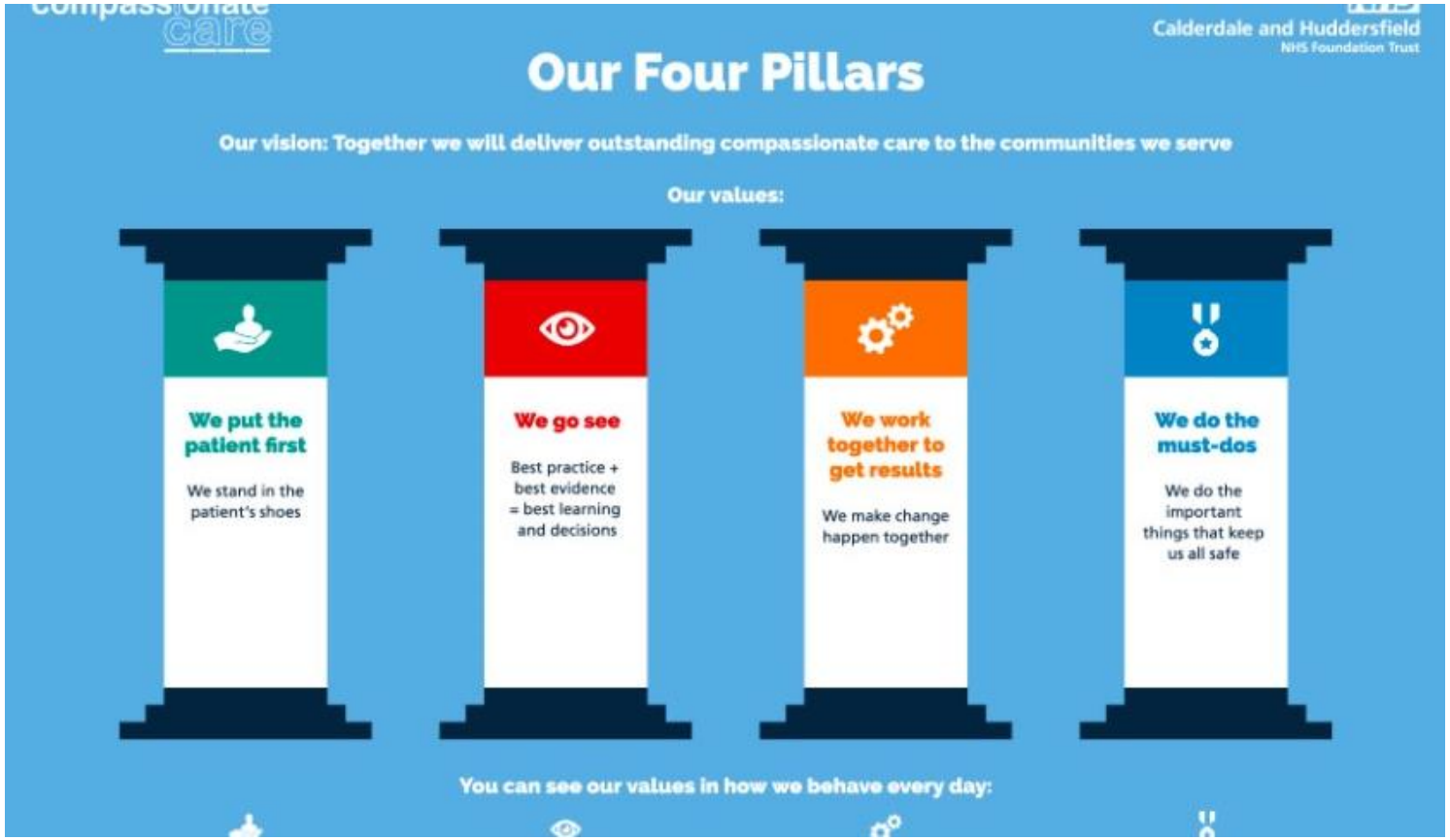
Implementing our Health and Safety Strategy in line with Our 4 Pillars and One Culture of Care



The Health and Safety Strategy is integral to our 4-pillars and one culture of care

- **Put the Patient First**– the environmental conditions for patients and colleagues alike will continue to be a significant part of future discussion. We will appoint a patient advocate and Staff Governor who will work with us to champion health and safety
- **Go See**– During the next 5 years we will benchmark best practice with other NHS organisations, taking part in and establishing helpful networks
- **Work together to get results** – we will work closely with ISS, Engie and CHS Ltd and all our partners on shared matters.
- **Must dos**– we will develop a series of safety Must Dos which include regular audits and inspections and regular lessons learned.

We will also ensure that we work as one team working towards the same goal, looking after each other along the way. We will all work together to create a compliance dashboard results/exception reports etc which focus on compliance, encouraging challenge improvement and reflection through open and honest conversations.

Inclusion and Health Inequalities

- We will assess and review all Health and safety data by protected characteristic. All RIDDOR reportable incidents, slips trips and falls, sharps injuries and training data will be presented with a full breakdown of data
- We will also review patient and colleague Health and Safety data by IMD, identifying patterns and rectifying inequality
- A full EQIA of Health and Safety policy, activity and progress will be completed annually

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Continuous improvement and learning from COVID

- The impact of the COVID-19 pandemic has changed the way colleagues deliver care to patients, with new and innovative ways of working to protect both colleagues and patients, including a closer focus on PPE, social distancing, and hygiene
- We will ensure that Health and Safety activity adapts to our new ways of working, beginning with new requirements for working from home/more flexible working and virtual clinics

NHS Workplace Safety Standards

- The Standards are written by the NHS and Health and Safety Executive to help provide every Trust develop a health and safety management system. There are 30 standards which are straight forward and simple to understand. The Trust has adopted each standard and work is being carried out now and over the next couple of years to develop and implement them into CHFT.

- We will achieve self-certification to provide assurances to outside bodies including the Health and Safety Executive and the Trust insurance provider. The achievement of the certification will send a positive message that the Trust continues to do everything possible to keep colleagues, partners patients and visitors safe, and therefore look after their wellbeing

Key Activities over next 5 years

Ref	Priorities	1	2	3	4	5
1	Development and Implementation of the NHS Workplace Health and Safety Standards across all departments which include reference to risk assessment review. Outcome: reliable and measurable management systems in place, providing a safe environment for everyone	x	x	x		
2	COVID-19 Compliance Review and Monitoring Standards. Outcome: a safe environment for everyone entering and using CHFT services	x	x	x	x	x
3	Community Division Compliance Project Improvement Plan and Collaborative Working with subject matter experts. Outcome: safer environment and stronger oversight of standards for colleagues and service users	x	x			
4	Accident Reduction Planning/Initiatives. Outcome: ability to identify upward trends and early intervention	x	x	x	x	x
5	Developing Health and Safety Training and Collaborative Working with Training Lead. Outcome: improvement in the content quality which is relevant to CHFT	x	x			
6	Collaborative working with CHS Ltd and ENGIE/ISS Ltd on building compliance matters, including floorplate safety. Outcome: direct oversight of the compliance data produced by our partners, including risk assessments and inspections	x	x			
7	Networking across NHS Trusts to benchmark and share best practice . Outcome : best practice within CHFT		x			
8	RIDDOR reporting awareness campaigns. Outcome : the Board has as a true picture and reduction plans can be developed and mobilised	x		x		x
9	Engagement with the reconfiguration building plan meetings for CRH and HRI. Outcome : to monitor risk and provide relevant input when necessary leading to a successful build	x	x	x	x	x

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One Culture of care

How we will monitor our progress

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22. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1 July 2021
Meeting:	Public Board of Directors
Title:	Board Assurance Framework – Update 1 2021/22
Author:	Andrea McCourt, Company Secretary
Previous Forums:	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 and is presented to the Board three times a year.

This report presents the first update of the Board Assurance Framework (BAF) for 2021/22 for approval. The full BAF will also be reviewed by the Audit and Risk Committee on 21 July 2021, with specific risks reviewed by Board Committees at agreed timeframes.

Key Points to Note

Risk Profile
The Trust has the following risk profile for its strategic risks as at 18 June 2021:

BAF Risks	Total Number of Risks	Change
Red Risks (15 - 25)	**12**	**↓ 2**
Amber Risks	**8**	**↑ 2**
Green Risks	**2**	**↑ 1**
Total	**22**	**0**

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

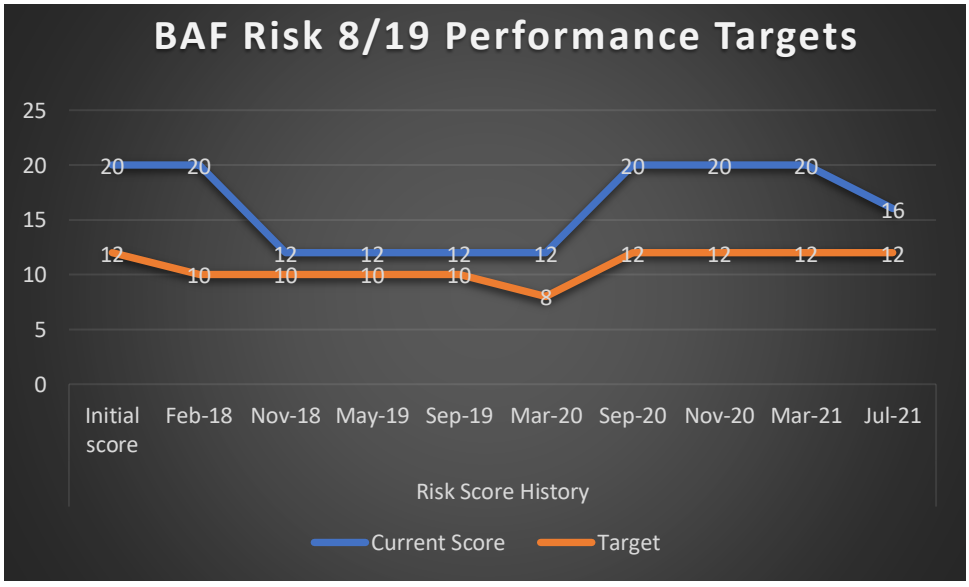
All BAF risks have been reviewed and updated by the lead Director with updates shown in red font for ease of reference in the enclosed full BAF document.

Risk Score Movement
There have been reductions in five risks scores and an increase in 1 risk score shown below. Rationale for this movement in risk score is given below.

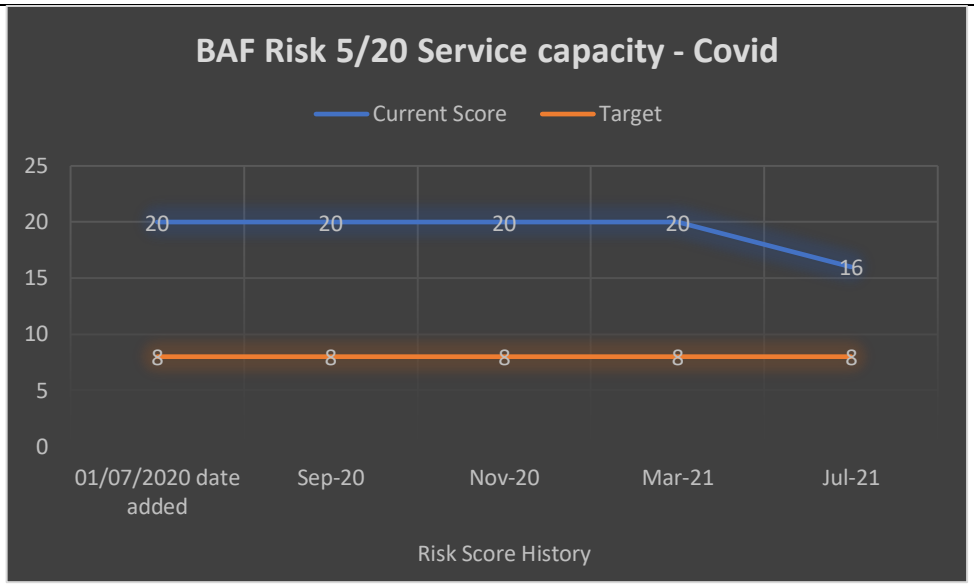
Risk score movement	Risk reference and score
↓ 15 to 12	1/20 Clinical Strategy

↓ 20 to 16	8/19 Performance targets
↓ 20 to 16	5/20 Service capacity due to Covid response
↓ 9 to 6	15/19 Commercial growth
↓ 16 to 12	6/20 Climate change
↑ 15 to 20	7/19 Compliance with NHS England/ Improvement

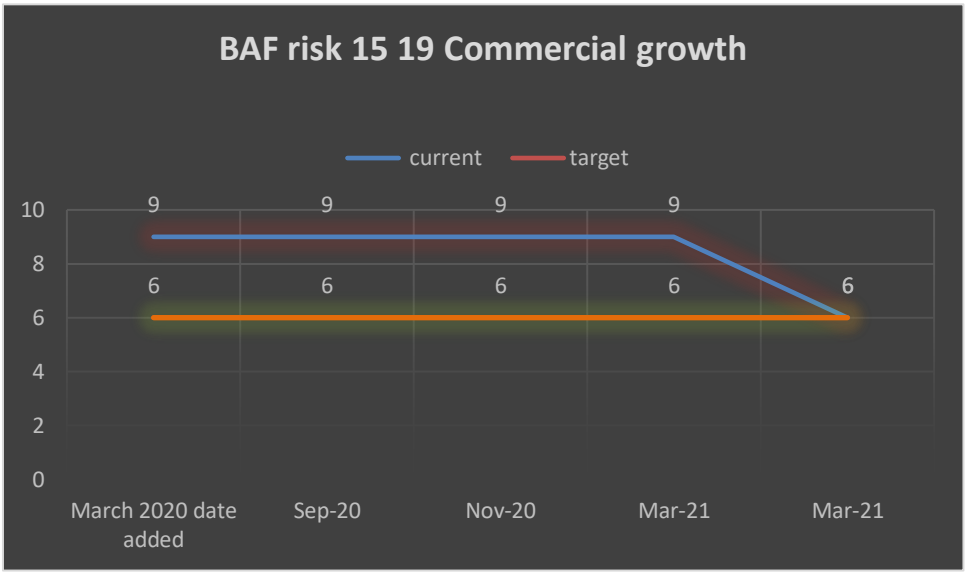
- *1/20 clinical strategy* - reduced risk score from 15 to 12 due to refreshed clinical strategy, effective working with partners and networked approaches to services.



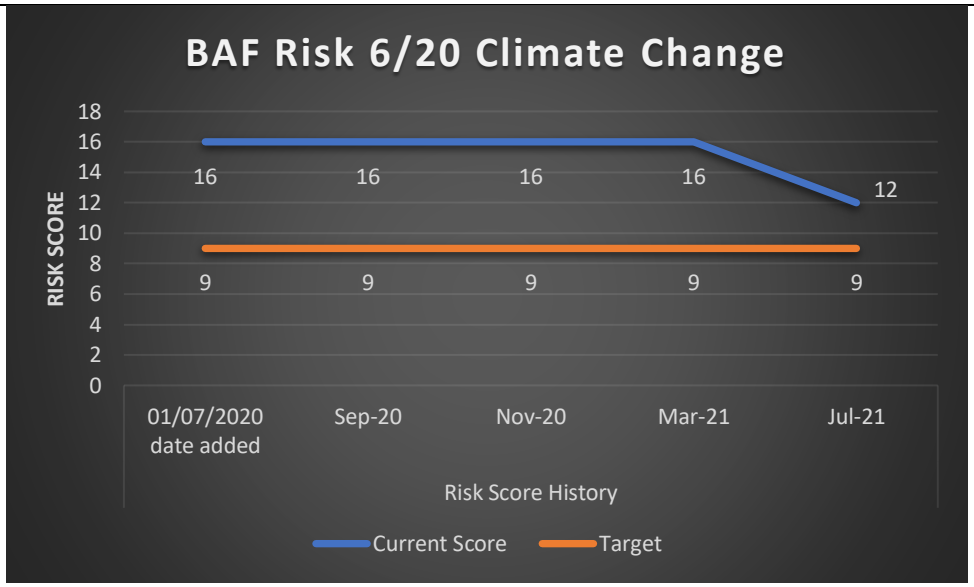
- *8/19 performance targets* - reduced risk score from 20 to 16. The risk score reduction reflects the combination of some capacity increase with the needs based prioritisation plan. This plan and alternative prioritisation to chronological order has been accepted by the regulators minimising the reputational impact.



- *5/20 capacity* - The reduction in risk score from 20 to 16 is due to a sustained reduction in COVID admissions enabling redeployed staff to return to base and the resumption of activity in line with agreed Board priorities. There is an agreed surge plan in place that seeks to mitigate, for as long as possible, the impact of any further Covid admissions.



- *15/19 Commercial Growth* - reduction in risk score from 9 to 6 due to lower planned income which is covered for 2021/22. BAF risk to remain although reached its target score this year as position may be different for 2022/23.



- *6/20 Climate Change* - reduction in risk score from 16 to 12, with likelihood reduced from 4 to 3, due to the actions relating this risk now being monitored and will be reported annually to the Trust Board, specifically:

  - Board approved Green Plan now in place
  - Green Planning Committee established chaired by a Non-Executive Director, Andy Nelson (with Manging Director for CHS as deputy Chair)
  - travel plan in place

- *7/19 Compliance with NHS England / Improvement* - increase in risk score from 15 to 20. In the absence of a financial framework for H2 (months 7 -12 2021/22), the estimated challenge for H2 leads us to an undeliverable efficiency requirement. Costs have increased and, unless additional funding is provided, the trajectory agreed with regulators will not be met.

Risk Exposure

Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate 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.

As at 18 June 2021 the Trust has 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	20 ↑	Regulation	Moderate
8/19 Performance targets	16 ↓	Regulation	Moderate

5/20 Service capacity due to Covid-19	16 ↓	Harm and safety	Low
Strategic Goal: Sustainability			
14/19 Capital funding	16=	Financial/Assets	Moderate
18/19 Long term financial sustainability	16=	Financial/Assets	Moderate

These areas of risk exposure are shaded in grey in the summary sheet of risks in the enclosed BAF.

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 has a regular report on progress with health inequalities actions at Board meetings.

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

Recommendation

The Board is asked to **APPROVE** the updated Board Assurance Framework as at 22 June 2021, noting the movement in risk scores and areas of risk exposure.

Update 1 - 1 July 2021
2020/21

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK 2020/21

Contents:

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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	12 ↓	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	12	12 =	9	MG	7,617	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	16 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 England / Improvement resulting in enforcement action	25	20 ↑	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	16 ↓	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	16 ↓	8	OW	7689, 7683, 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	None	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 =**	6 ↓	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	**12** ↓	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)					
Likely (4)			02/20 Digital Strategy =	14/19 Capital = 07/20 Health Inequalities = 04/20 CQC rating = 4/19 Public involvement = 18/19 Long term financial sustainability = 05/20 Service Capacity due to Covid-19 response ↓ 8/19 National and local performance targets ↓	10a /19 Medical Staffing levels = 10b/19 Nurse Staffing levels = 7/19 Compliance with NHS Improvement ↑
Possible (3)		3/19 Seven day services = 15/19 Commercial growth ↓	12/19 Staff engagement = 16/19 Health & Safety =	6/19 Compliance with quality standards= 11/19 Clinical leadership = 03/20 Business Better Than Usual service transformation = ↓ 01/20 Clinical Strategy ↓ 06/20 Climate Action Failure	1/19 Approval of hospital reconfiguration strategic outline case, outline business case and full business case = 9/19 HRI Estate fit for purpose =
Unlikely (2)					
Rare (1)					

= no change to risk score

Assessment is Likelihood x Consequence

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 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**	**Current**	**Target**
								5x5 = 25	**3x5 = 15**	**2x5 = 10**
Gaps in Control					**Timescales**			**Lead**		
1.Trust and CCGs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH and a hospital travel plan is required.				1. Discussions are taking place with YAS and activity modelling and clinical protocols will be agreed and confirmed in the OBC. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been drafted and is progressing to completion. 4. The Trust is finalising design plans and supporting documentation to enable submission of a planning application for the mutli-storey car park to Calderdale Council in July 2021. The Trust's Travel Plan and Green Plan have been developed. The Travel Plan has been approved by the TPB and the Green Plan by the Trust Board.			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
JUNE 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 JUNE 2021** **Risk category: Regulation** **Risk appetite: Moderate**		
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, Learning from Deaths group and Care of the Acutely Ill Programme re-established, reports to Clinical Outcomes Group and Quality Committee. Quality Comittee oversight of SHMI / HSMR. • 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 better than expected, SHMI increasing though remains within expected range largely as a result of out of hospital mortality. Second line Deep dive report on this risk to Quality Committee 30.12.20. minor amend to risk description Integrated Board report with SHMI/HSMR reporting. Annual Learning from Deaths report to Board July 2021. Quarterly Learning from Deaths report to Board (4 March 2021, 1 July 2021) Single Oversight Framework. 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 IPC. Endoscopy waiting lists are challenging - action: plan additional internal activity as part of Recovery response; in -sourcing and outsourcing under consideration : COO/HB Resource to audit 4 standards to be confirmed, report of audit to Quality Committee Audit to assess impact of expanded 7 day working on outcomes: Working Together to Get Results session June 2021 on Quality Directorate capacity to identify resource EA/ DB.	• 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 third Covid-19 wave may impact delivery of 7 days services in some specialities as a result of changes to both medical and nursing rotas.	**Initial**	**Current**	**Target**
								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	June 2021	CP

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

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 2021 Risk category: Regulation Risk appetite: Moderate**		
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 March 2021) <u>Second line</u> Regualr Patient Story to Board meetings Governor attends Patient Experience Group Patient Experience Group reporting to Quality Committee quarterly. Review of risk at Quality Committee January 2021 and increase of score from 12 to 16. CCG membersip at Quality Commitee. Board quality report inlcudes a section in relation to service users involvement <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 project 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, strategy to be signed off at July Quality Committee 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 - this was delayed as a result of pandemic response, to be picked up in Q2 2021	**Initial** **3x4 = 12**	**Current** **4x4 = 16 =**	**Target** **1x4 = 4**
Action					**Timescales**			**Lead**		
Patient and Service User Engagement Strategy to be approved by Quality Committee					Jul-21			AD Patient Experience		
Links to risk register: No risks on the high level risk register										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 2021 Risk category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to lack of collaboration across the West Yorkshire system to enhance the quality and resilience of clinical services due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk and 3/20 Business Better Than Usual risk .	Refreshed 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 ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Transformation Programme Board ensures estate is aligned with the clinical strategy. 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), refreshed Clinical Strategy July 2021 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** Vascular network established with Bradford WYAAT Pathology Board established. Common LIMS procured now being rolled out	Non-Surgical Oncology - acute system pressures across West Yorkshire require additional support from CHFT. Action: Working with LTHT, MYHT to ensure short term service support in place, contributing to ongoing work to identify a sustainable solution across West Yorkshire (check dates for intented turnaround time). Recruiting for additional Oncology staff. West Yorkshire and Harrogate Clinical Strategy under development WYAAT and ICS system-wide approaches to reset Consideration to be given to primacy of PLACE v system.		3x5=15	3x4=12 →	2x5=10
Action					**Timescales**			**Lead**		
WYAAT - agreement of West Yorkshire Clinical Strategy					Clinical Lead WYAAT			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
JUNE 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 JUNE 2021 Risk Category; Innovation/Technology Risk Appetite: High**		
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, with reviewed terms of reference. 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 Infrastructure Strategy and business case being developed. External agency has been procured to complete work with a July deadline. External agency also recruited to for in depth analysis of optimissation to develop action plan which will include digital leads/ambassadors	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. Review of digital health team capacity, EPR team capacity replacement of CNIO now being prioritised.	Managing Director Digital Health to launch Strategy at Divisonal Digital Boards Annual review Board 2021 July - annual review of digital strategy planned for Weekly executive board 24th June 2021, Finance and Performance committee 28th June and Board 2nd July	**Initial** **4x3 = 12**	**Current** **4x3 = 12**	**Target** **3x3=9**
Action					**Timescales**			**Lead**		
Ongoing monitoring via Finance and Performance Committeee					Ongoing			Mandy Griffin Gary Boothby		
Links to risk register 7617 cyber risks , see linked 1/19 reconfiguration risk										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 2021 Risk category: Strategic Risk appetite: Significant**		
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 have been 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 updates 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. Regular quarterly updates are being provided to the TPB, Quality, WOD and F&P Committees. Lead: Anna Basford Timeframe: ongoing every quarter - next progress report due July 2021	The work to implement BBTU is progressing and update on key milestones is being reported at quarterly intervals to Board sub-committees. Review meetings with each theme lead are being scheduled with regular fortnightly briefing update provided to the CEO.	**Initial**	**Current**	**Target**
								3x4=12	**3x4=12**	**2x4=8**
Action					**Timescales**			**Lead**		
Theme lead to develop blueprint of critical success factors -benefits, enablers, dependencies for each theme					Next progress report due in July 2021. Work to clarify the impact of BBTU on operating costs and efficiency is on-going.			Theme leads		
Links to risk register:None										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 2021 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 July 2020	Trust Board	Director of Nursing / Deputy Chief Executive	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Director of Nursing named Board Executive providing accountable leadership for tackling health inequalities. Chief Executive expertise in health inequalities. Health Inequalities Group, chaired by NED, ensures oversight of all Trust workstreams in relation to health inequalities. Reset and stabilisation and winter plan EQIA Equality impact assessment (EQIA) process for service and policy changes. Health Inequalities is reported formally into Trust Board. Board development sessions include deep dives on issues relating to health inequalities 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).The ethnicity of the Trust Board reflects its workforce and local communities. 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 session 3 June 2021 to increase knowledge and understanding re health inequalities locally and the imapct of becoming an anchor organsiation. Restoration service activity performance monitoring to include deprivation data (index of multiple deprivation) for patients from 20% most deprived neighbourhoods and communitties: Health Inequalities Group presented to 6 May Board, confirmation of leads for health inequalities and community respone, clinical prioritisation and recovery and workforce. A Board succession plan has been approved which seeks to ensure that there are clear talent pipelines for each Executive and non Executive role in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line**.External - none to date.	Health Inequalities Academy workstreams yet to be defined Leadership - Reflect our diverse community through a 5 year Board action plan for Board and senior staffing to match the BAME workforce by 2025.	There are no expectations on reporting externally. Lead: EA/HB Timescale: February 2021	4x4=16	4x4=16	2x4=8
Action					**Timescales**			**Lead**		
review requirements for action plan to address 8 urgent actions on health inequalities					Jun-21			Ellen Armistead		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 2021 Risk category: Regulation Risk appetite: Moderate		
								Initial	Current	Target
06/19	Post Board 4 March 2021	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 Strengthened quality section within performance review meetings mor ein deptha nalaysis of quality and dafety priortiies • 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 and rolled out • Regular leadership assurance visits are in place and findings uploaded onto Knowledge Portal.	First line Assessment of compliance with NICE guidance Ward accreditation - J2O Jouney to outstanding in early phases of roll out. Performance against saferty must dos reviewed at ward / matron level HSMR & SHMI Mandatory training compliance 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 CQC TMA visits have taken place in ED, Maternity and Vacciniation centre. 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 have been reviewed and implemented Q1, will need to be reviewed. Lead: Director of Nursing / Medical Director There are some gaps in chairs and medical representaiton at some of the Quality Commitee sub-structures. • Quality and Safety Strategy to be rolled out Q4 2020/21 and Q1 2021/22, Divisions need to adapt the strategy to their local needs	• 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 Quality and Safety Strategy to be adapted divisonal needs	August 2021 end September 2021	EA AD Quality & Safety

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 maxillofacial follow up appointment, 2827 ED middle grade medical staffing capacity, 7833 appointment slot issues for Trauma and Orthopaedics, 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
JUNE 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 JUNE 2021 Risk category: Regulation Risk appetite: Moderate
7.19	Finance and Performance Committee	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 • 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 Monthly monitoring of performance and Covid spend 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 UoR update provided to F&P on 1.6.21 that detailed actions taken from last inspection and provided evidence of where discussions take place and where further improvement remains in focus. A repository of information is available with evidence of discussions and actions along with updated metrics. On a control total basis the Trust has delivered a surplus financial position (£360k) for the 2nd year running and this has also resulted in a revised external audit VFM assessment that reflects the progress made. Third line Current use of resource score was 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 became a 4, and overall rating defaulted to a 3. This was 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 improved the score to a 2. The Trust closed 20/21 with a score of 2. Further autonomy granted from NHS E/I as result of performance and delivery of the 2019/20 control total from NHSE/I.		• Performance against key targets • Use of Resources rating of requires improvement. Use of Resources external assessment has not been completed as benchmarking data is not available and no external capacity to provide a valued assesment.	Initial: 5x5 = 25 Current: 4x5 =20 ↑ Target: 2x5 = 10

Action	Timescales	Lead

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 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 Performance Management and Accountability Framework to support delivery of national standards and Trust quality,financial and operational objectives. 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) Weekly 1:1 with COO & Directors of Operations. Local triggers for wave 4 agreed by Recovery oversight group - working well and used for wave 3 monitoring Daily touchpoint meeting with Divisional teams for timely escalation, action and joint visibility Planned care backlogs collated & presented to Finance & Performance Committee Trajectories and tracking included in IPR Thematic reviews commenced. Workforce and Respiratory service model underway Established Clinical Reference Groups for Modelling and Health Inequalities supporting the shaping of capacity. Developing a clinical prioritisation/holistics needs assessment matrix. Waiting time modelling completed,with parameters, and shared with regulators along with needs based focus; this has been accepted	<u>First line</u> Daily Incident Management Team meetings including escalation of risks, incidents, complaints and staff concerns Risk registers reviewed at Divisional PSQBs & PRMs. 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 <u>Second line</u> Board sub committee detailed appraisals of position & actions. Integrated Board Report discussed at each Board sub committee and Board of Directors. Clinical Prioritisation agreed as a key Quality Indicator, led by Medicl Director reporting via PRMs and into Quality Committee Detailed review of backlog position across planned care through Finance & Performance Committee. <u>Third line</u> 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 perforrmance 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. Under constant review and incorporated into IPR	**Initial** **4x5 = 20**	**Current** **↓ 4x4 = 16**	**Target** **4 x 3 = 12**
Actions					**Timescales**			**Lead**		
Developing outcome metrics					Ongoing			HB		
Links to risk register: 7615 4 hour Emergency Care standard										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 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, 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 10.11.21. 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.	A revised estates strategy is to be presented to Board in summer 2021.- Action Tom Donaghey. * HRI investment (£20M) full business case to be agreed by regulators, however current funding for early drawdown has been supported, 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. 2021/22 is resolved but not resolved recurrently with longer term shortfall No agreed solution for cladding 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 Tom Donaghey *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 Group to align Risk Register					Ongoing September 2021			G Boothby Gary Boothby/ CHS		
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
JUNE 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

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								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 Induction Training for CHFT colleagues • Director and Non-Executive Director Health and Safety Champion identified as well as Director responsible for Fire Safety Operational responsibility for H&S across sites sits with CHS for HRI and our PFI partners at CRH - recently appointed interim technical advisor in CHS. • Proactive Health & Safety Committee. • Head of Health and Safety involved in all new sub committees to H&S committee. • Health & Safety action plan in porgress • Annual report on Health and Safety to Board, 5 year strategy prepared and now at Health and Safety Committe consultation, will be be shared at BOD in July 2021 subject to any final ammedments. • Health and Safety action plan with updates to Board, Audit and risk Committee oversight. • Health and Safety mandatory training for staff (3 years). • Health and Safety training on staff induction. • COSHH training. • Risk assessment training design and implementation under review	First line Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health and Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information . Second line Board joint responsibility for risk understood. 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 to Board - January 2021, update in July 2021. • Lead Persons nominated and appointed as chairpersons of health and safety sub-groups. Updates to Board on H&S 3 September 2020, 14 Januayry 2021 and 1 July 2021 Third line External health and safety review (Quadriga) 2019. Progress monitored at Health and Safety Committee. Audit and Risk Committee and Board.	Draft 5 year Health and Safety Strategy to be presented to Health and Safety committee in June and Board in July 2021.	Lead for COSHH to be established to chair COSHH sub committee. This was previously chaired by Director of Pharmacy, Training may be required	3x3 = 9	3x3 = 9	2x2 = 4

Action	Timescales	Lead
5 year Health and Safety Strategy	Board July 2021, to be ratified by H&S Committee in June 2021.	Head of H&S
COSHH lead identified	Meeting to confirm COSHH lead held June 2021	Head of H&S

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

BOARD ASSURANCE FRAMEWORK
JUNE 2021
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
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								Initial	**Current**	**Target**
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 - Using the CQC TMA framework currently Process for internal assessment against CQC standards Dedicated CQC lead Independent Well-led Governance development review, completed. Risk group has been reviewed and has consistent membership from Divisions CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes (Journey to Outstanding) reveiwed and updated, pilotted and in early phases of roll out	**First Line:** Reports to CQC Response Group from divisions **Second Line:** Quality Committee reports from CQC Group Quality update report to each Board 6 May, 1st July 2021 Review by Quality Committee and Board of progress with CQC action plan . Quality report to January, March and July Board . CQC well-led governance phase 2 report shared at Board workshop July 2021 **Third Line:** Quarterly formal engagement meetings with CQC Current CQC rating of "good" including well-led governance	CQC preparation visits had been scaled back in response to Covid priorities, new process pilotted and is in the early stages of roll out Uncertainty of direction of future CQC inspection and rating regime - currently Transitional Monitoring Assessment in place while CQC new strategy for regualtion gets implmented. Developments identified from well-led governance review to be progressed Lead: Ellen Armistead/ Suzanne Dunkley	Journey to Outstanding in early phases of implementaion, as such there is little avaiable data to assure. CQC new regulatory framework not yet implemented nationally.	4x3=12	4x4=16 ←	3x2=6

Action	Timescales	Lead
Journey to Outstanding implementation underway via rolling programme	Ongoing	ADN Quality and Safety and Deputy Direcor of Nursing
Repeat audit of recently close 3 outstanding CQC actions with report CQC and Compliance Group	December 2021	Ellen Armistead

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 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	New surge plan developed and agreed across Divisions to support recovery whilst maintaining capacity and triggers for future surges. Bed plans and flow arrangements reflect the risk of increased non elective demand. IPC pathways amended to reflect national guidance, cross checked with Board of Directors principles on patient and staff safety. Maintaining separation of elective and non elective bed capacity Continuing to utilise the Independnent sector, commissoining activity for H1 and considering H2. Retained additonal diagnostic capacity to supplement reduced internal capcaity or provide additional capacity for backlog clearance and non elective demand increases 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 4. Covid risk register closed and outstanding risks moved to Divisional registers reflecting wider spread of risks and differences at specilaty level. Overseen by Divisoinal PSQB and PRMs	**First Line:** Daily review of Covid-19 activity and weekly review of all other waiting list data Submission of national data sets. Daily tactical meetings chaired by senior Operational manager monitoring demand and bed capacity 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 oversight of activity and backlogs with new IPR that includes a Recovery section Performance reports to relevant Board Sub-Committees (Finance and Performance, Quality Committee, Workforce Committee)	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, need to develop a mechanism for wider holistic scoring of patients to reflect Health Inequalities that will support decision making for scheduling Lead: Chief Operating Officer,	4 x 5 - 20	4 x4= 16	2x4=8
Action:					**Timescales**			**Lead**		
1. Clinical review for out patient activity					Ongoing			Medical Director David Birkenhead		
Links to risk register: 7689 out patient waits, 7683, isolation capacity, 7809 theatre and clinical capacity, 7834 elective orthopaedic in patient theatre capacity,										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 2021 Risk Category: Quality, Innovation & Improvement Risk appetite: Significant
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to 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	•Consultant Succession planning -divisional workforce planning including discussions with Consultants over age of 55 and "Grow our own" approach • CESR programme to increase Consultant workforce in appropriate specialties supports recruitment and retention Scenario planning for Covid wave 3, Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for all Consuslants 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 • 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) • Mitigate shortages in specialties nationally,eg Radiology by network working, explore advanced practitioner to support Consultant workforce, use external reporting for Radiology • WYAAT networking approach to pressured specialties, eg Non- Vascular Interventional Radiology • 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 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 28/ 291 wte. Recrutiment June 2021 to 7 substantive Consultant posts (to commence in 2021) and 14 full time locum Consultants. This includes a number of Radiologists, Gastroenterologists and Emergency Medicine Consultants..2 Consultants appointed via in-house CESR programme 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 Autumn 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 now concluded. 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. Sickness absences are unpredictable and contribute to rota gaps. Unknown impact of Covid on existing medical staff who may take early retirement or reduce job plans as a result of pressures of having worked through Covid-19 Accumulated annual leave from Covid-19 may pressure clinical service delivery.		Initial: 4 x 4= 16 Current: 4 x5= 20 Target: 3 x 3 = 9

Action	Timescales	Lead
E-rostering being rolled out to medics- current phase 1 implementation deadline is Autumn 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 Explore Global fellowships in other areas difficult to recruit	Autumn 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
JUNE 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 JUNE 2021 Risk Category: Quality, Innovation & Improvemnent Risk appetite: Significant		
								Initial	Current	Target
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 •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 Trust recruting to fill all HCSW vacancies Embarking on international recruitment programme 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: Q2 2021**	Ward accreditation process updated Journey to Outstanding) which will include an assessment of staffing leveles. Rolling out across all clinical areas over next 12 months.	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
To refocus nursing workforce on key deliverables of Time to Care	Q2 2021	Andrea Dauris

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

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 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 - – as at April '21 there were 28 vacancies across the Trust – a 9.6% vacancy rate Second line Integrated Performance Report and Workforce Committee reports show a rolling absence rate of 4.02% (excluding COVID absence) and a turnover of 7.72% 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 reviewer in June 2021. GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT trusts. Annual staff survey saw an increase in response rate to 50.1% and a 1% increase in our overall score.	• 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 and Socrates, 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	The Leadership Development programme will be updated to include additional modules for managing mental health and leading compassionatley A review of Clinical Directors is underway with induction, development and training focussing on non clinical skills	**Initial**	**Current**	**Target**
								4x4 = 16	**3x4 =12**	**3x3 = 9**
Actions					**Action, Lead, Timescales**			**Lead**		
Further modules added to Leadership Development programme					Dec-21			Suzanne Dunkley		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 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 Focus given to increased diversity of our engagement team has resulted in a more diverse team able to engage our diverse workforce <u>Second line</u> Integrated Board report shows a positive range of workforce metrics - attendance, trunover, vacanacies, appraisal compliance and essential safety training compliance Hot House events held focusing on a range of topics including Leadereship, Health and Well Being, Equality and Diversity, Apprenticeships, Staff Survey demonstrating engagement and collaboration informing people management policices and processes Staff survey results 2020 to Board in May 2021 with progress update in July and managed through Workforce Committee and PRMs. 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, 2020 survey increased response rate to 51% 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 continued throughout the pandemic with Leadership session in June attractign 70 attendees •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		**Initial**	**Current**	**Target**
								3x4 = 12	3x3 = 9	1x4 = 4
Action to address gap in control					**Action and timescale**			**Lead**		
Links to risk register: No high level risk register related risks scoring over 15.										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 2021 Risk Category: Financial / Assets Risk appetite: Moderate**		
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. Historic delivery of the plan. Contingency set within annual plan Transformation Programme Board established with oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience	First line Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes Second line Business case for reconfiguration continues to progress through NHS E/I approval process Third Line Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. However, the business case is yet to be approved. Strategic Outline Case flagged that additional resources woud be required above the SOC value for HRI. Funding for the Cladding at HRI and multi storey car park (MSCP) at CRH are reliant on ICS financial prioritisation Actual costs for cladding are not yet confirmed 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. No firm agreement reached with ICS for prioritisation of funds to cover cladding or MSCP after 2021/22	**Initial** 4x5 = 20	**Current** 4x4 = 16	**Target** 3x4=12
Action					**Timescales**			**Lead**		
Ongoing monitoring of financial position through Finance &Performance Committee and Board Continued pursuit of agreed ICS prioritisation of cladding and MSCP for 2022/23					Ongoing Ongoing			GB		
Links to risk register: None										

BOARD ASSURANCE FRAMEWORK
JUNE 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 JUNE 2021 Risk Category: Commercial Risk appetite: Moderate**		
								Initial	**Current**	**Target**
15.19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Huddersfield Pharmacy Specials (HPS), Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place Health Informatics Service (THIS) contract income for all customers approved and monitotred via quarterly contract review meetings	**First line** Individual boards (THIS, HPS, CHS) and report on performance against targets into Finance and Performance Committee **Second 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 The 2021/22 financial plans for THIS and HPS are reliant on lower contributions than previous years based on known reductions in activity and trading.	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. External advisers appointed and revieiwng the strategy, to be completed summer 2021. Lead: Director of Finance	**3x3 = 9**	**3x2 = 6**	**3*2= 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
JUNE 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 JUNE 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 - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Budgetary control process with increased profile and ownership Business better than usual forum established to support 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.	<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 have a balanced H1 plan for 2021/22 <u>Third line</u> Monthly return to NHS E/ I Strategic Outline Business Case submitted April 2019 and 5 year plan submitted October 2019. H1 Financial plan agreed by Board and ICS. Minimum income for H1 is agreed.	No clear financial framweork agreed for H2 2021/22. Efficiency process for 2021/22 is still being developed 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.	H1 identifies a £3m efficiency challenge which is low risk but current plans show a significant challenge from H2 onwards. This is yet to be clarified when the financial framework is agreed. Efficiency process yet to be agreed.	5x5 = 25	4x4 = 16	3x4=12

Action	Timescales	Lead
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
JUNE 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 JUNE 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.	CHS is rolling out Carbon Literacy Training for its senior management team and this will be cascaded to all colleague by the Environment Manager. 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 who is the Trust's lead for climate and sustainability. Green Planning Committee chaired by a NED within CHFT has been established to oversee delivery of sustainbility action plan which will report to Transformation Programme Board on quarterly basis. The Committee is attended by a range of internal and external partners and we continue to expand the membership. Reconfiguration design and build principles led by a Sustainability design brief and overseen by Transformation Programme Board. The Green Planning Committee 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. QIA procedure to be reviewed along with business case applications to ensure that a standing section for sustainability is featured and addressed in Board paper submissions.	First line Monthly monitoring of the Trusts energy consumption Second line 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at May 2021 Board meeting. 2. Annual Board paper on sustainability/climate change Climate change sustainability brief for the reconfiguration agreed and taken to Board 5 November 2020 Third line Working towards ISO14001 accreditation as a means of assuring environmental management systems across the CHFT	A Sustainable Development Management Plan and Action Plan is already in place and this has now been transposed into a Green Plan Green Plan was approved by the CHFT Board, including interventions to address carbon emissions and to further promote climate resiliance, reviewed by Transformation Programme Board 8 March 2021, and Trust Board 6 May 2021. Green Planning Committee Terms of Reference approved by Transformation Programme Board on 8 March 2021.	CHS MD will produce an annual report to Board on climate change and progress with actions based on the action plan contained in the Green Plan.	**4x4 = 16**	**4x3 = 12**	**3x3=9**
Action					**Timescales**			**Lead**		
								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
TMA	Transitional Monitoring Approach
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

23. Governance Report

a) Board Workplan

b) Board Meeting Dates 2022-23

c) Use of Trust Seal

d) Chair’s Action Quality Accounts

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 1 July 2021
Meeting:	Public Board of Directors
Title:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Owen Williams, Chief Executive
Previous Forums:	None

Purpose of the Report

This report brings together a number of governance items for the Board in July 2021.

Key Points to Note

a) Board Workplan

The business cycle for the Board for 2021/22 is attached at appendix P2. The Board workplan provides the basis for the preparation of Board agendas for the financial year 2021/22. Ad hoc items will be included on Board agendas as need arises following discussion with the Chair and Chief Executive.

RECOMMENDATION: The Board is asked to **NOTE** the Board Workplan for 2021/22 and advise the Corporate Governance Manager should there be any further items or amendments to the workplan.

b) Board Meeting Dates 2022/23

The public Board meeting dates and Board Development Sessions for 2022/23 are attached at appendix P3 for approval.

RECOMMENDATION: The Board is asked to **APPROVE** the public Board meeting dates and Board Development Sessions for 2022/23 and note the venue and format of these meetings will be confirmed in due course.

c) Use of Trust Seal

The Trust Seal has been used once since the last report to the Board on 6 May 2021. The details are available at appendix P4.

RECOMMENDATION: The Board is asked to **NOTE** the use of the Trust Seal during Q2.

d) Chair's Action - Urgent Decision for ratification

Urgent decisions can be made in line with the powers which the Board of Directors has retained to itself within the Standing Orders (SO 2.5). This decision-making process involves consideration of the decision by the Chair and Chief Executive, having consulted with at least two Non-Executive Directors not involved in recommending the decision. It is a requirement that the exercise of such powers by the Chief Executive and the Chair is reported to the next formal meeting of the Board of Directors for ratification.

This report presents for ratification an urgent decision taken in line with the above provision to delegate approval of the 2020/21 Quality Accounts from the Board to the Quality Committee to meet the national deadline date for publishing the 2020/21 Quality Accounts of 30 June 2021.

The Chair's action at P5 states the plan was for the Quality Committee to sign off the Quality Accounts at its meeting on 21 June 2021. This sign off date has since changed with an Extra Ordinary meeting of the Quality Committee being held on 23 June 2021 to approve the 2020/21 Quality Accounts.

RECOMMENDATION: The Board is asked to **RATIFY** the urgent decision 01/21 regarding delegation of approval of the 2020/21 Quality Accounts.

Recommendation

The Board is asked to:

- **Note** the Board workplan for 2020/21
- **Approve** the Board meeting dates and Board Development Sessions for 2022/23
- **Note** the use of the Trust seal during Q2
- **Ratify** the urgent decision 01/21 regarding delegation of approval of the 2020/21 Quality Accounts.

PUBLIC BOARD WORKPLAN 2021-2022

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Date of agenda setting/Feedback to Execs	7 December 2020	1 February 2021	7 April 2021	27 May 2021	2 August 2021	30 September 2021	8 December 2021	31 January 2022
Date final reports required	31 December 2020	19 February 2021	23 April 2021	18 June 2021	20 August 2021	22 October 2021	31 December 2022	18 February 2022
STANDING AGENDA ITEMS								
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓	✓	✓
Financial Update	✓	✓	✓	✓	✓	✓	✓	✓
Health Inequalities	✓ **Defer to March**	✓	✓	✓	✓	✓	✓	✓
Quality Committee update & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Audit and Risk Committee update & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Finance and Performance Committee update & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Workforce Committee update & Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓	✓	✓

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
COVID-19 Oversight Committee Minutes	✓	✓	✓					
Council of Governors Meeting Minutes		✓	✓		✓	✓		✓
STRATEGY AND PLANNING								
Strategic Objectives – 1 year plan / 10 year strategy		✓		✓ *- 2020/21 Strategic Objectives Progress Report*		✓		
Digital Health Strategy				✓		✓		
Workforce OD Strategy		**Defer to May**	✓					✓
Risk Management Strategy		✓					✓	
Service Reconfiguration Outline Business Case					✓* additional Board meeting may be required in later July TBC			
Annual Plan		✓	✓	✓				✓
Capital Plan	✓						✓	
Winter Plan					✓	✓		
Green Plan (Climate Change)			✓					
QUALITY								
Quality Board update	✓	✓	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓ Q2, Q3 2020/21		✓Q4		✓Q1	✓Q2	✓Q3	
DIPC Annual Report				✓				
Learning from Deaths Quarterly Report		✓ Q3		✓Q4	✓Q1	✓Q2		✓ Q3

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Safeguarding update – Adults & Children		✓			✓ (Annual report)			✓
Complaints Annual Report					✓			
WORKFORCE								
Staff Survey Results and Action Plan			✓	✓		✓		✓
Health and Well-Being			Deferred to September		✓			
Nursing and Midwifery Staffing Hard Truths Requirement (Bi-Annual report due annually in Sep; however, it will be Nov this year)		✓ (Bi-annual)				✓ (Bi-annual)		✓ (Bi-annual)
Guardian of Safe Working Hours (quarterly)	✓Q3		✓Q4		✓Q1	✓Q2	✓Q3	
Guardian of Safe Working Hours Annual Report			✓					
Diversity		✓						
Medical revalidation & appraisal Annual Report					✓			
Freedom to Speak Up Annual Report	✓ 6 month report FTSU themes				✓ Annual Report			
Workforce Committee Annual Report	✓ 2019/2020			✓ 2020/21				
Public Sector Equality Duty (PSED) Annual Report		✓						✓
GOVERNANCE & ASSURANCE								
Health and Safety Update	✓		✓	✓			✓	
Health and Safety Policy			✓					
Health and Safety Annual Report	✓						✓	

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Board Assurance Framework		✓ 3		✓ 1		✓ 2		✓ 3
Risk Appetite Statement					✓ with BAF			
High Level Risk Register	✓		✓		✓		✓	
Calderdale Huddersfield Solutions Managing Directors Report	✓	✓	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review			✓					
Non-Executive appointments		✓				✓		✓
Annual review of NED roles					✓			
Board workplan	✓	✓	✓	✓	✓	✓	✓	✓
Board meeting dates				✓				
Use of Trust Seal			✓	✓		✓		
Council of Governor elections		✓ timetable						
Declaration of Interests – Board of Directors (annually)		✓						✓
Attendance Register – (annually)			✓					
Fit and Proper Person Self-Declaration Register		✓						✓
Seek delegation from Board to ARC for the annual report and accounts 2020/21			✓					
BOD Terms of Reference		✓						✓
Sub Committees Terms of Reference	✓ Workforce ✓ NRC BOD	✓ QC	✓ F&P ✓ TPB	✓ Workforce	✓ ARC			✓
Constitutional changes (+as required)		✓	✓					
Compliance with Licence Conditions			✓					
Huddersfield Pharmaceuticals Specials Annual Report					✓			

	Public	Public	Public	Public	Public	Public	Public	Public
DATE OF MEETING	**14 Jan 2021**	**4 Mar 2021**	**6 May 2021**	**1 Jul 2021**	**2 Sep 2021**	**4 Nov 2021**	**13 Jan 2022**	**3 Mar 2022**
Health and Safety Annual Report	✓						✓	
Fire Safety Annual Report				✓				
Emergency Planning Annual Report (Bev Walker/Ian Kilroy/Karen Bates)					✓			
Charitable Funds Report 2019-20 and Accounts (Audit Highlights Memorandum)	✓							
Committee review and annual reports				✓	✓			
Audit & Risk Committee Annual Report 2020/2021					✓ 2020/21			
Finance & Performance Committee Annual Report 2020/2021				✓				
Quality Committee Annual Report 2020/21					✓ 2020/21			
WYAAT/WY&H Partnership Reports	✓	✓	✓	✓	✓	✓	✓	✓
WYAAT Annual Report and Summary Annual Report	✓							

Colour Key to agenda items listed in left hand column:	
Items for approval	To formally receive a report or strategy for discussion and particularly approve recommendations or a particular course of action
Items to receive	To discuss in depth, noting the implications for the Board or Trust without formal approval
Items to note	For the intelligence of the Board without in-depth discussion
Items for assurance	To assure the Board that effective systems of internal control are in place (see Review Room papers)

Calderdale and Huddersfield NHS Foundation Trust

Public Board of Directors Meetings Dates Proposal for 2022-2023

Date	Time	Location
Thursday 5 May 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 7 July 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 1 September 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 3 November 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 12 January 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 2 March 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital

Bank Holidays 2022
Friday 15 April 2022 (Good Friday)
Monday 18 April 2022 (Easter Monday)
Monday 2 May 2022
Thursday 2 June 2022
Friday 3 June 2022 (Platinum Jubilee)
Monday 29 August 2022

Calderdale and Huddersfield NHS Foundation Trust

Board Development Sessions
Proposal for 2022-2023

Date	Time	Location
Thursday 7 April 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 9 June 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 4 August 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 6 October 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 1 December 2022	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital
Thursday 2 February 2023	9:00 – 12:00 pm	Microsoft Teams Or alternate sites between Huddersfield Royal Infirmary and Calderdale Royal Hospital

Bank Holidays 2022
Friday 15 April 2022 (Good Friday)
Monday 18 April 2022 (Easter Monday)
Monday 2 May 2022
Thursday 2 June 2022
Friday 3 June 2022 (Platinum Jubilee)
Monday 29 August 2022

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS

1 APRIL – 30 JUNE 2021

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
01-21	27 May 2021	28 May 2021	SUMMARY OF URGENT DECISION: 1.1 The approval and execution of: 1.1.1 a variation agreement to a concession agreement dated 31 July 1998 between the Trust and Calderdale Hospital SPC Ltd ("Concessionco") ("Concession Agreement") in relation to works required to be undertaken by Concessionco and its contractors to enable the supply, installation and commissioning of two new MRI scanners ("Variation Agreement"); 1.1.2 a contractor's collateral warranty between the Trust, Concessionco and Engie Buildings Limited relating to the Variation Agreement; 1.1.3 a sub-contractor's collateral warranty between the Trust, Engie Buildings Limited and HeatWorks Limited relating to the Variation Agreement; 1.1.4 a notice of assignment between the Trust, Concessionco and Bank of Scotland plc (in its capacity as Security Trustee (as defined in such notice)) relating to the Variation Agreement; and 1.1.5 a certificate of the Trust to Concessionco and Bank of Scotland Plc (in its capacity as Senior Agent and as Mezzanine Agent under the Original	NAME: Owen Williams TITLE: Chief Executive NAME: Philip Lewer TITLE: Chair NAME: Peter Wilkinson TITLE: Non-Executive Director NAME: Alastair Graham TITLE: Non-Executive Director

			Senior Debt Agreements (as defined in the Concession Agreement) confirming that the Transaction Documents have been approved in accordance with the Trust's Standing Orders and Standing Financial Instructions, together referred to below as the "Transaction Documents". 1.2 It was noted that at a meeting of the Board of Directors of the Trust held on 9 January 2020 and subsequently at a meeting of the Commercial Investment & Strategy Committee held on 23 July 2020, the Board and the Commercial Investment & Strategy Committee had approved the recommended option of the installation of two new MRI scanners at the Trust and the associated service moves ("Recommended Option").	

Calderdale and Huddersfield NHS Foundation Trust

URGENT DECISION

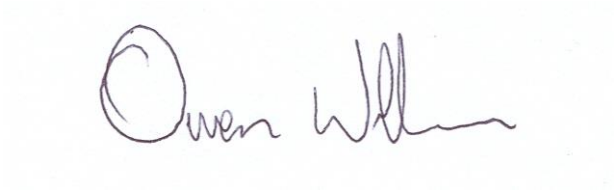
This urgent decision is being taken in line with the provision of the Board of Directors Standing Orders for Urgent decisions in line with the Constitution of Calderdale and Huddersfield NHS Foundation Trust.

This decision must be approved by the following, having consulted with at least two Non-Executive Directors not involved in recommending the decision:

- Chair
- Chief Executive

REFERENCE	**01/21**
MATTER FOR URGENT DECISION:	Delegation of authority to the Quality Committee for the approval of the 2020/21 Quality Accounts.
REASON FOR URGENT DECISION	The Department of Health and Social Care (DHSC) has confirmed that the deadline to publish 2020/21 Quality Accounts remains Wednesday 30 June 2021**.** The Trust does not have a Board meeting to approve the Quality Accounts within this timeframe, with the Trust Board next meeting on 1 July 2021. The Quality Committee has a meeting scheduled for 21 June 2021 where it would review the Quality Accounts with a view to approving these to enable submission within the deadline date. On 14 April 2020 NHS Providers distributed a communication from the DHSC to the effect that they were planning to amend the 2010 Quality Accounts Regulations to remove the 30 June publication date and preceding assurance requirements for this year. NHS Providers were informed by the DHSC that they no longer intend to do this and advised NHS Trusts of this in early May 2021. This means that Trusts now need to publish their quality accounts online by 30 June to comply with the regulations, rather than at a later date. The next available Board meeting to approve this plan is 1 July 2021, after the 30 June 2021 deadline.
PREVIOUS FORUMS (incl outcome of discussion)	None To note that the 2019/20 Quality Accounts were approved by the Quality Committee using delegated authority on behalf of the Board due to changes in national timelines due to the pandemic.
KEY RELATED DOCUMENTS	https://www.england.nhs.uk/financial-accounting-and-reporting/quality-accounts-requirements-2020-21/ Link to NHS England / NHS Improvement website confirming deadline dates.

<table>
<tr><td></td><td>To note Quality Accounts are not required to be included as part of the 2020/21 annual report, nor is any external audit of the quality accounts required as per NHS E/I guidance in the NHS Foundation Trust Annual Reporting Manual, para 2.105:

https://www.england.nhs.uk/wp-content/uploads/2021/03/FT_Annual_Reporting_Manual_2020-21_March.pdf</td></tr>
<tr><td>DURATION OF DECISION:</td><td>One time only</td></tr>
<tr><td>DECISION:</td><td>APPROVED</td></tr>
<tr><td>DATE OF DECISION:</td><td>7 June 2021</td></tr>
<tr><td>CHIEF EXECUTIVE</td><td>Name: Owen Williams
 
Signature:
Date: 15 June 2021</td></tr>
<tr><td>CHAIR</td><td>Name: Philip Lewer
Signature:
 
Date: 7 June 2021</td></tr>
<tr><td>CONSULTATION WITH 2 NON-EXECUTIVE DIRECTORS</td><td><table><tr><td>Name: Alastair Graham

Date: 7 June 2021</td><td>Name: Richard Hopkin

Date: 4 June 2021</td></tr></table>Consultation by: Chair / Company Secretary</td></tr>
<tr><td>DATE REPORTED TO TRUST BOARD</td><td>1 July 2021</td></tr>
</table>

24. Review of Sub-Committee Terms of Reference

a) Workforce Committee

To Approve

Presented by Suzanne Dunkley and Karen Heaton

WORKFORCE COMMITTEE

TERMS OF REFERENCE

Version:	2.4 Amendments following review by Committee Chair and Director of Workforce and Organisational Development 2.5 Amendments following November 2020 review by Committee.
Approved by:	Board of Directors
Date approved:	14 January 2021
Date issued:	5 July 2018, January 2021, May 2021
Review date:	May 2022

WORKFORCE COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Workforce Committee ("the Committee").

2. Authority

2.1 The Committee is constituted as a Standing Committee of the Board of Directors ("the Board"). Its constitution and terms of reference are subject to amendment by the Board.

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 The Committee is authorised by the Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1 The purpose of the Committee is to provide assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. This includes but is not limited to recruitment and retention, colleague health and wellbeing, learning and development, colleague engagement, organisational development, leadership, workforce spend and workforce planning.

3.2 The Committee will assure the Board of the achievement of the objectives set out in the 'A workforce fit for the future' section of the Trust's 10-year strategy.

3.3 The Committee may set up subgroups aligned to key areas of its activity as it deems appropriate.

4. Duties

4.1 The Committee is required to:-

4.1.1 Consider and recommend to the Board, the Trust's overarching Workforce Strategy and associated activity/implementation plan.
4.1.2 To obtain assurance of the delivery of the strategy through the associated activity/implementation plan.
4.1.3 To obtain assurance of the delivery of strategies and associated activity/implementation plans in relation to Equality, Diversity and Inclusion, Freedom to Speak Up, Staff Survey, education and training, leadership development, one culture of care
4.1.4 Provide advice and support on the development of significant workforce related policies .
4.1.5 Consider and approve strategies associated to the delivery of the Workforce Strategy
4.1.6 Consider and recommend to the Board the key workforce performance

targets for the Trust and

4.1.7 To receive regular reports to assure itself that key workforce performance targets are achieved and to request and receive exception reports where this is not the case.

4.1.8 Review the workforce risks of the high level risk register and the Board Assurance Framework.

4.1.9 Hold the Executive Director of Workforce and Organisational Development to account in relation to risk, risk mitigation and future activity/plans.

4.1.10 Receive reports in relation to internal and external quality and performance targets relating to workforce.

4.1.11 To conduct reviews and analysis of strategic workforce issues and to agree an operational response.

5. Membership and attendance

5.1 The Chair of the Committee is a Non-Executive Director and at least one other Committee member will be a Non-Executive Director. In the absence of the Chair, the other Non-Executive Director shall be nominated and appointed as Chair for the meeting.

5.2 The Chair of the Board of Directors shall not be a member of the Committee but may be in attendance.

5.3 Formal Committee meetings will be supported by at least four strategic sessions known as Hot Houses. Arrangements for the strategic sessions are set out in Appendix 1.

5.4 The core membership of the Committee is as follows:-

Two Non-Executive Directors, Director of Workforce and Organisational Development, Chief Operating Officer, Director of Nursing, Medical Director, Director of Finance, Company Secretary, Deputy Director of Workforce and Organisational Development, Workforce Business Intelligence Lead, Public Governor.

<u>The following may be requested to attend as required for specific agenda items:-</u>

Workforce and Organisational Development Assistant Directors and Human Resources Business Partners.
Staff side representatives.
Divisional Directors and Directors of Operations from each Division.
5 ‘free’ places to any member of staff, with a minimum of 3 apprentices.

5.5 A quorum will be four members and must include at least one Non-Executive Director and one Executive Director.

5.6 Attendance is required at 75% of meetings, Members unable to attend should indicate in writing to the Committee Secretary at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.7 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Committee shall be supported by the Secretary, whose duties in this respect will include:-

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting
- Maintaining a record of attendance

7. Frequency of meetings

7.1 The Committee will meet quarterly as a minimum to carry out a deep dive review of workforce performance and metrics and quarterly to discuss strategic issues (Appendix 1).

8. Reporting

8.1 The Committee Secretary will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2 An action schedule will be articulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers.

8.3 The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4 Formal minutes shall be taken of all Committee meetings. Once approved by the Committee, the minutes will go to the next Board meeting.

8.5 In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, currently the Education Committee. It should review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

8.6 A summary report will be presented to the next Board meeting.

9. Review

1.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

1.2 The terms of reference of the Committee shall be reviewed by the Board at least annually.

Appendix 1

The following is the proposed list of invitees to the quarterly strategic, Hot House sessions:-

Group one: Chief Operating Officer, Director of Nursing, Medical Director, Director of Finance and their Deputies plus any member of the Executive group with a special interest in the subject.

Group two: A maximum of 3 x Non-Executive Directors, 2 x Governors as invited by the Chair of the Workforce Committee.

Group three: Workforce and Organisational Development team members who lead on the 'hot house' topic plus Deputy Director of Workforce and Organisational Development, Workforce and Organisational Development Assistant Directors and Human Resource Business Partners.

Group four: Staff side representatives.

Group five: Network colleagues from colleague engagement network and BAME network.

Group six: a minimum of 3 apprentices.

Group seven: 5 'free' places to any member of staff who has a particular interest in the subject.

Group eight: national leaders in the subject field and/or representatives from best practice organisations.

Hot House topics will be determined at the end of the calendar year and can be subject to change as service need dictates.

25. Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)

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

To Note

Presented by Richard Hopkin, Karen Heaton, Denise Sterling and Andy Nelson

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Richard Hopkin, Non-Executive Director
Date(s) of meeting:	1 June 2021
Date of Board meeting this report is to be presented:	1 July 2021

ACKNOWLEDGE

- Overall IPR score in April was 69% with good performance on the Safe domain and some improvement seen in stroke indicators
- New format of IPR presented including a number of enhancements e.g. SWOT analysis, Recovery section, Quality Priorities etc
- Financial performance in Month 1 £0.55m better than plan, with a surplus of £0.62m
- Significant progress on Use of Resources position since 2018 'requires improvement' rating (see below)

ASSURE

- Recovery Coordination &Oversight Group Terms of Reference approved
- Detailed report (with NED input) reviewed on Use of Resources covering progress on key metrics, feedback of UOR work groups, benchmarking results, evidence database etc
- Presentation on CHFT's 'Fiscally Unique' position (updated from 2 years ago) highlighting continuing impact of PFI costs, two site configuration and higher CNST costs
- Committee Self Assessment Action Plan approved, with early progress noted
- Work Plan for 21/22 updated and approved

AWARE

- ED extremely busy with urgent need to expand footprint
- Concerns over comparative length of overall waiting lists (albeit P2 position is improving)
- Other challenges noted from IPR are complaints closure, dementia screening, some cancer metrics and fractured neck of femur access

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Workforce and Organisational Development Committee
Committee Chair:	Karen Heaton, Non-Executive Director
Date(s) of meeting:	Monday 10 May 2021 (Deep Dive) Monday 7 June 2021
Date of Board meeting this report is to be presented:	Thursday 1 July 2021

ACKNOWLEDGE

The following points are to be noted by the Board following the meetings of the Committee on 10 May and 7 June 2021.

- The positive progress being made to improve the level of return to work interviews conducted. Maintaining progress is important but needs to be seen without the aid of HRPs.
- Approved the Gender Pay Gap Report.
- Further analysis required on EDI metrics.
- Quality Performance Report – agreed a deep dive into AHP recruitment and vacancy position.
- Education Committee restarted and an update to come to November meeting.
- Presentation on Business Better than usual and agreed a quarterly report to be presented to the Committee on progress against Workforce actions.
- Future deep dive into Estates and Ancillary sickness absence.
- FSU annual report – more staff standing up but anonymously which remains a concern.
- Hot house delivered on Leadership Skills /competencies post COVID.

ASSURE

The Committee's annual report was approved, and an action plan will be formulated and presented to the next meeting.
Further work continues to be undertaken to update the Trust's Workforce Strategy and the contents of "The Cupboard".
July Board of Governors will receive a progress report on the 2020 national survey action plan.

AWARE

No issues to bring to the attention of the Board.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Quality Committee
Committee Chair:	Denise Sterling, Non-Executive Director
Date(s) of meeting:	24 May 2021, 21 June 2021, June 23 2021 (extra ordinary meeting)
Date of Board meeting this report is to be presented:	1st July 2021

ACKNOWLEDGE

- Clinical Ethics Panel launched in April 2020 good feedback received from members of the panel and those submitting discussion requests
- The Clinical Effectiveness and Audit Group, updated policy for the implementation of national guidance with a robust process for divisions to manage partially compliant guidelines. The NICE compliance backlog position is now improving.

ASSURE

- Reviewed the refreshed Quality and Equality Impact Assessments of the Reconfiguration plans, the overall impact of the EQIAs and QIAs is positive.
- Maternity report presented - Maternity services continue to demonstrate compliance against the requirements as outlined in the Ockenden Report. Evidence is being collated to be submitted against the seven Immediate and Essential Actions of the Ockenden Report by end June 2021. Minutes from Perinatal Quality Surveillance Meeting will come to Quality committee.
- Quality Report received, areas of focus on the quality agenda highlighted, progress is being made against the measures for quality improvement on the Quality Account Priority and Focussed Quality Priorities presented.
- Received the Annual Infection Prevention Control Report 2020/21, assurances noted and the IPC team commended for their exceptional work over the reporting period.
- Reviewed updated High Level Risk Register

Approved:

- The Experience, Participation and Equalities Strategy and Transformation Programme
- The Annual Learning from Deaths Report and recommendations
- Terms of Reference for Trust PSQB, Ethics Panel and Clinical Effectiveness and Audit Group
- Quality Accounts 2020/1 presented to committee on 23rd June reviewed and approved in line with the agreed Board delegation.

AWARE

- A delayed Never Event was reported and is currently under investigation. Actions have been put in place following review.
- IPR – Concerns with access targets in particular ED 4 hr standard reflecting the national picture and 52 week waits analysis ongoing.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Audit and Risk Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	10th June 2021
Date of Board meeting this report is to be presented:	1st July 2021

ACKNOWLEDGE

- The ARC meeting on 10th June was an Extra-ordinary meeting to sign off the Annual Report and Accounts for the financial year 2020-21

ASSURE

- The following papers were approved by the committee:
  - The Going Concern Report which with new guidance is now focussed on the foreseeable future as opposed to indefinitely
  - Audited Annual Accounts in which a surplus of £355k was reported and an improved net asset position of £90m of net positive assets (vs £55m deficit in 2019/20)
  - Letter of Representation
  - Annual Governance Statement (AGS) in which the Trust declared no significant control issues and the AGS is in line with the Head of Internal Audit Opinion and KPMG year-end report
  - Annual Report
  - Internal Audit Annual Report
- The following papers were noted by the committee:
  - The Annual Auditor and Year-End Reports from KPMG
  - The Self-Certification Statements which had been approved at the May 2021 meeting of the Trust Board
- The Head of Internal Audit gave an opinion of significant assurance for the year which is an outstanding outcome given the challenges of the year
- The Draft Audit Opinion was reviewed which this year places greater focus on fraud and any breaches in laws and regulations. KPMG stated there was nothing to flag to the committee

AWARE

As can be seen from the above there are no major issues to highlight to Board. However, it should be noted that sign-off has been delayed from the agreed date of 16th June. NHSE/I granted an extension to 29th June, and we now expect sign-off on 24th June.

26. Committee Review Annual Reports 2020/2021

- Finance and Performance Committee
- Workforce Committee

For Assurance

Presented by Gary Boothby and Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 1 July 2021
Meeting:	Public Board of Directors
Title:	Finance and Performance Committee Annual Review 2020/21
Author:	Rhianna Lomas – PA to Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance and Performance Committee 5 May 2021

Purpose of the Report

Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2020/21 setting out how it has met its Terms of Reference and key priorities.

Key Points to Note

The Committee has carried out its business in the last 12 months in accordance with the terms of reference and the meetings have been well attended. A good balance has been achieved between financial and operational matters and there has been valuable input from other executives, clinicians and managers outside the Committee. In year regular updates have been provided in how the Trust responds to the pandemic including impact on performance and review of activity recovery plans, alongside financial implications. A self-assessment has been recently completed and an action plan will be formed in response to this feedback.

EQIA – Equality Impact Assessment

Individual decisions made by the committee during the course of the year will have been required to undergo a QIA and EQIA as appropriate

Recommendation

The Board is asked to **NOTE** the assurances in the annual review that the Finance and Performance Committee has carried out in its business during April 2020 to March 2021 in accordance with the terms of reference.

Finance and Performance Committee
Annual Review 2020/21

1. Background

Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2020/21 setting out how it has met its Terms of Reference and key priorities. These were reviewed and updated in March 2021.

The purpose of the Committee is laid down in its terms of reference. In summary it is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues and for providing assurance that these are being managed safely. This report will consider the work of the Committee over the course of the last 12 months against each of the key areas of responsibility as laid out in the terms of reference.

2. Finance and Financial Performance

Monthly reporting is provided to the Committee by way of a comprehensive pack of financial metrics and narrative on the year to date and forecast position against the plan for the year. This pack covers the activity, income and expenditure position including cost improvement programme (CIP), capital, cash and use of resources metric. The financial risks which form part of the overall Trust risk register are reviewed against the intelligence in this report and discussed by the Committee on a monthly basis. The financial elements and other specific risks from the Board Assurance Framework are also reviewed by the Committee against the in-year performance and longer-term outlook.

In year, the committee has been advised of regular changes to the finance and cash regime and the impact for CHFT and the ICS.

A Commercial Strategy for the Health Informatics Service (THIS) was delivered to the Committee in March. This provided assurance to the Committee that a contribution to the Trust would be continued.

3. Performance Delivery and Assurance

The Committee receives the monthly Integrated Performance Report which is presented by the Trust's Chief Operating Officer who is able to draw out key messages from the comprehensive report, highlighting particularly positive performance and areas of concern and management actions to maintain the former and address the latter. New activities in year have included greater analysis on the growing waiting list challenge and data to demonstrate any inequalities in access to service.

During the course of the year the Committee has requested a number of deep dives into specific clinical specialties or areas of performance which have been highlighted either as having challenges or opportunities, examples include the Outpatient Improvement Work facilitated by Meridian and a deep dive into stroke performance. These areas have provided

follow up reports which has enabled the monitoring of reporting against action plans. These presentations have been made directly to the Committee by the lead clinicians and managers who were able to bring the topics to life and answer questions which was well received by committee members.

4. Business and Commercial Development

The Trust's Long-Term Plan (5 year) was presented to the Committee at the draft submission stage and a second time in line with the final Trust submission to the ICS. This submission indicated that the 21/22 Financial Improvement Trajectory is in line with the Strategic Outline Case (SOC).

The Committee's understanding of the Long-Term Plan set the context for the Operational Plan (1 year) draft submission for 21/22 to the ICS and NHSI. The Committee reviewed this plan and approved a plan submission in line with the Financial Improvement Trajectory acknowledging that the forthcoming year would be extremely challenging in terms of the CIP expectations. The capital plan was ratified by the Committee and formed part of the overall plan submission.

The Committee routinely receives the Board minutes and annual reports from the Trust's commercial areas, Huddersfield Pharmacy Specials and The Health Informatics Service. In addition, minutes are received from the Commercial Investment Strategy Committee and Capital Management Group detailing business case approvals, progress and expected deliverables. Minutes are also received from the Joint Liaison Committee where the relationship between the Trust and CHS, its wholly owned subsidiary is managed. Notes from meetings of the Pennine Property Partnership are also received following board meetings.

5. Treasury Management

In April 2021 the Committee received a report on treasury management in 2020/21 which also highlighted points to note in relation to the 2021/22 plans. The report concluded that the cash position has been managed in 2020/21 through the challenges brought on by the Covid19 pandemic. The cash position will continue to be managed and monitored closely.

The in-year management and monitoring of treasury matters has been reported to the committee through the monthly financial performance pack. This includes information on levels of borrowing, aged debt and performance against the Better Payment Practice Code. This information is routinely discussed and challenged by the Committee.

The activities undertaken through the Cash Management Committee are reported to the Committee through receipt of the minutes on a quarterly basis in support of the Committee's review of debtor ageing and credit control procedures.

6. Procurement

The Procurement service is provided under contract from Calderdale and Huddersfield Solutions (CHS). The Committee receives minutes on a quarterly basis from the CHFT/CHS Joint Liaison Committee.

7. Membership, Attendance and Monitoring Effectiveness

The Committee is held on a monthly basis and was quorate for all 12 of the meetings. A register of attendance is shown at Appendix 1.

A self-assessment questionnaire in relation to the effectiveness of the committee is carried out on an annual basis. The latest was completed in February 2021 and the responses were positive. An action plan is to be agreed to address any specific comments raised at the next meeting of the Committee.

8. Summary and Recommendation

The Committee has carried out its business in the last 12 months in accordance with the terms of reference and the meetings have been well attended. A good balance has been achieved between financial and operational matters and there has been valuable input from other executive colleagues, clinicians and managers outside the Committee. A self-assessment has been recently completed and an action plan will be formed in response to this feedback.

The Committee is recommended to note the contents of this report.

FINANCE & PERFORMANCE ATTENDANCE – 2020/21

	May M 1 1 June	June M 2 29 June	July M 3 3 Aug	Aug M 4 1 Sept	Sept M 5 28 Sept	Oct M 6 2 Nov	Nov M 7 30 Nov	Dec M 8 11 Jan 2021	Jan M 9 1 Feb	Feb M10 1 Mar	March M11 29 Mar	April M12 Weds 5 May
Helen Barker	Apols	✓	Apols	✓	✓	Apols	✓	✓	✓	✓	✓	
Anna Basford	✓	✓	✓	Apols	✓	✓	✓	✓	✓	✓	Apols	
Gary Boothby	✓	✓	Apols	✓	✓	✓	✓	✓	✓	✓	✓	
Owen Williams	✓	Apols	✓	Apols	✓	✓	✓	✓	✓	✓	✓	
Richard Hopkin – Non-Exec (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Peter Wilkinson – Non-Exec (Vice-Chair)	✓	✓	✓	✓	Apols	✓	Apols	✓	Apols	✓	✓	
Ellen Armistead		✓						LR				
Kirsty Archer	✓	✓	✓	Apols	✓	✓	✓	✓	✓	✓	✓	
Stuart Baron	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Stephen Baines - Governor						✓	Apols	✓	✓	✓	✓	
Peter Bamber – Governor Will only attend if there is anything specific on the Agenda												
Philip Lewer	✓	✓	X	✓	✓	X	✓	X	X	✓	✓	
Andrea McCourt	X	✓	✓	Apols	✓	✓	✓	✓	✓	✓	✓	
Peter Keogh			✓	✓	✓	✓	✓	✓	✓	✓	✓	

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	1 July 2021
Meeting:	Board of Directors
Title:	Workforce Committee Annual Report 2020-2021
Author:	Tracy Rushworth, Secretary to the Workforce Committee Jason Eddleston, Deputy Director of Workforce and Organisational Development
Sponsoring Director:	Suzanne Dunkley, Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee 7 June 2021

Purpose of the Report

- This annual report describes the activities of the Workforce Committee between April 2020 and March 2021 and captures how the Committee met the duties within its Terms of Reference.

Key Points to Note

The report includes:-

- Overview of the role of the Workforce Committee
- Details of membership and attendance between April 2020 and March 2021
- Information of the work of the Committee
- Effectiveness of the Committee – this section summarises the response of the self – assessment by members which reviewed the committee's focus and objectives, committee team working, committee effectiveness, committee engagement and committee leadership. Six out of eleven members completed the assessment, and the summarised findings can be found at Appendix 1.

This annual report is presented for assurance purposes following approval from the Workforce Committee on 7 June 2021.

EQIA – Equality Impact Assessment

Equality impact assessments for specific actions arising from the Annual Report will be assessed, considered and mitigated as appropriate.

Recommendation

The Board is asked to note the assurances in the Annual Report that the Workforce Committee met its duties for 2020/2021.

WORKFORCE COMMITTEE ANNUAL REPORT 2020/2021

This Workforce Committee annual report for 2020/2021 details:-

- The role of the Committee, membership and attendance between 1 April 2020 and 31 March 2021 and the terms of reference
- The activities of the Committee between 1 April 2020 and 31 March 2021
- A self-assessment completed by core Committee members of the effectiveness of the Committee

1. INTRODUCTION

1.1 Purpose of the Workforce Committee

The purpose of the Committee is to provide assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. This includes but is not limited to recruitment and retention, colleague health and wellbeing, learning and development, colleague engagement, organisational development, leadership, workforce spend and workforce planning.

The Committee oversees that there is continuous and measurable improvement in workforce activities through review of key workforce metrics in order to support the delivery of workforce performance targets.

The Committee receives assurance in relation to internal workforce activity from a number of annual reports prior to national publication. These reports include Freedom to Speak Up, Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap. The Committee is responsible for reviewing and monitoring performance and improvement against the associated action plans.

1.2 Terms of Reference

The Committee has approved terms of reference in place.

The Committee made considerable amendments to the terms of reference in January 2021. There was significant change to the structure of the Committee. Formal meetings focus on key workforce issues with a deep dive meeting taking place quarterly. Bi-monthly strategic sessions (Hot Houses) support the development of workforce strategies and frame approaches and responses to other workforce themes. Divisional representatives attend on invitation to provide updates on particular workforce issues at formal meetings and contribute to the discussions at the strategic sessions.

The terms of reference were reviewed again by the Committee in June 2021. The Committee agreed no further amendments were required and set a review date of May 2022.

1.3 Workforce Committee Membership and Attendance in 2020/2021

In March 2020 the Trust focused its attention on manging the impact of the Covid pandemic and as a consequence Committee meetings in April and June 2021 were cancelled. To ensure that discussions and Board oversight continued particularly with regard to colleague health and wellbeing, recruitment, sickness and staffing levels it was agreed the agenda for the Workforce Committee and the Quality Committee for meetings scheduled in May 2020 and June 2020.

Sole Workforce Committee meetings re-commenced in July 2020 and between July 2020 and March 2021 the Committee met on 7 occasions.

The core membership and attendance at the 7 Committee meetings is set out below:-

Name	Role	Number of meetings attended
CORE MEMBERS		
Karen Heaton	Non-Executive Director **(Chair)**	7/7
Ellen Armistead	Chief Nurse	3/7
Helen Barker	Chief Operating Officer	1/7
David Birkenhead	Medical Director	6/7
Gary Boothby	Director of Finance	1/7
Suzanne Dunkley	Director of Workforce Organisational Development	7/7
Jason Eddleston	Deputy Director of Workforce & Organisational Development	5/7
Jude Goddard	Council of Governors	1/7
Andrea McCourt	Company Secretary	5/7
Helen Senior[1]	Staff Side	1/2
Denise Sterling	Non-Executive Director	6/7

[1] Member from February 2021

2. WORKFORCE COMMITTEE ACTIVITIES 2020/2021

The activities in 2020/2021 of the Committee are set out below.

2.1 Covid Pandemic Response

Covid Health and Wellbeing Plans
In specific response to the pandemic a health and wellbeing strategy was developed, broken down into three phases – prepare, active and recover. Multiple guides were made available to colleagues including a guide to working from home, how to reduce COVID-19 anxiety, mindfulness and one-to-one support. Podcasts and sessions were streamed to colleagues and the development of activities to enhance a sense of community and shared purpose. 24/7 specialist counselling and psychological support continues to be available. Debrief sessions, listening events and assignment of wellbeing buddies to services and teams offered to colleagues to provide wrap around support. In October 2020, a consolidated action plan was developed using intelligence from risk assessments and feedback from friendly ear telephone conversations.

Covid Health and Wellbeing Risk Assessment
In August 2020, the Committee received confirmation that the Trust is using a range of data sources to inform its approach to risk assessments and risk responses. A health and wellbeing risk assessment tool was introduced for all colleagues. In October 2020 approximately 50% of the workforce had completed the risk assessment.

Staff Re-Deployment Plans
In August 2020, the approach and activities in response to workforce escalation, reset and stabilisation was presented to the Committee. The Committee was assured the Trust has a robust skills matrix for the future particularly beneficial over the winter months and also the importance on colleagues maintaining new skills through ongoing CPD.

On 9 December 2020, the Committee received a comprehensive presentation from the Workforce and OD team which described the extent of support and activities in response to the urgent need to strengthen wellbeing support.

2.2 Workforce Strategies

On 8 March 2021 the Committee received an update on a review of the Trust's Workforce (People) Strategy and progress in taking action on NHS provider specific NHS People Plan activities. The review was initiated in October 2019 and had been impacted by a focus on Covid19 activity, the first phase has ended with an assessment against the original review ask identifying partial completion.

The review focussed on the key elements of the Strategy:-

- Talent Management
- Equality, Diversity & Inclusion
- Health and Wellbeing
- Corporate Social Responsibility
- Work Together Get Results (WTGR)
- Workforce Design
- Colleague Engagement

The next phase of activity will concentrate on:-

- changing the strategy content so it is fresh and importantly up to date, ensuring the workforce priorities for the 2021/2022 service year are incorporated and capturing NHS People Plan themes and required actions
- amending the strategy concept so the focus is always on the content ie what we do to deliver one culture of care
- building broader and deeper colleague/stakeholder engagement

The Committee noted that:-

- NHS England/Improvement published a 2020/2021 people plan in August 2020 setting out actions for the NHS
- A Trust action plan has been developed capturing the obligations/responsibilities placed on NHS employing organisation
- An assessment shows good progress against the employer actions.

2.3 Freedom to Speak Up

An update of activity and improvements was provided to the Committee on 10 August 2020. Nine concerns were reported in 2018. This increased to 67 in 2019 and at the end of June 2020, 52 concerns have been reported. Increased focus on colleague accountability and a culture of 'your voice matters' is making a real difference in the Trust.

2.4 Leadership Development

A comprehensive package of learning modules available to all staff in a management role was launched on 31 July 2020 with 1542 colleagues were enrolled onto the programme at its launch. Due to the pandemic the programme launched as fully on-line learning.

2.5 Education Committee

The first meeting of the Education Committee took place on 18 February 2020. The pandemic halted future meetings. The Education Committee will be relaunched in 2021. A design group has been established to create clear foundations for the Committee.

2.6 Workforce Race Equality Standard (WRES)

On 16 November 2020 the Committee received the annual report. The Trust's equality networks had been instrumental in the development of the action plan which will be monitored by the Inclusion Advisory Group on a bi-annual basis along with regular discussions at the Trust's Equality groups. A progress update was provided on 8 March 2021.

2.7 Workforce Disability Equality Standard (WDES)

On 16 November 2020 the Committee learned that positive indicators were seen in the likelihood of disabled colleagues being appointed from shortlisting across all posts. An increase had been seen in colleagues believing the Trust provides equal opportunities for career progression/ promotion. The Committee endorsed the response to increase positive outcomes for colleagues. A progress update was provided on 8 March 2021.

2.8 Board Assurance Framework (BAF)

The Committee regularly reviews the BAF to ensure that all risks relating to workforce are identified and managed to mitigate the risks. Four workforce risks are noted:

- Medical Staffing
- Nurse Staffing
- Recruitment/Retention inclusive leadership
- Colleague Engagement

2.9 Improving People Practices

On 9 December 2020 the Committee received a paper which provided an assessment of our current practice against NHS Improvement (NHSI) recommendations and guidance to improve people practices based primarily on learning from a critical incident involving a London NHS Trust. The paper set out the actions implemented to ensure compliance with NHSI guidance.

2.10 Pay Anomalies

A report was presented to the Committee on 8 February 2021 to provide information about an exercise to examine payments made to employees in the Trust that fall outside nationally agreed and locally implemented terms and conditions of employment. A review of the payments will be led by the operational HR team in conjunction with service leads. The review outcome will be presented to the Committee at its May 2021 meeting.

2.11 Revalidation and Appraisal of Non-Training Grade Medical Staff

The annual report is submitted to the Workforce Committee to provide assurance that the agreed processes for GMC revalidation and appraisal have been adhered to prior to submission to the Board of Directors for sign off. The report provides a summary of work through to the end of March 2020 providing comparative data from previous years. A significant difference this year being the suspension of the appraisal and revalidation process by the NHSE/NHSI on 23 March 2020.

2.12 Annual Health Education England Trust Self-Assessment Report

The HEE Quality framework identifies the standards that organisations are expected to have in place to provide a quality learning environment for our learners (for example doctors in training, nursing and midwifery students, apprentices, therapists, pharmacists). The Trust is required to assess annually which standards are fully or partially in place via the use of an annual self-assessment review (SAR). The purpose of the report is to make the Committee aware of the submission which has been made and provide assurance that the Trust complies with standards and domains as set out in the HEE Quality framework.

2.13 Review and Monitor Key Workforce Metrics

At each of its meetings the Committee reviews the Quality and Performance (Workforce) report. The report comprises of key workforce metrics:-

- Sickness absence
- Retention and Turnover
- Essential Safety Training
- Appraisal
- Recruitment
- Bank/Agency Spend

2.14 Exit Interviews

On 15 July 2020 the Committee was provided with an update on Exit Interview Data for the period 1 January 2020 to 30 June 2020. 248 colleagues left the Trust during the period. 72 colleagues completed the leavers survey (29%). The top reason for leaving is retirement age, with some peaks

in voluntary resignation, lack of opportunities, promotion, and relocation. 55 colleagues said their managers had a conversation with them about their reason for leaving. Overall colleague satisfaction working at the Trust is positive. Health and wellbeing question answers were overwhelmingly positive (84%).

2.15 Recruitment

On 10 August 2020 the Committee learned that an external company had been commissioned to develop a consultant recruitment micro internet website. On 9 December 2020 the Committee was updated on the development plans. The build and background material including updating starter packs, recording of podcasts and videos has been prepared by the Medical HR team however the actual internet site was paused due to the furlough of the external company.

A paper which set out the Trust's recruitment Key Performance Indicators (KPIs) and identified the improvements made to data reporting and compliance was presented to the Committee on 9 December 2020. The KPIs now align to the themes identified in the national NHS Enabling Staff Movement programme which looks to streamline employment processes to increase efficiency. Four out of five targets are attaining compliance.

2.16 Return to Work (RTW) Interviews

On 8 February 2021 the Committee was updated on the compliance position for RTW interviews and the steps being taken to improve compliance. The compliance rate for RTW interviews has seen an ongoing decline since the end of 2019. The metric has not achieved its 95% target in the last 24 months. The Committee noted the actions to support improvements and a further update is to be provided to the Committee in May 2021.

2.17 Strategic Sessions (Hot Houses)

Three of the five Hot Houses sessions were cancelled due to the pandemic. The two Hot House sessions which did take place were:-

<u>19 October 2020 – Extended New Roles and Skill Mix</u>
The purpose being to agree an approach to new roles, extended roles and skills mix. Collectively generating ideas and identifying the barriers to progress so that we can work together to remove them.

<u>8 March 2021 – Divisional Presentations of Staff Survey Action Plans</u>
Divisions each presented to the Committee their Staff Survey action plan which also included an overview of how they are doing now, position against survey themes, progress against last year's action plan, what's gone well and where to focus. Positive outcomes and key priorities were outlined.

3 EFFECTIVENESS OF WORKFORCE COMMITTEE

On an annual basis, the Committee undertakes a self-assessment exercise to gauge its effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place, in May 2021. The results are set out in Appendix 1. The action plan will be developed at a future meeting.

4. CONCLUSION

As described above, the Committee has received assurance through the course of 2020/2021 from a number of sources. The Committee therefore confirms that it has fulfilled its role to the Board during 1 April 2020 to 31 March 2021 in fulfilling its key functions of providing assurance that that there is continuous and measurable improvement in the development of workforce strategies and the effectiveness of workforce management in the Trust that align to one culture of care, in addition to ensuring workforce risks are managed appropriately.

5. NEXT STEPS 2021/2022

In drawing this report together, it is necessary to give context as the Covid-19 pandemic was declared in March 2020. Significant changes were made to the Trust's workforce arrangements to reflect the needs of the organisation during this phase, much of which has been around the specific challenges to the workforce whilst still being able to deliver safe, high quality patient care. The Committee will continue to undertake its key function of ensuring the workforce arrangements are effective in ensuring the safety and health and wellbeing of staff.

Tracy Rushworth
Workforce Committee Secretary

Jason Eddleston
Deputy Director of Workforce and OD

June 2021

Appendix 1

Self – assessment of effectiveness of Quality Committee

Seven responses were received, and the findings are below:

- ***Committee focus***

  - The Committee sets itself a series of objectives for the service year.
    - Strongly agree = **33%**
    - Agree = **67%**

  - The Committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.
    - Strongly agree = **33%**
    - Agree = **67%**

  - Committee members contribute regularly across the range of issues discussed.
    - Strongly agree = **17%**
    - Agree = **50%**
    - Disagree = **17%**

  - The committee is fully aware of the key sources of assurance and the key individuals/teams responsible for risk mitigation.
    - Strongly agree = **50%**
    - Agree = **50%**

  - The purpose of the Committee is to provide assurance to the Board on the quality of workforce and organisational development strategies and the effectiveness of workforce management in the Trust.
    - Strongly agree = **67%**
    - Agree = **33%**

- ***CommitteeTeam Working***

  - The Committee has the right balance of experience, knowledge and skills to fulfil its role.
    - Strongly agree = **33%**
    - Agree = **67%**

  - The Committee has structured its agenda to cover the full range of workforce matters and priorities including, Recruitment, Retention, Workforce Planning, Agency Spend, Attendance Management, Colleague Engagement Colleague Health and Wellbeing, Organisation Development and Leadership. This list is not exhaustive.
    - Strongly agree = **33%**
    - Agree = **67%**

  - The Committee ensures that the relevant director/manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.
    - Strongly agree = **33%**
    - Agree = **67%**

  - The Committee is fully briefed via the assurance framework including the Board Assurance Framework) on key risks, assurances and gaps in control in a timely fashion eradicating the potential for 'surprises'.
    - Strongly agree = **17%**
    - Agree = **67%**

  - Relevant information from other committees is provided/shared to the Committee thereby eradicating the potential for 'surprises'.
    - Strongly agree = **17%**
    - Agree = **83%**

- I feel sufficiently comfortable within the committee environment to be able to express my views and opinions, raise concerns and to ask questions.
  - Strongly agree = **67%**
  - Agree = **33%**

- Committee members hold to account individuals who attend meetings to provide assurance for late or missing information.
  - Strongly Agree = **17%**
  - Agree = **83%**

- When a decision has been made or action agreed, I feel confident that it will be implemented in accordance with its associated implementation timeframe.
  - Strongly agree = **50%**
  - Agree = **50%**

➢ ***Committee Effectiveness***

- The quality of committee papers received allows me to perform my role effectively.
  - Strongly agree = **67%**
  - Agree = **33%**

- Committee members provide real and genuine challenge – they do not just seek clarification and/or reassurance.
  - Strongly agree = **17%**
  - Agree = **67%**

- Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints.
  - Strongly agree = **67%**
  - Agree = **33%**

- Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is ie who is doing what, when and how and how it is being monitored.
  - Strongly agree = **67%**
  - Agree = **33%**

- At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc
  - Strongly agree = **67%**
  - Agree = **33%**

- The committee provides a written summary report of its meetings to the Board of Directors.
  - Strongly agree = **33%**
  - Agree = **67%**

- The Board of Directors challenges and understands the reporting from this Committee.
  - Strongly agree = **17%**
  - Agree = **67%**
  - Unable to answer = **17%**

- There is a formal appraisal of the committee's effectiveness each year which is evidence based and takes into account my views and external views.
  - Strongly agree = **50%**
  - Agree = **50%**

➢ ***Committee engagement***

- The Committee actively challenges members and those attending to provide assurance.
  - Strongly agree = **33%**
  - Agree = **67%**

- The Committee is clear about the complementary relationship it has with other Board Committees.
  - Strongly agree = **33%**
  - Agree = **67%**

- The committee receives clear and timely reports from other Board Committees which set out the assurances they have received and their impact (either positive or not) on the Trust's assurance framework.
  - Strongly agree = **17%**
  - Agree = **83**

- I can provide two examples of where the Committee has focused on improvements to the system of internal control as a result of assurance gaps identified.
  - Strongly agree = **33%**
  - Agree = **50%**
  - Unable to answer = **17%**

➢ ***Committee leadership***

- The Committee Chair as a positive impact on the performance of the Committee.
  - Strongly agree = **83%**
  - Agree = **17%**

- Committee meetings are chaired effectively and with clarity of purpose and outcome.
  - Strongly agree = **83%**
  - Agree = **17%**

- The Committee Chair is visible within the organisation and is considered approachable.
  - Strongly agree = **40%**
  - Agree = **40%**

- The Committee Chair allows debate to flow freely and does not assert his/her own views too strongly.
  - Strongly agree = **100%**

- The Committee Chair provides clear and concise information to the Board of Directors on the activities of the Committee and the implications of all identified gaps in assurance/control.
  - Strongly agree = **67%**
  - Agree = **33%**

27. Items for Review Room

- CHS Managing Directors Report

To Note

28. Date and time of next meeting

Thursday 2 September 2021, 9:00 am

Venue: Microsoft Teams

To Note

Presented by Philip Lewer