Public Board of Directors

Schedule	Thursday 6 May 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: Stephen Baines, Veronica Woollin, Sheila Taylor

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Receive

4. Minutes of the previous meeting held on 4 March 2021

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 4 March 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 **(until end of item 32/21)**
Mandy Griffin	Managing Director, Digital Health
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager **(minutes)**
Alison Schofield	Public Elected Governor
Christine Mills	Public Elected Governor
Lindsay Rudge	Deputy Director of Nursing **(for item 41/21)**
Asifa Ali	Research and Innovation Lead **(for item 33/21)**
Cornelle Parker	Deputy Medical Director **(for item 33/21)**

OBSERVERS

Elise McAlpine	Trainee Assistant Finance Manager (FSS)

25/21 Welcome and Introductions

The Chair welcomed Elise McAlpine, Trainee Assistant Finance Manager (FSS) to the meeting who was observing as part of her new role, Asifa Ali, Research and Innovation Lead and Cornelle Parker, Deputy Medical Director who were attending to share a patient and staff story on the impact of Covid research.

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 and in due course the minutes of this meeting will also be published.

26/21 Apologies for absence

Apologies were received from Stephen Baines, Lead Governor.

27/21 Declaration of Interests

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

28/21 Minutes of the previous meeting held on 14 January 2021

The minutes of the previous meeting held on 14 January 2021 were approved as a correct record subject to the following amendments.

AN corrected wording on page 8 to 'A five year Health and Safety Strategy is being developed and will be a key target for 2020/2021.'

AN asked for clarity on the post meeting note which suggests the Fire Strategy was circulated to Board members on 12 February. The Fire Strategy was shared with Non-Executive Directors on 11 February; therefore, the minutes will be corrected.

AN agreed to share revised wording on page 9 in terms of the assurance he received from the Director of Nursing regarding strong divisional representation at the Risk Group meetings.

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held 14 January 2021 subject to the amendments above.

29/21 Action log and matters arising

The action log was reviewed and updated accordingly.

30/21 Chair's Report

The Chair reported that the Trust had been awarded an exceptional partnership certificate from the NHS Blood and Transplant for the work that the Trust has undertaken during the Covid-19 pandemic. The Chair added that CHFT are one of the best Trusts in the region for responding to the demand for organ donation and he is very proud as Chair of the Organ Donation Committee, which has seen some challenges during the pandemic.

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

31/21 Chief Executive's Report

Covid Vaccine Update

The Medical Director provided an update on the Covid Vaccination Programme and the total number of staff vaccinated to date.

Out of 6,030 Trust staff, a total of 4,776 (79.2%) staff have received their first dose and 902 (15%) have received their second dose. Once all forms have been reconciled for the first vaccination, the percentage should increase to around 85%. Overall, the programme has delivered over 25,000 doses to partners and the community and just over 26,000 doses overall.

The Medical Director reported the Trust are aiming to conclude the second dose programme over the next two months after commencing on 15th March 2021. To date, over 8,500 people have now booked their second dose. There was a technical issue sending the link out to android devices which is currently being resolved.

The overall vaccine compliance per Division was shared. There are some Divisions with a lower percentage where many staff are not in public facing roles.

The Medical Director shared data on first vaccinations given by ethnicity, which shows a high percentage for Indian background at 84.4% which is positive. The areas with a lower percentage are those with a Black or Black British-Caribbean background which has the lowest uptake of 35% and those of an Asian or Asian British -Pakistani background which is at 58.4%. The Trust are trying to seek to understand from these colleagues why these uptakes are lower.

The Medical Director shared that there had been a few incidents reported on Datix but that staff made a quick recovery. The majority of people have been very complimentary about the service and numerous letters of thanks have been received by the Covid Vaccination Programme.

The Trust are the lead organisation for the mass vaccination centre for Kirklees at the John Smiths Stadium, with between 500 – 600 doses being provided a day, which is likely to increase as vaccine supply improves to up to 1,500 vaccines a day. The Medical Director is the accountable person, supported by Asifa Ali who is ensuring policies and procedures are in place.

KH congratulated the Medical Director and his team for all their hard work supporting the successful Vaccination Programme. DS highlighted the fantastic achievement of the Trust and sought to understand why there is a low take up from the BAME community and what other strategies could be explored to improve take up. Acknowledging the challenge, the Medical Director responded that from a 'place' point of view, the Trust are going to Community Centres and Mosques. For colleagues the next step will be an individual discussion with people they can relate to. The Director of Workforce and Organisational Development added that the Trust had been focusing on different staffing groups, such as porters and domestics and plans to record podcasts on a "seek to understand" for those colleagues who have concerns or are reluctant to have the vaccine. A letter will be issued today suggesting that individual meetings take place, by 12 March 2021, with all healthcare workers who have refused their vaccine. The Chief Executive noted that such conversations would not extend beyond contractual boundaries and the Trust's approach is to not discriminate against staff groups because of the choices they have made.

OUTCOME: The Board **NOTED** the update from the Medical Director on the ongoing work of the Covid Vaccination Programme.

32/21 2020/21 Strategic Objectives Update

The Director of Transformation and Partnerships shared an update on progress made against the 2020/21 Strategic Plan which shows 19 key deliverables. Each deliverable is RAG rated, of these, one is fully completed, fourteen are rated green on track and four are rated amber (off track but have a plan).

RH highlighted the significant number of on-track deliverables and expressed surprise that the recruitment and vacancy rates for nursing staffing was rated green and asked if the Trust are making significant progress on this. The Director of Workforce and Organisational Development confirmed there was confidence in this rating due to work on international recruitment and health care support workers and planned work from 2021/22 to convert some of the vacant roles into alternative roles, with colleagues operating at the top of their licence. It was noted Trust turnover is currently low at 7.7% and there are 140 registered nurse (RN) vacancies, with the Trust comparing favourably to other Trusts, acknowledging nurse staffing remains a national issue.

The Director of Nursing re-iterated the large amount of work undertaken by the Trust throughout the Covid pandemic on the management of daily staffing shortages and is now in a much stronger position managing on-the-day risks for RN vacancies. Focus nationally is to have no health care support worker vacancies and the Trust are on track to achieve the target. The Trust was successful in its bid for £148k to support international nursing recruitment and over the next 12 months and expects to recruit 70 overseas recruits, the largest number recruited for some time. In addition, the Trust is offering paid placements and a support package for third year nursing students and is confident this will lead to an increase in applications for employment.

AN queried what progress had been made with key items of the Trust's clinical strategy which is rated green. The Medical Director confirmed that whilst this is a challenge due to Covid-19, work has continued on reconfiguration, therefore he is comfortable with the green rating as this remains on track. The Chief Operating Officer shared examples of how the clinical strategy had progressed, including the move of Vascular services, Trust participation in Oncology services across the region and proactive support working in partnership with Leeds Teaching Hospitals Trust throughout the pandemic with their primary angioplasty service, which is aligned with the clinical strategy.

KH asked which countries the Trust are aiming to recruit from, the Director of Nursing confirmed national guidance confirms around 7 countries the Trust can recruit from and offered to share this information with KH.
Action: Director of Nursing to share the list of approved countries for international recruitment with KH

OUTCOME: The Board **NOTED** the assessment of progress against the 2020/2021 Strategic Plan.

33/21 Staff/Patient Story – The Impact of Covid-19 Research on our Patients and the Trust

AG introduced the work of the Research and Development team and introduced Cornelle Parker, Deputy Medical Director and Asifa Ali, Research and Innovation Lead, who shared a staff and patient story on the impact of Covid-19 research. AG noted the research has been of local benefit for our patients and is significant both nationally and globally. AG noted this achievement is to be celebrated and will help understand how the Trust will progress research in the future.

Cornelle explained how the pace of research had significantly quickened due to a landmark Covid-19 study called Recovery, the biggest worldwide randomised control trial looking at treatments for Covid. The Trust has been in the top 10 UK recruitment sites for the Recovery trial out of 140 acute Trusts, which has benefited our patients by having early access to treatment, resulting in more lives saved. As an acute physician looking after acutely ill medical patients in the first 72 hours of admission Cornelle explained how such research has led to the development of more effective treatments for Covid-19, having previously had limited treatment options of oxygen and critical care support.

Asifa Ali, Research and Innovation Lead shared the background to the Covid research, noting that the research department were informed by the Public Health of England to pause all research trials from March 2020 and focus on opening Covid-19 research trials. As a result, the Trust opened nine Covid research trials over the last 12 months, with regional comparison data showing the Trust had the highest recruitment of patients per 1,000 Covid-19 hospital admissions, with 2288 participants recruited.

The Recovery trial, which began on 1 April 2020, was for patients hospitalised with suspected or confirmed Covid-19, with patients on the trial randomised to receive any of the treatment options or no treatment, i.e. standard care. Four treatments which had no effect were stopped, however two treatments were approved by the Medicines and Healthcare Products Regulatory Agency (MHRA): Dexamethasone, shown to reduce death by one third of patients receiving invasive mechanical ventilation and one fifth of patients receiving oxygen, and Tocilizumab, which reduces the need for mechanical ventilation. The global study trial is continuing.

Asifa acknowledged the phenomenal work undertaken by the Pharmacy team who ensured the drugs were available for patients, the majority provided by infusion during the week and weekends.

Asifa explained the Trust is now one of the top 20 recruiting Trusts in the country and remain the highest across Yorkshire and Humber. Recognition of this work has come from Chris Whitty, Chief Medical Officer, who has written to the network acknowledging the work of the Trust with his thanks and the Trust winning the Nursing Times Award 2020 in Clinical Research Nursing.

Asifa shared a video of an interview undertaken by Tracy Wood, Lead Clinical Research Nurse with two patients in the recovery trial. The emotive video showed the patients' reasons for joining the trial, their positive outcome (as they received Tocilizumab treatment they did not need ICU care), their emotions through their patient journey and their thanks to the Trust, showing the importance of recovery trials and confirming it saves lives. The Chief Executive commented, 'this story was one of the most powerful and moving patient stories in his nine years at CHFT'.

Asifa outlined the next steps for research, including the proposal to develop a research hub as a step-down clinical trial unit, which would require Trust and commercial funding.

In response to a question from the Director of Workforce and Organisational Development about any other trends from this research e.g. age, ethnicity, underlying health conditions, BMI, that can feed into the global understanding of risk factors and the Trust's Health and Wellbeing Strategy, Asifa confirmed there have been some emerging trends and the information can be shared to help target support for colleagues through the Strategy. The Director of Workforce and Organisational Development stated she is proud to be working for a Trust which has achieved this work.

RH said it was a fantastic story, it is great to see CHFT at the forefront of this research and it is important to share it with existing staff, the local community and potential recruits. Asifa responded to confirm this story will be shared more widely and there has been extensive media interest from news organisations; filming had taken place for ITV in November 2020, which is yet to be aired.

Cornelle Parker formally thanked Tracy Wood, Lead Clinical Research Nurse and Purav Desai, Principle Clinical Investigator, who have gone above and beyond in their roles, and Asifa Ali as Research Lead who has done a phenomenal job releasing research nurses in the first wave of the pandemic as well as managing the non-Covid studies position, which the Trust are looking to restart.

AG and the Chair passed on thanks to Cornelle and Asifa for a great presentation and leading a remarkable journey.

OUTCOME: The Board **NOTED** the staff and patient story on the impact of Covid research on our patients and the Trust.

34/21 Health Inequalities

The Chief Operating Officer presented the health inequalities report for based on the following key themes:

1. The external environment, how we connect with our communities and use this to inform our business as usual planning – led by the Director of Transformation and Partnerships
2. The lived experience, with initial focus on families accessing our maternity service – led by the Director of Nursing
3. Health inequalities data and how we use this to complement clinical prioritisation and our post Covid delivery model – led by the Chief Operating Officer

With reference to the proposed prioritisation of patients with a learning disability, AN asked if there are any other groups that may have similar challenges of life expectancy. The Chief Operating Officer explained this is something to consider going forwards and explained there is a flag on the EPR system for learning disability and frailty patients which will be reviewed as progress is made and an Equality Impact Assessment (EQIA) will be completed in terms of the learning disability work. AN suggested the wording changes to 'initially prioritise' to be clear that learning disability is not the only prioritisation.

AG suggested the wording "business as usual" is changed to 'business better than usual'. He asked if the Trust know what service would be reviewed next after Maternity services. AG commented reset planning is broader than prioritisation and may include a different approach to how the Trust deliver services, such as outreach work. The Director of Nursing responded that part of the workplan of the Health Inequalities group, chaired by Peter Wilkinson, is to decide which service will be reviewed next and why and PW agreed that planning the direction of travel would be helpful.

KH supported the recommendations and agreed with the initial priority and reporting to the Board and stated it would be interesting to see how progress in one category could positively impact other boundaries.

The Chief Executive commented on the need to appreciate the Trust's significant breakthrough conversations on the analysis of health inequalities and those areas that the Trust can influence and acknowledged that CHFT's awareness in considering how we might be contributing to inequalities is ahead of other organisations. The Chief Executive encouraged the Board to be patient regarding prioritisation of 'where next' noting the amount of work and learning for the three areas recognised. There is optimism that this subject area will improve morale with clinical colleagues as an area of focus away from the pandemic.

KH recognised that leadership engagement of this work is key, noted the length of time it could take to make a difference and cautioned against over analysis of data.

OUTCOME: The Board **NOTED** the three focus themes in relation to health inequalities and the decision to split the leadership of these, **NOTED** the progress already made on Continuity of Carer for BAME families access to Maternity services and **APPROVED** the proposal to initially prioritise the learning disabilities for treatment after cancer and urgent patients and **APPROVED** health inequalities becoming a standing item at the Board of Directors.

35/21 Month 10 Financial Summary

The Director of Finance presented the month 10 financial summary and highlighted the key points below.

- Year to date (YTD) deficit position of £305k, a favourable variance against plan
- Covid Vaccination Centre costs incurred £450k on supporting the vaccine centre at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary and as the host of the John Smiths Stadium vaccine programme, there is an assumption this will be fully funded as reasonable costs
- £1.75m further income assumed for various PCR testing
- Year-end forecasting a £3.6m deficit which is £1.69m worse than plan but is an allowable variation due to increasing the annual leave provision and including a £1.5m provision to cover the estimated cost of the 'Flowers' National tribunal taking place
- Significant capital programmes to be delivered over the last few weeks with close scrutiny daily
- Overall, not forecasting to underspend on any internal schemes

- Significant capital creditors at year end discussed at Finance and Performance Committee
- ICS position – The Trust's favourable variance on it's deficit position has arisen due to not being able to deliver elective activity levels which the plan was based on; however, overall, the Trust is in the same position as other organisations and commissioners across the Integrated Care System which financially will deliver its plan
- Finance risks on the risk register were discussed at Finance and Performance Committee with agreement to reduce the risk scores
- Elective incentive scheme – no longer to be levied which moves our position favourable by £100k
- RH agreed this was a comfortable year-end position reflected in the lower risk ratings agreed for the finance risks.

OUTCOME: The Board **NOTED** the information provided in the Month 10 Financial Summary.

36/21 Annual Plan 2021/22

The Director of Finance presented an update on the financial planning process for 2021/22 which has been deferred and noted the three staged approach for the planning process, with current financial arrangements remaining in place until at least the end of Q1. An allocation of funding will come to the Trust via the Integrated Care System (ICS), which is linked to the allocation given for Q3 for 2020/21 which includes a number of adjustments, such as an inflationary uplift and adjustment for the Clinical Negligence Scheme for Trusts, the premium for which drops significantly by over £1m for next year. At this moment in time, an adjustment for a pay award is not planned as this is yet to be agreed.

To ensure the Trust progresses with the challenge to recover activity and retains budget holder accountability an internal process will be followed to agree 2021/22 budgets. Budgets will be agreed with Calderdale Huddersfield Solutions (CHS), The Health Informatics Service (THIS) and Huddersfield Pharmacy Specials (HPS) by 31 March 2021 recognising that related service level agreements can be changed as needed. There is a process underway with budget holders to normalise their current budget position (stage 1). From 1 April 2021 the Trust will need to identify funding in terms of recovery, to support additional activity or external sourcing of activity.

In terms of the capital programme, the capital plan was previously brought to a Board meeting and further allocations are likely to be received and agreed. The budget book will be brought to Board in May 2021 and a further budget brought back to Board in July 2021 when further clarification has been received on allocations and recovery.

AG asked what the staged approach meant for Cost Improvement Programme (CIP) targets and if stage two will include consideration of invest to save options. The Director of Finance responded that nationally it has been suggested the delivery of CIPs that has been paused throughout 2020/21 would continue into Q1. It is expected that there will be some support for missed CIP opportunities in 2021/22.The terminology 'Cost Improvement Programme' is being reframed to engage colleagues and link to business better than usual, 'Getting it Right First Time' (GIRFT) and recovery of activity to understand how we can deliver activity more efficiently. Conversations have taken place between the Chief Executive and Director of Finance with an organisation to hold workshops to reframe the efficiency challenge. The Director of Finance added that Divisional teams have identified developments, some of which meet the criteria of invest to save, however, these are on hold until a recovery plan has been identified.

OUTCOME: The Board **NOTED** the update to the Board on the financial planning progress for 2021/22.

37/21 Diversity Update

The Director of Workforce and Organisational Development presented the Trust's response to the West Yorkshire and Harrogate Partnership BAME review report on health inequalities.

The paper detailed positive progress on the four key themes from this review and further activities to progress this work identified in the action plan. One of the key recommendations is population planning looking at data and engagement to explore all aspects of our communities. In terms of mental health outcomes there are definite plans to reduce disparities of BAME and non-BAME patients.

There was an agreement that a further update will come to the Board under the Health Inequalities standing agenda item as a combined paper. AG and KH agreed with this and suggested the update on the population planning recommendation comes back to the Trust Board, rather than the Transformation Board.

The Chief Operating Officer agreed with this approach and the Director of Nursing advised a conversation will take place to take stock and a proposal will be brought back to the Board.

OUTCOME: The Board **NOTED** the actions identified in the report published by WY&H and the progress CHFT has made against actions to date and **APPROVED** actions to progress and improve our compliance and **APPROVED** that a further update will come back to the Board under the Health Inequalities standing agenda item as a combined paper.

38/21 Covid-19 – Phase 4 Update

The Chief Operating Officer presented an update on phase 4, looking forward to the draft elective recovery framework. Board members were reminded of the core principles of recovery determined by the Board in May 2020, which had since had the following changes:

- To include a request to describe patient and staff wellbeing and safety as a priority
- To insert 'ensure appropriate opportunities for training' as a new principle
- Re-word 'needs based' to 'health inequalities guided'

Patients who have a rating priority P1 or P2 are being prioritised and will be treated immediately or within the next 4 weeks. The wording agreed on prioritising patients with a learning disability will be incorporated. There is some inconsistency of waiting times for BAME and non-BAME patients and work is taking place on this. Patients who are worried they are on a lower priority list that have a risk of deterioration, with an impact on their outcome or independence, have been added to the priority list following agreement with clinical colleagues through the Clinical Reference Group.

Modelling has taken place to understand what success would look like by the end of September 2021 and March 2022 for inpatients and outpatient services. The modelling headlines were:

- Initial activity numbers were lower than anticipated and for many specialties, lower than pre-Covid levels.
- Two specialties contribute to 42% of the first Outpatients backlog (ENT and Ophthalmology)
- Referrals are expected to increase with impact on some specialties unknown e.g. long Covid with different co morbidities
- Remodelling with a target of achieving pre-Covid backlog position by 31 March 2022, with Endoscopy as the next priority

- A different approach to capacity allocation is required

HB outlined the key operational changes including all patients having a priority rating and administration support teams keeping in touch with patients, virtual appointments and longer day case theatre sessions and outpatients clinics, which will require additionality (eg waiting list initiatives, use of the independent sector) and job plan flexibility, with no same day cross site working. Interdependencies were highlighted, such as working with community and primary care services. Details of engagement with colleagues regarding recovery work was shared.

AG asked if the needs-based principle can be retained and a health inequalities guided principle added to the list to include both, with a focus on the highest level of need and not only length of time e.g. 104 week waiters. The Chief Operating Officer supported both principles being included and explained there is a very small number of 104-week waiters (2 years) with a significant focus to ensure there are none.

Discussion took place on the following in response to Non-Executive Directors questions:

- progress on waiting times (improved for priority 2 patients but widening gap on average wait for BAME patients)
- the process for assessment and prioritisation status of patients (new patients allocated a priority status based on clinical presentation)
- timescale of recovery plan investment requirement (within the next month)
- workforce modelling
- consultation with primary care and local authority colleagues on the Trust model (positive and constructive with buy in of Trust principles and joint ownership of the solution)
- the importance of the wellbeing agenda given the increasing workload (noting this will be undertaken on a voluntary basis or via external solutions)
- potential for variable rates of progress and challenges in different specialties due to different experiences through the pandemic (e.g. ENT)

OUTCOME: The Board **NOTED** the Covid-19 phase 4 update and **APPROVED** a further update on priorities will come back to the next Board for consideration.

39/21 CHFT Fire Strategy

The Chief Operating Officer presented the CHFT Fire Strategy which was produced in partnership with Mott MacDonald, based on statutory and advisory requirements and has been approved at the Fire Committee. The Strategy covers the Trust estate, staff and patients in the estate and staff working in other estates managed by others.

PW suggested the Fire Strategy is not explicit about future projects and building alterations, such as reconfiguration. The Chief Operating Officer clarified the Strategy includes narrative to reflect what happens going forward and agreed that to ensure the Strategy is future proof this wording can be strengthened, with updated wording shared for approval.
Action: COO to update the wording on the future projects/reconfiguration in the Fire Strategy

AG queried if contractors and partners are included in the Strategy. The Chief Operating Officer confirmed the Strategy applies to everyone that comes into our estate and agreed to review the wording to make sure it is explicit regarding contractors.
Action: COO to ensure contractors and partners are explicit in the Strategy

AG queried the timescale for response to the audit and the action plan and the Chief Operating Officer confirmed the fire section of the capital programme and the audit has

started and work is underway. HB confirmed an update on the fire investment priorities will go to the next Fire Committee.

The Chief Executive explained the Director of Workforce and Organisational Development had asked if the Strategy had been approved at the Health and Safety Committee and shared at the Disability Network Group in relation to the 2010 Equality Act, section 20, duty to make adjustments. The Director of Workforce and Organisational Development confirmed the Fire Strategy has been approved via Richard Hill, Head of Health and Safety at the Fire Committee who will report back to the Health and Safety Committee. The Chief Operating Officer confirmed the Strategy has not yet been to the Disability Group and will pick this up.

Action: COO to share the Fire Strategy with the Disability Group

AN sought assurance about fire safety arrangements in the many other properties (120) that the Trust is not responsible for used by staff and the Chief Operating Officer confirmed there are specific fire safety leads for these and a process which includes a combination of the fire officer visiting the building for assurance and documentation review.

OUTCOME: The Board **APPROVED** the CHFT Fire Strategy subject to the comments above regarding contractors, reconfiguration work and from the Disability Group being considered and reflected in the Strategy.

40/21 Maternity Ockenden Review

The Director of Nursing presented an update on Maternity Services and Trust response to the Ockenden review recommendations following the Board Development Session on 4 February 2021.

The two required submissions have been made in response to the Ockenden review, the original submission on the 12 clinical priorities and the more detailed submission included as an appendix to the paper, the Maternity Assessment and Assurance template detailing actions to achieve the further recommendations of the Ockenden Review. Going forward, learning from maternity complaints and incidents will be included in this report.

The Director of Nursing reported the Continuity of Carer (CoC) trajectory of 35% of women being booked on a pathway by March 2021, the likelihood is about 24% of all women booked onto a pathway in January 2021, however, 40% of BAME women were booked on a pathway.

The Director of Nursing has asked for further assurance on the RAG rating of red on induction of labour.

OUTCOME: The Board **NOTED** the update on the submissions as part of the Ockenden Review and the assurance provided within the report in respect of safety and quality of maternity services.

41/21 Nursing and Midwifery Staffing Hard Truths Requirement

Lindsay Rudge, Deputy Director of Nursing presented the Nursing and Midwifery Safer Staffing report and acknowledged the commitment, courage, care and compassion from nursing and midwifery colleagues during the pandemic, noting the impact and challenges this presented were captured in the report. The following report highlights were shared:

- Expanded workforce models to deploy the nursing workforce across services
- An increase in sickness absence
- High nursing fill rates initially due to deployment of student nurses in wave 1 then a Downward trend due to retraction of nursing students

- Impact on quality, e.g. an increase in falls and pressure ulcers
- Strengthened governance arrangements
- Stronger position regarding recruitment, particularly international recruitment
- Focus on health and wellbeing.

KH fed back on discussions at the Workforce Committee on retention and the importance of accelerating the international recruitment campaign. The Deputy Director of Nursing confirmed that the national recruitment programme is much stronger, with significant investment to support the health care support workers and international recruitment programme for the first time, which puts the Trust in a strong position. The Director of Nursing added that the Trust are looking to strengthen clinical educator roles at ward level and there is a challenge to Band 7's to make their clinical area the place to work.

RH asked for assurance and views in terms of reducing absence levels and how the Trust position compared to other Trusts. The Director of Nursing confirmed the Trust are in a better position than other Trusts who have been working at much higher absence levels than CHFT. The positive impact of the health and wellbeing offer was noted, which provides a strong platform for the future as part of business better than usual.

DS asked if the national commitment to increase nurses and midwives in the system had positively impacted on the Trust and the Deputy Director of Nursing confirmed details of work with universities, with membership on the Local Workforce Action Board, increased placement capacity in the Trust and an increase in the number of places on programmes by the universities. DS asked about the extent to which progress had been made with using different roles in teams as part of the Nursing and Midwifery Strategy and the Director of Nursing explained there were some areas that moved more quickly, such as the use of Pharmacy Technicians, and that this will be taken forward as part of workforce redesign. She added that Allied Health Professionals have been working differently during the pandemic and been more ward based, which has helped with proof of the concept.

PW asked if there is any evidence to understand if Brexit is an enabler or barrier to this moving forward and the Director of Workforce and Organisational Development noted only 100 colleagues were impacted and none of these were negatively impacted.

OUTCOME: The Board **NOTED** the Nursing and Midwifery Staffing Hard Truths Report.

42/21 Risk Management Strategy

The Director of Nursing presented the updated Risk Management Strategy which was previously approved at the Risk Group and Audit and Risk Committee.

The purpose of the updated Strategy was to merge the policy and strategy into a combined document and provide more clarity on roles and responsibilities and reporting arrangements.

OUTCOME: The Board **APPROVED** the updated Risk Management Strategy.

43/21 Board Assurance Framework

The Company Secretary presented the updated Board Assurance Framework (BAF) with all changes in red. The key highlights were below:

- There are currently 22 risks on the BAF
- No new risks added since the last report
- There has been an increase in the scores for 2 risks relating to (4/19) Patient and Public Involvement and (4/20) CQC rating, largely linked to the pandemic impacting

on activities that can be undertaken to mitigate the risks and the change in the way CQC is currently operating in response to the pandemic response
- the oversight role for one risk has switched from Finance and Performance Committee to the Transformation Programme Board (9/19) relating to the Trust estate

RH pointed out the reduction of the long term financial risk (18/19) need to be reflected on the heat map and risk 7/19 on NHS Improvement compliance was a Finance and Performance Committee risk responsibility. The Company Secretary confirmed this was initially Board and will be updated to Finance & Performance (F&P) Committee.

Action: Company Secretary to update the heat map for risk 18/19 and responsibility of risk 7/19 to the F&P Committee

AG asked for an update on risk 04/20 regarding CQC and the three outstanding actions and if the risk score had increased as CQC have changed how they are monitoring organisations, or, if the Trust are more worried about maintaining their rating. The Director of Nursing confirmed this is around a CQC inspection, noting the process pre-Covid and beyond will be different. She confirmed processes internally around CQC checks are on hold for valid infection prevention and clinical prioritisation reasons. Must-do assurances and leadership checks remain in place; however, these are not as thorough as normal. Internal CQC checks will be progressed during March at pace and are expected to be on track in the next 4-6 weeks. There are no concerns that the services are in a different place; however, there is not currently the same level of in-depth internal scrutiny for good reason.

AN stated the overall rigour of the BAF keeps improving and noted the score on 4/19 relating to CQC following the challenge around engagement. AN suggested reviewing the risk score for 15/19 on the commercial income from HPS and THIS as there will be further challenges next year. The Director of Finance agreed to review this again and provided re-assurance that the commercial elements of these businesses are relatively small in terms of turnover.

OUTCOME: The Board **APPROVED** the Board Assurance Framework and noted the updates.

44/21 Learning from Deaths Q3 Report

The Medical Director presented the Learning from Deaths report for Q3, noting a total of 187 deaths in Covid positive patients during this period. The challenges on clinical staff have been significant; therefore, the number of reviews has been impacted; however, the high rate of reviews for Covid patients has continued. The target of 50% for mortality reviews has not been met through this year due to the Covid response. Details of the quality of care scores were shared in the report and the findings are common themes, e.g. poor documentation. He added that the Care of the Acutely Ill Patient Programme will be re-established. The Medical Examiner role will be complementary to this and will help strengthen the process.

OUTCOME: The Board **NOTED** the Q3 Learning from Deaths Report.

45/21 Safeguarding Update – Adults & Children

The Director of Nursing presented the Safeguarding Adults and Children interim report. The following points were highlighted:

- Maintained as safe as possible a full safeguarding service during the pandemic

- Established a discharge equality improvement group to assess the quality of hospital discharges
- Ensuring discharges are expedited with a safe and appropriate discharge particularly for elderly patients
- Reviewing health assessments for children looked after which has maintained a good compliance of these assessments, much of this virtual which the Trust would want to continue as business better than usual

The Chair stated it is impressive that this work has been maintained throughout the pandemic.

AG challenged that in the key achievements it stated the Trust continue to attend virtual safeguarding meetings for adults and children for Kirklees; however, doesn't mention Calderdale. The Director of Nursing confirmed this was an omission of the report and Calderdale meetings are still attended.

The Chair added he was impressed that the Trust continued deprivation of liberty during these challenging times. The Director of Nursing confirmed this will be business better than usual.

OUTCOME: The Board **NOTED** the quarterly Safeguarding Adults and Children update.

46/21 Quality Report

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

- Dementia screening continues to present a challenge for the Trust, with a re-focus on some of this work
- CQC's new transitional approach to monitoring services and the Trust's Maternity Services are the first to present to the CQC in line with this new approach
- Recommendation 9 & 10 (Facing the Future Standards) work requires a re-focus now the pandemic surge has eased, largely around paediatric patients in A&E and an urgent report has been requested from the department on risk mitigation- it is acknowledged by the CQC that as this is dependent on configuration of services the Trusts is likely to be non-compliant
- Workshops are taking place focused on Use of Resources to get back on track
- Pressure ulcers remains an area of limited assurance and a comprehensive report will be presented to the Quality Committee which will monitor improvement work
- Complaints – seeing an improved picture which should be reported in March, due to lots of work undertaken and closer working with Divisions leading to a tighter complaint turnaround time

AN asked if the divisions are getting the appropriate skills resource for complaint responses and the Director of Nursing confirmed resources have been deployed in Divisions which has helped speed up the return of complaints to the corporate complaints team and a weekly catch up takes place to review each complaint. A new framework of KPIs is being pulled together to target improvement.

In relation to the 14 open enquiries with the CQC AN asked if there are any key themes and the Director of Nursing responded there are no key themes as yet.

RH confirmed working groups are continuing looking at Use of Resources and an internal review is taking place by the Director of Finance to see where the Trust is against areas previously noted as requiring improvement. A further update is due at the Finance and Performance Committee by May 2021.

RH noted issues regarding dementia screening performance, pressure ulcers and hydration and stated it would be good for the Trust to see progress in these areas. RH queried why falls were not included in the report, which had been briefly discussed at F&P Committee and asked if this can be picked up in the next report. The Director of Nursing confirmed a deep dive from the lead of the Falls Collaborative has taken place which will be included in future reports.

Action: Director of Nursing to include falls in future Quality Reports

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

47/21 Integrated Performance Report – January 2021

The Chief Operating Officer stated the performance position for the month of January 2021 highlighting the key issues and noting that the report has been through all relevant sub-committees.

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

48/21 Governance Report

The Company Secretary presented the updated declarations of interest of members of the Board and the compliance position for the Fit and Proper Persons Regulations under the Health and Social Care Act 2008 Regulations 2014 following an annual update.

The Company Secretary presented the annual review of the Board terms of reference where reference has been added to section 8 to the format of the Board noting these may take place virtually.

OUTCOME: The Board **NOTED** the updated Board of Directors Register of Interests and Fit and Proper Persons Register and **APPROVED** the updated Board Terms of Reference.

49/21 Annual/Bi-Annual Reports

The Public Sector Equality Duty (PSED) Annual Report for 2020 was shared by the Director of Workforce and OD for approval.

AN said it was an encouraging report detailing all the work has been done despite the pressures of last year. He highlighted the leavers report which shows figures for the older age group increasing and asked if this was natural retirement or concern the older age of the workforce are fatigued. The Director of Workforce and Organisational Development confirmed there has been movement in the market and the age group nearer retirement has found the pandemic difficult in their career. She added that there are a few colleagues who can currently retire at age 55 due to their special class status. The leavers report is being reviewed in more detail in terms of age.

The Chair acknowledged this was a comprehensive report detailing the last 12 months.

OUTCOME: The Board **APPROVED** the Public Sector Equality Duty (PSED) Annual Report for 2020.

50/21 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 and 01.02.21
- Quality Committee meeting held 30.12.20 and 25.01.21
- Workforce Committee meeting held 08.02.21
- Covid-19 Oversight Committee meeting held 26.01.21
- Audit and Risk Committee meeting held 26.01.21
- Council of Governors meeting held 28.01.21

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

51/21 Items for Review Room

- Calderdale and Huddersfield Solutions Ltd – Managing Director Update January 2021
- Council of Governors Election Timetable

OUTCOME: The Board **RECEIVED** the Calderdale and Huddersfield Solutions Limited (CHS) Managing Director Update for January 2021 and the Council of Governors Election Timetable.

52/21 Any Other Business
There was no other business.

Date and time of next meeting
Date: Thursday 6 May 2021
Time: 9:00 – 12:30 pm
Venue: Microsoft Teams

The Chair closed the meeting at 12.27 pm.

5. Action Log and Matters Arising

For Review

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 26.04.21

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

DATE DISCUSSED	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
14.01.21 09/21	**Patient Story – Learning from a Complaint in ED** Louise Croxall to share the lessons learned from the complaint more widely across the Trust	LC	Email sent to Louise with action 26.1.21 11.03.21 - Louise confirmed a learning summary is being sent to all the Divisions. 22.03.21 – Learning summary shared and added to all Divisional PSQB meetings in April 2021.	March 2021		22.03.21
04.03.21 32/21	**2020/2021 Strategic Objectives Update** Director of Nursing to share the list of approved countries for international recruitment with KH	EA	This was actioned after the Board meeting and a link was provided to Karen on 16.03.21 which details the countries that are not on the approved list.	March 2021		16.03.21
04.03.21 39/21	**CHFT Fire Strategy** Chief Operating Officer to update the wording on the future projects/reconfiguration in the Fire Strategy Chief Operating Officer to ensure contractors and partners are explicit in the Strategy Chief Operating Officer to share the Fire Strategy with the Disability Group	HB	Completed	May 2021		
04.03.21 43/21	**Board Assurance Framework** Company Secretary to update the heat map for risk 18/19 and responsibility of risk 7/19 to the F&P Committee	AM	Completed	March 2021		08.03.21

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2021

Position as at: 26.04.21

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
04.03.21 46/21	**Quality Report** Director of Nursing to include falls in future Quality Reports	EA	This is in included in the Quality Report for 6 May 2021.	May 2021		

6. Chair’s Report

- Wellbeing Guardian

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

To Note

Presented by Owen Williams

Transforming and Improving Patient Care

8. Staff Story - Getting it Right First Time (GIRFT) Annual Update

Presented by Neeraj Bhasin / Asifa Ali / Nicola Bailey / Clare Vickers

To Note

9. Health Inequalities Group

To Note

Presented by Ellen Armistead, Helen Barker and Suzanne Dunkley

Minutes of the Health Inequalities Group
Tuesday 23 March 2021, 9am-10am
Via Microsoft Teams

Attendees

Amanda McKie (AMc) – Matron for Learning Disabilities
Adele Muir (AM) – Project Manager, PMO
Anna Basford (AB) – Director of Transformation and Partnerships
Bex Sharpe (BS) – PMO Manager
Ellen Armistead (EA) – Executive Director of Nursing
Calum MacIver (CM) – Information Manager, HIS
Helen Barker (HB) – Chief Operating Officer
Luke Stockdale (LS) – Director of Digital Transformation and Innovation
Nicola Hosty (NH) – Assistant Director of HR
Peter Wilkinson (PW) – Non-Executive Director (Chair)
Rachel White (RW) – Assistant Director of Patient Experience
Stephane Jones (SJ) – Personal Assistant (Minutes)
Tomasina Stacey (TS) - Reader (Associate Professor) in Midwifery Practice

	Agenda Item	Action	By when
1	**INTRODUCTIONS** EA opened the meeting and colleagues introduced themselves. No apologies were noted. EA set the context of the group and explain colleagues had been invited due to their involvement in the Health Inequalities (HI) work that is happening throughout the Trust. It was noted CEO, Owen Williams has taken a personal interest in health inequalities and had led a piece of work nationally around the impact of covid on health inequalities and disadvantaged communities. The Board of Directors are keen to progress health inequalities work and received a paper to its March meeting which described the work being undertaken within the Trust. Anna Basford, Helen Barker and Ellen Armistead all have a key role in leading the health inequalities agenda. Anna's work will have a strategic overview, working into reconfiguration and community in reach. Helen will lead on the impact of health inequalities from a clinical prioritisation and waiting list perspective and Ellen will lead from an internal focus looking at an inpatient and community patient perspective, with particular focus on maternity. Peter Wilkinson, Non- Executive Director, will chair the meeting going forward.		

2	**<u>UPDATES FROM ANNA BASFORD AND HELEN BARKER</u>** **ANNA BASFORD** AB shared a slide pack which gave an overview of the different aspects of work going that Anna and her team are leading on. AB described 4 areas of work: ***Area 1: Business Better Than Usual*** The Business Better Than Usual work had been borne from Covid19 pandemic learning and identified 12 key themes that changed the way the Trust worked during the pandemic and will continue going forward. Reducing health inequalities is one of the learning themes and AB described a blueprint that outlined the process of this piece of work which includes *visions and ambitions, critical success factors, key enablers and key milestones.* Each theme is assigned a workstream lead with programme manager support. Initially this theme will focus on two areas; migrant workers and asylum seekers. The work will address gaps in health inequalities for these communities and will help test how we fundamentally change the relationship with communities; building back trust and confidence and responding to the needs of those communities. The Trust have agreed to be a partner with the Huddersfield Mission in putting forward a bid for ICS funding to change improving access and support. Consideration to how the work can be focussed as a learning area by working with primary care networks. Work will be done to understand how services the Trust provide are accessed and whether there is variation in access and experience of care based on protected characteristics and health inequalities. There has been dialogue between the Trust and primary care networks to share learning and connect the primary care information with Trust tools such as the Knowledge Portal (KP). ***Area 2: Impact Assessment Process for Service Change*** The Impact Assessment process for Service Changes has been reviewed with a new robust process now embedded. Service change submissions will be reviewed by a Screening Panel with some submissions having further scrutiny by a formal Impact Assessment Panel. This model developed has been adopted by other Trusts across the WYAAT patch. ***Area 3: Reconfiguration*** Since 2013 there has been a continuous process for assessing the quality and equality impact of proposed changes in service models. This year the improved versions of the impact assessment tools and clinical and workforce leads in the Reconfiguration Team have met with all clinical services to undertake a desktop review of the impact assessment. They will then be tested with colleague with particular protected characteristics. This work will be completed by the end of April 2021 and will be reported into the Quality Committee as a refresh of the process of evaluating the impact of proposed service changes. ***Area 4: Reducing the Impact of Covid19 on BAME communities – Calderdale Council*** During the pandemic Calderdale Council has undertaken extensive engagement work with their communities to understand the differential impact the pandemic has had on those communities from which an action plan has been developed. AB has been		

	invited to chair a partner wide steering group that will oversee the action plan. No questions were raised by colleagues. **HELEN BARKER** HB gave a position update on the Recovery Plan in relation to health inequalities. In response to the National letter received in July 2020 there were 8 urgent actions that related to health inequalities. The Trust is progressing compliance on all actions and will formally respond to the letter by April 2021. Within the Recovery Plan the 8 urgent actions have been referenced and the 3 elements of work overseen by EA, AB and HB will be included. It was noted a diverse and inclusive workforce with equal access to opportunities will be incorporated within the recovery plan HB described a set of principles and priorities, agreed by the Board of Directors, around health inequalities and need based as opposed to chronological waiting list order. It was noted from waiting list data BAME and Learning Disabilities patients are disproportionately affected by the length of wait and specific work will be carried out to address this. A Clinical Reference Group has been established looking at health inequalities. A robust Learning Disabilities Programme has been developed with the Matron for Learning Disabilities and the initiatives within that programme were described. No questions were raised by colleagues.		
3	**MATERNITY WORKSTREAM** TS gave a presentation regarding health inequalities in maternity highlighted partly due to the Covid19 pandemic. Other reports also suggested the position was becoming more severe particularly in relation to pro-natal outcome. A focus on patient experience shows Nationally disadvantaged mothers and their babies have a poorer experience and locally, following a Covid survey, BAME women have a lower satisfaction level for feeding support and postnatal care. Birth outcomes have been reviewed in relation to different areas of inequality for the period 2019/2020 and the following was noted: • Perinatal mortality was at a much higher rate for women of non-white ethnicity as well as pre-term birth and small for gestational age was disproportionate. • Ethnicity and IMD showed high rates in Park and Warley areas of Calderdale. The data sourced will help informed how maternity services are shaped going in the future. It was noted the Asian community live in the more deprived areas. In January 2021 a working group was established which identified some key priority areas and workstreams to be developed; *Organisation of care, Communication/health*		

	literacy, Training/awareness, Smoking, Obesity/diabetes, Data and Community Engagement. TS described the work undertaken to date by the workstreams and the next steps. No questions were raised.		
4	**<u>WORKFORCE</u>** NH reported that the Equality Groups have become more involved following the revised Impact Assessment Service Change process and the two departments are working closely together to ensure the process and engagement is right. Funds have been received through Charitable Funds to implement a new role for a BAME Community Engagement Advisor who will work 4 days a week (fix term contract for 12 months). From April, Talia will work 2 days in the Trust engaging with BAME colleagues and 2 days in the community. This will help engage communities with Trust services.		
5	**<u>AGREED WORKPLAN</u>** **Workplan** EA described the workplan of the group and the areas that would be covered; *Service Planning, Service Delivery, Lived Experience and Workforce.* Colleagues considered whether there are any other groups that are not captured by the Quality Committee, Workforce Committee or Patient Experience that need to be covered by this group. The following suggestions were put forward: **ICS (West Yorkshire):** AB suggested the group should have oversight of the ICS work (West Yorkshire Plan). **Community Engagement**: RW and NH are working with the CCG around EDS and the community engagement. A potential theme from this work will be around reset and recover and health inequalities. **Population Health Management (CCG):** CM reported the HIS are doing a piece of work led by Calderdale CCG around population health management. The work started pre-covid but has been put on hold. This will be a large piece of work and the CCG are wanting to involve other organisations. **Complaints:** RW/CM have done some recent work with Owen Williams in relation to complaints which should be considered. EA agreed this work sits under Lived Experience. **Outpatients, remote consultations and digital exclusions:** work on outpatients, remote consultations and adaptations to those consultations; sign language, work on digital exclusion. Feedback from Roadshows: HB suggested to link with Owen Williams in relation to any feedback from roadshows which should come into this group.		

	Board of Directors reporting: Health Inequalities will be a standing item on the Board of Directors agenda and HB suggested the minutes from this group should be submitted to the Board of Directors. Action: SJ to liaise with Board Secretary with regards submitting minutes. **Membership** AB suggested there should be clinical engagement and although it was not necessary for a clinician to join the group it should be reference on the workplan that clinical engagement is taking place. The current membership was agreed. Action: • EA to develop the Terms of Reference/membership/plan a page. • SJ to arrange meeting between EA and PW. EA asked colleagues to consider what success from this group might look like in 12 months' time.	**SJ** **EA** **SJ**	
6	**ANY OTHER BUSINESS** No further business was discussed.		
7	**DATE AND TIME OF NEXT MEETING** 20 April 2021 11.30am – 12.30pm Microsoft Teams		

Sustainability

10. Annual Plan

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 6th May 2021
Meeting:	Board of Directors
Title:	Recovery Framework and Annual plan
Author:	Helen Barker, Chief Operating Officer Gary Boothby, Director of Finance
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Weekly Executive Board Finance & Performance Committee

Purpose of the Report

These papers describe the framework and associated finance arrangements for the Trust over the next 12 months as CHFT moves from Pandemic response to recovery. It includes the Financial and Activity Plan for 2021/22.

Key Points to Note

Recovery

The response to the Pandemic has been robust, timely and aligned with the core values and behaviours of the organisation.

Backlogs have developed across all planned care services and the framework describes how we will refocus our capacity to those patients who are waiting to access care.

This will require the same level of planning at pace, execution, and governance as the initial response.

The recovery framework seeks to build on our successful track record of delivery with the aim of managing recovery at pace. This will require more focus on prioritisation, health equality and the wider patient experience with a reduction in variation within and across specialties.

The foundation for this remains the Four Pillars, previously agreed Board of Director Principles and the Trust Must Dos.

The framework will predominately require changes within the Clinician Divisions who in turn will need a refocussing of corporate support to ensure they can deliver this as quickly, efficiently and safely as possible.

There is an assumption that we will continue to see Covid -19 within the general population, have a number of Covid-19 positive inpatients and care for patients who are positive within our community services. This also means that we may continue to see some level of staff absence as a consequence of Covid.

The framework references some high level health inequality informed priorities. Work will continue, in parallel with the framework, to fully understand our Health Inequity data which, as it evolves will further inform decision making.

This is a framework document that will continue to evolve as we work through the next 12months; the content has been socialised widely with clinical and operational colleagues as well as external partners whose comments have been reflected.

Recovery is built into the financial plan that is recommended for approval. The key points to note are:

- The baseline budgets, including pre-approved developments for 2021/22 have been set
- Funding has been set aside for specific Covid measures / recovery actions - £8m in total
- Funding has been earmarked for new prioritised developments at £2.8m (£5m in total)
- Recovery planning assumes internal and independent sector capacity
- Based on these parameters, £3m efficiency is required to achieve a balanced budget in H1
- The full year efficiency requirement is planned at £17.2m, with heightened pressure in H2 due to assumed reversion to business as usual funding arrangements

EQIA – Equality Impact Assessment

An EQIA is in progress for the framework and individual EQIA will be developed to support elements of the financial plan including developments and efficiency opportunities.

Recommendation

The Board is asked to **APPROVE** the Recovery Framework and Annual Plan for 2021/22.

Signed off by: H Barker and Gary Boothby

Date signed off: 28th April 2021

Recovery Framework and Annual Plan

Introduction

The recovery framework has been discussed in a number of forums previously and the detailed framework is provided within the reading room.

Recovery of activity is the top priority for CHFT in 21/22 and the Executive Summary provided within this paper describes our Approach.

The Financial plan incorporating recovery is then described.

Recovery Framework - Executive Summary

This framework sets out how, within CHFT and with system partners we are proposing to restart care for our patients, by reopening our services and reducing the waiting lists safely and at pace in the face of immense challenges post-Covid. This will be delivered under the umbrella of One culture of care and ensuring Health Inequalities is central to all decision making. The Board of Directors principles agreed in May 2020 and refreshed in February 2021 form the cornerstone of the framework.

CHFT and the wider system has always performed well but has developed significant planned care backlogs, as a consequence of managing the pandemic, that will take many months to eliminate and this framework describes the way the organisation will work to deliver this building on four core foundations alongside our existing 'Must Do's and enhanced colleague engagement.

Principles	Priorities	Health Inequalities	Modelling
•Patient & colleague safety & wellbeing •Resilience •Needs based •Ensure learning reviewed & embedded •Understand interdependencies including financial implications •Ensure a positive training environment •Incorporate our agreed Must Do's	•Priority 1 & 2 patients •People with a learning disability •Waiting time equity for BAME & non BAME •Appropriate waiting time equity across specialties •Patients with a harm or independence risk •Robust administrative support •Services where increased risk of harm •Services where no alternative provision •All additionality will be voluntary •Widen access to recruitment •Compassionate leadership	•Compliance with the 8 urgent actions •Connection with communities used to inform including digital inclusion •The lived experience with initial focus on families accessing maternity services •Overlay clinical prioritisation to ensure recovery reduces health inequalities and ensure those most likely to benefit are prioritised •Ensure a diverse and inclusive workforce with equal access to opportunities	•Clinical reference group in place •Sept & March Milestones •Based on priorities & current level of demand •New outpatients, inpatient/daycase & Endoscopy completed •Follow up outpatients, other diagnostics & therapies to be completed

Service models will include the following:

- Reviewing the old ways of working – staffing models, care pathways, Outpatient appointments.
- Adopting the new ways of working delivered through Business Better than Usual
- Enhanced use of technology and digital capabilities
- Closer working with GPs and all our healthcare partners across West Yorkshire
- An ability to retract and move back into surge, at pace, should we see any further Covid surge

The key CHFT challenges and therefore opportunities.

1 Tackling the backlogs/waiting lists.

- Adopting new ways of working borne out of Covid and reviewing the old ones will be key to a timely reset.

- Our reset will be informed by a Clinical Reference Groups formed with Operational, Clinical and THIS colleagues who will meet regularly.
- Beds and ward planning will be split into quarters 1,2,3 and 4 to reflect the variations in demand and capacity and the move into next winter with associated pressures.
- Extra close working with our partners in West Yorkshire will be key.

2 Productivity opportunities

- As much activity as we can by virtual means including meetings and MDTs via teams.
- Outpatients - maximise all innovative solutions to deliver capacity at pre-Covid levels to maximise the face to face capacity.
- All patients will be scheduled as a day case by default (or converted to an inpatient at pre-assessment)
- All theatre sessions will be all day (2 sessions) and a session will be a minimum of 4hours
- Clinicians will have flexibility to run non face-to-face clinics outside normal working hours

3 Workforce

Filling vacancies and the health and wellbeing of staff is key so focus will be on:

- Expediting recruitment to staffing gaps which existed both pre-Covid and as a result of Covid
- Exploring the potential of new roles and new models at pace..
- Consider new models not currently recognised to meet demands in clinical areas.

4 Children's Services

- Ensuring sufficient capacity in place so as to manage increased demand following potential delayed referrals
- There will be focussed work with the Children's Directorate and external partners and areas of high numbers of children eg ENT.
- The Children's Emergency Care pathway will move towards national standards
- We will continue to work with community teams in the delivery of immunisation programmes

5 Research & Development

- The Trust has been one of the top recruiters to Covid-19 research and this has enabled our patients to receive early access to new treatments.
- We will continue to participate in relevant trials as well as restart other research paused during the pandemic and further expand our portfolio of NHS and Commercial research.

6 Estate

Estate usage will be prioritised as follows:

- Direct patient care where this can't be delivered virtually
- Adjacency that facilitates efficiency
- Training & education, where this can't be delivered virtually
- Patient support services where there is no off site/ WFH opportunity
- Flexible team/Hot Desk

7 Working from Home

It is recognised that a large cohort of staff have worked from home since the commencement of the pandemic and a long term strategy will be developed prior to any definitive decision on the future service model for these colleagues.

8 Infection Prevention and Control

- new pathways to minimise the risk of contact between Covid positive and negative patients whilst also optimising capacity and therefore reducing the risk of harm from waiting
- all elective pre attendance swabs will be taken using the home swabbing
- options to implement individual waiting pods will be explored.
- both EDs will be desegregated (with a clear trigger for reversal should we see any further surge in Covid 19).

9 Community

The Community Division will support those patients who can be cared for outside of a hospital setting and working together will ensure timely discharges.

Working with Primary care Network (PCN) Clinical Directors (CDs) we will look at reducing admissions and enabling early supported discharge. The Quest team will continue to input to care homes but with a renewed focus on prevention.

Work will commence with PCNs, LMCs and CCGs to agree community priorities and right size capacity

10 Diagnostics

As we reset there is the potential for diagnostics to be overwhelmed. So measures to prevent this will be built into modelling

11 Pharmacy

Ward-based pharmacists will be rolled out with a focus on safe and timely admission and discharge

12 Critical Care

We have capacity for 13 funded beds and the staffing model for these will revert back to pre Covid-19 position

13 Corporate functions

More support directed towards Divisions to support governance and workforce activities including complaints, risk management, validation, and staff survey improvements.

14 CHS & ISS

A comprehensive review of all Covid variations to determine future need.

15 THIS

Ensure sufficient THIS capacity to support modelling, Health Inequalities, and performance reporting as key priorities

16 Digital /New Technology

Continue to build on the current foundations to explore further opportunities via Business better than usual and aspirant Trust developments

17 External partners

We will engage with all partners at local place, WYAAT& ICS level to maximise the opportunities for recovery at pace

18 Risks

All new developments will be considered against a risk rating.

19 Performance

The Performance Management Framework will be reviewed and implemented

20 Finance & Contracting

- Budgets will be set for recovery delivery in Q1 & 2 now called H1 (half year 1)
- The Chief Executive and Director of Finance will lead on the approach to achieving and sustaining Financial Balance.

21 Governance

New measures include:

- The Incident Management Team construct will be closed and replaced by a more Divisionally led response supported by a Recovery Coordination and Oversight group reporting into Weekly Exec Board (WEB) and ultimately Finance & Performance Committee
- Each Clinical Division will develop a 10 year Strategy and a plan on a page for 21/22
- The Directors will be buddied up with areas &/or services to provide both informal support and greater assurance.
- Incidents and complaints will continue to be closely monitored

22 Colleague Health and Wellbeing

A huge area of activity, development and expansion during Covid and many new measures will be continuing which include:

- Leadership forums and walkrounds
- Annual Health and Wellbeing Risk Assessment for all colleagues
- Listening events and The Wellbeing Hour
- Continued access to free parking

23 Leadership

- The Trust launched an online leadership programme and weekly leadership briefings will continue.
- Divisions will have forums for their leadership teams and wider staff groups.
- The health & wellbeing of our leaders will be supported in addition to colleague support

24 Timelines

Clinicians and managers want to progress at pace with restart. With the second dose vaccine within the Trust and with the rollout of vaccinations within the community there is a level of confidence that numbers will continue to reduce to a level that facilitates the resumption of planned care.

25 Communications & Engagement

- Our communications will be honest, transparent and clear about what we do and do not know.
- Updates will be provided in CHFT bulletin and through the various weekly briefing sessions
- A feedback route will be established for teams and individuals.

The full framework is available in the reading room

Financial Plan including Recovery Support

Background

The 2021/22 budget setting was agreed by the Board in March to be completed in a staged approach.

1. Realignment of budgets and additional funding to support previously approved recurrent business cases. Covid funding will be set aside separately rather than applied to individual budgets.
2. Review of additional funding requests for new developments.
3. Review of requests to support additional activity recovery.

This staged approach was taken to reflect the extended national planning submission timetable, to allow further time for understanding of the operational position and in the context that the funding regime and Integrated Care System (ICS) funding envelopes for 2021/22 were not issued.

National regime and ICS approach

It has been confirmed that the existing financial framework will be rolled over for the first half of 2021/22, known as Half 1 (H1) of 2021/22. These arrangements comprise ICS funding envelopes, incorporating Covid top up funds and separate funding streams outside of the envelopes for items such as Covid testing costs and vaccinations.

It has been agreed by the West Yorkshire ICS that the top up funding will be distributed to individual organisations on the same proportionate share basis as in the latter half of 2020/21. In addition, it has been agreed that each individual organisation will plan for a break-even financial position to form the aggregate system breakeven plan.

Further Elective Recovery Funding (ERF) funding will be made available at ICS level based on system achievement of incremental monthly thresholds of activity split by point of delivery measured against a 2019/20 activity baseline.

This funding position aligns closely with the planning assumptions that had been made by CHFT in advance and discussed at Finance and Performance Committee in late March 2021. The national guidance for the second half of 2021/22 (H2) and funding availability is awaited.

Progression of financial plan

Against the staged approach described above, progress has been made:

- Stage 1 is complete and budget holders are being asked to approve budgets on this basis. Covid funding of £8m had initially been set aside. This has since been reviewed against the Trust's operational position and plan to exit from Covid expenditure. Following this review the requirement has been reduced to £4.5m. The balance of £3.5m remains held but will be redirected to elective activity recovery actions (Stage 3).
- Stage 2, a further £5m of Developments were put forward for consideration. Following Executive review £2.8m accepted to progress to business case stage for consideration at Commercial Investment Strategy Committee. The Committee was sighted on the overall financial context and the need for investments to deliver a return on investment, including qualitative, productivity and efficiency benefits.
- Stage 3, planning for elective activity recovery incorporates existing internal capacity supplemented by independent sector provision. The funding referenced above at Stage 1 will support these plans. At this stage it is assumed that any additional Elective Recovery Funding based on system performance is fully committed against expenditure to achieve these targets.

The combined impact of these decisions in H1 2021/22 drives a requirement for a £3m efficiency in H1 to deliver a balanced budget. This represents a transactional level of savings and for context £5.8m of efficiency was achieved through 2020/21 in spite of the Covid pressures.

It should be noted that the impact of these decisions drives a significantly greater efficiency requirement in H2 2021/22 of £14.2m. No additional financial pressure from elective activity recovery is assumed in H2. Alongside this it is important to say that funding arrangements for H2 at present are not settled, there is national recognition that a hard stop to the H1 funding could lead to a financial 'cliff-edge' and some tapering may be required. The Trust cannot however rely on this.

Summary

In summary:

- The baseline budgets, including pre-approved developments for 2021/22 have been set
- Funding has been set aside for specific Covid measures / recovery actions at £8m combined
- Funding has been earmarked for new prioritised developments at £2.8m (£5m in total)
- Recovery planning assumes internal and independent sector capacity and ERF is assumed to be committed to expenditure
- Based on these parameters, £3m efficiency is required to achieve a balanced budget in H1
- The full year efficiency requirement is planned at £17.2m, with heightened pressure in H2 due to assumed reversion to business as usual funding arrangements

Recommendations

- To approve the H1 financial plan with an efficiency requirement of £3m
- To note the greater efficiency requirement upon exiting the temporary Covid funding arrangements in H2.

Appendix A and B show the planned income and expenditure position for 21/22 and also the planned level of activity compared to previous years.

Appendix A – Income and Expenditure Plan

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	400.98	0.00	400.98
Other Income[1]	51.39	57.71	51.02	0.25	51.27
TOTAL INCOME	424.70	479.94	451.99	0.25	452.24
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)	(41.68)	(0.09)	(41.76)
Clinical Supplies & Services	(29.50)	(30.47)	(30.95)	0.00	(30.95)
Other Costs	(69.21)	(91.09)	(72.35)	6.07	(66.28)
NON PAY EXPENDITURE	(139.03)	(162.52)	(144.98)	5.99	(138.99)
TOTAL EXPENSES	(400.31)	(452.87)	(440.09)	16.99	(423.11)
EBITDA	**24.39**	**27.07**	**11.90**	**17.24**	**29.13**
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**	**(17.24)**	**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

Appendix B - Activity

Planned Activity Compared to 2019/20 and 2020/21

	2019/20 Activity - Actual				2020/21 Activity - Actual				2021/22 Activity - Plan			
Month	**DC**	**EL**	**DC&EL**	**OP**	**DC**	**EL**	**DC&EL**	**OP**	**DC**	**EL**	**DC&EL**	**OP**
April	3,057	414	3,471	32,215	1,160	111	1,271	16,672	2,875	246	3,121	29,038
May	3,244	415	3,659	32,845	1,269	89	1,358	21,556	2,918	250	3,168	27,483
June	3,089	448	3,537	31,816	1,746	123	1,869	31,020	3,248	300	3,548	31,880
July	3,546	435	3,981	35,812	2,200	182	2,382	36,975	3,086	261	3,347	31,540
August	3,101	429	3,530	30,684	2,191	188	2,379	32,211	2,945	249	3,194	30,106
September	3,349	446	3,795	33,813	2,485	242	2,727	29,025	3,086	261	3,347	31,540
Total H1	**19,386**	**2,587**	**21,973**	**197,183**	**11,051**	**935**	**11,986**	**167,459**	**18,157**	**1,568**	**19,725**	**181,587**

Planned Activity Levels Compared to 2021/22 Thresholds

		% of 19/20 Activity Delivered (adjusted for working day differences)				Distance from Threshold %				Distance from Threshold - activity			
Month	**19/20 Threshold**	**DC**	**EL**	**DC&EL**	**OP**	**DC**	**EL**	**DC&EL**	**OP**	**DC**	**EL**	**DC&EL**	**OP**
April	70%	94%	59%	90%	90%	24%	-11%	20%	20%	735	- 44	692	6,488
May	75%	99%	67%	96%	92%	24%	-8%	21%	17%	716	- 31	685	5,195
June	80%	96%	61%	91%	91%	16%	-19%	11%	11%	529	- 94	435	3,882
July	85%	91%	63%	88%	92%	6%	-22%	3%	7%	202	- 93	110	2,423
August	85%	95%	58%	91%	98%	10%	-27%	6%	13%	310	- 115	194	4,025
September	85%	88%	56%	84%	89%	3%	-29%	-1%	4%	103	- 136	- 33	1,430
Total H1										**2,596**	**- 513**	**2,083**	**23,444**

11. Month 12 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 6th May 2021
Meeting:	Board of Directors
Title:	Month 12 Finance Report
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby – Director of Finance
Previous Forums:	Finance and Performance Committee

Purpose of the Report

To provide a summary of the financial position and forecast as reported at the end of Month 12 (March 2021).

Key Points to Note

20/21 Year End Summary

For the financial year ending 31st March 2021, the Trust delivered a surplus of £0.36m, a favourable variance of £2.27m compared to plan. This favourable variance was largely driven by the confirmation of additional income from NHS Improvement in support of those elements that were driving the planned deficit position; the Annual leave accrual and loss on non-NHS income due to the pandemic.

- The surplus shown excludes non-cash related year-end adjustments for impairments (£12.67m expenditure), for donated assets including donated PPE (net. £3.13m income) and for donated asset depreciation (£0.216m expenditure), all of which are excluded by NHS Improvement for the purposes of assessing financial performance.
- £10.87m of system Covid funding has been allocated for M7-12, with additional cash allocations from NHS England of: £1.26m to cover lost non-NHS income, £5.71m towards an increased Annual Leave accrual, £0.46m for the 'Flowers' national legal case (for backdated annual leave), and £0.14m for Lateral Flow Testing. In addition, the Trust has requested a further £3.30m to Covid cover costs outside of the system envelope for testing, vaccinations, 3rd year students and research costs.
- This additional funding contributes towards costs incurred: £6.33m increase in the Annual Leave accrual, £1.25m of lost non-NHS income and estimated costs of £2.19m for the ‘Flowers’ case.
- The Trust has incurred costs relating to Covid-19 of £33.54m. M12 costs incurred were £3.51m driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the expansion of the workforce, staff working additional shifts, the segregation of patient pathways, and 3rd Year Student Nurses.
- The remaining funding shortfall is offset by an underspend on activity reset and business as usual activity.
- The Trust continued to deliver some efficiency savings. CIP achieved for the year was £5.84m, £8.93m below the original Trust plan. Compared to the Phase 3 Plan, the

Trust has delivered £3.87m of savings in 6 months, slightly below the £4.82m described in the revised plan. This is not a target being monitored by NHS Improvement in 2020/21.

- Agency expenditure year to date is £4.51m, £0.28m below the revised planned level.

Key Variances (compared to Phase 3 plan submission)

- Whilst the majority of the Trust's Clinical Contract income has been fixed due to block and top up arrangements including a fixed monthly allocation to cover Covid-19 expenditure, there remain some variable elements. As described above, additional income of £3.30m has been assumed to cover 'outside of envelope' Covid costs. The Trust has also received additional system support of £0.81m and has assumed a total of £7.43m additional NHS England funding as advised to cover Annual leave costs, the 'Flowers' case and to compensate for lost non-NHS income. The Trust is also required to account for additional employer pension contributions paid on the Trust's behalf by NHS England and offset by notional income of £11.27m. In overall terms income was above plan by £24.51m, (excluding Donated Asset Income).
- Pay costs were £15.08m above the planned level year to date, although this includes the £11.27m notional pensions costs mentioned above. Excluding this value, pay costs were £3.81m higher than planned. The Annual Leave accrual has been increased by £6.33m (£5.83m higher than planned), reflecting the impact of the Covid-19 second wave on our staff's ability to take their allocated leave. This pay pressure has been offset by slippage in recruitment to the additional posts required to deliver Phase 3 activity plans.
- Non-pay operating expenditure was higher than planned by £7.58m, (excluding Donated consumables expenditure). This is due to higher than planned Covid-19 related expenditure particularly Vaccination costs, costs due to the 'Flowers' legal case, an increase in provisions, and non-recurrent legal costs.

Attachment: Month 12 Finance Report

EQIA – Equality Impact Assessment

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

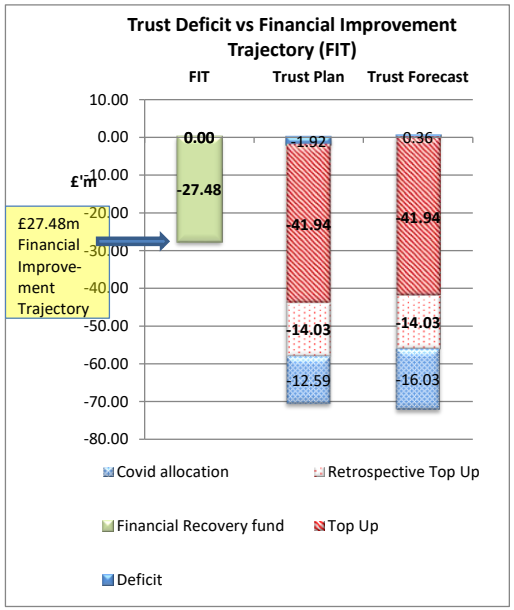
Recommendation

The Board is asked to **NOTE** and receive the Month 12 Finance Report and note the financial position for the Trust as at 31 March 2021.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Mar 2021 - Month 12

KEY METRICS

	M12				YTD (MAR 2021)				Forecast 20/21			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£0.96)	£0.22	£1.18		(£1.92)	£0.36	£2.27		(£1.92)	£0.36	£2.27	
Agency Expenditure	(£0.47)	(£0.46)	£0.01		(£4.78)	(£4.51)	£0.28		(£4.78)	(£4.51)	£0.28	
Capital	£3.66	£12.09	(£8.43)		£20.85	£27.01	(£6.16)		£20.85	£27.01	(£6.16)	
Cash	£28.03	£48.22	£20.19		£28.03	£48.22	£20.19		£28.04	£48.22	£20.19	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95%	95%	0%		95%	89%	-6%					
CIP	£1.23	£0.65	(£0.58)		£14.77	£5.84	(£8.93)		£14.77	£5.84	(£8.93)	
Use of Resource Metric	3	1			2	2			2	2		



Year to Date Summary

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- Agency expenditure year to date is £4.51m, £0.28m below the revised planned level.

Key Variances (compared to Phase 3 plan submission)

- Whilst the majority of the Trust's Clinical Contract income has been fixed due to block and top up arrangements including a fixed monthly allocation to cover Covid-19 expenditure, there remain some variable elements. As described above, additional income of £3.30m has been assumed to cover 'outside of envelope' Covid costs. The Trust has also received additional system support of £0.81m and has assumed a total of £7.43m additional NHS England funding as advised to cover Annual leave costs, the 'Flowers' case and to compensate for lost non-NHS income. The Trust is also required to account for additional employer pension contributions paid on the Trust's behalf by NHS England and offset by notional income of £11.27m. In overall terms income was above plan by £24.51m, (excluding Donated Asset Income).
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- Non-pay operating expenditure was higher than planned by £7.58m, (excluding Donated consumables expenditure). This is due to higher than planned Covid-19 related expenditure particularly Vaccination costs, costs due to the 'Flowers' legal case, an increase in provisions, and non recurrent legal costs.

Total Group Financial Overview as at 31st Mar 2021 - Month 12

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M12

CLINICAL ACTIVITY

	M12 Plan	M12 Actual	Var
Elective	2,245	1,708	(537)
Non-Elective	53,875	47,403	(6,472)
Daycase	28,176	26,787	(1,389)
Outpatient	298,401	312,107	13,706
A&E	133,952	125,522	(8,430)
Other NHS Non-Tariff	1,190,677	1,217,308	26,631
Other NHS Tariff	49,737	69,963	20,227
Total	**1,757,064**	**1,800,799**	**43,735**

TOTAL GROUP: INCOME AND EXPENDITURE

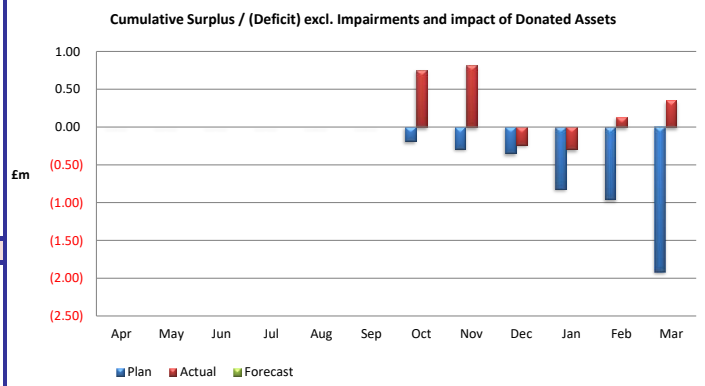
	M12 Plan	M12 Actual	Var
	£m	£m	£m
Elective	£18.01	£18.01	£0.00
Non Elective	£114.89	£114.89	£0.00
Daycase	£30.72	£30.72	£0.00
Outpatients	£46.12	£46.12	£0.00
A & E	£23.16	£23.16	(£0.00)
Other-NHS Clinical	£105.78	£124.64	£18.86
CQUIN	£3.79	£3.79	£0.00
Other Income	£46.96	£50.71	£3.76
Total Income	**£389.43**	**£412.05**	**£22.62**
Pay	(£286.54)	(£301.62)	(£15.08)
Drug Costs	(£41.90)	(£40.96)	£0.94
Clinical Support	(£31.01)	(£30.47)	£0.53
Other Costs	(£64.57)	(£73.63)	(£9.05)
PFI Costs	(£13.44)	(£13.44)	£0.00
Total Expenditure	**(£437.46)**	**(£460.12)**	**(£22.66)**
EBITDA	**(£48.03)**	**(£48.06)**	**(£0.04)**
Non Operating Expenditure	(£24.06)	(£23.59)	£0.47
Surplus / (Deficit) Adjusted*	**(£72.08)**	**(£71.65)**	**£0.43**
Conditional Funding (MRET/FRF/Top Up)	£70.17	£72.01	£1.84
Surplus / Deficit*	**(£1.92)**	**£0.36**	**£2.27**

* 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

	M12 Plan	M12 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£17.51	£20.65	£3.14
Medical	£31.43	£31.38	(£0.05)
Families & Specialist Services	(£7.45)	(£5.73)	£1.72
Community	(£3.90)	(£2.44)	£1.46
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£46.03)	(£47.87)	(£1.85)
THIS	£1.49	£1.45	(£0.04)
PMU	£3.00	£3.40	£0.40
CHS LTD	£0.71	£0.15	(£0.55)
Central Inc/Technical Accounts	£0.38	(£0.59)	(£0.97)
Reserves	£0.94	(£0.06)	(£0.99)
Unallocated CIP	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£1.92)**	**£0.36**	**£2.27**

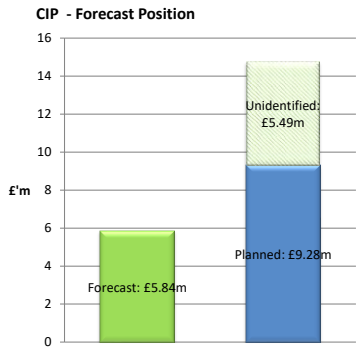
TOTAL GROUP SURPLUS / (DEFICIT)

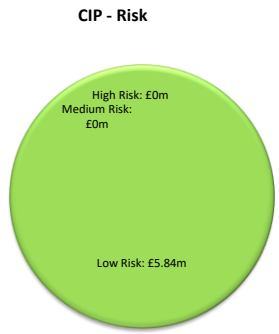


KEY METRICS

	Year To Date			Year End: Forecast			
	M12 Plan	M12 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£1.92)	£0.36	£2.27	(£1.92)	£0.36	£2.27	
Capital	£20.85	£27.01	(£6.16)	£20.85	£27.01	(£6.16)	
Cash	£28.03	£48.22	£20.19	£28.04	£48.22	£20.19	
Invoices Paid within 30 days (BPPC)	95%	89%	-6%				
CIP	£14.77	£5.84	(£8.93)	£14.77	£5.84	(£8.93)	
	Plan	Actual		Plan	Forecast		
Use of Resource Metric	2	2		2	2		

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £14.77m **Total Forecast £5.84m**

YEAR END 20/21

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	2,245	1,708	(537)
Non-Elective	53,875	47,403	(6,472)
Daycase	28,176	26,787	(1,389)
Outpatient	298,401	312,107	13,706
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Other NHS Tariff	49,737	69,963	20,227
Total	**1,757,064**	**1,800,799**	**43,735**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£18.01	£18.01	£0.00
Non Elective	£114.89	£114.89	£0.00
Daycase	£30.72	£30.72	£0.00
Outpatients	£46.12	£46.12	£0.00
A & E	£23.16	£23.16	(£0.00)
Other-NHS Clinical	£105.17	£124.64	£19.48
CQUIN	£3.79	£3.79	£0.00
Other Income	£47.57	£50.71	£3.14
Total Income	**£389.43**	**£412.05**	**£22.62**
Pay	(£286.54)	(£301.62)	(£15.08)
Drug Costs	(£41.90)	(£40.96)	£0.93
Clinical Support	(£31.01)	(£30.47)	£0.53
Other Costs	(£64.57)	(£73.64)	(£9.06)
PFI Costs	(£13.44)	(£13.42)	£0.01
Total Expenditure	**(£437.46)**	**(£460.12)**	**(£22.66)**
EBITDA	**(£48.03)**	**(£48.06)**	**(£0.04)**
Non Operating Expenditure	(£24.06)	(£23.59)	£0.47
Surplus / (Deficit) Adjusted*	**(£72.08)**	**(£71.65)**	**£0.43**
Conditional Funding (MRET/FRF/Top Up)	£70.17	£72.01	£1.84
Surplus / Deficit*	**(£1.92)**	**£0.36**	**£2.27**

* 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

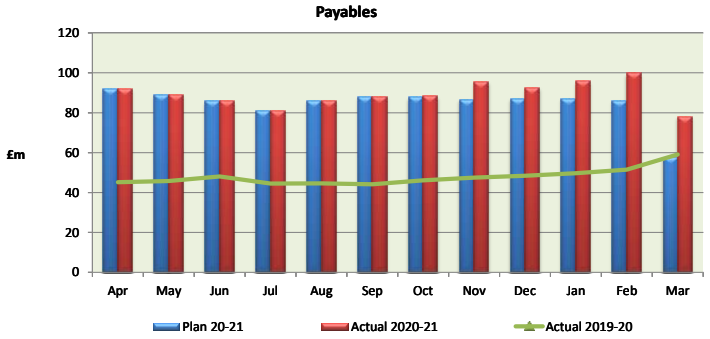
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£17.51	£20.65	£3.14
Medical	£31.43	£31.38	(£0.05)
Families & Specialist Services	(£7.45)	(£5.73)	£1.72
Community	(£3.90)	(£2.44)	£1.46
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£46.03)	(£47.87)	(£1.85)
THIS	£1.49	£1.45	(£0.04)
PMU	£3.00	£3.40	£0.40
CHS LTD	£0.71	£0.15	(£0.55)
Central Inc/Technical Accounts	£0.38	(£0.59)	(£0.97)
Reserves	£0.94	(£0.06)	(£0.99)
Unallocated CIP	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£1.92)**	**£0.36**	**£2.27**

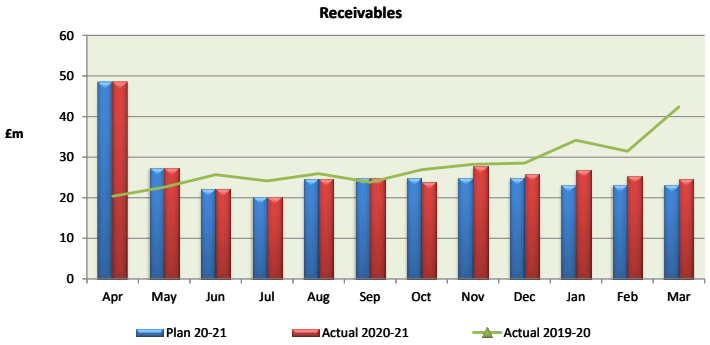
Total Group Financial Overview as at 31st Mar 2021 - Month 12

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

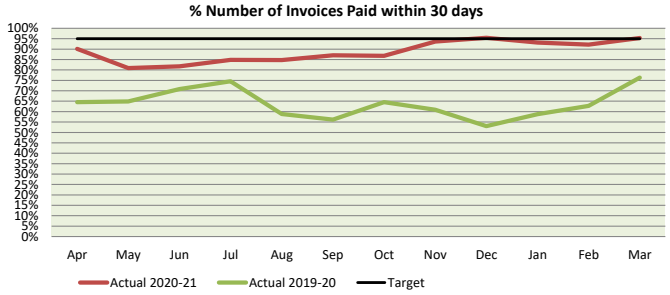
WORKING CAPITAL

	M12 Plan £m	M12 Actual £m	Var £m	M12
Payables (excl. Current Loans)	(£58.02)	(£77.99)	£19.97	
Receivables	£23.27	£24.61	(£1.34)	



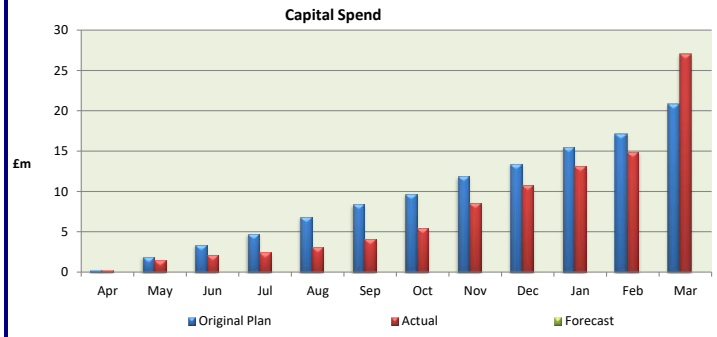


BETTER PAYMENT PRACTICE CODE



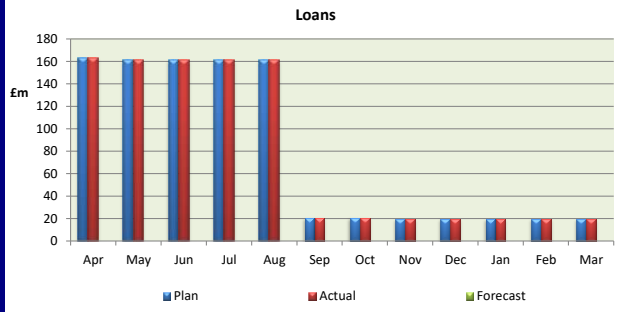
CAPITAL

	M12 Plan £m	M12 Actual £m	Var £m	M12
Capital	£20.85	£27.01	(£6.16)	

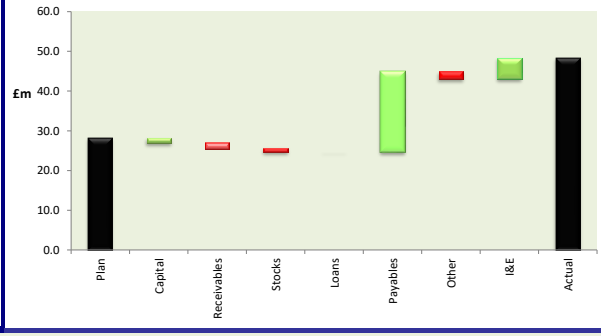


CASH

	M12 Plan £m	M12 Actual £m	Var £m	M12
Cash	£28.03	£48.22	£20.19	
Loans (Cumulative)	£19.88	£19.88	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- For the financial year ending 31st March 2021, the Trust delivered a surplus of £0.36m, a favourable variance of £2.27m compared to plan. This favourable variance was largely driven by the confirmation of additional income from NHS Improvement in support of those elements that were driving the planned deficit position; the Annual leave accrual and loss on non-NHS income due to the pandemic.
- The Trust's Clinical Contract income has been largely fixed due to block and top up arrangements including a fixed monthly allocation to cover Covid-19 costs, but there remain some variable elements. Additional income of £3.30m has been assumed to cover 'outside of envelope' Covid costs. The Trust has also received additional system support of £0.81m, a £1.26m cash allocation to compensate for lost non-NHS income and £5.71m funding in support of an increase in the Annual Leave accrual.
- Whilst Outpatient activity was above the Phase 3 plan for the period, all other areas of activity were below plan due to increased Covid-19 admissions.
- Year to date the Trust has incurred costs relating to Covid-19 of £33.54m. M12 costs incurred were £3.51m.
- Capital expenditure is higher than planned at £27.01m against a planned £20.85m. This includes £2.46m of Donated Assets, including Ventilators, Imaging and Testing equipment procured centrally during the pandemic.
- The Trust continued to deliver some efficiency savings. CIP achieved for the year was £5.84m, £8.93m below the original Trust plan.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 2. This excludes the exceptional adverse impact on the Capital Service Cover Metric of the repayment of Interim revenue and capital support loans, due to changes in the NHS cash regime.

NOTES

- The surplus shown excludes non-cash related year end adjustments for impairments (£12.67m expenditure), for donated assets including donated PPE (net. £3.13m income) and for donated asset depreciation (£0.216m expenditure), all of which are excluded by NHS Improvement for the purposes of assessing financial performance.
- The total loan balance at year end was £19.88m as planned. All Revenue and Interim Capital Loans (totalling £140.72m) were repaid and replaced by PDC funding during September.
- The Trust has a cash balance of £48.22m, £20.19m higher than planned. Whilst contract income is no longer received a month in advance as seen in previous months this year, the Trust retains more cash than planned due to an increase in accruals and provisions, in particular those relating to the Annual Leave accrual and the 'Flowers' legal case for back dated annual leave. These payments will made in cash terms in the next financial year.

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

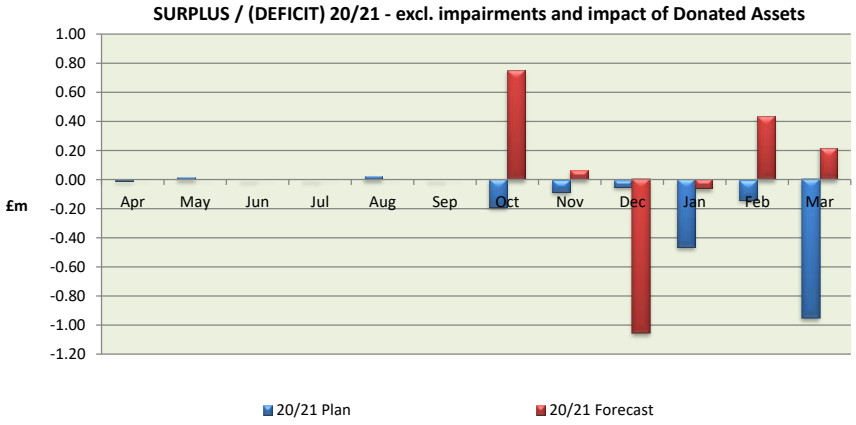
YEAR END POSITION 20/21

YEAR END 20/21

Statement of Comprehensive Income	Plan £m	Actual £m	Var £m	
Income	£459.73	£491.21	£31.48	
Pay expenditure	(£286.54)	(£301.62)	(£15.08)	
Non Pay Expenditure	(£150.92)	(£162.52)	(£11.60)	
Non Operating Costs	(£24.14)	(£36.47)	(£12.33)	
Total Trust Surplus / (Deficit)	**(£1.87)**	**(£9.40)**	**(£7.53)**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	£12.67	£12.67	
Donated Asset depreciation	£0.09	£0.22	£0.13	
Donated Asset income (including Covid equipment)	(£0.13)	(£2.46)	(£2.33)	
Net impact of donated consumables (PPE etc)	£0.00	(£0.67)	(£0.67)	
Adjusted Financial Performance	**(£1.92)**	**£0.36**	**£2.27**	

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

MONTHLY SURPLUS / (DEFICIT)



Final Position vs Month 7-12 (Phase 3) Financial Plan

The plan submitted to the ICS and NHSI assumed an underlying unfunded gap (deficit) of £1.92m as described below. This deficit position was primarily driven by a loss of non-NHS income, for which national funding has now been agreed and the impact of increasing the Annual Leave accrual. Whilst the Annual Leave accrual has increased by £6.54m, much more than planned, national funding of £5.71m has been agreed to cover up to a maximum of 5 days carried forward leave, offsetting the majority of this increased cost.

	Plan £'m	Actual £'m	
Technical Accounting Adjustment:	£0.00		*Removed from Plan and Forecast*
Loss of 'Other' Income:	-£1.61	£0.00	National Funding agreed
Annual Leave Accrual:	-£0.50	-£0.62	National funding agreed up to 5 days
Other	£0.19	£0.98	
Total Planned Surplus / (Deficit)	**-£1.92**	**£0.36**	

Statement of Comprehensive Income

The table to the left shows how the Income & Expenditure position will be shown in the year end accounts. There are a number of technical adjustments that are not included by NHS Improvement for the purposes of assessing the Trust's financial performance and have therefore been excluded from the most of the pages of this report. The full reported position is shown here for completeness.

- Following the annual valuation of Land, Property and Equipment, impairments of £12.67m have been recognised in the financial position.
- The Trust has recognised the value of assets that have been donated to the Trust this year including: £1.65m Ventilators and Associated equipment, £0.56m Diagnostic imaging equipment, £0.19m Testing equipment and £0.06m of equipment purchased using donations to Trust charitable funds.
- The Trust has also recognised the value of consumables (PPE etc) that were procured centrally by the Department of Health during the pandemic and were provided to the Trust free of charge over the last 12 months. The majority of these have been used, but there remains some stock that will be available to use in the next financial year, the cost of which has been recognised in the accounts.

COVID-19

Revenue Impact of Covid-19 - YTD MAR 2021					
Division	**Annual Leave Accrual**	**Covid-19 Direct Costs**	**Impact on activity**	**Loss of Income**	**Total**
	£	£	£	£	£
Central & Technical	6,328,846	9,838,919	42,208	0	16,209,973
Medicine	0	12,870,339	334,083	0	13,204,421
Families & Specialist Services	0	2,202,948	(198,263)	698,511	2,703,196
Calderdale & Huddersfield Solutions Ltd	0	1,456,207	(119,501)	123,000	1,459,706
Corporate Services	0	2,366,526	(40,525)	2,351,423	4,677,424
Community	0	1,407,261	0	30,346	1,437,607
Health Informatics	0	147,354	0	0	147,354
Surgery & Anaesthetics	0	3,249,256	(3,255,204)	0	(5,948)
NHS Nightingale (Hosted Costs)		3,264			3,264
Total costs identified	**6,328,846**	**33,542,074**	**- 3,237,203**	**3,203,280**	**39,836,998**
Retrospective Top Up requested (M1-6)		**14,031,213**			**14,031,213**
Covid System Top Up (M7-12)		**10,866,000**			**10,866,000**
Covid funding 'outside of envelope'	**5,713,000**	**3,439,498**		**1,256,000**	**10,408,498**
Total funding	**5,713,000**	**28,336,711**	**-**	**1,256,000**	**35,305,711**

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

The Trust has incurred Covid-19 direct costs totalling £33.54m in this financial year as shown in the table and these have been reported to NHSI in support of the requested 'Retrospective Top Up' (M1-6), Covid system funding provided from M7 and additional funding requested to cover 'outside of envelope costs'. Additional Covid funding totalling £3.30m has been assumed to cover costs for: Covid-19 Testing £1.61m, Covid-19 Vaccination Programme £1.52m and NIHR SIREN £0.02m. The Trust has also been allocated cash funding of £0.14m to cover the cost of delivering Lateral Flow Testing, £1.26m in support of lost non-NHS income and £5.71m in support of the Annual Leave accrual.

Key areas of spend are as follows:

Pay - £18.73m

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

Pay expenditure that requires additional funding as 'outside of envelope' is as follows:
- £0.050m for staff costs to support PCR virus testing using platforms procured prior to Sep 20.
- £0.827m to support the Vaccination programme delivered within the hospital setting.
- £0.015m for NIHR SIREN
- £0.161m for 3rd Year Student Nurses

Non Pay - £14.81m

Non pay costs categorised as inside of system envelope total £12.56m, including: £5.28m for locally procured PPE, costs related to increased ICU capacity of £1.02m, £1.12m on Covid testing, £2.32m for segregation of patient pathways, £1.18m for decontamination and £0.75m to support remote management of patients.

Non pay expenditure that requires additional funding as outside of envelope is as follows:
- £1.556m for testing kits and associated equipment for PCR virus testing using platforms procured prior to Sep 20 (this includes PCR testing for SIREN)
- £0.665m for the Huddersfield Vaccination Centre at the Johns Smiths Stadium and £0.024m for the Hospital based Vaccination programme.
- £0.002m for NIHR SIREN

Income Losses

The Trust has lost income totalling £3.20m over the full 12 months including: loss of Car Parking Income, (£2.25m which is a combination of income from staff permits and income from patients and visitors), loss of catering income (£0.12m), loss of apprentice levy income (£0.08m from pausing of HCAs apprenticeships delivered internally) and loss of private patient income (£0.70m mainly from Yorkshire Fertility). Funding of £1.26m has been agreed by NHS England to offset the proportion of these losses that relates to the second half of the year.

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

Capital funding of £0.88m for Covid-19 costs was requested, of which £0.84m has been approved and received in cash.

12. CHFT Green Plan (Climate Change)

To Approve

Presented by Stuart Sugarman and Andy Nelson

Date of Meeting:	Thursday 6th May 2021
Meeting:	Board of Directors
Title:	CHFT Green Plan
Author:	Robert Dadzie, Environment Manager
Sponsoring Director:	Stuart Sugarman, Managing Director, Calderdale and Huddersfield Solutions
Previous Forums:	Transformation Programme Board (TPB) / Green Planning Committee

Purpose of the Report

This document introduces the CHFT Green Plan which has been developed to outline the Trust's ambition for sustainability across the next 5 years. The paper has already been submitted to and approved by the Transformation Programme Board (TPB) in March 2021 and is presented to the Board for approval.

Key Points to Note

The Green Plan supersedes the existing CHFT Sustainable Development Management Plan (SDMP) and the Trust's Climate Change Plan which was approved by CHFT Board in November 2020 and which outlines actions for carbon reduction. The plan will eventually become the overarching document for Sustainability across the Trust.

What is a Green Plan?

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

Developing a Green Plan will help CHFT to:

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

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

The Green Plan calculates a carbon baseline for the Trust using ERIC (estates) data spanning between 2013 and 2020. Work is currently underway to provide further

verification of this baseline and to calculate an earlier baseline that estimate changes to consumption ranging as far back as 1990, in line with national expectations.

Additionally, the Sustainability Action Plan (SAP) behind this document is also being submitted for the Board to note. It's important to note that the SAP is a live document and will continue to be developed as the strategy is delivered.

EQIA – Equality Impact Assessment

The Green Plan proposes a range of key aspirations that will address socio-economic issues in and around our local areas. It identifies several targets which include a focus on sustainable procurement. Through this objective the Trust will promote local sourcing and ethical purchases, ensuring that future Capital projects invest funds within our surrounding community. More broadly speaking targets for ethical procurement also reduce the risk of Modern Slavery / child labour and enforce fair employment standards within construction.

The key themes behind the Green Plan are also aligned with the Trust's care models and our plans for governance and adaptation. The SAP will allow the Trust to assess risks associated with climate change and identify ways to mitigate these risks. The SAP encourages the development of adaptation and resilience strategies and a review of our heatwave plans, cold weather plans and flood management plans.

The Green Plan is also aligned with the Trust's aspirations for Corporate Social Responsibility and promotes further engagement with voluntary organisations. This ensures that the Trust is acting as a responsible corporate citizen and helps to increase the social value that we provide as an organisation.

Recommendation

The Board are asked to **APPROVE** the Green Plan. In addition, the Board are asked to **NOTE** the requirements within the accompanying Sustainability Action Plan and **APPROVE** the proposed amendments to Board papers.

Calderdale and Huddersfield
NHS Foundation Trust

CHFT Green Plan

February 2021 – February 2026

Commissioned for **CHFT** by Calderdale and Huddersfield Solutions **(CHS)** through consultation with **WRM**

Integrated Facilities Management

Reviewed by the Transformation and Programme Board – Monday 8th March 2021

compassionate care

Contents

1.0 GLOSSARY OF TERMS

Air Pollution- the presence and introduction into the air of a substance which is harmful to human health

Carbon Intensity- a means of calculating the amount of carbon generated for a specific energy source (e.g. electricity)

Carbon Net-Zero- a state in which an organisation emits no carbon emissions from its activities. Or a state in which all carbon emissions are offset.

CO_2e (Carbon dioxide equivalent)- a unit used to express total greenhouse gas emissions. There are multiple GHGs, each with a different impact on climate change. CO_2e equates all GHGs to the impact of carbon dioxide. CO_2e is used to report all GHG emissions.

Greenhouse Gas (GHG)- a gas that contributes to the greenhouse effect, leading to climate change (e.g. CO_2)

Global Warming Potential- a measurement that enables the comparison of global warming impacts of different greenhouse gases

kWh (kilowatt hours)- a unit of measurement for energy usage (e.g. gas and electricity)

Direct emissions- CO_2e emissions from sources which are owned or controlled by the Trust

Indirect emissions- CO_2e emissions from sources which are not owned or controlled by the Trust, but are generated due to the Trust's activities (e.g. purchase of electricity, procurement, waste disposal)

Scope 1 emissions- direct emissions from owned or controlled sources (e.g. on-site fuel combustion, company vehicles, anaesthetic gases)

Scope 2 emissions- indirect emissions from the generation of purchased electricity, steam, heating and cooling

Scope 3 emissions- all other indirect emissions that occur in an organisation's supply chain (e.g. purchased goods, employee commuting, waste disposal)

2.0 FOREWORD

At Calderdale and Huddersfield NHS Trust we know that our natural environment is a precious legacy.

This Green Plan sets out how the Trust will contribute to protecting and enhancing the environment for the next generation. The Plan provides a strategic framework that the Trust can use to address the three areas of concern that we will be focussing on:

- Reducing our carbon emissions
- Reducing our contribution to air pollution
- Reducing our generation of waste and improving recycling.

The plan demonstrates our commitment to meeting national NHS and local government targets for reductions in carbon emissions. We have already taken huge strides to reduce our environmental impact, through the establishment of a Green Planning Committee, procuring 100% of our energy from renewable energy tariffs and significantly reducing the amount of waste going to landfill. However, we recognise there is still lots to do and this plan sets out the further actions we will take to deliver on our commitments & targets.

We look forward to working with our colleagues, local partners and stakeholders, patients and visitors as we continue on our journey to develop new ways of working which put sustainability and environmental issues at the heart of everything that we do as a Trust.

3.0 INTRODUCTION

3.1 Our Commitment to Sustainability at Calderdale and Huddersfield NHS Trust

At Calderdale and Huddersfield NHS Trust ("CHFT" or "the Trust") we recognise our responsibility to reduce our impact on the environment. This Green Plan establishes our commitment to delivering sustainability and reducing our environmental impacts. We will reduce our impact on the environment by focussing on the three key issues of climate change, air pollution and waste. The Green Plan provides a strategic framework that the Trust can use to address these three areas of concern.

Sustainability is not new a new concept at CHFT. In 2015 we adopted our Sustainable Development Management Plan (SDMP) which has guided our sustainable development throughout the past 5 years. The implementation of the SDMP has enabled the Trust to begin its journey towards becoming a sustainable organisation. However, we recognise that we need to go further if we are to reach carbon net-zero by 2040 and continue to reduce our impact. This Green Plan builds upon the success of the previous 5-years and provides a renewed focus and impetus for further improvement.

This Green Plan builds upon the work already taking place at the Trust and provides a strategic framework that will guide sustainability initiatives at the Trust over the next five years. The plan will act as the central document for the Trust's sustainability agenda and sets out key sustainability targets and objectives and the actions the Trust will take to meet them.

The sustainability agenda at CHFT is led by the Managing Director of Calderdale and Huddersfield Solutions and our Environment Manager, who is charged with managing and delivering our sustainability agenda. Our Environment Manager is supported by colleagues across the organisation, including through our Green Planning Committee which is chaired by one of the Trust's Non-Executive Directors. The purpose of the Green Planning Committee is 'to develop, promote and monitor the delivery of the Trust's Green Plan and accompanying Sustainability Action Plan (SAP)'. In October 2020, a Climate Change Plan was taken to the Board to outline the next steps that should be taken to ensure the Trust remains resilient and is able to achieve the carbon targets set. The Green Plan supersedes the Climate Change Plan and will be governed and managed by the Trust's Transformation Programme Board.

The Trust is well aware that the key issues of climate change, air pollution and waste go far beyond the walls of our estate and are issues that impact everyone in the country. In recognition of this reality, the Trust is committed to a partnership working approach on sustainability with our peer organisation regionally and nationally. The Trust is part of the West Yorkshire and Harrogate Health and Care Partnership and the West Yorkshire Associate of Acute Trusts (WYAAT). Both of these groups have sustainability commitments and workstreams and CHFT are key members of both. We will continue to engage with and support the sustainability agendas of our partner organisations. The Trust operates in two local authorities, Calderdale Council and Kirklees Council. Both of these councils have declared a Climate Emergency and the Trust is aware of the ambition of our local partners to become more sustainable and ultimately carbon net-zero.

3.2 Centralising Sustainability at CHFT

This Green Plan brings together a number of different plans and reports that are currently in use at the Trust, to provide one overarching strategic document governing the sustainability agenda at the Trust.

The Green Plan brings together key actions, targets, and commitments from the following documents:

- Sustainable Development Management Plan (2015-2020)
- Climate Change Paper
- Sustainability Design Brief for Reconfiguration
- Travel Plan

3.3 Sustainability at a National level

Sustainability and climate change are issues of national and international concern. These concerns are particularly prevalent in the health and care sector as climate change and air pollution both present significant threats to public health. The threat of climate change to health is internationally recognised, with the World Health Organisation (WHO) stating that climate change is the greatest threat to global health in the 21st century. Furthermore, NHS England has declared climate change a 'health emergency'. Air pollution is another factor that also impacts public health, with NHS England estimating that it contributes to 36,000 deaths annually in the UK. The NHS is responsible for an estimated 4-5% of the UK's carbon footprint and contributes over 25% of public sector emissions, thus representing a significant cause of climate change and air pollution within the UK.

To address this issue, the UK has committed to a target of becoming carbon net-zero by 2050, with the NHS setting a more ambitious target of becoming carbon net-zero by 2040. The targets set out within this Green Plan are in line with the Climate Change Act 2008 and the national NHS targets.

The *For a Greener NHS* campaign was announced in January 2020 by the CEO of NHS England. The campaign aims to encourage and support Trusts to reduce their impact on the environment and improve health. The campaign will build on the great work already being done in the NHS and will provide high-level backing to ensure the NHS can reach net-zero. An expert panel has been established to chart the best route for the NHS to become carbon net-zero, the Trust shall continually review the findings of the panel and update this plan as required.

3.4 Sustainability at a Local and Regional level

The Trust is split across two local authorities, with Huddersfield Royal Infirmary in Kirklees Council and Calderdale Royal Hospital in Calderdale Council. Both Kirklees and Calderdale councils have set a target to become carbon net-zero by 2038. Furthermore, both councils have signalled their commitment to sustainability by declaring "Climate Emergencies". The Trust works closely with both councils and as such, their commitments to sustainability, climate change, air pollution and resource efficiency provide additional drivers to improve the level of sustainability at CHFT.

3.5 Key Areas of Focus

This Green Plan aims to drive standard for sustainability across the Trust. The strategy will deliver on the NHS Long Term Plan and support the Trust's ambition for financial resilience and legislative compliance. The plan will be valid for 5 years and will focus on three key areas:

- Reducing our carbon emissions
- Reducing our contribution to air pollution
- Reducing our generation of waste and improving recycling

3.6 Carbon Net-Zero

One of the principal aims of national and local policy and a principal aim of this Green Plan is to become carbon net-zero. Carbon net-zero (sometimes referred to as Carbon Neutral) is a state in which an organisation avoids emitting greenhouse gases (GHGs) though its generation and use of energy. In this state, the organisation is powered by 100% renewable energy and achieves a level of operational performance in line with national climate targets. In circumstances where emissions cannot be fully reduced then carbon offsetting can be sought through investment into natural carbon sinks such as oceans and forests.

3.7 Format of the Green Plan

The three national policies which have guided the areas of focus for this Green Plan are outlined in Section 4.0 *Drivers and Targets.* Section 3 also establishes our objectives and targets for this plan.

Whilst climate change, air pollution and waste are our key areas of focus, the Green Plan will also address wider sustainability issues. As detailed in Section 7.0, the Trust will work towards the UN Sustainable Development Goals.

Section 5.0 *Progress to Date* details the actions that have already been taken at the Trust to reduce environmental impacts.

Section 6.0 *A Pathway to Net Zero* describes the measures that will be taken both within the Trust and at a regional and national level to help the Trust to become carbon net-zero.

Finally, Section 7.0 *Our Sustainable Action Plan* outlines the actions we have set out for the next 5 years.

4.0 DRIVERS AND TARGETS

This section establishes the UK legislation and health sector specific policy that drives sustainable development within the NHS. The section also outlines the national and NHS targets which the Trust will adopt to help achieve national objectives.

4.1 Sustainability Drivers

The UK Government has set itself a legal commitment to be carbon net-zero by 2050, through the Climate Change Act 2008. In recognition of this target, and the NHS's role in UK emissions, the NHS has set its own target to become carbon net-zero by 2040.

The NHS has already made considerable progress in implementing sustainability. Between 1990 and 2020 the NHS has achieved a 62% reduction in its carbon footprint. This has been achieved by reducing carbon dioxide equivalent (CO_2e) and air pollution emissions, whilst also improving waste management

There are four key NHS specific documents that establish sustainability drivers for the Trust;

- NHS Long Term Plan
- NHS Standard Service Contract 2020/21
- NHS Operational Planning and Contracting Guidance
- Delivering a Net Zero National Health Service

The *NHS Long Term Plan* establishes how the NHS will transform and improve over the next 10 years and includes considerations pertaining to sustainability. The *NHS Standard Service Contract* contains a series of targets and objectives pertaining to sustainability. In order to achieve the environmental targets, set by the government, and sustain the NHS in the future the *NHS Operational Planning and Contracting Guidance* provides guidance on the actions required.

Delivering a Net Zero National Healthcare Service report outlines the immediate actions the NHS will take to reduce emissions. The report details the modelling and analytics used to establish the NHS carbon footprint and future projections as well as the actions required to meet the 2040 carbon net-zero target. This report will be continuously reviewed to ensure the NHS is on track to meet its long-term commitments and the level of ambition will be increased over time.

The *For a Greener NHS* campaign which launched in January 2020, has been developed to help to address the NHS' impact on climate change, air pollution and waste and deliver the NHS's commitment of reaching net zero carbon emissions by 2040. In order for the campaign to be a success it will require the commitment of NHS staff, Trusts and partners throughout the UK to build on the achievements already made and take further action.

The Climate Change Act 2008 set out a legislative requirement for the UK to achieve net zero carbon emissions by 2050. This is the primary legislative driver for carbon reduction in the UK and has established a mandate for UK organisations to manage and reduce their carbon emissions. The Act outlines a clear framework to guide the UK in reducing emissions and adapting to climate change. Having recognised the urgency to make greater carbon reductions, the UK's legally binding carbon reduction targets as required by the Climate Change Act were increased to net zero in 2019. The government have now established a target to reduce the UK's emissions by at least 68% by 2030, compared to 1990 levels.

The following targets and objectives are established in the above documents:

- For carbon emissions controlled directly by the NHS (the NHS Carbon Footprint), achieve net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032.
- For carbon emissions the NHS can influence (the NHS Carbon Footprint Plus), achieve net zero by 2045, with an ambition to reach 80% reduction by 2036 to 2039.
- Deliver a 4% reduction (in carbon emissions) by shifting to lower carbon inhalers
- Deliver a 2% reduction (in carbon emissions) by transforming anaesthetic practices
- Purchase 100% renewable electricity at all NHS organisations by April 2021
- Transition to zero-emissions vehicles by 2032
- Adopt the single use plastics pledge

4.2 Our Commitment and Targets

In consideration of the national and local sustainability drivers, the Trust will adopt the following targets.
In addition to the targets, the Trust will commit to developing a governance structure to deliver on these targets.

4.2.1 Carbon Reduction

The Trust will achieve an 100% reduction of direct (scope 1) carbon dioxide equivalent (CO_2e) emissions by 2040. An 80% reduction will be achieved by 2032 at the latest.

The Trust will achieve an 100% reduction of indirect (scope 2&3) CO_2e emissions by 2045. An 80% reduction will be achieved by 2039 at the latest.

The Trust will purchase 100% renewable electricity by April 2021.

Nb. Refer to glossary for definition of Scope 1,2 &3 Greenhouse Gas Emissions.

4.2.2 Air Pollution

The Trust will convert 90% of our fleet to low, ultra-low and zero-emission vehicles by 2028.

The Trust will cut air pollution emissions from business mileage and our fleet by 20% by March 2024.

4.2.3 Waste

The Trust will achieve a minimum recycling target of 40% for non-clinical waste streams.

The Trust will sign and adopt the Single-Use Plastic Pledge.

The Trust will adopt a Zero to Landfill policy- sending no waste to landfill by 2021.

4.2.4 Governance

The Trust will manage and deliver the Green Plan through the nomination of relevant leads and through management groups.

Key personnel include the Trust's sustainability lead, with overall accountability for the sustainability agenda, who is the Managing Director of Calderdale and Huddersfield Solutions. A non-executive director has also been nominated as a Board level sustainability leader. The Trust's Environment Manager will coordinate and manage the delivery of the Green Plan.
Key groups for managing the delivery of the Green Plan include the Green Planning Committee, which will be chaired by the non-executive director and which reports to the Transformation Programme Board.

4.2.5 Sustainable travel

A Travel Plan has been drawn up for the Trust to support the planning procedure for upcoming capital projects. This strategy targets a 5% reduction in single occupancy vehicle use by employees over a five-year period. Based on the staff travel survey from November 2020 this would mean a reducing single occupancy vehicle use at HRI to 58% and at CRH to 61%.

The Travel Plan also identifies a range of travel related interventions which will increase Active Transport by patients, staff and visitors, whilst also improving access to our assets by public transport. In addition, the plan promotes the use of low / ultra-low emission vehicles through fleet transportation and visitor travel.

Biannual surveys and continuous consultation with staff, patients and visitors will ensure that the perceived benefits of active travel are collected and recorded.

4.2.6 Sustainable procurement

The Trust will carry out an assessment of its supply chain to ensure that ethical procurement standards are implemented. Supply chain survey will be developed and distributed to key contractors. A sustainable procurement plan will be developed for future capitals works, which promotes ethical sourcing and local investment.

4.3 Achievements to date

Our achievements so far include the following:

- Development of a Sustainable Action Plan;
- Our service providers at CRH have reduced plastic reliance within the hospital's canteen and the CHS is working to increase recycling provisions across the Trust.
- Establishment of a Green Planning Committee;
- Securement of public sector funding towards our LED lighting programme at HRI and CRH. Aiming to reduce energy consumption by more than 3 megawatts at both sites;
    - 64% of existing fittings at HRI have now been replaced with energy efficient LED)
- The Trust also procures 100% of its electricity from renewable energy tariffs;
- The CHS Managing Director is also appointed as the Climate and Sustainability Lead for the Trust;
- We are fully engaged in the climate/sustainability agenda, attending groups through West Yorkshire and Harrogate Health & Care Partnership and the West Yorkshire Combined Authority;
- CHFT is also signed up to the WYATT sustainable procurement policy.
- Upcoming capital projects are working towards BREEAM standards.

5.0 OUR CARBON FOOTPRINT

In order to meet our carbon reduction targets, it is vital that we know our starting position and are able to monitor and track changes in our CO_2e emissions. This section of the report presents our carbon footprint and also provides commentary on our progress to date.

5.1 Developing our Carbon Baseline

Our Carbon Baseline has been developed using multiple sources of data. The main source data has been obtained form is the Estates Return Information Collection (ERIC). ERIC data is reported on annual basis to NHS England/Improvement and provides information on electricity and gas consumption in addition to waste and water consumption. The carbon emissions are calculated by multiplying consumption data (e.g., kWh for gas) by a carbon conversion factor. The carbon conversion factors, except for anaesthetic gases and waste, are sourced from the Department for Business, Energy, and Industrial Strategy (BEIS) greenhouse gas reporting figures.

The Trust's Carbon Baseline is measured using annual emissions of carbon dioxide equivalent emissions (CO_2e). Our baseline begins in 2013. This year has been chosen as a start date because of NHS Sustainable Development Unit (SDU) guidance, which allows for baselines to begin from either 1990 or 2013. Given the quality and availability of data, 2013 has been adopted as our baseline year and will be the year against which all subsequent years will be compared. The Green Plan reports carbon emissions from 2013 – 2018. Data for gas and electricity consumption (the two main carbon emitting aspects) for the years 2019-20 was not available at the time of developing this Green Plan.

5.1.1 Scope of the Carbon Baseline

Our Carbon Baseline covers the following aspects of the Trust's operations which are significant contributors to our carbon dioxide equivalent (CO_2e) emissions:

- Electricity consumption
- Gas consumption
- Oil consumption
- Water consumption
- Waste arisings and disposal
- Anaesthetic Gases

5.2 Our Overall Carbon Baseline

As shown in Table 1, in the year 2013-14 the Trust emitted 19,855 tonnes CO_2e (tCO_2e). This figure will be used as the carbon baseline, against which all subsequent years will be compared. In the baseline year, approximately 50% of emissions were from electricity and a further 44% from gas. These two aspects are the most significant contributors to emissions at the Trust.

Table 1 - Carbon Baseline for CHFT based on data from 2013 in tCO_2e

Year	Electricity	Gas	Oil	Water	Waste Arisings	Anaesthetic Gas	Total
2013	10,095	8,751	232	227	549	n/a	19,855

Table 2 shows a significant reduction in the Trust's annual carbon emissions from the baseline. Between 2013 and 2018, our total emissions have reduced by 31%, from 19,855 tCO_2e to 13,740 tCO_2e. We have successfully exceeded the Climate Change Act 2008 target of reducing our annual carbon footprint by 28% by the year 2020, compared to the 2013 baseline. This is only an interim target and we will continue to work to reduce our emissions in line with the carbon net-zero 2040 target.

At Calderdale Royal Hospital, emissions have been reduced by 31% and at Huddersfield Royal Infirmary, by 33% since 2013. As shown in Table 2, in 2014 there was a small increase in emissions at CRH, whereas HRI have achieved a reduction in emissions each year since the baseline. A 61% rection in emissions from the baseline has been achieved at the Trust's community sites, however these sites make up only 3.7% of the baseline emissions.

Table 2 - Annual carbon emissions for the Trust's key sites in tCO_2e

Year	CRH	HRI	Community Sites	Total
2013	9,488	9,633	734	**19,855**
2014	9,863	7,992	830	**19,338**
2015	9,249	7,597	846	**18,221**
2016	8,246	7,166	644	**16,607**
2017	7,713	6,602	450	**15,302**
2018	6,546	6,382	286	**13,740**
2019	3362	5702	435	**9932**

As shown in Figure 1, there has been a continual reduction in total carbon emissions at across all sites at the Trust. Emissions at Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) and the Community Sites have all fallen since the baseline year.

As of 2018, annual emissions for the entire Trust had been reduced to 13,740 tCO_2e. Therefore, the Trust still has significant amount of CO_2e emissions that will need to be eliminated or offset, in order to become carbon net-zero by 2040.

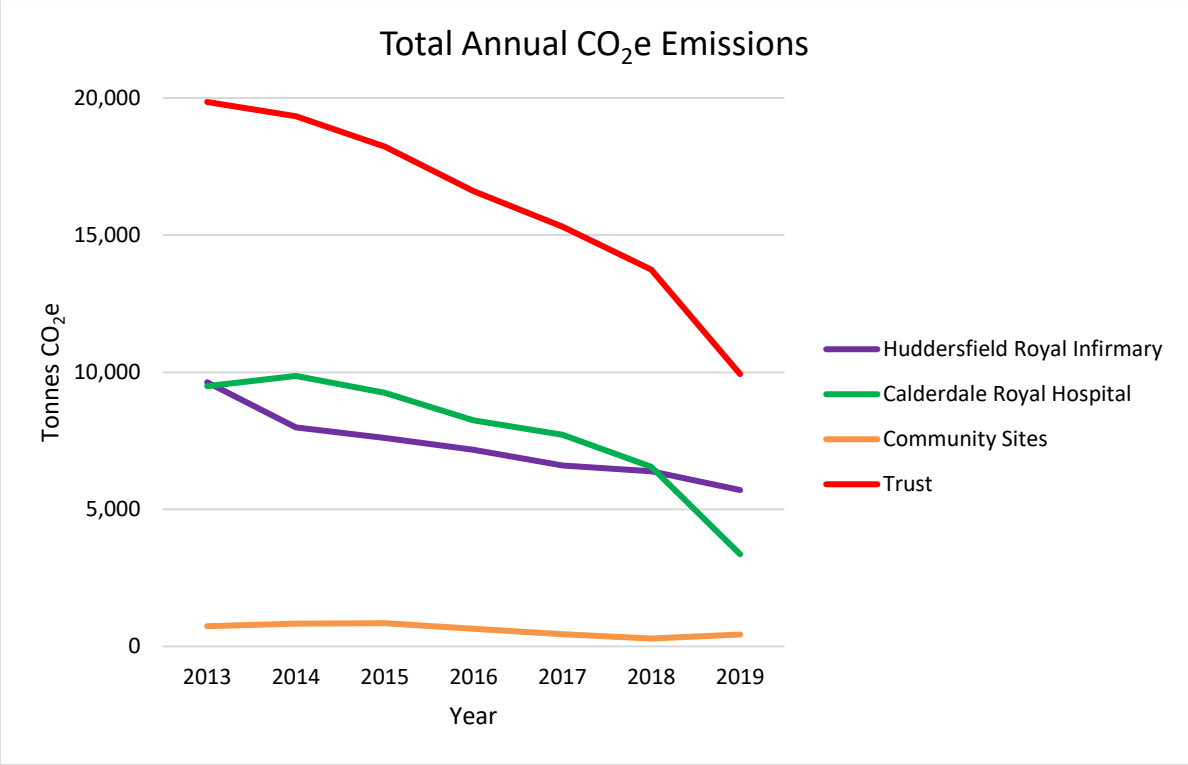


Figure 1 - Total annual CO_2e emissions at the Trust

Reductions in carbon emissions were achieved across all aspects of the Trust's operations, excluding waste arisings (Table 3). Electricity and gas now only contribute 89% of emissions compared to 94% in the baseline year. The largest reduction achieved was in emissions from electricity which has been reduced by 3,360 tCO_2e from the baseline year. The largest reduction relative to the baseline was in emissions from water, where at 38% reduction was achieved. The specific reductions made in each aspect and how they have been achieved are detailed in section 4.3.

Table 3 - Comparison of emissions between the baseline year and most recent year with a complete data set (tCO_2e)

Year	Electricity	Gas	Oil	Water	Waste Arisings	Anaesthetic Gas	Total
Baseline	10,095	8,751	232	227	549	653	19,855
2018	6,735	5,582	1	140	757	526	13,740
Reduction	3,360	3,170	231	87	-208	127	6,115

5.3 Key Aspects

The following sub-sections provide a detailed explanation of the Trust has been able to reduce our CO_2e emissions over the previous seven years, broken down into the key aspects.

5.3.1 Electricity

Electricity consumption is one of the key causes of carbon dioxide equivalent (CO_2e) at the Trust. Between 2013 and 2019, emissions from electricity consumption at the Trust have decreased considerably from the baseline year, as illustrated in Figure 2 (below). In total, a 49% reduction in CO_2e emissions from electricity consumption has been achieved at the Trust from the baseline year.

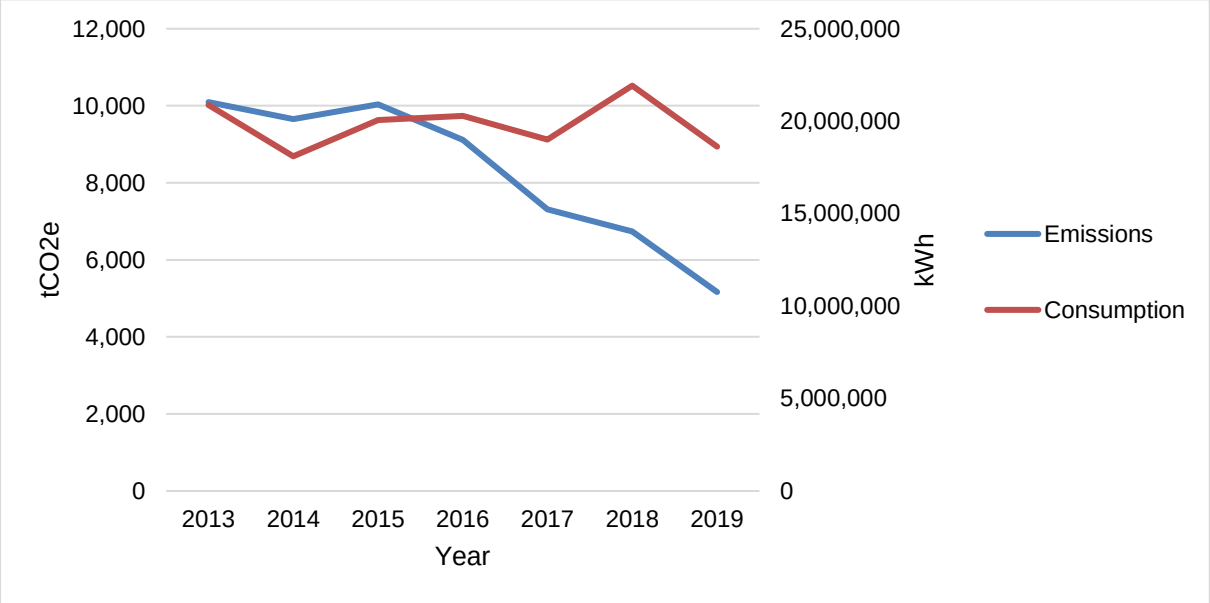


Figure 2 – electricity consumption (kWh) and CO_2e emissions (tCO_2e) from electricity consumption at the Trust

This is in part due to Trust interventions resulting in an 11% reduction in electricity consumption. However, this decrease in emissions is primarily due to the significant reduction in the carbon intensity of imported electricity (Figure 2). Carbon intensities are calculated annual by the Department for Business, Energy, and Industrial Strategy (BEIS). The carbon intensity of electricity is subject to significant variations on annual basis. In 2013-14 (our baseline year) the carbon intensity for electricity was 0.48 $kgCO_2e$. This means that for every kWh of electricity that the Trust used, it emitted 0.48kg of CO_2e.

In 2019-20 the carbon intensity for electricity had decreased to 0.28 $kgCO_2e$ or by 43%.

The changes in carbon intensity for electricity are due to changes in how the National Grid creates electricity. For example, a decrease in coal generation and an increase in renewables generation in the UK will lead to a reduction in carbon intensity. The comparison between consumption of electricity and the associated emissions can be seen in Figure 2. This indicates that further reductions in emissions could be made through interventions to reduce electricity consumption at the Trust.

The Trust now procures 100% renewable electricity ahead of the April 2021 NHS target this will help reduce the Trust's emissions from electricity. The Trust have secured funding to begin an LED lighting programme across HRI and CRH which will replace inefficient light fittings with

more efficient LED lights. So far, the scheme at HRI has saved approximately £11,000, 97,000 kWh in electricity and 24.5 tonnes of CO_2e. This project is expected to reduce electricity consumption by more than 3 megawatts at both sites, saving approximately £460,000 and 985 tonnes of CO_2e.

5.3.2 Gas

There has been a significant decrease in gas consumption across the Trust, with the Trust consuming 27.4 million kWh less gas in 2018-19 than in 2013-14. This equates to a 36.2% reduction in CO_2e emissions from gas consumption in the six years since the baseline year (Figure 3). This reduction exceeds the 28% reduction that was required to achieve the 2020 target despite a short-term increase in consumption between 2016-17. The reduction in emissions has been achieved at both major Trust sites Calderdale Royal Hospital and Huddersfield Royal Infirmary, as well as across the peripheral Trust sites.

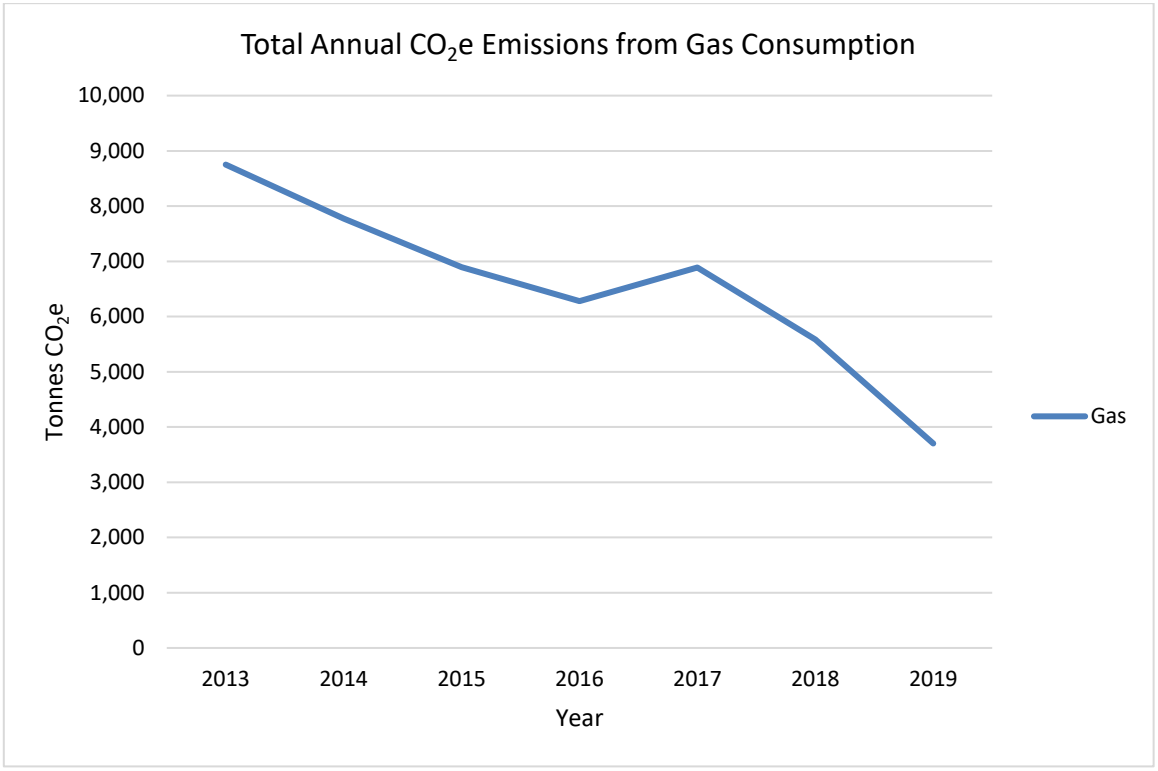


Figure 3 - CO_2e emissions from gas consumption at the Trust

These savings in heating have been achieved by estate rationalisation at the Trust. The total heated volume of the Trust site has been decreased by 83,835 m^3 from the baseline year, a reduction of 23%. As seen in Figure 4, the gas consumption per m^3 of the Trust estate has fluctuated, therefore the reduction in gas consumption can primarily be attributed to the estate rationalisation and not due to efficiency improvements within the Trust. As with electricity consumption at the Trust, this highlights that there is still scope to reduce emissions resulting from gas use. This can be achieved by a range of interventions, such as behaviour change campaigns and upgrade to our current means of heating the estate. These measures from a key component of actions that we will take as part of this Green Plan to move towards carbon net-zero.

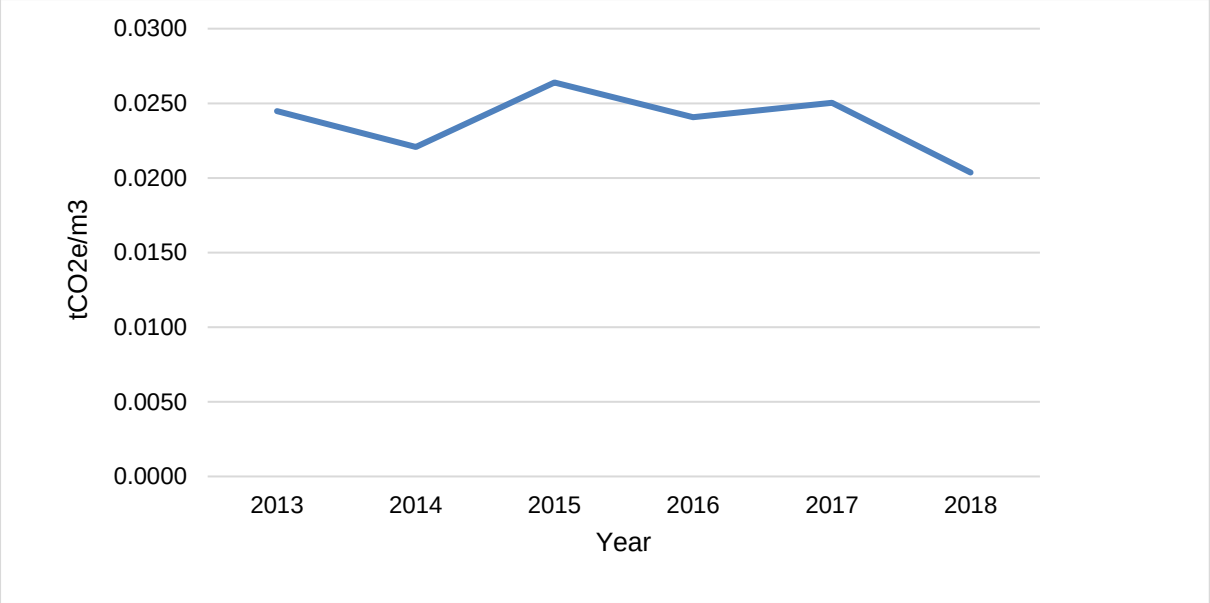


Figure 4 - CO_2e emissions per m^3 of site heated at the Trust

5.4 Oil

Oil is used at the Trust as a secondary energy source, in the event that there is disruption to the electricity and or gas supply. The use of oil as a back up energy source is mandated by Healthcare Technical Memoranda (HTM). The Trust only use oil in emergency situations and try to minimise its use through the effective maintenance and upkeep of its primary energy sources. Oil produces 1.4 times as much CO_2e/kWh than gas, therefore, having a much more significant impact on the environment. This is a primary reason why oil use is avoided.

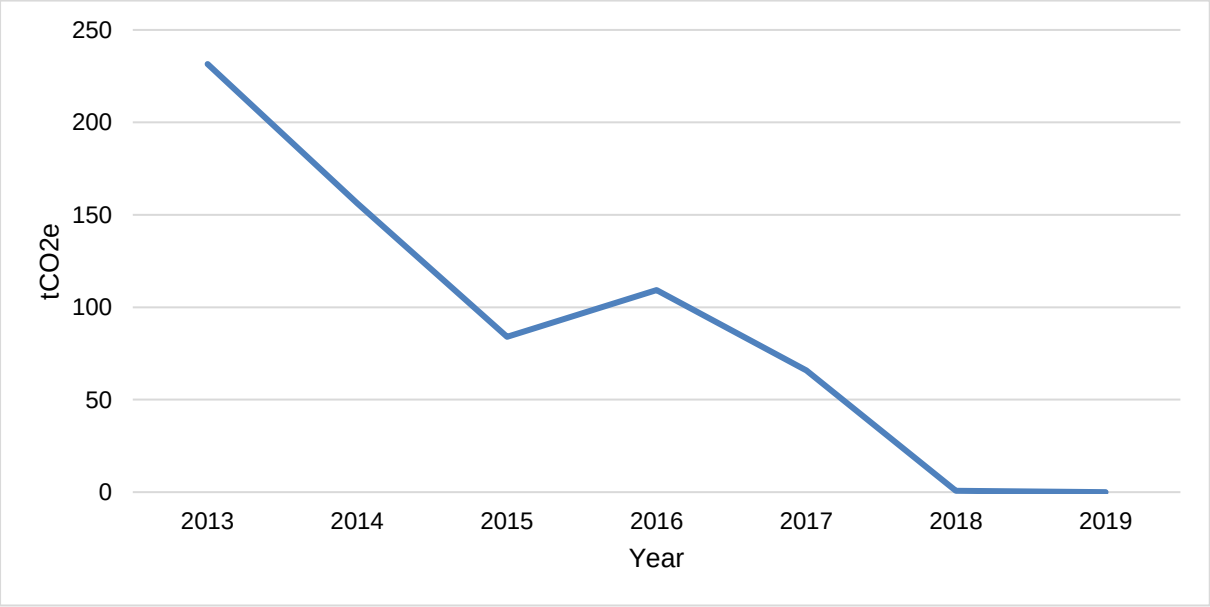


Figure 5 - CO_2e emissions from oil consumption at the Trust

5.5 Water

The total carbon emissions from water use at the Trust have been reduced from the baseline year, despite an increase in 2018-19. In 2013-14 CO_2e emissions from water totalled 227 tCO_2e per annum this was reduced by 21% to 180 tCO_2e per annum in 2018-19 as shown in Figure 6.

This reduction in water consumption and associated CO_2e emissions, has been achieved by implementing monitoring of water use across key Trust sites. Through monitoring water consumption closely, the Trust has been able to identify leaks that would otherwise have gone unnoticed and limit the amount of water wasted. This scheme has proven successful, with water use reduced by up to 66% at some sites.

Carbon emissions associated with water are significantly lower than that of electricity and gas and made up only 1.1% of the Trust's baseline emissions. Comparatively, electricity and gas contributed to 95% of the baseline emissions. In terms of reducing our emissions to carbon net-zero, reducing emissions from water will have a relatively minor impact. However, it is still important that we reduce our water consumption to preserve resources and reduce costs.

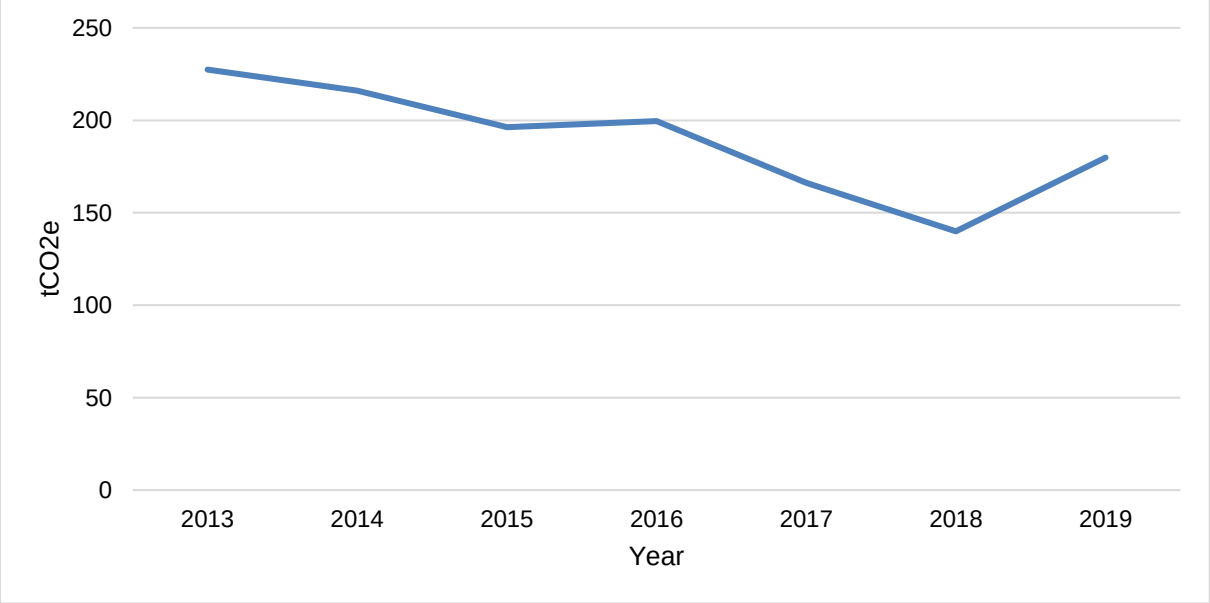


Figure 6 - CO_2e emissions from water consumption at the Trust

5.6 Waste

Carbon emissions from waste at the Trust have fluctuated significantly, from 549 tCO_2e per annum in the baseline year to 451 tCO_2e per annum in 2019, as seen in Figure 7. This gives a total reduction from the baseline year of approximately 17%. The Trust have implemented several measures to reduce clinical and non-clinical waste. The Trust, alongside other Trusts in the region, were placed into contingency measures for waste in September 2018 due to issues between our waste contractor and the Environment Agency. These contingency measures lead to an increase in CO_2e emissions from waste management. CO_2e emissions have begun to reduce as the Trust adopts new waste management processes.

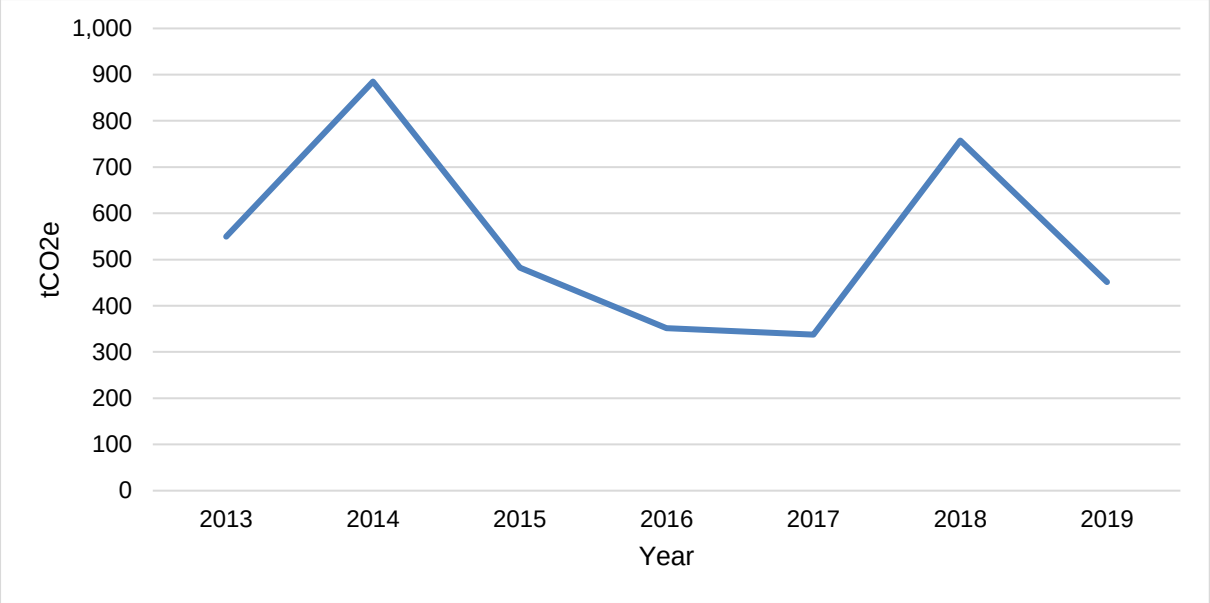


Figure 7 - carbon emissions from waste processed

In clinical areas the Trust have increased waste segregation and increased the amount sent for incineration instead of landfill. Sending waste to landfill generated 2.4 times more CO_2e per tonne of waste processed than incineration. Some of the waste incinerated is processed using waste to energy technology which also saves carbon and generates energy for the local area.

The Trust have also signed new waste contracts which ensure that clinical waste is now dealt with locally to reduce the CO_2e emissions and air pollution associated with transportation.

In non-clinical areas individual bins under desks will be removed and replaced with a single centralised bin and recycling bin per office. The Trust has worked to increase the provision of recycling facilities at the Trust and has recently ordered 150 recycling bins to be used across the Trust. The rollout of these bins will be accompanied with information for staff on what can and cannot be recycled to increase the correct use of the bins. A 40% recycling target for non-clinical waste will be achieved by the end of Financial Year 2021. This would help to reduce the carbon impact of waste at the Trust as sending waste to landfill or incineration creates 27 and 11 times more carbon emissions, respectively, than recycling. The Trust also plans to increase the repair and reuse of equipment such as crutches and walking frames to limit the amount of waste created.

5.7 Anaesthetic Gases

The Trust carries out many medical procedures which require patients to be anaesthetised using volatile agents, most commonly Desflurane, Sevoflurane and Isoflurane. In 2014 653 tCO_2e were created from anaesthetic gas used at the Trust. By 2019-20 these emissions had been reduced by 33.7% to 433 tonnes CO_2e per annum (Figure 8). This reduction in anaesthetic gas emissions has been achieved by encouraging anaesthetists to use Sevoflurane instead of Desflurane, where clinically appropriate. Desflurane has a GWP of 6,810, compared to Sevoflurane which has a Global Warming Potential (GWP) of only 440. Therefore, the environmental impact of using Sevoflurane is approximately 15 times less than that of using Desflurane. The Trust have provided training materials for clinical staff to educate them on the environmental impacts of anaesthetic gases

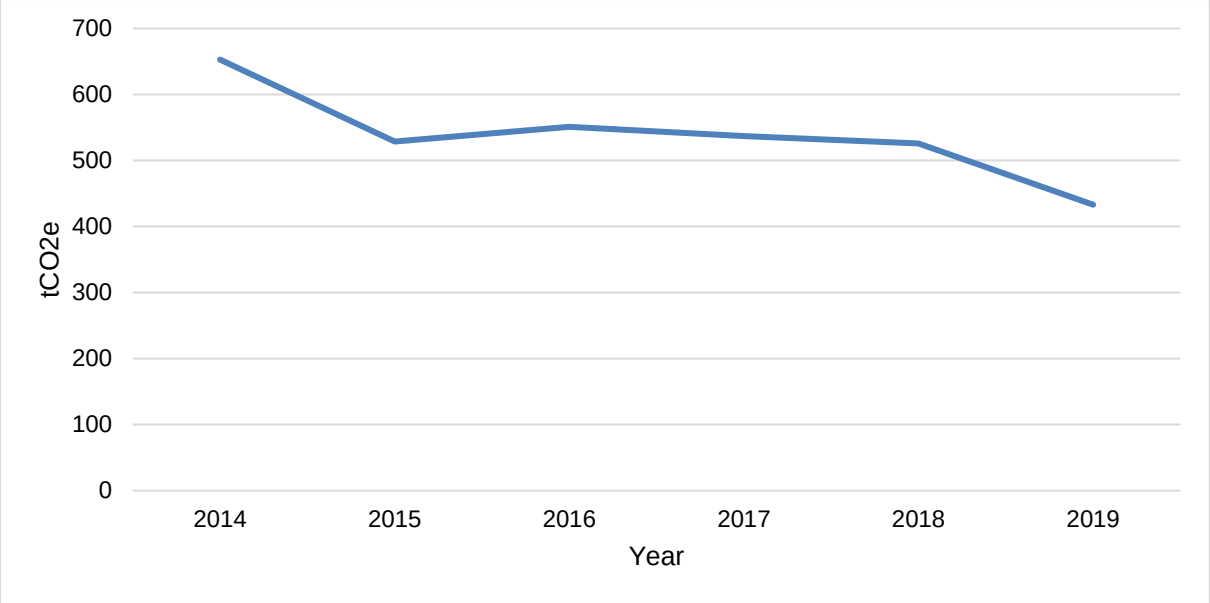


Figure 8 - CO_2e emissions from anaesthetic gases at the Trust[1]

The use of anaesthetic gases at the Trust is unavoidable and therefore we will not be able to reduce these gas emissions to zero. However, the Trust can reduce these emissions further by increasing the use of Sevoflurane in favour of Desflurane. The Trust have partnered with other local Trusts including Airedale NHS Foundation Trust as part of this reduction scheme to share best practice to further increase the CO_2e emissions from anaesthetic gases.

5.8 Travel

Emissions from travel (both for staff and patients) have not been quantified as part of the carbon baseline, due to lack of data. An action for this Green Plan is to begin quantifying travel emissions to enable effective reporting on this aspect. Whilst Travel emissions have not been quantified, there are measures that the Trust have put in place which will have led to reduced emissions, both in terms of CO_2e and air pollutant emissions.

In early 2020 all relevant staff were given access to Microsoft Teams to enable them to work from home when required. Staff received training to ensure that they were competent using the platform to avoid disruptions to services if staff had to work from home. Throughout the COVID-19 pandemic office-based staff have worked from home where possible. This is expected to have reduced the Trust's scope 3 emissions from employee commuting. Following the pandemic, the Trust will continue to allow staff to work from home and will also encourage the use of teleconferencing software to conduct meetings to save transport costs, emissions, and travel time as part of its Building Back Better scheme.

The Trust has installed electric vehicle charging points, including triple charging points, for fleet vehicles in preparation for the transition from a diesel fleet to an electric fleet. Improving the provision of EV charging points has been incorporated into the Trust's reconfiguration plans, including the new multistorey carpark at Calderdale Royal Hospital which will provide 900 spaces, of which 30% will have charge points and 70% will be enabled for charging points.

[1] Anaesthetic gas data prior to 2014 is unavailable.

6.0 A PATHWAY TO CARBON NET ZERO

The Trust has already achieved interim targets on the pathway towards carbon net-zero through the measures detailed in section 4.0. This section outlines the trajectory that the Trust is required to follow to reach the carbon net-zero by 2040 target.

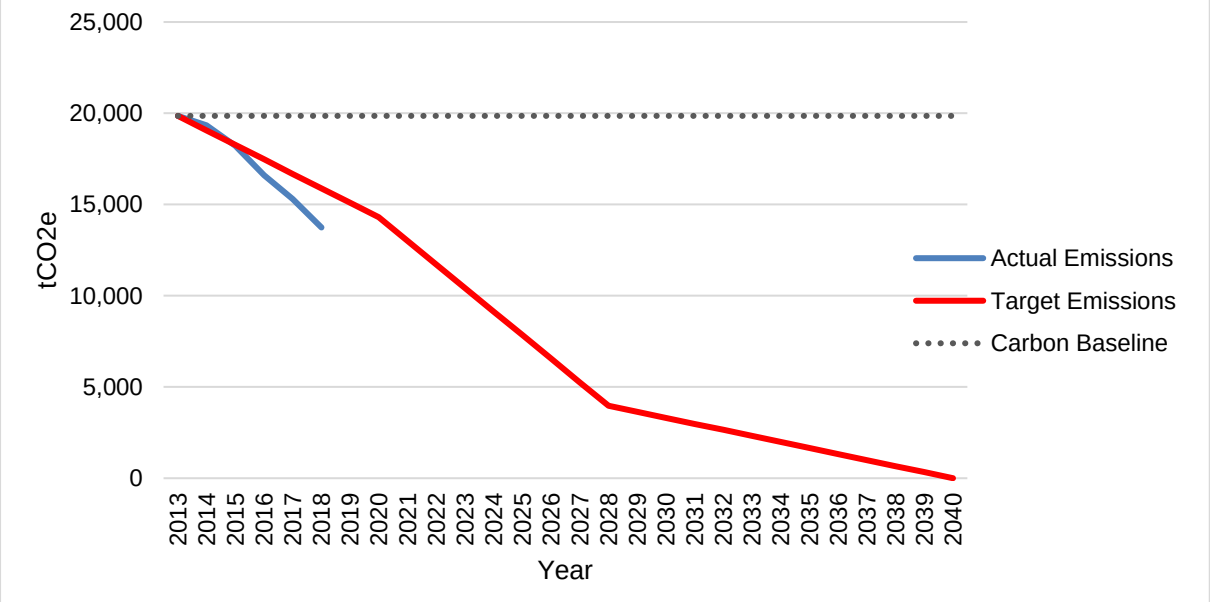


Figure 9 - The Trust's progress against long term CO_2e emissions targets

The trajectory the Trust must follow or exceed to meet the 2040 carbon net-zero emissions target is shown in Figure 9. The figure demonstrates that to date the Trust is ahead of the trajectory and has exceeded the 2020 target of a 28% reduction. The Trust attained a 31% reduction as early as 2018-19, this was achieved through the implementation of the measures detailed in section 5.0 *Progress to Date*. The carbon baseline for actual emissions is only given up to 2018-19 as this is the most recent year with a complete data set.

Table 4 (below), outlines the target emissions set by NHS England in percentage terms and tonnes of CO_2e. The carbon net-zero target was brought forward from 2050 to 2040 in October 2020. The NHS have set an ambition to achieve an 80% reduction with a target year of 2028 or 2032. These targets are not legally binding but have been put in place to ensure that the NHS reaches carbon net-zero in advance of the 2050 national target set by the Climate Change Act 2008. The Trust shall monitor our total carbon emissions performance against the targets and will report this annually.

Table 4 - Target emissions in percentage terms and tCO_2e

Metric	2013 Baseline	2020	2032	2040
Target Emission Reduction (%)	n/a	28	80	100
Target Emissions (tCO_2e)	19,855	14,295	3,970	0

As of 2018, our measured carbon emissions totalled 13,470 tCO_2e. To reach the next interim target of 80% reduction by 2032, the Trust will need to reduce our carbon emissions by 9,770 tCO_2e. This requires an annual reduction of at least 814 tCO_2e for 12 years. This will require a significant commitment from across the Trust. If the Trust is to achieve this ambitious target, it is vital that we achieve commitment and support from colleagues across all areas of the Trust.

Should the Trust be successful in achieving the 2032 interim target, the to reach carbon net-zero by 2040 will require an annual reduction of 496 tCO_2e.

The Trust has made a great start in reducing our carbon emissions and wider environmental impacts in line with the interim emissions targets through the implementation of a range of measures. However, it is important that we remember the scale of the reduction required moving forwards if we are to achieve net-zero emissions by 2040. This challenge will require a huge effort from the Trust to ensure we can reduce our emissions, air pollution and waste whilst not compromising the high standard of care we provide. We will implement our Sustainable Action Plan (Section 6) to reduce our environmental impacts over the next five years but there are several other schemes at the Trust which will contribute to reducing our emissions in the short to medium term including the trust reconfiguration programme, decarbonisation grants and changes to travel.

6.1 Reconfiguration

The Trust is undergoing a significant reconfiguration programme to improve the efficiency of working practices and the Trust estate. The project, which addresses approximately 30% of Trust estate, will involve decommissioning old and inefficient sites to improve efficiency and will also focus on restructuring service delivery across CRH and HRI. A new A&E department will be developed at Huddersfield Royal Infirmary and significant changes will be made to the Calderdale Royal Hospital site, including the addition of a new multi-story carpark.

Sustainability is being incorporated throughout the design stage of the reconfiguration plan and is intrinsic to the programme. All works have been designed to be as sustainable as possible within the available budget. The Trust have committed to designing and constructing the new estate to the BREEAM standard. The BREEAM standard is a sustainability assessment method which is used to address the environmental performance in new constructions and refurbishments. BREEAM can be used to ensure construction projects are designed to maximise sustainability in areas including (but not limited to); energy efficiency, mitigating pollution, waste segregation and recycling. Following the BREEAM standard will allow us to ensure that the reconfiguration project is built in a way that enables us to achieve our sustainability objectives.

The BREEAM standard is split into 10 key modules. The energy, waste and water modules will help assist the Trust in reducing the embodied carbon associated with the project. Aligning the project to the standard will encourage the Trust to consider the land used for the reconfiguration and the materials that will be used throughout the construction, maintenance, and repair of the project to reduce environmental impacts as well as how to limit pollution. Transport is included within the standard to improve access to sustainable means of travel for building users, which will be incorporated into the reconfiguration. BREEAM also has a focus on innovation and management to ensure that sustainability is carried through into the operation of the building.

The Trust have committed to achieving a minimum score of “Very Good” for all new construction works, this includes the new A&E proposed at HRI.

The reconfiguration programme will deliver carbon reductions through rationalising both the estate and services. Through reducing the total space occupied by the Trust and also optimising use of space, the Trust can expect to reduce gas and electricity emissions. Electricity and gas consumption currently account for over 80% of the Trust's direct carbon emissions. Through rationalising services and encouraging care closer to home to Trust will also be able to reduce scope 3 emissions.

The Trust intends to incorporate low carbon heating provisions into the design, including air source and ground source heat pumps, solar photovoltaic and other technologies. The heating technology chosen for the reconfiguration project will be informed by lessons learnt during the decarbonisation grant projects (see 5.2).

To reduce travel emissions and improve air quality, the reconfiguration programme will optimise service design to reduce the need for unnecessary travel between sites. A new multi storey car park will also be built at CRH with capacity for EV charging points to be installed in advance of the national transition to electric vehicles. The reconfiguration programme will be supported by a Green Travel Plan, which will guide the Trust in reducing the impacts of Travel.

The Trust shall use new technology and innovation to reduce our environmental impacts and improve our service. We are exploring a variety of digital solutions to reduce the demand for paper use to reduce waste and make our services more efficient. We will also incorporate teleconferencing hardware in the reconfiguration programme to enable the provision of telemedicine and consulting.

Buildings designed as part of the reconfiguration will look to incorporate green spaces. We will aim to protect and enhance our existing green spaces and biodiversity and use them to benefit the wellbeing of our staff and patients.

6.2 Public Sector Decarbonisation Grant

The Public Sector Decarbonisation Scheme (PSDS) provides grants to public sector organisations, such as the Trust, to fund the implementation of heat decarbonisation and energy efficiency measures. The scheme is part of the government's 'Plan for Jobs 2020' which aims to help the economic recovery from COVID-19 and supports the UK's carbon net-zero ambition by encouraging the public sector to move away from gas and oil heating systems.

£1 billion is available as part of the scheme, the Trust are in the process of applying for a grant as part of the Decarbonisation Scheme which will be completed by January 2021. If the application is successful, the Trust will receive funding to be spent on decarbonisation projects by September 2021.

If successful, we will use the funding received to upgrade our estate and decarbonise our gas heating system. New renewable heating technology such as air source and ground source heat pumps will be considered as well as Building Management System (BMS) upgrades and improved insultation. The Trust will also consider implementing solar energy systems, battery storage and efficient cooling systems. The funding will be used separately to the reconfiguration programme due to differing timescales. However, best practice and lessons learnt from the decarbonisation scheme will be used to decide the best ways to heat the new estate constructed as part of the reconfiguration programme.

Emissions from natural gas at the Trust account for around 40% of all Trust emissions, therefore decarbonising the gas heating system would have a significant impact on the Trust's carbon profile and bring us much closer to reaching the 2040 carbon net-zero target.

6.3 Transport

6.3.1 Staff Travel

A staff and patient travel survey was conducted in November 2020. The Trust received 1,487 responses. When asked how they usually travelled to work the most common answer was by single occupancy car at 66% of Trust staff, with a further 8% in a car with other passengers. The us of private cars as the primary form of commuting to the Trust will cause significant levels of CO_2e and air pollutant emissions. Identifying means to reduce the number of staff travelling to site in private cars is a key way in which the Trust can move towards carbon net-zero/

The second most common method of travel was bus at 9% followed by 8% who choose to walk. Convenience was the biggest factor (18%) that determined staff's transport choices, with only 5% considering the environmental impacts of their travel as a deciding factor.

Almost half of the staff surveyed live within 5 miles with 6% living within 1 mile and 43% living between 1 and 5 miles from the Trust. More can be done at the Trust to encourage these local staff to adopt active travel methods such as providing improved facilities for cyclists, car sharing schemes and better information on routes and safety. F or staff who live further than 5 miles options such as car sharing, and shuttle buses could help to reduce the amount of single occupancy vehicles. Of the 232 patients surveyed, 76% usually travel to the Trust by car, 38% in a single occupancy car. This is much higher than staff travel and could be attributed to a larger proportion of patients and visitors having health restrictions which limit their ability to take other methods of transport. As with staff travel, convenience was the largest factor in patients travel choices at 33% however, 21% of patients had no alternative mode of travel and 12% were restricted by health issues.

Around 40% of respondents claimed that nothing would encourage them to cycle to work. However, several measures to improve facilities on site would encourage some staff to cycle including improved shower facilities, secure cycle locks, and improved cycle paths between sites. Staff also highlighted that cycle training and road safety training, as well as discounts for purchase of equipment would enable them to cycle to work. The Trust currently participates in a cycle to work salary sacrifice scheme so promotion of this scheme may be beneficial in increasing the number of staff who cycle to work. Improved lighting and security, safer road crossings, improved shower and changing facilities, onsite lockers and having other people to walk with were measures identified by the survey that would encourage staff to walk to work.

Overall, 7% of staff stated that they already informally car share and a further 15% said that they were would be willing to car share. 32% of staff commented that the only reason they are not willing to car share is due to the pandemic, therefore it is expected that following the pandemic a total of 47% of staff would consider joining a car share scheme. Measures including assistance in finding car share partners, priority parking spaces, reduced parking charges and a guaranteed ride home in the event of an emergency were listed as ways that would encourage staff to join a scheme and would reduce the number of single occupancy vehicles travelling to the Trust.

70% of staff would consider using the shuttle bus service if measures were implemented to provide more frequent, direct, and reliable services. Other measures identified included subsidised fares and up to date travel information. The Trust could also provide shuttle bus services from train stations to increase the use of trains for those who live further afield and reduce the reliance on vehicles.

The survey showed the 98% of staff who travel to work by car use a petrol or diesel vehicle and only 2% use an electric vehicle. Staff confirmed that measures such as priority parking

spaces for EVs, the provision of charging spaces, reduced parking charges and salary sacrifice schemes would encourage them to use an electric car.

Implementing some of these measures would have a significant impact on the number of cars travelling to the Trust. 21% of staff said that parking frequently negatively impacts their experiences of working, with a further 10% claiming it always negatively impacts their working experience. Reducing the number of single occupancy vehicles travelling to the Trust would reduce pressure on the limited car parking facilities. The Trust will also capitalise on the reduction in environmental impacts as a result of the home working during the COVID-19 pandemic. The Trust will seek to remove barriers which prevent agile working and ensure that where possible staff are able to work from home to reduce travel. Promoting greener travel would also reduce carbon emissions and air pollution substantially and allow the Trust to get closer to the carbon net-zero by 2040 target.

6.3.2 Trust Fleet

The Trust's fleet is made up of 47 vehicles, including:

- 24 commercial vehicles;
- 9 private cars;
- 7 minibuses; and
- 7 agricultural vehicles.

The Trust has undergone a review of the fleet and has identified how the fleet will be upgraded to reduce emissions. Of the vehicles that are being replaced, 4 vehicles will be replaced with fully electric vehicles and 10 will be replaced with hybrid vehicles. The Trust are also looking for hybrid alternative to 9 of the commercial vehicles and are looking to replace 5 minibuses with hybrid shuttle buses. If all 28 vehicles are successfully upgraded with hybrid and electric vehicles, then 59% of the fleet will be comprised low, ultra-low and zero emission.

From 2021, new fleet tenders will specify electric and hybrid vehicles as a minimum standard and will promote the use of electric vehicles wherever possible. This in line with the NHS Operational Planning and Contracting Guidance which specifies that all vehicles purchased on leased from April 2020 shall support the transition to low and ultra-low emission. This will be accompanied by the installation of additional electric vehicle charging points at HRI to facilitate the expanding electric fleet and the demand from staff and patients.

The NHS has targeted to cut business mileages and fleet air pollutant emissions by 20% by 2023/24 and requires at least 90% of the NHS fleet to use low-emission engines by 2028.

6.4 National Considerations

Achieving carbon net-zero by 2050 is a national ambition and one that is a priority to the UK Government. Although it is the Trust's responsibility to reduce our environmental impacts as much as possible, once we have reached optimal efficiency on our estate and have implemented all possible actions to reduce our emissions, we will rely on national strategies to reduce the residual emissions to carbon net-zero.

In 2020 the Government set out their Ten Point Plan which set out the framework for a Green Industrial Revolution. The plan aims to generate 250,000 jobs by 2030 to generate green energy and create zero-carbon technologies including offshore wind farms, nuclear

plants, hydrogen power technologies and carbon capture. this will be supported by over £5 billion in funding to support the green recovery from the COVID-19 pandemic.

This section will detail some of the key changes that are expected to reduce emissions and air pollution nationally over the next 30 years and assist the Trust in reaching net zero by 2040.

6.4.1 Renewable Energy

The proportion of renewables generation in the UK fuel mix consumed in power stations increases every year, reducing the carbon emissions of the electricity generated. The Government intends to expand renewable energy generation and produce 40 GW energy through offshore wind. This would be combined with the increased use of carbon capture technologies and battery storage so this energy can be utilised effectively. The UK also has plans to increase the number of nuclear power plants. This increase in the amount of renewable energy generated would make a significant difference to the carbon emissions associated with electricity and reduce reliance on fossil fuels. The Trust already procures green electricity at our main sites so this would have the greatest impact on the carbon emissions from sites where we do not have control over the utilities.

6.4.2 Emerging Technologies and Opportunities

Point 2 of the Ten Point Plan Driving the *Growth of Low Carbon Hydrogen* intends to help the UK transition from natural gas heating to hydrogen technologies which will be supported by a £240 million Net Zero Hydrogen Fund. The UK is exploring the use of hydrogen for heating, which would replace fossil fuels such as natural gas and oil with hydrogen blends, converting the gas grid to hydrogen could reduce UK carbon emissions by an estimated 73%. Carbon capture will also be utilised to ensure that hydrogen heating can be generated at scale and costs that can rival the fossil fuels currently used for heating. This will hopefully contribute to reducing heating emissions from the Trust in the long term which is currently one of the largest emissions and will support the heating of the estate in areas where alternative technologies are not viable. The government intends for large village heating trials to be carried out by 2025 in addition to other privately funded schemes such as the H21 City Gate Project which seeks to begin converting the gas grid to enable hydrogen between 2026 and 2029.

Combined Heat and Power (CHP) units utilise natural gas to co-generate heat and power. CHP have traditionally been viewed as a sustainable option for heating and powering a site, especially in comparison to traditional boilers. The Trust have explored installing CHP in the past. However, with the emergence of novel technologies such as Air Source and Ground Source Heat Pumps (ASHPs or GSHPs), CHPs are now no longer considered the most sustainable option. Therefore, the Trust will no longer consider CHPs and will focus on more sustainable means of decarbonise our estate. This example illustrates the changing landscape from a sustainability perspective. Novel technologies continue to emerge, become more cost effective and more efficient. The Trust has approximately two decades to become carbon net-zero and remaining up to date with emerging technologies that are developed is a key means by which we can ensure we continue to decarbonise by 2040.

6.4.3 Transport

Following on from the drop in emissions seen during 2020 lockdowns, the Government are encouraging the public to increase the share of journeys they take by public transport to reduce emissions and air pollution. Tens of billions of pounds has been promised to improve and renew the UK's rail and bus networks. This will include the electrification of rail lines, integrated bus and rail networks, smart ticketing, and additional bus lanes. In 2021 the first

National Bus Strategy will be published which will outline plans to build more zero emission buses and more frequent and cheaper ‘superbuses’. These schemes are likely to incentivise more people to travel on public transport and could hopefully reduce the amount of people reliant on cars to travel to the Trust.

Thousands of miles of segregated cycle lines are expected to be built in England to allow people to travel safely by bike. Many staff highlighted in the travel survey that they would be encouraged to cycle if there were designated cycle lanes, a cycle lane is planned between CRH and HRI which would increase the number of staff able to commute by bike and reduce emissions and air pollution. an Active Travel body has been set up to assess local authorities on their performance with active travel and allocate funding. This will also indirectly impact the Trust by encouraging people to be more active and improving air quality and therefore improving the physical and mental health of the population.

In addition to promoting public and active travel the UK is beginning the transition to electric vehicles. From 2030 the sale of new petrol, diesel vehicles will be banned, this has been brought forward by ten years to accelerate the decarbonisation of private vehicles. This will be supported by the development of ‘Gigafactories’ to produce batteries to accommodate the increase in electric vehicle manufacturing. The Trust are continually increasing the provision of electric charging facilities at the Trust to enable the Trust fleet to transition to electric.

The emissions associated with procurement are considered scope 3 emission and are one of the hardest areas for the Trust to reduce as how our suppliers operate is outside of our control. The shift to electric vehicles and green ships will assist in reducing the impacts of transporting goods to the Trust in the long term which will help us to reduce our scope 3 emissions to carbon net-zero.

7.0 OUR SUSTAINABLE ACTION PLAN

This section provides an overview of the Sustainable Action Plan that has been developed to enable the Trust to meet our carbon, air pollution and waste reduction targets.
The comprehensive Sustainable Action Plan commits the Trust to a list of x actions to be implemented over the next five years which will enable us to achieve our strategic objectives and bring the Trust closer to reaching the 2040 carbon net-zero target.

To ensure that the Green Plan incorporates all elements of sustainability as described by the UN, the Trust have adopted the SDAT format into our action plan. The SDAT tool is a self-assessment tool developed by the Sustainable Development Unit (SDU) to allow NHS organisations to evaluate their progress with sustainable development and was developed in alignment with the 17 UN Sustainable Development Goals (SDGs).

Figure 10- UN Sustainable Development Goals

As guided by the Sustainable Development Assessment Tool (SDAT), the Sustainable Action Plan is separated into the following 10 sections:

- Corporate Approach
- Asset Management and Utilities
- Travel and Logistics
- Adaptation
- Capital Projects
- Greenspace and Biodiversity
- Sustainable Care Models
- Our People
- Sustainable Use of Resources
- Carbon and Greenhouse Gases

7.1 Methodology

The Sustainable Action Plan has been carefully developed to ensure that it is practicable and achievable with the resources available at the Trust. Each action stated has been assigned a

dedicated lead and a timescale for implementation to enable the Trust to easily manage the implementation and monitoring of each action.

The Trust began by conducting staff interviews to understand the level of commitment from colleagues at the Trust, find out what has already been implemented and identify key areas where improvements could be made. The Trust interviewed key colleagues from Estates, Facilities Management, Pharmacy, Procurement, Transport, the reconfiguration programme, and the sustainability lead. Actions within the Corporate Approach section of the Sustainable Action Plan will ensure that the entire Trust is considered, consulted and involved in the Green Plan. The information gathered from these colleagues was then used to complete the SDAT assessment which provided additional actions. A horizon scan of actions that have successfully been implemented at other Trusts was also conducted to identify actions that could be applied at CHFT.

The actions from each of these stages were combined to form a longlist, the Trust then selected the actions from the longlist that would be most impactful and feasible at the Trust to generate the Sustainable Action Plan (SAP).

The delivery of the SAP will be overseen by the Green Planning Committee, which consists of key departments across the Trust and its service partners. Theme leaders have been identified for each of the sections identified in chapter 7.2 who will ensure that progress is made in their relevant areas. The Green Planning Committee will meet monthly and report to the Transformation and Programme Board, who will in turn will ensure that any interventions outlined within the SAP are aligned with future plans for reconfiguration and development projects across the Trust.

7.2 Sections of the Sustainable Action Plan

7.2.1 Corporate Approach

The corporate approach actions focus on securing top-level buy in at the Trust. There are 18 actions within this section. These actions aim to embed sustainability throughout the Trusts policies and services. Senior level staff at the Trust are responsible for monitoring the Trust's progress against the Green Plan to ensure we can successfully reduce our emissions, air pollution and waste. Actions include ensuring that sustainability is considered, reviewed and managed at the highest level of the organisation and partnership working with local government and local peer organisations.

7.2.2 Asset Management and Utilities

Energy consumption is the greatest source of carbon emissions at the Trust. There are 11 actions within this section. It is essential that these emissions are reduced through improved efficiency and utilities management to enable the Trust to achieve our carbon net-zero targets. Actions include exploring funding opportunities to support decarbonisation of our estate and improving the level of sub-metering across our estate to enable a greater targeting of energy savings interventions.

7.2.3 Travel and Logistics

Staff, patient, visitor, and supplier travel at the Trust contributes to carbon emissions and air pollution. There are 21 actions within this section. Reducing the impacts of travel is a key focus of the Trust and is the principal way in which we can reduce our contribution towards air pollution. Actions include working to quantify our air pollution and CO_2e emissions resulting from travel and transport and work to reduce our emissions. Addressing our Trust fleet and moving to low and ultra-low emission vehicles is also a key action.

7.2.4 Adaptation

The Trust recognises that it is well placed as a health and care organisation to address the health-related impacts threatened by climate change. There are 19 actions within this section. Climate change is considered the greatest threat to public health this century, so it is crucial that the Trust is able to adapt to ensure that our services are resilient in the long term.

7.2.5 Capital Projects

Inefficient estate is a large contributor to emissions at the Trust. The Trust will be undergoing a significant reconfiguration project to improve the efficiency of Trust estate and centralise services. The reconfiguration will address approximately 30% of estate and will take place between 2022 and 2026. By refurbishing, decommissioning, and rebuilding inefficient areas of the estate the Trust aims to significantly reduce carbon emissions, air pollution, waste and running costs. There are 14 actions within this section. Actions include ensuring all new builds achieve BREEAM “Good” ratings as a minimum and considering the sustainability impacts of all new builds such as construction methods and materials and the heat and power systems which will be installed.

7.2.6 Greenspace and Biodiversity

Protecting and enhancing greenspace and biodiversity is hugely beneficial for the environment and can positively impact wellbeing. There are 24 actions within this section. By improving greenspace and biodiversity the Trust can help remove some of the carbon emitted and improve local air quality. Actions include maintaining, protecting and improving existing green spaces on our estate and incorporating trees into the design of the reconfiguration of our estate.

7.2.7 Sustainable Care Models

Ingraining sustainability into our clinical care models is a vital consideration if the Trust is to become carbon net-zero. There are 10 actions within this section. Ensuring that our high standards of care do not negatively impact our environmental, social, or economic impacts. Actions include monitoring and managing our use of anaesthetic gases and incorporating the use of telemedicine into our services permanently following the Covid-19 pandemic.

7.2.8 Our People

People are at the heart of our organisation; it is crucial that we provide a positive and inclusive work environment for our staff to protect their wellbeing and ensure we can provide the best care for our patients. There are 15 actions within this section. Actions include providing Carbon Literacy training to our staff and becoming a Carbon Literate organisation and supporting the health and wellbeing of our staff.

7.2.9 Sustainable Use of Resources

A significant amount of waste is produced by the Trust in order to deliver our services. Through improving waste management, the Trust can reduce the amount of waste produced, reduce carbon emissions, and save money. There are 31 actions in this section. Actions include reducing single use plastics across the Trust and improving waste segregation and recycling rates.

7.2.10 Carbon and Greenhouse Gases

Reducing our emissions to carbon net-zero requires effort from all departments at the Trust. There are 28 actions within this section. Actions incorporate those approved by the board in the Climate Change Paper. Actions include improving the reporting and monitoring of our carbon baseline, investing in decarbonisation technologies and becoming working towards our target of becoming carbon-net zero by 2040.

APPENDIX 1- SUSTAINABLE ACTION PLAN ROADMAP

Module	Short-Term (3-12 months)	Medium-Term (1-2 years)	Long-Term (3+ years)
Corporate Approach	CA-1 CA-4 CA-6 CA-7	CA-2 CA-3 CA-5 CA-8	CA-9
Asset Management & Utilities	AM-4 AM-6	AM-3 AM-5	AM-1 AM-2
Travel & Logistics	TL-1 TL-2 TL-8 TL-11	TL-4 TL-5 TL-9 TL-10 TL-12	TL-3 TL-6
Adaptation	AD-5 AD-9 AD-10	AD-3 AD-4 AD-6 AD-11	AD-1 AD-2 AD-7 AD-8
Capital Projects	CP-1 CP-4 CP-5 CP-10	CP-2 CP-6 CP-7 CP-11	CP-3 CP-8 CP-9
Greenspace & Biodiversity	GS-5 GS-6 GS-11 GS-12 GS-13	GS-1 GS-3 GS-4 GS-9 GS-10	GS-2 GS-7 GS-8
Sustainable Care Models	SC-4 SC-5	SC-1 SC-2 SC-6	SC-3 SC-7 SC-8
Our People	OP-2 OP-3	OP-1 OP-4 OP-5	
Sustainable Use of Resources	SU-2 SU-6 SU-9	SU-1 SU-3 SU-8	SU-4 SU-5 SU-7

	SU-12 SU-13 SU-15 SU-16	SU-10 SU-14	SU-11
Carbon & GHGs	CG-2 CG-4 CG-5 CG-14 CG-15	CG-3 CG-6 CG-7 CG-12 CG-13	CG-1 CG-8 CG-9 CG-10 CG-16

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Calderdale & Huddersfield Green Plan
Sustainable Action Plan

Module	Reference	Nominated Lead	Number of Actions	Completed Actions
Corporate Approach	CA	Stuart S / Kelly Sanders	18	2
Asset Management & Utilities	AM	Tom Donaghey / Robert Dadzie	11	3
Travel & Logistics	TL	Andy M. / Fran / Stuart S.	21	6
Adaptation	AD	Ian Kilroy / Gemma Berrimen	19	14
Capital Projects	CP	Tom D	14	4
Greenspace & Biodiversity	GS	Jammal / Jack Szlachcic	24	5
Sustainable Care Models	SC	TBC (ask Bev Walker for lead)	10	
Our People	OP	Gemma Cartman	15	3
Sustainable Use of Resources	SU	Nigel M / Robert Dadzie / Email Kelly Sanders for procurement lead	31	2
Carbon & GHGs	CG	Robert Dadzie	28	4

Completed
Working towards
Procurement Delivery Required

Corporate Approach								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
CA-1	**The Trust will communicate its sustainable development aims to staff.**	*The Trust will develop a clear communications plan around the promotion of sustainable development to staff. This communication will facilitate behaviour change and raise awareness of sustainability and our impact.*	**All**	An external provider has been sought to support Internal Comms and to help develop our communications plan.	Jacqui Booth	Internal Comms	*Annually*	Q4 FY21/22
		We will use a staff engagement campaign to facilitate behavioural change and increase workforce participation in sustainability events, training and online platforms.	**All**	As above. Workforce engagement will be an integral component within emerging comms plan.	Jacqui Booth	Internal Comms	*Annually*	Q4 FY21/22
		We will utilise our online platforms to promote carbon awareness and individual action.	**All**	An internal communications package will be developed.	Jacqui Booth	Internal Comms	*n/a*	Q4 FY22/23
CA-2	**The Trust shall prioritise sustainability at Board level.**	*Our Board papers will feature a standing section on sustainability.*	**All**	Previously discussed. RD to pick up with CHFT / CHS	Andrea McCourt / Jayne Taylor	Trust	*Annually*	Q4 FY22/23
		Consideration of sustainability will be a requirement in all business case applications.	**All**	RD to pick up with S. Baron	Stuart Baron	Trust	*Annually*	Q4 FY22/23
CA-3	**The Trust shall support the Green Champions.**	*Our team of sustainability champions will be supported through regular training and information to make their engagement effective and impactful.*	**All**	Some early stage conversations held with potential champions. SS to speak to internal unions.	Comms provider to engage Trust.	n/a	*Annually*	Q4 FY22/23
CA-4	**The Trust shall aim to embed ethical labour standards in procurement policies.**	*We will evidence which products pose a high ethical and labour standards risk and have implemented mitigation processes.*	**n/a**	Procurement policy will be an essential driver for this target. Supplier engagement will be required and tender stage specifications should be written into agreements. Procurement policy for reconfiguration will promote the responsible sourcing of materials. Supply chain survey will be required in order to promote ethical labour standards in construction.	Kelly Sanders	Procurement	*Annually*	Q4 FY22/23
		We will report on the value/volume of goods that we source ethically.	**n/a**	As above. To be obtained following reconfiguration. BREEAM standards promote the use of Ethical Sourcing. IHP to report quantity of certified materials following project completion.	Kelly Sanders	Procurement	*Annually*	Q4 FY22/23
		We shall allocate a senior leader with responsibility for all aspects of sustainable procurement and social value and support them with training.	**n/a**	TBC - Deputy Procurement Manager to assume role	Kelly Sanders	Procurement	*n/a*	Q4 FY21/22
CA-5	**The Trust shall integrate sustainability considerations into the procurement process.**	*We will include sustainability specification and evaluation criteria into all procurement contracts.*	**All**	Procurement policy will be an essential driver for this target. Supplier engagement will be required and tender stage specifications should be written into agreements.	Kelly Sanders	Procurement	*n/a*	Q4 FY22/23
		We will develop a process to ensure that our procurement team understand and can maximise the benefits of whole life costing and circular economy.	**All**	As above	Kelly Sanders	Procurement	*Annually*	Q4 FY22/23
		We shall develop a supplier engagement programme to communicate our sustainability commitments to suppliers and expect them to work with us to help implement our sustainable vision.	**All**	As above.	Kelly Sanders	Procurement	*Annually*	Q4 FY22/23
CA-6	**The Trust shall continually review legislative drivers and examples of best practice.**	*We will develop a process for scanning for best practice, changes to mandatory and legislative drivers and adopt these early.*	**All**	NHSE case studies continually reviewed alongside legislative priorities. CHS to explore the development of legal register with Watermans	Robert Dadzie		Annually	Q4 FY21/22
CA-7	**The Trust shall develop a communications plan to promote the publication of the Green Plan.**	*We shall communicate our Green Plan to patients, visitors and the local community.*	**All**	Roadmap to be developed by external communications provider. To be distributed through patient groups and stakeholder comms.	Jacqui Booth	Prime Creative to produce	*Annually*	Q4 FY21/22
CA-8	**The Trust will develop processes to maximise the opportunities for our local community.**	*We will work with volunteers and other members of the local community in the delivery of our sustainable development objectives.*	**All**	Emma Kovaleski / Nikki Hosty to explore volunteering and CSR opportunities. National Volunteering Day?	Emma Kovaleski		*Annually*	Q4 FY22/23
CA-9	**The Trust shall work with similar organisations to maximise the sustainability benefits.**	*We will demonstrate stewardship/leadership in sustainable development with local stakeholders (e.g. Local authority and other healthcare organisations) by leading local forums or being successful in sustainable award schemes.*	**All**	SS / RD already connected to council groups. SS engaged with Huddersfield MP Health and Wellbeing group. RD & CD engaged with Calderdale Cycle Forum.	Stuart Sugarman / Robert Dadzie		*n/a*	Complete
		Senior Trust and CHS staff will work with Calderdale and Kirklees council Climate Commission.	**All**	Already underway as part of reconfiguration			*n/a*	Complete
CA-10	**The Trust shall ensure that our plans are inclusive.**	*We will seek to ensure that underrepresented and disadvantaged groups within our local community are engaged in our Green Plan and initiatives through providing accessible multi format/language resources, information and advice where appropriate.*	**All**	To be carried out as part of EQIA. Also to be explored through increased representation on Green Planning Cttee. Improved representation from disabled and youth groups to be promoted.	Stuart Sugarman / Robert Dadzie		*Quarterly*	Q4 FY22/23

Completed

Working towards

Procurement Delivery Required

Asset Management and Utilities								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
AM-1	**The Trust shall establish an evidence base to support energy reduction opportunities in defined areas of the Trusts (e.g. wards)**	*Across major sites the Trust shall implement significant sub metering for electricity to better help the management of demand.*	**C**	New Capital works across the Trust will include plans for sub-metered supply. Works information packs to include requirement for sub-meters	Tom Donaghey / Daniel Smith / Michael Taylor	Lendlease (PM) to include requirement within Works information packs	*Annually*	Q4 FY23/24
AM-2	**The Trust shall explore further avenues for project funding.**	*The Trust will apply for the Public Sector Decarbonisation Grant Scheme, in an attempt to secure funding to decarbonise the heating systems across the Trust.*	**C & A**	Applications for Salix decarbonisation funding to be completed by the CHS	Tom Donaghey / Robert Dadzie	**n/a**	*Quarterly*	On-going
		The Trust will consider applying to the Combined Authority's Energy Accelerator scheme and associated European Local Energy Assistance (ELEA) fund and consider requirements for the CHFT reconfiguration.	**C & A**	Application to the ELEA	Tom Donaghey / Robert Dadzie	**n/a**	*Deadline for Capital works 31st July 2021*	Q2 FY21/22
		The Trust shall invest funding into onsite energy generation (i.e. photovoltaics), insulation, combined heat and power (CHP), heat pumps and efficient plant equipment.	**C & A**	Capital works to explore feasibility of energy generation solutions. New A&E department at HRI to include design for heat pump. Cladding design to include thermal analysis and considerations relating to natural heating, ventilation and cooling. Enabling works for Photo-voltaic will be included in design for the A&E at HRI.	Tom Donaghey / Robert Dadzie	Project Management and Design Team to factor considerations into plans	*Annually*	Q4 FY23/24
		The Trust will monitor any future funding opportunities pertaining to decarbonisation opportunities, either through heating or installation of renewable technologies.	**C & A**	As above. Applications to be made as funding opportunities arise.	Tom Donaghey / Robert Dadzie	**n/a**	*Annually*	On-going
		We will pursue external consultation through the Low Skills Fund and to assist with developing the decarbonisation plan for the Trust.	**C**	Applications to Salix for Low Carbon Skills funding. External consultation to be sought through Inenco irrespective of Salix funding allocation.	Robert Dadzie	**n/a**	*Quarterly*	Complete
AM-3	**The Trust shall work with suppliers to improve efficiency.**	*We will work with our on-site contractors and suppliers to ensure they help reduce our waste and energy usage where relevant.*	**All**	New Capital projects will work towards the 2018 BREEAM standards for new construction. Requirements will include the development of a Site Waste Management Plan by main contractors on key Capital works. Additionally a pre-demolition audit will be specified and targets set for landfill diversion and waste reduction.	Tom Donaghey / Robert Dadzie	Lendlease (PM) to include requirement within Works information packs	Quarterly	On-going
AM-4	**The Trust shall review existing building performance.**	*We will develop a process to assess buildings/locations (when leasing, procuring or designing) to ensure buildings are energy efficient and have adequate public transport.*	**C & A**	Energy performance certificates to be checked by Capitals team prior to leasing and factored into decision making process	Tom Donaghey / Kirsty Rider	**n/a**	Annually	On-going
AM-5	**The Trust shall develop a Sustainable Buildings Plan.**	*We will review our building stock and develop a sustainable buildings action plan. We will communicate this clearly to staff and key partners (e.g. PFI contractors, NHS Property services and other landlords and maintainers).*	**All**	Sustainable building action plan to be developed by CHS to set targets for operational management. New builds will work towards BREEAM standards to ensure an efficient project design.	Robert Dadzie / Tom Donaghey / Kirsty Rider	**n/a**	Annually	Q4 FY23/24
AM-6	**The Trust shall support the community to improve their energy efficiency and reduce emissions.**	*The Trust will ensure that local community groups and/or third sector have access to and can use our built assets and estate as appropriate (e.g. green space, commercial space).*	**n/a**	Green-wellbeing garden developed at CRH. Potential second development at HRI, dependant on funding allocation.	Nicola Hosty	Capital funding	Annually	TBC
		We will offer energy efficiency advice and warm homes support to patients, users, carers and the local community to improve their health and wellbeing (e.g. energy efficiency advice and warm homes support).	**C**	Supporting documents and online advice	Jacqui Booth	Corporate comms	Annually	Q4 FY23/24

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Travel and Logistics								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
TL-1	**The Trust shall review travel and transport impacts.**	*We will assess our travel and transport and calculate the carbon footprint for our business travel.*	**C & A**	**Fleet emissions calculated in annual SECR reports - tracker package due for renewal within the tender we can include CO2 reporting. Further work needed to understand carbon footprint associated with travel survey.**	Andrew Mould	External consultation to determine travel related footprint	Every two years	Q2 FY21/22
TL-2	**The Trust shall set targets to improve travel impacts.**	*We shall set a local carbon reduction target for business mileage emissions, which is aligned to/or exceed the Climate Change Act 2030 target.*	**C & A**	**Targets to be agreed with Trust for reducing Business mileages. CHS tracker package also due for renewal within the tender we can include CO2 reporting.**	Andrew Mould	As above	Annually	Q4 FY21/22
TL-3	**The Trust shall begin the transition to electric vehicles.**	*The Trust will move to a 90% low, ultra-low and zero emissions fleet by 2028.*	**C & A**	**% of CHS fleet is on ultra low as part of the new tender process.**	Andrew Mould	ULEV fleet vehicles	*Annually*	2028
		We shall continue to install electric car charging points at HRI in line with demand.	**C & A**	**In Progress, 2 in Estates & 2 in Transport HRI. ESPO or CCS framework will be sought to tender bids for public facing charge points**	Robert Dadzie		*Annually*	Q4 FY21/22
		The design for a multi-storey car park at CRH should complement the proposed Green Travel plan for the Trust. The initial design must include charging points and allow for future installations, with an overall target of around 10%.	**C & A**	**CHS consulted in the design of the Trust's travel plan. Travel Plan will inform design of the car-park**	Robert Dadzie	MSCP design team to consult CHS	*TBC*	After planning approval
TL-4	**The Trust shall monitor and try to reduce the environmental impacts associated with our suppliers.**	*Transport shall be considered when procuring key products and services. Efforts will be made to ensure that contracts are locally sourced, i.e. within the Yorkshire region.*	**C & A**	**Procurement Policy to promote local sourcing - Transport department is included in the process & vehicle supplier is Yorkshire based**	Andy Mould / Kelly Sanders	Procurement	*TBC*	Q4 FY21/22
		We will monitor the environmental impacts including CO2e and air pollution associated with the transport and logistics from our supplier.	**C & A**	**Procurement - supply chain survey will help to determine carbon footprint. Trust sustainable procurement policy includes a review of Air Quality**	Marie Whitaker / Kelly Sanders	Procurement	*TBC*	Q4 FY21/22
TL-5	**The Trust will actively engage with suppliers to reduce our environmental impacts.**	*The Trust shall engage with suppliers frequently to find solutions to minimise their environmental impacts, such as planning deliveries efficiently and using low-emission vehicles.*	**C & A**	**Supply chain survey needed from Procurement**	Marie Whitaker / Kelly Sanders	Procurement	*TBC*	Q4 FY21/22
TL-6	**The Trust shall create and publicise site Green Travel Plans.**	*The Trust will develop site Green Travel Plans, which shall be communicated to staff, patients, visitors, suppliers and the local community.*	**C & A**	**Notices, CHFT Intranet and issued with appointment letters and orders? Being picked up within the green travel plan Group**	Robert Dadzie / Colin Duffield	n/a	*Monthly*	On-going
		The Green Travel Plans will seek to promote active travel and seek to limit single occupancy journeys.	**C & A**	**Travel Survey? Being picked up within the green travel plan Group**	Robert Dadzie / Colin Duffield	n/a	*Monthly*	On-going

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TL-7	**The Trust will develop a process for monitoring which staff use personal vehicles for business use.**	*A process will be developed to ensure that all staff using their personal vehicles for business use has appropriate and valid drivers license and insurance, in compliance with our duty of care under the Corporate manslaughter Act 2007.*	**n/a**	**E-Expenses travel claims etc? - valid documents have to be supplied when claiming - (grey fleet) included in Induction using vehicles on Trust Business (to & from different sites)**				Complete
TL-8	**The Trust will reduce high carbon business travel.**	*Carbon intensive travel to be avoided through board approved Business Travel Policy. This policy promotes teleconferencing and limits high carbon travel through Board approval for flight expenses or high emission hire vehicles.*	**C & A**	**Business Travel Policy to be reviewed**				Q4 FY21/22
			C & A	**Teleconferencing and to be promoted through THIS**	TBC	THIS	*Annually*	Q4 FY21/22
TL-9	**The Trust will monitor the transport choices made by staff and patients and help them to reduce their impacts.**	*We will support staff to make lower carbon options (e.g. information on cost and air pollution benefits of salary sacrifice low carbon vehicles).*	**C & A**	**Salary sacrifice Vehicles, Electric Bicycles Staff benefits. Tender for electric vehicle lease should be sought.**	Robert Dadzie	Workforce Engagement	*Annually*	On-going
		We will provide staff with information about the cost savings and personal benefits of sustainable modes of commuting (e.g. personal travel planning advice, health benefits of active travel, potential personal savings of different modes of transport).	**C & A**	**Communications, notices, intranet payslip messages & options. Electric vehicle benefits are communicated through intranet page.**	Robert Dadzie	Workforce Engagement	*Annually*	On-going
		We will monitor the travel choices of our visitors, patients and staff and carry out an annual staff travel survey to measure the shifts in modes of transport. We will work alongside Calderdale and Kirklees local authority and WYCA to promote this survey.	**C & A**	**Staff Travel Survey carried out in 2020. On-going engagement with WYCA and Local Authorities.**	Robert Dadzie		*Annually*	Complete
		We will provide detailed information to patients, staff and users on how to avoid using a car when accessing our sites.	**C & A**	**Appointment letter - Bus/train routes etc**	Robert Dadzie	Internal communications	*Annually*	Q4 FY21/22
TL-10	**The Trust will explore ways to reduce staff reliance on cars.**	*We shall explore the option of running a shuttle bus to reduce between CRH and Halifax station. The Trust will explore a shuttle bus service between CRH and HRI.*	**C & A**	**Work in progress**	Andy Mould	Transport	*Annually*	TBC
		We shall work with Workforce and Organisational Development (WOD) and Occupational Health to encourage sustainable staff travel through cycle schemes and public transport discounts.	**C & A**	**WYCA metro cards available across Trust. Salary Sacrifice in place to provide access to electric vehicles & cycling schemes.**				Complete
TL-11	**The Trust shall introduce requirements for the procurement of vehicles.**	*We shall evaluate new fleet tender and specify electric or hybrid vehicles as a minimum.*	**C & A**	**In progress - a number of vehicles have already been changed to electric & hybrid where practicable possible**	Andrew Mould	ULEV fleet vehicles	*Annually*	Q4 FY21/22
TL-12	**The Trust will use technology to facilitate remote working and services to reduce travel.**	*We will work with Workforce and Organisational Development (WOD) to increase the use of agile working where appropriate to reduce staff travel.*	**C & A**	**Covid Pandemic - more staff WFH - obtain numbers from WOD**		THIS	Annually	On-going
		We will work to increase the provision of digital services to reduce the requirement for patients to travel to outpatient appointments. This will be incorporated into the communications strategy.	**C & A**	**Covid pandemic - out patients appointment held via telephone or teams**		THIS	Annually	On-going

Adaptation								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
AD-1	**The Trust shall monitor overheating events and use the results to modify our strategy.**	*We will implement a monitoring process for overheating events. The information gathered about overheating events will be used to improve our strategy which will be implemented to mitigate the risk of overheating, particularly in wards and other clinical areas.*	**C**	**Flood plan, heat plans and winter plans are currently in place across the Trust as part of emergency planning. Incorporated into business continuity plans. Service provider strategy also in place and will be reviewed as part of monitoring process.**	Ian Kilroy		*EPRR reviewed every two years.*	Complete
AD-2	**The Trust shall assess the risks associated with climate change and the ways to mitigate these risks.**	*The Trust will include the potential impacts of climate change in the Trust's Risk Register. As part of this process, the Trust shall review its Heatwave Plan, Cold weather Plan, Excess Death Management Plan, Rapid Relocation Plan and Flood Management Plan*	**C**	**As above this is covered through the corporate risk register. Table top exercises in place to test out plans within EPRR. Annual reports will evidence actions in place.**			*EPRR reviewed every two years.*	Complete
		The Trust shall review the identified risks to the workforce and delivery due to changes in disease patters and population health; and find mitigation actions to tackle these challenges.	**C**	**Pandemic plan is currently under development to address winter viruses. EPRR and business continuity plans will address heat related health problems.**	Lindsay Rudge			Q4 FY21/22
		We shall assess the risk to local communities from the impacts of our adaptation strategy, e.g. ensuring that flood attenuation doesn't divert water flow to residential areas.	**C**	**Multiple approaches in place. Linked to Kirklees LA and Calderdale LA. Bi-monthly meetings attended by Trust to LA emergency planning groups / resilience governance groups. The Trust is a CAT 1 responder under Civils contingency plans 2004. Trust also linked into local CCG meetings and NHSE EPRR meetings.**			*Trust Flood Plan developed in partnership with CCGs - Live document*	On-going
AD-3	**The Trust will align protocols to national adaptation plans.**	*We will develop local protocols aligned to national heat wave plans, cold weather plans and multiagency flood plans) in relation to Civil Contingencies Act, Climate Change Risk Assessment and National Adaptation Plans.*	**C**	**Carried out as part of core standards. All referenced plans are aligned to national protocols.**			*Annually*	Complete
AD-4	**The Trust shall involve staff in the creation and implementation of a climate change adaptation strategy.**	*We will involve representatives from sustainability, finance, estates management, emergency preparedness/planning, HR, business continuity and local partner organisations and communities to ensure we develop a co-ordinated and integrated adaptation plan.*	**C**	**Further representation required within SRGG board as required to discuss sustainability adaptation.**			*Annually*	Q4 FY22/23
		The adaptation plan shall be developed inline with the Green Plan and the Trust's resilience planning.	**C**	**Carried out as part of this process**			*Annually*	Complete
		The adaptation plan shall be approved by the Board.	**C**	**Core standards are approved by Trust Board along with the Trust Green Plan**			*Annually*	Complete
		We will provide training to ensure that our workforce is prepared and trained to deal with different extreme weather scenarios such as staff know how to keep clinical and ward areas cool in the event of hot weather, and how to report high indoor temperatures.	**C**	**Carried out yearly through EPRR action plan. Trust to develop timescale for delivery.**			*Annually*	Complete
		Training is provided to staff relevant to their role, to ensure they understand their roles and responsibilities in relation to adaptation planning.	**C**	**As above.**			*Annually*	Complete
AD-5	**The Trust shall assess the flood risk to the site.**	*We will carry out an assessment of flood risk of our estate, access routes and supporting infrastructure (e.g. utilities, IT and supplies) and workforce based on current and future projected climate conditions.*	**C**	**Main sites unlikely to flood. Community sites have flood management plans in place. Community risk review will continue to develop resilience.**			*Annually*	On-going

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AD-6	**The Trust shall assess the financial impacts of climate change on the organisation.**	*We have assessed the financial impacts of climate change to our organisation and the cost of doing nothing, this is clearly communicated to our board.*	**C**	**RD to pick this up with SB**				
AD-7	**The Trust will look to safeguard vulnerable people during extreme weather events by establishing a coordinated care plan.**	*The Trust shall develop a care plan in coordination with the JSNA or other local organisation, to ensure the safety of vulnerable groups during extreme weather events.*	**C**	**Partnership meetings set up with Local Authority to review plans for vulnerable communities. Community division and LA to lead initial response.**			*EPRR reviewed every two years.*	On-going
AD-8	**The Trust shall ensure that vulnerable groups are protected during extreme events.**	*The Trust shall develop plans to ensure vulnerable communities and vulnerable existing patients are prioritised and supported in the event of major and extreme events.*	**C**	**As above. Additionally business continuity plans address risks to vulnerable patients.**			*EPRR reviewed every two years.*	On-going
AD-9	**The Trust shall appoint an Adaptation Lead who shall manage the adaptation planning.**	*The Adaptation lead will be responsible for coordinating adaptation planning, resilience and emergency preparedness at the Trust.*	**C**	**IK in post as Adaptation lead**	Ian Kilroy			Complete
		The Trust shall provide the Adaptation lead with sufficient training, CPD opportunities and access to forums to share local and national best practice information.	**C**	**Adaptation lead linked in with PHE, NHSE and EMERGO training. Professional qualifications also held. On-going requirements for CPD to be identified.**	Ian Kilroy			Complete
AD-10	**Monitor the impacts of climate change and the impacts it has on the communities served by the Trust.**	*The public health lead within the trust shall maintain a record of notable and/or extreme weather events on an annual basis including health and care related impacts. The records created by this action will be used to update the trust Risk Register.*	**C**	**Public health lead to be identified and approach to monitoring to be discussed - TBC**				Q4 FY22/23
AD-11	**The Trust shall work with suppliers to ensure their contingency plans are integrated so delivery of care at the Trust during an extreme event will not be hindered by the supply chain.**	*The Trust will engage with our key suppliers to understand their resilience and contingency plans for extreme weather events and other incidents.*	**C**	**Supplier engagement and survey to be developed. Service provider strategy to be confirmed. EPRR is linked in with Procurement and plans in place to address risks.**	Kelly Sanders			Q4 FY22/23
		The Trust shall develop a contingency strategy to ensure that crucial resources such as anaesthetic gases and medicines can be provided during extreme events and do not impact delivery of care.	**C**	**Incident Command Centre (ICC) set up for critical incidents and in extreme events to ensure that there's no impact on quality of care.**	Helen Barker			Complete

Capital Projects								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
CP-1	**The Trust will aim for certification on all new builds.**	*Our new buildings will achieve a minimum rating of "Good" on the BREEAM assessment and we will aim for "Very Good".*	**All**	**Reconfiguration projects planned with an aspiration to achieve BREEAM. Emergency department working towards Very Good at a minimum.**				
CP-2	**The Trust shall ensure all staff receive adequate support to design and use Trust buildings sustainably.**	*The Trust shall ensure that all Capital Project staff are sufficiently trained to be able to achieve sustainable outcomes in the projects they contribute to. Job descriptions should specify that Capital Project staff should have experience of energy efficient technologies, space utilisation and adaptation.*	**All**	**Job descriptions for Capital team state requirement to deliver sustainability.**				
		The Trust shall provide an induction for staff upon occupation of a new building so it can be utilised efficiently.	**All**	**To be included as part of handover with main contractor**				
CP-3	**The Trust will assess the environmental performance of the building once occupied.**	*Once new buildings have been occupied for a suitable period of time, the Trust will assess the resource consumption and carbon emissions of the new building to ensure that the building meets the designed objectives. This will identify any areas of the building which aren't performing*	**All**	**carried out as part of SERC report and carbon baseline**				
CP-4	**The Trust will consider the long-term requirements of new buildings in the design process.**	*Whole life costing shall be applied to the design and construction of new buildings and refurbishments.*	**All**	**CHS sustainable procurement policy to be devised as part of reconfiguration. Trust promoting offsite fabrications and modern construction methods.**				
		When designing new buildings the Trust should assess projected climate and temperature profiles to ensure that the buildings can cope with changes in climate and extreme weather events.	**C**	**Over cladding project to include thermal massing investigation to determine solar gain and impact on carbon neutrality targets.**				
CP-5	**The Trust shall establish a commissioning protocol from the outset of capital projects.**	*The Trust shall use a soft landings extending commissioning protocol to ensure the building is commissioned in a way that facilitates maximum energy efficiency, building performance and maximum usability.*	**All**	**As above. Planned projects under reconfiguration will include BIM, which involves soft landings and handover.**				
	The Trust shall	*The opinions of staff, patients, visitors and the local population shall help guide the design process of key capital projects.*	**All**	**Key stakeholder group set up to inform design for reconfiguration - Led by internal comms and TPB**				

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CP-6	**consult key stakeholders including staff, patients, visitors and the local community when embarking on a new capital project.**	*The Trust shall engage with local health and social care organisations and the local community when designing new buildings and infrastructure to ensure the buildings will meet the needs of its users and allow high quality integrated care to be provided.*	**All**	**As above. Project planned projects under reconfiguration will include BIM, which involves soft landings and handover.**				
CP-7	**The Trust will conduct a strategic estates review process to identify potential energy efficient building fabric improvement**	*The Trust shall extend current review activity beyond the critical works register to identify other priority areas where a spend to save approach could yield cost and carbon savings from estate refurbishment and upgrades.*	**All**	**Over cladding scheme and LED scheme. Applications to be made for future SALIX funding opportunities.**				
CP-8	**The Trust will utilise brownfield sites for developments.**	*The Trust will ensure that it is policy to consider brownfield sites rather than greenfield sites for capital projects.*	**C & A**	**No immediate plans for new builds. However Capital projects will prioritise refurbishment of existing properties, for instance Dryclough.**				
CP-9	**The Trust shall integrate green space into capital projects.**	*The Trust shall design new builds and access routes to buildings with embedded green spaces.*	**C & A**	**Exploring as part of learning centre development, open space has been identified for green space development for staff wellbeing.**				
CP-10	**The Trust shall ensure sustainability plans are fully aligned with and support the hospital reconfiguration plans.**	*The Transformation Programme Board will use the Sustainability Design Brief to ensure the sustainability plans support the reconfiguration plans.*	**C & A**	**Sustainability design brief for reconfiguration approved by Board.**				
CP-11	**The Trust will consider the use of materials in all new builds.**	*We will ensure that innovative, low carbon materials are embedded into the designs of future builds in order to reduce the embodied carbon associated with construction.*	**C & A**	**Modern construction methods and offsite fabrication will reduce wastage in construction. Sustainable procurement plan proposed for ED - this is to prioritise the use of materials with a low embodied carbon and recycled content. Targets are also set for social value.**				

Greenspace and Biodiversity								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
GS-1	**The Trust shall develop and implement a green space and biodiversity strategy.**	*The Trust shall ensure the greenspace and biodiversity strategy receives approval from our board. The board will be regularly updated with the progress of the strategy and the quality and accessibility of our green spaces.*	**n/a**	Currently not available. Demolition of learning centre and new ED will consider biodiversity. BAP may need to be designed by Motts or IBI				
		Staff with relevant expertise will be made available to manage the implementation of the green space and biodiversity strategy.	**C & A**	Managed by subcontractors or by CHS groundskeepers				
		The Trust will provide the necessary resources to successfully implement the green space and biodiversity strategy.	**C & A**	To be included in BAP				
GS-2	**The Trust shall encourage food cultivation both onsite and in the community.**	*The Trust will designate some of our green space to food growth and cultivations.*	**All**					
		The Trust will look to work with local food projects and food banks, as well as look to provide educational opportunities in the community.	**All**	Christmas food appeal / donations drive already in place. Opportunities will be explored as well through Emma K.				
		The Trust will encourage staff to engage with food growing schemes at the Trust and at home.	**All**					
GS-3	**Catering contracts shall be improved to meet government guidelines.**	*Catering and food contracts will be changed to improve their sustainability credential and meet government guidelines including Government Buying Standards such as Food for Life, red tractor, sustainable fish cities etc.*	**All**	Adrian / Procurement. New catering specification attempts to promote sustainability.				
GS-4	**Biodegradable materials from wastes at the Trusts will be composted.**	*The Trust shall explore the possibility of introducing onsite composting or using a contractor to provide composting or anaerobic digestion for the Trust's organic waste.*	**W**	Currently exploring composting onsite at HRI. AD to be considered at later stage.				
GS-5	**The Trust shall only procure timber and paper products that meet government guidelines.**	*We will ensure that all timber and paper products at least meet government guidelines including the Government Buying Standards, FSC and recycled content. The Trust shall also aim to reduce the amount of paper used.*	**W**	To be included in the CHS contractor specification moving forward. Sustainable Procurement policy for reconfiguration will promote FSC / PEFC timber.				
GS-6	**The Trust will make the green space at the Trust available and accessible to patients, staff, visitors and the local community.**	*We will make our plans for maintaining and improving green spaces and biodiversity available to the public and ensure that this information is clear and accessible with maps and images.*	**n/a**	To be delivered once BAP is completed.				
		Will communicate our Biodiversity Strategy with staff, patients and stakeholders.	**n/a**	As above				
GS-7	**The Trust will actively work to improve the biodiversity on Trust estates.**	*The Trust will work with local biodiversity partners such as the Yorkshire Wildlife Trust to improve biodiversity on our estates, I line with local strategy.*	**C**	To be considered as part of BAP. Bat boxes installed near Acre Mills.				
		The Trust will monitor protected species and maintain green spaces which provide habitats.	**n/a**	As above. Acre mills pond also developed.				
GS-8	**The Trust shall monitor the impacts of the greenspace provided.**	*The effect of increasing greenspace on biodiversity at the Trust will be monitored closely. This can be measured by looking at the number of species found, the number of invasive species and other parameters.*	**n/a**	To be carried out as part of survey and BAP				
		The Trust shall monitor the impact of access to green space at the Trust on staff wellbeing. This will be monitored through staff feedback and surveys.	**n/a**	Peace Garden currently under consideration by Nicola Hosty. Funding opportunities currently being explored.				

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	greenspace provided.	*We will report on the quality and accessibility of our green spaces and biodiversity regularly to the Board, emphasising the value of green space in health environments.*	**n/a**	To be reported to TPB after delivery of BAP				
GS-9	**We shall assess the impacts of the delivery of our services on local biodiversity and then implement relevant mitigating actions.**	*Depending on the results of the biodiversity assessment this could include actions such as diming external lighting, checking bunding on fuel stores or better treatment of waste etc.*	**All**	Survey and site assessments carried out as part of reconfiguration				
GS-10	**The Trust shall assess the green spaces provided to ensure they are suitable for users.**	*An assessment of the health and safety, cleanliness and accessibility of the Trust's green spaces will be completed, including engagement with users of the spaces, to ensure the green spaces are safe to use.*	**n/a**	As above				
GS-11	**The Trust will integrate green spaces into constrained areas of the site.**	*We will aim to provide green and natural areas on our estate even where land is constrained (making use of small areas even when we don't have large external areas. e.g. window boxes, verges and potted plants).*	**All**	Day surgery unit and estates yard and BOC cylinder				
GS-12	**The Trust shall protect existing areas of greenspace and biodiversity.**	*We shall protect and maintain the trees onsite at both CRH and HRI. The Trust will design the reconfiguration plan to incorporate the use of trees in the layout of new facilities. If any of these trees need to be cut down the Trust will replace them.*	**C & A**	Tree surveys carried out as part of reconfiguration. Demolition of learning centre and ED survey's available. TPOs in place and managed by Estates.				
		We will conduct a strategic tree review.	**C & A**	Annual tree survey carried out.				
		We will work with CHS Estates to minimise vegetation loss.	**C & A**					
GS-13	**The Trust shall incorporate greenspace into mental wellbeing initiatives.**	*We will integrate our greenspace and biodiversity plans with our wellbeing initiatives.*	**n/a**	TBC after peace garden development		Trust to identify capital funding		
		We will work to maintain our existing wellbeing garden and herb boxes.	**W**	As above.				

Sustainable Care Models								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
SC-1	**The Trust will recognise the impact of sustainability as a strategic threat to care models and objectives by including it in the Trust's Corporate Risk Register**	*The Corporate Risk Register will be updated to include; sudden demand on services, extreme weather events and environmental impacts.*	**n/a**	Flood plan, heat plans and winter plans are currently in place across the Trust as part of emergency planning. Incorporated into business continuity plans. Service provider strategy also in place and will be reviewed as part of monitoring process.	Ian Kilroy		*EPRR reviewed every two years.*	Complete
SC-2	**The Trust will work to understand sustainability in the increasing focus on clinical care pathways**	*The Trust shall provide support to consultant led work in pockets of the organisation to gain insight into good practice which can be shared across the Trust.*	**All**					
SC-3	**The Trust shall assess the environmental impacts associated with emerging care models.**	*We will calculate the environmental / carbon impact of a specific care model(s), to help us identify the most impactful areas or hotspots which allows us to minimise the environmental impact.*	**All**					
SC-4	**The Trust will work to reduce emissions from clinical practices**	*The Trust will continue to work to reduce the use of the most environmentally damaging anaesthetic gases and will develop a strategy with Pharmacy. . Where clinically appropriate, the Trust will reduce the use of Desflurane, in favour of lower emitting alternatives, such as Sevoflurane.*	**C**	Anaesthetic gas usage / quantities are reported as part of annual ERIC returns. Pharmacy department are actively engaged in agenda to promote low carbon gases.	Liz Street - Pharmacy			
		The Trust will work to reduce the prescription of Metered Dose Inhalers, in favour of Dry-Powder Inhalers. Where clinically appropriate.	**C**	As above. Pharmacy department already engaged with intervention and are working to replace Metered Dose Inhalers across the Trust.	Liz Street - Pharmacy			
SC-5	**The Trust will promote telemedicine**	*Following the changes enforce by Coivd-19 to our service delivery, the Trust will promote the use of telemedicine, where clinically appropriate, as a core part of our service delivery.*	**All**					
SC-6	**The Trust will use a variety of measures to ensure that the care models developed are sustainable and can provide the highest quality of care to patients.**	*We will use a population needs assessment, JSNA or equivalent, to make our systems of care more clinically, socially, environmentally and financially sustainable.*	**All**					
		The Trust will use several mechanisms, including engaging with patients and staff, using incentives and using technology more innovatively, to test the effectiveness of our sustainable care models.	**C & A**					
SC-7	**The Trust will incorporate the sustainable use of resources into the decision criteria in the care model development and commissioning process.**	*To reduce the environmental impact and cost resources associated with care delivery sustainability should be integrated into the decision making process when designing care models.*	**All**					
SC-8	**The Trust shall report progress on sustainable care models to the Board.**	*We will routinely and formally report on our progress (to board and publicly) in regards to developing holistically sustainable (clinically, socially, environmentally as well as financially) care models.*	**All**					

Our People								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
OP-1	**The Trust shall work to improve employment opportunities.**	*We will aim to become a living wage employer to reduce the staff risk of food and fuel poverty.*	**n/a**	**TBC**	TBC			TBC
		We shall work with local partners to improve access to employment opportunities at the Trust.	**n/a**	**Trust currently recruiting Employability Manager to assess equal opportunities and access to employment opportunities. Trust is planning to becoming a signatory to the Diversity Equals Innovation Group set up in Huddersfield to reduce unemployment. Trust is also engaged with Kirklees council as part of this group. Engagement is being sought with Calderdale council.**	Pam Wood/Widening participation team			Employability Manager to be hired - July 2021. Already members within Equality group.
		We shall implement schemes to help long-term unemployed people into work, including work placements and apprenticeships.	**n/a**	**Apprenticeship team in place to promote healthcare careers. Opportunities to be explored to promote work placements in non-clinical departments.**	Pam Wood/Widening participation team			On-going
OP-2	**The Trust shall incorporate sustainability into staff training and promote workforce engagement.**	*The Trust will explore the option of becoming a Carbon Literate organisation, by providing Carbon Literacy training to our staff.*	**All**	**WRM to propose training for carbon literacy**	Robert Dadzie / WRM			Dec-21
		We shall analyse the training needs of our workforce and produce talent maps to identify potential to upskill staff and to support succession planning.	**All**	**Trust is currently exploring talent management providers and opportunities for managerial support in succession planning.**	Nikki Hosty		*Annually*	Dec-21
		At the induction, staff shall be given information on the organisation's sustainability plans and how they can support our objectives.	**All**	**Trust to review on-boarding and induction programme**	Rachael Pierce	Further development training and on-boarding / culture setting. CHFT goals.		
OP-3	**The Trust shall support staff to make healthy choices.**	*We shall develop an action plan to promote and support health choices in all parts of the workplace, including off site, (e.g. an absence management policy, alcohol drugs and stress management strategies and promotion of healthy food choices).*	**All**	**Trust Wellbeing advisors have been developed as a new role. Calendar for wellbeing days is currently in development. Conversation needed regarding policy development.**	Nikki Hosty OR Samantha Lindl / Jill Palmer (Wellbeing advisors)			
		The Trust estate shall become smoke free. Smoking cessation services shall be increased for staff.	**All**	**Trust is designated as a smoke free site although further implementation needed. Trust exploring plans to remove smoking shelters.**	Colin Duffield			
		We shall provide support and provide schemes to all staff dependant on their specific needs (e.g. parents and carers and childcare vouchers, play areas, space for breastfeeding)	**All**	**Child care vouchers already offered along with spaces for breastfeeding. Nursery onsite with discount given to staff.**	Samantha Lindl / Jill Palmer (Wellbeing advisors)			
		We will work with Occupational Health to set up a 'Green Gym' for staff to volunteer in projects such as planting trees and local clean ups.	**All**	**TBC**	Christine Bouckley OR Samantha Lindl / Jill Palmer (Wellbeing advisors)			
OP-4	**The Trust shall monitor the success of health and wellbeing initiatives.**	*We shall monitor the health and wellbeing of our workforce through surveys, sickness absences and staff health to ensure that our initiatives are improving wellbeing.*	**n/a**	**Annual staff survey carried out along with Covid health and wellbeing risk assessments. Exploring plans to continue post covid**	Nikki Hosty		*Annually*	
		We shall monitor and look to improve staff retention.	**n/a**	**TBC - Retention likely to become part of talent management initiatives**	Azizen Khan/Nikki Hosty/+tbc			
OP-5	**The Trust shall work with our suppliers to ensure that they meet our standards.**	*We shall request access to our suppliers approaches to equality and diversity (e.g. staff diversity figures or % leaders that are female and/or from underrepresented groups).*	**n/a**	**Procurement to engage with supply chain and develop supplier surveys**	Nikki Hosty / Kelly Sanders			
		We shall put clear processes in place to manage our duty of care (e.g. health and safety) to all contractors and third party personnel working on our sites or on our behalf.	**n/a**	**Procurement to engage with supply chain and develop supplier surveys**	Nikki Hosty / Kelly Sanders / Richard Hill			
		Where appropriate we shall ask prospective suppliers to confirm that they comply with the Modern Slavery Act 2015.	**n/a**	**Procurement to engage with supply chain and develop supplier surveys**	Nikki Hosty / Kelly Sanders			

Completed

Working towards

Procurement Delivery Required

Sustainable Use of Resources								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
SU-1	**The Trust shall work to improve the impacts of food at the Trust.**	*We will track the food miles, consumption patterns and disposal of food and drink products for staff and patients to reduce the environments of catering and food.*	**C & A**	Procurement policy will be an essential driver for this target. Supplier engagement will be required and tender stage specifications should be written into agreements. Procurement policy for reconfiguration will promote the responsible use of resources. Emerging catering specification attempts to address food wastage.	Adrian Brown / Kelly Sanders / Service Performance	**Supply chain survey / procurement policy**	*Every two years*	Q4 FY22/23
		We will establish targets to increase the amount of healthy and sustainable food choices in our organisation, including from catering services as well as on sale to staff, patients and public in vending machines and retail outlets located within our estate.	**C & A**	Addressed through revisions to catering specification. Additionally NHS food review to feed into emerging Procurement policy. Supplier engagement will be required and tender stage specifications should be written into agreements. Current review through CHFT catering departments will help to understand compliance with Defra standards for 'Public Procurement: Food & Catering'.	Adrian Brown / Kelly Sanders / Service Performance		*Every two years*	Q4 FY22/23
		We will review our catering contracts include a require to maximise the use of fresh and seasonal food to minimise the need for transportation which exceeds government guidelines.	**All**	As above.	Adrian Brown / Kelly Sanders / Service Performance	**Procurement / NHS food review**	*Every two years*	Q4 FY22/23
		We will support staff on how to reduce food wastage to reduce the environmental impact and to help support staff avoid food poverty.	**W**	As above. This is to be address through NHS food review.	Adrian Brown / Kelly Sanders / Service Performance	**Procurement / NHS food review**	*Every two years*	Q4 FY22/23
SU-2	**The Trust will manage waste at the highest level of the waste management hierarchy**	*The Trust shall set a target of recycling 40% of non-clinical waste by 2030.*	**W**	Efforts already underway to increase recycling across the Trust.	Nigel Murphy / Robert Dadzie		*Annually*	Q4 FY21/22
		We shall improve waste segregation at the Trust to reduce reliance on high temperature incineration.		Efforts already underway to increase recycling across the Trust. Conversations planned with clinical departments to encourage further segregation of hazardous and offensive waste streams. Staff training and communications would support plans to improve the segregation of clinical waste streams.	Nigel Murphy / Robert Dadzie	**Internal comms / WOD**	*Annually*	Q4 FY21/22
		We will develop a resource and waste management action plan to apply the waste minimisation hierarchy in our organisations as requirement under the Waste Regulations (England and Wales) 2011.	**W**	Waste hierarchy has already been adopted by Trust. Waste & resource action plan to be developed.	Nigel Murphy / Robert Dadzie		*Annually*	Q4 FY22/23
SU-3	**The Trust will continue its focus on reducing medicines waste and will build on successes to date to become a leader in this area**	*Our Pharmacy department will undertake an audit of medicines wastage to understand further waste prevention and reuse opportunities which can consolidate existing activity. This shall be linked to monitoring.*	**W**	Conversations underway with Pharmacy regarding wastage within the department. Initiatives to reduce waste medicines have been adopted. Pharmacy review to be included within Waste & resource action plan.	Nigel Murphy / Robert Dadzie	**Pharmacy**	*Annually*	Q4 FY22/23
SU-5	**The Trust will improve stock management to reduce waste generation.**	*We will use stock management and streamlining of products lines to reduce waste across all areas of the organisation (e.g. Pharmacy, Catering - e.g. the Green Kitchen Standard, FM etc.).*	**W**	Stock control and management techniques already underway within Pharmacy and Catering. Emerging catering specification, continues to encourages efficient stock management.		**Pharmacy / Catering**	*n/a*	Complete
		We shall review the top-up process as part of a material management project.	**W**		Chan Dhaliwal	**Materials Management**		
	The Trust shall encourage staff to make more	*The Trust will explore discount schemes or initiatives which would allow staff to purchase more substantiable products.*	**W**					
		The Trust will advertise the ways in which staff can access more sustainable products.	**W**	Carried out through internal comms and website updates	PrimeCreative / Robert Dadzie	**Internal comms / PrimeCreative**	*Annual*	Q4 FY21/22

Completed

Working towards

Procurement Delivery Required

SU-6	**sustainable choices, and aim to make this more accessible.**	*The Trust will communicate to staff the benefits of using more sustainable products and services and encourage staff to procure items sustainably at home.*	**W**	To be highlighted through emerging comms strategy with PrimeCreative	PrimeCreative / Robert Dadzie	**Internal comms / PrimeCreative**	*Annual*	Q4 FY21/22
SU-7	**The Trust will engage with stakeholders to ensure resources are managed efficiently throughout the supply chain.**	*We will collaborate with our supply chain to enable the reparation and reuse of relevant goods at the Trust, such as furniture, building materials, wheelchairs, and reusable medical equipment.)*	**W**	Procurement policy will be an essential driver for this target. Supplier engagement will be required and tender stage specifications should be written into agreements to encourage returns of excess material and outdated supplies.				
		We shall promote the use of Warp-it, an online platform for the reuse for items .	**W**	WARP-IT platform currently in use to facilitate recycling and re-use of waste furniture.			*Annual*	Complete
SU-9	**We will work to convert our waste products into useful resources**	*We will develop a system/process that identifies suitable opportunities to convert our "waste" into a resource (e.g. furniture re-use schemes and donations of IT and medical supplies etc.) to community groups or charities.*	**W**	WARP-IT platform currently in use to facilitate recycling and re-use of waste furniture.			*Annual*	Complete
SU-13	**The Trust shall look to recycle all food waste.**	*Explore the opportunity and where practicable, implement a Trust wide organics (i.e. food waste) collection.*	**W**	Already under contract with ReFood who collect food waste from Trust. Food caddies have been trialled across the Trust with limited success. Further workforce engagement needed alongside engagement with domestic services.				
SU-15	**The Trust shall promote recycling.**	*We shall provide guidance on recycling for staff and increase the provision of recycling bins around the Trust.*	**W**	Efforts already underway to increase recycling provisions. Refuse, Reduce, Reuse, Recycle message has been communicated at entrances. Improved bin labels have been purchased. Poster campaign planned through an external provider.	PrimeCreative / Robert Dadzie	**Internal comms / PrimeCreative**	*Annual*	Q4 FY21/22

Carbon and Greenhouse Gases								
Reference	**Green Plan Intervention**	**Action Detail**	**Target Area (Carbon , Waste or Air Pollution Reduction)**	**Implementation Evidence**	**Implementation Lead**	**Implementation Support**	**Monitoring Frequency**	**Timescale Implementation**
CG-1	**The Trust will assess new builds to ensure they meet the standards set.**	*After occupancy we will assess energy / carbon performance of the building in-use to ensure the parameters set in the design process have been achieved and will work with the contractor to rectify any areas of poor performance.*	**C**	Carried out as part of ongoing carbon assessment. Requirements for post occupancy evaluation will need to be stipulated in Tender.	CHS Capital team / Robert Dadzie	**Capital**	*Annually*	Q4 FY21/22
CG-2	**The Trust shall communicate the importance of reducing emissions to staff and patients.**	*We will communicate with staff and patients the importance of being a low-carbon organisation due to the adverse effects of climate change on human health.*	**C**	External provider has been sought to support integral communications. Proposal received from PrimeCreative in Huddersfield, includes Carbon Footprint engagement piece.	Robert Dadzie	**Internal Comms/ Prime Creative**	*Annually*	Q4 FY21/22
CG-3	**The Trust will publish the emissions from key high emissions activities.**	*We will make carbon emissions 'visible' in key identified high carbon activities where patient and staff choice is available to encourage behaviour change (e.g. choice of lease car, options for travel mode, use of dry power rather than metered dose inhalers, data heavy IT use, turning off lights/equipment).*	**C & A**	Information available on the intranet regarding lease vehicle options for E-Vehicles.	Robert Dadzie / Environment Coordinator		*Annually*	Q4 FY22/23
CG-4	**The Trust will improve the monitoring and reporting of carbon emissions.**	*We will monitor our energy and water use closely, across all our sites (owned and leased) and over time.*	**C**	Carried out as part of ongoing carbon assessment and reported in mandatory ERIC returns and SERC reports.	Robert Dadzie / Environment Coordinator		*Monthly*	Complete
		Annually will we measure our carbon impact including core emissions such as energy, water, waste, anaesthetic gases and business travel, and analyse trends over time to help validate performance and ensure lessons are learnt.	**C, A & W**	As above. Anaesthetic gas emissions also reported through ERIC reports. On-going engagement.	Robert Dadzie / Environment Coordinator		*Annually*	Complete
		We will report key performance indicators to the Board on a regular basis (at least 6 monthly) encompassing the measurement of areas such as; use of resources, carbon, air pollution and waste arisings.	**C, A & W**		Robert Dadzie / Environment Coordinator		*Bi-Annually*	Q4 FY22/23
		Our carbon emissions and trend data will be reported to staff, patients and the public annually through our annual sustainability reporting (e.g. using the SDU sustainability reporting tool).	**C**		Robert Dadzie / Environment Coordinator		*Annually*	Q4 FY22/23
CG-5	**The Trust will set targets for reducing CO_2e emissions and develop a plan to achieve these targets.**	*The Trust will become carbon net-zero by 2040, in line with NHS England targets.*	**C**	Support for decarbonisation plan will be sought through Inenco our current Energy consultants / brokers. Applications have already been made for Salix and further public sector investment will be sought after.	Robert Dadzie / Environment Coordinator		*Annually*	2028/32 (interim targets)
		We will set smart targets relating to various carbon hotspots e.g. energy, travel and water, with a baseline year and clear target dates.	**All**	Currently in development with CHS energy consultant, Inenco.	Robert Dadzie	**Inenco**	*Annually*	Q4 FY21/22
		We will develop plans (that link to our Green Plan) to reduce our energy and water demand to improve our water and energy efficiency, in line with the NHS Sustainable Development Strategy and the Climate Change Act (2008).	**C**		Robert Dadzie			
		We will measure our carbon impact annually including core emissions such as energy, water, waste, anaesthetic gases and business travel, we analyse trends over time to help validate performance and ensure lessons are learnt.	**C**	Carried out as part of ERIC returns	Robert Dadzie / Environment Coordinator		*Annually*	Complete
		We shall integrate our carbon reduction targets into our corporate objectives and will publicly report our ambitions and progress within our annual publications.	**C**					
CG-6	**The Trust will assess travel impacts to reduce emissions**	*We will assess our transport and travel and calculate the carbon footprint of our business travel (all road, rail and air) and patient transport services.*	**C & A**	Fleet related emissions carried out as part of mandatory public sector SERC reporting. Staff travel survey should help to determine travel related footprint.	Robert Dadzie / Environment Coordinator		Annually	Complete
		We will set a local carbon reduction target for business mileage emissions, which is aligned to/or exceed the Climate Change Act 2030 target.	**C & A**	Addressed to some extent through the procurement of electric vehicles within Estates and Transport.	Robert Dadzie / Environment Coordinator		Annually	Q4 FY22/23
CG-7	**The Trust shall explore options to work with other organisations to maximise carbon reductions.**	*We will regularly benchmark our performance/approach to sustainable development and social value with similar organisations (e.g. on carbon reduction, resource USE).*	**C & A**					
CG-8	**The Trust shall take a pan-organisation approach to reducing emissions.**	*We will work to identify and maximise carbon reduction opportunities in all estates investments, particularly in energy and transport*	**C & A**	LED lighting replacements underway. Renewable energy contracts have been procured. Long term plan to decarbonise Estate will be devised through collaboration with Inenco.	Tom Donaghey		Annually	Q4 FY21/22
CG-9	**The Trust shall adopt new technology to reduce carbon emissions.**	*We will encourage innovation and support new technologies that will help improve our usage and carbon performance related to energy and water usage*	**C & A**					
CG-10	**The Trust will work with suppliers to reduce our scope 3 emissions.**	*We will identify our strategic suppliers and evidence that we are working with them to reduce the overall carbon impacts of the goods and services that they provide to our organisation.*	**C & A**	Procurement policy will need to stipulate environmental objectives.	Kelly Sanders		Every two years	Q4 FY22/23
		We will invite our providers and suppliers to disclose/share their organisation-wide carbon and other environmental impacts (e.g. NO2 and PM2.5) with us and encourage/support them to reduce these.	**C & A**					
CG-11	**The Trust will work with staff and patients to reduce our scope 3 emissions from travel.**	*We will quantify our 'citizen' footprint; the carbon impact we have some influence over such as staff commuting habits and patient and visitor travel as well as staff home utility usage.*	**C & A**	Staff travel survey to be carried out every two years. Associated carbon footprint to be determined.	Robert Dadzie / Environment Coordinator		Every two years	Q4 FY21/22

Completed

Working towards

Procurement Delivery Required

CG-12	**The Trust will work to reduce emissions in the local community.**	*We will work to consistently encourage our staff and patients to consider and reduce the carbon emissions and climate change impacts of high impact activity such as air travel, vehicle use, energy use and food supply.*	**C & A**	To be combined with emerging communications strategy with PrimeCreative	Robert Dadzie / Environment Coordinator	Internal Comms/ Prime Creative		Q4 FY21/23
		We will work closely with other local agencies such as our local authority, universities and third sector organisations to contribute to the delivery of area wide carbon reduction strategies and plans.	**C & A**	Stakeholder consultation is presently underway and being carried out as part of reconfiguration. Local Authority representation on Green Planning Cttee has been sought.	Robert Dadzie			On-going
CG-13	**The Trust shall assess and work to reduce the emissions associated with procurement.**	*We will estimate the carbon emissions of our procurement to identify areas for targeted action.*	**C & A**	Supply chain survey will be an essential component. Procurement support required.	Kelly Sanders		Every two years	Q4 FY22/23
		We will identify which of the products and services that we source have the biggest contribution to our overall carbon footprint and will implement interventions to reduce these impacts.	**C & A**	Supply chain survey will be an essential component. Procurement support required.	Kelly Sanders	Procurement	Every two years	Q4 FY22/23
		Where possible we shall promote local procurement policy to address Scope 3 supply chain emissions.	**C & A**	Procurement policy will be an essential driver for this target. Supplier engagement will be required and tender stage specifications should be written into agreements. Procurement policy for reconfiguration will promote the responsible use of resources and set targets for locally sourced materials.	Kelly Sanders	Procurement	Every two years	Q4 FY22/23
CG-14	**The Trust shall explore methods for decarbonising heat.**	*We shall conduct a feasibility study on the heat decarbonisation plan and explore options including low-loss energy systems, air/ground source heat pumps, thermal storage, insulation improvement and smart roofing.*	**C & A**	Initial conversations held with Inenco regarding Heat Decarbonisation Plan and feasibility investigations.	Robert Dadzie	Inenco		Q4 FY21/22
CG-15	**The Trust shall explore methods for reducing heat loss on Trust estate.**	*We shall work to understand the impact recladding will have on the heat demand at the Trust.*	**C & A**	Thermal analysis planned as part of re-cladding project.	Tom Donaghey	Lendlease / Capital & Project Team		Q4 FY21/22
CG-16	**The Trust shall explore opportunities for offsetting carbon emissions.**	*The Trust will plant 6,000 trees, one for every member of staff on our estate, within the local community and as part of the NHS National Forest to help mitigate the impacts of carbon in the atmosphere.*	**C & A**					

Appendix F4 – Proposed amendment to Board cover sheet

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	
Meeting:	Board of Directors
Title:	
Author:	
Sponsoring Director:	
Previous Forums:	
Purpose of the Report	
Key Points to Note	
EQIA – Equality Impact Assessment	
Corporate Responsibility	
How does the paper support the Trust's ambition to meet commitments outlined within the Sustainability Action Plan?	
Recommendation	
The Board is asked to…	

compassionate care

COMFORT BREAK – 10 MINUTES

A Workforce for the Future

13. Workforce and Organisational Development Strategy including Staff Survey Results and Action Plan

To Note

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 6 May 2021
Meeting:	Board of Directors
Title:	Workforce Strategy/2020 Staff Survey
Author:	Nikki Hosty, Assistant Director of Human Resources Jason Eddleston, Deputy Director of Workforce and Organisational Development
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	Workforce Strategy/NHS People Plan update Workforce Committee 8 March 2021 2020 Staff Survey update Workforce Committee 8 February 2021 and 8 March 2021, Executive Board 11 March 2021

Purpose of the Report

The report (via a slide deck presentation) provides the Board of Directors with an integrated update on implementation of the Trust's workforce strategy, the NHS People Plan, feedback from the 2020 national staff survey and the Trust's survey response.

Key Points to Note

- One Culture of Care is our guiding principle
- Our workforce strategy is consistent with NHS People Plan themes
- The 2020 staff survey response supports implementation of our workforce strategy and NHS People Plan
- The staff survey actions are principally divisionally owned
- Primary Board oversight for delivery of the workforce strategy, NHS People Plan actions and the 2020 staff survey response will be through the Workforce Committee.

EQIA – Equality Impact Assessment

The equality impact for specific actions arising from the audit will be assessed, considered and mitigated as appropriate.

Recommendation

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

One Culture of care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

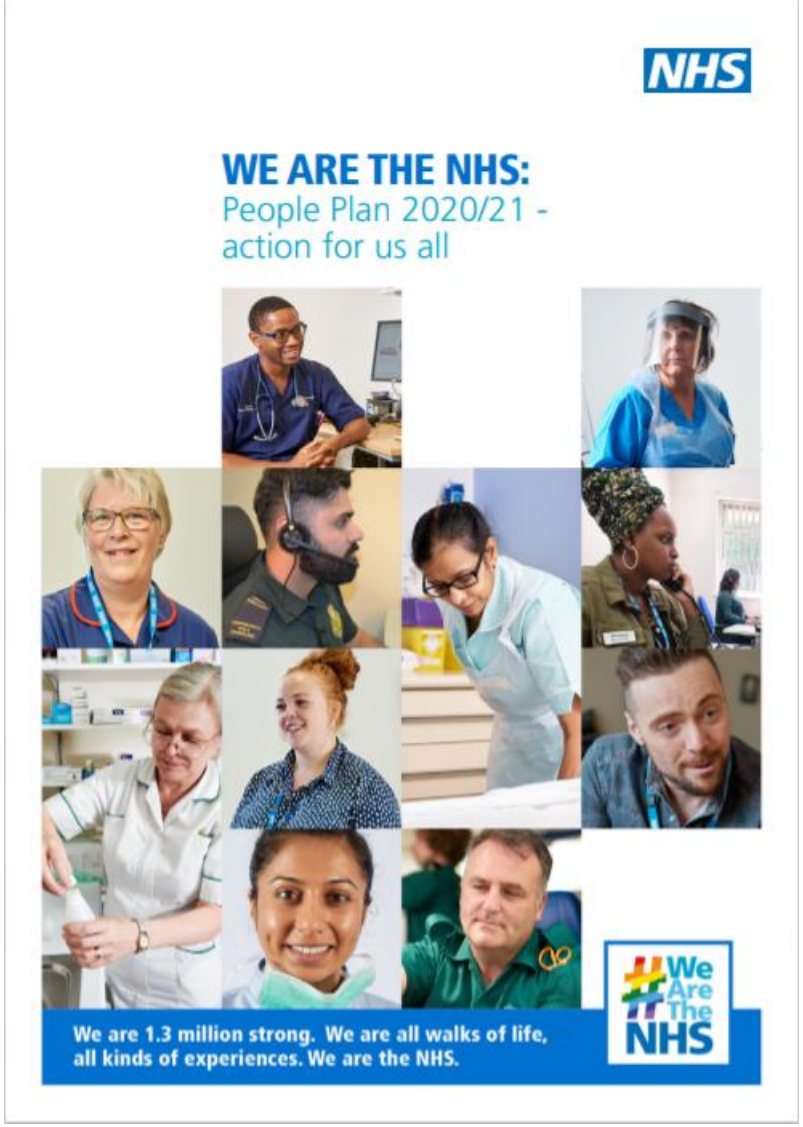
BOARD OF DIRECTORS
6 MAY 2021

Workforce Strategy and 2020 Staff Survey

One Culture of care

Caring for each other the same way we care for our patients

NHS People Plan



- Looking after our people
- Belonging in the NHS
- New ways of working and delivering care
- Growing our workforce

Workforce Strategy

Workforce Strategy Review

What we have done:

Undertaken a review and asked for feedback and apply our learning as we work through the pandemic

The narrative on the landing page announces the strategy – discussed if 18 months in does that narrative need to change?

Clear measurable actions and KPIs that are aligned with our performance reporting regime

Discussed how we keep content fresh and live – ensuring links are checked and assessed

Ensure one culture of care appears throughout and enhanced our information linked to Health & Wellbeing

Will apply a regular check/governance schedule

Reviewed the reference to community and partners

Refresh communication and engagement plan – feedback from the review highlights colleagues are not using the cupboard as much as we hoped

Understood the gaps and link to the NHS People Plan

What we plan to do:

- Inclusive learning and development offer for all
- Inclusive recruitment
- Widening participation
- Leadership development (Phase 2)
- Workforce design
- Consolidate health and wellbeing offer

Our Survey Activity

- Picker overview data shared with Executive Directors January 2021
- Overview shared with Workforce Committee 8 February 2021
- Trust and divisional overview and actions plans presented to Workforce Committee on 8 March 2021
- Executive Board presentation of Trust and divisional overview and action plans 11 March 2021

Positive Response: Workforce Committee approved approach and Divisions acknowledge the action plans need to be developed and acted upon locally

Survey Coordination Centre

Organisation details

NHS England

Calderdale and Huddersfield NHS Foundation Trust

2020 NHS Staff Survey

Organisation details

Completed questionnaires	2,799
2020 response rate	50%

See response rate trend for the last 5 years

Survey details

Survey mode	Mixed
Sample type	Census

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2020 benchmarking group details

Organisations in group: **128**

Median response rate: **45%**

No. of completed questionnaires: **402,201**

2020 Staff Survey Data

- Our overall staff engagement score has improved by 1%, and is placed at #15 in the Trusts who have made improvement. Our 2019 engagement score was 6.9

- Engagement scores are calculated by the answers to 9 questions, split into 3 main indicators of engagement: advocacy, involvement and motivation. Overall, we have improved our advocacy score. Overall, our involvement and motivation score has decreased.

- Our response rate increased from 45.7% in 2019 to 50.1% in 2020

One Culture of care

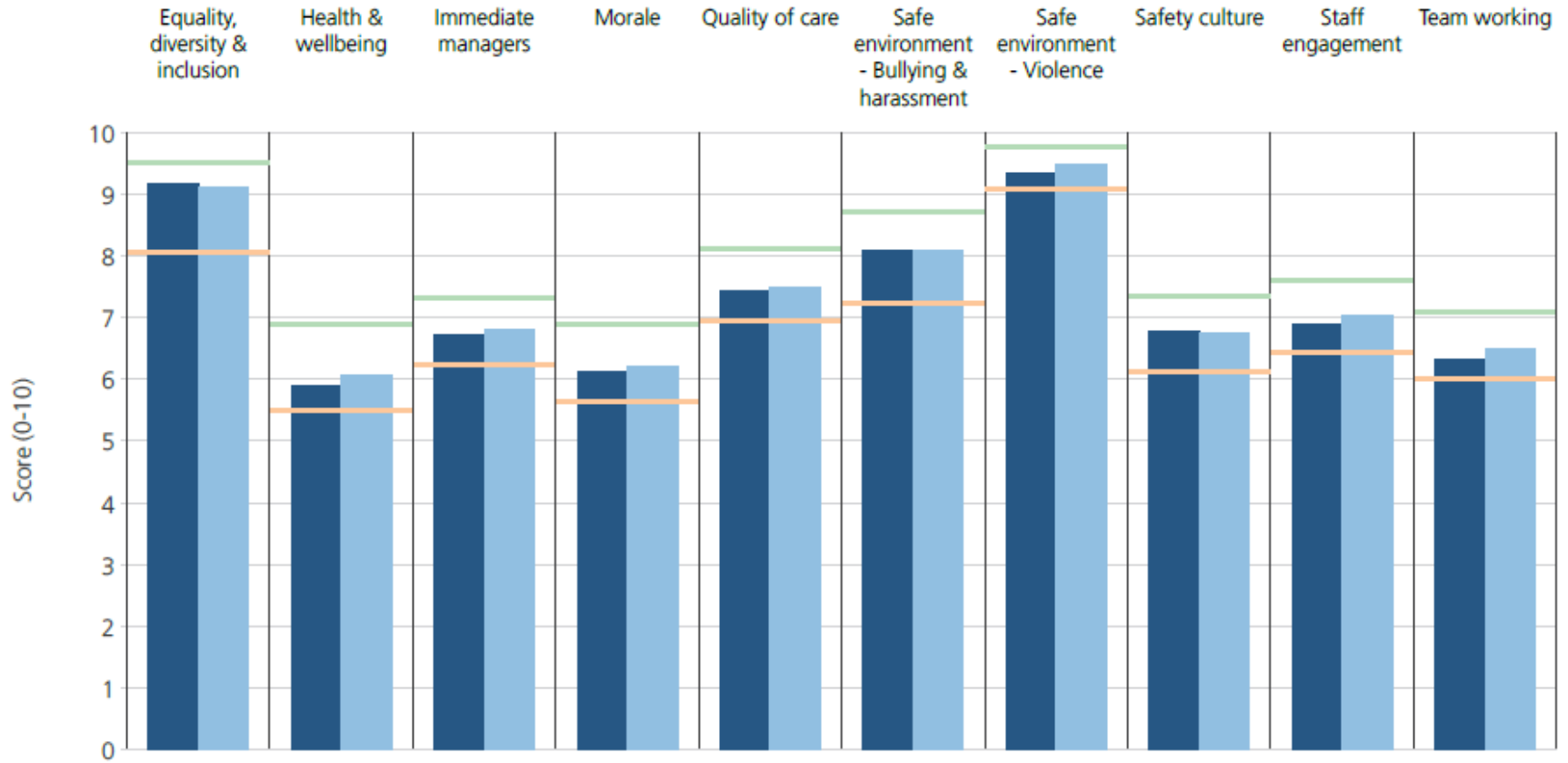
2020 Staff Survey Results

NHS Calderdale and Huddersfield NHS Foundation Trust

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Overview

NHS England



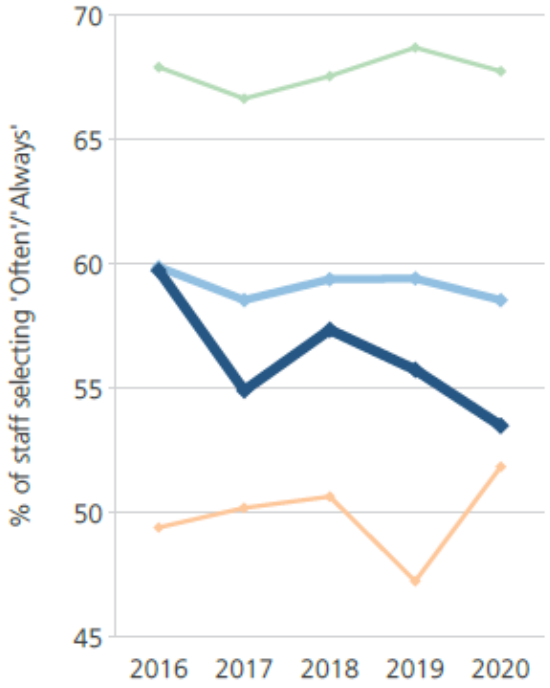
	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	6.9	7.3	6.9	8.1	8.7	9.8	7.4	7.6	7.1
Your org	9.2	5.9	6.7	6.1	7.4	8.1	9.3	6.8	6.9	6.3
Average	9.1	6.1	6.8	6.2	7.5	8.1	9.5	6.8	7.0	6.5
Worst	8.1	5.5	6.2	5.6	7.0	7.2	9.1	6.1	6.4	6.0
Responses	2,678	2,697	2,711	2,651	2,442	2,586	2,680	2,673	2,748	2,722

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Detailed information > Staff engagement – Motivation

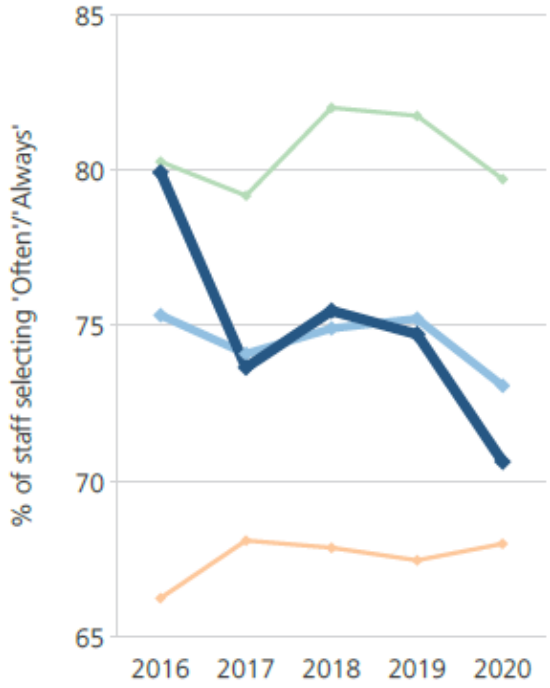
NHS England

Q2a
I look forward to going to work



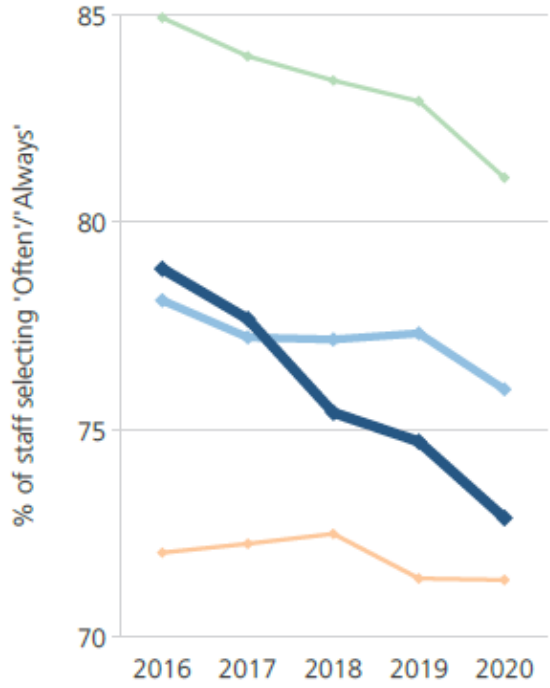
	2016	2017	2018	2019	2020
Best	67.9%	66.6%	67.6%	68.7%	67.8%
Your org	59.7%	54.9%	57.3%	55.7%	53.5%
Average	59.9%	58.5%	59.4%	59.4%	58.5%
Worst	49.4%	50.2%	50.6%	47.2%	51.8%

Q2b
I am enthusiastic about my job



	2016	2017	2018	2019	2020
Best	80.3%	79.2%	82.0%	81.8%	79.7%
Your org	79.9%	73.6%	75.5%	74.7%	70.6%
Average	75.3%	74.1%	74.9%	75.2%	73.1%
Worst	66.2%	68.1%	67.8%	67.4%	68.0%

Q2c
Time passes quickly when I am working



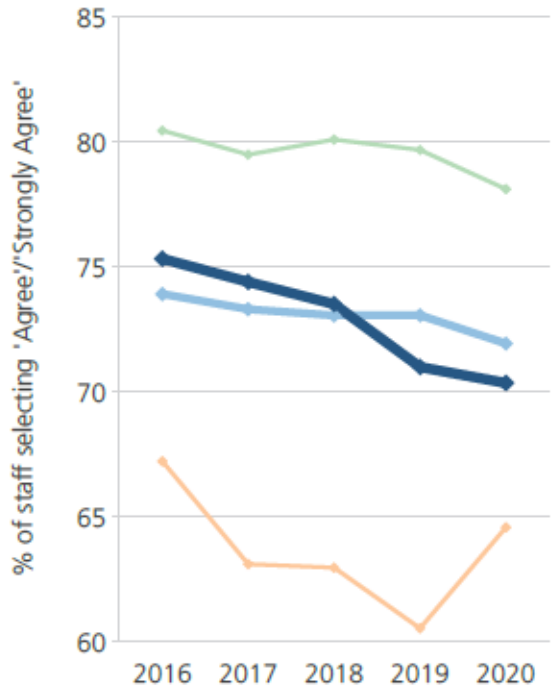
	2016	2017	2018	2019	2020
Best	84.9%	84.0%	83.4%	82.9%	81.1%
Your org	78.9%	77.7%	75.4%	74.7%	72.9%
Average	78.1%	77.2%	77.2%	77.3%	76.0%
Worst	72.0%	72.2%	72.5%	71.4%	71.4%

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Detailed information > Staff engagement – Ability to contribute to improvements

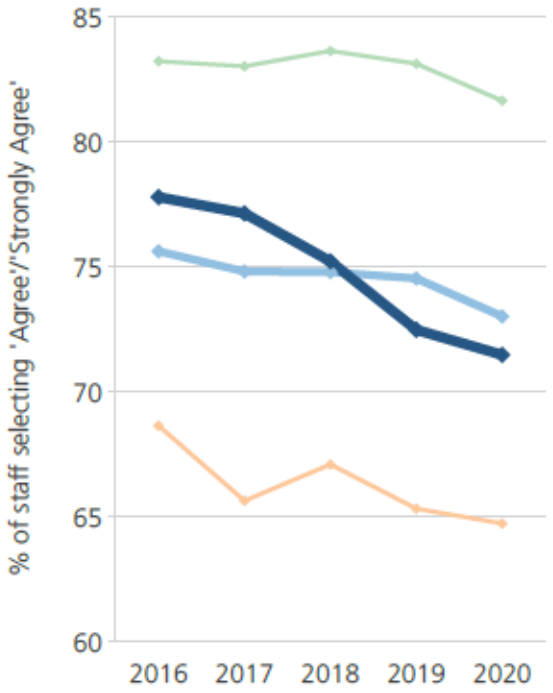
NHS England

Q4a
There are frequent opportunities for me to show initiative in my role



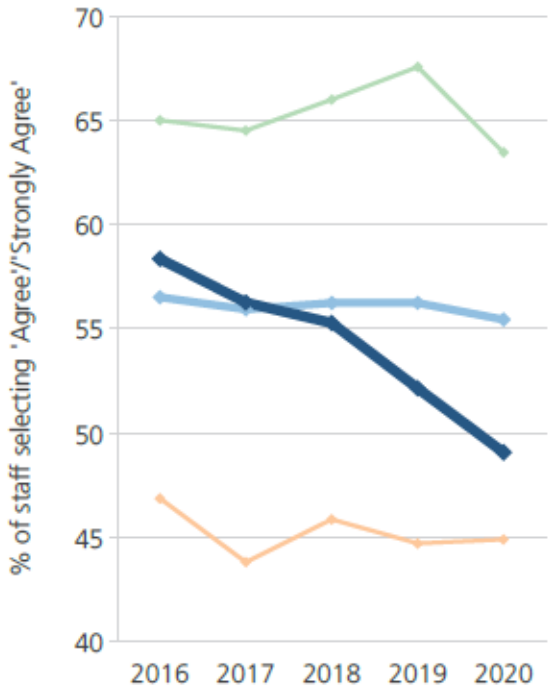
	2016	2017	2018	2019	2020
Best	80.5%	79.5%	80.1%	79.7%	78.1%
Your org	75.3%	74.4%	73.5%	71.0%	70.3%
Average	73.9%	73.3%	73.0%	73.0%	71.9%
Worst	67.2%	63.1%	62.9%	60.5%	64.5%

Q4b
I am able to make suggestions to improve the work of my team / department



	2016	2017	2018	2019	2020
Best	83.2%	83.0%	83.6%	83.1%	81.7%
Your org	77.8%	77.1%	75.2%	72.5%	71.5%
Average	75.6%	74.8%	74.8%	74.5%	73.0%
Worst	68.6%	65.6%	67.1%	65.3%	64.7%

Q4d
I am able to make improvements happen in my area of work



	2016	2017	2018	2019	2020
Best	65.0%	64.5%	66.0%	67.6%	63.5%
Your org	58.4%	56.3%	55.3%	52.1%	49.1%
Average	56.5%	55.9%	56.2%	56.2%	55.4%
Worst	46.8%	43.8%	45.8%	44.7%	44.9%

One Culture of care

2020 Staff Survey Results

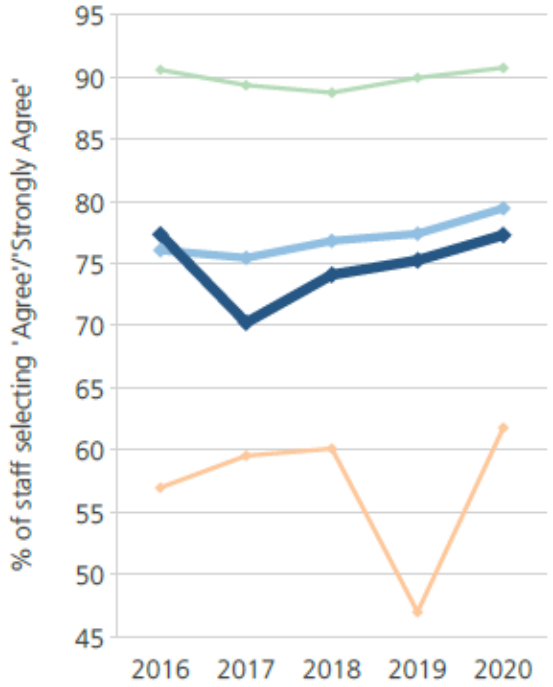
NHS Calderdale and Huddersfield NHS Foundation Trust

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Detailed information > Staff engagement – Recommendation of the organisation as a place to work/receive treatment

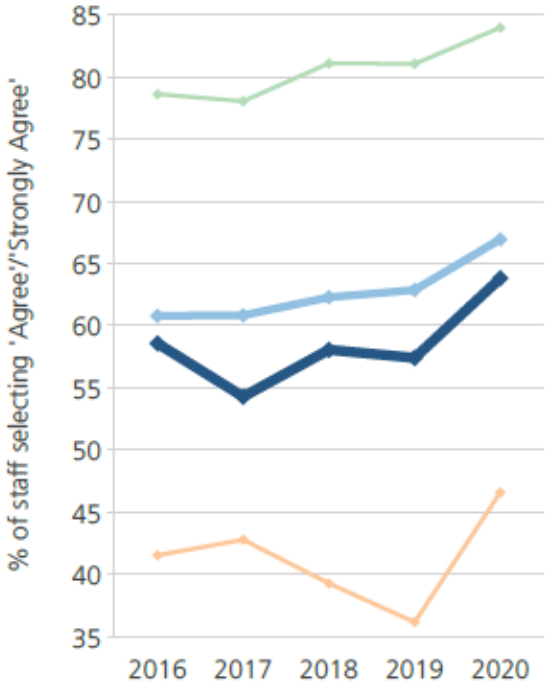
NHS England

Q18a
Care of patients / service users is my organisation's top priority



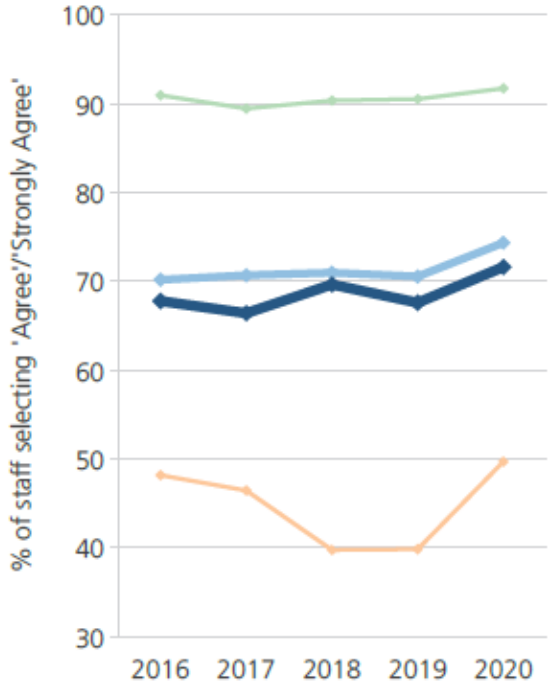
	2016	2017	2018	2019	2020
Best	90.6%	89.3%	88.7%	89.9%	90.7%
Your org	77.3%	70.2%	74.1%	75.3%	77.3%
Average	76.1%	75.5%	76.8%	77.4%	79.4%
Worst	57.0%	59.5%	60.1%	47.0%	61.8%

Q18c
I would recommend my organisation as a place to work



	2016	2017	2018	2019	2020
Best	78.6%	78.1%	81.1%	81.1%	84.0%
Your org	58.6%	54.3%	58.1%	57.4%	63.8%
Average	60.8%	60.8%	62.3%	62.9%	66.9%
Worst	41.5%	42.8%	39.3%	36.1%	46.6%

Q18d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation



	2016	2017	2018	2019	2020
Best	90.9%	89.4%	90.4%	90.5%	91.7%
Your org	67.8%	66.4%	69.6%	67.6%	71.6%
Average	70.2%	70.7%	71.0%	70.5%	74.3%
Worst	48.2%	46.4%	39.7%	39.8%	49.7%

Trust wide improvements between 2019 and 2020 (4% or more)

- Q11d have come to work in the last 12 months despite not feeling well enough reduced from 61% to 47%
- Q11a organisation takes positive action on health and wellbeing, 10% increase from 22% to 32%
- Q18c would recommend organisation as a place to work has improved from 57% to 64%
- Q4f have adequate equipment and materials to do my work has increased from 49% in to 58%
- Q4g there are enough staff for me to do my job properly increased from 28% to 34%
- Q7c able to provide the care I aspire to has increased from 63% to 68%
- Q18d if a friend/relative needed treatment would be happy with standard of care provided by organisation increased from 67% to 72%
- Q17c would feel confident that organisation would address concerns about unsafe clinical practice rose from 57% to 61%
- Q19c I am not looking to leave this organisation rose from 58% in 2019 to 62% in 2020

Areas where our scores have declined between 2019 and 2020 (4% or more)

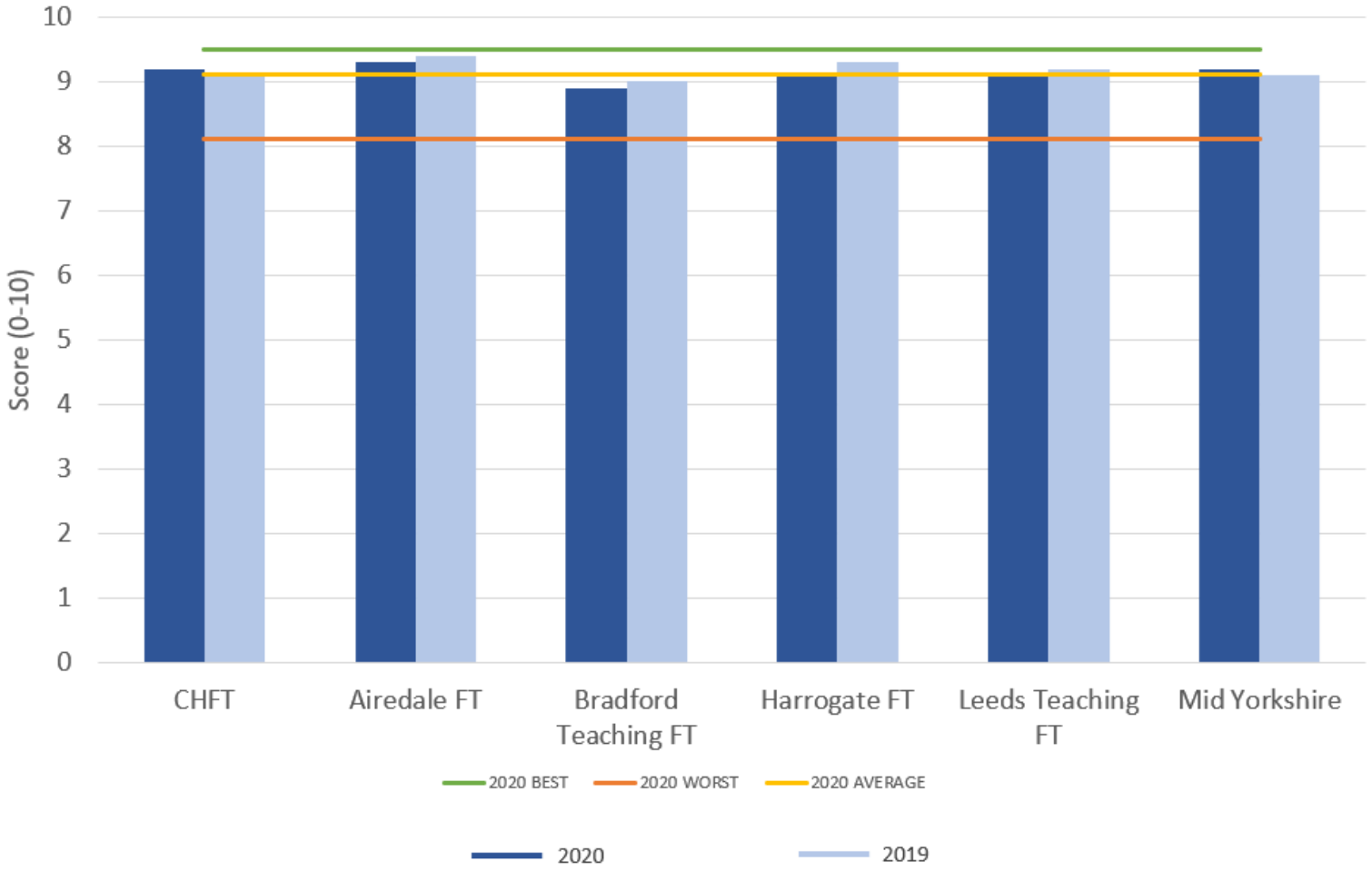
- Q2b always/often enthusiastic about my job has decreased from 75% to 71%
- Q4i team often meets to discuss teams effectiveness has decreased from 56% to 52%
- Q13d when last experienced harassment, bullying or abuse at work did you report it reduced from 47% to 43%
- Q4d able to make improvements happen in my area of work has decreased from 52% to 49%

What are our Governance arrangements to manage all this?

- Workforce Committee
- Performance Review Meetings
- Workforce and OD Monthly Workforce Monitoring Meeting
- Workforce Design Pilot Projects
- Wellbeing Guardian/Wellbeing Ambassadors
- Leadership Community
- Equality Groups

Our ED&I Position

Equality, Diversity and Inclusion



How are we aligning the workforce strategy, NHS People Plan and staff survey ?

Workforce Strategy	People Plan	Staff Survey
Inclusive Learning & Development offer for all	Looking after our people	Wellbeing
Inclusive Recruitment	Belonging in the NHS	Leadership Development
Widening Participation	New ways of working and delivering care	Development for all
Leadership Development (Phase 2)	Growing for the workforce	Inclusion
Workforce Design		Involvement – Team CHFT
Consolidate HWB Offer		

One Culture of care

Caring for each other the same way we care for our patients


Q
&
A

Keeping the Base Safe

14. Director of Infection Prevention Control (DIPC) Report

To Approve

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 6th May 2021
Meeting:	Board of Directors
Title:	Director of Infection Prevention Control (DIPC) Report
Author:	Jean Robinson, Matron Lead IPC Lindsay Rudge, Deputy Director of Nursing/ Assistant DIPC Anu Rajgopal, Infection Control Doctor
Sponsoring Director:	David Birkenhead, Medical Director
Previous Forums:	None

Purpose of the Report

To provide the Board a report on the position of Healthcare Associated Infections (HCAIs) in Q4 from 1st December 2020 to 31st March 2021.

Key Points to Note

- Trust Healthcare Associated Infections performance data and deteriorated position in relation to C. difficile
- Themes associated with Trust COVID outbreaks and response
- COVID Vaccination uptake
- COVID assurance audits

EQIA – Equality Impact Assessment

This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. It is noted that the impacts of COVID-19 may be greater in those with chronic conditions/disability, those from communities with high levels of deprivation or from certain ethnic groups. Such groups are also impacted by differential rates of COVID vaccine uptake.

Recommendation

The Board is asked to **NOTE** the performance against key Infection Prevention Control (IPC) targets and **APPROVE** the report.

Calderdale and Huddersfield NHS Foundation Trust

DIPC Report
1st December 2020 to 31st March 2021

1. Introduction

This report covers the period from 1st December 2020 – 31st March 2021. Calderdale and Huddersfield Foundation Trust recognises that effective infection prevention practice, underpinned by the implementation and audit of evidence-based policies, guidelines and education are fundamental to the reduction of risk and patient harm from Healthcare Associated Infections (HCAI). The report will provide assurance against key infection prevention and control performance and quality indicators. Please also see Appendix for Infographic IPC highlight report 2020/21.

2. Performance targets

Indicator	End of year ceiling 20/21	Year to date performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	1	1 post case. Post infection review completed, deemed as non-preventable.
C.difficile (trust assigned)	DoH directive not issued due to Pandemic – Trust advised to follow objective set for 2019/20. Which was **40**	49 in total:- 37 HOHA 12 COHA	37 HOHA = 12 preventable, 24 unpreventable and 1 pending 12 COHA = 4 preventable, 8 unpreventable
MSSA bacteraemia (post admission)	None set	16	
E.coli bacteraemia (post admission)	None set	29	
MRSA screening (electives)	95%	Not reported.	Data accuracy issues under review and re-aligning with ward moves and change in reporting from EPR links. This will hopefully be resolved by end of April 2021.
ANTT Competency assessments (doctors)	90%	69.28%	Divisions have been tasked to ensure medical staff to complete ANTT assessment.
ANTT Competency assessments (nursing and AHP)	90%	91.67%	
Hand hygiene	95%	99.4%	
Level 2 IPC training	90%	92%	This is now an e-learning package

3. Quality Indicators

Indicator	Year-end agreed target	YTD performance	Comments
MRSA screening (emergency)	95%	Not reported	Data accuracy issues under review and re-aligning with ward moves and change in reporting from EPR links. This will hopefully be resolved by end of April 2021.
Isolation breaches	**Non set**	Not recorded during this time scale	COVID-19 patients were given priority over side room isolation during this time frame.
Cleanliness	Non set	92.3%	

4. MRSA bacteraemia:

None to report during this period.

5. MSSA bacteraemia:

There have been 16 post-admission MSSA bacteraemia cases during 1st April 2020 to 31st March 2021, which is a 20% reduction (20 cases) compared to 2019/20. A review of cases has been undertaken and there is no common theme. The IPC team will continue to review cases monthly.

6. Clostridium difficile:

The trust has not been notified of its performance measure and awaits notification of the ceiling for cases in 2020/21. The current number of cases during 2020/21 is 49:- (37 HOHA and 12 COHA).
All cases are subject to an RCA investigation of which

- 16 have been deemed as preventable,
- 32 unpreventable
- 1 pending.

A focused deep-dive has been arranged for the end of April to identify key themes and reducing C-diff cases will form part of the IPC action plan for 2021/22.

7. E. coli bacteraemia:

There have been 29 post-admission *E. coli* bacteraemia cases since the 1st April 2020 to 31st March, which is similar to last year when we had 28 cases. A case note review has been undertaken with no common themes identified.

8. Outbreaks & Incidents:

COVID Outbreaks: - There have been 15 outbreaks 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.

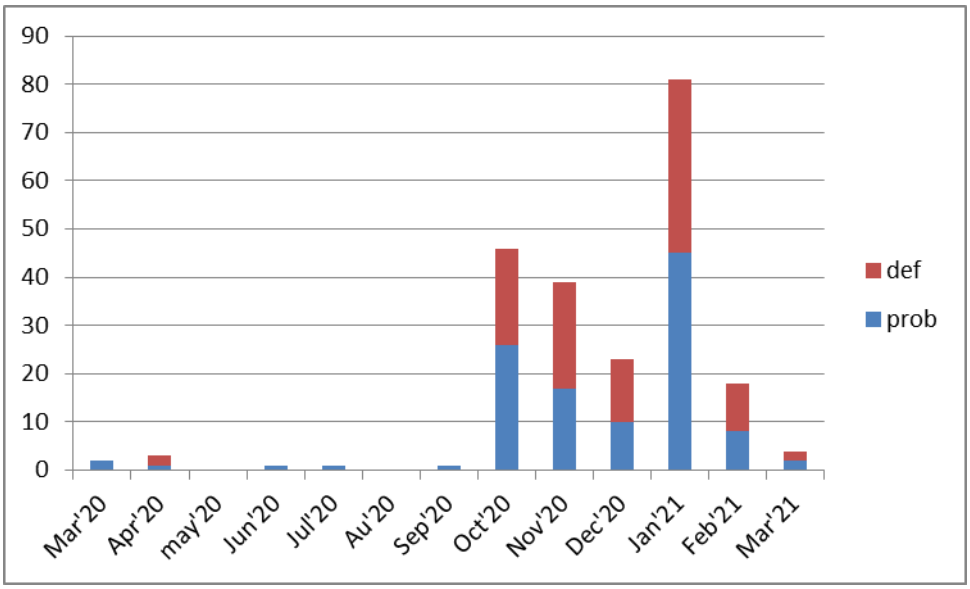
- Staff break and changing areas – social distancing not maintained, and area not always appropriately cleaned
- Mobile patients with cognitive impairment
- Multiple bed moves
- breaches in PPE
- Staff attending work with symptoms

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.

As we move through the recovery and reset stage of resuming services, IPC gold has been stood down to once a week and will continue to feed into the Trust COVID Recovery board. The IPC team is supporting all divisions with their recovery and reset plans whilst ensuring compliance with the national COVID IPC recommendations

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 datixed at CHFT. This quarter, 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.

GIRFT:- 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 Covid 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.

Communication: - has been key throughout the pandemic and IPC have been involved in the following: -

- IPC team established the Trust COVID intranet page for staff to access relevant IPC guidance and SOPs including PPE donning doffing videos and patient & 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.

Staff data: -

Staff Covid test and trace

From the onset of staff and household PCR check via the Occupational Health department, in April 2020 there have been 4607 calls followed up. From Jan 2021 to present 1244 PCR checks have been undertaken, of which 280 were positive Staff only results in the first 3 months of 2021 show a rapid decline in positive results as staff began to access vaccines from late December 2020 and second doses from March 2021

Jan 57 staff positive; Feb 25 staff positive; March 6 staff positive.

Lateral Flow testing recorded on intranet (KP+)

- Jan 8,078 (22 positive)

- Feb 5482 (8 positive)
- Mar 4954 (0 positive)

Vaccines

Covid vaccination uptake for CHFT staff is:

- 82% have received 1st dose vaccine
- 65.8% have had 2 doses of Covid vaccine

Flu vaccine uptake for winter 2020-21 was revised monthly but achieved around 80% frontline staff uptake

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

FFP3 FIT testing:-

Since the onset of the 2020 pandemic of Covid-19, there has been a fluidity of disposable masks supplied from the national stock and difficulties encountered with supply of reusable masks, filters, and 3M disposable masks. There is a National programme to build resilience in the supply chain and reduce reliance on 3M as a manufacturer. The 'ask' is that at least 4 mask types are in place to mitigate against unforeseen circumstances and for staff to be fit tested to at least 2 masks. Therefore, masks from the National programme catalogue have been trialled and adopted.

- **Fit testing:** To introduce new masks requires fit testing large numbers of staff. There are currently over 100 trained fit testers in clinical areas and 2 external fit testers supplied by NHSEI to help introduce these new masks. So far 272 staff have been fit tested to one of the new masks, but there is a long way to go until all staff have the option of one of the new masks. Divisions are asked to continue supporting their fit testers to progress this change and compliance is monitored via the monthly IPC performance board

- **Valves:** On the 21st January 2021, guidance was issued by the DoH including specific advice that valved respirators should not be worn by staff in sterile areas such as theatres/surgical settings/where undertaking sterile procedures such as line insertion, as the exhaled breath is unfiltered. This is not related to the spread of Covid-19, where the risk of the HCW transmitting COVID to the patient is extremely small, but the contamination of sterile sites with exhaled bacteria from the wearer/ condensate from the expiration valve. Our reusable masks have valves, as do our second and third choice disposable FFP3 masks. The solution needs to maintain both staff and patient safety. A paper has been approved by the IMT to mitigate risk.

9. Isolation Breaches

Isolation breaches since 1st April 2020 have not been reported

10. Audits:

COVID Assurance audits :-
Included in this is the following: -

- IPC BAF framework self assessment – currently being updated to include HSE and CQC recommendations.
- Daily must do compliance by ward managers
- Weekly leadership walkround every Wednesday
- Weekly IPC Covid 19 assurance – completed by the Matrons
- 2 weekly FLO audits
- Night matron's assurance audit to monitor compliance OOHs to IPC and social distancing recommendations
- 7 day on site Senior Leadership rota – weekend walkrounds

Quality Improvement Audits
The programme was put on hold during the reporting period, this has been reviewed and will recommence in May 2021.
Quality Priorities
Focussed Quality Priority Quarter 4 report - Reduce the spread of nosocomial infections
The IPC team have supported the implementation of 4 key areas identified which were;

- Consistent application of national IPC guidance and use the IPC Board Assurance Framework (BAF)
- Using PPE in line with the latest guidance from PHE
- Minimising potential COVID-19 Health Care Worker transmission through supporting staff
- Use of face masks in line with wider government guidance (staff, patients, visitors)

The Focussed Quality Priorities identified in 21/22 for reducing Hospital Acquired Infections including COVID 19

Our focus for this quality priority is to:

- Implement patient testing strategies aligned to national guidance.
- Support a system wide approach to the vaccination programme.
- Review and implement the CPE screening toolkit.
- Reduce the number of preventable Clostridium Difficile infections.
- Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection

FLO (Front Line Ownership) audits: These are carried out by clinical areas to confirm compliance with set elements of staff and patient safety indicators, teams identify where good practice and areas where standards need improving.

Quarterly FLO audits: These are completed by the IPCNs on acute areas, again these were put on hold during the reporting period, these will recommence in April and will be undertaken along the Matron and Senior nurse for the area.

11. Aseptic None Touch Technique (ANTT)

All staff who undertakes ANTT requires re-assessment every three years. This has had an initial impact on the ANTT performance matrix as staff ESR records automatically lapsed to RED if their previous assessment was more than 3 years ago (before 1st September 2016). The current Trust compliance is 88.14% with nursing colleagues at 91.67% and medical colleagues 69.28%. The infection control performance board is monitoring compliance closely and divisions have been asked for focus on improving compliance.

12. Level 2 IPC training

This is now a national e-learning module via ESR (the content of which is currently under review), compliance has increased over the last 12 months from 82% in 2019/20 to 92% in 20/21.Escalations through the IPC governance and IMT framework has been in place where training is below the trust target.

13. Recommendations

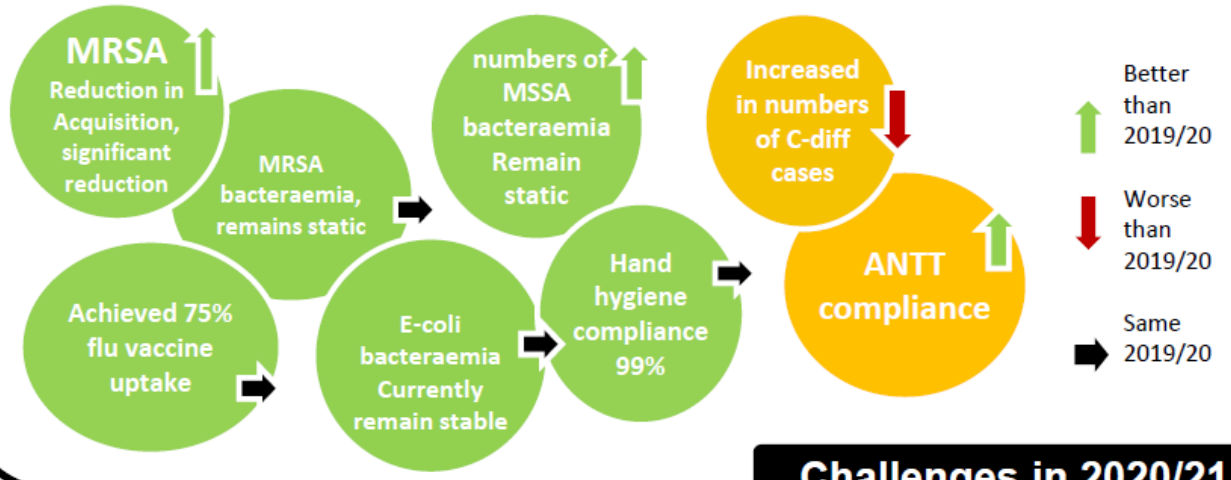
The Board is asked to note the performance against key Infection Prevention Control (IPC) targets and approve the report.

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



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

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

Data overview for 2020/21

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

15. Guardian of Safe Working Hours Q4 Annual Report

Presented by Anu Rajgopal, Guardian of Safe Working Hours

To Note

Date of Meeting:	Thursday 6 May 2021
Meeting:	Board of Directors
Title:	Quarter 4 report (Jan'21-March'21) from the Guardian of Safe Working Hours, CHFT
Author:	Anu Rajgopal, Guardian of Safe Working Hours
Sponsoring Director:	David Birkenhead, Medical Director
Previous Forums:	None

Purpose of the Report

In line with Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016, the purpose of this report is to provide an overview and assurance of the Trust's compliance with safe working hours for junior doctors and to highlight any areas of concern or commendation.

Key Points to Note

1. Increase in educational exception reports from foundation trainees
2. Improved engagement with trainees

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to **NOTE** and receive the report.

Q4 report: (1st January 2021 to 31st March 2021)

Guardian of safe working hours (GOSWH), CHFT

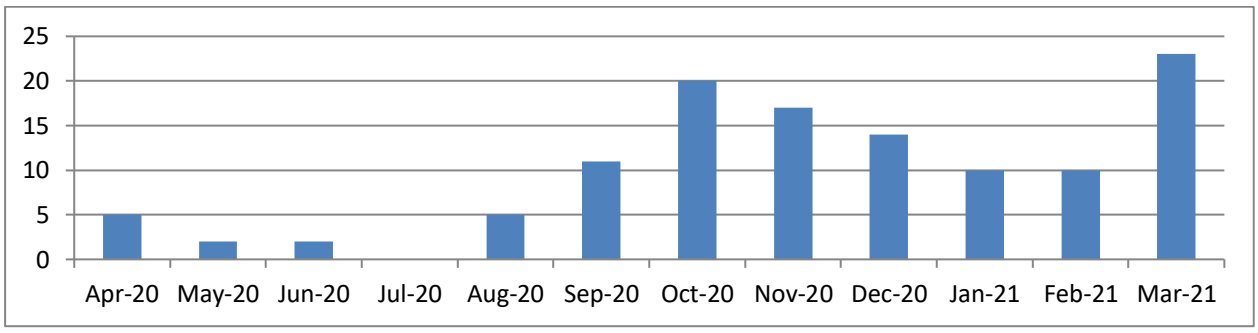
This paper will update the Trust board on issues relating to safe working hours of doctors in training and provide assurance that junior doctors at CHFT are safely rostered and enabled to work hours that are safe.

Executive summary

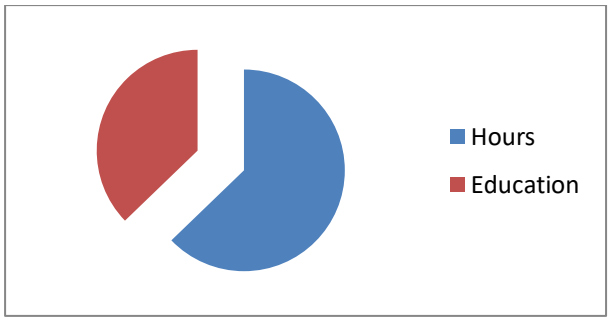
Majority of the overtime exception reports in the first part of Q4 were as a result of increased workload due to patient acuity and staff absences. However there has been a significant increase in the educational exception reports from foundation trainees reflecting the lack of access to self-development time (SDT).

There has been an improvement in trainee engagement within the Trust including with me as GOSWH.

a) Exception reports (ERs) per month (April'20-Mar'21)



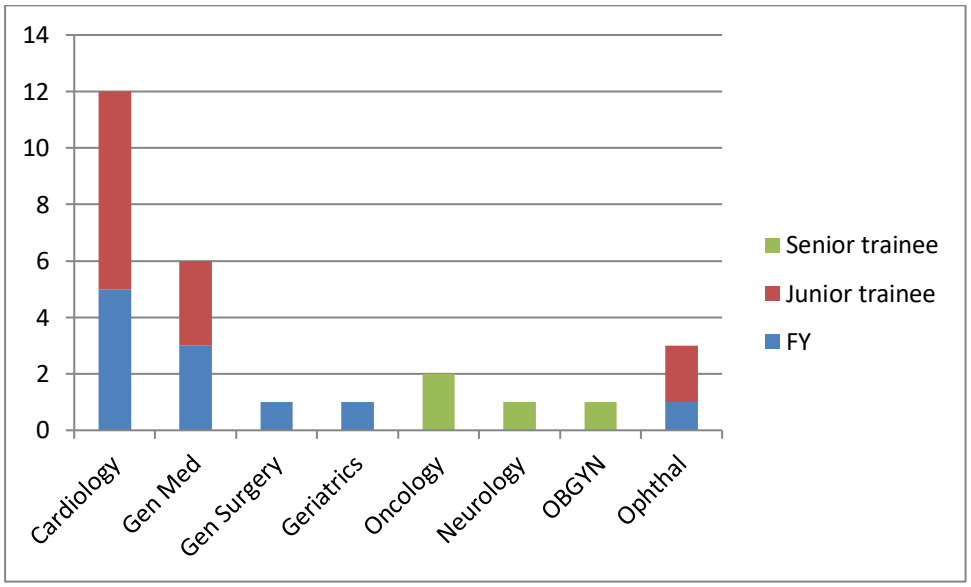
i. Type of ERs



There were 43 exception reports this quarter with more than half of these related to lack of access to SDT by foundation trainees from medicine and cardiology. SDT is designed to be non-clinical time within the foundation doctor's work schedule which is used for activities to support their career and personal development. This was introduced by the HEE foundation

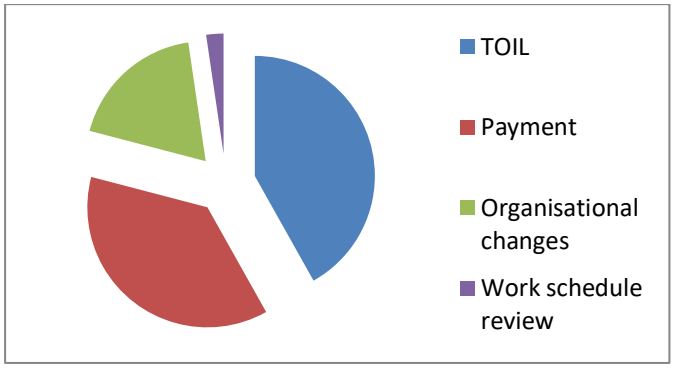
programme in September 2020 and the 2016 Terms and Conditions of Service for doctors in training states that SDT is now a contractual requirement for foundation trainees. It has been agreed nationally that missed SDT can be exception reported as missed educational opportunities. All Divisions, CDs, rota coordinators and trainees received the relevant information and the intention was that it be applied flexibly by the divisions. Surgical and A/E directorates have rostered SDT within the trainee rota, however other specialities have decided to give it flexibly. However, following concerns raised by trainees and the trend in exception reports, the SDT is now rostered for medical foundation trainees as well who have been encouraged to be proactive in taking it.

ii. ERs by grade & speciality



The ERs have been submitted from across the divisions with only one from general surgery. There is a slight trend in more submissions from junior trainees compared to foundation year doctors.

iii. Outcome of ERs



All reports have been completed. There remain some which are awaiting trainee agreement and medical HR continues to communicate with trainees to close the report when outcome is agreed.

Most ERs have resulted in time off in-lieu or payment. Those that have led to organisational changes have resulted in improved processes for trainee handover, early escalation from trainees for senior medical support in oncology, geriatrics, junior staffing levels in medical wards and a work schedule review for a senior trainee in neurology.

There has been only one work-schedule review requested for an FY1 in cardiology to roster in the SDT.

There have been no ERs with immediate safety concerns submitted this quarter.

b) **Rota changes, gaps and updates**

The most significant gaps remain on the paediatric, ED and OBGYN rotas. These gaps are covered by trust and speciality doctors, and some long-term bank staff and bank/agency locums.

In orthopaedics, ACPs have been pulled to assist with ICU and frailty from November'20 which leaves wards and on-calls covered by junior doctors only.

There are a few deanery gaps at registrar grade in surgical specialities covered by bank/agency locums.

The escalated junior doctor (JD) rota from November'20 was stood down in March'21 in response to declining COVID-19 activity in the Trust. There were a small number of trainees that joined a 'parallel rota' for short period of time in February when the numbers exceeded the previous peak numbers. This 12 person rota was populated by junior trainees who volunteered to support and were sourced by colleagues from trauma and orthopaedics, general surgery and urology, paediatrics, obstetrics and gynaecology, ENT and ophthalmology. Two weeks' notice was given as per the agreement with the LNC and BMA in January. The rota was only in place for several days and those that joined it mirrored the duties of the FY1 already on duty on the Acute Floor so that they had support and a 'buddy' to work alongside. The rota was stood down as soon as Covid numbers started to reduce as a result of national lockdown measures.

c) Trust and guardian engagement with trainees

This has significantly improved over the last two quarters with the increased use of Microsoft teams. There are monthly meetings with foundation trainees, workforce briefings with junior doctors, rota meetings, junior doctor's forum and ad hoc meeting with trainee representatives to escalate trainee concerns.

Trainee input into specific editorials in the CHFT weekly newsletter to share positive stories and experiences over the pandemic

Over February & March the workforce team organised specific on-line 'Time for you' well-being sessions for all staff, some of which were tailored specifically for medical staff and junior doctors.

Medical HR has also organised monthly meetings with GP training programme directors and the GOSWH to discuss any issues relevant to GP trainees.

I have supported the involvement of trainee representatives in the Trust social distancing & catering work-streams and in improving medical colleague engagement within the Trust.

Along with the Trust colleague engagement advisor, the medical education department and speciality specific college tutors, we are in the process of drafting a junior doctor bulletin with input from trainee representatives.

A couple of JD representatives raised issues to improve junior doctor working lives at CHFT to me directly. These included the trust shuttle bus timings, installation of phones in the doctor's offices, repair of PCs & improved changing room and locker facilities at CRH. This was discussed and supported at the Trust COVID-19 Incident management meeting. There has been progress with these issues and majority are resolved now.

d) Junior doctor forums

The forums in January and March were well represented. Main topics of discussion were:

- Concerns with foundation year trainee access to SDT in medicine –this has been further discussed with the medical division, FY supervisors & college tutors. It was agreed that SDT will be rostered in their work schedules and trainees are encouraged to be proactive in taking the time allocated.
- Delayed notice given for FY2 training days- This is a problem nationally and is being progressed by the Foundation year lead.
- Positive trainee feedback was received on improved engagement and trainee support when planning the stepdown rotas in February'21. A series of engagement sessions had been organised which were well attended. Medical HR had drafted a series of FAQs addressing common concerns and questions following input from trainee representatives. The trainee reps requested further medical HR sessions in specific speciality meetings (e.g. OBGYN)
- The Trust has received a one-off payment of £10k to be used for wellbeing initiatives for trainees. Suggestions have been invited from members of the JDF and the trainee via their JDF representatives to agree on how this should be spent.
- Trust-wide communication for the yearly junior doctor awards was sent out in March and nominations are open. The event will be held virtually in May'21.

Summary

This quarter has seen the step-down in early February'21 of the escalated trainee in response to declining COVID-19 hospital admissions. There was a positive response from junior doctor representatives regarding the support provided by the Trust during this period of rota change and the regular (sometimes twice daily) meetings for trainees to raise any immediate rota concerns. Trust engagement with junior doctors has significantly improved and the COVID Incident management team has supported me to be responsive in a timely manner to improve their working lives at CHFT.

In the early part of Q4, ERs submitted reflected the increased workload on our junior doctor workforce due to the higher acuity of patients and increased colleague absences. There was a significant trend of increasing ERs submitted by foundation trainees because of lack of access to SDT. This issue has been dealt with by the divisional teams and will be monitored and followed up in subsequent GOSWH reports.

Recommendation

The Trust Board is asked to note and receive the Guardian of Safe Working Hour's report.

Anu Rajgopal
Guardian of safe working hours, CHFT
April 2021

16. Health and Safety Policy and Update

To Approve

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 6 May 2021
Meeting:	Board of Directors
Title:	CHFT Health and Safety Policy
Author:	Richard Hill, Head of Health and Safety
Sponsoring Director:	Suzanne Dunkley, Director of Workforce and OD
Previous Forums:	Audit and Risk Committee 12 April 2021 Weekly Executive Board 22 April 2021

Purpose of the Report

The health and safety policy is the CHFT overarching health and safety policy which is underpinned by supporting safety related policies.

It is a legal requirement to have in place a written health and safety policy and for it to be communicated to all staff members.

Key Points to Note

1. Reference to the 5-year health and safety strategy 2020-2026 has been highlighted.
2. Reference has been added about the new health and safety management system for CHFT (NHS Workplace Health & Safety Standards).
3. Reference to the 4-pillars of care added and its link to safety wellbeing.
4. 'Statement of Intent' added, with a view to it being a stand-alone page, and shared across the Trust.
5. A health and safety update will come to the Board on 1 July 2021.

EQIA – Equality Impact Assessment

Shared previously and accepted by the BAME Network Group.

Recommendation

The Board is asked to **APPROVE** the updated Health and Safety Policy.

UNIQUE IDENTIFIER NO: G-129-2002
Review Date: April 2023
Review Lead: Head of Health and Safety

Calderdale and Huddersfield
NHS Foundation Trust

HEALTH AND SAFETY POLICY

Version 7

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

Document Summary Table		
Reference Number	G-129-2002	
Status	Approved	
Version	8	
Implementation Date	2002	
Current/Last Review Date	April 2021	
Next Formal Review	April 2023	
Sponsor	Director of Workforce and Organisational Development	
Author	Head of Health and Safety	
Where available	Intranet	
Target audience	All Staff	
Ratifying Committee		
Board of Directors		
Executive Board		22 April 2021
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Audit and Risk Committee	Non-Executive Director	12 April 2021
Health & Safety Committee	Director of Workforce and Organisational Development	February 2021

Does this document map to other Regulator requirements?	
Health and Safety at Work Act 1974 Management of Health & Safety at Work Regulations 1999. Health & Social Care Act – 2008 "Essential Standards of Quality & Care" Outcome 10 & 11	The Act and Regulations set the standards that must be met to ensure the health and safety of all employees and others who may be affected by any work activity. Safety and Suitability of Premises (10) Safety, Availability and Suitability of Equipment (11)

Document Version Control	
Version 7	Included reference to the CHFT 4 Pillars and articulated their relationship with health and safety within the Trust. Added a page 'statement of intent' which is to be signed by CEO and displayed as a 1-page across areas of the Trust. This is standard best practice across all other organisations to have a 'statement of intent'. Added a reference to CHFT 5 year health and safety strategy 2021-2026. Added reference to CHFT's adopting a new health and safety management system titled 'NHS Workplace Health and Safety Standards'.

Version 6	Removal of list of principles in INDG 417 from part 2 as these are already detailed in the health and safety statement, already contained in this policy. Removal of reference to the 'strategic health and safety committee' as this no longer meets. Changes to information provided about individual responsibilities including: • General duties for Directors, other than for those with specific health and safety duties. • Reduction of duplication in duties to one category 'All Managers". Reduction in detail about specific hazards. Reference is instead made to hazard-specific Trust policies that already exist.
Version 5	This policy has been updated to reflect the health and safety roles and responsibilities and incorporate general arrangements. Risk scoring matrices have been updated in line with risk management policy.
Version 4	The policy is a statement of intent which identifies strong and active leadership from the Board of Directors. The policy is part 1 of the Trust's health and safety management system. Part 2 "Organisation and Responsibilities" and Part 3 "General Arrangements for Health and Safety" provides the detailed framework.

Contents

Definitions

Term	Definition
Accident	An undesired circumstance leading to ill health or injury, damage to property, plant, products or environment, increased liabilities
CHFT	Calderdale and Huddersfield NHS Foundation Trust
CHS Ltd	Calderdale and Huddersfield Solutions Ltd
Danger	Exposure to Harm
Dangerous Occurrence	A “near miss” that could have led to serious injury or loss of life and is reportable to the enforcing authorities.
Environmental Protection	Arrangement to protect the environment from the effects of workplace activities
Hazard	The potential of a substance, activity or process to cause harm
Health	The protection of the bodies and minds of people from illness
Health Surveillance	Monitoring of employee’s health to detect signs or symptoms of work-related ill health so that steps can be taken to eliminate or reduce the probability of further harm
Ill Health	Acute/chronic ill health caused by physical, chemical or biological agents as well as adverse effects on mental health
Incident	Undesired circumstances and near misses which have the potential to cause harm
Near Miss	An incident that could have caused harm, injury
Occupational Ill Health	Illness or physical and mental disorders caused or triggered by workplace activities
Policy	Intentions, approach and objectives of an organisation
Risk	Definitions relating to risk as the likelihood of harm occurring, categorised in several ways • Acceptable Risk • Residual Risk • Risk • Risk Acceptance • Risk Analysis • Risk Assessment • Risk Avoidance • Risk Control • Risk Evaluation • Risk Identification • Risk Management • Risk Reduction • Risk Transfer • Risk Treatment • System Failure
Safety	The protection of people from injury
Suitable and Sufficient	A set of criteria that has to be met to fulfil a duty
Welfare	The provision of facilities to maintain the health and wellbeing of individuals

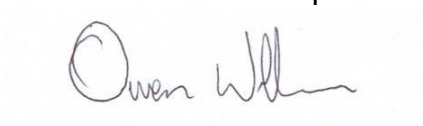
1. Statement of Intent

This policy is intended for use across Calderdale and Huddersfield NHS Foundation Trust (CHFT), where responsibilities state all staff, managers, senior managers and directors.

The Calderdale and Huddersfield NHS Foundation Trust (CHFT) policy has been developed in accordance with the Health and Safety at Work Act 1974 (HASAWA) which requires employers to ensure, as far as is reasonably practicable, the health and safety of their employees and others who may be affected by their work activity.

Health and safety is the responsibility of staff at all levels of the Trust and a culture of safety is important to minimise human costs with regards to injury, pain and incapacity for our staff, patients, contractors and visitors. Our policy aims to:

- Recognise health and safety accountability from the Chief Executive and the Board and all the responsibilities for management and staff groups
- Ensure that information, instruction, training and supervision is provided to all staff members
- Ensure that the health and safety policies, are developed, implemented and maintained
- Reduce the risk of injury, near misses or ill-health so far as is reasonably practicable
- To promote good health and safety standards across the Trust
- Ensure that staff are appropriately consulted on matters affecting their health and safety
- Ensure the provision of personal protective equipment which continues to be issued free of charge to staff members that require it
- Provide safe equipment for staff members to use
- To ensure competent advice is provided to all staff members



…… ……

Owen Williams Dated
Chief Executive for and on behalf of the Trust Board

2. Purpose

The purpose of this policy is to provide assurance that the Trust is meeting the requirements of the Health and Safety at Work Act etc 1974 and the Trust recognises this responsibility as the employer under the Act. The content of this policy gives the responsibilities of the employer and the employees in ensuring that a health and safety culture is developed and meets the requirements of the Health and Safety at Work Act 1974 and subordinate health and safety legislation.

The target audience for this policy is all staff, visitors, contractors and patients as all staff are required to work within this policy by ensuring risk is reduced so far as is reasonably practicable.

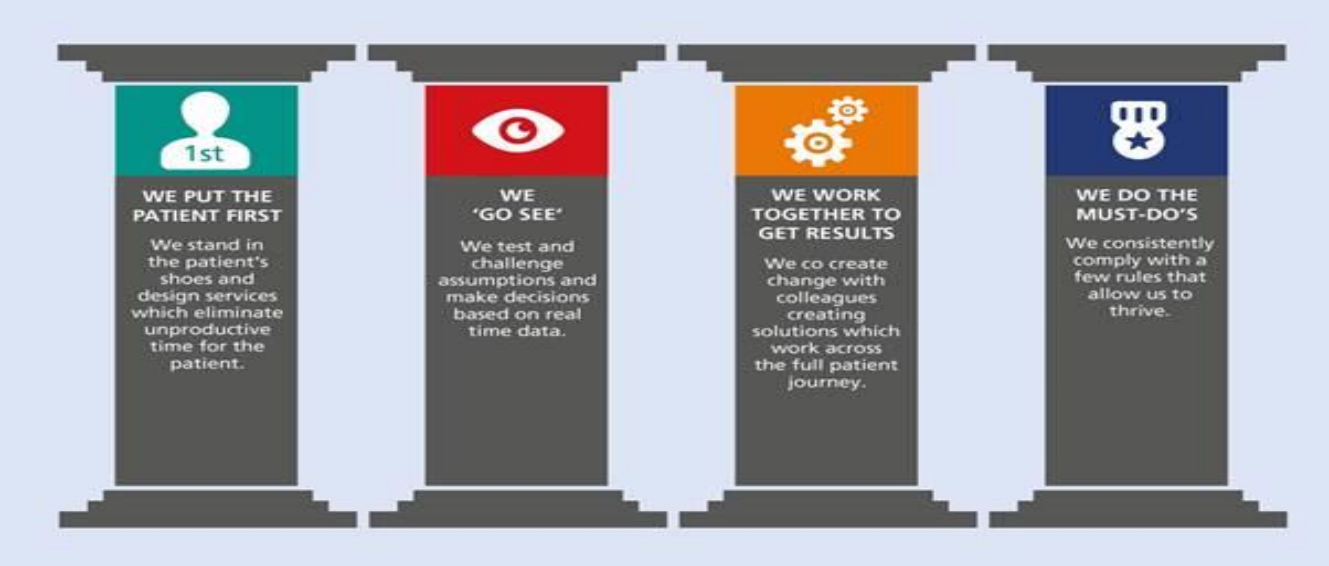
Good health and safety benefits individuals and the Trust by:

- Protecting staff, visitors, contractors and patients from injury or illness
- Ensuring that risk is continually being monitored to keep the base safe, minimise personal injury, financial losses, claims and to learn from incidents and risks to prevent reoccurrences.
- Promoting a positive health and safety culture towards staff members.
- Ensuring that risk assessments are in place for the identification of hazards and the allocation of resources to control them.
- Ensuring that there is an escalation and cascading processes in place to ensure the effective communication to all levels.
- Ensuring compliance with this policy and other health and safety related policies and evidencing these when needed.

3. Principles of Health and Safety

CHFT aims to fulfil required statutory obligations as laid out in the Health and Safety at Work Act 1974 (H&SAWA) and the Health and Social Care Act 2008 and related legislation and guidance. The Trust is committed to ensuring the health, safety and welfare of patients, staff, contractors and visitors who may be affected by our activities. A key component of our vision is about “keeping the base safe”.

CHFT's 4 key principles to deliver the vision are:



CHFT is obligated to comply with the Health and Safety at Work Act etc 1974 and associated regulations. Failure to do so may lead to prosecutions, higher risk of injuries and sickness. The Trust will adhere to this health and safety legislation by:

- Provision of adequate and appropriate resources to review and implement this policy, including the updating of roles and responsibilities for all staff levels and specialist roles
- Ensuring that health and safety policies are in place so any hazards arising from work activities are identified and that appropriate risk assessments and reporting of incidents take place to a) keep the workforce safe, and b) to ensure that incidents are appropriately monitored and investigated and lessons are learned to prevent recurrence
- Ensuring that the Health and Safety Committee meeting arrangements are in place
- Maintaining safe working conditions (including the provision of adequate welfare facilities and PPE)
- Provision of suitable and sufficient information, instruction, training and supervision to ensure all employees are competent to carry out their roles, safely
- To seek assurance of compliance from work being carried out by Calderdale and Huddersfield Solutions Ltd, ISS and Engie
- Continuing to embed standards that allows adequate control measures which will be supported by the development and implementation of the NHS Workplace Health and Safety Standards
- Recognise the Trust 'One Culture of Care' ethos "Look after colleagues to look after patients" - acknowledging that people are a key resource to the Trust and act to promote the general health, safety and wellbeing of its staff

4. Trust Health and Safety Structural Duties

4.1 Board of Directors

The Board of Directors is responsible for leadership of health and safety. Failure to include health and safety as a key business risk in board decisions can have catastrophic results to individual life, financial and reputational consequences.

4.2 Audit and Risk Committee

The Audit and Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities.

This Committee reviews processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other board committees in relation to the Trust's overall internal control and risk management position and ensures compliance of the adequacy of policies with regards to relevant regulatory, legal and conduct requirements

4.3 CHFT Health and Safety Committee

The Health and Safety Committee is a meeting that promotes co-operation between employers and employees in instigating, developing and carrying out measures to ensure the health, safety and welfare at work of the employees. It provides evidence of communication held between recognised trade unions and the organisation and is a formal group by which it assures the Trust in areas of compliance with their responsibilities.

The Committee supports delivery of CHFT's 5-year health and safety strategy by providing assurance that health and safety arrangements are in place to meet statutory obligations of a functioning Health and Safety Committee. It is a sub-group to the CHFT Audit and Risk Committee who in turn reports to the Board and the Health and Safety Committee is chaired by the Executive Director of Workforce and Organisational Development, who champions health and safety on behalf of the Board.

This Committee meets bi-monthly and reports into the Audit and Risk Committee. Its main functions are to:

- Support the Audit and Risk Committee in providing health and safety assurance to the Board

- Oversee implementation of the Health and Safety Policy and reviewing, monitoring and making recommendations with regards to health and safety related policies. Monitoring of the health and safety policies is a standing agenda item to ensure that these are current, reviewed and approved in a timely manner

- Provide a forum for discussion of health and safety risks to staff and those accessing Trust services or working on behalf of the Trust

- Challenging processes and escalating risks to the Audit and Risk Committee as required

- Monitor health and safety activity within the Trust by receiving minutes from the Calderdale and Huddersfield Solutions Ltd health and safety committee meetings and health and safety subgroups

5. General Roles and Responsibilities

5.1 Chief Executive

The Chief Executive has overall accountability for health and safety in the Trust. The Chief Executive will ensure the following:

- That the Trust complies with all relevant health and safety legislation
- That the 5-year health and safety strategy is created, implemented and maintained
- Ensure that adequate resources, including competent health and safety advice is available to allow the Trust to comply with this policy and its legislative requirements
- Ensure that correct governance is in place to provide the Board of Directors with the assurance that health and safety risk are appropriately assessed and controlled
- Support the promotion of a positive health and safety culture

5.2 Trust Directors

Trust Directors are responsible for allocating roles and responsibilities for health and safety to embed a positive health and safety culture. These responsibilities include:

- Interpreting the Health and Safety policy and cascade responsibilities within their sphere of operations to teams working within their remit
- Ensuring that staff are competent to carry out their role and receive the appropriate resources, information, instruction, training and supervision required to enable them to work safety and manage/reduce the level of risk in work areas
- Escalating the need for the availability of sufficient resources for anything that is deemed necessary and appropriate under legislation to reduce the level of risk in their area
- Provision of training and distribution of personal protective equipment as per legislative compliance
- Ensuring that health and safety policies are implemented in their Directorate and that these are communicated to staff to ensure health and safety compliance. There are risk assessments in place to ensure that hazards are identified, and adequate controls are put in place
- Ensuring staff are aware of the need to report incidents and near misses

- Ensuring that suitable investigations of incidents takes place and that these are recorded on the Datix incident reporting system
- Providing timely feedback to staff, within their remit, regarding health and safety risks, incidents, controls and mitigating actions
- Ensuring health and safety information is effectively communicated to all staff and they are consulted regarding proposed changes that might affect their health and safety
- Exercising collaborated working with Calderdale and Huddersfield Solutions Ltd with regards to relevant health and safety matters
- Alerting the Head of Health and Safety Manager of any health and safety issues as required

5.3 Non-Executive Director / Health and Safety Champion

The Trust has appointed a Non-Executive Director as its health and safety champion and non-executive scrutineer. They are accountable for, so far as it is within their control:

- Raising the profile of health and safety at Board level by ensuring that health and safety is considered during corporate debate and the decision-making process
- Raising matters pertaining to health and safety at board level that have been escalated or from other sources

5.4 Executive Director, Workforce & Organisational Development

The Director of Workforce and Organisational Development is the Champion for Health and Safety for the Trust. This role has the same health and safety responsibilities as all other Trust Directors with the additional responsibility for escalating health and safety issues to the Board of Directors. The Executive Director will:

- Chair the Trust's Health and Safety Committee
- Champion health and safety within the Trust
- Ensure that professional health and safety advice is available for the Trust
- Provide an occupational health service for all staff

5.5 Head of Health and Safety

The Head of Health and Safety CHFT will have strategic responsibilities for and safety within CHFT and provide guidance and advice, as the competent person. This role will:

- Manage and monitor health and safety compliance in line with this policy, and the health and safety 5-year strategy
- Be responsible for collaborating risk identification and mitigation for health and safety, compliance using relevant legislation
- Provide direction on health and safety compliance with regards to activity within the Trust and associated activities undertaken by Trust staff members

- Act as the main contact and co-ordinator for health and safety related visits and inspections conducted by regulatory bodies ensuring that comprehensive documentary evidence is available
- Continue to develop, and to provide continues assurance to the Trust in relation to health and safety compliance, including the Health and Safety 5-year strategy
- To monitor the results of audits and inspections carried out across the Trust
- Report on staff incidents via quarterly reports to identify trends and to report into the Trust Health and Safety Committee.
- To work collaboratively with our service providers, and Calderdale and Huddersfield Solutions Ltd on relevant matters.

5.6 Directors of Operations/General Managers

Directors of Operations/General Managers are accountable for ensuring that this policy is adhered to, safeguard the safety of staff, and others affected by the work of their departments. These responsibilities include:

- To interpret the Health and Safety Policy, and associated health and safety policies
- Ensuring that staff are aware of the health and safety policies, and that there is a communication process in place to make sure information is accessible and available to all staff
- Ensuring that staff are competent to carry out their role and receive the appropriate resources, information, instruction, training and supervision required to enable them to work safety and manage/reduce the level of risk in work areas
- Escalate the need for the availability of sufficient resources for anything that is deemed necessary and appropriate under legislation to reduce the level of risk in their area
- Distribution of personal protective equipment as identified or as per legislative compliance
- Ensuring there are controls put in place to control the risks in their area(s) of responsibility
- Staff are aware of the need to report incidents and near misses in line the incident reporting process. Ensuring that suitable investigations of incidents takes place and that these are recorded on the Datix incident reporting system
- They provide feedback to staff, regarding incidents, and mitigating actions by representing at the Trust Health and Safety Committee
- Ensuring that health and safety information is effectively communicated to all staff and they are consulted regarding proposed changes that might affect their health and safety
- Exercise collaborated working with Calderdale and Huddersfield Solutions Ltd on health and safety matters
- Alert the Head of Health and Safety Manager of any health and safety issues as required

5.7 All Managers

Managers are responsible for ensuring that policies, processes, legislative requirements and health and safety compliance is cascaded down to staff. These responsibilities include:

- Interpreting the Health and Safety Policy and the cascading of responsibilities within their sphere of operations to teams working within their remit
- Ensuring that staff are competent to carry out their role safely and receive the appropriate resources, information, instruction, training and supervision
- Ensuring that all staff are aware of the health and safety policies, and that there is a communication process in place to make sure information is accessible and available to all staff
- Maintaining staff competencies by monitoring attendance at relevant training
- Ensuring that relevant risk assessments risks are carried out
- Escalating the need for the availability of sufficient resources for anything that is deemed necessary and appropriate under legislation to reduce the level of risk
- Provision and distribution of relevant personal protective equipment
- Ensure the reporting and replacement of defective equipment
- Ensuring that health and safety information is communicated to all staff and they are consulted regarding proposed changes that might affect their health and safety
- Ensuring that staff are aware of the need to report incidents and near misses Ensuring that suitable investigations of incidents takes place and that these are recorded on the Datix incident reporting system
- Provision of timely feedback to staff, regarding, incidents, and mitigating actions
- Collaborate with the carrying out of workplace inspections and audits to ensure that the base remains safe
- Exercise collaborated working with Calderdale and Huddersfield Solutions with regards to health and safety matters
- Alert the Head of Health and Safety Manager of any health and safety issues as required

5.8 All Trust Staff

All Trust Staff are responsible for complying with policies, and any other health and safety compliance as cascaded down by managers. These responsibilities include:

- Work in accordance with the Trust Health and Safety Policy and associated health and safety policies to take care of themselves and others who may be affected by his / her actions
- Maintaining staff health and safety competencies by attending relevant training
- Use personal protective equipment provided as determined by risk assessment. Report defects and failures to managers for remedial action/further escalation
- Reporting all incidents, accidents and near misses to their manager
- Alert managers of any health and safety issues as identified

6. Specialist CHFT Health and Safety Responsibilities

The following post-holders have additional health and safety duties above the standard outlined responsibilities previously covered.

6.1 Senior Risk Manager

The Senior Risk Manager role holder is responsible for ensuring that systems are in place to:

- Provide expertise in clinical and corporate governance, risk management and assurance
- Manage the Datix incident reporting system
- Maintain oversight of the Trust's risk register processes, and serious incident investigations

6.2 Trust Resilience & Security Management Specialist

Trust Resilience & Security Management Specialist is appointed to provide advice on security and violence and aggression issues. These include:

- Advice and support for staff on security matters
- Support and keep updated any staff involved in a prosecution
- Where necessary assist with measures to have people excluded from the Trust
- Be involved in serious violence and aggression/security related incident investigations and organise post-accident incident reviews
- Ensure that all physical assaults are reported to the NHS protect and liaise with risk management and health and safety for possible reporting of assaults to the Health and Safety Executive, in compliance with RIDDOR regulations as required

6.3 Fire Officer

The Fire Officer is responsible for the provision of fire safety advice to the Trust Divisions and Subsidiary organisation, CHS.

6.4 Moving and Handling Advisor

The Moving and Handling Advisor is responsible for:

- Developing and updating the Trust's Moving and Handling Policy
- Developing, designing, delivering and evaluating appropriate training programmes based on evidence, best practice and statutory requirements
- Providing information to Divisions on training activity at a minimum annually
- Providing assessment and problem-solving advice for staff from wards, departments and community bases, where specialist knowledge and skills are required for patient and object handling

- Assisting managers in the investigation of significant moving and handling incidents and injuries

6.5 Health and Safety Representatives

The Trust recognises a number of trade unions and involves them in collective bargaining and the consultation process with regard to health and safety matters as required under the Safety Representatives and Safety Committees Regulations 1977 (as amended). Trade Union staff are represented on the Trust's Health and Safety Committee.

6.6 Communications Manager

The CHFT Communications Team is responsible for managing all contacts with the media regarding health and safety issues.

6.7 Other Specialist Advisors

CHFT has access to other health and safety advisors including:

- Infection Prevention and Control Leads
- Radiation Protection Officer
- Medical Gases Leads
- Control of Substances Hazardous to Health Leads

6.8 Partnership Companies

Roles and responsibilities for partnership companies, Engie and ISS are documented in the Health and Safety Policies of these organisations.

6.9 Subsidiary Company

Calderdale and Huddersfield Solutions Ltd (CHS) provide soft and hard services for the wider Trust and has in place its own health and safety policies. (CHS) ensures that its services are in compliance with health and safety requirements, having its own policies and procedures in place to help reduce the risk of injury to CHFT staff members, visitors and patients.

7. Trust Equalities Statement

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

8. Consultation & Approval

8.1 Consultation

This policy has been developed and reviewed by the Head of Health, CHFT Health and Safety Committee and the Risk and Audit Committee. This policy is reviewed every 2 years.

8.2 Approval

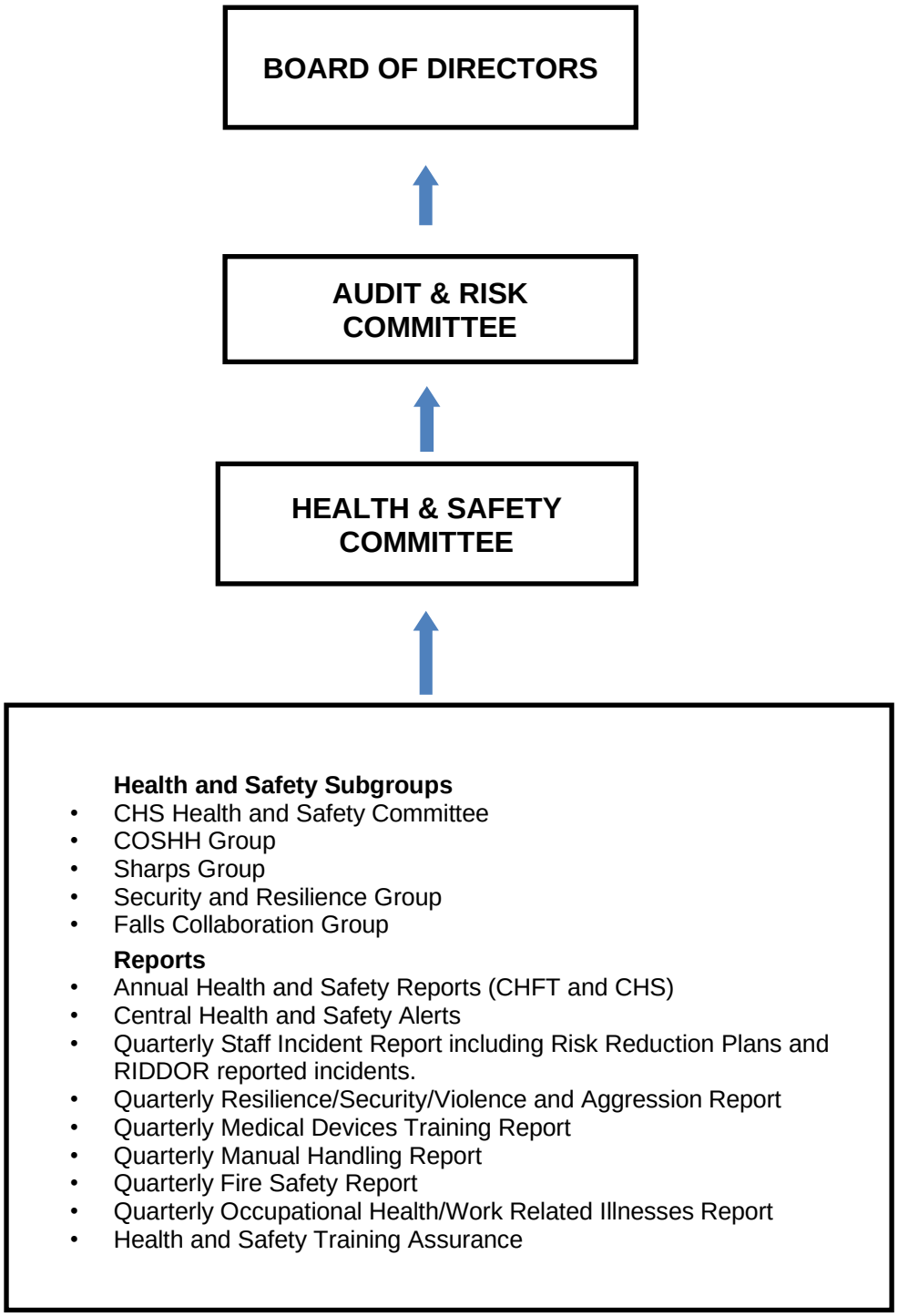
This policy has been approved by the CHFT Health and Safety Committee and ratified by the Audit and Risk Committee.

8.3 Monitoring and Auditing

Health and safety checks are included in regular external inspections, including those carried out by the Care Quality Commission (CQC) and the Health and Safety Executive. Written reports and action plans are provided to the relevant areas with corrective action progress monitored.

APPENDIX 1

HEALTH AND SAFETY REPORTING GOVERNANCE FRAMEWORK



17. Quality Report

To Note

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 6 May 2021
Meeting:	Board of Directors
Title:	Trust Quality Report (Reporting period February 2021 to March 2021)
Author:	Doriann Bailey, Assistant Director of Patient Safety
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Quality Committee - April 2021

Purpose of the Report

The purpose of this report is to provide the Trust with ongoing oversight of the current quality issues.

It is to provide the Board of Directors is with a level of assurance around key quality and patient experience outcomes and confirmation that during the ongoing response to the COVID-19 pandemic as we move into recovery, the processes and systems within the Trust to ensure oversight and scrutiny to quality and safety.

To highlight the refreshed Focussed Quality Priorities and Quality Account Priorities for 2021/22.

Key Points to Note

The Quality Report aims to provide further detail on areas of key focus and complements the Integrated Performance Report.

Care Quality Commission (CQC):

- The Trust has maintained is engagement meetings with the regulator. The trust. presented a COVID-19 Maternity service update to CQC in line with the current CQC Transitional Monitoring Approach (TMA) and subsequent maternity focused Key Lines of Enquiry (KLOEs).

- The Trust facilitated a CQC TMA review for the Johns Smiths Stadium (JSS) Vaccination Centre, again this was in line with CQCs TMA approach to regulation and vaccination hub KLOEs.

Substantial assurance has been provided to CQC for the above.

- The Trust has three actions to complete from the 2018 CQC inspection which are currently rated green provided substantial assurance:
- MD1 - The trust must improve its financial performance to ensure services are sustainable in the future
- The trust should develop processes to measure the outcomes of mental health patients

in order to identify opportunities to improve care
- SD9 - The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.

Central Alert Systems
- CHFT is showing an improved position for the Central Alert System (CAS) indicators.

Experience, Participation, Equalities
- To note the progress, update the programme project

Complaints and PAL
- To note the performance.

Incidents
- To note the decline of incidents resulting in severe harm or death due to the reduction in the number of HOCI incidents and reduction in the number of overdue actions.

Sepsis
- To note the work on Sepsis to continues as a Quality Account Priority with reporting into Trust Board quality report bi-monthly.

Pressure Ulcers
- To note the work on Pressures Ulcers to continues as a Focussed Quality Priority with reporting into Trust Board quality report bi-monthly.

Nutrition and hydration
- To note the work on Nutrition and Hydration to continues as a Focussed Quality Priority with reporting into Trust Board quality report bi-monthly.

Venous Thromboembolism (VTE)
- The Trust has met the target for this indicator, the achievement of the >95% target of patients being risk assessed for developing a VTE, the audit findings and action plan.

Maternity
- To note the proposal for Local Perinatal Quality Surveillance Meeting

Quality Priorities
To note the introduction of the Quality Account Priorities and the Focussed Quality Priorities for 2021/22
Quality Account priorities
- Recognition and timely treatment of Sepsis
- Reduce number of Hospital Acquired Infections including Covid 19
- Reduce waiting times for individuals attending the ED

Focussed Quality Priorities
- Falls resulting in harm
- End of Life
- Clinical documentation
- Clinical Prioritisation
- Nutrition and Hydration
- Pressure Ulcers
- Making Complaints Count

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 of Directors is asked to **NOTE** the content of the report and the ongoing activities across the Trust to improve the quality and safety of patient care.

Contents

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 of Directors 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.

The report includes the new Quality Account Priorities and the Focussed Quality Account Priorities for 2021/22.

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 placed upon the Trust in the face of the COVID -19 Pandemic and acknowledges the hard work from all staff as we seek to keep all our patients safe and continue to provide high levels of care. 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.

This report provides an update on assurances against several quality measures for the last quarter and the plans for the new financial year 2021/22.

CHFT Care Quality Commission (CQC) Workstreams

During February 2021 and March 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.

The meeting also focused on COVID-19 operational updates for both Acute and Community services. CQC expressed no concerns and were assured with all updates received.

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

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

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

Compliance	Current Position	Plan for Q1	Assurance
	The Trust's submitted draft financial plan for 20/21 was in line with the required five-year Financial Improvement Trajectory, this plan was overridden subsequently due to Covid-19. The Month 5 reported position was break-even, based upon the temporary financial regime in	This action is a long-term action which continues to progress a further update is scheduled to be received at the April 2021 CQC & Compliance	**Substantial Assurance**

	place to support Covid pressures. Very long-term strategic recommendation, the plans linked to this were around reconfiguration. We continue to progress but due to current environment we are breaking even on a month on month basis to support Covid activity. Planning for the next financial year is taking place.	Group.	
SD3 - The trust should develop processes to measure the outcomes of mental health patients in order to identify opportunities to improve care	Substantial work has been undertaken to meet this recommendation including: - a strategy document - operational policy guidance document - ED process improvement for signposting - Recommissioned CAMHS pathway including OOH - risk assessment tool now piloted in CRH acute floor ready for roll out - development of a pilot of a dashboard in the MH operational group - revised the MCA training - strengthened the process and training around receipt and scrutiny papers - Reviewed our SLA with the SWYPT - MHLT - met with CCG colleagues to align our system approach which will need a refresh - been part to the SRG work stream for MH which measured system outcomes so we can update this into the evidence	All work to be sign off at the Mental Health Operational Group in April 21 and to be presented back at the CQC & Compliance Group in May 21 with aim to close.	**Substantial Assurance**
SD6 - The trust should continue to strengthen staff knowledge and training in relation to mental capacity act and deprivation of liberty safeguards.	This action was closed in December 2020. But as this action relates directly to ED it was requested by the Chair of the CQC Response Group in January 2021 that a snapshot audit of MCA training and testing be presenting at the March 2021 group. This will ensure there is a suite of evidence available to support the decision to close. A periodic snapshot audit took place with good outcomes.	To be agreed at the April 21 CQC and Compliance group that no further action is required by the group and that ongoing period snapshot audits will be undertaken by ED to provide assurance re compliance.	**CLOSED**
SD9 - The Trust should ensure they work to meet the Royal College of Emergency Medicine recommendations of 16 hours consultant presence in the department.	Continuous work has been undertaken to look at risk mitigation when unable to meet the standard. We are trying innovative ways of working to deliver care and have introduced a virtual consultation which covers some evenings of the week. There is an advert to recruit more consultants but due to current Covid situation there are a lack of applicants. To mitigate the situation locum consultants are being recruited and we are providing a virtual consultation service. The QI forum is being used to demonstrate how we are monitoring safety and quality. Suggestion that current work on the quality and safety strategy could also be linked.	Request has been made for the narrative around routinely monitoring, safety, risk in ED to be put together and brought to the April CQC & Compliance Group with the hope to close.	**Substantial Assurance**

CQC Engagement Meetings
Regular meetings between CQC and CHFT have continued to take place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services.

CQC Enquiries
CQC currently have 16 open enquires with CHFT, 7 new enquires have been opened and 8 enquires closed in the last reporting period. The CHFT CQC Compliance Manager manages the process within the Trust and provides CQC with regular progress updates and final reports from investigations.

CQC Transitional Monitoring Approach (TMA)
CQC are adapting and developing their methods of regulation by using a transitional approach to monitoring services. This focuses on safety, how effectively a service is led and how easily people can access the service. It includes:

- a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so they can continually monitor risk in a service
- using technology and local relationships to have better direct contact with people who are using services, their families and staff in services
- targeting inspection activity where we have concerns

CHFT CQC TMA Reviews to Date
The Trust has undertaken 2 Transitional Monitoring Approach reviews one across Maternity Services and one of the Johns smiths Vaccination Centre. CHFT Maternity Colleagues provided assurance to CQC via a self-assessment submission detailing the services position, evidence, and future ambitions against a set of KLOE as set out by CQC.

Maternity Colleagues at the meeting presented their findings against the Maternity TMA KLOE self-assessment. The presentation was a focus on each of the CQC Domains, Safe, Effective, Caring, Responsive and Well-Led. The presentation also included case studies, patient care and business better than usual examples.

CHFT was also required to lead and facilitate a CQC TMA call for Johns Smiths Stadium (JSS) Vaccination Centre, again this was in line with CQCs TMA approach to regulation and vaccination hub KLOEs. The TMA call took place on 25th March 2021 and consisted of representatives from all the JSS partners including, CHFT, Curo, LCD and LOCALA. As per the Maternity TMA call a self-assessment submission was made to CQC and a presentation presented in line focusing on the CQC domains.

Initial feedback from CQC for both TMA reviews was positive, no further actions were required, and substantial assurance was provided.

CQC TMA Next Steps
CQC have published a set of TMA KLOEs at Trust wide level and for a number of specific Core Services. CQC will use these KLOEs to carry out focused inspections with providers where they have risk-based concerns.

As part of the Trust CQC preparation it has been agreed that a self-assessment will be completed for the Trust Wide, Urgent & Emergency Care and Children & Young People TMA KLOE.

The CQC Compliance Manager will be furnishing the selected Core Services with templates and tools to assist with the self-assessment process. Core Services will be required to present regular progress updates at the CQC & Compliance Group.

Focused Support Framework
The Focused Support Framework reviews remained suspended during February and March 21 due to the operational pressures and the infection, prevention and control implications conducting these reviews may have. The Trust remained assured that Must Do audits continue to be undertaken such as the leadership walk arounds and the COVID-19 assurance monitoring.

Work has begun developing the Focus Support Framework and combining this with the Trust patient experience monitoring tool Observe and Act.

Both frameworks will form the overall patient safety and patient experience review at ward and departmental level.

The reviews will be launched as combined initiative in May 2021.

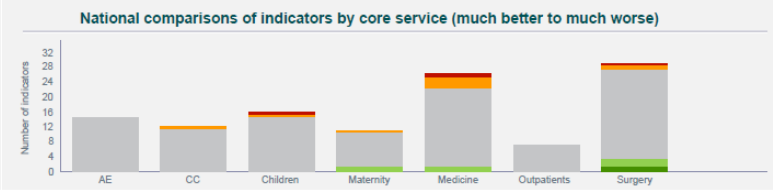
CQC Insight Report
The most recent CQC Insight Report was published in March 2021 with the previous report been published in January 2021.

CHFT Performance
Of the 79 trust wide indicators, 3 (4%) are categorised as much better, 0 (0%) as better, 6 (8%) as worse and 2 (3%) as much worse. 63 indicators have been compared to data from 12 months previous, of which 7 (11%) have shown an improvement and 5 (8%) have shown a decline.

There are currently 0 active outliers for maternity and 0 for mortality. For maternity 0 are with the panel and 0 are with the regional team. For mortality 0 are with the panel and 0 are with the regional team.

Much better compared nationally	Much worse compared nationally	Improved	Declined
• Hospital Standardised Mortality Ratio (HSMR) • Hospital Standardised Mortality Ratio (Weekday) • Sick days for medical and dental staff-[set target 3.5%] (%)	• CAS alerts closed late in preceding 12 months • CAS alerts not closed by the trust in the preceding 12 months	• Digital maturity capabilities score (%) • Digital maturity infrastructure score (%) • Digital maturity readiness score (%) • Health & wellbeing • Morale • Ratio of ward manager nurses to senior and staff nurses • Safety Culture	• CAS alerts closed late in preceding 12 months • Never events (total events with rule-based risk assessment) • Never events (total events with statistical comparison to bed days) • Stability of Nursing and Midwifery staff • Stability of other clinical staff

For each core service, there are different numbers of indicators. When compared nationally, each has been categorised as much better, better, about the same, worse or much worse. The graph shows the number of Indicators for each core service and the number within each category:



CAS Alerts

The status of patient safety alerts which are beyond their deadline:

Completion Due Date	Alert Title	Current Status	Progress
5 March and 3 June 2020	NatPSA/2020/001/NHSPS Ligature and ligature point risk assessment tools and policies	AWAITING CLOSURE	**April 2021:** The first two actions of the alert have now been completed, with documents removed from publicly accessible website (EMbeds), and now placed on internal website (Policies and Document Library); and local publication revised to ensure safety of patients or

			public, prior to upload to public-facing websites. Work is underway on the last action in relation to reviewing local policies. A risk to be placed on trust wide risk register in relation to access to ligature cutting devices.

The following patient safety alerts are currently within deadline date:

Completion Due Date	Alert Title	Current Status	Progress
13 May 2021	NatPSA-2020-005-NHSPS Steroid emergency card to support early recognition and treatment of adrenal crisis in adults	Ongoing	**April 2021:** One of four actions now complete.
1 June 2021	NatPSA-2020-006-NHSPS Foreign body aspiration during intubation, advanced airway management or ventilation	Ongoing	Work underway
1 June 2021	NatPSA-2020-008-NHSPS Deterioration due to rapid offload of pleural effusion fluid from chest drains	Ongoing	**April 2021:** One of two actions now complete. Work underway to get chest drain observation chart uploaded onto EPR

The following patient safety alerts have now been closed:

Completion Due Date	Alert Title	Current Status	Progress
6 Nov 2020	NatPSA-2020-004-NHSPS Risk of Death from unintended administration of sodium nitrite	CLOSED	**ALERT CLOSED ON DATIX**
9 April 2020	NatPSA-2020-003-NHSPS Blood control safety cannula & needle thoracostomy for tension pneumothorax	CLOSED	**ALERT CLOSED ON DATIX**
31 March 2021	NatPSA-2021-001-MHRA Supply distribution of sterile infusion sets, and connectors manufactured by Becton Dickinson (BD)	CLOSED	**ALERT CLOSED ON DATIX**

Facing the Futures Standards for Children in Emergency Care settings

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

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

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

CHFT Current Position with Recommendation 9 & 10 & Next Steps

It has been identified that the Trust is currently not compliant with standards 9 & 10.

A full review of standards 9 & 10 and the required mitigation set out in the CQCs facing the futures briefing guide has been commissioned and undertaken by the Emergency Department.
An update was presented at the March CQC Response Group, while a number of risk mitigations have been progressed the group acknowledge this is a long-term issue and further mitigations need to be explored and evidenced.

Use of Resources

The Trust has carried out a Use of Resources (UOR) self-assessment process focusing on the key lines of enquiry (KLOE) set out in the CQC UOR criteria. This piece of work has progressed over the pandemic period with a number of teams meeting to gather evidence and draw conclusions. Following on from the work that has been done to date a mini showcase event for the KLOE groups and Executive leads to present their findings has taken place. It is noted that many of the metrics and benchmarks have become out of date during the Covid period, however the work done should round-up and celebrate the progress made since the last UOR assessment. Discussion following the presentations involving all attendees will give us the chance to pick up on common themes, note any further achievements that would add to the story and highlight any opportunities for ongoing improvement as we go into 2021/22.

CQC Strategy

The Trust executive team has partaken in 2 CQC Consultations Surveys in March 2021.

- CQC Strategy 2021 – *Closed 4th March 21*
- Flexible and Responsive Regulation – *Closed 23rd March 21*

CQC will publish their final strategy for 2021 in May this year. Future CQC preparation within the Trust will be guided by the new strategy

Venous Thromboembolism (VTE)

Venous Thromboembolism (VTE) is a collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE).

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

VTE Outcome	Feb and March 2021	Assurance
To meet the 95% target of patients being risk assessed for developing a VTE	The 95% trust target was achieved in both February and March 2021. The Trust achieved the target every month in 2020/21	**SUBSTANTIAL ASSURANCE**
Maintain the level of Hospital acquired VTE episodes, not more than 20% of all VTE episodes	January 2021: 5 HA-VTE cases out of total of 49 total cases of VTE noted – all unavoidable (January 2021 was obtained using coding records for VTE as trial and will be compared with the usual method of obtaining data – radiology database)	**SUBSTANTIAL ASSURANCE**
No Avoidable hospital acquired VTE Deaths	None identified	**SUBSTANTIAL ASSURANCE**
Audit actions plan and schedule of re audit	Pharmacy led annual audit on VTE risk assessment and prescribing of thromboprophylaxis presented at the committee. Key findings were: Action plan to be developed by the committee based on findings. To be confirmed at June Committee. The audit and findings from recent complaint investigations have Identified the need to complete a records audit of how patient compliance is recorded this will be added to the 2021/22 Committee Audit Plan GIRFT data is still awaiting presentation with senior management	**REASONABLE ASSURANCE**

Pressure Ulcers

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

Pressure Ulcer Collaborative meetings are held on a monthly basis.

Objective	Feb and March 2021	Assurance
Reduction in pressure ulcers	There were 104 pressure ulcers in February 2021 March data still being validated	**LIMITED ASSURANCE** The Trust has been unable to evidence a sustained reduction in pressure ulcers. The reports outlined above demonstrate the initiatives in place.
No Category 4 declared	1 category 4 pressure ulcer was reported in February 2021 March data still being validated	**LIMITED ASSURANCE** The Trust has been unable to maintain zero incidence of category 4 pressure ulcers since October 2020
Reduction in CHFT Acquired Medical Device Related Pressure Ulcers (MDRPU)	There were 11 MDRPU in Feb 2021. March data still being validated.	**LIMITED ASSURANCE** The reduction is not sustained, and actions are in place to address MDRPU.
Reduction in Category 3 Pressure Ulcers	March data still being validated	**LIMITED ASSURANCE**
Education and Training	• First care home training programme complete. Agreement with CCG and Local Authority to continue virtual training on a rolling programme. • React To Red face to face care home training to commence May/June 2021. • Trust wide compliance with React to Red Pressure Ulcer Essential Training at 89%	**REASONABLE ASSURANCE**
Documentation	SSKIN bundle developed for prone patients in ICU	**REASONABLE ASSURANCE**
Resources / Policies	No development with policies currently to due capacity in tissue viability service	**REASONABLE ASSURANCE**
Provision of appropriate pressure redistributing equipment	• Trolley mattress audit repeated in March 2021. Conclusion: • 68/124 (55%) mattresses in an acceptable condition • Mattress replacement nearing completion at time of writing. • Powered air alternating pressure mattress evaluation events taking place 13/14th April. • Trust specification developed for profiling bed frames. • Heel offloading devices place on top up in Acute Floor wards to improve availability.	**REASONABLE ASSURANCE**

Nutrition and Hydration

The Nutrition Operational Group (NOG) continues to meet monthly and is currently being chaired by the Head Nurse for the Division of Medicine with consistently good representation from its multi-disciplinary team (MDT) members, however, there remains no clinical lead representative for nutrition and hydration. This has recently been escalated to the General Manager for the Medical Specialities directorate of the Division of Medicine for discussion at the next Consultant gastroenterologist meeting.

Training & Compliance

Malnutrition Universal Screening Tool (MUST) training

MUST (nutritional screening for adults) online training compliance remains good with all Divisions scoring 90% or above.

Division	Complete	Incomplete	Grand Total	% Training Complete
372 Community L3	2	0	2	100.00%
372 Corporate L3	1	0	1	100.00%
372 Families & Specialist Services L3	17	1	18	94.44%
372 Medical L3	542	56	598	90.64%
372 Surgery & Anaesthetics L3	174	17	191	91.10%
Grand Total	736	74	810	90.86%

Enteral feeding training

The online training module available for updating clinical staff in the ongoing care and management of nasogastric tubes is accessible on the intranet. Training Compliance is monitored by the NOG for wards identified as having regular or a high utilisation of nasogastric tubes.

There is some variation across the high user areas and identifies those areas requiring performance improvement. The training compliance rates as of March 2021 are:

HIGH USER									
17	100%	**ICU**	52.80%	**Paeds**	85.70%	**Comm. Paeds**	60%	**HOOP**	72.70%
MEDIUM USER									
5A-D	64.80%	**6AB**	21%	**8C**	53.8%	**7A-D**	71.0%		

The training for medical staff remains as a theoretical session at induction, but there is not a practical competency programme of assessment in place, unless it is undertaken at the individual's request. This currently sits on the risk register (risk 6924) scoring 10.

Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) training

Training compliance has improved significantly in the last month; compliance at the time of producing this report is 71.5%. The Division of Families & Specialist Services continue to drive further improvement and work is underway to add the training to Electronic Staff Record (ESR).

Nutritional and Hydration documentation compliance

Compliance in all aspects of clinical documentation remains of concern, with limited assurance provided in four out of five sections for nutrition and hydration. Monthly compliance remains low in the objectives that provide limited assurance, and no singular objective demonstrates any sustained improvement.

The nutrition and hydration improvement plans recently produced by the Divisions address the objectives. It is the intention of the NOG group to monitor the improvement plans and their progress bi-monthly in order to sustain development.

At the monthly NOG meeting documentation compliance is monitored; reasons for fluctuations and actions required for improvement are discussed.

The compliance rates as of March 2021 are:

NUTRITION & HYDRATION OVERALL SCORE	29.5%	32.2%	32.7%	26.8%	29.9%	26.3%	28.1%	29.7%	28.0%	29.9%	29.9%	29.3%
All patients (>LoS 8hrs) have a completed fluid balance chart?	15.2%	29.6%	26.0%	12.8%	22.9%	8.4%	11.3%	9.0%	20.2%	21.4%	18.3%	20.1%
Nutritional support care plans will be evident for all adults patients with MUST of 2 or above?	89.0%	88.6%	93.3%	84.7%	90.0%	86.1%	86.6%	94.4%	88.5%	97.0%	90.3%	89.0%
Patients with a MUST score of 2 or above will be referred to a dietician	4.1%	5.4%	5.3%	3.8%	4.2%	3.6%	3.2%	2.5%	3.5%	3.1%	2.5%	3.7%
Food charts will be completed for patients with a MUST of 2 or above	23.3%	20.3%	17.7%	9.3%	13.7%	16.0%	22.4%	28.1%	12.7%	12.5%	22.2%	16.3%
All adult patients will receive a MUST assessment within 24 hours admission/ transfer to the ward?	16.1%	16.9%	20.9%	23.3%	18.6%	17.4%	16.9%	14.4%	14.9%	15.3%	16.0%	17.2%

Incidents and Complaints

Year to date, there has been 63 incidents and 3 complaints and in the latest reporting period (February and March 2021) the inclusion of paediatric incidents has commenced and there has been 7 incidents and 0 complaints. The incidents are reviewed to identify common themes and potential opportunities for improvement. There has been no never events reported.

Paediatric update

New paediatric guidelines have been shared with the NOG for information and feedback prior to submission to the paediatric forum group.

Dementia screening compliance

National Drivers

Objective	February 2021	March 2021	Assurance
Dementia screen	Target -90% Overall compliance - 19.89%	Target 90% Overall compliance-19.86%	**Limited assurance**
Dementia training	Target 95% Overall Compliance 97.6%	Target 95% Overall compliance 97.8%	**Substantial assurance**

Assurance to increase dementia screening compliance

The acute assessments areas have commenced a project starting with Calderdale acute floor and surgical assessment area to work with the whiteboard functionality on EPR to identify dementia screening outstanding. This will enable at huddles each day the outstanding dementia screening and then a job will be assigned to a doctor to complete.
The band 7 will focus on dementia screening and will work closely with the medical teams to increase compliance.

Local drivers

Objective	February 2021	March 2021	Assurance
Person centred dementia care training	This classroom training, which involves group work activities has been suspended due to COVID, and being reviewed where we can deliver this training safely	This classroom training, which involves group work activities has been suspended due to COVID, and being reviewed where we can deliver this training safely	**Limited Assurance**
Dementia strategy	Dementia Strategy	Carers work on going to identify and recognise carers as partners in care and signposting to local support networks	**Substantial assurance**
Delirium screening	Target 90% Overall Compliance *New indicator, Data will be presented in the next report*	Target 90% Overall Compliance *New indicator, Data will be presented in the next report*	**Limited assurance**
Depression screening	Target 90% Overall Compliance *New indicator, Data will be presented in the next report*	Target 90% Overall Compliance *New indicator, Data will be presented in the next report*	**Limited assurance**

Assurance to increase Person centred dementia care training, delirium and depression screening

A full review of how person-centred dementia training can take place and be delivered will take place in April. Delirium screening has now been added due to below average compliance. There is currently a quality improvement project underway to increase this compliance utilising a new screening tool called the 4AT. The 4AT will be done in the emergency department (ED) and be added into FirstNet to be done on attendance to ED. This will then be built into power chart assessment so enable all staff to be able to screen for delirium using the same tool. People should not be screened for dementia until they have been screened for delirium and depression. The compliance for depression remains below average and this needs to be part of the quality project with delirium with a review of how all 3 are accessed on EPR.

Patient Advice and Complaints Service (PACS)

Making Complaints Count

CHFT views any complaint as an extension of our service user's care and the Trust is committed to having effective processes and procedures in place to handle concerns and complaints.

Key Objectives

The current objectives that have run through the year 2020/21 have been subsumed within the Making Complaints Count Collaborative Work Plan.

The Patient Advice and Complaint team's main objectives for the forthcoming year 2021/22 are as follows:

Objective	Current level of assurance	Comments
1. Working with the divisions effectively to deliver strong complaints performance	**LIMITED Assurance**	Progress but with some potentially significant concerns regarding delays in completing actions and demonstrating organisational learning and impact
2. Delivering on making complaints count collaborative action plan	**SUBSTANTIAL Assurance**	Good progress.

Progress against key objectives

Performance

Complaints & PALS Performance Summary

	Feb	Mar
Complaints received	28	24
Complaints closed	51	20
Complaints closed outside of target timeframe	24	8
% of complaints closed within target timeframe	53%	60%
Complaints reopened *1	0	1
*1 Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix		
PALS contacts received	203	227
Compliments received	41	40
PHSO complaints received	0	1
PHSO complaints closed	0	1
Complaints under investigation with PHSO	8	8

A large number of complaints (50) were closed within February, which has equated to nearly double the numbers that were closed in previous month's activity. These included a significant number of complaints that had breached their target timescale, and this has reduced the current active caseload.

Experience, Participation, Equalities Report Feb – March 2021

Points for escalation

Work has been prioritised and remains ongoing on the following seven projects:

1. **Commitment to Carers**
   - A baseline audit tool has been designed based on NICE guideline 150 (supporting adult carers). This will be used to assess practice at service level (e.g., Learning Disability, Dementia, Stroke) identifying good practice and current gaps
   - Collaborative working taking place with colleagues from the Local Authority and 3rd sector organisations to map the existing processes between services and opportunities for improved integration

2. **Reducing Noise at Night**
   - Project position presented to senior nursing colleagues
   - Further actions required to embed best practice and evidence improvement

3. **Making Complaints Count**
   - Priorities being progressed through an operational group
   - Survey developed to capture complainant experience and feedback
   - Developing processes to improve data quality and complaints pathway
   - Outputs from these actions will be used to inform a standard operating procedure which is aligned with the PHSO standards

4. **Winter and Covid Volunteering programme**
   - Recruited to a Winter and Covid volunteer project co-Volunteer
   - The Front of House meet and greet service commenced as a pilot w/c 8.3.21 (includes supporting Covid – 19 safety measures)
   - Property drop off and pick up for relatives (Belongings to loved ones) pilot arrangements commencing with 2 wards at HRI
   - Further successful NHSEI bid to support the introduction of ward based 'Safety Guardians'

5. **Friends and Family Test**
   - Following a period of suspension (focus on covid-19 priorities), and in line with national guidance FFT has been stood back up in the trust
   - Response rates are currently extremely low for inpatient, community and maternity services. 37 responses in Maternity for the March submission.
   - Higher numbers achieved in services utilising SMS messaging (ED and OPD)
   - Promotions/ relaunch includes improvements to the digital platform, advertising through posters (containing the URL link and QR code)

6. **Observe and Act**
   - Test pilot is underway
   - Core project team has been trained and project plan in place
   - Evaluation from the test project work to date is fine tuning the framework to ensure it is fit for purpose within the context of CHFT and local priorities are integrated into the framework
   - Work is ongoing to ensure a fit / integration within the FSF

7. **Quality Priority:** Learning lessons to improve patient experience
   - A draft process is being tested to identify 'topics' from across the range of Quality activities (insight, incidents, QI, etc) that will translate into learning and impact material.

- The concept of an integrated 'learning from' report is under development (incidents, complaints, concerns, compliments, feedback, legal claims)

Participation
Participation and engagement are a significant part of the Trust's transformation programme. Work to build closer working relationships with our strategic partners is ongoing this is predominately driven within the carers workstreams and via the connection with the transformation programme. Key work operates within the WY partnership arrangements.

In March 2021 our local communities were encouraged to share their views via an online survey of our proposed clinical building development on both acute hospital sites. The engagement strategy provides the opportunity for public participation, listening to local people who use and care about our health facilities and services. The strategy also incorporates engagement with equality groups to gain a greater understanding of their diverse health needs and impact on service redesign for our future services

Representatives of the Trust have joined the membership of a new Collaborative hosted by Calderdale CCG.

Equalities
Progress the approach that has been developed for the systematic involvement of BAME communities - these details the opportunities and methodologies to achieve greater contacts with black and minority ethnic communities.

The inclusion of equality impact assessment and quality assessment monitoring has been formally reviewed and an improvement programme has been commenced to better understand the process required for supporting service development quality initiatives as well as service redesign. This involves utilising our established equality network groups but also reaching out to community groups to facilitate an inclusive process of engagement. It is proposed to develop a portfolio of examples to support colleagues undertaking this process in future quality initiatives.

The Trust has in place a Health Inequalities working group to look at a range of issues relating to the Index of Multiple Deprivation (IMD). Working in partnership with local authority the Trust has invested significant time into understanding how the BAME community have been impacted by Covid. The process of clinical prioritisation of those patients where treatment may have been delayed as a result of the pandemic response has been mapped across to all IMD groups. Work is ongoing to understand any differential between in relation to delays and IMD grouping

The Trust is engaging with the Pakistani community to look at cancer information needs for newly diagnosed patients. This is being facilitated through NHS England Cancer Improvement Collaborative and will result in the provision of appropriate and timely information designed and deliver in partnership with the community. This work has formed a template for engaging with other BAME communities to support coproduction of other cancer services.

Chaplaincy Services
Pastoral and spiritual support has continued for patients and staff members by the multi faith team over recent months. The faith rooms continue to be open and available for individual use but services for prayer and worship have not yet been reintroduced, this will be reviewed in line with the easing of lockdown. The successful introduction of virtual services over the past year will continue and will become an alternative way to access faith services for our patients.

Legal

Introduction

Calderdale and Huddersfield NHS Foundation Trust ("the Trust") is committed to:

- Promoting the highest possible standards of care for patients in an environment that is safe and effective for staff and visitors.
- 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).
- Using learning arising from claims and inquest investigations to promote improvements to the quality of care provided to patients.

Recent Data

This report covers the period **1 February – 31 March 2021**.

Clinical Negligence

- 168 active clinical negligence claims
- 14 new clinical negligence claims were received.
- 13 clinical negligence claims were concluded.
- Damages totalled £573,121

Employers' and Public Liability (EL/PL) Claims

- 24 active EL/PL claims
- 5 EL/PL claims
- 2 EL/ claims were concluded
- Damages totalled £1,750

Lost Property

- 18 active lost property claims
- 9 lost property claims were received
- 1 lost property claims were concluded
- Nil paid in respect of lost property claims

Inquests

- 137 active inquests
- 21 inquests were opened
- 5 inquest files were closed

Incidents

This is a summary of patient safety incidents and incidents with severe harm or death, for the year January 2020 to January 2021, and number of serious incidents (SIs) reported by month.

The number of incidents resulting in severe harm or death is starting to decline largely due to a significant reduction in the number or HOCI incidents.

Month reported	No of Patient Safety Incidents reported (all)	No of Patient Safety Incidents of severe harm or death	SIs By the month externally reported on StEIS
Feb 2020	962	3	2
March 2020	876	4	0
April 2020	625	2	1
May 2020	790	4	1
June 2020	931	7	9
July 2020	994	5	2
Aug 2020	937	3	2
Sept 2020	954	7	4
Oct 2020	992	4	2
Nov 2020	1079	31	1
Dec 2020	900	14	3
Jan 2021	1037	28	5
Feb 2021	961	16	2
March 2021	1042	8	2

Never Events
There are no new reported Never Events:

Summary of Progress with SI Actions
Work continues with the division to manage outstanding actions to include the development of a robust process to ensure all action owners are aware of their actions and that they are responded to in a timely manner. There has been a significant reduction in the numbers of open actions which are overdue by 6 months.

The Never Events List 2018 has been updated and was published in February 2021. This was shared at the Trust PSQB.

https://www.england.nhs.uk/wp-content/uploads/2020/11/2018-Never-Events-List-updated-February-2021.pdf

Medicine Safety

The Medication Safety and Compliance group 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 CD registers to improve our CD documentation and compliance with legislative requirements
- Scoping and business case for installation of electronic medication storage cabinets to ensure we have robust storage facilities, reduce risk of medication error selection, reduce risk of medication diversion and free up nursing time to care
- Go live for active temperature monitoring for medication stored in fridges and then expansion of system to include ambient temperature monitoring

Main concerns of the group are:

- Oxygen training for clinical staff on Flexible workforce contracts, ensuring this training is completed and recorded
- Lack of divisional representation at MSCG meetings

Maternity

Ockenden report

Calderdale and Huddersfield NHS FT (CHFT) submitted the assessment and assurance tool on the 15th February 2021. There has been no further instructions received relating to evidence submission. However maternity services are required to deliver a perinatal quality surveillance model of assurance at local, regional and national level. CHFT has undertaken a 3Rs review. Please see appendix 1.

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.

In March 2017 NHS resolution introduced an 'Early Notification scheme' for potential severe brain injury at birth. NHS Resolution asks trusts to notify to them all incidents of babies born at term (≥37 completed weeks of gestation), following labour, that had a potentially severe brain injury diagnosed in the first seven days of life. Specifically, these are any babies that had one or more of the following:

- diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
- active therapeutic cooling; or
- all three of the following signs: decreased central tone; comatose; seizures of any kind.

The above criteria have been identified by the Royal College of Obstetricians and Gynaecologists (RCOG) through their independent Each Baby Counts (EBC) Programme as being markers for severe brain injury at birth. For a proportion of these incidents, different care might have made a difference to the outcome

2020/21 Q3 PMRT reportable cases

Stillbirth/ Late Foetal Loss

Date	Date PMRT review commenced	Gestation	PMRT number	Status
1.11.20	3.11.20	30+2	71949	Completed report
5.11.20	5.11.20	28	71978	Completed report
20.11.20	24.11.20	22+2 twins	72305	To review
25.11.20	27.11.20	35+4	72349	Completed Report

Neonatal Deaths

2020/21 Quarter 3 PMRT and NHS ENS reportable case: None reported

Healthcare Safety Investigation Branch (HSIB)

As of 31st March 2021, CHFT currently has 11 completed cases, 2 cases rejected by HSIB as they did not meet the Covid- 19 criteria for HSIB investigation and 5 open cases at varying stages of investigation.

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.

Maternity Incidents

Maternity services have a high reporting culture with incident trigger lists embedded in each clinical area.

2021 Q4 incidents reported by Type

	Jan 2021	Feb 2021	Mar 2021	Total
Appointment/Admission/Transfer/Discharge	26	23	35	84
Assessment/Treatment/Diagnosis	2	5	2	9
Blood Transfusion Related Issues	2	2	0	4
Confidentiality/Communication/Consent/IG	1	2	3	6
Health and Safety/Sharps/Security	0	1	1	2
Infection Control	0	1	3	4
Infrastructure/Resources/Staffing	9	12	6	27
Investigations (Scans/Tests/Results)	1	3	2	6
Maternity Incidents	70	41	80	191
Medical Device	0	0	2	2
Medication	0	1	0	1
Slips, trips and falls	1	3	1	5
Total	112	94	135	341

2020/21 Q4 incidents reported by level of investigation

	Green	Yellow	Orange	Total
Appointment/Admission/Transfer/Discharge	82	2	0	84
Assessment/Treatment/Diagnosis	6	2	1	9
Blood Transfusion Related Issues	2	1	1	4
Confidentiality/Communication/Consent/IG	6	0	0	6
Health and Safety/Sharps/Security	2	0	0	2
Infection Control	3	1	0	4
Infrastructure/Resources/Staffing	24	3	0	27
Investigations (Scans/Tests/Results)	5	1	0	6

Maternity Incidents	183	7	1	191
Medical Device	2	0	0	2
Medication	1	0	0	1
Slips, trips and falls	5	0	0	5
Total	321	17	3	341

The 3 orange incidents were all reviewed at Divisional Orange panel whilst the green and yellow incidents are investigated at ward/ department level. However, the FSS Governance Lead conducts a spot check of all green and yellow incident investigations on a random day each month. The findings of this review are reported back to Divisional Orange panel for assurance that local level investigation processes are robust.

Maternity Complaints

Maternity services currently have 3 open complaints all under investigation and within timescale.

Maternity Staffing

In 2015 NICE produced 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.

	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	YTD
1:1 Care in labour	99.7%	100%	100%	100%	99.7%	99.7%

Unfortunately, this metric is not recorded on the regional dashboard, so it is not possible to benchmark CHFT against other services.

As of 31.3.21 midwifery has a vacancy factor of 2.3% with a further 2.8% staff on maternity leave, 2.3% long term sickness and absence and 4.6% staff shielding who are planned to return to the workforce following the end of shielding.

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 however this has been delayed due to covid travel restrictions. The risk is reflected on the Directorate risk register.

User feedback

In preparation for compliance with NHS guidance “Supporting pregnant women using maternity services during the coronavirus pandemic” maternity services have used service users feedback and the Maternity Voices Partnership to deliver a road map for allowing partners to attend maternity contacts in line with the national easing of covid restrictions. This was accelerated on the 12th April with full implementation following a mandate from the Secretary of State for Health.

Appendix 1

Proposal for Local Perinatal Quality Surveillance Meeting

Reality

Following release of the Ockenden Report (December 2020) provider organisations were asked to assess their current position against 7 Immediate and Essential Actions. One of these - Safety Action 1 asked providers to implement the perinatal quality surveillance model.

Currently the Board Executive and Non-Executive Safety Champions, Maternity and Neonatal Safety Champions and HOM meet bimonthly. The HOM meets with Commissioner Representatives monthly, and maternity services report to Board bimonthly via Quality Committee.

At local level the maternity services Dashboard is produced monthly, shared at maternity forum, with Commissioners and the LMS (via the LMS maternity Dashboard subgroup). Maternity incidents are managed at local level via the weekly maternity governance meeting and escalated to Divisional Orange Panel and trust wide SI panel as appropriate. Externally maternity services report relevant cases to the Healthcare Safety Investigation Branch (HSIB), the National Perinatal Mortality Review Tool (PMRT) and the NHS resolution Early Notification Scheme and the Care Quality Commission.

There is currently no formal meeting for representatives of maternity services, CHFT Board, Commissioners and the LMS to formally review maternity safety metrics.

Response

The bimonthly Safety Champions meeting and monthly HOM meeting with Commissioners are amalgamated and renamed the Perinatal Quality Surveillance Meeting.

Attendees:

- Trust Board Executive Maternity Safety Champion – Ellen Armistead
- Trust Board Non- Executive Maternity Safety Champion – Karen Heaton
- Maternity Safety Champion – Dr Shamsuddin
- Neonatal Safety Champion- Dr Ohadike
- Head of Quality CCG's – Debbie Winder
- Kirklees Public Health Maternity – Cathy Munro
- LMS – Karen Poole
- HOM/ Deputy HOM – Karen Spencer/ Diane Tinker

Terms of Reference:

- Receive assurance of high-quality care provision and compliance with National and local guidelines, standards and requirements
- Gain assurance from maternity services that they implement the activity required to achieve compliance with local and national governance standards
- Maintain effective system to maximise the opportunities for learning lessons and sharing these across all areas of maternity services.

Result

CHFT maternity services are able to provide assurance to the Board, Commissioners and Local Maternity System 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.

Immediate and essential action 1 (Enhanced Safety) of the Ockenden report can be evidenced by CHFT maternity services.

Quality Priority update

Set out below is the first report in relation to the Trust Focussed Priorities and the Quality Account Priorities for 2021/22. The report details each priority and the measures to be monitored and reported into the Quality committee this coming year.

There are 3 Quality Account Priorities and 7 Focussed Quality Priorities which map across to the following CQC domains for 2021/22:

No	Domain	Quality Account Priorities
1	Effectiveness	Recognition and timely treatment of Sepsis
2	Safety	Reduce number of Hospital Acquired Infections including Covid 19
3	Experience	Reduce waiting times for individuals attending the ED

No	Domain	Focussed Quality Priority
1	Caring	Falls resulting in harm
2	Caring	End of Life
3	Safe	Increase the quality of clinical documentation across CHFT
4	Responsive	Clinical Prioritisation
5	Caring	Nutrition and Hydration
6	Safe	Pressure Ulcers
7	Effective	Making complaints count: Implementation of the national regulations & PHSO standards (phased introduction)

Below are the details of the Quality Account Priorities for 2021/22

1. Recognition and timely treatment of Sepsis

Executive Leads
Cornelle Parker

Operational Leads
Rob Moisey, Paula McDonagh

Confirm the forum this priority will feed/report into

- Sepsis and Deteriorating Patient Group (name of group not yet finalised).
- Care of the Acutely ill Patient Programme (CAIPP)
- Clinical Outcomes Group (COG)
- Quality Committee

Confirm the measure/ focus for the priority / what you aim to achieve

- Recognition and timely treatment of Sepsis.
  We must keep our patients safe and appropriately treated by utilising the triggers and resources available to CHFT so we quickly recognise when someone has suspected sepsis. Our patients place their trust in us to diagnose and administer the treatment pathways based on NICE and Trust guidelines/policies for sepsis in a timely way, that is our duty of care without exception. In order to improve our response to recognition of the suspected septic patient we should: -

Our focus for this quality priority is to:

- 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.
- Compliance of all elements of the sepsis 6 (BUFALO) to be improved to 50%.
- Establish sepsis skills training as part of essential safety training and achieve 40% concordance for eligible staff in year 1.

2. Reduce the number of Hospital Acquired Infections including COVID-19

Executive Leads
David Birkenhead DIPC

Operational Leads
Lindsay Rudge, Anu Rajgopal, Jean Robinson

Confirm the forum this priority will feed/report into

- **I**nfection Control Performance Board
- Infection Control Committee
- Quality Committee

Confirm the measure/ focus for the priority / what you aim to achieve

- Reduce the number of Hospital Acquired Infections including COVID-19

  We know that an estimated 300,000 patients a year in England acquire a healthcare associated infection (HCAI) as a result of care within the NHS.

  Hospital acquired infections – also referred to as nosocomial infections – are significant both because of the effect on the health of patients and staff and the risk of transmission between patients and staff. We know that HCAIs pose a serious risk to patients, staff and visitors, can incur high costs for the NHS and can cause significant morbidity to those infected. The emergence of new infections also poses a risk to patients and staff, as highlighted by the transmission of COVID-19 in health and care settings during the pandemic.

  Reducing health care-associated infections remains high on the Trust's safety and quality agenda and in the general public's expectations for quality of care.

Our focus for this quality priority is to:

- Implement patient testing strategies aligned to national guidance.
- Support a system wide approach to the vaccination programme.
- Review and implement the CPE screening toolkit.
- Reduce the number of preventable Clostridium Difficile infections.
- Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection.

3. Reduce waiting times for individuals in ED

Executive Leads
Helen Barker

Operational Leads
Jason Bushby, Amjid Mohammed, Louise Croxall, Jayne Robinson

Confirm the forum this priority will feed/report into
- Medical division PSQB
- Trust PSQB
- Quality Committee

Quality Priority
This quality priority is to ensure patients attending CHFT for urgent & emergency care have a safe and positive experience.

We will this year undertake quality improvements to:
- Reduce waiting times for individuals attending the Emergency Department

Our focus for this quality priority is to:
- Monitor the standard operating procedure within the emergency department to ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards
- Ensure lesson learnt are implemented where patients remained in department longer than national guidance.

Below are the details of the Focused Quality Priorities for 2021/22

1. Reducing the number of Falls resulting in harm

Executive Leads - Ellen Armistead

Operational Leads - Abhijit Chakraborty / Helen Hodgson / Charlotte Anderson

Confirm the forum(s) this priority will feed/report into:
- Falls Collaborative
- Clinical Outcomes Group
- Quality Committee – Bimonthly

Confirm the measure/Focus for the priority/ what you aim to achieve.
Reduce the number of inpatient falls and those resulting in harm by 10% by end of 21/22.

Falls and fractures in older people are often preventable. Reducing falls and fractures is important for maintaining the health and wellbeing of older people.
Hip fractures alone account for 1.8 million bed days and £1.1 billion in hospital costs every year, excluding the cost of social care.
In hospital falls invariably cause an increase in the patients' length of stay and drastically reduces the confidence in the elderly person.
Falls were the 9th highest cause of disability adjusted life years (DAYLES) in 2013 and the leading cause of injury.
Falls in hospitals are the most commonly reported patient safety incident with more than 240,000 reported in acute hospitals and mental Health Trusts in England and Wales. (Public Health, England, Get Up and Go, 31/1/2020)
The total cost of fragility fractures has been estimated at £4.4 billion which includes £1.1 billion for social care, hip fractures account for around £2 billion in one year in the UK.

Short and long terms outcomes are generally poor for a hip fracture with an increased one-year mortality between 1 and 33% and negative effects on daily living activities such as shopping and walking. This is why we need to focus on the reduction of falls in hospital.

Our focus for this Quality Priority is to:
Audit and embed changes proven to reduce the number of inpatient falls. We will do this though implementing the CQUINN targets for prevention of inpatient falls, embed learning from serious incidents, produce bite size learning, develop workshops and strengthen the influence of falls link nurses.

2. End of Life Care

Executive Leads
Ellen Armistead

Operational Leads
Mary Kiely, Christopher Roberts, Christopher Button

Confirm the forum this priority will feed/report into
- End of Life Steering Group
- Corporate PSQB
- Quality Committee

Focussed Quality Priority
We will this year undertake quality improvements to
- 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.
- To ensure improved resources for relatives and carers relating to breaking bad news relating to End of Life care

Our focus for this quality priority is to:
- Implement 7 day working across inpatient/ community services
- Improve access to ePaCCs
- Introduce a standard(s) that will improve a person's experience pre and post bereavement delivered by the ward teams
- Review the Bereaved relatives telephone support service

3. Increase the quality of clinical documentation across CHFT

Executive Sponsor
David Birkenhead DIPC

Operational Leads
Lindsay Rudge, Carol Gregson, Graham Walsh

Confirm the forum this priority will feed/report into
- Clinical Outcomes Group – Bi Monthly
- Clinical Records Group – Monthly
- Quality Committee – Bi Monthly

Confirm the measure/ focus for the priority / what you aim to achieve

The Trust implemented the electronic patient record (EPR) in 2017. Whilst the vast majority of patient data is recorded in EPR it is not always recorded in the correct fields and the quality of records are not of the appropriate standard.

The measure of 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.

Our focus for this quality priority is to:

- Optimise the Clinical Record through
  - In-depth analysis of the current process around electronic documentation
  - Benchmark
  - Set standards
- Trial the use of the Digital White Board within the hospital setting in 2 designated areas
- Review the Ward Assurance Tool within KP+ setting appropriate metrics
- Assign responsibility to Ward Managers and Matrons to drive improvement in clinical documentation within their ward area
- Ensure Ward Managers own their ward data using KP+ and to react to the quality therein
- Audit clinical records using an agreed audit tool
- Identify and establish a project team that can drive the improvement of data entry into EPR across the Trust
- Ensure that training in the use of EPR reflects the standards laid down by the Trust and that it reflects the varying training needs of the staff

4. Clinical Prioritisation (Deferred care pathways)

Executive Leads – David Birkenhead

Operational Leads - Divisional Directors, Directors of Operations

Confirm the forum(s) this priority will feed/report into:

- Recovery Framework Board
- Quality Committee – Bimonthly

Calderdale and Huddersfield Foundation Trust has an excellent track recording in the delivery of safe and timely access for patients across all pathways The above Priority was selected for 2020/21. Further to the review of the Quality Strategy and Quality Priorities for 2021/22 it has been agreed that this priority remains a focus for the trust. The recently developed recovery framework seeks to build on our successful track record of delivery with the aim of managing recovery at pace. This will require more focus on prioritisation, health equality and the wider patient experience with a reduction in variation within and across specialties

We will this year undertake quality improvements to:

- Maintain a clear and comprehensive understanding of deferred care pathways as a result of COVID 19

Our focus for this quality priority is to:

- Ensuring known health inequality groupings are not disadvantaged as we recover and reset
- Maintain compliance with the agreed clinical prioritisation process across the trust.

5. Nutrition and Hydration for in-patient adult and paediatric patients

Executive Lead
Ellen Armistead

Operational Lead
Gemma Berriman

Confirm the forum this priority will feed/report into
- Nutrition operational Group
- Quality Committee

Confirm the measure/ focus for the priority / what you aim to achieve:
The delivery of safe and high-quality nutrition and hydration care for all in-patients at CHFT. Malnutrition and dehydration are both causes and consequences of illness which can impact significantly on clinical outcomes for adults, children and young people. Around 1 in 3 patients of patients admitted to acute care are malnourished or at risk of, therefore it is vital that nutritional assessments take place in a timely manner and appropriate actions are taken to provide adequate nutrition in the form of food, drinks, oral supplements and safely administered fluids and enteral feeds.

Our focus for this quality priority is to:
- Provide safe and high-quality nutrition and hydration care that is aligned to National guidance and delivered by a Multidisciplinary team.
- Provide healthy and nutritional foods, drinks, supplements and artificial feeds.
- Nutritionally screen all patients and plan care accordingly using a person-centred approach.
- Ensure nutrition and hydration care is delivered by a trained and competent workforce.
- Develop ongoing monitoring and assessment processes to ensure high standards are maintained during meal service.
- Ensure monitoring of nutritional intake and appropriate assistance is given to all vulnerable patient groups.

6. Reduction in the number of CHFT acquired pressure ulcers

Executive Lead
Ellen Armistead

Operational Leads
Judy Harker

Confirm the forum(s) this priority will feed/report into:
- Clinical outcomes Group
- Trust PSQB
- Quality Committee – Bimonthly
- Pressure Ulcer Collaborative

Our measure:

Hospital
- Hospital pressure ulcers per 1000 bed days
- The level of harm associated with hospital acquired pressure ulcers
- The number of patients with completed SSKIN bundle documentation
- The number of patients with a Pressure Ulcer Prevention Care plan implemented

- The number of patients with a Pressure Ulcer Care plan implemented
- The use of safety huddles to handover pressure ulcer information

Community
- The number of patients with a Pressure Ulcer Prevention Care plan implemented
- The number of patients with a Pressure Ulcer Care plan implemented
- The level of harm associated with community acquired pressure ulcers

Trust-wide
- The number of RN, Nursing Associates and HCAs completing React To Red or equivalent pressure ulcer training

Our focus for this quality priority is to:
- Support a system wide approach to pressure ulcer prevention and management
- Strengthen clinical leadership at the frontline by empowering healthcare workers to provide exemplary care
- Implement over-arching policy recommendations aligned to national guidance
- Review, amend and implement new documentation processes on EPR
- Engage, challenge, motivate and educate healthcare workers via a robust training programme

7 <u>Making complaints count: Implementation of the national regulations & PHSO standards (phased introduction)</u>

Executive Leads: Ellen Armistead

Operational Leads: Head of Complaints & AD – Patient Experience

Forums: MCC Collaborative (Steering group and Operational Group)

Governance:
- PECG
- Trust PSQB
- Quality Committee / Board

- as needed to be assured of compliance and that operations are fully supported.

Metrics: Phased approach to the implementation of the standards focussing on the standards the collaborative self-assured at red rag rating. Success measure will be a shift change in the assurance from red to green over the year. Improvements will be noted via performance reporting
- IPR
- Quality dashboard
- Weekly tactical meeting
- Datix Dashboard
- Weekly performance reports

Informatics Support: Data / health informatics support – Datix manager, informatics team re IPR / dashboard

Our focus for this quality priority is to:
- Fully align the work of the Making Complaints Collaborative to ensure it is delivering against the national complaints regulations and the emergent PHSO standards.
- Support a trust wide / user led approach to ‘Making Complaints Count’.

Review existing processes, policy and operating procedures

Appendix 1 – Report BRAG rating assurance table

RAG RATING	Evidence of fulfilling RAG rating
WHITE	• Not yet started
GREEN 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.
AMBER 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.
RED 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
BLUE Full assurance	• Completed with documented evidence • Evidence of compliance with standards or action plans to achieve compliance.

18. High Level Risk Register

To Approve

Presented by Suzanne Dunkley

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 6th May 2021
Meeting:	Board of Directors
Title:	High Level Risk Register
Author:	Naheed Razzaq, Risk Manager Doriann Bailey, Assistant Director of Patient Safety
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing
Previous Forums:	Risk Group January, February, March and April 2021. Quality Committee meetings.

Purpose of the Report

To provide the Trust Board with assurance as to the robust identification and management of risk across the Trust and to present an update on risks on the High Level Risk Register.

Key Points to Note

There is an established governance processes for the identification, scoping, management, and oversight of risk in place through the remit of the Risk Group which continues to review the High Level Risk Register (HLRR) and make collective decisions for the proposed acceptance and removal of risks from the HLRR.

This paper reports the current HLRR and highlights changes to the HLRR in January, February, March and up to the 7th April 2021, following the last update to the Board on 14 January 2021. Appendix 1 details risk movement, the heat map and risk score history. Appendix 2 provides the full high level risk register.

As at April there are 28 risks on the high level risk register with the profile of the risk scores is as follows:

Risk score	Number of risks
25	3
20	7
16	13
15	5

Since the HLRR report to Board on 14 January 2021 6 risks have been added to the HLRR and 5 removed. An overview of updates to risks is described below, with the risks presented in the High Level Risk Register report.

New risks onto the HLRR since last report to Board on 14 January 2021 = 6 in total (all from Surgery and Anaesthetics Division)

7769 (25): Progression of eye diseases resulting in increased risk of sight loss (Covid risk)
7930 (20): Ophthalmology delayed treatment for glaucoma resulting in an increased risk of sight loss (Covid risk)
7809 (25) Theatre and clinic capacity (Covid risk)
7834 (25) Elective orthopedic inpatient theatre capacity (Covid risk)
7328 (16) ENT staffing shortage
7803 (16) Delays in surgery general trauma

Existing top risks = 6 in total

7454 (20): Radiology Staffing Risk
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
7689 (20): Waiting for diagnostics, operations and outpatients (COVID)
7474 (20): Medical devices
7833 (20): Increase in ASI and holding lists (increased score from 16 to 20)

Total number of risks scoring 20 and 25 = 10: 4 new and 6 existing

Risks removed from HLRR since last report to Board on 14 January 2021 = 5 in total

7942 – Overarching staffing risk, risk score reduced 16 to 12
7797 – Variable IPC guidelines, risk score reduced 16 to 8
7796 - Track and trace – whole team shortages, risk score reduced 16 to 12
2830 – ED mental health breach, risk score reduced 16 to 10
7248 -- Failure to complete essential safety training, risk score reduced 16 to 9

Rationale for risk removal from the HLRR is given at Appendix 1.

Movement of risks on the HLRR (see Appendix 1 for rationale):

Risks **reduced** in score = 3 in total, all 3 risks scores reduced from 20 to 16.

- 7964 - delayed treatment for patients with macular/medical retina eye conditions
- 2827 - over-reliance on locum middle grade doctors in A&E
- 7683 - lack of isolation capacity

Risk i**ncreased** in score = 1 in total

- 7833 (20) Increase in ASI and holding lists, increased risk score from 16

EQIA – Equality Impact Assessment

The equality impact of specific risks is articulated within the risk controls and gaps with mitigations put in place where indicated. The risk owner is accountable to determine any proposed actions to mitigate any equality impact arising from a risk.

Recommendation

The Board is asked to:

I. **NOTE** the current risks on the HLRR

II. Consider, challenge and confirm that potential significant risks within the high level risk register are being appropriately managed and / or advise on any further risk treatment required

III. **APPROVE** the current risks on the risk register

Appendix 1 High Level Risk Register – April 2021: Summary of movement, heat map and score history

TOP RISKS

The following risks **score 25 or 20** on the high level risk register:

NEW risks to the HLRR

7769 (25): Progression of eye diseases resulting in increased risk of sight loss (COVID risk) – increased risk rating from 12
7930 (20): Opthalmology delayed treatment for glaucoma resulting in an increased risk of sight loss (COVID risk)
7809 (25) Theatre and clinic capacity (COVID risk) – increased risk rating
7834 (25) Elective orthopaedic inpatient theatre capacity (COVID risk) – increased risk rating

EXISTING risks:

7454 (20): Radiology Staffing Risk
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
7689 (20): Waiting for diagnostics, operations and outpatients (COVID)
7474 (20): Medical devices
7833 (20) Increase in ASI and holding lists

NEW Risks

7769 Progression of eye pathology and sight loss (C5 x L5 =25) SAS (Surgery and Anaaesthetics)
There is a risk of progression of eye diseases and increased risk of sight loss due to the impact of COVID-19 pressures and the need to cancel all non-essential outpatients and surgeries, and current constraints resulting in two thirds reduction in capacity through Ophthalmology, Orthoptic, Optometry clinics resulting in a potential impact on disease progression, and prognosis and clinical outcomes.

Clinical validation and disease risk stratification is being undertaken as described above, according to Moorfields Eye Hospital guidance that has been approved by the Royal College of Ophthalmologists and implemented nationally. There is a lack of clinical space and waiting room space to see the required demand resulting in an increase in holding list and ASI lists with potential to impact prognosis.

7930 - **Ophthalmology delayed treatment for Glaucoma resulting in sight loss (C5 x L4 =20) SAS**
There is a risk of progression of glaucoma and sight loss due to the impact of COVID-19 pressures and subsequent backlog of patients who were initially stratified as low risk, being deferred 6 months now being high risk, alongside reduction in capacity through the glaucoma service resulting in long delays to receive follow up assessment which may impact on prognosis, clinical outcome.

Ophthalmology continue to clinically validate and undertake risk stratification according to Moorfields Eye Hospital guidance that has been approved by the Royal College of Ophthalmologists and implemented nationally, as described above.Ophthalmology continue to clinically validate and undertake risk stratification.

7809 Theatre and clinic capacity (C5 x L5 =25) SAS
There is a risk of being unable to deliver timely clinical activity due to a lack of capacity (theatre and clinic) resulting in potentially poor outcomes for patients and a poor experience.

7834 Elective orthopaedic inpatient theatre capacity (C5 x L5 =25) SAS
There is a risk that Orthopaedic elective patients are unable to have surgery within timescale due to no availability of elective theatres or ward staff resulting in lengthy delays and poor patient outcomes.

7328 – ENT staffing shortage (C4 x L4 – 16) SAS
There is a risk of uncovered tier one non-resident ENT on-call rota gaps de to only 4 out of 6 posts currently filled resulting in staff burn out and risk of uncovered on-call shifts. Possible knock-on effect includes impact on outpatient clinics and theatre lists activity post busy on-call if consultants end up covering the gap. This also adds a financial pressure.

7803 – Delays in surgery (General Trauma) (C4 x L4) SAS
There is a risk that general trauma patients are suffering significant delays in surgery due to organisational factors resulting in poorer surgical outcomes for patients.

INCREASED RISKS

7833 (20) – Increase in the number of ASI and holding lists SAS
There is a risk that the ASI (appointment slot issues) and holding lists will continue to increase due to the lack of outpatient areas in Trauma and Orthopaedics resulting in delays in patients being seen and poorer outcomes.

Update: The number of clinics in the CHFT premises are half of capacity up to 31 March 2021 and there are no longer clinics in the independent sector. The numbers on the ASI list will increase and more patients are likely to not achieve optimal outcomes.
Likelihood increased 4 to 5 and risk score increased from 16 to 20

REDUCED RISKS

7964 - Delayed treatment for patients with macular/medical retina eye conditions SAS
Reported December 2020 at risk score of 20, March 2021 likelihood reduced 5 to 4 and risk score reduced from 20 to 16
There is a risk of capacity reduction and delayed treatment for patients with macular / medical retina eye conditions due to COVID 19 social distancing pressures and the redeployment of nurse practitioner injectors to support inpatient care pressures resulting in permanent sight loss for patients

2827 Over-reliance on locum middle grade doctors in A&E risk reduced from 20 to 16 due to reduction in likelihood **Medicine**
There is a risk of poor patient outcomes, safety and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage resulting in the reliance of locum doctors to fill gaps.

Update:Two clinical fellows are now in post. Recruited in January 2021 to appoint further a ACP to mitigate risk. Exploring further alternate roles to support middle grade rota and further international recruitment underway, and exploring Trust Grade Dr role that combines clinical and leadership opportunities

7683 Lack of isolation capacity Trustwide
There is a risk of not having adequate isolation (Side room) facilities due to an increase in demand and initiation of testing of asymptomatic patients resulting in failure to safety isolate patients and further transmission of Covid-19 to vulnerable patients and impacting patient flow

Update: ward 18 remains open and currently all Covid positive patients are placed on this ward. POC testing in place to ensure that patients are placed in side rooms appropriately and to move patients out of side rooms when necessary. POC testing reduces the risk to other patients when placed in bays on wards All patients requiring admission to speciality beds eg CCU, Cardiology or stroke have a POC test to establish Covid status before admission. Reducing the risk of transmission to other patients on the ward.

RISKS REMOVED FROM THE HIGH LEVEL RISK REGISTER (HLRR)

7942 – Overarching staffing risk risk score reduced from 16 to 12, removed from HLRR March 2021 **Trustwide**
There is a risk of: staffing levels decreasing to a level that effects safe staffing due to: covid infections affecting delivery of safe, effective and responsive patient care.

Rationale: Absence at CHFT compares well with other Trusts in the North East and Yorkshire. CHFT is ranked #5 of all Trusts in the region. Non COVID absence has reduced to pre COVID levels, and whilst slightly above the Trusts rolling absence target of 4%, is an improvement in q4 2020/21. COVID absence also compares well.

Leadership Walkrounds are being conducted regularly and are well received by colleagues. A spot check of risk assessments and social distancing takes place as part of the walkrounds, and compliance is generally good. The Wellbeing Hour continues to be supported by the Trust, and a task and finish group led by the Chief Nurse has helped to understand the positive impact that the hour has had.

7797 – Variable compliance with IPC guidelines, risk score reduced from 16 to 8, removed from HLRR March 2021 **Trustwide**
There is a risk of variable compliance with IPC guidance due to staff working in different areas and with different equipment and consumables whilst also wearing restrictive PPE resulting in IPC outbreaks

Rationale: Majority of staff have returned to their original areas of work. Weekly Matron covid assurance checklist implemented. Regular IPC gold meeting scheduled to quickly identify any compliance issues.

2830 – ED Mental Health Breach, risk score reduced from 16 to 12, removed from HLRR March 2021 **Medicine**

There is a risk to safety and experience for mental health patients who are at risk of harming themselves or others, and of absconding from the department due to excessive waits for Mental Health Act assessments and mental health in-patient bed availability resulting in a lack of supervision and care provided in the wrong place

Update: No long waits in department in 4 months we have seen a continued reduction therefore reducing risk level.

7796 – Track and trace, risk score reduced from 16 to 10, removed HLRR March 2021 **Trustwide**

There is a risk of staff or whole team shortages due to the Government Track and Trace system advising self-isolation for contacts of Covid resulting in potential for reduction in services and impact on patient care

Update: Falling prevalence rates have led to a reduced number of colleagues requiring to isolate, meaning that attendance rates are rising. CHFT ranks 5th amongst Trusts in NE and Yorkshire and therefore there is a higher confidence that absence overall will fall.

7248 – Failure to complete Essential Safety Training, risk score reduced from 16 to 9 **Corporate**
There is a risk of not all colleagues completing their designated core 'Essential Safety Training' (EST) Resulting in practicing without the recorded required knowledge or understanding.

Update: Our core 10 EST subjects have been consistently above target since April 2020/21 with an average of 94.84%. The focus therefore is on the compliance of the 34 role specific subjects. Compliance for these subjects range from 97.60% to is 85.54% which is a vast improvement on the previous years 50.04% but still short of the 90% target. Task and finish group that sits in the Medical Division is looking at Basic Life Support and Moving and Handling which are both currently around 55% compliance. We expect all role specific training to be on target by August 2021.

↓TRUST RISK PROFILE AS AT DATE OF RISK REGISTER

KEY: = Same score as last period ↓decreased score since last period

! New risk since last period ↑ increased score since last period

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant	**Minor**	**Moderate (3)**	**Major (4)**	**Extreme (5)**
Highly Likely (5)			= 6715 Poor quality / incomplete documentation =7615 Emergency Care Standard	= 6345 Nurse Staffing = 7078 Medical Staffing =7454 Radiology staffing =7689 Diagnostics,OPD, operations =7474 Medical Devices ↑7833 Increase in ASI and holding lists	!7809 Theatre and clinical capacity !7834 Elective orthopeadic theatre capacity !7769 Progression of eye pathology and sight loss
Likely (4)			↓2830 ED Mental Health Breach	=6829 Pharmacy Aseptic Dispensing Service =7617 Cyber risks =7557 Meeting RCPCH guidelines ED =6596 Delay in SI investigations =7778 Staff infected with Covid =7527 Maxillofacial follow up appointment =7936 Social distancing (Staff behaviours) !7328 ENT staffing Shortage !7803 Delays in Surgury – General Trauma ↓2827 Over reliance on locum middle grade doctors in A&E ↓7964 Delay treatment for eye conditions ↓7683 Isolation facilities = 6453 Delay of surgical report #NOF	!7930 Ophthalmology delayed treatment Glaucoma
Possible (3)			↓ 7248 Essential Safety Training	↓ 7942 Overarching staffing risk	= 5747 Vascular /interventional radiology service =7413 Fire compartmentation HRI =7414 Building safety
Unlikely (2)		↓ 7796 Track &trace		↓7797 Variable IPC guidelines	
Rare (1)					

Risk Appetite – August 2020

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

SUMMARY OF HIGH LEVEL RISK REGISTER BY TYPE OF RISK as at 7th April 2021

BAF ref	Risk ref	Strategic Objective	Risk	Executive Lead/ Divisional Director	Risk Score his					
					Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	April 21
QUALITY AND SAFETY RISKS										
06/19	5747	Keeping the base safe	Vascular / interventional radiology service	Divisional Director of FSS (WA)	=15	=15	=15	=15	=15	=15
06/19	6453	Keeping the base safe	Delay surgical repair #NOF	Clinical Director	=16	=16	=16	=16	=16	=16
08/19	6596	Keeping the base safe	Delay in SI investigations	Director of Nursing (EA)	=16	=16	=16	=16	=16	=16
06/19	6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (EA)	=15	=15	=15	=15	=15	=15
06/19	6829	Keeping the base safe	Pharmacy Aseptic Dispensing Service	Director of Nursing (EA)	=16	=16	=16	=16	=16	=16
~~11/19~~	~~7248~~	~~Developing our workforce~~	~~Essential Safety Training~~	~~Director of Workforce and OD (SD)~~	~~=16~~	~~=16~~	~~=16~~	~~=16~~	~~↓9~~	
10a	7328	Keeping the base safe	ENT Middle Grade rota gaps	Director of Operations SAS (TS)	=16	=16	=16	=16	=16	=16
16/19	7474	Keeping the base safe	Medical Devices Risk	Director of Finance (GB)	16	↑20	=20	=20	=20	=20
05/19	7527	Keeping the base safe	Maxillofacial follow up appointment	Divisional Director of SAS (WA)	=16	=16	=16	=16	=16	=16
08/19	7615	Keeping the base safe	Emergency Care standard	Director of Nursing (EA), Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15
02/20	7617	Keeping the base safe	Cyber risks	Managing Director Digital Health (MG)	=16	=16	=16	=16	=16	=16
05/20	7683	Keeping the base safe	Isolation facilities	Medical Director (DB)	=20	=20	=20	=20	↓16	=16
05/20	7689	Keeping the base safe	Delay in diagnostics, OPD and operations	Director of Transformation (AB)	=20	=20	=20	=20	=20	=20
05/20	**7769**	Keeping the Base Safe	**Ophthalmology disease progression**	Director of Operations SAS (TS)		**!25**	**=25**	**=25**	**=25**	**=25**
05/20	7778	Keeping the base safe	Staff infected with Covid-19	Chief Operating Officer (HB)	=16	=16	=16	=16	=16	=16
~~05/20~~	~~7797~~	~~Keeping the base safe~~	~~Variable IPC guidelines~~	~~Medical Director (DB)~~	~~=16~~	~~=16~~	~~=16~~	~~=16~~	~~↓8~~	
05/20	**7803**	Keeping the base safe	**Delays in general trauma surgery**	Divisional Director of SAS (WA)	**=12**	**↑16**	**=16**	**=16**	**=16**	**=16**
05/20	**7809**	Keeping the base safe	**Theatre and clinic capacity SAS**	Director of Operations SAS (TS)	**=16**	**↑25**	**=25**	**=25**	**=25**	**=25**

05/20	7833	Keeping the base safe	ASI Orthopaedics appointment slots	Divisional Director of SAS (WA)	**=16**	**=16**	**=16**	**=16**	**=16**	**↑20**
05/20	**7834**	Keeping the base safe	**Orthopaedic elective surgery**	Divisional Director of SAS (WA)	**=16**	**↓25**	**=25**	**=25**	**=25**	**=25**
05/20	**7930**	Keeping the base safe	**Ophthalmology glaucoma**	Clinical Director Head & Neck (PL)	**!20**	**=20**	**=20**	**=20**	**=20**	**=20**
06/19	7936	Keeping the base safe	Social distancing (staff behaviours)	Chief Operating Officer (HB)	!16	=16	=16	=16	=16	=16
05/20	**7964**	Keeping the base safe	**Ophthalmology capacity retinal problems**	Director of Operations SAS (TS)		**!20**	**=20**	**=20**	**=20**	↓16
WORK FORCE RISKS										
01/19	2827	Developing our workforce	Over reliance on locum middle grade doctors in A&E	Medical Director (DB) Emergency Dept Clinical Director (AM)	=20	=20	=20	=20	↓16	=16
10b/19	7557	Keeping the base safe	Meeting RCPCH guidelines ED	Director of Nursing (EA)	=16	=16	=16	=16	=16	=16
10b/19	6345	Keeping the base safe	Nurse Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (EA), Director of Workforce	=20	=20	=20	=20	=20	=20
10a/19	7078	Keeping the base safe	Medical Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (EA), Director of Workforce	=20	=20	=20	=20	=20	=20
10a/19	7454	Keeping the base safe	Radiology service provision staffing risk	Divisional Director of FSS (JO'R)	=20	=20	=20	=20	=20	=20
~~11/19~~	~~7942~~	~~Keeping the base safe~~	~~Overarching staffing risk~~	~~Director of Workforce and OD (SD)~~		~~!16~~	~~=16~~	~~=16~~	↓12	
ESTATES / SAFETY RISKS										
09/19	7414	Keeping the base safe	Building cladding	Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15
09/19	7413	Keeping the base safe	Fire compartmentation at HRI	Chief Operating Officer (HB)	=15	=15	=15	=15	=15	=15

KEY: = Same score as last period, ↓ decreased score since last period, **!** New risk since last report to Board ↑ increased score since last period
Newly added risks highlighted in bold.

Board Assurance Framework risks referenced above:

01/19	Risk re approval of the hospital services reconfiguration business cases
05/19	Risk that the resource, capacity and capability of full optimisation of the EPR system due to lack of optimisation of the system does not continue to further enhance quality and safety
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
11/19	Risk of not attracting or retainng colleagues who are confident and competent to provide compassionate care to patients and inclusive leadership to colleagues.
13/19	Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longert term and meet safety and regulatory standards resulting in patient harm and regulatory intervention
16/19	Compliance with Health & Safety
2/20	Investment for Digital Strategy ambitions
5/20	Unable to maintain current levels of Covid-19 capacity or response to surges in Covid-19 demand and non-Covid 19 patients

April 2021 updated BAF references

High Level Risk Register
Board of Directors – 6 May 2021

	Risk No	Div.	Dir	Dep	Opened	Status	Objective	Risk Description plus Impact	Existing Controls	Gaps in Controls	Initial	Current	Target	Action Plans	Progress Update	Review	Target	RC	Exec Dir	Lead
Very High	7769	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2020	Active	Keeping the base safe	There is a risk of progression of eye pathology and sight loss due to the impact of COVID-19 pressures and the need to cancel all non-essential outpatients and surgeries resulting in an impact on prognosis and clinical outcomes. Continual social distancing measures are added constraints resulting in 2/3 reduction in capacity through Ophthalmology, Orthoptic, Optometry clinics.	Department undertaken risk stratification according to Moorfields Eye Hospital guidance that has been approved by the Royal College of Ophthalmologists and implemented nationally.	Unable to review routine (moderate and low risk) patients face to face for complete assessment to support management and treatment decision making. Lack of clinical space and waiting room space to see the required demand resulting in an increase in holding list and ASI lists.	12 4 x 3	25 5 x 5	4 4 x 1	Risk stratification guidance being followed Validate all patients booked into clinics March-end June Validate all patients due an appointment March to end of June Validate complete 'to be scheduled list' Moved all paediatrics and emergency eye care services to CRH All ED presentations eye specific to be phoned through to emergency eye clinic (supported by a Consultant) Recover plan being devised and failsafe team ensuring patients identified	1/4/21 CH/PL review - eye theatres restarted this week. OP activity update needed. 26/1/21 DMT update: in 3rd wave of pandemic. review in 3 months 23 December 2020 - Score increased from 20 to 25. IMT decision 22 December 2020 to not re-allocate injectors back to Ophthalmology in January 2021 which leaves the department short of 160 injection slots based on treatment plans. Action taken: Decline further annual leave applications and put shifts out as extras.	May-2021	Oct-2021	PSQB	Thomas Strickland	Louise Corp
Very High	7834	Surgery & Anaesthetics	Orthopaedics	All wards/departments Orthopaedic	Jul-2020	Active	Keeping the base safe	There is a risk that Orthopaedic elective patients are unable to have surgery within timescale, due to their being no availability of elective theatres or ward staff resulting in lengthily delays and poor patient outcomes. There is currently no elective Orthopaedic inpatient theatre capacity at CHFT.	A number of Elective Day case lists have been sourced in the independent sector at the Spire and BMI hospitals up to 24 December 2020. After this the NHSE IS contract finishes and there is currently no agreement in place for IS theatre capacity thereafter. All Consultants are reviewing their current waiting lists and telephone clinics have been established for review and stratification of the patients on the waiting lists. Following clinical validation, the patients are clinically prioritised and categorised from 1 (that being the most urgent) - 4 (being the least urgent) according to Royal College guidance on clinical prioritisation of surgical patients.	There is currently no elective Orthopaedic inpatient theatre capacity at CHFT. Limitations of IS criteria for patient cohort dependent on co-morbidities. A lot of our patients don't fit the criteria for surgery in the independent sector. The nursing staff from the Orthopaedic elective ward at CRH have been redeployed during the Covid-19 pandemic to the acute respiratory floor and there are no current plans for their return into Orthopaedics. A number of patients that were risk stratified in May/June time at a certain level (1-4) are now moving in to the lower more urgent categories with no plan to operate.	16 4 x 4	25 5 x 5	9 3 x 3	There is currently no elective orthopaedic inpatient theatre capacity at CHFT and there are no actions we can take to alleviate this.	April 2021. Elective Orthopaedic lists start 07/04/2021. These lists will gradually gather momentum and hopefully demonstrate a change in numbers. 15.12.20 - Risk updated with Jane Peacock, General Manager for T&O. CCG have this on their register at 25, Tom Strickland, D'Op has requested that our scoring as a Trust be brought in to line with theirs. The contract has still not been agreed as of 15 December 2020. 14.12.20 - Risk Group requested rationale from Division for score of 25. Contract negotiations are ongoing between the Trust and the independent sector regarding the ability to perform any Orthopaedic surgery in the independent sector from 24 December 2020 onwards.	May-2021	Aug-2021	PSQB	William Ainslie	Gautam Chakrabarty

Very High	7809	Surgery & Anaesthetics	All Directorates S&A	All Departments/Wards S&A	Jun-2020	Active	Keeping the base safe	There is a risk of being unable to deliver timely clinical activity due to a lack of capacity (theatre and clinic) resulting in a potentially poor outcomes for patients and a poor experience.	MDTs in place to identify and manage high risk patients. Virtual clinics taking place. Division involved in reset plans to reinstate activity. Theatre lists being allocated according to clinical priority. Theatre scheduling taking place with clinical involvement.	Currently only one elective theatre per day at CHFT available and with the NHSE IS contract finishing on 24 December there is currently no agreement in place for IS theatre capacity thereafter. Staff unavailability also impacting due to sickness, shielding and deployment to other areas.	16 4 x 4	25 5 x 5	3 1 x 3	Each directorate team is working through plans to clinically assess and prioritise patients overseen by IMT. Revised pathways of care being developed to safely manage demand across all specialities. Continue to ensure optimum use of current theatre space with escalation of issues through to DMT.	March 2021 Update: Planning to restart more elective work from 1 April but as of yet staff moves etc. are not confirmed. There is new IS contract in place but this provides limited capacity for the Trust 04.12.20 - RISK INCREASED TO 25 AS REQUESTED BY TOM STRICKLAND, D'OP FOR SURGERY AND REFLECTIVE OF CCG RISK. 24 August 2020 - Accepted at PSQB on	Apr-2021	May-2021	PSQB	William Ainslie	Thomas Strickland
Very High	7833	Surgery & Anaesthetics	Orthopaedics	Orthopaedic Outpatients	Jul-2020	Active	Keeping the base safe	There is a significant risk that the ASI (appointment slot issues) and holding lists will continue to increase due to the lack of outpatient areas in Trauma and Orthopaedics resulting in delays in patients being seen and poorer outcomes.	- Increase in number of VFC appointments to review patients in a timely manner - Daily Consultant led Covid # Clinic in place at HRI site - Telephone appointment clinics have been set up for review of patients where appropriate	There is a significant reduction in the number of clinic rooms available for T & O to use to see patients due to both CRH & HRI ED's taking these areas to undertake review of ED minors in these areas. There are no Orthopaedic Outpatient areas available at the CRH presently.	16 4 x 4	20 4 x 5	4 2 x 2	- Increase in number of VFC appointments to review patients in a timely manner - Daily Consultant led Covid # Clinic in place at HRI site - 48/72 hour review of Urgent New referrals by Consultant - plans to increase capacity by sourcing elective Orthopaedic clinic space at both Independent Sector Hospitals (BMI & Spire) 5 days per week x 3 rooms 15.12.20 - Looking to source rooms for consultations within GP practices (Lister Lane Surgery and Todmorden Health Centre).	07.04.21 The situation has worsened as we no longer have clinics in the Independent sector. The number of clinics in the CHFT premises are half of what was done up to 31 March 2021. The numbers on the ASI list will increase and more patients are likely to come to harm. Risk score increased to 20. 15.12.2020 - No capacity for elective neither within the Trust or externally in the independent sector. Negotiations between the Trust and independent sector ongoing regarding contract, from 24 December 2020 there is no provision.	May-2021	Jun-2021	PSQB	William Ainslie	Gautum Chakrabarty
Very High	7930	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Nov-2020	Active	Keeping the base safe	There is a risk of progression of glaucoma and sight loss due to the impact of COVID-19 pressures and subsequent backlog of patients who were initially stratified as low risk, being deferred 6 months now converting to high risk and in need of face to face assessment. Continual social distancing measures are continuing to result in 2/3 reduction in capacity through the glaucoma service resulting in long delays to receive follow up assessment which may impact on prognosis, clinical outcomes, and quality of life.	Department continuing to undertake risk stratification according to Moorfields Eye Hospital guidance that has been approved by the Royal College of Ophthalmologists and implemented nationally. Additional sessions added ad hoc where possible.	Lack of clinical space and waiting room space to see the required demand resulting in an increase in holding list and ASI lists.	20 5 x 4	20 5 x 4	1 1 x 1	Risk stratification guidance being followed Validate all patients due an appointment up to the end of December 2020 Consider alternative ways of working- diagnostic clinic, high volume IOP check clinics. Seek additional estate.	1/4/21 CH/PL review: updated numbers requested from Emma. Risk ongoing. Review June 2021 March Total list size- 1167 Validations completed up to this time- 978 26/1/21 DMT update: in 3rd wave of pandemic. review in 3 months Accepted at PSQB on 21 December 2020 with a score of 20. December total list size = 652 Validations up to end of December still to complete = 307 Validations up to end December COMPLETED - 345	May-2021	Dec-2021	PSQB	PNT Laloë	Emma Griffiths

Very High	7689	Trust wide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk that patients may have to wait for outpatient appointments, diagnostic tests or routine operations Due to cancellations of routine surgery and rescheduling of clinics Resulting in their condition deteriorating, potential impact on treatment options available and a less positive outcome	EPR booking and validation processes Urgent fast-track processes in place Risk assessment for re-prioritisation of appointments Virtual appointments commenced in some prioritised areas	Unable to meet target KPI's for RTT and diagnostics, and that patients will wait longer than is best practice for outpatient appointments with an increase in the ASI list and holding list.	20 4 x 5	20 4 x 5	4 2 x 2	Clinical review and prioritisation of essential patients Medicine: risk assessment of booked and due, consider remote or delay 3-6 months. Working up CAS model and recovery plan. Incident reporting for identifying patient harm or impact on prognosis or outcome Complaints and PALS Team logging enquiries and concerns re waits for appointments, and patients not wishing to attend for appointments	March 21: Customer Contact meetings have been reinstated for most specialities. Clinical validation and prioritisation in place (via M page) numbers of validated patients are increasing. Specialities are formulating recovery plans and templates. Slight increase in the number of requests for F2F clinics. ASI F/U backlog numbers are starting to decrease Feb 2021: Clinical validation and prioritisation in place (via M page). Recovery meetings still weekly to discuss backlog etc. Phone/Virtual appointments are still in place - a large number of F2F clinics have been cancelled or replaced with phone consultations due to the third wave. Customer contact meetings have been cancelled in most areas. ASI F/U backlog numbers continue to increase. January 2021: Clinical validation and prioritisation in place, Buddies have been started they will contact patients and give information when validated as high P value. Phone/Virtual appointments are still in place - a large number of F2F clinics have been cancelled or replaced with phone consultations due to the second wave. Divisional CAS coordinators have employed and are now in divisions. Customer contact meetings have been cancelled in most areas. ASI F/U backlog numbers continue to increase.	Apr-2021	Jul-2021	NA	Anna Basford	T Strickland, S Shepley, L Willia
Very High	6345	Corporate	Workforce & Organisational Development	Resourcing / Recruitment	Jul-2015	Active	Keeping the base safe	There is a risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Establishment reviews/CHPPD and national workforce models) - Inability to adequately staff flexible capacity ward areas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster to set nurse staffing within agreed workforce models, approved by Matron and general managers - risk assessment of nurse staffing levels for each shift reviewed at least three times each 24 hour period using the Safer Care tool with formal escalation to Director of Nursing to agree mitigating actions. - staff redeployment where possible - nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream - Active recruitment activity, including international recruitment - Introduction of new roles e.g. Nurse associate	Low numbers of applications to nursing posts across grades and specialities National shortage of RGN's	16 4 x 4	20 4 x 5	9 3 x 3	• Local/domestic recruitment - monthly assessment centres • International recruitment project • Nursing associate role development and deployment of graduating cohorts • Workforce transformation (NA's, TNA's and ACP's) • Developing nursing retention strategy • Use of flexible workforce • Utilisation of nursing workforce using safe care live • Response to the NHS interim people plan - significantly grown the number of undergraduate Health students to improve the pipeline of nurses to recruit (See attached milestone plan/tracker in documents)	March 2021 International Recruitment programme increased to take 70 nurses before year end 31 Dec 2021- supported by further financial investment by NHSE/I 3rd year students providing care hours in paid placements further to HEE and NHSE/I response to Covid Surge. Active engagement of this cohort to ensure CHFT is The Place to Be for newly qualified nurses upon registration in summer 2021 Recruitment to June 2021 TNA cohort has commenced. January 2021: Full review of the risk completed New graduates now in shift fill Planning for the deployment of the first NA cohort in June 2020 International recruitment continues Planning for the next cohort of TNA's Hosting increased numbers of undergraduate students Risk 5937 merged to this risk (6345)	Apr-2021	Sep-2021	WF	Ellen Armistead, Suzanne Dunkley	Janet Youd

							Nurse Staffing Risk (see also medical staffing risk 7078 and therapy staffing risk 7077).												
Very High	7078	Corporate	Medical Director's Office	Operational	Oct-2017	Active	Keeping the base safe	Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to difficult to recruit to Consultant posts in Gastroenterology, Radiology, Dermatology and Ophthalmology, and dual site working which impacts on medical staffing rotas resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives	Medical Staffing Job planning established which ensures visibility of Consultant activity. E-rostering roll out commenced to ensure efficient use of Consultant time Establishment of staff bank to ensure vacant posts filled WYAAT networked approach to pressured specialties Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment at Specialty Doctor level - new electronic recruitment system implemented (TRAC) - HR resource to manage medical workforce issues. - Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements	Medical Staffing Risk of pensions issue impacting on discretionary activity National shortage in certain medical specialties Regional re-organisation could potentially de-stabilise the workforce E-rostering partially implemented for doctors (expected by Sept 2020) - centralised medical staffing roster has commenced but not fully integrated into the flexible workforce team - measure to quantify how staffing gaps increase clinical risk for patients	20 4 x 5	20 4 x 5	9 3 x 3	• Monitored by Medical Workforce Programme Steering Group • Active recruitment including international	March 2021: As Covid inpatient numbers have now declined the daily medical workforce meetings have ceased. The flexible workforce team liaise daily with the managers within the division of Medicine so any staffing pressures will be picked up through that route. Rotas that were previously escalated are now being phased out for all grades so it is anticipated that by April all medical staff within the Medicine division will be working their usual, 'normal' rota. The requirement for year 5 medical students to undertake bank shifts will be reviewed within division as part of their usual discussions with regards to staffing levels. Some international travel has been possible which means we have some new colleagues joining us from overseas during March and April. This includes a consultant Anaesthetist that has relocated to the UK from Australia, a Specialty Doctor for Obstetrics, and one of the Radiology Global Fellows. The possibility of a Medical Training Initiative for a Radiologist from Sri Lanka is currently being explored, A new consultant has been appointed as the Clinical Lead for Fertility services and is expected to commence in post in May 2021. An AAC for a Consultant Cardiologist and Obstetrician with a special interest in Fertility has been arranged for late March, and further AACs are planned for Respiratory Medicine, Geriatric Medicine, Neurology and Haematology in April 2021. A new national contract for SAS doctors has been proposed by NHS Employers following consultation negotiation with the British Medical Association. A ballot has been undertaken with BMA members and the outcome will determine whether a new contract is implemented, once ratified by Ministers. This will offer the opportunity for some of our highly experienced doctors who are able to work independently to apply for senior posts without the necessity for Specialist Registration with the General Medical Council.	May-2021	May-2021	WF	David Birkenhead	Pauline North

Very High	7454	Family & Specialist Services	Radiology	Main X-Ray	Apr-2019	Active	Keeping the base safe	Service Delivery Risk There is a risk to Radiology service provision due to a reduction in Consultant capacity resulting in a reduction of cover in some specialist areas and overall general capacity with the potential for breaching national targets.	- Agency Sonographer cover. - NHS Locum cover. - Lung and chest: Additional reporting support from external providers and temporary change to job plan. Ad hoc support from WYAAT Trusts. - IR: Daytime support from neighbouring organisation (1 day per week); reconfiguration completed in November and now sharing OOH cover with WYVAS, NHS locum in place providing block cover (x weeks on/ x weeks off). Head & Neck - part time consultant in post, US scanning supported by locum sonographer - Additional reporting support from external providers. - Neuro: Additional reporting support from external providers and temporary change to job plans. - General on-call: Increase in use of external provider cover and existing Consultants picking up additional stand-by shifts.	Vacancies in all areas, including: - Lung and chest: Gap during annual leave of one remaining Consultant. - IR: Gap when contracted NHS Locum is on annual leave/other leave. - Neuro: Reduced capacity and no capacity during annual leave/other leave. - Paediatrics. - Head and Neck.	15 3 x 5	20 4 x 5	1 1 x 1	- Actively seeking recruitment in all areas including use of introduction agencies. - Actively seeking NHS and agency locum for all required areas. - Actively seeking a second overseas fellow. - Existing consultants working through competencies to enable coverage of gaps. - Outsourcing increased to free up capacity where possible. - Locum support employed when available e.g. breast radiologists - Appointed a NHS Locum Chest Radiologist, due to commence August 2020. Feb update - this consultant has now given back word.	December 2020 update: We continue to work towards the development of shared posts with our LTHFT colleagues and progress is being made. The locum appointed for IR has given backword however a second Leeds IR consultant has made himself available for locum shifts at HRI. We still await the commencement of 3 overseas global fellows, currently dependent on Covid restrictions. We are currently facilitating a clinical attachment, if successful we are hopeful it will lead to the appointment of an additional specialist doctor. This doctor has been appointed by the department and is awaiting GMC registration before commencement. March 2021 Update: Risk reviewed, all areas updated as required. Position remains the same as December 2020 update.	Apr-2021	Mar-2022	DB	Stephen Shepley	Sarah Clenton
Very High	7474	Trustwide	All Divisions	All Departments/Wards	May-2019	Active	Keeping the base safe	There is a risk to the organisation of out of service medical devices being in circulation and in use across CHFT due to the lack of assurance about the Trust Asset Register being up to date as it doesn't include equipment which has been gifted or bought without CHS involvement resulting in potential patient harm to patients. This is also due to wards/departments not managing their equipment effectively, those which are out of service date and have not been seen for extended periods of time and are in use or available for use within CHFT for patient care, there is risk of patient harm. CHS Risk 7438	CHS Medical Engineering are attempting to rectify the problem and identify all devices in the high, medium, and low risk category to provide an up-to-date register. To check if devices have a date on when they were last inspected as this would assist CHFT colleagues to identify equipment out of date. CHFT staff are aware of the need to report medical devices requiring maintenance/repair however a reminder is deemed appropriate to ensure colleagues follow this process which will support CHS achieve their objectives. Equip database enabled providing increased divisional control and ability to see which items of equipment are overdue.	Failure to manage, maintain and service medical devices which are both know/unknown to EBME	5 5 x 1	20 4 x 5	6 3 x 2	Schedule the maintenance of those devise identified prioritising high-risk devices first 2021/03/01-Update- working with divisions to audit asset register and ensure devices are in correct locations, adding assets to asset tracking system and to allocated ward areas.	2021/03/01-Update High risk fallen to (718 to 686), Medium risen to (1983 to 2930), Low risen to (1307 to 1500) a total of (4008 to 5116). Progress has been affected by higher demand and reactive repairs, acceptance testing of National Loan kit & having to move Engineering locations from ward 9 to 10 has also had significant impact on unaddressed workload.	Apr-2021	Apr-2022	RC	Ellen Armistead	Robert Ross

High	7527	Surgery & Anaesthetics	Head and Neck	All wards/departments Head & Neck	Aug-2019	Active	Keeping the base safe	There is a risk that patients will develop a recurrent cancer or more invasive cancer if they are missed for their follow up appointments, this is due to patients not being booked back in for their require time frame of appointment for the surveillance check - resulting in patients / hospital cancelling the appointments and patients are not being seen at the designated timeframes.	A failsafe process has been implemented for the post cancer patients? recurrent cancer / Surveillance through the cancer head and neck services. The validation team are prioritising the maxillofacial validation of 591 patients. Checks that all orders at placed following outpatients' attendance Added onto care plans of review of follow ups dates required for all cancer diagnosed patients	EPR system (Lists) Lists of patients Failsafe Escalation process to implemented within appointment centre, secretaries. Appropriate training within the department	15 x 3	16 4 x 4	4 2 x 2	Review outstanding validations- Completed Develop process with appointment centre (Validation team) Completed Develop escalation process with appointment centre, secretaries for cashing up of clinics, and process to add further requests if appointments are cancelled. Completed Communication plan within the head and neck services. Completed High level process to roll out within the division. - Ongoing, process map developed, awaiting sign off by division.	1/4/21 PL/CH: emailed Natalka/Caroline (cc: Sharon Berry) for update. Remains 16 for now. 23 December 2020 - Reviewed by PNT with Helen Marsh. Head & Neck Service Manager redeployed to Endoscopy due to Covid-19. Score remains at 16. Review 3 months. December 2020: Crib sheet in design for ENT consultant not specialised in H+N cancer to support seeing patients and picking appropriate diagnostic tests. Waiting radiology approval. Locum ENT Consultant out to advert to support H+N cancer due to 1 clinician on phased return and not seeing F2F.	Jun-2021	Aug-2021	PSQB	Thomas Strickland	Sharon Berry
High	7557	Medical	Emergency Care	Accident & Emergency CRH/HRI	Oct-2019	Active	Keeping the base safe	There is a risk to patient safety and experience for children and families visiting the Emergency Departments at CHFT. Due to the current workforce model which does not support the RCEM and National guidelines (RCPCH) which recommend 2 x Qualified Registered Children's Nurses on a shift in an ED at any one time. Resulting in the inability to : Provide care appropriately for sick children Recognise the sick and deteriorating child Have staff trained in appropriate distraction techniques for children Lack of awareness of all safeguarding flags and signs to be aware of in children attending the department.	2 RSCN nurses employed at Calderdale 6 Nurses currently on the Child In ED course via the university RN's working in the department who have previously completed the child in ED course APNP's attending the HRI site to care for sick children Work on going to look at an interim model while awaiting reconfiguration	Unable to recruit RSCN's in current workforce model Risk of recruiting RSCN's leading to poor morale and leaving the trust Unable to send a large proportion of staff on the Child in ED course due to study leave	16 4 x 4	16 4 x 4	1 1 x 1	To subscribe to the child in ED course at every intake via the university. Create a business case to increase the work force model to achieve RSCNs on each shift	March 2021: Planning study days at the moment to upskill all staff with paediatric skills. Work on going with FSS task and finish group to recruit Paeds nurses and start working towards a Paediatric ED. February 2021: Still awaiting decision on Paediatric wfm for CRH ED. Work on going with Paeds regarding cover for HRI ED site and opening a dedicated unit at CRH site. January2021: Awaiting decision regarding moving all Paediatric patients across to CRH from HRI. If so CRH have vacancies to recruit into paediatric nurses however can only do this is if we have a dedicated ED for Paediatric patients.	Apr-2021	Apr-2021	NWG	Ellen Armistead	Louise Croxall/Jayne Robinson
High	7328	Surgery & Anaesthetics	Head and Neck	Ear, Nose and Throat	Sep-2018	Active	Keeping the base safe	Risk of uncovered tier one non-resident ENT on-call rota gaps due to only 4 out of 6 posts currently filled. This could result in staff burn out and risk of uncovered on-call shifts. Possible knock-on effect includes impact on outpatient clinics and theatre lists activity post busy on-call if consultants end up covering the gap. This also adds a financial pressure.	- All current staff (AP, TT) are signed up on bank to help cover gaps (Nov 2018) - Previous trainees (DM, BY) and Speciality doctors (JI) are also signed up on bank (Oct 2018) - Spec Doctor ENT job advert gone out. Interviewing 2 candidates on 14/11/18 - Tier 2 non-resident consultant rota staffed	Sep 2018 rotation of trainees includes a Less Than Full Time (LTFT) colleague (60% FTE) therefore in October 2018, the situation may get worse.	12 3 x 4	16 4 x 4	1 1 x 1	Recruit more ENT doctors (Nov 2018)	26/1/21 DMT update: Retiring SprDr. Risk unchanged. Further doctors due to start March & June 2021. January 2021 Update: New recruited middle grade starting next week. Risk score to be reduced to 12 (likelihood 3) in February 2021 if started on-calls. Rota gap remains. November 20 - 10th December interview for Middle Grade to join on call and clinics. Agency Dr started 30/11/20 as started Middle Grade position to help on call. 1 substantive starting 11/1/21, 1 substantive starting 8/3/20. Total of 3 Gaps.,.	Jun-2021	Jun-2021	PSQB	Thomas Strickland	Pnt Laloë

High	7617	Corporate	THIS	THIS -Operational	Dec-2019	Active	Keeping the base safe	Risk of: being in breach of contractual obligations, reputational damage to the Trust and becoming an NHS England/Improvement (the Cyber Risks and Operations group) trust of concern. Due to: non- compliance with the Data Security protection toolkit Resulting in: inability to trade due to contractual obligations not being met, loss of income and reputational damage. In addition, as a HSCN consumer, we are responsible for maintaining compliance with relevant NHS Digital Information Governance and data security standards and accreditation including the Data Security and Protection Toolkit (DSPT) which is one of our obligations under the HSCN Connection Agreement. It is not necessary to complete a Data Security and Protection Toolkit (DSPT) assessment in order to gain access to HSCN.	Control Group established – Governance Risk and Compliance (GRC) IT Workstreams in place to address areas of non-compliance Operational control by THIS Director Project management in place to steer progress Data Protection Officer oversight Digital Investment (Darktrace etc) Aug 2020 - Plan in place	Password Policy (inc Rollout) Delivery of planned work for March 21 Cyber Essentials Certification	16 4 x 4	16 4 x 4	4 4 x 1	3 workshops have taken place to understand the resource and capital investment needed to close the gaps and meet the required level of compliance. The output from these workshops is the compilation of a plan with timescales and deliverables. This plan will be complete in Dec 19 with the first actions commencing in January 2020 where funding allows for resource and infrastructure investment. Plan underway with positive outcome expected July/Aug 2020. Revised plan going to Divisional Board in Aug 2020. Revised plan agreed. Plan now in place and on track to deliver compliance for March 2021	Jan 2021 - Work continues on track with the plan, resource is in place until 31st March with possible extension if needed. No change in the current score. Feb 2021: as above, no further update and no change in current score. March 2021: Following a discussion at THIS EB in Feb, whilst there is good progress towards DSPT, there will be no change in the current score until we are confident in compliance.	Apr-2021	Jun-2021	DB	Mandy Griffin	Rob Birkett
High	7683	Trustwide	All Divisions	All Departments/Wards	Mar-2020	Active	Keeping the base safe	There is a risk of not having adequate isolation (Side room) facilities Due to an increase in demand and initiation of testing of asymptomatic patients Resulting in failure to safety isolate patients and further transmission of Covid-19 to vulnerable patients and impacting patient flow	Infection Control policies and procedures PHE guidance In-house testing of patients. Daily IMC VC meetings. SITREPS Monitored by Tactical with reporting and escalation into Covid re bed capacity and patient flow. Reason to Reside reviewed on a daily basis and meeting arranged with GP, CCG, and social care partners Discharge team working with consultants to expedite discharges Strategic Command	One platform for testing and if this goes down will need to revert for testing to Leeds with results taking longer to receive Aerosol generating respiratory interventions should be in single side rooms or require all in the area to wear PPE.	12 4 x 3	16 4 x 4	6 3 x 2	In-house testing to move negative out of isolation - in place POC testing in place to reduce the need to admit directly to a side room and reduce risk to other patients on the ward. Review anti-microbial protocols for antibiotic prescribing to reduce patient contact and move to early discharge Plan for commencement of testing of asymptomatic patients - in place Manage patient flow, discharge planning, admission avoidance, reason to reside assessment	March 2021- Ward 18 remains open and currently all Covid positive patients are placed on this ward. POC testing in place to ensure that patients are placed inside rooms appropriately and to move patients out of side rooms when necessary. POC testing reduces the risk to other patients when placed in bays on wards All patients requiring admission to speciality beds e.g., CCU, Cardiology or stroke have a POC test to establish Covid status before admission. Reducing the risk of transmission to other patients on the ward. January 2021- Ward 18 opened on the 28th of December 2020 which increases the number of isolation room by 15 at HRI. Implementation of lateral flow testing for all ED admissions to enable direct admissions for patients with a positive COVID-19 test to the isolation ward. Roll out of covid-19 vaccinations.	May-2021	May-2021	NA	David Birkenhead	Claire Speight, Bev Walker

High	2827	Medical	Emergency Care	Accident & Emergency CRH/HRI	Apr-2011	Active	Developing our workforce	Risk of poor patient outcomes, safety, and efficiency due to the inability to recruit sufficient middle grade emergency medicine doctors to provide adequate rota coverage results in the reliance of locum doctors to fill gaps. Risks: 1. Risk to patient safety using staff unfamiliar with department processes and systems, results in complaints and clinical incidents 2. Risk to the emergency care standard due to risk above and increased length of stay 3. Risk of shifts remaining unfilled by flexible workforce department 4. Risk to financial situation due to agency costs ***It should be noted that risk 6131should be read in conjunction with this risk.	Associated Specialist in post and Regular locums used for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Consultants act down into middle grade roles to fill gaps temporarily 4 weeks' worth of rota's requested in advance from flexible workforce department Expansion of CESR programme Ongoing ACP development Weekly meeting attended by flexible workforce department, finance, CD for ED and GM EMBeds website for induction of locum staff. Allocated a further 10 Senior ED trainee placements by School of EM	Difficulty in recruiting Middle Grade and longer-term locums Variable quality of locum doctors Relatively high sickness levels amongst locum staff. Flexible Workforce not able to fill all gaps ACP development will take 5 yrs. from starting to achieve competence to support the middle grade level Inability to recruit to CESR posts. CESR training will extend time to reach Consultant level with no guarantee of retention Inability of School of EM to allocate trainees.	20 4 x 5	16 4 x 4	12 4 x 3	1. Recruitment including overseas and part time positions 2. Increase to senior ED trainee placement	March 2021- looking to overseas recruitment with a partner agency. increasing number of clinical fellow posts advertised	Apr-2021	Apr-2021	WEB	David Birkenhead	Dr Amjid Mohammed
High	6453	Surgery & Anaesthetics	Orthopaedics	All wards/departments Orthopaedic	Sep-2018	Active	Transforming and improving patient	Risk of poor patient experience, safety, quality of care, extended length of stay due to failure to undertake surgical repair of #NOF within 36 hours of admission and maintain BPT in 85% of patients.	- Senior clinical review of patients waiting for surgery - Anaesthetic pathways of care embedded - Job plans to provide cross cover for THR surgeon availability - Discuss with theatres the need for additional trauma lists as and when needs arise	- Availability of surgeons with appropriate skills to undertake THR - Surge in activity of #NOF & general trauma overwhelming capacity to treat within 36 hours of admission. This has now been further compounded due to Covid 19 pandemic and lack of theatre capacity for trauma. - No additional trauma theatre sessions in place 3 per week to keep up with demand following second wave of Covid-19 pandemic	16 4 x 4	16 4 x 4	9 3 x 3	Enhanced monitoring and escalation as required.	07/04/2021 Dedicated Trauma 2 lists reinstated; trial of golden patient commenced to improve efficiency same to be audited end May 2021. 24/04/2020 - There is additional risk of poor patient experience, safety, quality of care and extended LOS due to failure to undertake surgical repair of # NOF <36 hours due to current situation with lack of theatre to capacity to deal with surges in activity due to Covid 19 pandemic.	Jun-2021	Jul-2021	DB	Helen Barker	Gautum Chakrabarty
High	6596	Corporate	Corporate Quality	Governance and Risk Quality	Jan-2016	Active	Keeping the base safe	There is a risk of not complying with the national SI framework March 2015 due to not conducting timely investigations into serious incidents (SIs) resulting in delays to mitigate risk, to realise learning from incidents and share the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Scheduling of SI reports into orange divisional incident panels to ensure timely divisional review of actions. - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Investigator Training - to update investigator skills and align investigations with report requirements. - Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Risk Team support to investigators with timely and robust	1. Operational pressures and impact on capacity to undertake investigations in a timely way, further exacerbated by Covid 2. Sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation, particularly doctors. 4. Lack of access to documents on EPR to non-clinical investigators. 5. Operational pressures impacting on time for conducting investigations 6. Requirement to undertake SI investigations is not in Consultant job plans 7. delivery of RCA training workshop suspended due to Covid	16 4 x 4	16 4 x 4	4 4 x 1	Increase number of trained investigators Be clear in delivering training there is a requirement to participate in SI investigations - complete Learning Group to develop approach on learning and a learning event - Quality Priority for 2020/21 Paper with options for investigators - complete Use of staff who are shielding to support investigations Quantify volume of Covid incidents meeting threshold for investigation in accordance with SI Framework	February 2021: review of Covid incident reporting to assess HOCI harm meeting requirement for SI investigation, to quantify volume of investigation work and support required for DoC January 2021: Interim Senior Risk Manager in post, part time Investigation Manager on bank contract to support SI investigations.	Mar-2021	Oct-2021	QC	Ellen Armistead	Doriann Bailey

									Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divisional learning											
High	6829	Family & Specialist Services	Pharmacy	Pharmacy	Aug-2016	Active	Keeping the base safe	The risk of the Trust having insufficient capacity from the Pharmacy Aseptic Dispensing Service to provide the required number of aseptically prepared parenteral medicines. This is due to the CRH unit being temporarily closed for a refit and the HRI ADU having quality issues as highlighted in the May 2018 and January 19 EL (97) 52 external audit which reported 3 major deficiencies limiting its capacity to make parenteral products. Resulting in the unavailability of chemotherapy / parenteral treatments in a timely manner (i.e. delays in treatment for patients), increase in cost of buying in ready to use products and increase in staff time (and error risk) from nursing staff preparing parenteral products including syringe drivers on the wards.	A business case has been approved 2017/18 to provide update facilities on the CRH site. It is planned that the new unit will open ~ Feb 2020 and the HRI unit will close. An action plan has been produced (and agreed by the auditor) to remedy the major deficiencies at HRI unit which includes a capacity plan to limit products made on site. The action plan is monitored by the Pharmacy Board at monthly team meetings and FSS Divisional Board and PSQB with monitoring of non-compliance. Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. HRI ADU currently being re-audited every 6 months - re audit Jan 19 and July 19 In order to provide assurance regarding capacity during the interim period there are a number of strategies to be implemented before October 2019, including: buying in ready to administer injectable medicines (mainly chemo), reviewing products which are prepared in the units on both sites to reduce activity (to include: syringe drivers, adult parenteral nutrition), update the product catalogue, and from June 2020 - outsource radio pharmacy (buy in MDVs of radioisotopes from Bradford)	Until the strategies outlined above to improve capacity have been implemented, we will not know that this workload is safe to deliver. other options to consider will be working hours of the unit - currently operational Mon-Fri 8.30-5pm. Potentially when CRH closes, will open HRI unit earlier at 7.30am to prepare those doses required at CRH and ensure timely transport. Delay in project- new unit not now due to open until Aug 20	15 3 x 5	16 4 x 4	3 3 x 1	Agreed Action Plan October 18 to reduce capacity at HRI ADU i - key points relate to process measures in department (being addressed) and the need to progress consolidation of the units leading to closure of the HRI unit. Delays in project have delayed the temporary closing of the CRH unit to November 2019. Syringe drivers are now made on wards and procurement of ready to use TPN bags is now being phased in. Phasing in of ready to use chemo batches also underway.	Feb 21 update: building work for new unit continues. Aim for completion March 21 and then validation of unit takes approx. 8 weeks. Aiming for Go Live May 21. In the meantime, continue to use HRI aseptic facilities and complete required quality assurance/ micro monitoring to ensure unit fit for purpose/ safe to use.	Mar-2021	Jun-2021	DB	Ellen Armistead	Elisabeth Street

High	7778	Trustwide	All Divisions	All Departments/Wards	May-2020	Active	Keeping the base safe	There is a risk of staff potentially becoming infected with Covid 19 Due to caring for patients with the virus Resulting in sickness and potentially death	Covid IPC guidance including PPE available on the intranet Any updates disseminated via regular workforce briefings and red border emails COVID IPC SOPs available on intranet and daily IPC presence at tactical and IMT All relevant PPE/hand gels are provided in clinical and non-clinical, communal areas. The PPE group provides an oversight on fit testing of relevant staff through divisional assurance. This assurance is communicated to the monthly IPC assurance board. Staff testing - asymptomatic testing of staff commenced. symptomatic staff have access to in-house testing with a rapid turnaround time Social Distancing guidance and signage is visible Any non-compliance with guidance is managed as per workforce SOPs and 'seek to understand' meetings CEV colleagues to have individual risk assessments via OH and divisions Working from home - reduce infection and allow for greater social distancing	Non-adherence to social distancing failure to properly wear, or remove PPE at appropriate times Failure to adhere to IPC guidance at home and at work	15 5 x 3	16 4 x 4	5 5 x 1	Monitor staff sickness absence Provision of Occupational Health advice Staff testing for symptomatic, asymptomatic and those isolating due to family symptoms Provision of PPE appropriate to task WYAAT position on application of RIDDOR	Jan 2021- Must Do's- communication on the requirements on the must dos to all staff, this is focused on IPC, patients flow, safe staffing. Roll out of staff vaccinations for COVID-19 Dec 2020 Leadership walkabouts Matrons ward managers reminding staff with regards to correct wearing of PPE	Feb-2021	Apr-2021	NA	Helen Barker	Helen Barker
High	7936	Trustwide	All Divisions	All Departments/Wards	Nov-2020	Active	Keeping the base safe	STAFF BEHAVIOURS There is a risk of being unable to achieve national standard of social distancing of 2 metres Due to staff behaviours and failure to follow government guidance Resulting in potential for cross infection from patients to/from staff, and staff to staff and reputational damage to the Trust	Covid IMT oversight Social Distancing workstream Posters and routine weekly bulletin Separation of seating in communal areas Risk assessment of offices and communal spaces	influencing the change in staff behaviours in the communal area for those who have been working closely together in a clinical area Canteen and restaurant queueing and failure to adhere to social distancing requirements	16 4 x 4	16 4 x 4	4 4 x 1	Regularly reinforce social distancing where possible messages to staff	March 2021 All risk assessments revised. Regular reminders sent out. All actions continuing as per December December 2020 All risk assessments of office areas / clinical spaces have been completed and reviewed Audiobant messaging now in place Further signage is in place Must Do's include reminders on social distancing Leadership assurance walkabouts include social distancing	Apr-2021	May-2021	WF	Helen Barker	Catherine Riley

High	7803	Surgery & Anaesthetics	Orthopaedics	All wards/departments Orthopaedic	Jun-2020	Active	Keeping the base safe	There is a risk that general trauma patients are suffering significant delays in surgery due to organisational factors resulting in poorer surgical outcomes for patients.	- The existing controls available currently are to liaise with theatres regarding any additional lists we can secure each week which is minimal. - General trauma patients are reviewed daily in the trauma meeting and assessed as whether or not they are suitable to be operated on an acute list at CRH.	We know that Covid-19 precautions are reducing theatre efficiency and now lockdown is lifting we have returned to pre-lockdown trauma patient levels, but we have reduced theatre throughput. This combined with a reduction in the number of trauma 2 lists compared to pre COVID days is causing significant issues.	16 4 x 4	16 4 x 4	4 2 x 2	task & Finish Group for Fractured NOF - Action plan for NOF also applied to General Trauma. Reviewing infection control precautions to look at re-establishing the use of the anaesthetic room and re-assess the current policy for cleaning of theatres in between cases to improve throughput and efficiency. UPDATE 15.12.2020 - The above position is now irrelevant due to the second wave of Covid-19 pandemic. When the need arises for general trauma lists this request now have to be made through Tom Strickland, D'Op for SAS. However, this is not always possible due to staffing pressures in theatres.	07/04/21 - The provision of regular trauma2 lists have improved. Numbers likely to increase with end of lockdown and the number of lists will become inadequate. 15/12/2020 - Reviewed with Jane Peacock, General Manager for T&O, score increased to 16 from 12 to reflect worsening position brought about by the second wave of the Covid-19 pandemic.	May-2021	Jun-2021	PSQB	Will Ainslie	Gautum Chakrabarty
High	7964	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Dec-2020	Active	Keeping the base safe	There is a high risk of capacity reduction and delayed treatment for patients with macular / medical retina eye conditions due to COVID 19 social distancing pressures and the redeployment of nurse practitioner injectors to support inpatient care pressures, resulting in permanent sight loss for patients.	Utilising medical workforce to provide injector roles where the rota allows. Continue to provide WLI macular capacity on a Saturday to support the delivery of a timely high-risk service to patients.	Lack of resilience within the workforce to provide this sub-specialty and the continual social distancing and estate pressures to deliver continual rise in demand. Unless the 2 nurse practitioners return by 4th January 21 the macular / medical retina service will be unsafe.	20 4 x 5	16 4 x 4	0 0 x 0	Request the return of 2 nurse practitioner injectors from redeployment.	1/4/21 CH/PL review: 2 ANP now back from critical care. Louise to update patient numbers. Risk downgraded likelihood from 5 to 4. Total currently 4 * 4 =16 26 January 2021 DMT Update: We are in the 3rd wave of pandemic. Review in 3 months. Accepted at PSQB on 21 December 2020 with a score of 20. Position as of 17 December 2020: Number of patients affected by Nurse Practitioners not returning to the service = approx. 120 patients (this number at present, it could still increase as we are still seeing patients for the rest of this month and we see most patients back every 28 days) without an appointment / injection and with possible irreversible sight loss. Total number of patients that go through the Macular service on a fully staffed week with no leave (during Covid) we have a through put of 293 patients per week (this number includes our weekly Saturday WLI clinic in Acre Mills which we need on a weekly basis due to clinic reductions from social distancing). Pre Covid we had through put of 381 patients per week on a fully staff week with no leave.	May-2021	Sep-2021	PSQB	Tom Strickland	Louise Corp

High	6715	Corporate	Corporate Nursing	Workforce and Clinical Development	Apr-2016	Active	Keeping the base safe	There is a risk to patient safety, outcome, and experience Due to inconsistently completed documentation on EPR Resulting in a potential increased length of stay, lack of escalation when deterioration occurs, poor communication difficulties with efficient multidisciplinary working.	Structured documentation within EPR. Training and education around documentation within EPR. Monthly assurance audit on nursing documentation. Doctors and nurses EPR guides and SOPs. Datix reporting Appointment of operational lead to ensure digital boards focus on this agenda	Remaining paper documentation not built in a structured format in EPR- lead Jackie Murphy, via back office team, December 2018 Establish a CHFT clinical documentation group.- lead Jackie Murphy timescale December 2017. Use of reporting tools from EPR with regards to documentation. To be addressed by clinical documentation group. Limited assurance from the audit tool - to be discussed at clinical documentation group. There are gaps in recruitment	20 4 x 5	15 3 x 5	6 3 x 2	September 2020 - Action plan to review current status and progress improvement - Clinical Records Group - review attendance and TOR - Review data extraction for clinical records relating to Ward Assurance in KP+ model to ensure accuracy. - Roll out White Board Functionality in EPR - identify areas to formulate improvement before rolling out across the organisation - Support improvement at ward level in improvement of key metrics - promote ward ownership - Implementation of Optimisation Strategy in stages - Stage 1 In-depth Analysis of current working practices amongst staff working in the trust - OPD and In-patient services. Stage 1 results will determine Stage 2 relating to recommendations and development of Digital Champions - Explore Training and Support - alternative methods of delivery and at the elbow support - Work Together Get Results - Workshops to collectively discuss and promote digital record keeping within the work environment - understand barriers for failure to comply and put measures in to support change as a result	March 2021 1. External organisation commissioned to carry out the in-depth analysis - expectation for this work to commence in April 2021 2. White Board Functionality enabled in 2 areas to for proof of concept. Hardware currently in the 2 areas, roll out 29.03.21 when the month-long pilot will commence. Alongside this a business case is being developed to understand the impact of rolling this out across the organisation dependent on the findings of the pilot. 3. Looking to form a Rapid Improvement Group with senior leadership to promote improvement to the clinical record in line with the Trusts Quality Improvement to clinical documentation. December 2020 1. Optimisation Strategy - sourcing external organisation who can perform in-depth analysis before the end of March 2021 - expect to take 1-2 months depending on specification yet to be determined 2. Task and finish group suspended due to Covid pressures 3. Clinical Records Group - meeting deferred this month due to Covid pressures 4. Audit Tool - to roll out to wards when digitised 5. White Board Functionality - engagement commenced with identified wards and demo of the system delivered to the areas - awaiting deployment of hardware to the identified areas operational priority. 3. Clinical Records Group has refocused with review of TOR and attendees. Continue to meet monthly. 4. Audit Tool developed - in the process of being digitised prior to circulation with the Nursing Teams - proposal to perform 5 in a month - 4 by ward manager and 1 by Matron. 5. White Board in EPR - ability for designated managers to have access to the clinical and nursing list regarding outstanding patient care actions. This is being progressed in conjunction with our EPR provider, EPR Team and 2 designated ward areas - Surgical Assessment (HRI) and Acute Floor (CRH). The proposal is that this will support timely completion of tasks within EPR.	Apr-2021	Aug-2021	WEB	Ellen Armistead	Carol Gregson/Graham Walsh

High	5747	Family & Specialist Services	Radiology	Angiography & Fluoroscopy	Mar-2013	Active	Keeping the base safe	Service Delivery Risk There is a risk of patient harm due to challenges recruiting to vacant interventional radiologist posts resulting in an inability to deliver OOH vascular cover as part of the WYVAS commitment and in hours on site cover.	- 1 NHS Locum in post (on 12 month contract, due to be renewed in the Summer). - 1 NHS (Bank) Locum supporting the service in tandem with the above. - 1 day per week support from a neighbouring organisation. - 1 day per week support under private agreement from a private provider (ended August 2020) - Working closely with WYVAS to plan and secure adequate cover.	- Uncertainty over date vascular reconfiguration will be complete. Aug 2020 update - date set for 16th Nov 2020 - Difficulty in securing cover long term whilst reconfiguration discussions are ongoing. - Reconfiguration of services completed in November 2020	16 4 x 4	15 5 x 3	6 2 x 3	1. Continue to try to recruit to the vacant post, advertising for joint post with Bradford Teaching TH. 2. Working with WYVAS to progress a regional approach.	December 2020 update – Reconfiguration went ahead as planned in November. Cover is planned centrally without the need for hot week cover. CHFT is sharing responsibility with Bradford and the WYVAS service. Further IR consultants are still required, and the service is looking to recruit. The locum consultant appointed in October has given backword. March 2021 update - current cover is via temporary arrangements but cover is stable. Working with WYVAS colleagues to plan future strategy/joint cover.	Apr-2021	Jun-2021	DB	Stephen Shepley	Sarah Clenton
High	7413	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	There is a risk of fire spread at HRI due to insufficient fire compartmentation in areas which could result in fire spread / damage to buildings / equipment and harm to staff, patients, and visitors.	Following a fire compartmentation undertaken in 2014 capital funding has been made available to improve compartmentation and fire safety across HRI Site. Fire committee has been established Chief Operating Officer, is the nominated executive lead for fire safety Works undertaken by CHS includes:- • Replacement of fire doors in high risk areas • Replacement fire detection / alarm system compliant to BS system installed • Fire Risk Assessments complete • Decluttering of wards to support ensure safe evacuation • Improved planned preventative maintenance regime on fire doors • Regular planned maintenance on fire dampers Fire Safety Training	Number of areas awaiting fire compartmentation works Consequence of decanting ward area to carry out risk prioritised compartmentation works	15 5 x 3	15 5 x 3	1 1 x 1	Dec 2019 - CHFT Fire Committee established with involvement from CHS and PFI. Fire Strategy to be developed to provide a short-, medium- and long-term plan aligning with Trust's reconfiguration plans. Fire Committee to review fire risks. July 2019: NHSI capital bid for 19/20 June 2019: Fire risk assessments, installation of sockets	December 2020 60-minute Fire Door replacement scheme nearing completion and Ward 18 now fully compartmentalised. 30-minute sub compartmentation still outstanding	Mar-2021	Mar-2022	FIREC	Helen Barker	CHS / CHFT
High	7414	Corporate	Finance and Procurement	Corporate Finance	Feb-2019	Active	Keeping the base safe	Building safety risk - there is a risk of falling stone cladding at HRI which is due to the aged and failing fixings originally designed to retain the cladding to the external structure of the building. This could result in significant incident and harm to patients, visitors, and staff. CHS RISK = 7318	Damaged cladding observed at HRI Ward Block 1 resulting in immediate action to ensure surrounding area safe. Capital funding provided to support works. CHS commissioned Structural Engineers to repair the areas observed along the west side elevation of the building and carry out a site wide survey of the existing cladding surrounding HRI. Areas originally observed requiring immediate repair made safe and full detailed site survey carried out. CHS carry our visual inspections of cladding on a regular basis.	CHS and Trust received the full structural site survey which identified areas of high, medium, and low risk and a solution to rectify the risk. Further capital funding required to support the planned work.	15 5 x 3	15 5 x 3	1 1 x 1	Feb 2019 - Structural Engineers requested to provide costings based on high risk, medium risk, and low risk to enable the Trust to phase in repairs in a planned and prioritised manner. Costs expected March 2019. Progress managed at monthly Governance Contract and Performance meetings between CHS and CHFT. Any risks =>15 is escalated to Risk and Compliance for discussion / approval. Discussion to take place at Capital Planning to support prioritised plan	MARCH 2021 A Feasibility Study is progressing. The preliminary results indicate an over cladding option is achievable. A mock-up of the preferred solution is due to be installed April.2021. This exercise will allow the final solution to be determined, the detailed design to be progressed and the construction phase to be determined. In the meantime, structural inspections are to take place on a 6-monthly basis. The next inspection is due in May 2021. DECEMBER 2020 Pre-start meeting for Re-Cladding Design held on Friday 23/10. Options appraisal to be developed with an aim to be complete by January 2021. IHP to provide indicative programme for Stage 3 (design) and Stage 4 (construction).	Jun-2021	Jun-2021	FC	Gary Boothby	C Davies / Ian Rawson

High	7615	Medical	All Directorates Medical	All Departments/Wards Medical	Dec-2019	Active	Keeping the base safe	There is a risk of not meeting the four hour emergency care standard Due to increasing demand on Emergency Care, patient flow issues, delays in assessment and discharge due to lack of social care staffing (hospital based social work team), lack of timely domiciliary care in community More recently there have been increasing demand for side rooms due to the need to isolate patients with possible COVID-19, this has caused increasing delays. Resulting in poor patient experience, patient harm, increased scrutiny and reputational damage	Operational procedures to improve patient experience and flow are in place and reviewed at 3 hourly bed meetings Ambulance hand over time Time to triage Seen in 60 minutes by a medic Digital - manages time and RAG rates Clinical site commanders KPI - refer for inpatient bed before 3 hours Coordinators managing ED Matrons in place at both EDs Urgent care action cards direct staff Housekeepers providing fundamental care External support for dept in times of pressure - e.g. gynae, paeds Surge and Escalation plan - OPEL Training of on call managers and teams Skill mix- training for newly qualified nurses Streaming from the front door and admission avoidance services - frailty, streaming, Covid IMT and tactical oversight of patient flow	Partners not being able to deliver YAS - transport - escalation and response times and transfer to bed base Interruption of the Local Care Direct Service, GP closures for training Vacancy Non-compliance with action cards and process without escalation Engagement and understanding of the risk at ward level and across teams	15 3 x 5	15 3 x 5	1 1 x 1	Patient Flow action plan in place Governance - reported monthly at WEB Patient Flow action plan owner – Deputy COO, Accountability- Directors	January 2021- ED Action plan in place to monitor standards of care especially for those patients who remain in the department over 4 hours. December 2020 Protocol for managing long waits in ED has been reviewed Tactical meetings twice a day focusses on ED pressure Virtual assessment of capacity pressures by Clinical Lead. Daily critically ill patients huddle now in place.	Jun-2021	Jun-2021	WEB	Helen Barker/ Ellen Armistead	Bev Walker

19. Integrated Performance Report – March 2021

To Note

Presented by Helen Barker

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 6 May 2021
Meeting:	Board of Directors
Title:	Quality & Performance Report
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Executive Board, Finance & Performance Committee, Quality Committee

Purpose of the Report

To provide the Board of Directors with the performance position for the month of March 2021.

Key Points to Note

Trust performance for March 2021 was 72.5% which is a significant improvement on last month due to the achievement of ALL cancer targets in month, an excellent result.

Narratives have been provided for any key indicators that are failing to hit target including Complaints, ED 4 hours and Stroke admitted directly to a stroke unit within 4 hours.

SHMI has improved its 12 month position to just above 100 with further work continuing to analyse out of hospital deaths. 3 out of 4 stroke targets were still missed in March although a comprehensive review has taken place including the relocation of the Stroke Assessment Bed to ED at CRH. The bed is also now open 24/7.

Overall sickness is now red although long and short-term sickness have reduced in March back to levels last seen in Summer 2020.

A number of access indicators continue to be affected adversely by the COVID situation although Diagnostics 6-week waits has improved again to its best position since March 2020 at 74%. ASIs (9,937) and 52 week waits (3,890) continue to increase. All these areas are being addressed as part of the Elective Recovery Framework.

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

The Board of Directors is asked to **NOTE** the contents of the report and the overall performance score for March 2021.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

March 2021

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

Contents

RAG Key	
Not achieving target or threshold	
Achieving target	
Between target and threshold	

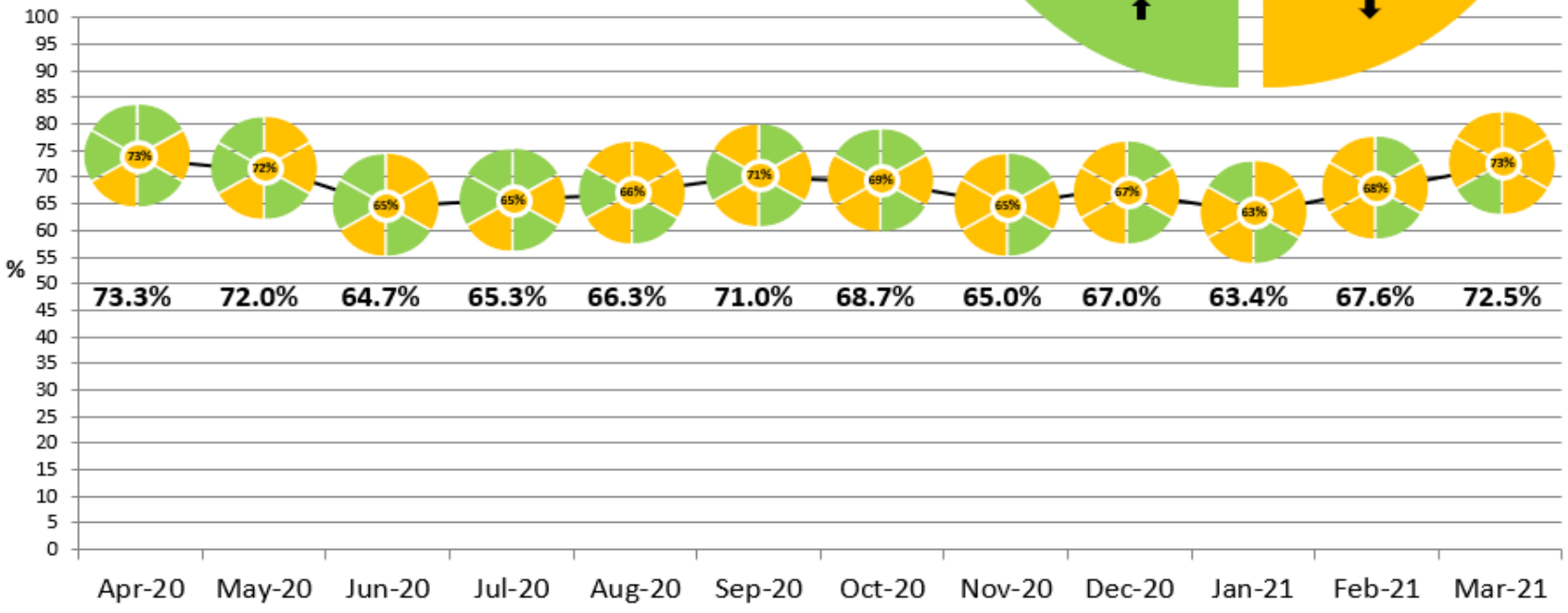
Performance Summary

March 2021

OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

RESPONSIVE	
Diagnostics 6 weeks	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover



Key Indicators

	19/20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Performance Range		
SAFE															Green	Amber	Red
Never Events	1	0	1	1	0	0	0	0	0	0	0	0	**0**	**2**	0		>=1
CARING															Green	Amber	Red
% Complaints closed within target timeframe	42.00%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	63.0%	52.9%	**in arrears**	**60.1%**	100%	86% - 99%	<=85%
EFFECTIVE															Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	1	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	5	1	1	2	2	0	0	0	0	0	0	0	**in arrears**	**6**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	98.63	98.4	98.68	99.05	99.74	100.88	101.31	102.27	102.71	100.94				**100.94**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	88.6	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98	90.32	90.49			**90.49**	<=100	101 - 109	>=111
RESPONSIVE															Green	Amber	Red
Emergency Care Standard 4 hours	87.48%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	87.82%	86.48%	**87.83%**	**88.81%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	51.21%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	56.06%	25.42%	**38.60%**	**65.30%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.59%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	98.55%	98.80%	**98.76%**	**98.74%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.66%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	97.35%	96.45%	**97.34%**	**97.86%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.64%	99.42%	97.37%	98.26%	97.83%	97.69%	100.00%	98.67%	96.23%	96.71%	96.82%	98.55%	**99.22%**	**98.08%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	98.96%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	73.91%	92.31%	**100.00%**	**90.99%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	100.00%	**98.04%**	**99.15%**	>=98%		<=97%
38 Day Referral to Tertiary	53.08%	76.00%	45.45%	40.00%	65.00%	47.06%	39.13%	58.33%	35.71%	50.00%	43.75%	61.54%	**91.67%**	**54.64%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.81%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.76%	90.00%	90.10%	87.58%	**95.65%**	**91.47%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	90.80%	72.22%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	85.19%	83.33%	73.91%	**100.00%**	**63.98%**	>=90%		<=89%
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	78.06%	70.98%	85.89%	73.70%	80.21%	83.19%	82.94%	82.52%	80.91%	81.48%	71.76%	82.50%	**80.21%**	**79.84%**	>=75%		<=70%
WORKFORCE															Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	3.93%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	4.59%	4.52%	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	2.50%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	3.07%	3.07%	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.43%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	1.52%	1.45%	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.81%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	97.63%									95.15%	95.15%	95.15%	95.15%	-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	84.10%													-	>=95%	>=90%	<90%
FINANCE															Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	9.76	(0.00)	0.00	0.00	0.00	0.00	0.00	0.95	0.16	-1.00	0.41	0.58	**1.18**	**2.27**			

Executive Summary

The report covers the period from March 2020 to allow comparison with historic performance. However the key messages and targets relate to March 2021 for the financial year 2020/21.

Domain	Area
Safe (71%)	**All key indicators are achieving target.**
Caring (65%)	• **Complaints closed within timeframe** - 51 cases were closed in February 2021. This represents an 89% increase in closed cases over January 2021. This reflects the clearance of a backlog of overdue cases that had built up across the winter at the height of the Covid-19 pandemic. As a result there has been a decrease in the percentage of complaints closed within the target timeframe (53% in February compared to 64% in January). The improvement work by the collaborative is ongoing with a forensic focus on performance and improvements to process to streamline and move to a more user-centric service with negotiated timescales. A weekly tactical performance meeting is in place working in collaboration with the divisions. Current improvement focus is on: consistent Datix narrative, consent, Service User experience questionnaire, Datix data quality issues and SOP development. Recruitment work is underway to build the central delivery team with the planned recruitment of a permanent Head of Complaints and Team Coordinator. A Quality Support Coordinator has recently been appointed.
Effective (73%)	• **SHMI -** The rolling 12-month SHMI (January - December 2020) has fallen slightly to 100.94. The out of hospital deaths are under current review with our community colleagues in Calderdale and Kirklees to ascertain if there are any concerns.
Responsive (76%)	• **Emergency Care Standard 4 hours** - Performance for March was 87.83%, an improvement in month considering attendances have increased back to pre-Covid levels. We have continued with a number of actions which look to be driving some further improvements in performance, key actions being: The cross-divisional weekly breach investigation meetings are continuing with some tangible actions for improvement being identified. We are focussing on four key areas of improvement; admissions into the medical bed base; admissions into the surgical bed base; transport breaches and diagnostics breaches. There is wide engagement into these meetings both internally and externally and the data to support these meetings has now been developed on a dashboard in KP+. National 111 appointments programme has expanded and some additional slots have now been opened up in the afternoon with the view of evenly distributing NHS111 patient attendances during busy periods. Work has continued on the virtual clinical support service with trials completed and KPIs defined. Work is progressing with setting up the 12 month Tytocare trial to ensure we have the appropriate technology in place to enable virtual consultations with some of our more complex patients and we are aiming to go live with this during June 2021. Work continues on developing our directory of services and we are now being supported in this by NHS Digital. Meetings are scheduled during April with CCG partners and NHS digital to progress this. Engagement has started with colleagues across the organisation to ensure there is broad understanding of the new ED standards and what they mean operationally. • **Stroke targets** - % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival did improve to 39% in month but was well below the 90% target and even the full year position of 65%. Following the sharp decrease in SSNAP performance during February, a comprehensive review has taken place and a number of actions implemented. The stroke assessment bed has now been reallocated to a dedicated bay within the ED at CRH and from 29th March is now operational 24/7. This alone could have prevented 16 breaches in February and would have increased performance by 27%. This increase in the hours of the SAB plus the significant reduction in the number of Covid+ patients is expected to drive an improvement in performance. It is however worth noting that although the SAB will be operational we do not have on-site out of hours consultant cover.
Workforce (73%)	• **Overall Sickness absence/Return to Work Interviews -** Sickness absence data does not include self / household / shielding isolation. Sickness rolling 12 month total continues to increase. Both long-term and short-term sickness levels fell in March back to levels last seen in Summer 2020. As a result short-term 12 month rolling total is now green. Data Security Essential Training target increased to 95% in the autumn hence performance is now amber for this area.
Finance (73%)	**All key indicators are achieving target.**

Safe - Key messages

Area	Reality	Response	Result
Health & Safety Incidents (RIDDOR)	1 Health & Safety RIDDOR Incident for the month of March	Member of staff burnt arm on hot soup resulting in over 7 days absence from work.	Remind staff to be vigilant and try and learn from all incidents to prevent this happening in the future. Accountable: All Staff

Safe - Key measures

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Performance Range		
																Green	Amber	Red
Falls / Incidents and Harm Free Care																		
All Falls	1,815	161	93	117	141	155	132	170	162	185	163	186	173	**174**	**1,851**	Refer to SPC charts		
Inpatient Falls with Serious Harm	25	4	0	0	3	4	1	6	2	1	1	0	2	**2**	**22**	Refer to SPC charts		
Falls per 1000 bed days	7.7	9.4	8.2	9.6	10.2	10.2	8.5	11.3	9.7	11.3	10.0	11.2	11.6	**10.9**	**10.2**	Ongoing Monitoring		
Number of Serious Incidents	36	0	1	1	8	2	2	4	2	1	3	5	2	**2**	**33**	Refer to SPC charts		
Number of Incidents with Harm	2,236	145	127	146	172	195	143	160	206	233	202	254	225	**201**	**2,264**	Refer to SPC charts		
Percentage of Duty of Candour informed within 10 days of Incident	99%	91%	100%	100%	100%	93%	90%	100%	100%	100%	100%	100%	100%	**100%**	**97%**	100%	96 - 99%	<=95%
Never Events	1	0	0	1	1	0	0	0	0	0	0	0	0	**0**	**2**	0		>=1
Percentage of SIs investigations where reports submitted within timescale – 60 Days	50.00%	none to report	25.00%	0.00%	0.00%	0.00%	100.00%	33.00%	40.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**13.50%**	Ongoing Monitoring		
% Emergency Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	75.00%	70.00%	78.00%	82.00%	88.00%	95.45%	82.14%	90.19%	79.25%	97.37%	97.44%	100.00%	Reported quarterly		**87.93%**	>=90%	86% - 89%	<=85%
% Inpatient Sepsis patients receiving antibiotic treatment within 1 hour of diagnosis	68.26%	68.75%	64.86%	60.00%	64.00%	86.36%	64.00%	77.14%	58.70%	84.91%	94.64%	95.65%	Reported quarterly		**74.06%**	>=90%	86% - 89%	<=85%
Maternity																		
Elective C-Section Rate	10.41%	11.89%	9.86%	9.30%	11.78%	13.03%	10.14%	10.42%	9.61%	11.65%	11.81%	9.43%	12.14%	**13.53%**	**11.07%**	<=10% Threshold		
Emergency C-Section Rate	15.77%	14.08%	14.25%	14.93%	15.18%	18.30%	14.52%	15.14%	16.50%	21.02%	17.86%	19.41%	15.61%	**17.04%**	**16.64%**	<=16% Threshold		
Total C-Section Rate	26.17%	25.97%	24.11%	24.23%	26.96%	31.33%	24.66%	25.56%	26.11%	32.67%	29.67%	28.84%	27.51%	**30.27%**	**27.43%**	<=27% Threshold		
% PPH ≥ 1500ml - all deliveries	3.06%	3.16%	3.01%	2.54%	4.19%	3.26%	4.11%	2.98%	3.69%	3.41%	2.20%	2.43%	1.73%	**3.26%**	**3.08%**	<= 3.0%	3.1% - 3.4%	>=3.5%
Antenatal Assessments < 13 weeks	92.13%	92.50%	92.93%	93.02%	92.84%	94.03%	94.74%	90.62%	92.70%	93.20%	90.65%	90.02%	90.05%	**94.60%**	**92.50%**	>90%	81% - 89%	<=80%
Maternal smoking at delivery	12.35%	13.11%	14.50%	11.80%	10.70%	9.00%	9.00%	10.90%	10.30%	11.40%	12.09%	9.97%	8.09%	**11.03%**	**10.74%**	<=12.9%		>=13%
Pressure Ulcers/VTE Assessments																		
Number of Trust Pressure Ulcers Acquired at CHFT	98	21	82	94	68	57	58	59	109	110	84	94	104	**under validation**	**919**	Refer to SPC charts		
Pressure Ulcers per 1000 bed days	1.38	1.22	3.70	3.18	2.32	1.56	1.29	2.20	3.25	3.31	2.42	2.13	2.65	**under validation**	**2.55**	Refer to SPC charts		
Number of Category 2 Pressure Ulcers Acquired at CHFT	291	20	29	40	36	27	35	24	45	47	34	49	35	**under validation**	**401**	Refer to SPC charts		
Number of Category 3 Pressure Ulcers Acquired at CHFT	33	1	7	10	2	2	1	1	2	6	2	6	3	**under validation**	**42**	Refer to SPC charts		
Number of Category 4 Pressure Ulcers Acquired at CHFT	0	0	4	0	0	1	0	0	1	0	1	1	1	**under validation**	**9**	0		>=1
Number of Deep Tissue Injuries	123	7	27	27	19	14	9	19	40	36	19	22	45	**under validation**	**277**	0		>=2
Number of Unstageable Pressure Ulcers	38	1	15	17	11	13	11	15	19	21	24	16	20	**under validation**	**182**	0		>=3
Number of patients with a Pressure ulcer	282	17	62	73	60	49	48	47	84	84	62	74	105	**under validation**	**748**	Refer to SPC charts		
% of leg ulcers healed within 12 weeks from diagnosis	92.07%	26.30%	40.00%	44.40%	12.50%	42.90%	50.00%	38.50%	43.80%	56.30%	84.60%	81.80%	66.70%	**not available**	**50.00%**	>=90%	86% - 89%	<=85%
Percentage of Completed VTE Risk Assessments	96.04%	95.46%	95.56%	96.05%	95.89%	96.26%	96.14%	95.54%	96.44%	96.13%	95.74%	95.67%	95.97%	**96.03%**	**95.97%**	>=95%	86% - 89%	<=85%
Safeguarding																		
Health & Safety Incidents	220	17	4	28	35	18	19	17	25	20	21	20	22	**18**	**247**	Ongoing Monitoring		
Health & Safety Incidents (RIDDOR)	4	0	2	2	1	0	1	0	0	0	2	1	1	**1**	**11**	0		>=1
Medical Reconciliation within 24 hours (excluding Children)	36.70%	39.60%	72.80%	57.60%	58.30%	61.20%	56.60%	58.90%	48.40%	54.60%	54.50%	46.80%	43.90%	**45.10%**	**54.30%**	>=68%		<=67%
Electronic Discharge																		
% Complete EDS	96.58%	93.58%	95.22%	95.00%	95.13%	94.62%	92.83%	95.54%	94.83%	94.76%	95.73%	94.52%	95.41%	**in arrears**	**95.66%**	>=95%	91% - 94%	<=90%

Caring - Key messages

Area	Reality	Response	Result
Number of Mixed Sex Accommodation Breaches	The privacy and dignity of all our patients remains a priority for the organisation. The current National COVID19 pandemic has increased the number of patients requiring the presence of high tech equipment such as CPAP & NIV and specialist nursing skill for their survival, the requirement for full segregation clearly takes a lower priority. High levels of observation and nursing attendance should mean that all patients can have their modesty preserved whilst critically ill. Staff training should be available to support this. However, this does not mean that no attempt at segregation should be made. At the very least, staff should consider whether it is possible to improve segregation. In absence on National guidance and EMSA in a pandemic the Trust has worked within the September 2019 National update relating to assessment areas and transferred this to COVID19. The privacy and dignity of all our patients will be maintained at all times. There have been 3 occasion involving 6 patients where this has occurred in the last 12 months.	Clinical triggers for the need to mix the genders have been developed and a SOP to maintain dignity. These have been approved at IMT. Patients are to be informed of the need/reason to mix genders within the ward area this is to be documented within the patients' EPR. Matrons and ward managers will have daily oversight. Additional dignity screens have been purchased to enhance segregation within the clinical area. Currently the Trust is not mixing genders on general wards due to COVID19 or any other reason. Mixing of genders will be clinically justified - the organisation will work within national guidance and the Trust policies, SOPs monitoring processes to keep breaches to a minimum.	The clinical needs and safety of patients is paramount.
% Complaints closed within target timeframe	51 cases were closed in February 2021. This represents an 89% increase in closed cases over January 2021. This reflects the clearance of a backlog of overdue cases that had built up across the winter at the height of the Covid-19 pandemic. As a result there has been a decrease in the percentage of complaints closed within the target timeframe (53% in February compared to 64% in January). It should be emphasised that complaints performance data is a lagging indicator as performance is calculated against cases closed that month (i.e. cases may feature in the total even if the initial target timeframe was two or three months prior). While the headline figure appears as a deterioration in performance from January 2021, this represents considerable underlying progress in moving the Trust to a satisfactory complaints position. .	The improvement work by the collaborative is ongoing with a forensic focus on performance and improvements to process to streamline and move to a more user- centric service with negotiated timescales. A weekly tactical performance meeting is in place working in collaboration with the divisions. Current improvement focus is on: consistent Datix narrative, consent, Service User experience questionnaire, Datix data quality issues and SOP development. Recruitment work is underway to build the central delivery team with the planned recruitment of a permanent Head of Complaints and Team Coordinator. A Quality Support Coordinator has recently been appointed. **Caring – Key Measures:** % of complaints closed within target: 53% Number of complaints closed within target timeframe: 27 Acknowledged within three days 100% Breaching complaints: 4 Complaints closed in month: 51 PHSO complaints received: 0 PHSO complaints closed: 0 Complaints under investigation with PHSO: 8 PALS contacts received: 203 Compliments received: 41	By implementing the recommendations highlighted in the recent service review and audits and improving processes, the Trust will achieve its performance targets and evidence quality improvements for patients and staff alike. Accountable: Head of Complaints & PALS

Caring - Key measures

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Performance Range		
																Green	Amber	Red
Complaints																		
% Complaints closed within target timeframe	42.0%	64.0%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	63.0%	52.9%	in arrears	60.1%	100%	86% - 99%	<=85%
Total Complaints received in the month	494	27	10	14	29	17	30	32	33	36	26	24	26	in arrears	277	no target		
Complaints re-opened	68	3	1	2	4	1	4	3	1	0	0	0	0	in arrears	16	no target		
Inpatient Complaints per 1000 bed days	2.12	1.57	0.93	1.17	2.17	1.15	2.26	2.26	2.1	2.39	1.74	1.46	1.84	1.45	1.74	no target		
No of Complaints closed within Timeframe	222	13	15	18	16	16	5	14	15	14	10	17	27	in arrears	167	Refer to SPC charts in Appendix		
Total Complaints Closed	545	21	16	22	20	23	7	26	34	28	24	27	51	in arrears	278	no target		
Friends & Family Test																		
Friends & Family Test (IP Survey) - % Positive Responses	96.88%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.63%	93.46%	88.32%	in arrears	91.09%	To be Confirmed		
Friends and Family Test Outpatients Survey - % Positive Responses	91.98%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.37%	93.10%	93.28%	in arrears	93.27%	To be Confirmed		
Friends and Family Test A & E Survey - % Positive Responses	84.54%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	90.38%	90.91%	89.37%	in arrears	90.16%	To be Confirmed		
Friends & Family Test (Maternity) - % Positive Responses	99.20%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	98.00%	100.00%	100.00%	in arrears	98.86%	To be Confirmed		
Friends and Family Test Community Survey - % Positive Responses	96.32%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	100.00%	100.00%	100.00%	in arrears	100.00%	To be Confirmed		
Caring																		
Number of Mixed Sex Accommodation Breaches	3	0	0	0	0	0	0	0	2	3	0	0	0	1	6	0		>=1
% Dementia patients screened following emergency admission aged 75 and over	46.23%	40.74%	35.28%	40.15%	40.09%	40.37%	42.49%	34.23%	29.78%	24.78%	22.60%	21.85%	19.89%	19.86%	30.07%	>=90%	88% - 89%	<=87%

Effectiveness - Key measures

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Performance Range Green	Amber	Red
Infection Control																		
Number of MRSA Bacteraemias – Trust assigned	1	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Total Number of Clostridium Difficile Cases - Trust assigned	26	5	1	2	4	7	2	2	4	2	6	4	1	**2**	**37**	No target		
Preventable number of Clostridium Difficile Cases	5	0	1	1	2	2	0	0	0	0	0	0	0	**in arrears**	**6**	<=4 & YTD <=40		
Number of MSSA Bacteraemias - Post 48 Hours	19	0	0	2	3	2	1	2	2	0	0	1	1	**1**	**15**	No target		
Number of E.coli - Post 48 Hours	29	5	2	5	4	2	1	2	3	0	3	2	1	**2**	**27**	No target		
MRSA Elective Screening – Percentage of Inpatients Matched	96.22%	95.80%	87.00%	69.00%	73.00%	68.40%	61.40%	75.00%	66.40%	49.70%	55.90%	51.90%	60.00%	**57.90%**	**57.80%**	>=95%	94% - 93%	<=92%
Mortality																		
Stillbirths Rate (including intrapartum & Other)	0.16%	0.24%	0.27%	0.00%	0.26%	0.50%	0.27%	0.25%	0.49%	0.85%	0.00%	0.80%	0.29%	**0.50%**	**0.37%**	<=0.47%		>=0.48%
Perinatal Deaths (0-7 days)	0.10%	0.00%	0.00%	0.00%	0.00%	0.25%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.29%	**0.25%**	**0.07%**	<=0.1%		>=0.11%
Neonatal Deaths (8-28 days)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	**0.00%**	**0.00%**	<=0.1%		>=0.11%
Local SHMI - Relative Risk (1 Yr Rolling Data)	99.94	99.94	98.40	98.68	99.05	99.74	100.88	101.31	102.27	102.71	100.94	Due May 21	Due June 21	Due June 21	**100.94**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	89.64	89.64	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98	90.32	90.49	Due May 21	Due June 21	**90.49**	<=100	101 - 109	>=111
Crude Mortality Rate	1.25%	1.62%	4.66%	2.30%	1.69%	1.37%	1.87%	1.50%	2.25%	2.54%	2.44%	2.81%	2.62%	**1.27%**	**2.22%**	No target		
Coding and submissions to SUS																		
% Sign and Symptom as a Primary Diagnosis	8.11%	7.10%	5.34%	7.84%	7.82%	8.18%	8.17%	7.79%	8.16%	8.42%	8.15%	7.41%	8.27%	**8.89%**	**7.94%**	<=8.3%	8.4% - 9.4%	>=9.5%
Average co-morbidity score	5.52	6.38	7.00	6.66	6.62	6.44	6.91	6.13	6.36	6.42	6.60	6.14	6.06	**5.94**	**6.46**	>=5.08 / >=5.30 from April 20		<=4.7
Average Diagnosis per Coded Episode	6.06	6.64	7.86	7.97	7.74	7.61	7.94	7.52	7.69	7.87	7.97	7.65	7.69	**7.16**	**7.71**	>=6.14 / >=6.48 from April 20		<=5.8
Recruitment to Time and Target (Research)	83.33%	82.90%	83.34%	83.10%	73.68%	77.78%	79.98%	80.49%	81.82%	82.22%	86.36%	83.72%	81.36%	**83.73%**	**81.47%**	>=80%	76% - 79%	<=75%
Best Practice Guidance																		
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	75.96%	77.08%	56.10%	56.67%	66.67%	42.86%	51.06%	74.36%	75.68%	67.39%	61.70%	45.83%	64.29%	**65.85%**	**60.20%**	>=85%	84% - 83%	<=82%
IPMR - Breastfeeding Initiated rates	76.39%	76.40%	78.57%	77.70%	81.10%	76.30%	75.30%	72.90%	76.50%	77.70%	75.30%	75.30%	75.70%	**75.80%**	**76.50%**	>=70%	66% - 69%	<=65%
Readmissions																		
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Trust (excluding ambulatory)	8.80%	10.41%	14.53%	11.47%	10.40%	11.23%	12.10%	10.73%	10.80%	10.86%	10.08%	10.18%	9.96%	**9.81%**	**11.01%**	<=7.96% as per Model Hospital		>=8.99%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG (excluding ambulatory)	9.70%	11.85%	14.53%	11.47%	10.40%	11.23%	12.10%	10.73%	10.80%	10.86%	10.08%	10.18%	9.96%	**9.81%**	**11.01%**	<=7.96% as per Model Hospital		>=8.99%
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG (excluding ambulatory)	9.62%	10.39%	14.95%	12.67%	13.12%	10.98%	12.39%	10.02%	8.70%	9.89%	11.90%	12.17%	10.77%	**10.75%**	**11.53%**	<=7.96% as per Model Hospital		>=8.99%
Community																		
% Readmitted back in to Hospital within 30 days for Intermediate Care Beds	5.78%	8.10%	17.50%	7.70%	2.00%	7.40%	6.30%	2.00%	3.80%	5.50%	6.10%	7.55%	7.40%	**0.00%**	**5.90%**	No target		
Hospital admissions avoided by Community Nursing Services	2,995	277	350	267	228	264	241	240	202	196	192	181	214	**257**	**2,832**	>=186		

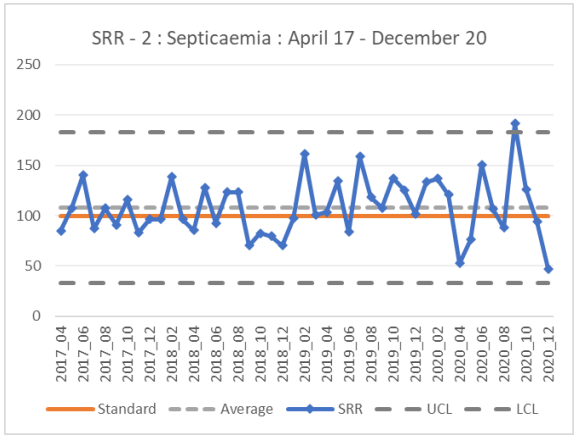
Summary for Integrated Performance Report

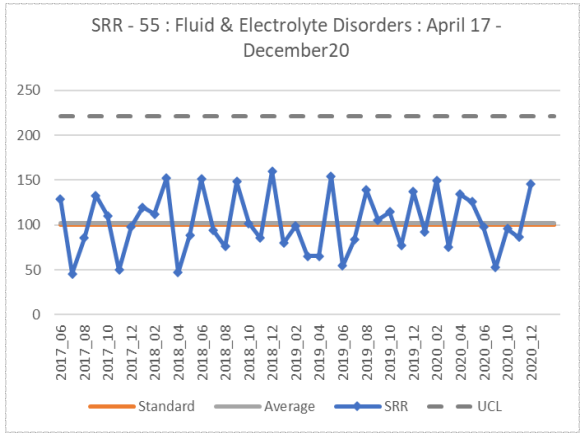
Outcome Indicators

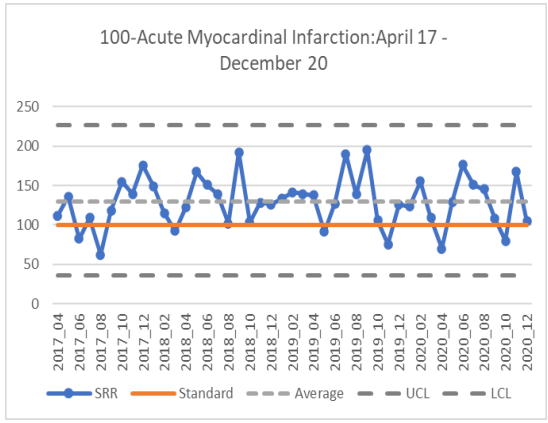
Approach taken - worked with our Benchmarking software providers Healthcare Evaluation Data (HED) to understand if they provided facility to monitor these areas as per Insight Report
Insight Report focuses on 10 Clinical Classification System (CCS) Diagnostis Groups - there are in total over 250, need to consider deep dive into all that are areas of potential concern.
HED advised that they do provide a facility within the Clinical Quality Module of their tool but it uses a marginally different methodology. The table below is used to illustrate how close the HED assessment is when balancing to the figures provided in the Insight report.
The latest 25 month figure from HED (March 19 to Dec 20) is also provided as is a graph for all 10 areas showing the trend over time going back to April 2017
In addition the number of additional readmissions than expected is provided as an attempt to illustrate the scale of any issue
All figures quoted in table are the relative risk score unless stated. A value greater than 100 means that the patient group being studied has a higher readmission level than NHS average performance

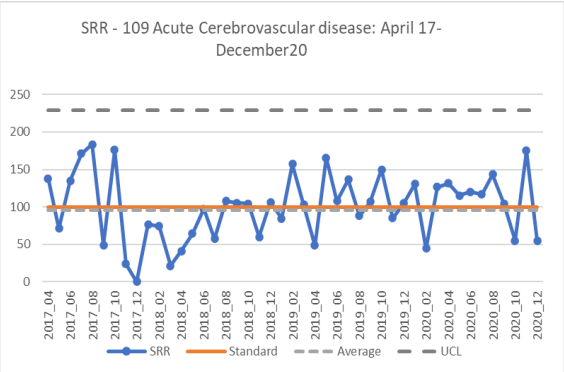
Insight Report Emergency Readmissions

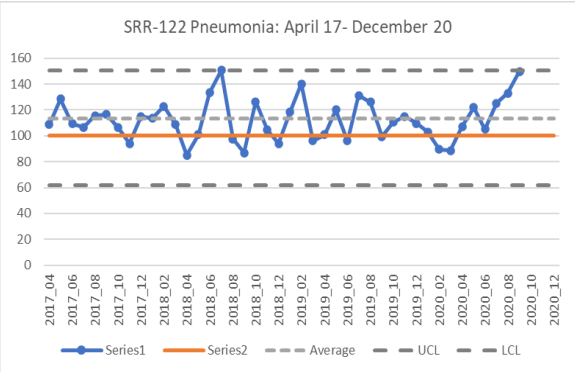
	Oct 17 - Sep 18		Oct 18 - Sep 19		Mar 19 - Dec 20			
CCS No & Diagnostic Group	Insight	HED	Insight	HED	HED	95% Confidence Interval	No of Discharges	No of Additional Readmissions
2 - Septicemia (except in labor)	101.5	102.2	112.7	107.2	112.8	(92.80, 135.80)	424	12.6
55 - Fluid and electrolyte disorders	110	105.8	106.9	97.1	99.8	(83.50, 118.30)	497	-0.3
100 - Acute myocardial infarction	137.8	139.2	134.8	138.1	128.3	(107.10, 152.60)	650	28.3
109 - Acute cerebrovascular disease	114.4	72.4	131.1	105	132.3	(42.60, 308.80)	21	1.2
122 - Pneumonia (except that caused by tuberculosis or sexually transmitted diseas	117.6	105.8	114	107.7	112.1	(102.30, 122.70)	1925	51.3
125 - Acute bronchitis	113.1	98.6	112.2	99	97.1	(83.30, 112.50)	953	-5.3
127 - Chronic obstructive pulmonary disease and bronchiectasis	117.9	119.7	106.9	111.8	105.2	(92.30, 119.40)	797	11.9
157 - Acute and unspecified renal failure	122.5	121.9	108.3	108	112.7	(95.20, 132.50)	515	16.6
159 - Urinary tract infections	117.9	109.2	120.8	111.9	107.2	(96.20, 119.10)	1491	23.1
226 - Fracture of neck of femur (hip)	94	87.2	79.7	84.3	88	(68.30, 111.50)	495	-9.3

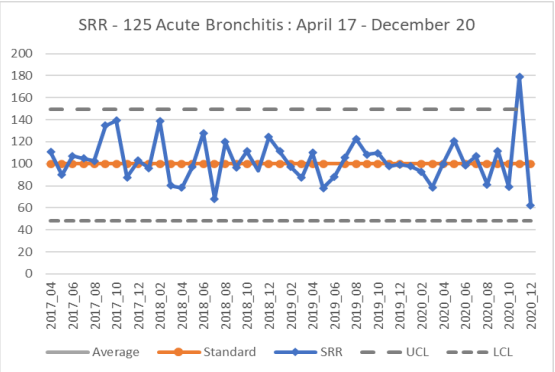


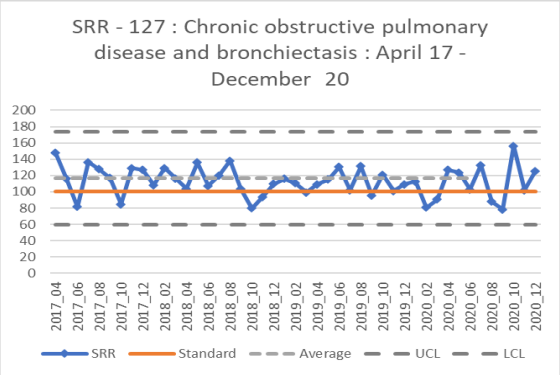


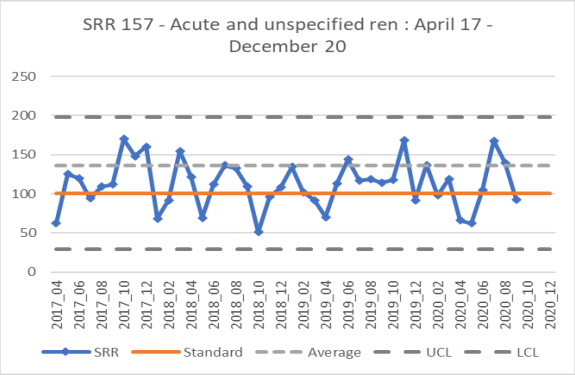


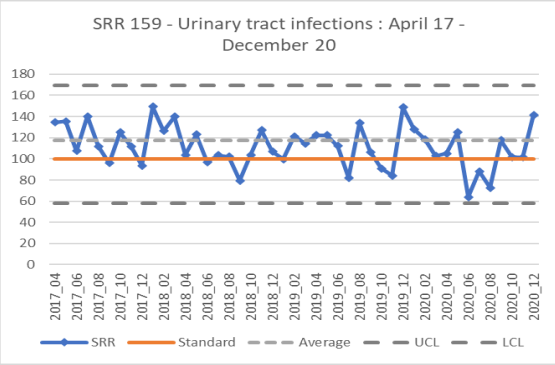

SRR - 109 Acute Cerebrovascular disease: April 17- December20
SRR
Standard
Average
UCL

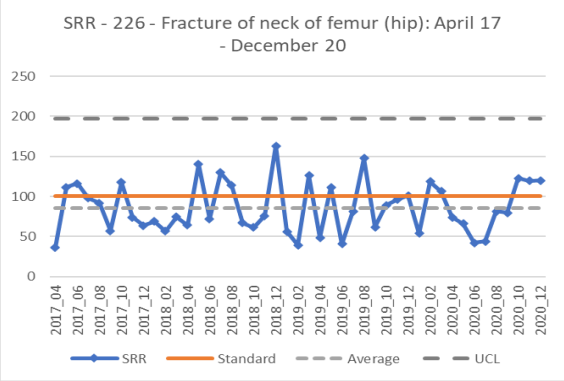

SRR-122 Pneumonia: April 17- December 20
Series1
Series2
Average
UCL
LCL


SRR - 125 Acute Bronchitis : April 17 - December 20
Average
Standard
SRR
UCL
LCL

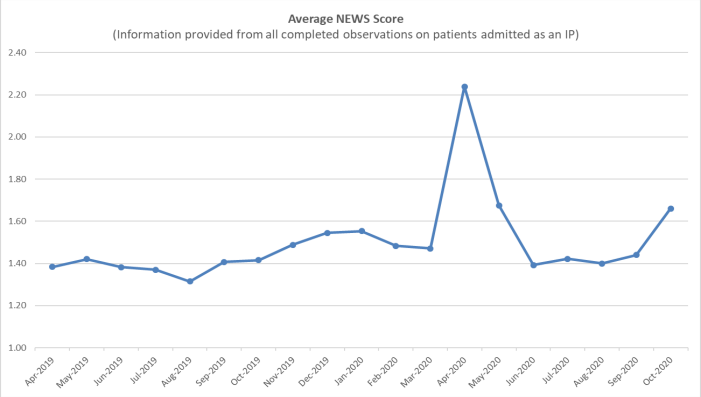

SRR - 127 : Chronic obstructive pulmonary disease and bronchiectasis : April 17 - December 20
SRR
Standard
Average
UCL
LCL

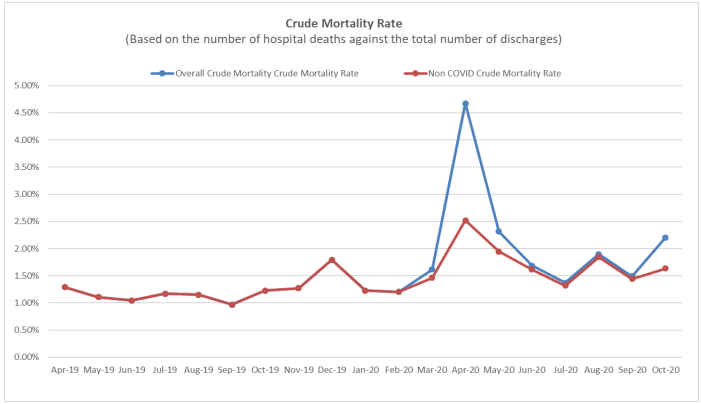

SRR 157 - Acute and unspecified ren : April 17 - December 20
SRR
Standard
Average
UCL
LCL

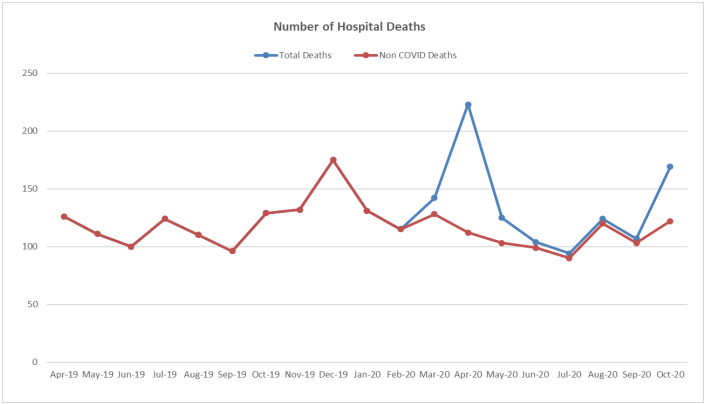

SRR 159 - Urinary tract infections : April 17 - December 20
SRR
Standard
Average
UCL
LCL

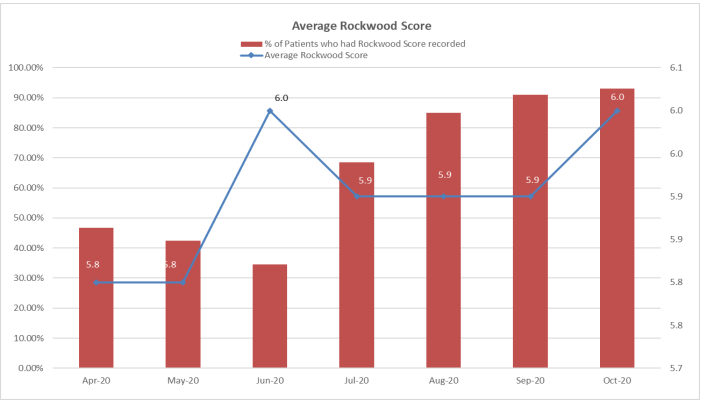

SRR - 226 - Fracture of neck of femur (hip): April 17 - December 20
SRR
Standard
Average
UCL

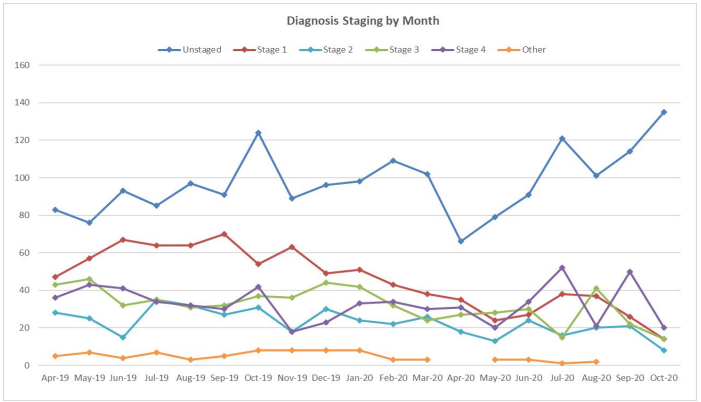
Outcome Measures

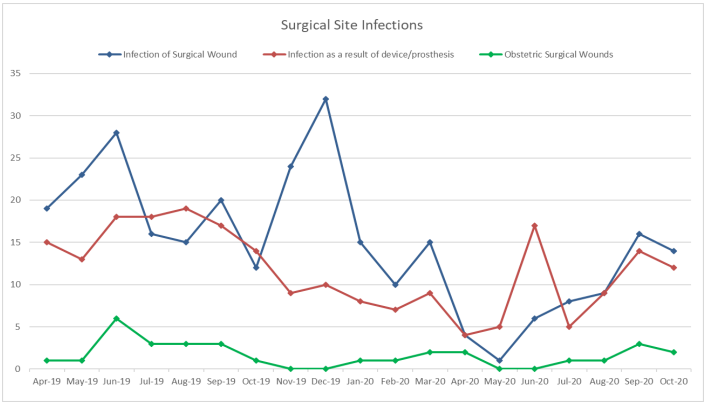












Responsive - Key messages

Area	Reality	Response	Result
Emergency Care Standard 4 hours	ECS - <4 hours performance - Slight improvement in month to 87.83% from 86.48% in February. Full year position 88.81%. A&E Ambulance Handovers 30-60 mins - 18 in month which is a slight increase from 15 in February however this remains significantly below the December position of 36. A&E Ambulance Handovers over 60 mins - 4 in month. There have been 58 in 2020/21. A&E Trolley Waits (from decision to admit) - 0.	We have continued with a number of actions which look to be driving some further improvements in performance in month, key actions being: - The cross-divisional weekly breach investigation meetings are continuing with some tangible actions for improvement being identified. We are focussing on four key areas of improvement; admissions into the medical bed base; admissions into the surgical bed base; transport breaches and diagnostics breaches. There is wide engagement into these meetings both internally and externally. The data to support these meetings has now been developed on a dashboard in KP+. - National 111 appointments programme has expanded and some additional slots have now been opened up in the afternoon with the view of evenly distributing NHS111 patient attendances during busy periods. This will be monitored moving forwards. - Work has continued on the virtual clinical support service with trials completed and KPIs defined. Work is progressing with setting up the 12 month Tytocare trial to ensure we have the appropriate technology in place to enable virtual consultations with some of our more complex patients and we are aiming to go live with this during June 2021. - Work continues on developing our directory of services and we are now being supported in this by NHS Digital. Meetings are scheduled during April with CCG partners and NHS digital to progress this. - Engagement has started with colleagues across the organisation to ensure there is broad understanding of the new ED standards and what they mean operationally.	A project plan has been put together which details a programme of improvement work over the next 2 years. Accountable: Director of Operations - Medicine
Stroke	Stroke - 1 out of 4 targets achieved in the month % Stroke patients spending 90% of their stay on a stroke unit has increased in month to 73.21% from 71.19% during February. This remains below the 90% target. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival was 38.60% which is an improvement from 25.42% the previous month. % Stroke patients Thrombolysed within 1 hour was 80% in month which is a significant improvement from 57.14% the previous month and well above the 55% target. % Stroke patients scanned within 1 hour of hospital arrival was 36.84% which is a decrease from 40.68% the previous month.	Following the sharp decrease in SSNAP performance during February, a comprehensive review has taken place and a number of actions implemented; - The stroke assessment bed has now been reallocated to a dedicated bay within the ED at CRH and from 29th March is now operational 24/7. This alone could have prevented 16 breaches in February and would have increased performance by 27%. This increase in the hours of the SAB plus the significant reduction in the number of Covid+ patients is expected to drive an improvement in performance. It is however worth noting that although the SAB will be operational we do not have on-site out of hours consultant cover. - Further steps have also been implemented to ensure the integrity of data and all identified breaches are now being validated clinically to ensure against any data errors before being reported. - Discussions with the stroke network have also taken place which have ensured clear reporting definitions have been obtained to ensure we are capturing and reporting data accurately and these have been shared with informatics. - We are also looking at how we can ensure patients attending the ambulatory unit with the recommendation that patients with stroke symptoms are not accepted and directed straight to the emergency department and follow the existing stroke pathway. - A further option to consider is the implementation of a dedicated stroke hub for the direct admission of stroke patients however this would require strong links with the general medicine bed base to ensure any patients that are confirmed non-stroke are quickly transferred to the main bed base.	Accountable: Divisional Director Medicine/Dr Rana.

Responsive - Key measures

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Performance Range		
																Green	Amber	Red
Accident & Emergency																		
Emergency Care Standard 4 hours	87.48%	87.96%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	87.82%	86.48%	**87.83%**	**88.81%**	>=95%		<95%
Emergency Care Standard 4 hours inc Type 2 & Type 3	89.08%	89.26%	93.12%	95.52%	95.11%	94.10%	91.13%	90.04%	82.44%	82.67%	87.69%	88.63%	87.43%	**88.63%**	**89.57%**	>=95%		<95%
A&E Ambulance Handovers 15-30 mins (Validated)	9,469	641	255	254	253	395	411	406	491	463	515	444	255	**335**	**4,477**	0		>=1
A&E Ambulance Handovers 30-60 mins (Validated)	369	14	3	0	1	3	8	7	45	40	36	12	15	**18**	**188**	0		>=1
A&E Ambulance 60+ mins	20	0	0	0	0	0	3	2	17	25	3	3	1	**4**	**58**	0		>=1
A&E Trolley Waits (From decision to admission)	9	0	0	0	0	0	0	0	15	21	0	0	0	**0**	**36**	0		>=1
Patient Flow																		
Delayed Transfers of Care	3.30%	3.94%	0.15%	0.21%	0.17%	0.22%	0.47%	0.21%	0.30%	0.09%	0.20%	0.02%	0.00%	**0.00%**	**0.19%**	<=3.5%	3.6% - 4.9%	>=5%
Coronary Care Delayed Discharges	591		COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	**COVID**	**COVID**		No target	
Green Cross Patients (Snapshot at month end)	25	25	17	48	49	52	47	51	60	53	61	59	58	**67**	**67**	<=40	41 - 45	>=45
Advice & Guidance responded within 48 hours	82.03%	83.50%	79.00%	84.30%	81.40%	78.90%	77.40%	82.30%	79.40%	72.90%	83.20%	76.00%	82.90%	**80.60%**	**79.70%**	>=80%	71% - 79%	<=70%
Stroke																		
% Stroke patients spending 90% of their stay on a stroke unit	73.62%	86.76%	92.86%	91.23%	74.14%	81.16%	82.98%	83.33%	83.87%	81.40%	83.67%	83.33%	71.19%	**73.21%**	**81.47%**	>=90%	89% - 86%	<=85%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	51.21%	55.88%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	56.06%	25.42%	**38.60%**	**65.30%**	>=90%		<=85%
% Stroke patients Thrombolysed within 1 hour	77.78%	75.00%	62.50%	53.85%	83.33%	90.00%	85.71%	75.00%	57.14%	66.70%	66.70%	80.00%	57.14%	**80.00%**	**73.20%**	>=55%		<=50%
% Stroke patients scanned within 1 hour of hospital arrival	53.99%	45.71%	48.84%	50.88%	57.63%	40.85%	48.98%	44.23%	61.29%	32.20%	51.00%	53.73%	40.68%	**36.84%**	**47.09%**	>=48%		<=45%
Cancellations																		
% Last Minute Cancellations to Elective Surgery	0.92%	0.81%	0.32%	0.30%	0.00%	0.13%	0.36%	0.38%	0.30%	0.23%	0.00%	0.16%	0.07%	**0.32%**	**0.21%**	<=0.6%		>=0.8%
Breach of Patient Charter (Sitreps booked within 28 days of cancellation)	0	0	17	0	0	0	0	0	0	1	2	0	0	**0**	**20**	0		>=2
No of Urgent Operations cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=2
18 week Pathways (RTT)																		
18 weeks Pathways >=26 weeks open	1,396	1,396	2,306	3,542	4,531	6,264	8,133	8,446	6,632	6,294	6,885	7,425	7,844	**8,483**	**8,483**	0		>=1
RTT Waits over 52 weeks Threshold > zero	5	5	28	76	176	331	509	777	1063	1523	1,989	2,683	3,526	**3,890**	**3,890**	0		>=1
% Diagnostic Waiting List Within 6 Weeks	95.04%	95.04%	40.24%	34.60%	46.98%	51.96%	46.14%	50.73%	60.36%	65.43%	61.05%	57.45%	67.65%	**73.76%**	**73.76%**	>=99%		<=98%
Cancer																		
Two Week Wait From Referral to Date First Seen	98.59%	99.20%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	98.55%	98.80%	**98.76%**	**98.74%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.66%	99.24%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	97.35%	96.45%	**97.34%**	**97.86%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	99.64%	99.30%	99.42%	97.35%	98.26%	97.83%	97.71%	100.00%	98.67%	96.23%	96.71%	96.82%	98.55%	**99.22%**	**98.08%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	98.96%	92.86%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	73.91%	92.31%	**100.00%**	**90.99%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	100.00%	100.00%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	100.00%	**98.04%**	**99.15%**	>=98%		<=97%
38 Day Referral to Tertiary	53.08%	61.11%	76.00%	45.45%	40.00%	65.00%	47.06%	39.13%	58.33%	35.71%	50.00%	43.75%	61.54%	**91.67%**	**54.64%**	>=85%		<=84%
62 Day GP Referral to Treatment	90.81%	91.44%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.76%	90.00%	90.10%	87.58%	**95.65%**	**91.47%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	90.80%	90.48%	76.47%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	85.19%	83.33%	73.91%	**100.00%**	**63.98%**	>=90%		<=89%
104 Referral to Treatment - Number of breaches - Patients Treated	29.0	2.5	0	2.0	3	1.5	0.5	2.5	1.0	0.5	1.0	2.0	2.0	**2.0**	**18.0**	0		>=1
104 Referral to Treatment - Number of breaches - Patients Still waiting	7	7	1	7	11	11	7	5	3	1	2	5	4	**4**	**4**	0		>=1
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	78.06%	79.81%	70.98%	85.89%	73.70%	80.21%	83.19%	82.94%	82.52%	80.91%	81.48%	71.76%	82.50%	**80.21%**	**79.84%**	>=75%		<=70%
Elective Access																		
Appointment Slot Issues on Choose & Book	28.15%	20.40%	130.03%	112.99%	105.12%	85.56%	79.00%	85.48%	84.49%	66.65%	78.00%	56.08%	73.38%	**in arrears**	**88.34%**	<=20%		>=21%
ASI (Appointment Slot Issues) > 22 Weeks	354	354	800	999	1585	2244	2012	1234	845	1118	1622	1,479	1,727	**2,008**	**2,008**	0		>=1
Total Holding List	10,663	10,663	14,562	17,946	19,911	21,651	21,591	20,286	19,244	19,734	21,037	21,517	21,885	**21,549**	**21,549**		No target	
Holding List > 12 Weeks	1,832	1,832	3,081	4,314	5,497	6,757	9,195	7,192	6,545	5,767	6,085	6,568	6,795	**6,280**	**6,280**	0		>=1

Workforce - Key Metrics

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Target	Threshold/Monthly
Staff in Post																	
Staff in Post Headcount		5721	5858	5869	5876	5870	5724	5738	5762	5782	5796	5836	5926	5956	-	-	
Staff in Post (FTE)		5049.46	5168.35	5173.65	5184.72	5195.15	5064.84	5096.10	5106.28	5124.91	5195.36	5174.58	5250.66	5286.49	-	-	
Vacancies																	
Establishment (Position FTE)**		5219.02	5314.42	5312.37	5323.61	5373.84	5376.13	5381.86	5408.16	5418.98	5416.56	5387.67	5387.67	5385.06	-	-	
Vacancies (FTE)**		169.56	146.07	138.72	138.89	178.69	311.29	285.76	301.88	294.07	221.20	213.09	137.01	98.57	-	-	
Vacancy Rate (%)**		3.25%	2.75%	2.61%	2.61%	3.33%	5.79%	5.31%	5.58%	5.43%	4.08%	3.96%	2.54%	1.83%	-	-	
Staff Movements																	
Turnover rate (%) - in month		0.73%	0.48%	0.57%	0.40%	0.56%	0.74%	0.77%	0.45%	0.65%	0.60%	0.67%	0.43%	0.78%	-	-	
Executive Turnover (%)		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-	-	
Turnover rate (%) - Rolling 12m		7.26%	7.09%	7.20%	6.86%	6.84%	6.98%	7.27%	7.24%	7.46%	7.47%	7.54%	7.48%	7.51%	-	**11.50%**	<=11.5% Green <=12.5 >11.5% >12.5% Red
Retention/Stability Rate (%) - rolling 12m		89.49%	90.38%	90.29%	90.53%	90.84%	90.70%	90.39%	90.62%	90.33%	90.48%	90.11%	90.21%	90.18%	-	-	
Sickness Absence - Rolling 12 month																	
Sickness Absence rate (%) - rolling		3.99%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	4.59%	4.52%	-	**4.00%**	=< 4.0% - Green 4.01% -4.5% Amber >4.5% Red
- Of which Covid related absence		0.04%	0.13%	0.18%	0.20%	0.20%	0.20%	0.21%	0.25%	0.34%	0.41%	0.51%	0.56%	0.55%	-	-	
- Of which Non Covid related absence		3.95%	3.99%	4.05%	4.05%	4.05%	4.04%	4.03%	4.05%	4.07%	4.05%	4.02%	4.03%	3.97%	-	-	
Long Term Sickness Absence rate (%) - rolling		2.51%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	3.07%	3.07%	-	**2.50%**	=< 2.5% Green 2.5% -2.75% Amber >2.75% Red
- Of which Covid related absence		0.00%	0.03%	0.06%	0.07%	0.07%	0.07%	0.07%	0.08%	0.12%	0.16%	0.20%	0.23%	0.24%	-	-	
- Of which Non Covid related absence		2.50%	2.58%	2.63%	2.66%	2.66%	2.67%	2.66%	2.70%	2.74%	2.77%	2.79%	2.84%	2.83%	-	-	
Short Term Sickness Absence rate (%) - rolling		1.43%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	1.52%	1.45%	-	**1.50%**	=< 1.5% - Green 1.5% -1.75% Amber >1.75% Red
- Of which Covid related absence		0.03%	0.11%	0.13%	0.13%	0.13%	0.14%	0.14%	0.17%	0.22%	0.26%	0.31%	0.33%	0.30%	-	-	
- Of which Non Covid related absence		1.40%	1.40%	1.41%	1.40%	1.39%	1.37%	1.37%	1.35%	1.32%	1.27%	1.23%	1.19%	1.15%	-	-	
Attendance rate (%) - rolling		96.07%	95.89%	95.78%	95.75%	95.75%	95.78%	95.78%	95.71%	95.59%	95.54%	95.47%	95.41%	95.48%	-	**96.00%**	
Sickness Absence - Monthly																	
Sickness Absence rate (%) - in month		4.67%	5.59%	4.61%	3.74%	3.61%	3.73%	4.09%	4.79%	5.45%	5.04%	5.11%	4.55%	3.83%	-	-	
- Of which Covid related absence		0.38%	1.24%	0.56%	0.19%	0.04%	0.03%	0.11%	0.50%	1.05%	0.85%	1.07%	0.64%	0.25%	-	-	
- Of which Non Covid related absence		4.29%	4.36%	4.05%	3.55%	3.57%	3.70%	3.99%	4.29%	4.40%	4.19%	4.04%	3.90%	3.58%	-	-	
Long Term Sickness Absence rate (%) - in month		2.75%	3.36%	3.16%	2.67%	2.51%	2.67%	2.74%	3.20%	3.49%	3.62%	3.20%	3.12%	2.66%	-	-	
- Of which Covid related absence		0.03%	0.29%	0.35%	0.14%	0.01%	0.00%	0.02%	0.15%	0.44%	0.47%	0.42%	0.37%	0.21%	-	-	
- Of which Non Covid related absence		2.72%	3.06%	2.81%	2.54%	2.50%	2.67%	2.72%	3.05%	3.04%	3.15%	2.78%	2.75%	2.45%	-	-	
Short Term Sickness Absence rate (%) - in month		1.92%	2.23%	1.45%	1.06%	1.11%	1.06%	1.34%	1.57%	1.98%	1.41%	1.90%	1.43%	1.17%	-	-	
- Of which Covid related absence		0.35%	0.94%	0.21%	0.05%	0.04%	0.03%	0.08%	0.35%	0.64%	0.38%	0.65%	0.27%	0.04%	-	-	
- Of which Non Covid related absence		1.57%	1.29%	1.24%	1.01%	1.07%	1.03%	1.26%	1.22%	1.34%	1.03%	1.25%	1.16%	0.96%	-	-	
Attendance rate (%) - in-month		95.37%	94.53%	95.48%	96.25%	96.39%	96.33%	95.92%	95.26%	94.51%	94.96%	94.89%	95.45%	96.17%	-	**96.00%**	
Attendance Management																	
Sickness Absence FTE Days Lost -in month		7238.10	8363.71	7244.23	5818.30	5801.84	5839.32	6195.16	7483.23	8260.64	7929.55	8101.55	6544.87	6235.71	-	-	
Average days lost (FTE) per FTE - Rolling 12 month		14.34	14.80	15.19	15.30	15.33	15.30	15.33	15.54	15.92	17.45	17.68	17.61	17.65	-	-	
Sickness Absence Estimated Cost (£) - month		£0.67M	£0.79M	£0.65M	£0.52M	£0.52M	£0.52M	£0.56M	£0.70M	£0.77M	£0.73M	£0.75M	£0.61M	£0.56M	-	-	
Return to work Interviews (%)		58.15%	51.54%	56.86%	60.32%	63.12%	65.03%	57.56%	61.39%	48.33%	51.61%	62.97%	67.75%	66.26%	-	**90.00%**	90% Green 65%-89% Amber <65% Red
Spend																	
Substantive Spend (£)		£20.15M	£21.07M	£20.89M	£21.34M	£20.25M	£21.38M	£20.92M	£21.25M	£20.93M	£20.78M	£21.40M	£23.85M	£35.87M	-	-	
Bank Spend (£)		£1.93M	£1.68M	£1.52M	£1.64M	£1.79M	£1.64M	£2.14M	£1.81M	£2.45M	£1.13M	£2.88M	£2.89M	£2.24M	-	-	
Agency Spend (£)		£0.47M	£0.37M	£0.21M	£0.23M	£0.32M	£0.43M	£0.40M	£0.37M	£0.44M	£0.61M	£0.43M	£0.43M	£0.46M	-	-	
Proportion of Temporary (Agency) Staff		2.07%	1.59%	0.94%	1.00%	1.42%	1.82%	1.69%	1.56%	1.85%	2.69%	1.76%	1.59%	1.20%	-	-	
Essential Safety (12m rolling)																	
Overall Essential Safety Compliance		94.81%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Conflict Resolution (3 Year Refresher)		96.27%	94.73%	95.94%	96.04%	96.04%	96.10%	96.41%	96.81%	96.86%	96.79%	96.60%	96.14%	96.44%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Data Security Awareness (1 Year Refresher)		94.32%	92.73%	90.76%	90.36%	90.36%	90.77%	92.13%	97.91%	92.27%	92.18%	92.13%	91.97%	91.97%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red
Dementia Awareness (No Renewal)		99.34%	97.49%	97.73%	97.72%	97.16%	97.48%	97.25%	97.64%	97.77%	97.80%	97.77%	97.88%	97.69%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Equality and Diversity (3 Year Refresher)		97.54%	96.07%	96.93%	97.16%	91.04%	97.21%	97.58%	92.96%	97.44%	97.45%	97.43%	97.43%	97.39%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Fire Safety (1 Year Refresher)		93.42%	90.40%	90.27%	91.04%	97.07%	90.29%	92.86%	97.88%	91.72%	91.51%	91.18%	91.54%	92.56%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Health and Safety (3 Year Refresher)		97.98%	96.28%	96.96%	97.07%	92.09%	97.32%	97.78%	93.43%	97.64%	97.54%	97.56%	97.50%	97.43%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Infection Control (1 Year Refresher)		94.86%	92.89%	92.84%	92.09%	90.36%	91.86%	93.17%	92.65%	93.67%	93.88%	93.52%	93.10%	92.55%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Manual Handling (2 Year Refresher)		89.81%	89.30%	91.57%	91.67%	91.67%	92.57%	94.29%	94.14%	93.33%	93.61%	93.56%	93.80%	93.67%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Safeguarding (3 Year Refresher)		89.55%	91.03%	91.62%	92.48%	94.43%	93.64%	93.64%	93.94%	92.86%	92.95%	92.68%	92.06%	91.99%	-	**90.00%**	>=90% Green >=85%<90% Amber <85% Red
Appraisal																	
Appraisal (1 Year Refresher) - Non-Medical Staff		90.12%	6.20%	20.85%	33.49%	47.31%	56.27%	68.29%	92.32%	93.74%	95.15%	95.15%	95.15%	95.15%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)		84.10%	80.76%	76.37%	72.83%	67.25%	63.07%	58.38%	55.28%	53.61%	50.00%	46.26%	38.74%	41.05%	-	**95.00%**	>=95% Green >=90%<95% Amber <90% Red

** Vacancy information is updated monthly and is based on the funded establishment held in ESR, this is updated monthly by Finance colleagues based on the establishment information stored in the Trust's financial systems.

- Sickness absence reporting has been enhanced to provide a clear split of the overall sickness rate composition by COVID / Non-COVID related absence, this will allow for post-COVID comparison to a non-COVID absence rate indicator
- Sickness absence data does not include self / household / shielding isolation due to COVID-19.
- Data is based on substantive ESR primary assignment information which may not be refelctive of temporary COVID-19 redeployments
- Staff in Post data, and therefore vacancy data, includes year 2 and 3 student nurses, recruited on a temporary basis to support the Trust during the COVID-19 crisis.
- Due to the postponement of Medical Appraisals, the monthly Metric is lower than would normally be expected

Workforce - Key Metrics

WORKFORCE	Current Month Score	Previous Month	Trend	Change	NHSi Submitted Position
Staff In Post (Headcount)	5956	5926	↑	30	-
Staff In Post (FTE)	5286.5	5250.7	↑	35.83	-
Establishment (FTE)	5385.1	5387.7	↓	-2.61	-
Starters	68.23	83.25	↓	-15.02	-
Leavers	40.86	32.80	↓	8.06	-
Vacancies (FTE)	98.57	137.01	↑	-38.44	-
Vacancies (%)	1.83%	2.54%	↑	-0.71%	-
Turnover Rate (rolling 12 month) (%)	7.51%	7.48%	↓	0.03%	*11.5%

ATTENDANCE MANAGEMENT	Current Month Score	Previous Month	Trend	Change	Target
Sickness Absence Rate (rolling) (%)	4.52%	4.59%	↑	-0.07%	4.0%
Long Term Sickness Absence Rate (rolling) (%)	3.07%	3.07%	↔	0.00%	2.5%
Short Term Sickness Absence Rate (rolling) (%)	1.45%	1.52%	↑	-0.07%	1.5%
Sickness Absence Rate (month) (%)	3.83%	4.55%	↑	-0.72%	4.0%
Long Term Sickness Absence Rate (month) (%)	2.66%	3.12%	↑	-0.46%	2.5%
Short Term Sickness Absence Rate (month) (%)	1.17%	1.43%	↑	-0.26%	1.5%
Return to work interviews completed (%)	66.3%	67.8%	↓	-1.49%	90.0%

APPRAISAL	Current Month Score	Previous Month	Trend	Change	Target
Appraisal (YTD)	95.15%	95.15%	↔	0.00%	95.00%
Medical Appraisal (YTD)	41.05%	38.74%	↑	2.31%	-

ESSENTIAL SAFETY TRAINING	Current Month Score	Previous Month	Trend	Change	Target
Data Security Awareness (1 Year Refresher)	91.97%	91.97%	↑	0.00%	95.00%
Infection Control (1 Year Refresher)	92.55%	93.10%	↓	-0.55%	90.00%
Fire Safety (1 Year Refresher)	92.56%	91.54%	↑	1.03%	90.00%
Manual Handling (2 Year Refresher)	93.67%	93.80%	↓	-0.13%	90.00%
Safeguarding (3 Year Refresher)	91.99%	92.06%	↓	-0.07%	90.00%
Conflict Resolution (3 Year Refresher)	96.44%	96.14%	↑	0.30%	90.00%
Equality & Diversity (3 Year Refresher)	97.39%	97.43%	↓	-0.04%	90.00%
Health, Safety & Wellbeing (3 Year Refresher)	97.43%	97.50%	↓	-0.07%	90.00%
Dementia Awareness (No Renewal)	97.69%	97.88%	↓	-0.19%	90.00%

Key

- ↔ No movement from previous month
- ↑ Improvement from previous month
- ↓ Deterioration from previous month
- * Internal target rather than NHSi Submitted Position
- Not achieving target
- Achieving target

* The recruitment data has been realigned to take into account the National Streamlining agenda and targets set locally. Data shows agenda for change (AFC) recruitment and Medical and Dental (M&D) only and excludes recruitment activity relating to deanery doctors, retirement, volunteers and rolling adverts.

RECRUITMENT	AfC Current Month Avg Days	AfC Previous Month	Medical Current Month Avg Days	Medical Previous Month	All Current Month Avg Days	All Previous Month	Trend	Change	Target (Days)
Vacancy approval to advert placement	5.8	5.9	9.3	4.4	6.0	5.9	↓	0.1	8
Shortlisting to interview	3.4	3.2	4.7	8.2	3.5	3.6	↑	-0.1	12
Interview to conditional offer	1.6	2.4	4.2	3.1	1.7	2.5	↑	-0.8	6
Pre employment to unconditional offer	17.4	19.9	37.7	51.5	18.0	22.2	↑	-4.2	18
Unconditional Offer to Acceptance	1.5	1.9	0.0	1.0	1.5	1.9	↑	-0.4	3

Vacancy approval to advert placement-The average number of days between a vacancybeing submitted for approved and the advert being placed.

Shortlisting to interview- The average number of days between date vacancy closed and date invited to interview

Interview to conditional offer- The average number of days between the interview date and the date of informing of a decision.

Pre employment to unconditional offer -The average number of days between the date Conditional Offer letter sent & the date Unconditional Offer letter sent

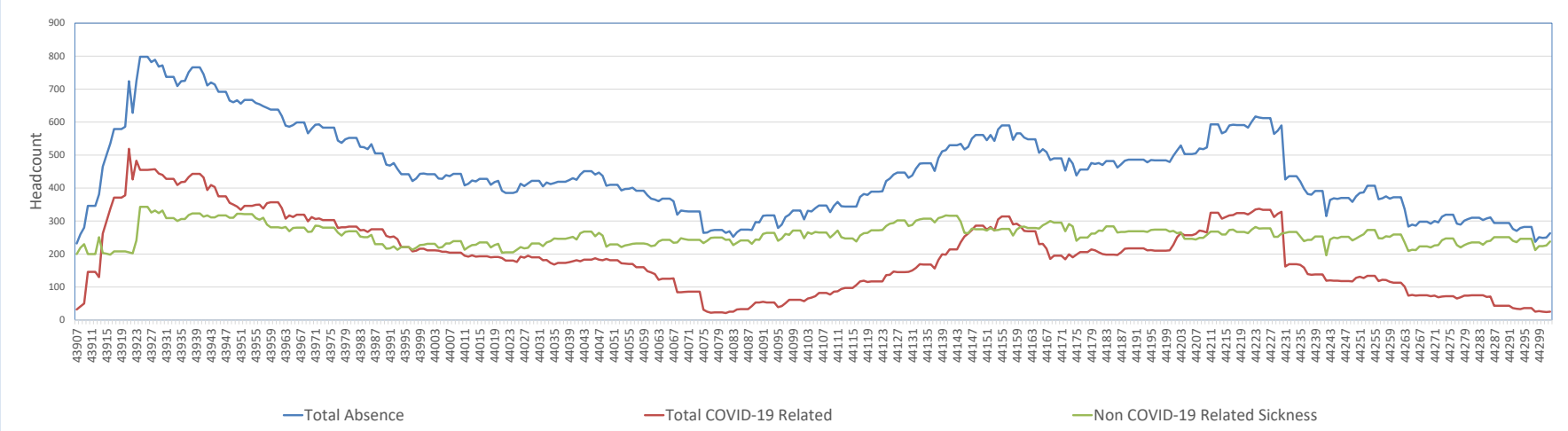
Unconditional Offer to Acceptance - The average number of days for Unconditional Offer to Acceptance

PAY	Current Month Spend	Previous Month	Trend	Change	Target (Budget)
Substantive Expenditure	£35.87M	£23.85M	↓	£12.02M	£22.58M
Agency Expenditure	£0.46M	£0.43M	↓	£0.03M	£0.47M
Bank Expenditure	£2.24M	£2.89M	↓	-£0.65M	£1.83M

Note - March 2021 substnative spend includes year end pension contributions of 6.3% (£11.2M). These contributions are paid by NHSE. As such while substantive spend shows a marked increase this is offset by an increase in income of the same ammount.

COVID-19 - Key Metrics

ABSENCE



The data above is taken from the Trust daily situation report. 17-18 March represents ESR absence data only. 19 March to 1 April 20 represents combined ESR absence data and Occupational Health call log data. 2 April 20 includes Roster isolation information. 3 April 20 onwards represents the full absence picture, combining ESR absence data, Roster absence data, and isolations recorded via the Occupational Health call log.

*Numbers for colleagues who were shielding (CEV or Pregnant) were removed from reported Covid-19 figures from 4 February to fall in line with WYATT reporting hence a drop off in numbers.

Workforce Absence @ 16 April 2021

	Headcount	% of workforce
Absence - COVID-19 Related	25	0.4%
Absence - Sickness (Non COVID-19 Related)	238	3.7%
Total Absence	263	4.1%

Testing

Location	Number Tested
CHFT	3820
Locala	6
Home	65
External	567
Total	4458

Results *		
Negative	3365	79.1%
Positive	886	21%
Awaiting	3	0.1%

* Excludes inconclusive tests

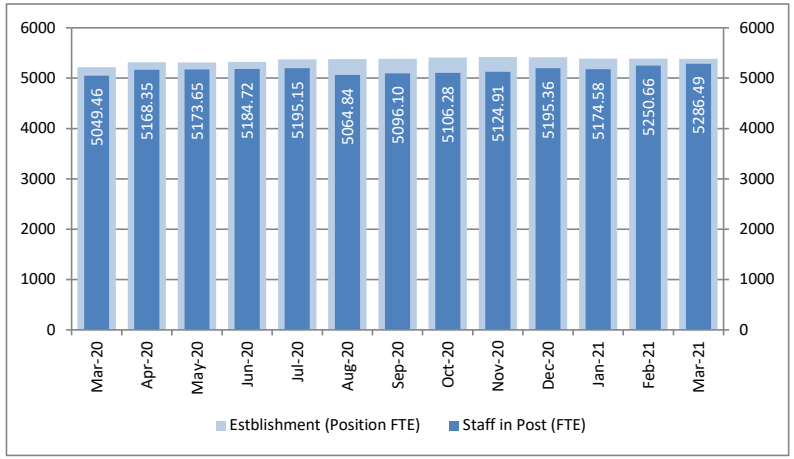
Self Isolation (Staff Presenting Symptoms) Testing

	Number Tested	Negative	Positive	Awaiting
BAME (incl mixed and other)	518	73%	27%	0%
White	1972	79%	21%	0%
Not Stated	114	74%	26%	0%

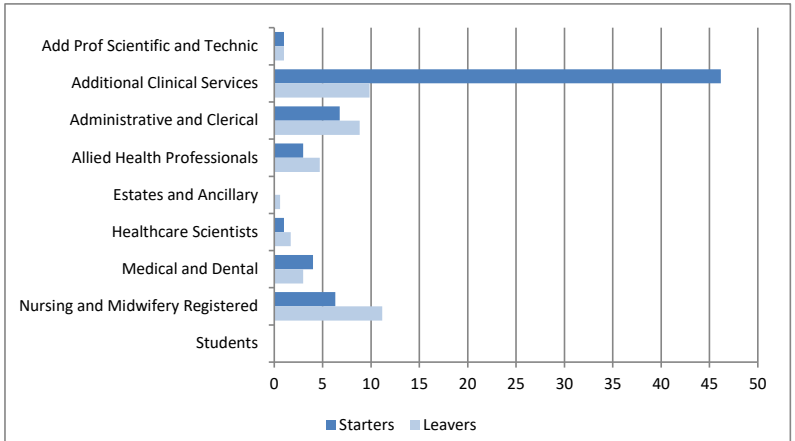
Covid Related Key Metrics

Reality

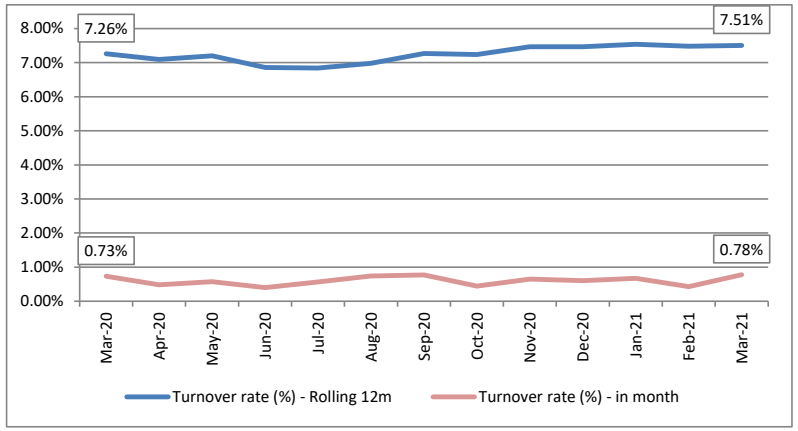
Staff in Post (FTE) v Establishment (FTE)



Starters & Leavers (FTE) by Staff Group - March 2021



Turnover



Turnover by Staff Group

Staff Group	In-Month	Rolling
Add Prof Scientific and Technic	0.48%	9.32%
Additional Clinical Services	0.87%	7.16%
Administrative and Clerical	0.86%	8.37%
Allied Health Professionals	0.93%	11.90%
Estates and Ancillary	1.25%	6.60%
Healthcare Scientists	1.38%	9.07%
Medical and Dental	0.77%	7.27%
Nursing and Midwifery Registered	0.64%	5.79%

Result

Have a Retention Strategy with interventions aimed at key staff groups which currently have a high turnover.

Response

The increase in staff in post seen in April 20 on the adjacent Staff in Post graph is due to the temporary recruitment of year 2 and 3 nursing students

Retention

The Trust has developed its People Strategy, which includes a focus on Recruitment and Retention. Specific initiatives have included:-

- More streamlined recruitment
- Improved induction
- Health and wellbeing
- Colleague engagement
- Recognition and Reward
- Career development

Further work is being developed to enhance our People Strategy in 'The Cupboard'.

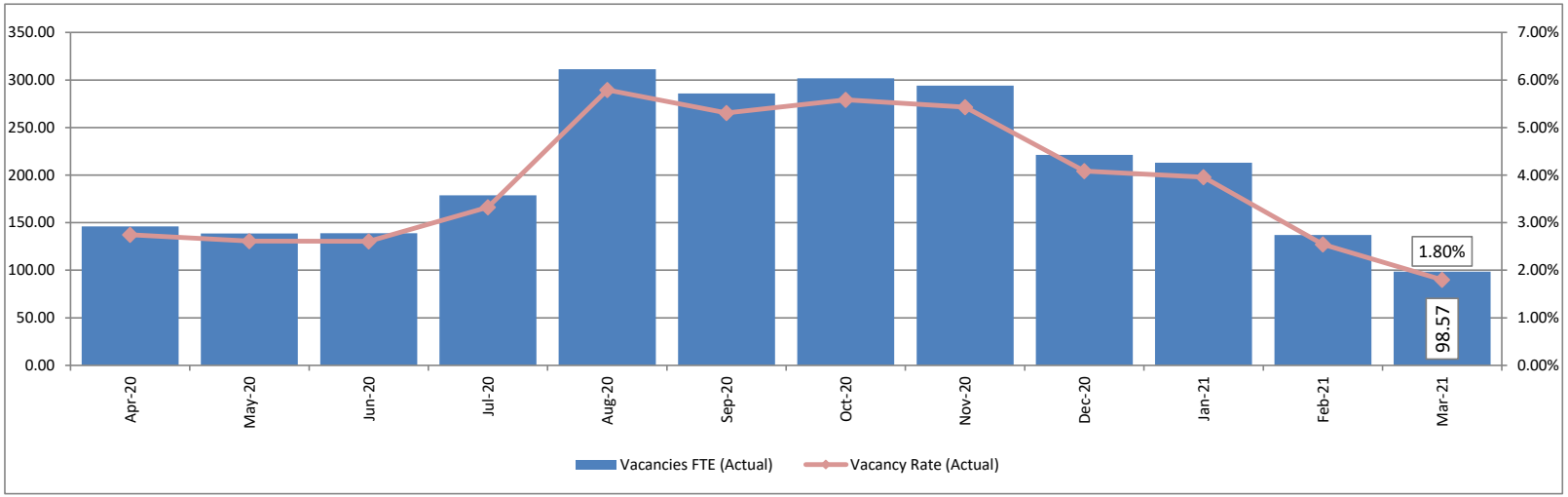
To support the retention of the Nursing workforce, the Trust offers a comprehensive induction and all new starters are enrolled on a year long graduate programme which is supported by the preceptorship programme.

The Trust is part of cohort 4 of NHSI Retention Direct Support Programme which is a clinically led programme aimed at supporting Trusts to improve their Nursing retention rates. The programme is currently on hold due to COVID-19 pressures.

Staff in Post / Starters & Leavers / Turnover

Reality

Vacancies



Vacancies by Staff Group

Staff Group	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Add Prof Scientific and Technic	224.48	209.09	15.39
Additional Clinical Services	1123.28	1151.95	-28.67
Administrative and Clerical	1088.80	1026.15	62.65
Allied Health Professionals	381.19	407.50	-26.31
Estates and Ancillary	56.07	46.96	9.11
Healthcare Scientists	125.84	123.30	2.54
Medical and Dental	651.03	629.51	21.52
Nursing and Midwifery Registered	1734.37	1623.24	111.13
Students	0.00	68.80	-68.80
Total	**5385.06**	**5286.49**	**98.57**

Additional Clinical Services Breakdown

Role	Establishment (FTE)	Actual (FTE)	Vacancies (FTE)
Asst./Associate Practitioner Nursing	29.23	25.75	3.48
Health Care Support Worker	77.60	62.81	14.79
Healthcare Assistant	708.11	708.25	-0.14
Nursery Nurse	1.83	1.03	0.80
Nursing Associate	10.91	40.60	-29.69
Trainee Nursing Associate	2.00	42.00	-40.00
Total (Unregistered Nursing)	**829.68**	**880.44**	**-50.76**

Other Additional Clinical Service	293.60	271.50	22.10

Result

CHFT to be the employer of choice in a competitive environment through a recruitment strategy which includes candidate attraction to the Trust.

Achieve and maintain a vacancy rate below 5.4%.

Response

Recruitment

The intensive recruitment of Healthcare support workers (HCSW) has been extremely successful with an envisaged zero vacancy rate by end of April 2021. There is continued recruitment of this workforce to establish succession planning at a rate of approximately 10 new HCSW per month. Recruitment of International Nurses continues to strive for the ambitious employment of 70 nurses by Dec 2021. Work by the clinical education team continues to support wards in providing good placement experience for student nurses to attract them to CHFT as new graduates. It is estimated around 60 students will choose to work for CHFT when they qualify in the summer. Recruitment of this final year cohort is well underway. In addition to traditional degree students, CHFT continues to support the apprenticeship RN Degree programme and the Nursing Associate programme, with 13 Nursing Associates expected to qualify in June 2021. A further cohort of 13 trainee nurse associates have been recruited internally from the substantive HCSW workforce to commence June 21. These will attract further investment monies from HEE of around £8000 each.

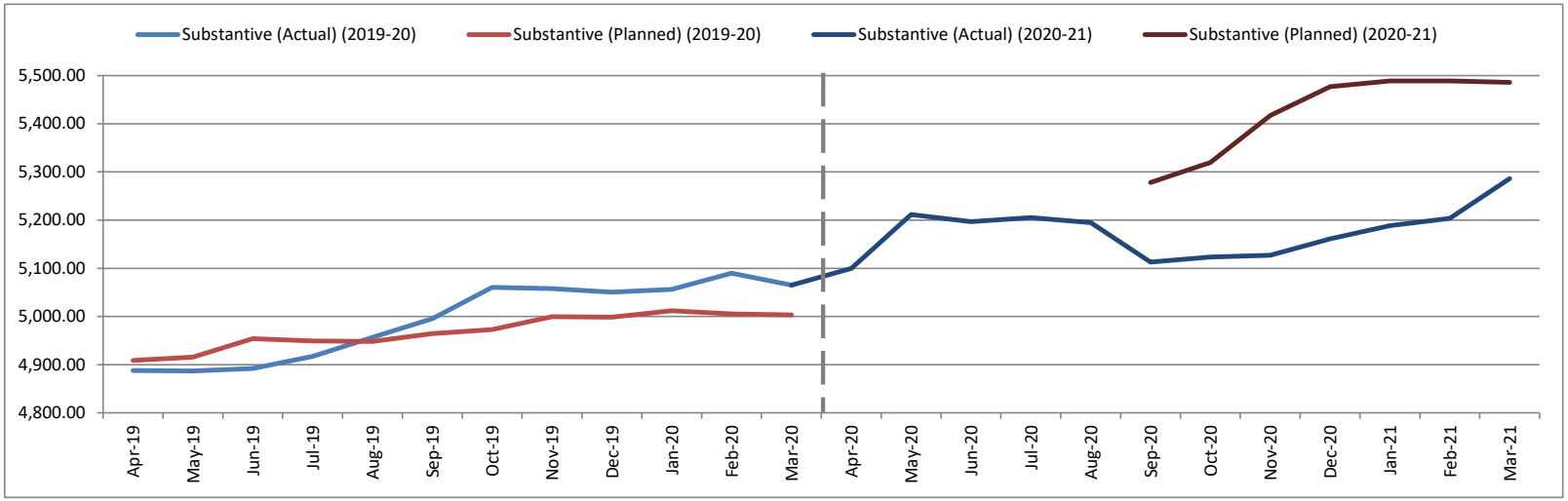
Medical Recruitment

With effect from 1 April 2021 there are two new nationally agreed terms and conditions for Medical and Dental staff. The Specialist role is expected to attract senior doctors with significant experience within a specific speciality. Existing Specialty Drs and Associate Specialists on the National Terms and Conditions are eligible to transfer over the next 6 months. Each has been written to, so that they can express an interest in moving. A task and finish group has been created to support the rollout across the Trust. Medical student support is no longer required in response to Covid pressures. Feedback from medical students that did undertake bank shifts was very positive, and as they hold a bank contract, they will be able to provide support if required in the future. Consultant recruitment has continued at pace and there are seven substantive consultants that have been appointed, including Neonates, Obstetrics (fertility), Cardiology, Medical Oncology, Stroke and Ophthalmology. There are also five locum consultants that have been appointed including in Gastroenterology and Emergency Medicine.

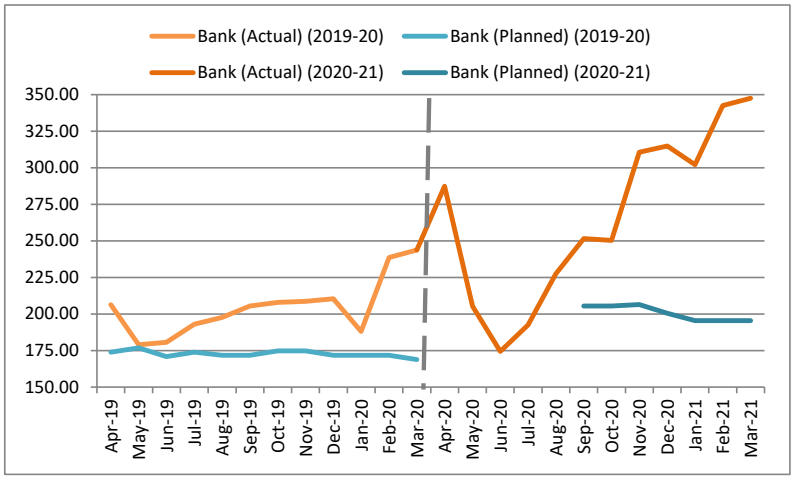
Vacancies

Reality

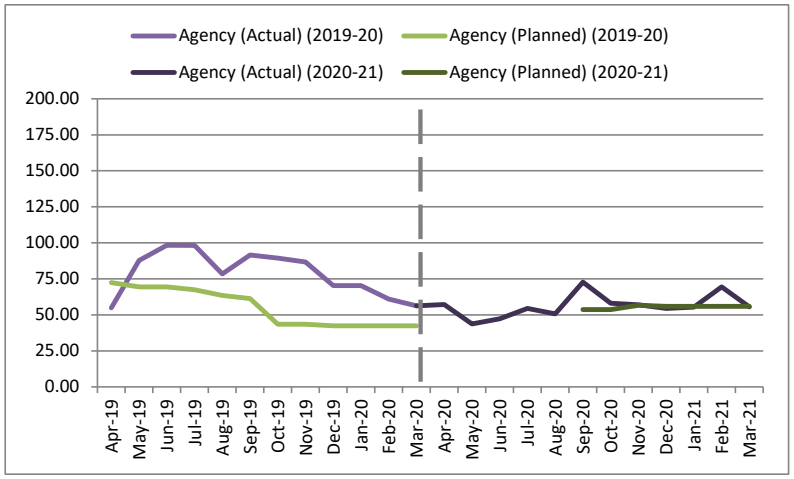
Substantive



Bank



Agency



Result

Increasing the substantive workforce whilst reducing the reliance on bank and agency usage.

These graphs show the FTE worked in-month for substantive, bank and agency workers, against the planned figures submitted to NHSi at the start of the

Response

These graphs show the hours worked in-month converted into FTE for substantive, bank and agency workers, against the planned figures submitted to NHSI at the start of the service year. In 2019/20 whilst the Trust reduced agency usage within the Medical & Dental staff group in particular, usage remained high in Nursing and Midwifery and The Health Informatics Service (THIS). This resulted in agency FTE being above plan.

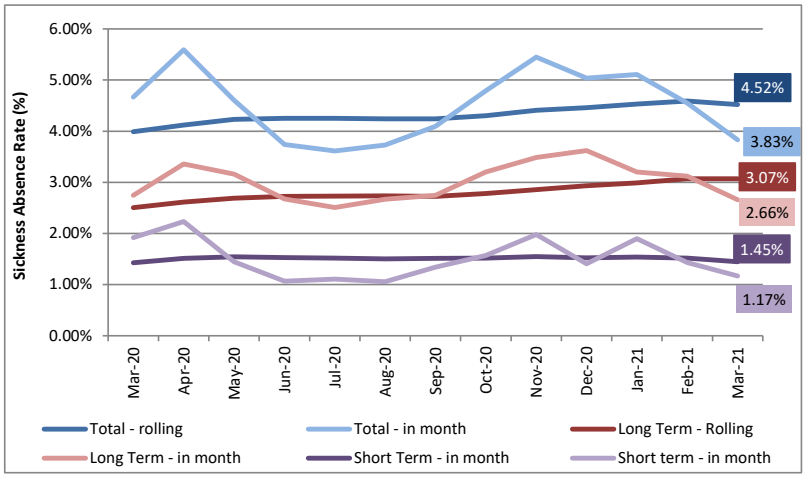
Operational planning was suspended by NHSi for an initial period of 1 April 2020 to 31 July 2020.

Final phase 3 workforce plans for the period September 20 to March 21 have been submitted to NHSI in September 2020.

Workforce Plan

Reality

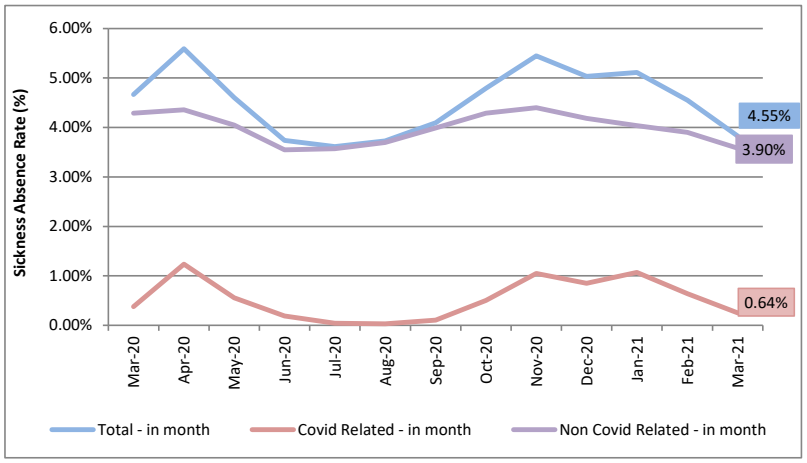
Sickness Absence



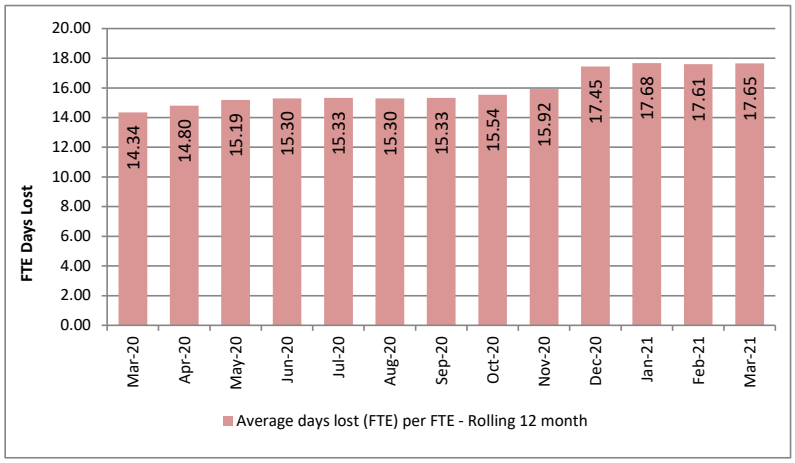
Sickness Absence Reasons - March 21

Reason	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	2293.24	36.78%
S12 Other musculoskeletal problems	668.61	10.72%
S15 Chest & respiratory problems	508.29	8.15%
S25 Gastrointestinal problems	458.41	7.35%
S11 Back Problems	370.92	5.95%
S13 Cold, Cough, Flu - Influenza	286.71	4.60%
S28 Injury, fracture	227.40	3.65%
All Other Reasons	1422.14	22.81%

Covid / Non-Covid Related Sickness Absence (monthly)



Average Days Lost Per FTE - rolling 12 month



Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

Sickness absence data does not include self / household / shielding isolation.

The OH Service have responded to 460 health and wellbeing assessments for Covid Age with letters of recommendations to managers where required. This is an increase of 66 relating to the return to the workplace for CEV and pregnant colleagues; 25 using the revised medical form and 3 using a paper format. Staff PCR swabbing continues, and the OH service is actively supporting track and trace activity for staff contacts within the workplace. There continues to be a significant reduction in the number of staff reporting symptoms to Occupational health, and the demand for PCR swabbing has reduced. There are currently no active staff outbreak areas, and no staff member has tested positive after having 2 doses of covid vaccine.

Staff immunisation for Covid-19 commenced on 30 December 2020, opening a full clinic at both CRH and HRI. This is providing significant coverage of vaccine to health and social care staff from across Calderdale and Kirklees CCG footprints, and clinics are now delivering second doses to schedule. Approximately 62% of CHFT staff have now had 2 doses of vaccine; 81.5% having had one dose.

OH services are working towards recovery and reset of services, and have launched a manager plus portal in the OH Software to improve referral processing and response times within one secure system at the start of April 2021.

Sickness Absence

Reality

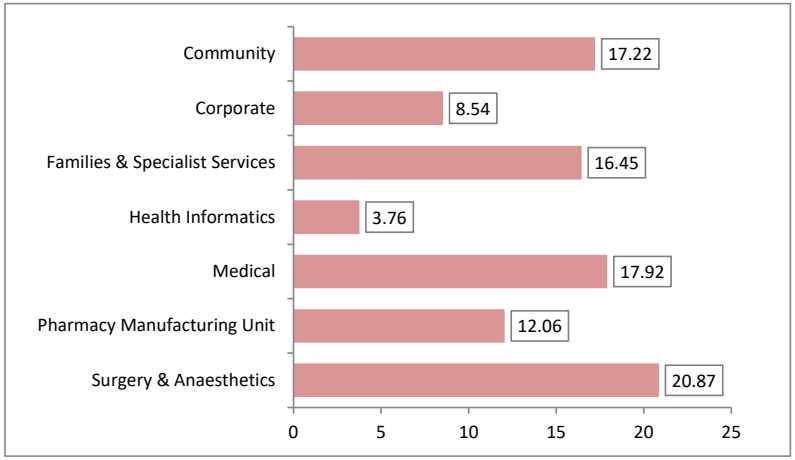
Sickness Absence - in-month

Division	Feb-21	Mar-21
Community	4.72%	4.72%
Corporate	2.34%	2.34%
Families & Specialist Services	4.48%	4.51%
Health Informatics	1.00%	1.03%
Medical	4.86%	4.91%
Pharmacy Manufacturing Unit	3.28%	3.30%
Surgery & Anaesthetics	5.59%	5.72%

Sickness Absence by Staff Group - rolling 12 month

Staff Group	Short Term	Long Term	Total
Add Prof Scientific and Technic	1.60%	1.85%	3.46%
Additional Clinical Services	2.26%	4.63%	6.89%
Administrative and Clerical	0.83%	2.26%	3.09%
Allied Health Professionals	0.96%	2.02%	2.99%
Estates and Ancillary	1.60%	4.02%	5.62%
Healthcare Scientists	1.15%	2.54%	3.68%
Medical and Dental	0.97%	1.01%	1.99%
Nursing and Midwifery	1.77%	3.80%	5.57%
Students	2.15%	0.47%	1.68%

Average Days Lost Per FTE - rolling 12 month



Result

Robust attendance management is in place to ensure rolling 12 month attendance rates achieve the 96% target.

Response

In **Surgery & Anaesthetics,** Absence is a concern for the Divison. Support is provided to managers regulary to ensure that colleagues are managed and supported accordingly through the process. It is acknowledged that the health and wellbeing of our colleageus is of high importance and support is being provided with the recent recruitment of the Health & Wellbeing Adviors input. Particular focus on RTW and the importance of these meetings takes place on a weekly basis with a new approach pulling real time data from the roster to enable managers to ensure RTW dates are input on to the system supported by a RTW meeting with colleagues - this will continue on a wkly basis supporting managers with increasing compliance

In **Medicine** the division is seeing a continued reduction in absence following the national reduction in Covid prevalence. The division has achieved the short term absence target in month. Deep dives are taking place in April for hotspot ares and RTW compliance during the month continues to rise due to the revised reporting process and tergets approach through One Stop Meetings with line managers

In **FSS** the team continue to review cases and sickness deep dives/summits are held across the directorates regularly. Final Attendance panels are planned in for several cases from now and into the new year. RTW compliance has seen a slight decrease in March following increased focus. Workforce reports have been shared regularly to teams throughout March and on an ongoing basis.

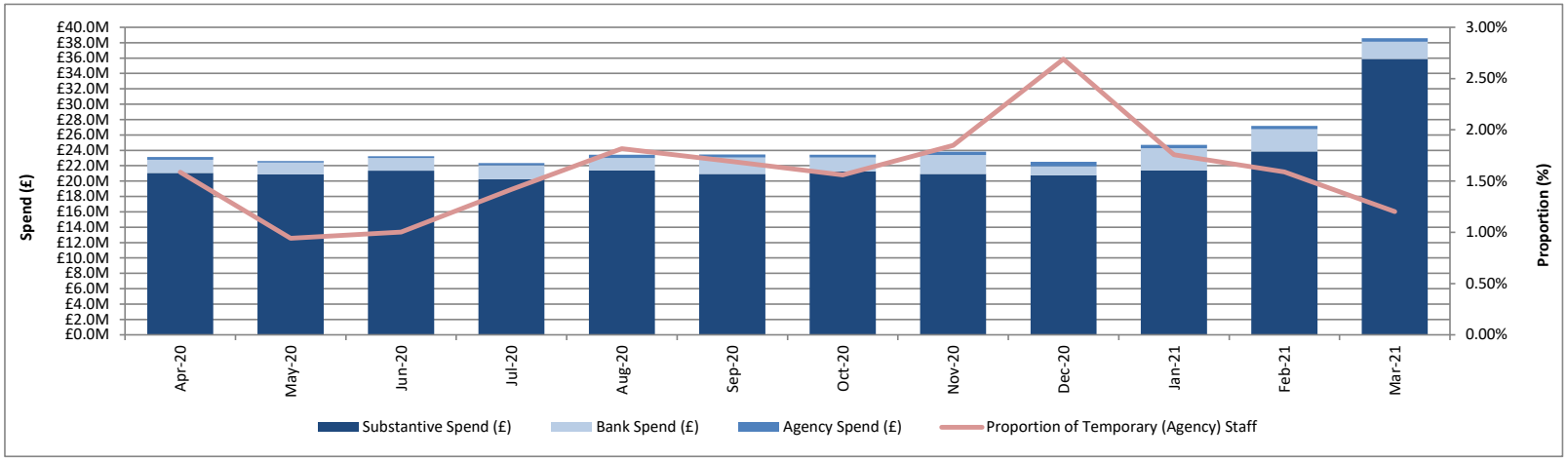
In **Community**, management of sickness absence continues. HR Adviser continues to support line managers with the management of Long term sickness Absence. Additional support has been provided to line managers in hot spot areas.

In **Corporate, PMU & THIS** HR Adviser continues to support line managers with the management of Long term sickness Absence. Additional support has been provided to line managers in hot spot areas.

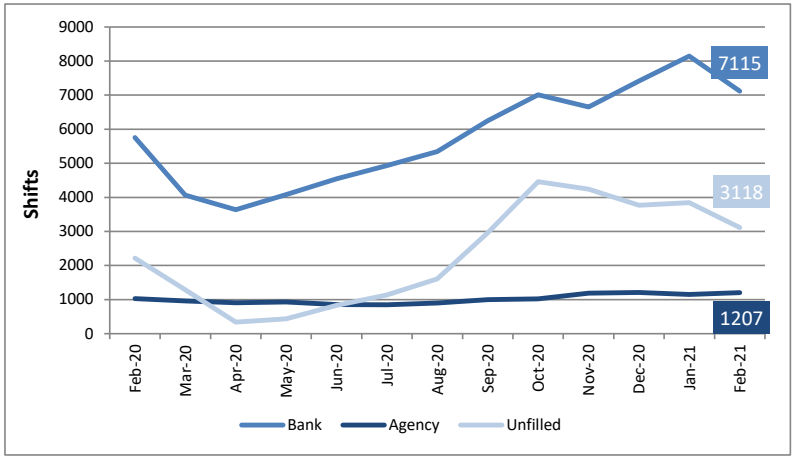
Sickness Absence - Divisional/Staff Group

Reality

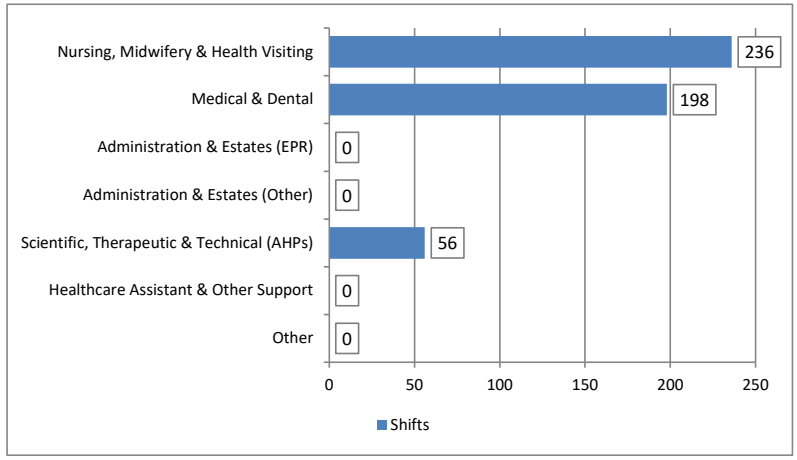
Workforce Spend



Agency, Bank and Unfilled Shifts



Number of shifts that broke the agency cap - January 2021



Result

Continue to reduce the use of agency colleagues and reduce the bank paybill in 2019/2020.

Response

Workforce Spend

March 2021 substnative spend includes year end pension contributions of 6.3% (£11.2M). These contributions are paid by NHSE. As such while substantive spend shows a marked increase this is offset by an increase in income of the same ammount.

Bank/Agency

A total of 380 shifts broke the agency cap in March 2021, this is an decrease on 409 in February 2021

From 6 April 2020 the Trust removed usage of short notice, high cost Tier 3 agency shifts for Nursing and migrated Tier 2 agencies to Tier 1.

Whilst agencies that supplied at Tier 2 and Tier 3 were framework providers, the shifts still represented a significant cost to the Trust when in comparison to Registered Nursing Staff through Bank and Tier 1.

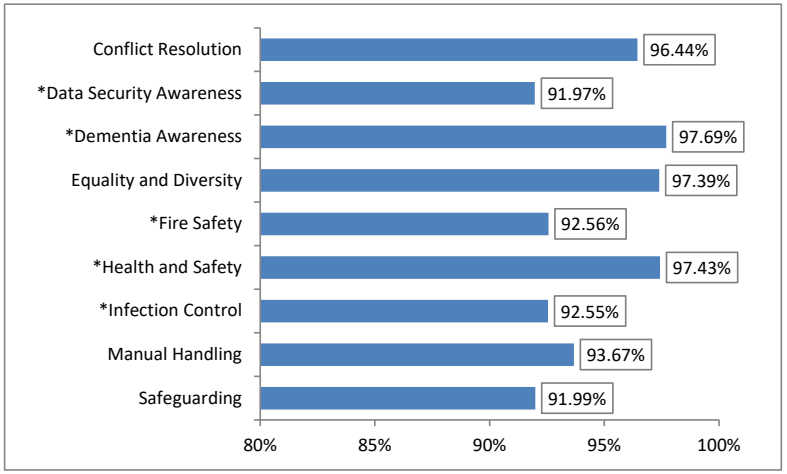
Removing these two Tiers has helped to achieve lower average hourly rates, from £34.01 to £31.17 per hour.

Agency usage remains low with 56% of Nursing shifts and 88% of Medical shifts filled by Bank.

Workforce Spend / Agency Usage

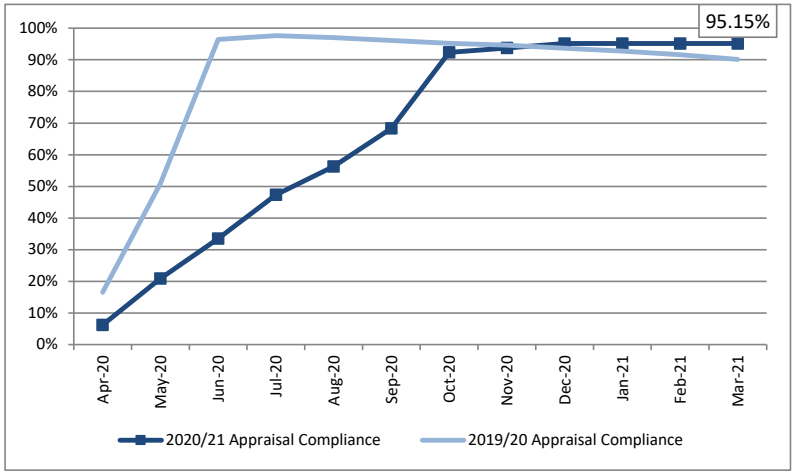
Reality

Essential Safety Training

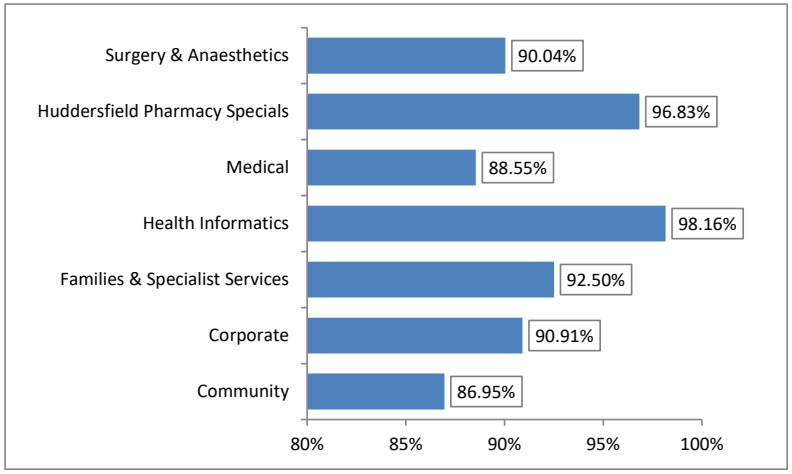


* Essential Safety Training elements that are covered at Corporate Induction.

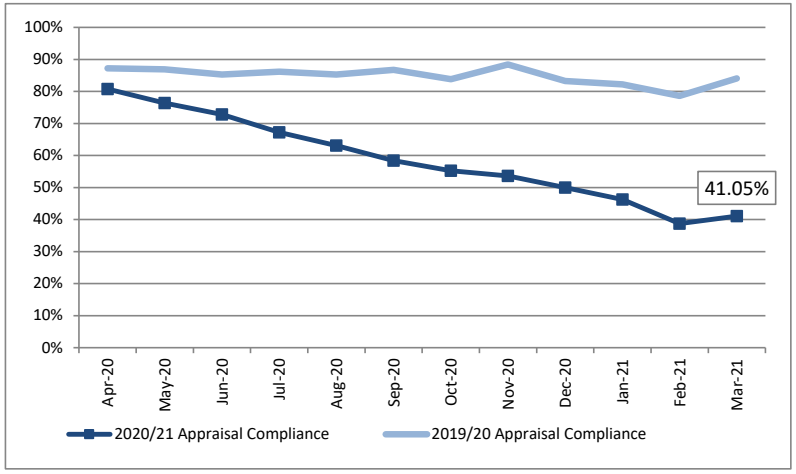
Non-Medical Appraisal Compliance



Non-Medical Appraisal Compliance by Division



Medical Appraisal Compliance



Result

Appraisal compliance is consistently above 95%.

Essential safety training compliance is consistently above 90% stretching to 95%.

Response

Essential Safety Training
A paper is presented weekly to Executive Board highlighting the compliance figures for all EST including role specific training.

The focus remains on improving role specific subjects with less than 85% compliance.

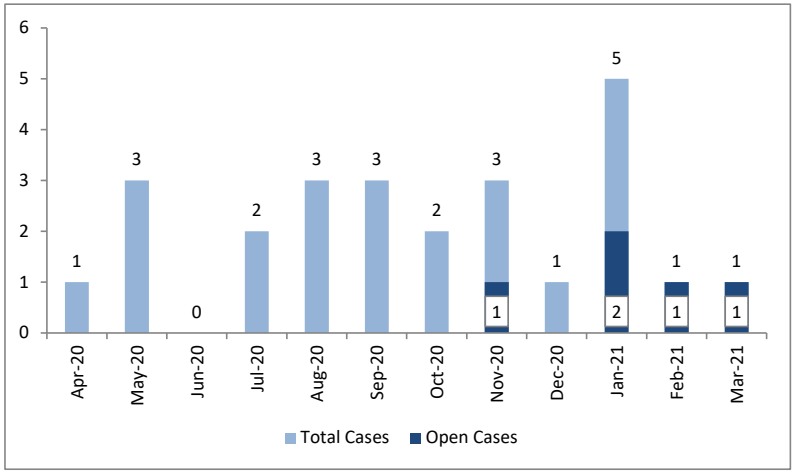
Appraisal
The Trust now adopts an appraisal season approach. The appraisal season ran from 1 July to 31 October this year. The final position for the 2020/21 appraisal season was 95.15%.

The appraisal season and Medical appraisals for 2020/21 is postponed due to the ongoing COVID-19 situation.

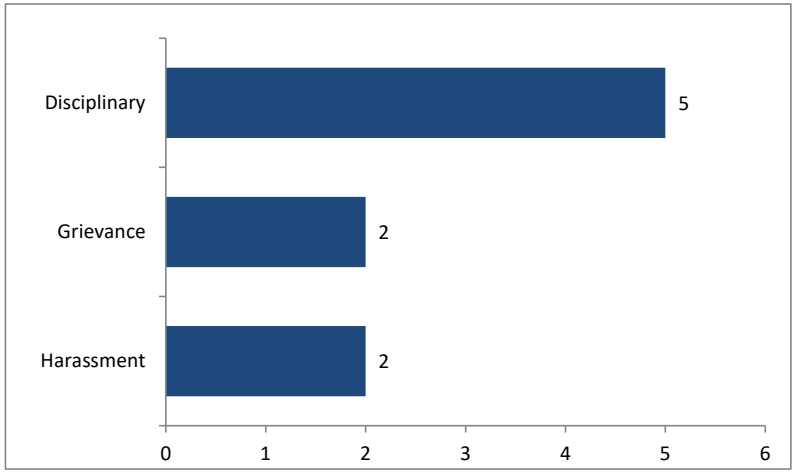
Essential Safety Training / Appraisals

Reality

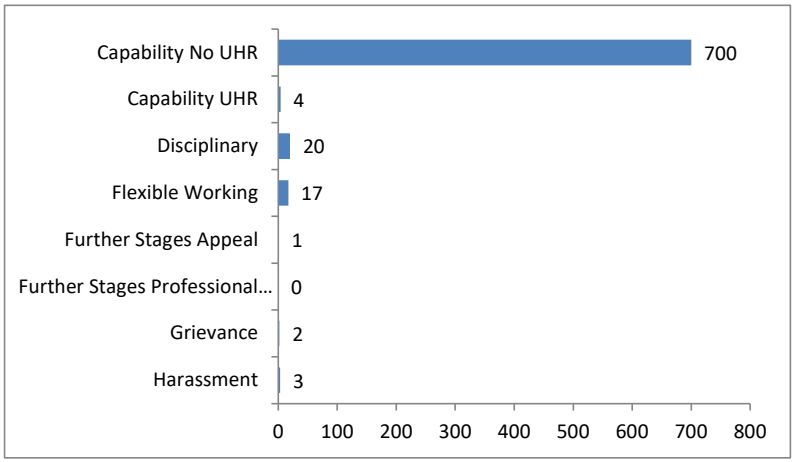
Disciplinary, Grievance, Harassment cases opened last 12 months



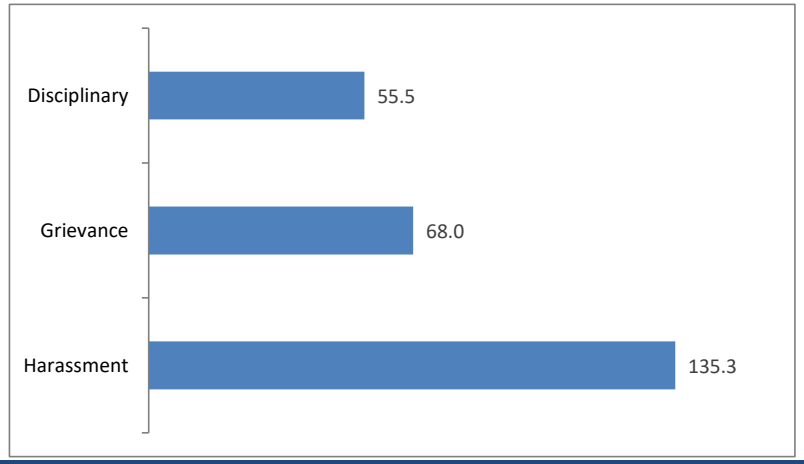
Open Disciplinary, Grievance, Harassment cases by type



All cases opened in the last 12 months by case type



Average number of days to close cases



Result

Maintain a robust capturing process.

Response

Following a deep dive into employee relations cases, the HR Team reviewed the way in which employee relations cases were been recorded and updated. This has resulted in a number of changes which will ensure consistency and enable automated reporting of case management.

- ESR will now be the sole recording system for employee relations cases. Previously the HR Team had been trying to maintain two different systems which led to discrepancies.

- If the employee has a registered disability, absence management cases will now be recorded under 'Capability UHR'. All other absence management cases will be recorded under 'Capability No UHR'.

- Long term sickness absence will now be captured on ESR.

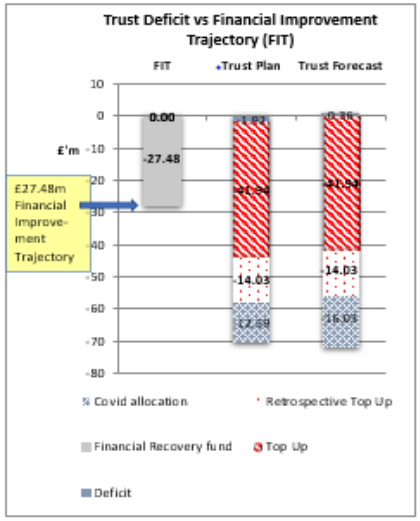
- Unsatisfactory performance during a probationary period will now be captured on ESR.

Employee Relations

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Mar 2021 - Month 12

KEY METRICS

	M12				YTD (MAR 2021)				Forecast 20/21			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£0.96)	£0.22	£1.18		(£1.92)	£0.36	£2.27		(£1.92)	£0.36	£2.27	
Agency Expenditure	(£0.47)	(£0.46)	£0.01		(£4.78)	(£4.51)	£0.28		(£4.78)	(£4.51)	£0.28	
Capital	£3.66	£12.09	(£8.43)		£20.85	£27.01	(£6.16)		£20.85	£27.01	(£6.16)	
Cash	£28.03	£48.22	£20.19		£28.03	£48.22	£20.19		£28.04	£48.22	£20.19	
Invoices paid within 30 days (% (Better Payment Practice Code)	95%	95%	0%		95%	89%	-6%					
CIP	£1.23	£0.65	(£0.58)		£14.77	£5.84	(£8.93)		£14.77	£5.84	(£8.93)	
Use of Resource Metric	3	1			2	2			2	2		



Year to Date Summary

For the financial year ending 31st March 2021, the Trust delivered a surplus of £0.36m, a favourable variance of £2.27m compared to plan. This favourable variance was largely driven by the confirmation of additional income from NHS Improvement in support of those elements that were driving the planned deficit position; the Annual leave accrual and loss on non-NHS income due to the pandemic.

- The surplus shown excludes non-cash related year end adjustments for impairments (£12.67m expenditure), for donated assets including donated PPE (net. £3.13m income) and for donated asset depreciation (£0.216m expenditure), all of which are excluded by NHS Improvement for the purposes of assessing financial performance.
- £10.87m of system Covid funding has been allocated for M7-12, with additional cash allocations from NHS England of: £1.26m to cover lost non-NHS income, £5.71m towards an increased Annual Leave accrual, £0.46m for the 'Flowers' national legal case (for backdated annual leave), and £0.14m for Lateral Flow Testing. In addition the Trust has requested a further £3.30m to Covid cover costs outside of the system envelope for testing, vaccinations, 3rd year students and research costs.
- This additional funding contributes towards costs incurred: £6.33m increase in the Annual Leave accrual, £1.25m of lost non-NHS income and estimated costs of £2.19m for the 'Flowers' case.
- The Trust has incurred costs relating to Covid-19 of £33.54m. M12 costs incurred were £3.51m driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the expansion of the workforce, staff working additional shifts, the segregation of patient pathways, and 3rd Year Student Nurses.
- The remaining funding shortfall is offset by an underspend on activity reset and business as usual activity.
- The Trust continued to deliver some efficiency savings. CIP achieved for the year was £5.84m, £8.93m below the original Trust plan. Compared to the Phase 3 Plan, the Trust has delivered £3.87m of savings in 6 months, slightly below the £4.82m described in the revised plan. This is not a target being monitored by NHS Improvement in 2020/21.
- Agency expenditure year to date is £4.51m, £0.28m below the revised planned level.

Key Variances (compared to Phase 3 plan submission)

- Whilst the majority of the Trust's Clinical Contract income has been fixed due to block and top up arrangements including a fixed monthly allocation to cover Covid-19 expenditure, there remain some variable elements. As described above, additional income of £3.30m has been assumed to cover 'outside of envelope' Covid costs. The Trust has also received additional system support of £0.81m and has assumed a total of £7.43m additional NHS England funding as advised to cover Annual leave costs, the 'Flowers' case and to compensate for lost non-NHS income. The Trust is also required to account for additional employer pension contributions paid on the Trust's behalf by NHS England and offset by notional income of £11.27m. In overall terms income was above plan by £24.51m, (excluding Donated Asset Income).
- Pay costs were £15.08m above the planned level year to date, although this includes the £11.27m notional pensions costs mentioned above. Excluding this value, Pay costs were £3.81m higher than planned. The Annual Leave accrual has been increased by £6.33m (£5.83m higher than planned), reflecting the impact of the Covid-19 second wave on our staff's ability to take their allocated leave. This pay pressure has been offset by slippage in recruitment to the additional posts required to deliver Phase 3 activity plans.
- Non-pay operating expenditure was higher than planned by £7.58m, (excluding Donated consumables expenditure). This is due to higher than planned Covid-19 related expenditure particularly Vaccination costs, costs due to the 'Flowers' legal case, an increase in provisions, and non recurrent legal costs.

Total Group Financial Overview as at 31st Mar 2021 - Month 12

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M12

CLINICAL ACTIVITY

	M12 Plan	M12 Actual	Var
Elective	2,245	1,708	(537)
Non-Elective	53,875	47,403	(6,472)
Daycase	28,176	26,787	(1,389)
Outpatient	298,401	312,107	13,706
A&E	133,952	125,522	(8,430)
Other NHS Non-Tariff	1,190,677	1,217,308	26,631
Other NHS Tariff	49,737	69,963	20,227
Total	**1,757,064**	**1,800,799**	**43,735**

TOTAL GROUP: INCOME AND EXPENDITURE

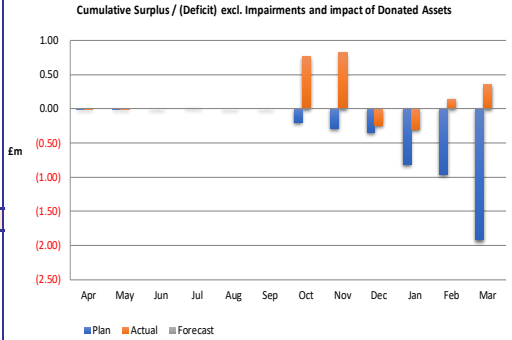
	M12 Plan	M12 Actual	Var
	£m	£m	£m
Elective	£18.01	£18.01	£0.00
Non Elective	£114.89	£114.89	£0.00
Daycase	£30.72	£30.72	£0.00
Outpatients	£46.12	£46.12	£0.00
A & E	£23.16	£23.16	(£0.00)
Other-NHS Clinical	£105.78	£124.64	£18.86
CQUIN	£3.79	£3.79	£0.00
Other Income	£46.96	£50.71	£3.76
Total Income	**£389.43**	**£412.05**	**£22.62**
Pay	(£286.54)	(£301.62)	(£15.08)
Drug Costs	(£41.90)	(£40.96)	£0.94
Clinical Support	(£31.01)	(£30.47)	£0.53
Other Costs	(£64.57)	(£73.63)	(£9.05)
PFI Costs	(£13.44)	(£13.44)	£0.00
Total Expenditure	**(£437.46)**	**(£460.12)**	**(£22.66)**
EBITDA	**(£48.03)**	**(£48.06)**	**(£0.04)**
Non Operating Expenditure	(£24.06)	(£23.59)	£0.47
Surplus / (Deficit) Adjusted*	**(£72.08)**	**(£71.65)**	**£0.43**
Conditional Funding (MRET/FRF/Top Up)	£70.17	£72.01	£1.84
Surplus / Deficit*	**(£1.92)**	**£0.36**	**£2.27**

* 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

	M12 Plan	M12 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£17.51	£20.65	£3.14
Medical	£31.43	£31.38	(£0.05)
Families & Specialist Services	(£7.45)	(£5.73)	£1.72
Community	(£3.90)	(£2.44)	£1.46
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£46.03)	(£47.87)	(£1.85)
THIS	£1.49	£1.45	(£0.04)
PMU	£3.00	£3.40	£0.40
CHS LTD	£0.71	£0.15	(£0.55)
Central Inc/Technical Accounts	£0.38	(£0.59)	(£0.97)
Reserves	£0.94	(£0.06)	(£0.99)
Unallocated CIP	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£1.92)**	**£0.36**	**£2.27**

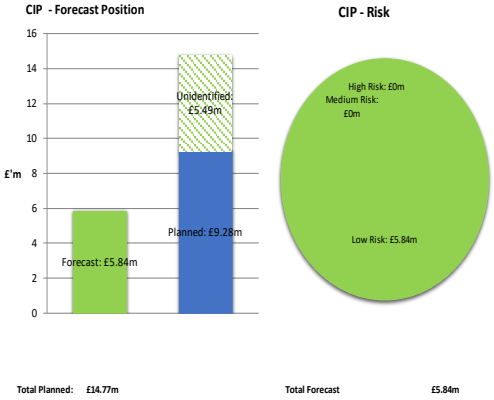
TOTAL GROUP SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date M12 Plan	Year To Date M12 Actual	Year To Date Var	Year End: Forecast Plan	Year End: Forecast Forecast	Year End: Forecast Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£1.92)	£0.36	£2.27	(£1.92)	£0.36	£2.27
Capital	£20.85	£27.01	(£6.16)	£20.85	£27.01	(£6.16)
Cash	£28.03	£48.22	£20.19	£28.04	£48.22	£20.19
Invoices Paid within 30 days (BPPC)	95%	89%	-6%			
CIP	£14.77	£5.84	(£8.93)	£14.77	£5.84	(£8.93)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	2	2		2	2	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14.77m

Total Forecast £5.84m

YEAR END 20/21

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	2,245	1,708	(537)
Non-Elective	53,875	47,403	(6,472)
Daycase	28,176	26,787	(1,389)
Outpatient	298,401	312,107	13,706
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Other NHS Tariff	49,737	69,963	20,227
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TOTAL GROUP: INCOME AND EXPENDITURE

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Drug Costs	(£41.90)	(£40.96)	£0.93
Clinical Support	(£31.01)	(£30.47)	£0.53
Other Costs	(£64.57)	(£73.64)	(£9.06)
PFI Costs	(£13.44)	(£13.42)	£0.01
Total Expenditure	**(£437.46)**	**(£460.12)**	**(£22.66)**
EBITDA	**(£48.03)**	**(£48.06)**	**(£0.04)**
Non Operating Expenditure	(£24.06)	(£23.59)	£0.47
Surplus / (Deficit) Adjusted*	**(£72.08)**	**(£71.65)**	**£0.43**
Conditional Funding (MRET/FRF/Top Up)	£70.17	£72.01	£1.84
Surplus / Deficit*	**(£1.92)**	**£0.36**	**£2.27**

* 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
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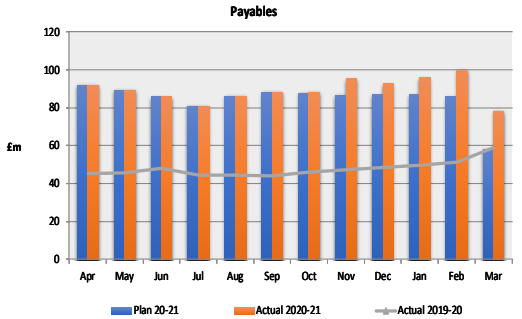
Medical	£31.43	£31.38	(£0.05)
Families & Specialist Services	(£7.45)	(£5.73)	£1.72
Community	(£3.90)	(£2.44)	£1.46
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£46.03)	(£47.87)	(£1.85)
THIS	£1.49	£1.45	(£0.04)
PMU	£3.00	£3.40	£0.40
CHS LTD	£0.71	£0.15	(£0.55)
Central Inc/Technical Accounts	£0.38	(£0.59)	(£0.97)
Reserves	£0.94	(£0.06)	(£0.99)
Unallocated CIP	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£1.92)**	**£0.36**	**£2.27**

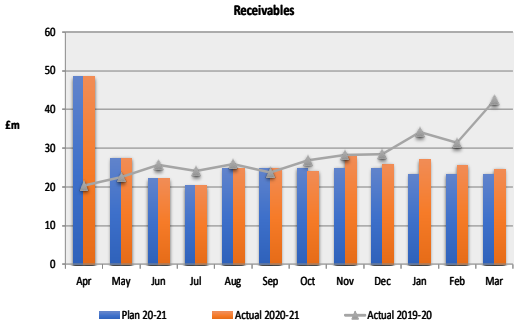
Total Group Financial Overview as at 31st Mar 2021 - Month 12

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

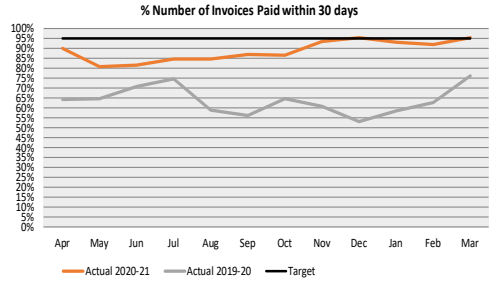
WORKING CAPITAL

	M12 Plan £m	M12 Actual £m	Var £m	M12
Payables (excl. Current Loans)	(£58.02)	(£77.99)	£19.97	
Receivables	£23.27	£24.61	(£1.34)	



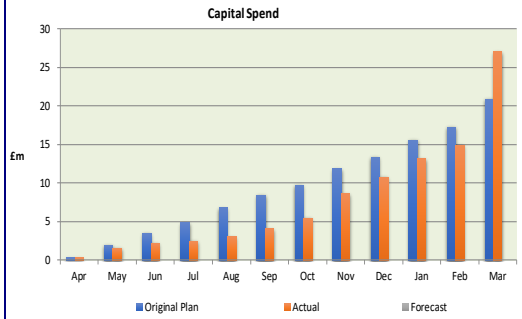


BETTER PAYMENT PRACTICE CODE



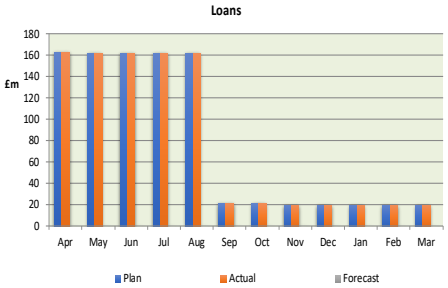
CAPITAL

	M12 Plan £m	M12 Actual £m	Var £m	M12
Capital	£20.85	£27.01	(£6.16)	

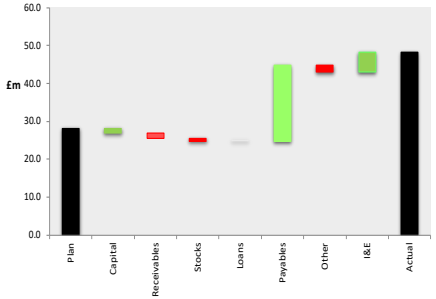


CASH

	M12 Plan £m	M12 Actual £m	Var £m	M12
Cash	£28.03	£48.22	£20.19	
Loans (Cumulative)	£19.88	£19.88	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- For the financial year ending 31st March 2021, the Trust delivered a surplus of £0.36m, a favourable variance of £2.27m compared to plan. This favourable variance was largely driven by the confirmation of additional income from NHS Improvement in support of those elements that were driving the planned deficit position; the Annual leave accrual and loss on non-NHS income due to the pandemic.
- The Trust's Clinical Contract income has been largely fixed due to block and top up arrangements including a fixed monthly allocation to cover Covid-19 costs, but there remain some variable elements. Additional income of £3.30m has been assumed to cover 'outside of envelope' Covid costs. The Trust has also received additional system support of £0.81m, a £1.26m cash allocation to compensate for lost non-NHS income and £5.71m funding in support of an increase in the Annual Leave accrual.
- Whilst Outpatient activity was above the Phase 3 plan for the period, all other areas of activity were below plan due to increased Covid-19 admissions.
- Year to date the Trust has incurred costs relating to Covid-19 of £33.54m. M12 costs incurred were £3.51m.
- Capital expenditure is higher than planned at £27.01m against a planned £20.85m. This includes £2.46m of Donated Assets, including Ventilators, Imaging and Testing equipment procured centrally during the pandemic.
- The Trust continued to deliver some efficiency savings. CIP achieved for the year was £5.84m, £8.93m below the original Trust plan.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 2. This excludes the exceptional adverse impact on the Capital Service Cover Metric of the repayment of Interim revenue and capital support loans, due to changes in the NHS cash regime.

NOTES

- The surplus shown excludes non-cash related year end adjustments for impairments (£12.67m expenditure), for donated assets including donated PPE (net. £3.13m income) and for donated asset depreciation (£0.216m expenditure), all of which are excluded by NHS Improvement for the purposes of assessing financial performance.
- The total loan balance at year end was £19.88m as planned. All Revenue and Interim Capital Loans (totalling £140.72m) were repaid and replaced by PDC funding during September.
- The Trust has a cash balance of £48.22m, £20.19m higher than planned. Whilst contract income is no longer received a month in advance as seen in previous months this year, the Trust retains more cash than planned due to an increase in accruals and provisions, in particular those relating to the Annual Leave accrual and the 'Flowers' legal case for back dated annual leave. These payments will made in cash terms in the next financial year.

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

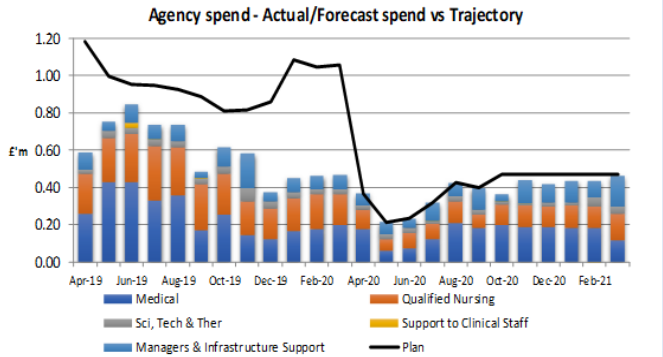
NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per NHSI risk indicator).

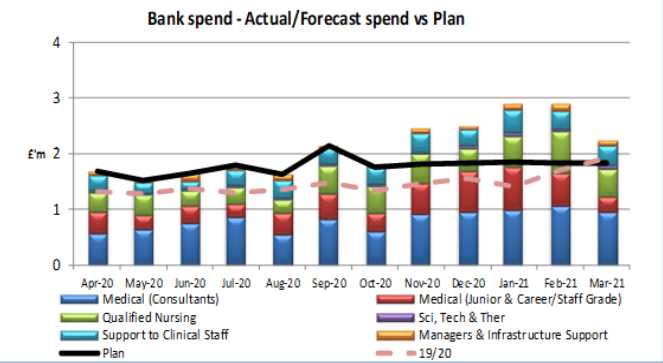
RAG KEY: UOR	
	All UOR metrics are at the planned level
	Overall UOR as planned, but one or more component metrics are worse than planned
	Overall UOR worse than planned

WORKFORCE

Vacancies

	Sci, Tech & Ther	Admin & Estates	Medical	Nursing	Support to Clinical	Total
Vacancies (WTE)	- 9	85	22	111	- 97	111
Staff in post (WTE)	741	1,427	630	1,623	1,221	5,641
% Vacancies	-1%	6%	3%	6%	-9%	2%





Cumulative Agency and Bank Spend	Plan	Actual	Var	
	£'m	£'m	£'m	
Agency Year to Date	(£4.78)	(£4.51)	£0.28	
Agency Forecast	(£4.78)	(£4.51)	£0.28	
Bank Year to Date	(£21.30)	(£25.16)	(£3.87)	
Bank Forecast	(£21.30)	(£25.16)	(£3.87)	

Vacancies

At the end of Month 12 the Trust was carrying 111 vacancies, 2% of the total baseline establishment (excluding Covid / Phase 3 response) and a reduction of 41 vacancies compared to Month 11. These figures include 68 WTE 3rd Year student nurses who have joined the Trust on temporary contracts for 10 weeks. Total Staff in Post increased by 38 in month to 5,641. Medical vacancies remained static in month at 3%. Nursing vacancies increased by 10 to 111 WTE or 6% of establishment. To Note: the establishment has not been adjusted to reflect any additional posts for the Phase 3 Covid response, therefore the vacancy rate is measured against the business as usual establishment.

Agency Expenditure

Total reported agency expenditure year to date is £4.51m; £0.28m below the planned value. The year to date underspend on agency costs is offset by an increase in the use of internal Bank staff.

Bank usage

Expenditure on internal Bank staff year to date is £25.16m, £3.87m higher than planned. £9.57m of these costs relate to the Covid-19 response including: additional medical costs of £5.13m due to changes to rotas, expansion of the workforce, segregation of patient pathways and support to the vaccination programme; and nursing costs of £4.16m due to backfill for higher sickness absence, expanded workforce, plans to release bed capacity and support to the vaccination programme. In January and February, the increase in bank usage was driven by the hospital site vaccination programme.

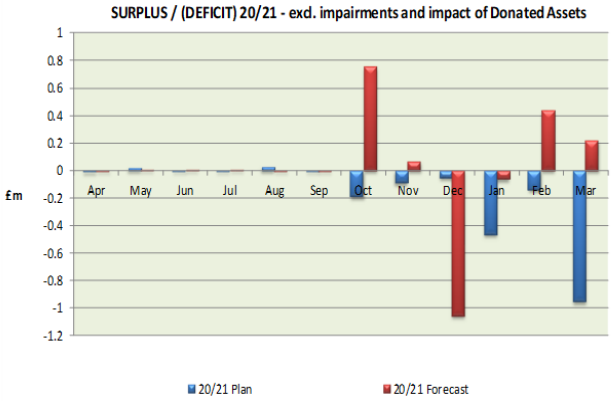
YEAR END POSITION 20/21

YEAR END 20/21

Statement of Comprehensive Income	Plan £m	Actual £m	Var £m	
Income	£459.73	£491.21	£31.48	
Pay expenditure	(£286.54)	(£301.62)	(£15.08)	
Non Pay Expenditure	(£150.92)	(£162.52)	(£11.60)	
Non Operating Costs	(£24.14)	(£36.47)	(£12.33)	
Total Trust Surplus / (Deficit)	**(£1.87)**	**(£9.40)**	**(£7.53)**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	£12.67	£12.67	
Donated Asset depreciation	£0.09	£0.22	£0.13	
Donated Asset income (including Covid equipment)	(£0.13)	(£2.46)	(£2.33)	
Net impact of donated consumables (PPE etc)	£0.00	(£0.67)	(£0.67)	
Adjusted Financial Performance	**(£1.92)**	**£0.36**	**£2.27**	

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

MONTHLY SURPLUS / (DEFICIT)



Final Position vs Month 7-12 (Phase 3) Financial Plan

The plan submitted to the ICS and NHSI assumed an underlying unfunded gap (deficit) of £1.92m as described below. This deficit position was primarily driven by a loss of non-NHS income, for which national funding has now been agreed and the impact of increasing the Annual Leave accrual. Whilst the Annual Leave accrual has increased by £6.54m, much more than planned, national funding of £5.71m has been agreed to cover up to a maximum of 5 days carried forward leave, offsetting the majority of this increased cost.

	Plan £'m	Actual £'m	
Technical Accounting Adjustment:	£0.00		*Removed from Plan and Forecast*
Loss of 'Other' Income:	-£1.61	£0.00	National Funding agreed
Annual Leave Accrual:	-£0.50	-£0.62	National funding agreed up to 5 days
Other	£0.19	£0.98	
Total Planned Surplus / (Deficit)	**-£1.92**	**£0.36**	

Statement of Comprehensive Income

The table to the left shows how the Income & Expenditure position will be shown in the year end accounts. There are a number of technical adjustments that are not included by NHS Improvement for the purposes of assessing the Trust's financial performance and have therefore been excluded from the most of the pages of this report. The full reported position is shown here for completeness.

- Following the annual valuation of Land, Property and Equipment, impairments of £12.67m have been recognised in the financial position.
- The Trust has recognised the value of assets that have been donated to the Trust this year including: £1.65m Ventilators and Associated equipment, £0.56m Diagnostic imaging equipment, £0.19m Testing equipment and £0.06m of equipment purchased using donations to Trust charitable funds.
- The Trust has also recognised the value of consumables (PPE etc) that were procured centrally by the Department of Health during the pandemic and were provided to the Trust free of charge over the last 12 months. The majority of these have been used, but there remains some stock that will be available to use in the next financial year, the cost of which has been recognised in the accounts.

COVID-19

Revenue Impact of Covid-19 - YTD MAR 2021					
Division	**Annual Leave Accrual**	**Covid-19 Direct Costs**	**Impact on activity**	**Loss of Income**	**Total**
	£	£	£	£	£
Central & Technical	6,328,846	9,838,919	42,208	0	16,209,973
Medicine	0	12,870,339	334,083	0	13,204,421
Families & Specialist Services	0	2,202,948	(198,263)	698,511	2,703,196
Calderdale & Huddersfield Solutions Ltd	0	1,456,207	(119,501)	123,000	1,459,706
Corporate Services	0	2,366,526	(40,525)	2,351,423	4,677,424
Community	0	1,407,261	0	30,346	1,437,607
Health Informatics	0	147,354	0	0	147,354
Surgery & Anaesthetics	0	3,249,256	(3,255,204)	0	(5,948)
NHS Nightingale (Hosted Costs)		3,264			3,264
Total costs identified	**6,328,846**	**33,542,074**	**- 3,237,203**	**3,203,280**	**39,836,998**
Retrospective Top Up requested (M1-6)		**14,031,213**			**14,031,213**
Covid System Top Up (M7-12)		**10,866,000**			**10,866,000**
Covid funding 'outside of envelope'	**5,713,000**	**3,439,498**		**1,256,000**	**10,408,498**
Total funding	**5,713,000**	**28,336,711**	**-**	**1,256,000**	**35,305,711**

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

The Trust has incurred Covid-19 direct costs totalling £33.54m in this financial year as shown in the table and these have been reported to NHSI in support of the requested 'Retrospective Top Up' (M1-6), Covid system funding provided from M7 and additional funding requested to cover 'outside of envelope costs'. Additional Covid funding totalling £3.30m has been assumed to cover costs for: Covid-19 Testing £1.61m, Covid-19 Vaccination Programme £1.52m and NIHR SIREN £0.02m. The Trust has also been allocated cash funding of £0.14m to cover the cost of delivering Lateral Flow Testing, £1.26m in support of lost non-NHS income and £5.71m in support of the Annual Leave accrual.

Key areas of spend are as follows:

Pay - £18.73m

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

Pay expenditure that requires additional funding as 'outside of envelope' is as follows:
- £0.050m for staff costs to support PCR virus testing using platforms procured prior to Sep 20.
- £0.827m to support the Vaccination programme delivered within the hospital setting.
- £0.015m for NIHR SIREN
- £0.161m for 3rd Year Student Nurses

Non Pay - £14.81m

Non pay costs categorised as inside of system envelope total £12.56m, including: £5.28m for locally procured PPE, costs related to increased ICU capacity of £1.02m, £1.12m on Covid testing, £2.32m for segregation of patient pathways, £1.18m for decontamination and £0.75m to support remote management of patients.

Non pay expenditure that requires additional funding as outside of envelope is as follows:
- £1.556m for testing kits and associated equipment for PCR virus testing using platforms procured prior to Sep 20 (this includes PCR testing for SIREN)
- £0.665m for the Huddersfield Vaccination Centre at the Johns Smiths Stadium and £0.024m for the Hospital based Vaccination programme.
- £0.002m for NIHR SIREN

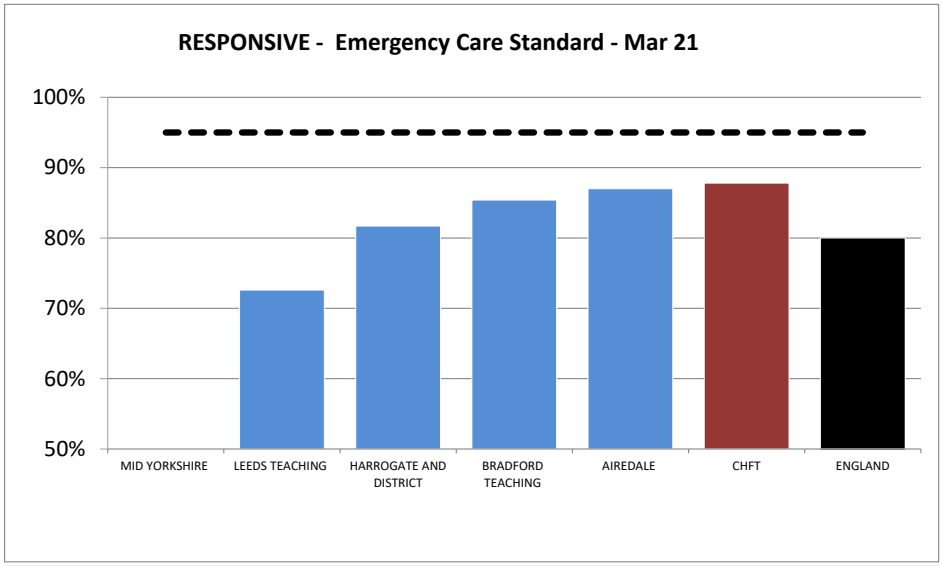
Income Losses

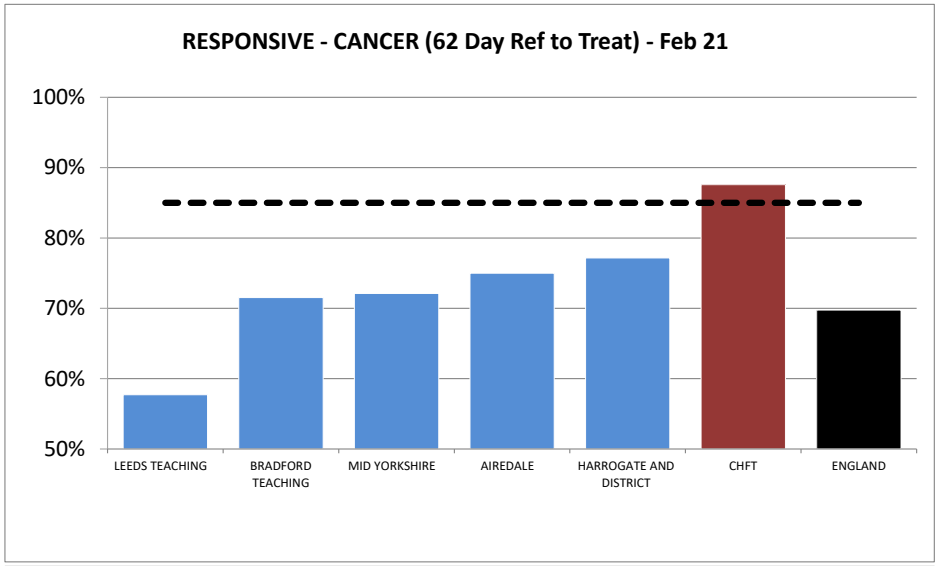
The Trust has lost income totalling £3.20m over the full 12 months including: loss of Car Parking Income, (£2.25m which is a combination of income from staff permits and income from patients and visitors), loss of catering income (£0.12m), loss of apprentice levy income (£0.08m from pausing of HCAs apprenticeships delivered internally) and loss of private patient income (£0.70m mainly from Yorkshire Fertility). Funding of £1.26m has been agreed by NHS England to offset the proportion of these losses that relates to the second half of the year.

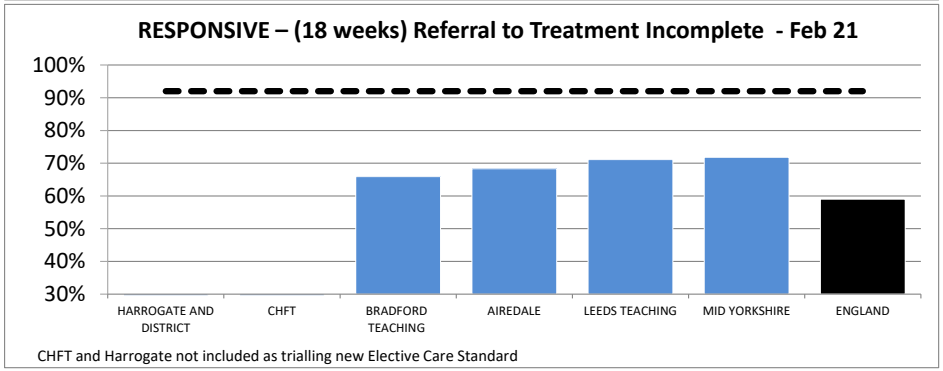
Additional costs have been offset to some extent year to date by the indirect impact of lower than planned costs in non-Covid areas where activity has reduced as a result of the Covid-19 response.

Capital funding of £0.88m for Covid-19 costs was requested, of which £0.84m has been approved and received in cash.

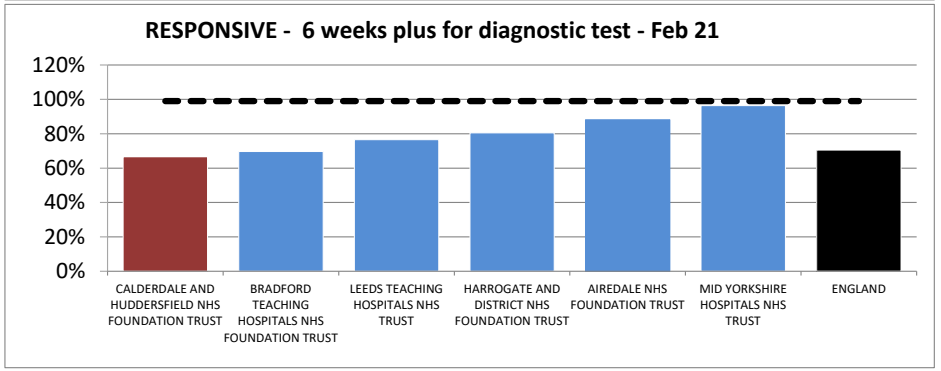
Benchmarking - Selected Measures

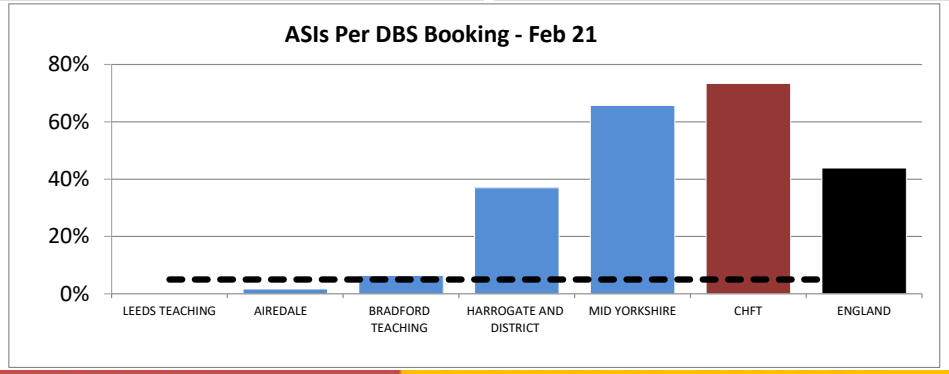






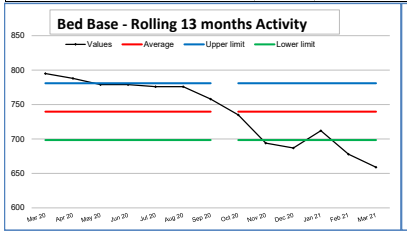
CHFT and Harrogate not included as trialling new Elective Care Standard

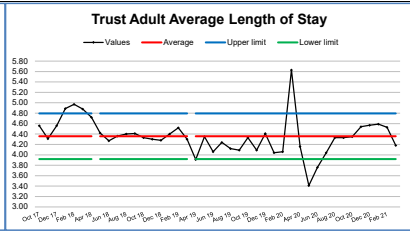


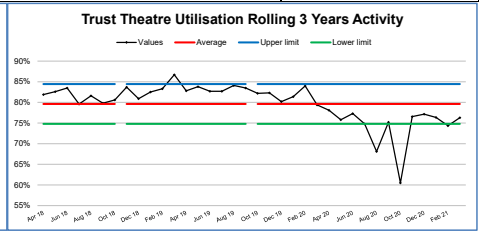


Efficiency & Finance - Key measures

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Performance Range		
Did Not Attend Rates																Green	Amber	Red
First DNA	7.70%	8.02%	4.47%	3.94%	3.01%	3.35%	3.31%	4.33%	4.41%	5.34%	5.24%	5.53%	5.98%	**4.35%**	**4.47%**	<=7%	7.1% - 7.9%	>=8%
Follow up DNA	6.67%	6.72%	5.57%	4.53%	5.00%	4.64%	5.25%	5.53%	5.25%	5.55%	5.35%	6.05%	5.98%	**5.07%**	**5.36%**	<=7%	7.1% - 7.9%	>=8%
Average length of stay																		
Average Length of Stay - Overall	4.26	5.63	4.16	3.41	3.76	4.04	4.33	4.33	4.35	4.54	4.57	4.59	4.53	**4.18**	**4.24**	<=5.19 / <=4.25 from April 20		>=5.30
Average Length of Stay - Elective	2.27	2.30	1.44	1.54	2.03	3.69	2.90	2.97	2.23	3.76	2.84	3.42	3.40	**3.05**	**2.83**	<=2.49 / <=2.30 from April 20		>=2.60
Average Length of Stay - Non Elective	4.50	6.03	4.26	3.45	3.81	4.06	4.40	4.42	4.53	4.56	4.62	4.64	4.59	**4.24**	**4.3**	<=4.62 / <=4.40 from April 20		>=5.50
Average Length of Stay - Non Elective - Excluding Ambulatory	5.64	7.28	4.88	4.16	4.54	4.81	5.29	5.37	5.62	5.63	5.8	5.67	5.75	**5.55**	**5.26**	<=5.56		
Average Length of Stay - Overall - Excluding Ambulatory	5.20	6.66	4.75	4.08	4.51	4.77	5.13	5.18	5.26	5.55	5.64	5.52	5.63	**5.43**	**5.13**	<=5.15 / <=5.10 from April 20		>=5.25
Pre-Op Length of Stay - Elective Patients	0.05	0.05	0.07	0.04	0.14	0.24	0.11	0.17	0.04	0.30	0.32	0.40	0.15	**0.28**	**0.18**	<= 0.02 as per Model Hospital		>0.04
Pre-Op Length of Stay - Non Elective Patients	0.64	0.85	0.52	0.48	0.56	0.72	0.69	0.73	0.70	0.65	0.69	0.73	0.68	**0.53**	**0.64**	<=0.73 as per Model Hospital		
Non Elective with zero LOS (not ambulatory)	8,055	620	439	581	528	553	501	533	526	471	492	480	404	**571**	**6,079**	Not applicable		
Elective Inpatients with zero LOS	907	73	27	11	16	9	19	25	22	2	2	7	5	**9**	**154**	<=75 YTD <=900		>=80
Day Cases																		
Day Case Rate	89.66%	89.43%	91.94%	94.55%	94.62%	93.56%	92.84%	92.26%	90.61%	96.32%	95.96%	94.70%	93.63%	**94.74%**	**93.84%**	>=89.25%	80.1% -89.24%	<=80%
Failed Day Cases	1,483	116	31	23	30	77	64	80	93	80	92	117	138	**130**	**955**	<=120 YTD <=1440		>=125
Beds																		
Beds Open in Month - Plan	801	801	785	770	770	770	770	770	770	770	770	793	793	**793**	**793**	Not applicable		
Beds Open in Month - Actual	795.00	795.00	788.00	779.00	779.00	776.00	776.00	758.00	735.00	694.00	687.00	712.00	678.00	**659**	**659**	Not applicable		
Hospital Bed Days per 1000 population - Adults	40.44	40.44	25.05	30.18	32.79	36.42	38.27	38.55	39.06	38.52	39.06	39.13	35.4	**38.27**	**35.90**	18/19 Baseline		
Emergency Hospital Admissions per 1000 population - Adults	0.08	0.08	0.06	0.08	0.08	0.09	0.08	0.08	0.09	0.08	0.08	0.08	0.08	**0.09**	**0.08**	18/19 Baseline		
Occupied Bed Days							14,714	14,834	15,327	14,943	15,166	15,304	13,852	**15,125**	**166,894**	Not applicable		
Cancellations																		
Clinical Slots not Utilised	8.70%	10.00%	32.30%	32.80%	24.10%	14.30%	11.60%	8.40%	9.10%	11.20%	9.60%	11.60%	15.50%	**12.60%**	**18.90%**	Not applicable		
Endoscopy Utilisations - Trust level	98.30%	COVID														>=90%	86% - 89%	<=85%
Endoscopy Utilisations - CRH	99.69%															>=90%	86% - 89%	<=85%
Endoscopy Utilisations - HRI	97.22%															>=90%	86% - 89%	<=85%
Hospital Cancellations within 6 Weeks	11,704	8,273	17,022	7,545	3,822	4,368	3,253	3,638	2,820	4,383	4,307	3,115	3,587	**3,634**	**3,634**	0		>=1
Theatre Utilisation																		
Theatre Utilisation (TT) - Main Theatre - CRH	83.60%	79.90%	89.16%	82.80%	80.30%	86.50%	80.00%	71.00%	58.50%	78.61%	78.15%	78.69%	74.54%	**76.94%**	**78.41%**	>=90%	86% - 89%	<=85%
Theatre Utilisation (TT) - Main Theatre -HRI	87.80%	82.70%	63.15%	72.30%	90.90%	64.60%	57.00%	63.00%	52.50%	66.29%	not applicable	not applicable	96.87%	**90.69%**	**68.64%**	>=90%	86% - 89%	<=85%
Theatre Utilisation (TT) - HRI DSU	73.80%	73.30%	57.62%	58.70%	62.50%	75.40%	70.00%	82.20%	64.20%	76.84%	76.43%	75.48%	72.75%	**74.25%**	**75.48%**	>=88%	85% - 87%	<=84%
Theatre Utilisation (TT) - Trust	82.40%	79.40%	78.09%	75.80%	77.30%	74.80%	68.10%	75.20%	60.50%	76.55%	77.14%	76.36%	74.36%	**76.31%**	**75.49%**	>=90%	84% - 89%	<=83%
% Theatre Scheduled Late Starts > 15 mins - Trust	37.29%	44.93%	56.76%	55.10%	45.45%	50.98%	65.17%	53.61%	45.18%	33.33%	30.43%	43.75%	29.41%	**41.84%**	**46.77%**	Not applicable		
Total Fallow lists - Trust	705	30	No Reallocation due to COVID													To be confirmed		
Flow																		
No. of Ambulatory patients	12,405	787	434	653	699	654	662	669	749	714	765	638	733	**946**	**8,316**	To be confirmed		
Emergency Hospital Discharges	51483	3732	2620	3095	3277	3439	3278	3435	3,548	3,394	3,599	3,317	3,120	**3,769**	**39,891**	<=4200 YTD <=50400		>=4201
Stranded 7 Days	48.07%	50.70%	37.50%	37.49%	39.58%	42.10%	44.40%	43.69%	42.77%	42.67%	44.87%	44.08%	41.93%	**43.45%**	**42.33%**	<=30%	31% - 99%	>=40%
Super Stranded 21 Days	97	97	24	22	31	40	49	55	53	46	57	51	48	**49**	**44**	<= 95	96 - 97	>=98
Average time to start of reablement (days)	6.94	4.20	2.00	2.50	2.80	3.10	4.20	4.50	4.20	3.50	4.50	6.00	2.40	**4.40**	**3.80**	<=5 days	6 - 8 days	>= 9 days
% Catheter Lab Utilisation	89.00%	not available														No target		







Efficiency & Finance Frailty- Key measures

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Performance Range
Acute Admissions - Aged 75+ Years																Green / Amber / Red
Acute Admissions aged 75+	9,851	757	581	635	692	741	739	745	866	798	904	840	789	**906**	**9,236**	not applicable
Frail* patients admitted aged 75+	3927	295	188	203	236	226	271	271	270	215	256	250	244	**243**	**2,873**	
% patients admitted aged 75+ who are frail**	39%	39%	32%	32%	34%	31%	37%	36%	31%	27%	28%	30%	31%	**27%**	**32%**	
Frailty Admissions with LOS < 3 days																
Patients 75+ with a LOS < 3 days	5060	320	260	327	340	377	362	367	404	347	429	396	371	**477**	**4,457**	not applicable
Frail* patients with a LOS < 3 days	1595	91	81	83	105	83	108	93	98	66	120	103	88	**99**	**1,127**	
% of patients with a LOS < 3 days who are frail**	32%	28%	31%	25%	31%	22%	30%	25%	24%	19%	28%	26%	24%	**21%**	**32%**	
Patients 75+ occupied bed days	69085	7011	3409	3005	3781	4561	4594	4545	5,121	4,699	5,233	5,378	4,597	**5,087**	**54,010**	
Frail* occupied bed days	32362	2926	1074	1170	1425	1872	1975	2179	1,962	1,444	1,434	1,762	1,413	**1,531**	**19,241**	
Average frail* non-elec IP LOS	42.0	9.92	5.71	5.76	6.04	8.28	7.29	8.04	7.27	6.72	5.6	7.1	5.8	**6.3**	**5.7**	
Average Frailty Rockwood Score		not available			6	6	6	6	6.00	6.00	5.90	6.00	5.90	**5.90**	**5.90**	
Re-admitted back to the Frailty Team within 30 days	1035	93	**84**	112	72	100	107	97	133	143	113	101	61	**73**	**1196**	
% Re-admitted back to the Frailty Team within 30 days	20%	18%	**17%**	20%	14%	17%	18%	17%	20%	22%	19%	18%	11%	**13%**	**17%**	

* Data is based on the following Treatment Functions: General Medicine; Endocrinology; Hepatology; Diabetic Medicine; Respiratory; Nephrology; Neurology; Rheumatology; Geriatric Medicine

** The frailty team at Calderdale and Huddersfield Foundation Trust have defined frail patients as being a patient over and including the age of 75 with one of the ICD 10 diagnosis codes described by the Acute Frailty Network (AFN).

Activity - Key measures

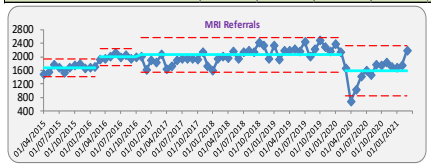
	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	YTD % Change
GP referrals to all outpatients																
02T - NHS CALDERDALE CCG	35,430	1,885	682	1,289	2,081	2,289	2,120	2,464	2,577	2,400	2,081	2,003	2,033	**2,166**	**24,185**	**-34.02%**
03A - NHS GREATER HUDDERSFIELD CCG	32,540	1,873	732	1,337	2,121	2,321	2,216	2,442	2,700	2,487	2,174	1,983	2,042	**2,046**	**24,601**	**-27.68%**
Other	6724	325	102	123	215	234	235	278	180	150	98	99	91	**239**	**2,044**	**-68.25%**
Trust	74,694	4,083	1,516	2,749	4,417	4,844	4,571	5,166	5,341	5,062	4,359	4,108	4,246	**4,451**	**50,830**	**-32.85%**
Trust - % Change on Previous year	0.09%	-37.31%	-78.89%	-60.01%	-29.12%	-32.70%	-29.37%	-26.41%	-28.45%	-18.62%	-14.36%	-34.84%	-21.69%	**5.42%**	**-32.85%**	
03J - NHS NORTH KIRKLEES CCG	2,533	119	42	54	102	112	121	126	102	82	42	24	54	**73**	**934**	**-62.70%**
02R - NHS BRADFORD DISTRICTS CCG	0	0	42	29	53	70	78	87	62	52	32	42	48	**62**	**657**	**-74.38%**
03R - NHS WAKEFIELD CCG	912	49	6	10	10	4	8	7	9	7	10	5	47	**43**	**166**	**-80.42%**
01D - NHS HEYWOOD, MIDDLETON AND ROCHDALE CCG	75	2	0	0	1	1	1	1	2	1	1	0	1	**3**	**12**	**-81.54%**
03C - NHS LEEDS WEST CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
02N - NHS AIREDALE, WHARFEDALE AND CRAVEN CCG	0	**0**	0	0	0	**0**	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
03G - NHS LEEDS SOUTH AND EAST CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**-100.00%**
02V - NHS LEEDS NORTH CCG	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	**0.00%**
15F - NHS LEEDS CCG	83	5	0	0	3	7	1	3	0	6	4	6	5	**6**	**41**	**-57.29%**
ACTIVITY VARIANCE AGAINST CONTRACT																
Day Case Variance against Contract	-284	-760	-2,796	-2,470	-2,578	-2,353	-1,717	-1,917	-1,634	-1,579	-1,370	-1,580	-1,420	**-1,306**	**-22,959**	
% Day Case Variance against Contract	-0.74%	-20.68%	-80.27%	-74.85%	-67.39%	-59.61%	-66.76%	-50.44%	-42.71%	-43.26%	-42.01%	-45.47%	-40.87%	**-32.64%**	**-52.88%**	
Elective Variance against Contract	-53	-76	-364	-365	-406	-346	-225	-237	-243	-396	-327	-323	-287	**-340**	**-3,866**	
% Elective Variance against Contract	-1.06%	-16.08%	-79.12%	-83.71%	-80.41%	-70.75%	-75.14%	-54.15%	-47.14%	-80.65%	-76.38%	-71.12%	-63.18%	**-65.15%**	**-69.36%**	
Non-elective Variance against Contract	-962	-823	-1,959	-1,201	-997	-1,062	-826	-1,002	-1,124	-1,336	-1,183	-1,116	-927	**-960**	**-13,932**	
% Non-elective Variance against Contract	-1.75%	-3.42%	-38.67%	-24.46%	-20.52%	-20.77%	-24.74%	-20.07%	-21.15%	-25.14%	-21.90%	-22.05%	-19.93%	**-18.07%**	**-22.96%**	
Outpatient Variance against Contract	162	-6,806	-18,441	-16,695	-15,365	-13,995	-11,147	-37,538	-15,472	-16,192	-14,664	-14,985	-15,742	**-16,531**	**-210,378**	
% Outpatient Variance against Contract	0.07%	-21.48%	-61.92%	-60.29%	-47.95%	-42.62%	-50.13%	-117.41%	-48.26%	-52.69%	-54.18%	-51.29%	-53.91%	**-49.83%**	**-57.65%**	
Accident and Emergency Variance against Contract	3,199	-2,310	-6,037	-4,326	-3,153	-2,512	-902	-1,655	-2,443	-2,543	-2,994	-3,072	-2,225	**-766**	**-32,627**	
% Accident and Emergency Variance against Contract	0.58%	-18.02%	-46.70%	-31.41%	-23.82%	-17.88%	-25.26%	-12.47%	-17.93%	-19.59%	-22.32%	-24.05%	-18.87%	**-5.77%**	**-20.63%**	

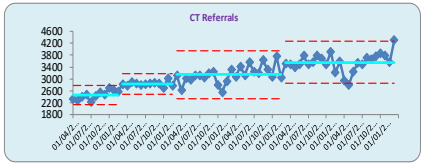
Please note further details on the referral position including commentary is available within the appendix.

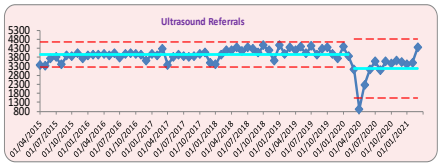
Radiology Summary of Activity of Key Modalities - March 2021

Referrals into Service

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD 20/21	YTD 19/20	Increase	%
MRI	2188	2230	2173	2444	2004	2228	2479	2303	2154	2374	2153	1671	689	1026	1418	1595	1469	1781	1743	1846	1708	1689	1750	2194	18908	26401	-7493	-28%
CT	3497	3380	3498	3785	3481	3572	3790	3683	3482	3911	3212	3599	2949	2807	3249	3545	3489	3717	3665	3762	3862	3786	3553	4304	42688	42890	-202	0%
Obstetrics	2288	2481	2247	2581	2400	2329	2480	2276	2287	2394	2175	2301	1909	1951	2235	2244	2076	2271	2236	2161	2296	2255	2125	2532	26291	28239	-1948	-7%
General Radiology	16909	17111	16426	18090	16876	16761	17406	16468	15653	18242	15665	12489	6629	8962	10935	12812	12348	13368	13255	12642	12470	12253	11936	15377	142987	198096	-55109	-28%
Ultrasound	4205	4382	4011	4445	3962	4256	4364	3975	3741	4375	3861	3112	912	2266	3107	3568	3098	3563	3462	3630	3534	3406	3493	4338	38377	48689	-10312	-21%
Total	29087	29584	28355	31345	28723	29146	30519	28705	27317	31296	27066	23172	13088	17012	20944	23764	22480	24700	24361	24041	23870	23389	22857	28745	269251	344315	-75064	-22%





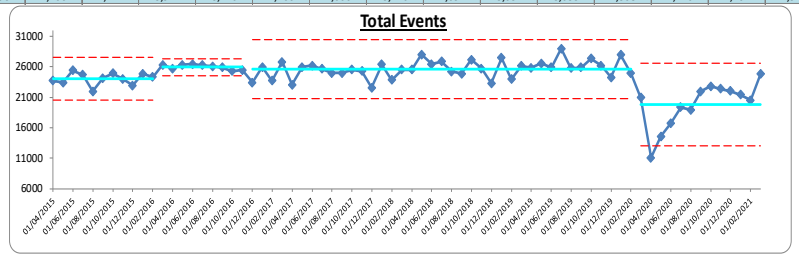


How does this compare to Trust activity Trend?

A&E Activity has decreased by 18.7%, Outpatients decreased by 21,0% and Inpatients (excluding Maternity) decreased by 32.3%

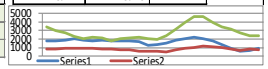
Activity

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD 20/21	YTD 19/20	Increase	%
Total Events	25,856	26,555	25,921	29,002	25,777	25,871	27,344	26,191	24,262	27,950	24,917	20,906	11,080	14,583	16,696	19,353	18,936	21,951	22,807	22,357	22,000	21,444	20,481	24,828	236,516	310,552	-74,036	-24%
MRI	1900	1778	1905	2041	1874	1992	1990	2132	1849	2068	1974	1832	502	698	822	1190	1201	1517	1812	1918	1828	1785	1471	1656	16400	23335	-6935	-30%
HRI -MRI	675	629	647	682	637	658	698	701	677	690	703	643	221	261	266	329	372	429	495	529	472	492	410	503	4779	8040	-3261	-41%
CRH - MRI	463	500	498	558	479	492	582	551	446	533	473	455	160	164	197	226	161	301	364	417	358	321	272	287	3228	6030	-2802	-46%
New Scanner - HRI	626	561	643	703	675	752	606	735	621	744	679	579	118	151	232	240	226	348	486	524	503	488	413	394	4123	7924	-3801	-48%
CRVAN	127	76	108	90	78	84	92	134	98	92	112	143	0	0	0	0	0	0	0	0	448	478	368	460	1754	1234	520	-
Other/Unknown	9	12	9	8	5	6	12	11	7	9	7	12	3	122	127	395	442	439	467	448	47	6	8	12	2516	107	2409	2251%
CT	3,053	2,925	3,072	3,302	3,009	3,206	3,331	3,132	3,024	3,389	3,187	2,718	1,755	2,576	2,579	2,836	2,911	3,196	3,397	3,378	3,477	3,415	3,003	3,818	36,341	37,348	-1,007	-3%
General Radiology	15,364	15,664	15,003	17,202	15,071	15,031	15,911	15,148	14,361	16,532	14,381	11,438	5,865	7,941	9,284	10,986	10,914	12,194	12,029	11,622	11,406	10,996	10,831	13,282	127,350	181,106	-53,756	-30%
Obstetrics	2,098	2,367	2,131	2,392	2,257	2,196	2,316	2,144	2,112	2,242	2,071	2,123	1,786	1,853	2,110	2,067	1,959	2,153	2,087	1,986	2,165	2,093	1,981	2,365	24,605	26,449	-1,844	-7%
Ultrasound	3,441	3,821	3,810	4,065	3,566	3,446	3,796	3,635	2,916	3,719	3,304	2,795	1,172	1,515	1,901	2,274	1,951	2,891	3,482	3,453	3,124	3,155	3,195	3,707	31,820	42,314	-10,494	-25%
Total Exams	28,260	29,008	28,480	32,306	28,619	28,405	29,930	28,739	26,521	30,743	27,471	23,073	12,387	16,402	18,715	21,526	21,122	22,355	47,710	24,919	20,494	21,835	20,769	25,277	273,511	341,555	-68,044	-20%
MRI	1964	1845	1985	2134	1956	2069	2058	2215	1934	2151	2046	1908	515	712	839	1210	1230	1567	1876	1995	1890	1847	1530	1720	16931	24265	-7334	-30%
HRI -MRI	698	654	663	707	667	680	711	729	708	700	719	670	223	273	270	340	380	454	510	545	484	505	423	524	4931	8306	-3375	-41%
CRH - MRI	471	513	524	575	495	512	598	572	456	556	486	462	168	168	205	239	169	302	363	429	373	330	285	292	3323	6220	-2897	-47%
New Scanner - HRI	653	587	681	751	706	783	643	766	663	790	721	618	121	149	235	251	235	369	520	567	536	520	442	427	4372	8362	-3990	-48%
CRVAN	133	78	108	93	81	87	94	137	99	96	113	145	0	0	0	0	0	0	0	0	450	485	372	465	1772	1264	508	-
Other/Unknown	9	13	9	8	7	7	12	11	8	9	7	13	3	122	129	380	446	442	483	454	47	7	8	12	2533	113	2420	2142%
CT	4,439	4,253	4,498	4,979	4,366	4,719	4,826	4,586	4,363	4,999	4,741	4,167	2,825	4,056	4,108	4,354	4,441	4,921	5,161	5,077	5,280	5,168	4,518	5,718	55,627	54,936	691	1%
General Radiology	15,971	16,342	15,657	18,318	16,062	15,647	16,560	15,785	14,885	17,253	14,974	11,820	5,948	8,068	9,492	11,312	11,293	12,655	12,506	12,053	11,787	11,347	11,187	13,751	131,399	189,274	-57,875	-31%
Obstetrics	2,107	2,372	2,134	2,398	2,264	2,200	2,320	2,153	2,119	2,248	2,079	2,125	1,791	1,856	2,115	2,072	1,962	0	24,663	1,991	-1,856	0	0	0	34,594	26,519	8,075	30%
Ultrasound	3,779	4,196	4,206	4,477	3,971	3,770	4,166	4,000	3,220	4,092	3,631	3,053	1,308	1,710	2,161	2,578	2,196	3,212	3,504	3,803	3,393	3,473	3,534	4,088	34,960	46,561	-11,601	-25%



Waiting List at Month End

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD 20/21	YTD 19/20	Increase	%
Total number on MRI Waiting List	1774	1803	1878	2044	1845	1761	1913	1779	1780	1755	1671	1295	1335	1527	1867	2042	2192	2092	1786	1409	969	602	654	962				
Total number on CT Waiting List	856	873	931	945	973	925	855	845	757	770	614	562	581	553	748	909	1017	1167	1143	1012	829	716	828	733				
Total number on US Waiting List	3454	3025	2727	2353	2085	2226	2111	1766	2024	2106	2231	2042	2008	2409	3173	3950	4625	4596	3962	3391	3194	2746	2403	2391				



Number of Exams reported

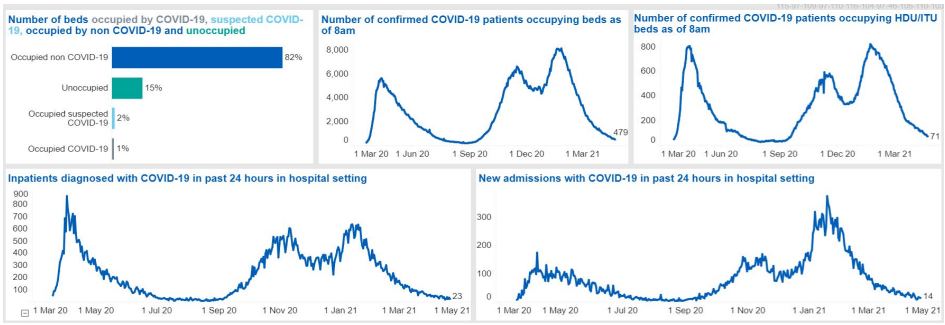
Internal (Planned)	13589	13823	12320	15530	13995	12592	13511	12221	12550	13959	12956	15532	9098	11411	12777	14472	14221	13578	15627	15319	14404	14497	13866	16210	165480	162578	2902	2%
Insourced (Extras)	253	152	102	283	17	0	0	0	0	0	46	23	0	0	0	0	92	100	137	36	0	0	17	0	382	876	-494	-
Locum Radiologist/Sonagropher	288	392	690	1114	217	1161	502	454	512	783	581	479	727	409	579	683	468	791	853	585	687	747	538	615	7682	7173	509	7%
Auto Reported	4216	2861	2476	2372	2126	3042	3266	3128	3458	4694	3355	2869	562	1042	2063	3008	1911	4669	4231	3490	3798	3183	3066	3542	34565	37863	-3298	-9%
Outsourced	3278	7511	7279	8759	7481	7409	8055	8310	10180	11003	10037	5418	707	1059	995	1298	1507	2830	3216	4308	4493	3999	3552	5537	33501	94720	-61219	-65%
Total	21624	24739	22867	28058	23836	24204	25334	24113	26700	30439	26975	24321	11094	13921	16414	19461	18199	21968	24064	23738	23382	22426	21039	25904	241610	303210	-61600	-20%
% Outsourced	15%	30%	32%	31%	31%	31%	32%	34%	38%	36%	37%	22%	6%	8%	6%	7%	8%	13%	13%	18%	19%	18%	17%	21%	14%	31%	-17%	
% Insourced/Outsourced	16%	31%	32%	32%	31%	31%	32%	34%	38%	36%	37%	22%	6%	8%	6%	7%	9%	13%	14%	18%	19%	18%	17%	21%	14%	32%	-18%	

Appendices

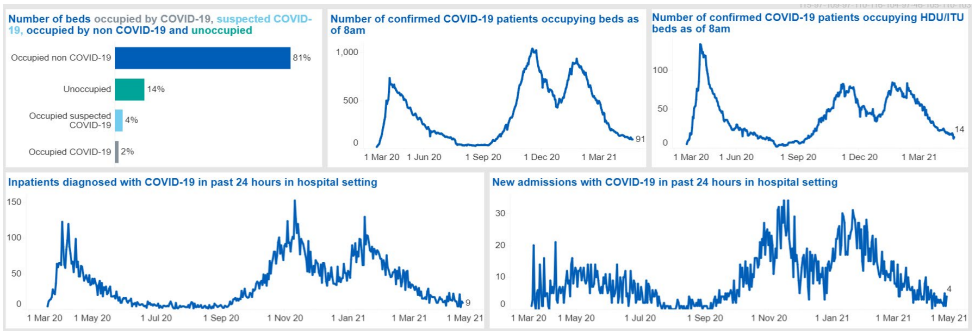
COVID-19 IPR APPENDIX

COVID Metrics across the Region:

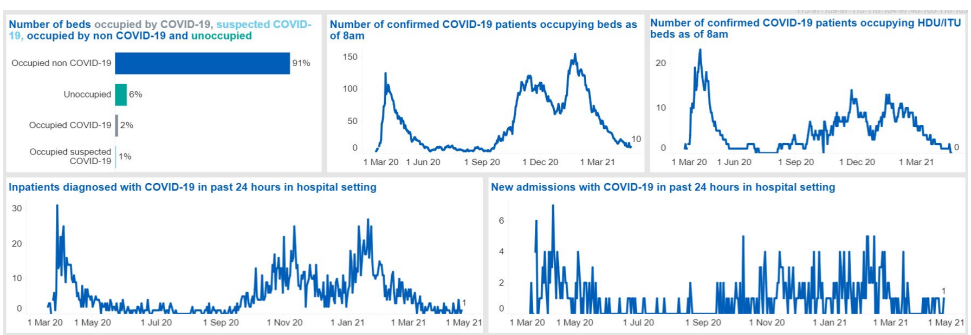
North East and Yorkshire and North West: Peak of Covid19 inpatients in early April followed by reduction until early September when second wave commenced and Covid19 admissions increased week on week. From mid-November numbers started to fall but with the 3rd wave starting towards the end of December. Covid19 patients occupying beds passed the peak of the 1st and 2nd wave towards the end of January. Covid patients occupying ICU/HDU beds also passed the peaks experienced in the 1st and 2nd waves towards the end of January. Since the end of January there has been a steady decrease in Covid+ patients occupying beds (including ICU/HDU beds). Occupied beds for Covid19 and suspected Covid19 are at 1% and 2% respectively compared to 4% and 2% respectively last month.



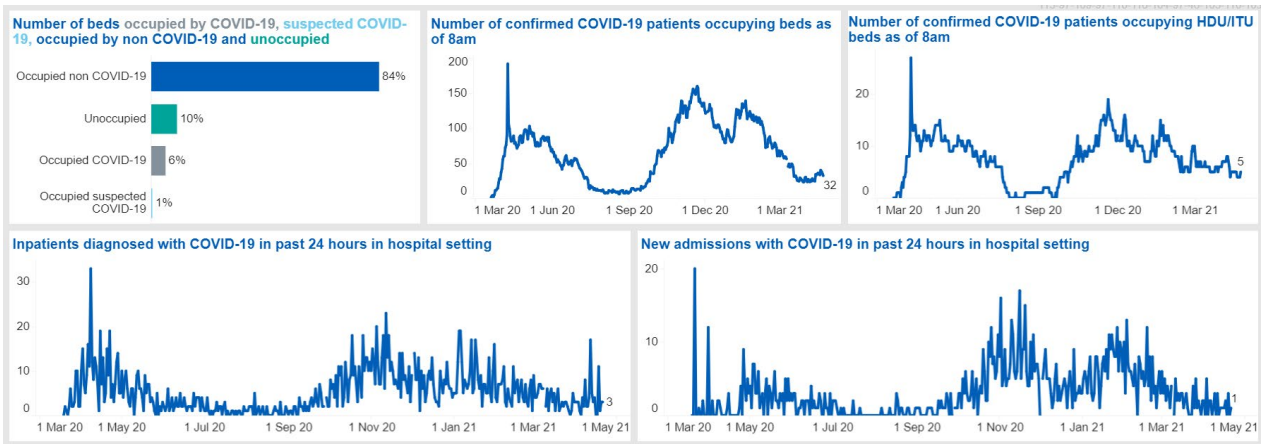
WYAAT: Same pattern as Region above. Covid19 patients occupying critical care beds did not see the same marked decline as the rest of the region. Occupied beds for Covid19 patients are 2% compared to 4% last month.



CHFT: Pattern for CHFT is similar with the 3rd wave exceeding the peaks of the 1st and 2nd wave for Covid19 patients occupying a bed. There has been a steep decline of Covid19 positive patients occupying a bed from 155 on 25th January to 65 on 22nd February to 31 on 23rd March to 9 on 21st April. Covid19 patients occupying critical care beds has seen a decline in Covid19 occupancy since mid-January and has been 0 since 19th April.



BTHFT: Bradford reduction in Covid cases was flatter since April than the areas above. From mid-September Bradford's second wave was similar to above with Covid19 admissions increasing week on week through to 2nd wave peak at the end of November. There was a gradual decrease until the start of January when there was a 3rd wave. Unlike CHFT the 3rd wave peak at Bradford was not as high as its 1st or 2nd wave. Occupied beds for Covid19 and suspected Covid19 are 6% and 1% respectively compared to 4% and 1% respectively last month.



Beds Occupied Position as at 22nd April across WYAAT – 1-day snapshot

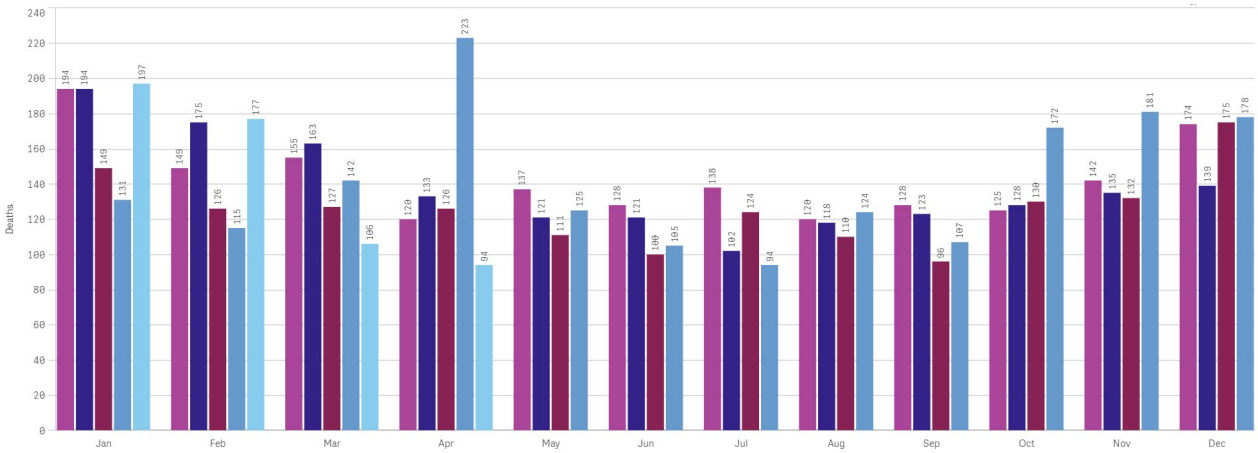
Number of beds (confirmed COVID-19, suspected COVID-19, other patients and unoccupied) reported as of 8am
Bed type:
Click on +/- sign to drill-down/roll-up. Top filters are not applied on this chart.

Region	Organisation				
North East and Yorkshire	Airedale NHS Foundation...	1 (0%)	0 (0%)	273 (84%)	50 (15%)
	Bradford Teaching Hospit...	32 (6%)	4 (1%)	478 (84%)	55 (10%)
	Calderdale and Huddersfi...	10 (2%)	4 (1%)	500 (91%)	34 (6%)
	Harrogate and District N...	4 (1%)	0 (0%)	259 (72%)	96 (27%)
	Leeds Teaching Hospital...	23 (1%)	155 (7%)	1,627 (77%)	314 (15%)
	Mid Yorkshire Hospitals ...	21 (2%)	11 (1%)	771 (83%)	121 (13%)

All WYAAT Trusts except Bradford have seen a decrease in the percentage of beds occupied by confirmed Covid19 patients. Bradford also has the highest bed occupancy of confirmed Covid19 patients at 6%. All Trusts have seen similar or increased % bed occupancy of non-Covid19 patients since the March snapshot.

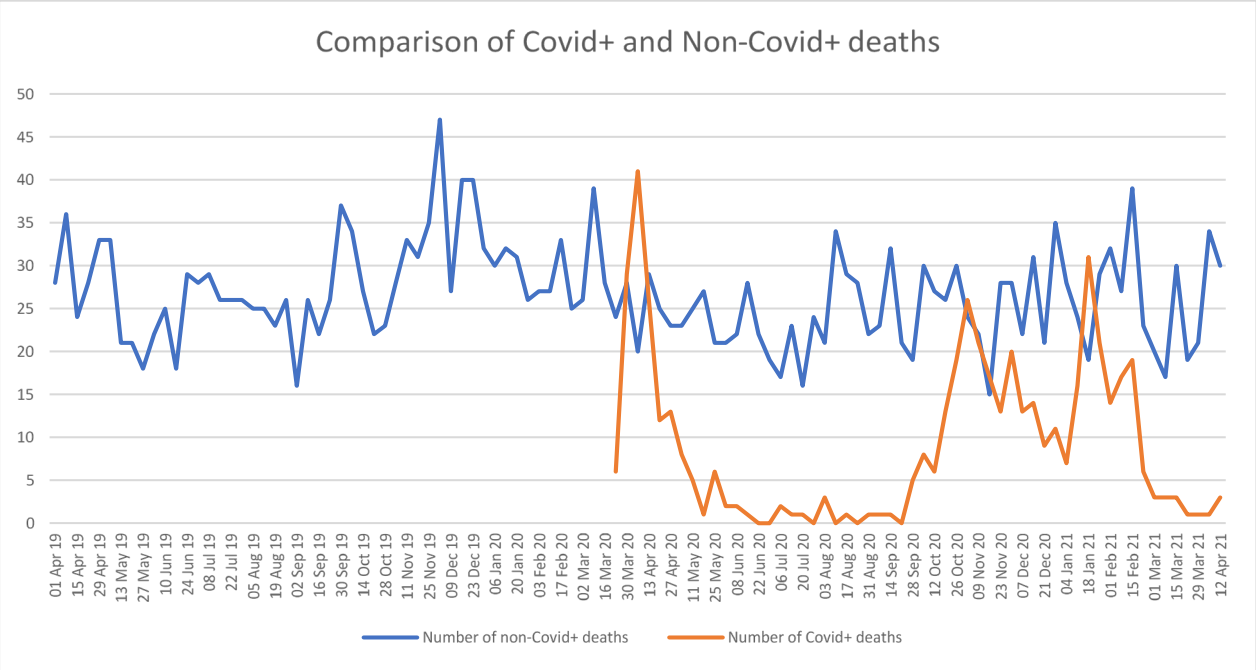
CHFT Mortality:

Historical Comparison



Impact of Covid19 deaths on historical trends seen particularly in April 20 and then less so since May 20 with the lowest number of deaths in July in the last 4 years. Deaths in October and November

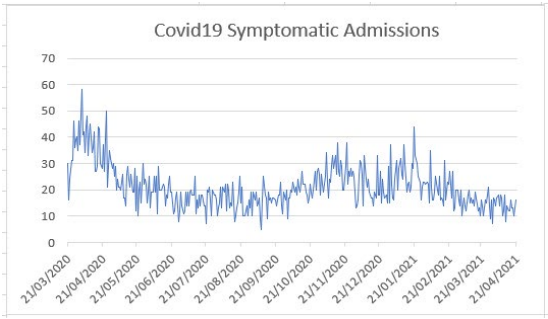
have been higher than previous 3 years but have not reached levels experienced in April. Deaths in March 2021 are the lowest in the last 5 years.

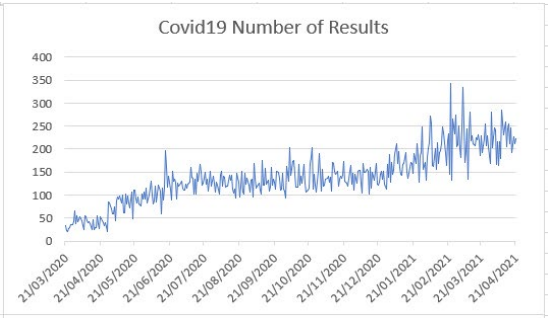


Peak number of Covid19 deaths in early April with a sustained reduction since then to mid/end September when deaths increased during the 2nd wave. There was an overall reduction from 1st week in November until the end of December. From the start of January and the 3rd wave there was an increase in Covid19 deaths with a peak of 31 deaths w/c 18th January and sustained reduction through the rest of January, February and into March and April.

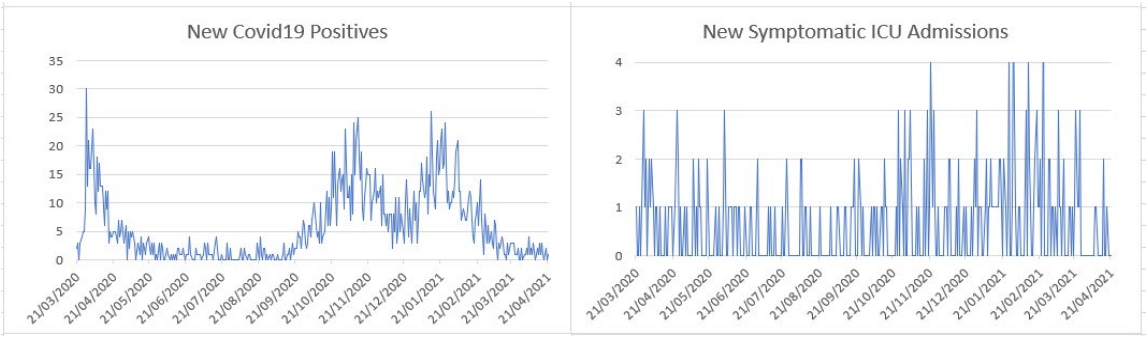
Covid19 Hospitalisation in England Surveillance System (CHESS) was developed by Public Health England (PHE) for monitoring hospitalised COVID-19. The scheme is based on the existing UK Severe Influenza Surveillance Scheme (USISS) that was created following the 2009 influenza pandemic. Objectives of CHESS are to monitor and estimate the impact of Covid19 on the population.

Since a peak in late March/early April there has been an overall reduction in symptomatic admissions to CHFT to a steady state with some daily variation since mid-June. There was gradual increase from mid Oct through to mid-November but daily numbers not as high as the first wave. Since mid-Jan the number of symptomatic admissions has gradually decreased. The increase in number of Covid19 results from start of May relates to a change in testing policy to include asymptomatic admissions and this has remained steady from May until the start of January when a change in testing policy has resulted in an increase in test results through January and into February.

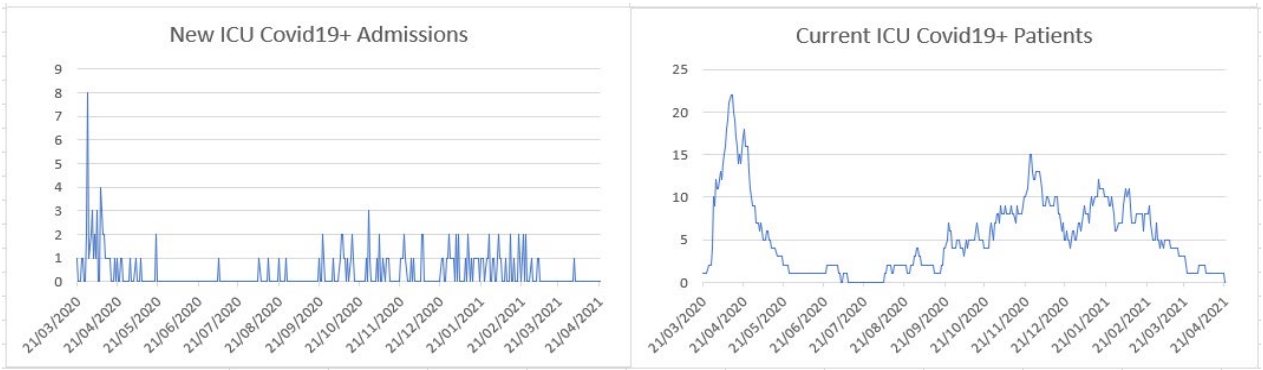




Since 29th March the trend was a gradual and sustained decrease in new Covid19 inpatients. There was a second wave from mid-September which has continued through October to mid-November. From mid-November towards the end of December there was a gradual decrease in numbers but with the 3rd wave from end of December through January with a gradual decrease in positives since the end of January through February, March and into April.



There was a peak of Covid19 patients in ICU from 10th - 12th April 20 and other than a small increase around 22nd April 20 there had been a continual decrease in patients in ICU. There was a gradual increase during August which continued through to end of November when numbers of Covid19 patients in ICU started to fall. There was a gradual increase from 25th December until mid- January since when numbers have gradually fallen. The March ICU Covid19 maximum was 4 at the start of March since when numbers have decreased and has been 0 since 19th April.



Appendix - Appointment Slot Issues

ASIs

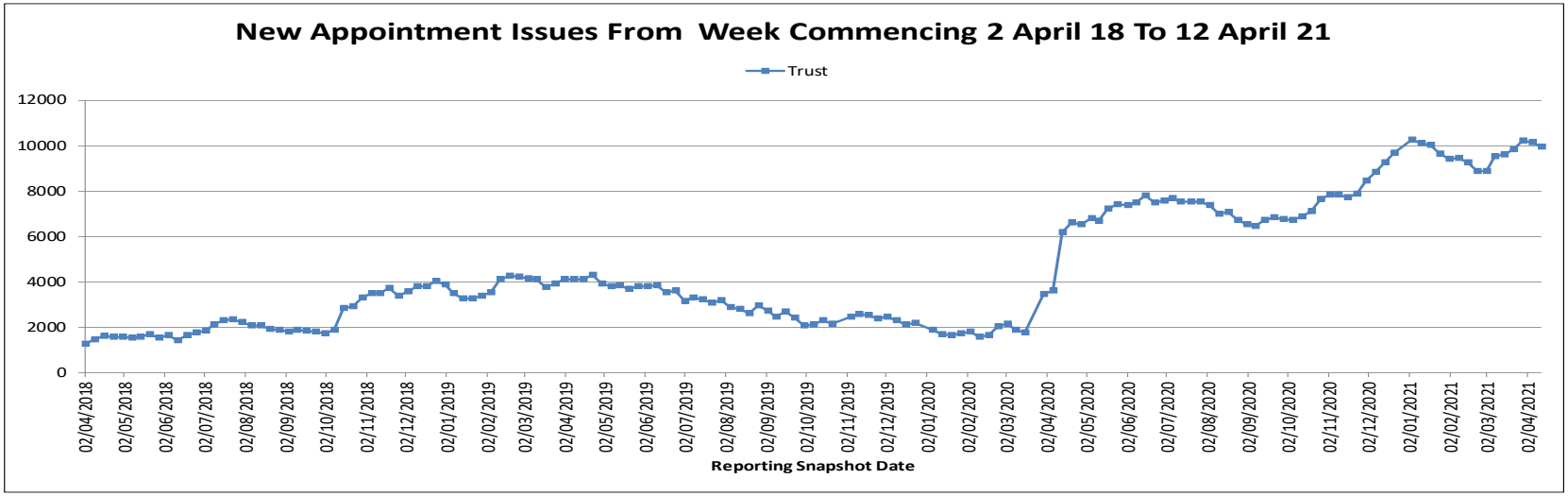
As at 20th April there were 9,937 referrals awaiting appointments.

The top specialties for ASIs backlog are:

hthalmology	1610
ENT	1489
Community	1157
MSK	1125
Paediatric ENT	1117
Trauma and Orthopaedics	608
General Surgery	505
Neurology	422
Urology	403
Gynaecology	354
Colorectal Surgery	343
Cardiology	307
Respiratory Medicine	153
Paediatric Ophthalmology	133
Rheumatology	115
Orthoptics	102

1,429 patients have been waiting over 6 months, (this was 1,211 on the last report)

Divison	Specialty	Weeks Waitng							
		Total	14-17	0-18	18-21	22-25	26-29	30-51	52+
FSS	Total	784	38	757	14	5	1	5	2
	Chemical Pathology	14	0	14	0	0	0	0	0
	Paediatric Epilepsy	1	0	1	0	0	0	0	0
	Paediatrics	85	4	81	1	1	0	2	0
	Yorkshire Fertility	330	21	317	6	2	0	3	2
	Gynaecology	354	13	344	7	2	1	0	0
Medicine	Total	1304	40	1254	17	14	5	11	3
	Cardiology	307	1	304	2	0	0	0	1
	Endocrinology	53	3	49	1	2	1	0	0
	Gastroenterology	72	2	71	0	0	0	0	1
	Dermatology	61	10	58	3	0	0	0	0
	Diabetic Medicine	59	2	59	0	0	0	0	0
	General Medicine	5	0	4	0	1	0	0	0
	Geriatric Medicine	17	1	17	0	0	0	0	0
	Hepatology	11	0	11	0	0	0	0	0
	Clinical Haematology	28	0	28	0	0	0	0	0
	Medical Oncology	0	0	0	0	0	0	0	0
	Nephrology	1	0	1	0	0	0	0	0
	Rheumatology	115	15	86	8	7	4	9	1
	Neurology	422	6	413	3	4	0	2	0
	Respiratory Medicine	153	0	153	0	0	0	0	0
Surgery	Total	6660	609	4614	587	341	206	660	252
	Colorectal Surgery	343	48	265	53	25	0	0	0
	Breast Surgery	52	0	51	1	0	0	0	0
	General surgery	505	67	406	82	15	0	1	1
	Ophthalmology	1610	170	1128	175	145	74	80	8
	Paediatric Ophthalmology	133	17	87	16	14	7	5	4
	Orthoptics	102	4	80	6	6	8	1	1
	Pain Management	42	0	41	1	0	0	0	0
	Urology	403	31	384	2	4	12	1	0
	Paediatric Urology	40	2	40	0	0	0	0	0
	Audiology	4	0	4	0	0	0	0	0
	ENT	1489	202	1291	151	6	6	29	6
	Paediatric ENT	1117	17	155	46	88	90	525	213
	Maxillo-Facial Surgery	2	0	2	0	0	0	0	0
	Plastic Surgery	51	2	50	0	0	0	1	0
	Paediatric Plastic Surgery	8	2	7	0	0	0	1	0
	Paediatric Surgery	34	1	33	1	0	0	0	0
	Trauma and Orthopaedics	608	43	479	52	36	9	14	18
	Paediatric Trauma and Orthopaedics	35	3	29	1	2	0	2	1
	Vascular Surgery	82	0	82	0	0	0	0	0
Community	Total	1157	131	659	113	105	108	171	1
	Podiatry	32	10	26	5	1	0	0	0
	MSK	1125	121	633	108	104	108	171	1
Unkown	Total	32	3	22	4	2	0	2	2
	Not CHFT	2	0	2	0	0	0	0	0
	Other CHFT	8	2	6	0	2	0	0	0
	-	22	1	14	4	0	0	2	2
Total	Total	9937	821	7306	735	467	320	849	260



Appendix - Referrals

•GP Referrals are down 34.4% financial YTD March 2021 compared with March 2020. This is completely understandable following the initial ceasing of all routine referrals during the Covid19 pandemic for a considerable period.

•From April to March 2021, there were 253 working days, one more than the corresponding period for 2019/2020.
•One additional working day could indicate an anticipated increase of GP referrals of 0.4%. Clearly the impact of Covid19 on referral demand has been far more dramatic, and no such increase has materialised
•NHS Calderdale GP referrals have seen a decrease of 34.0% (12,471) for the year to date and NHS Greater Huddersfield has had a decrease overall of 27.7% (9,416).

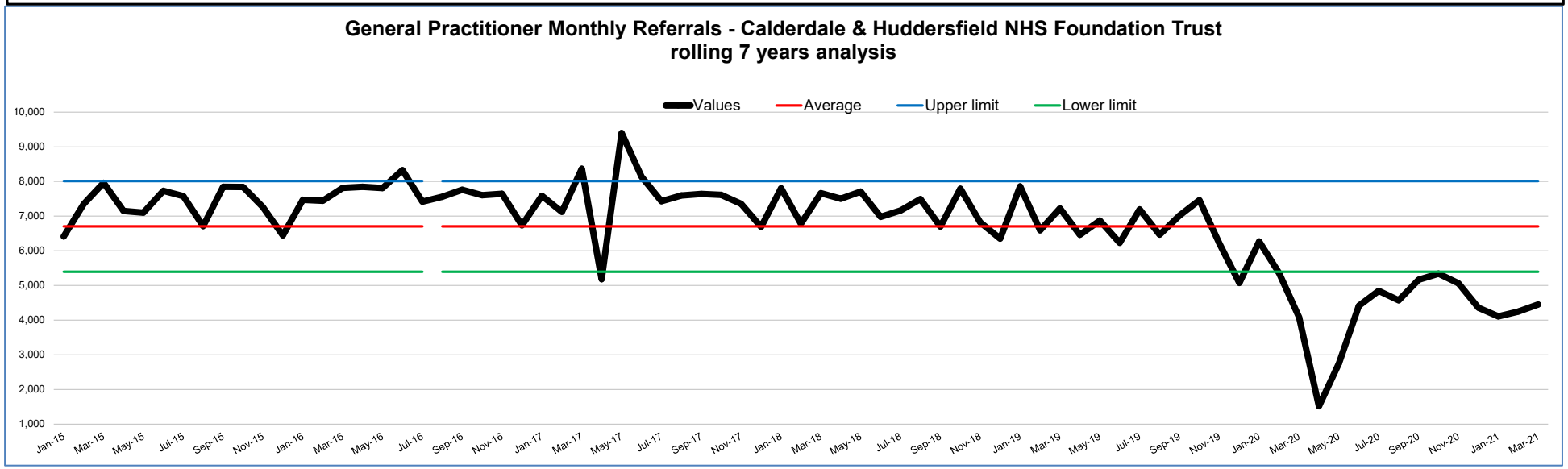
Detailed Investigation of movement at specialty level has not been considered as a result of the large overall decrease.

Please note that GP referrals that land on Appointment Slot Issue (ASI) lists as appointments cannot be booked when the referral is made are currently not counted in the referral figures. This explains an element of the decrease in referrals. Referrals do get counted once the ASI is resolved. Work is ongoing to enable immediate reporting of these ASI related referrals so a complete picture of referral demand is always available.

Other CCGs with contracts with CHFT have all had similar marked reduction in referral volumes

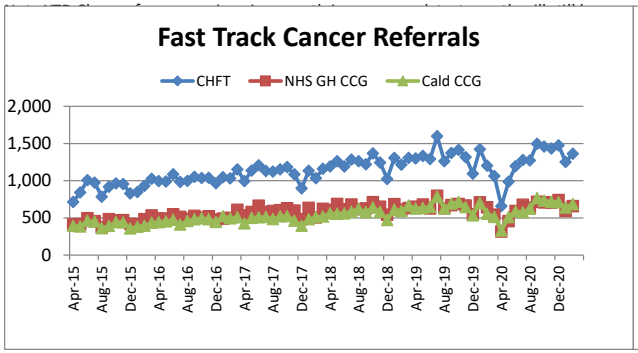
A brief summary is as follows

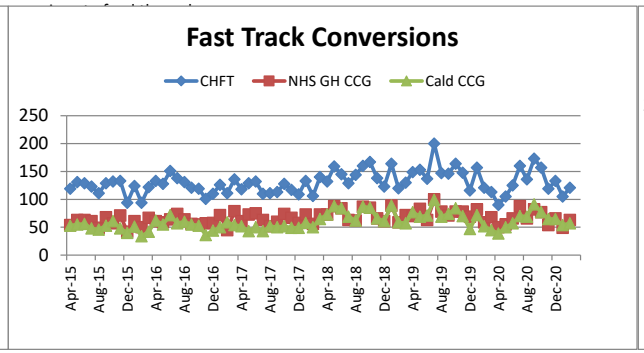
	19/20 YTD	20/21 YTD	Var	% Var
NHS Calderdale	36,656	24,185	-12471	-34%
NHS Greater Huddersfield	34,017	24,601	-9416	-28%
NHS North Kirklees	2,504	934	-1570	-63%
NHS Bradford District	2,029	644	-1385	-68%
NHS Bradford City	435	13	-422	-97%
NHS Wakefield	848	166	-682	-80%
NHS Heywood	65	12	-53	-82%

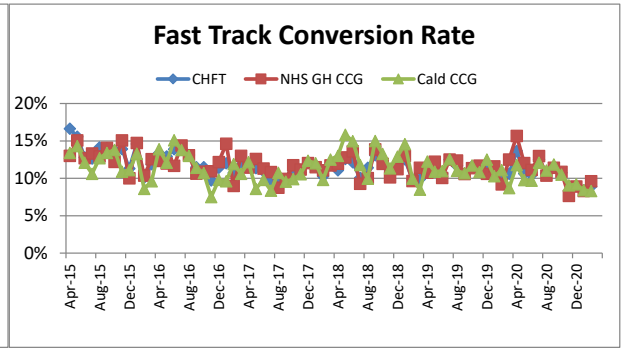


Activity - Key measures

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	YTD % Change
Fast Track Cancer referrals in month and of those referrals numbers that diagnosed with cancer (conversions)																
NHS CALDERDALE CCG Referrals	7,664	515	332	511	586	579	625	764	730	716	711	639	686	in arrears	6,879	
NHS CALDERDALE CCG Conversions	874	45	39	50	57	70	69	90	78	76	65	60	57	in arrears	711	
NHS CALDERDALE CCG Conversion Rate	11.4%	8.7%	11.8%	9.8%	9.7%	12.1%	11.0%	11.8%	10.7%	10.6%	9.1%	9.4%	8.3%	in arrears	10.3%	
NHS GREATER HUDDERSFIELD CCG Referrals	7,836	543	317	455	591	677	632	713	706	704	741	592	658	in arrears	6,786	
NHS GREATER HUDDERSFIELD CCG Conversions	929	68	50	54	66	88	65	81	78	66	69	57	63	in arrears	737	
NHS GREATER HUDDERSFIELD CCG Conversion Rate	11.9%	12.5%	15.8%	11.9%	11.2%	13.0%	10.3%	11.4%	11.1%	9.4%	9.3%	9.6%	9.6%	in arrears	10.9%	
Other CCG Referrals	159	6	10	21	21	22	16	19	25	14	24	18	18	in arrears	208	
Other CCG Conversions	16	0	1	1	2	2	2	2	4	0	2	2	1	in arrears	19	
Other CCG Conversion Rate	10.1%	0.0%	10.0%	4.8%	9.5%	9.1%	12.5%	10.5%	16.0%	0.0%	8.3%	11.1%	5.6%	in arrears	9.1%	
CHFT Fast Track Referrals	15,659	1,064	659	987	1,198	1,278	1,273	1,496	1,461	1,434	1,476	1,249	1,362	in arrears	13,873	
CHFT Fast Track Conversions	1,819	113	90	105	125	160	136	173	160	142	136	119	121	in arrears	1,467	
CHFT Fast Track Conversion Rate	11.6%	10.6%	13.7%	10.6%	10.4%	12.5%	10.7%	11.6%	11.0%	9.9%	9.2%	9.5%	8.9%	in arrears	10.6%	
% Change on Previous year																

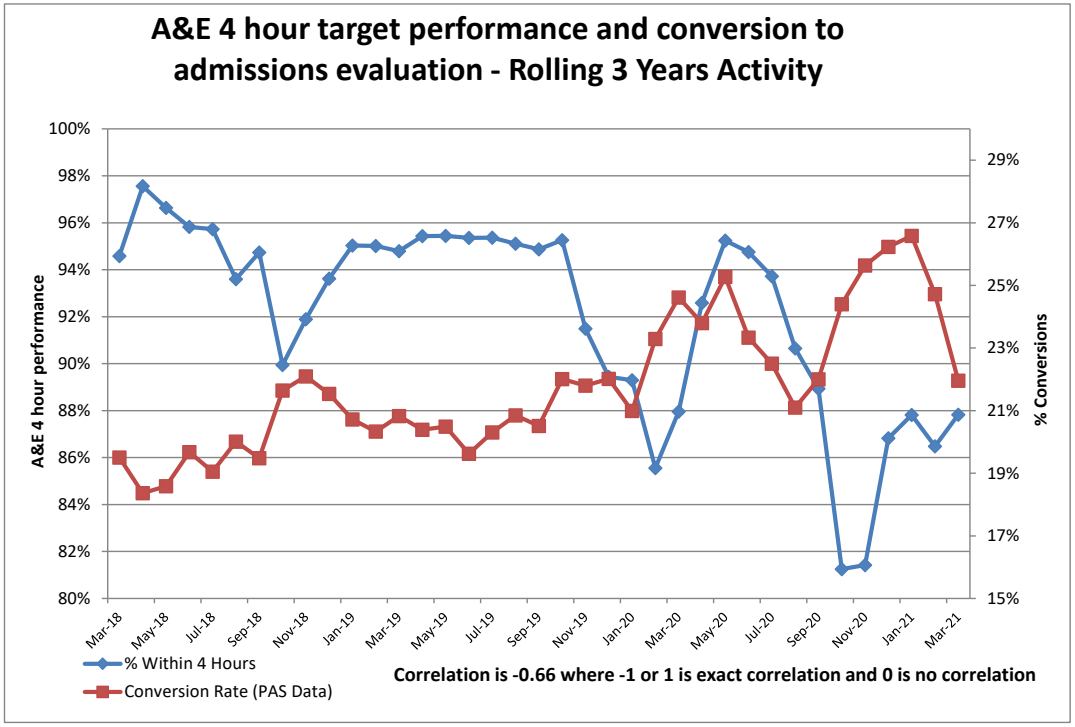






Appendix - A and E Conversion rates and Delayed Transfers

	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	YTD % Change
Analysis of A and E activity including conversions to admission																
A and E Attendances	154,445	10,511	6,895	9,445	10,087	11,544	12,129	11,620	11,174	10,434	10,415	9,703	9,569	**12,506**	**125,521**	-18.7%
A and E 4 hour Breaches	19,339	1,266	511	450	529	725	1,134	1,286	2,095	1,939	1,373	1,182	1,294	**1,522**	**14,040**	-27.4%
Emergency Care Standard 4 hours	87.48%	87.96%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	87.82%	86.48%	**87.83%**	**88.81%**	1.0%
Admissions via Accident and Emergency	34,851	2,489	1,937	2,387	2,353	2,597	2,559	2,556	2,727	2,675	2,732	2,579	2,365	**2,746**	**30,213**	-13.3%
% A and E Attendances that convert to admissions	22.57%	23.68%	28.09%	25.27%	23.33%	22.50%	21.10%	22.00%	24.40%	25.64%	26.23%	26.58%	24.72%	**21.96%**	**24.07%**	-2.2%



Delayed Transfers of Care (Reportable & Not reportable) Snapshot on 20th April 2021	Calderdale	Kirklees	Other	Total
Total number of patients on TOC Pathway	29	20	2	51
Awaiting Completion of Assessment	18	1	1	20
Awaiting Care package in own home	9	8		17
Awaiting Residential home placement	1	3		4
Awaiting public funding				0
Awaiting further non-acute NHS Care	1		1	2
Awaiting community equipment and adaptations		2		2
Awaiting nursing home placement		4		4
Disputes				0
Patient or Family choice		2		2
Housing - Patients not covered by Care Act				0

Appendix - Cancer - By Tumour Group

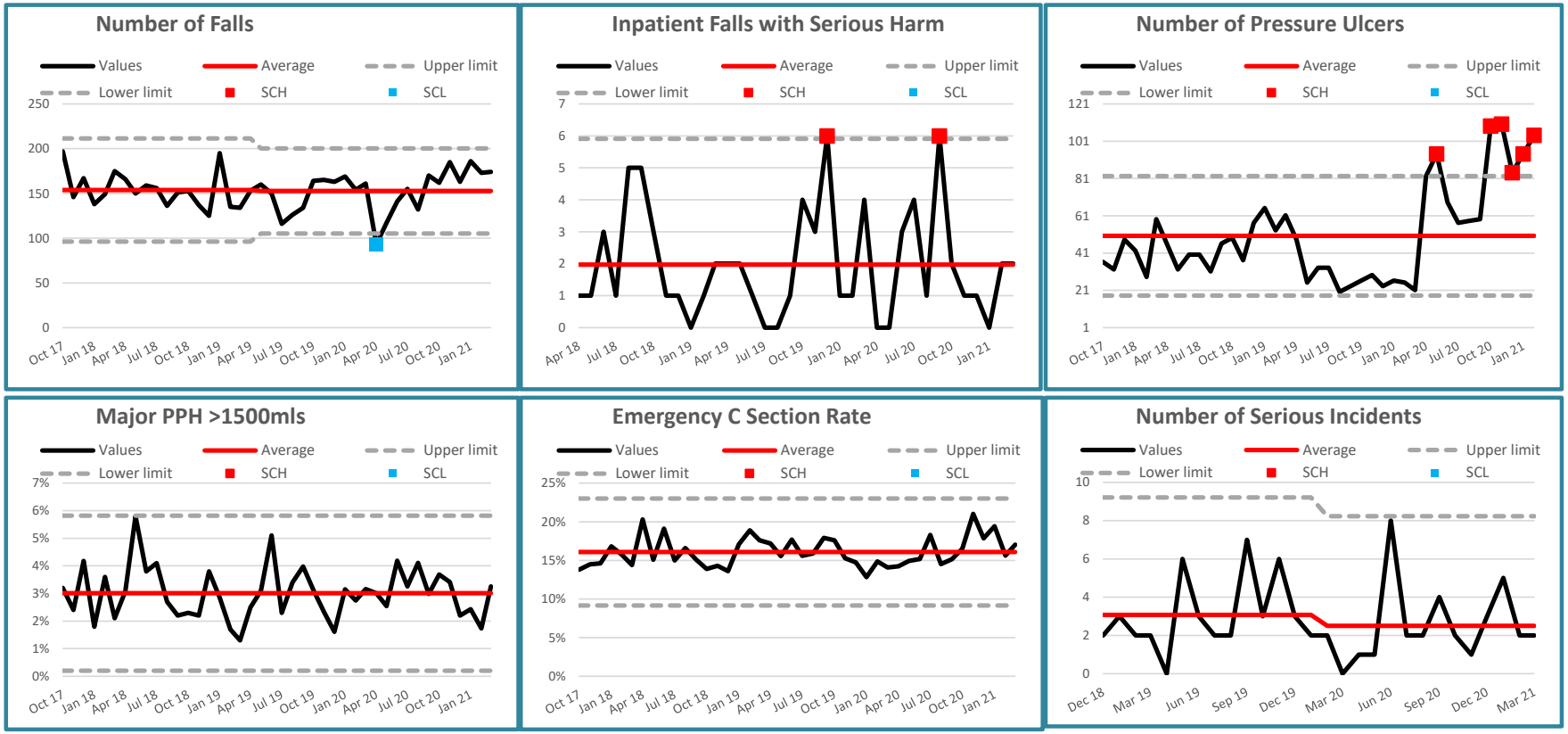
	19/20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	YTD	Performance Range		
62 Day GP Referral to Treatment																Green	Amber	Red
Breast	99.19%	100.00%	100.00%	100.00%	100.00%	100.00%	88.89%	100.00%	100.00%	100.00%	83.33%	100.00%	100.00%	**100.00%**	**97.72%**	>=85%	81% - 84%	<=80%
Gynaecology	91.67%	100.00%	90.00%	93.33%	100.00%	80.00%	100.00%	66.67%	78.57%	100.00%	100.00%	66.67%	100.00%	**100.00%**	**88.57%**	>=85%	81% - 84%	<=80%
Haematology	87.40%	90.91%	100.00%	100.00%	100.00%	100.00%	91.67%	77.78%	100.00%	88.89%	71.43%	50.00%	60.00%	**100.00%**	**84.40%**	>=85%	81% - 84%	<=80%
Head & Neck	56.72%	60.00%	53.85%	0.00%	45.45%	60.00%	66.67%	40.00%	50.00%	66.67%	80.00%	75.00%	100.00%	**100.00%**	**58.90%**	>=85%	81% - 84%	<=80%
Lower GI	83.08%	100.00%	90.91%	66.67%	46.15%	62.50%	80.00%	100.00%	47.06%	100.00%	88.89%	82.76%	80.95%	**94.74%**	**79.72%**	>=85%	81% - 84%	<=80%
Lung	82.26%	73.08%	100.00%	100.00%	100.00%	85.71%	100.00%	93.33%	90.91%	66.67%	100.00%	100.00%	85.71%	**85.00%**	**92.86%**	>=85%	81% - 84%	<=80%
Sarcoma	87.50%	0.00%	none to report	100.00%	none to report	100.00%	none to report	none to report	100.00%	100.00%	100.00%	0.00%	none to report	**none to report**	**85.71%**	>=85%	81% - 84%	<=80%
Skin	99.76%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.88%	95.24%	95.45%	100.00%	**100.00%**	**98.77%**	>=85%	81% - 84%	<=80%
Upper GI	84.81%	100.00%	75.00%	91.67%	33.33%	100.00%	80.00%	76.47%	85.71%	100.00%	83.33%	81.82%	50.00%	**100.00%**	**82.69%**	>=85%	81% - 84%	<=80%
Urology	89.96%	91.11%	96.30%	80.00%	100.00%	93.75%	94.12%	94.29%	94.59%	100.00%	92.00%	97.73%	89.47%	**95.24%**	**94.93%**	>=85%	81% - 84%	<=80%
Others	100.00%	100.00%	100.00%	100.00%	none to report	100.00%	100.00%	none to report	50.00%	0.00%	none to report	none to report	none to report	**none to report**	**84.21%**	>=85%	81% - 84%	<=80%
Two Week Wait From Referral to Date First Seen																		
Brain	94.70%	100.00%	80.00%	100.00%	77.78%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	85.71%	100.00%	**85.71%**	**94.64%**	>=93%	86% - 92%	<=85%
Breast	98.43%	99.01%	100.00%	100.00%	96.57%	97.81%	99.05%	99.56%	99.57%	96.37%	97.27%	98.25%	97.87%	**98.49%**	**98.25%**	>=93%	86% - 92%	<=85%
Childrens	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**97.73%**	>=93%	86% - 92%	<=85%
Gynaecology	98.48%	100.00%	100.00%	97.73%	98.13%	97.64%	100.00%	98.75%	96.50%	100.00%	98.86%	98.46%	96.08%	**96.95%**	**98.12%**	>=93%	86% - 92%	<=85%
Haematology	98.59%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**92.31%**	**99.26%**	>=93%	86% - 92%	<=85%
Head & Neck	99.16%	97.56%	94.34%	95.93%	96.46%	99.22%	99.13%	92.42%	99.24%	98.10%	99.31%	94.62%	99.29%	**98.82%**	**97.47%**	>=93%	86% - 92%	<=85%
Lower GI	99.26%	100.00%	100.00%	100.00%	100.00%	99.63%	100.00%	99.68%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**99.94%**	>=93%	86% - 92%	<=85%
Lung	98.67%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	96.15%	90.91%	**96.43%**	**98.22%**	>=93%	86% - 92%	<=85%
Sarcoma	96.48%	100.00%	100.00%	100.00%	100.00%	88.89%	100.00%	100.00%	100.00%	100.00%	94.12%	100.00%	100.00%	**100.00%**	**98.02%**	>=93%	86% - 92%	<=85%
Skin	98.42%	98.76%	98.18%	99.50%	99.51%	100.00%	99.60%	96.30%	98.62%	97.79%	99.59%	99.58%	100.00%	**99.68%**	**99.02%**	>=93%	86% - 92%	<=85%
Testicular	97.47%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**100.00%**	**100.00%**	>=93%	86% - 92%	<=85%
Upper GI	96.87%	98.18%	89.80%	100.00%	100.00%	100.00%	100.00%	96.58%	99.24%	98.54%	99.32%	99.11%	100.00%	**100.00%**	**98.96%**	>=93%	86% - 92%	<=85%
Urology	99.34%	100.00%	100.00%	98.39%	100.00%	96.88%	100.00%	99.12%	98.29%	97.27%	98.53%	98.10%	98.72%	**97.46%**	**98.43%**	>=93%	86% - 92%	<=85%

Appendix 1 - ESR Staff Groups - Roles

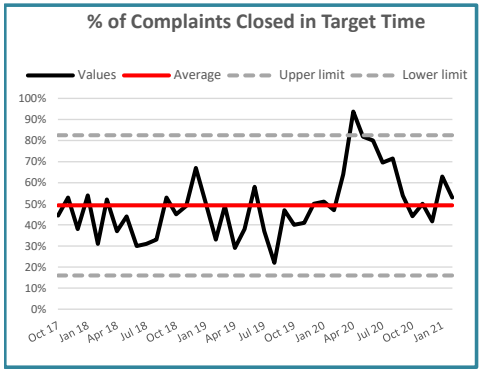
Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals
Chaplain	Assistant	Accountant	Advanced Practitioner
Clinical Director	Assistant Practitioner Nursing	Adviser	Chiropodist/Podiatrist
Manager	Assistant/Associate Practitioner	Analyst	Chiropodist/Podiatrist Manager
Operating Department Practitioner	Counsellor	Architect	Dietitian
Optometrist	Health Care Support Worker	Board Level Director	Dietitian Manager
Pharmacist	Healthcare Assistant	Chair	Dietitian Specialist Practitioner
Physician Associate	Healthcare Science Assistant	Chief Executive	Multi Therapist
Practitioner	Healthcare Science Associate	Clerical Worker	Occupational Therapist
Psychotherapist	Nursery Nurse	Finance Director	Occupational Therapist Manager
Technician	Nursing Associate	Librarian	Orthoptist
	Phlebotomist	Manager	Orthoptist Manager
	Technical Instructor	Medical Secretary	Physiotherapist
	Technician	Non Executive Director	Physiotherapist Manager
	Trainee Healthcare Science Practitioner	Officer	Physiotherapist Specialist Practitioner
	Trainee Healthcare Scientist	Other Executive Director	Radiographer - Diagnostic
	Trainee Nursing Associate	Personal Assistant	Radiographer - Diagnostic, Manager
		Receptionist	Radiographer - Diagnostic, Specialist Practitioner
		Researcher	Speech and Language Therapist
		Secretary	Speech and Language Therapist Manager
		Senior Manager	
		Technician	

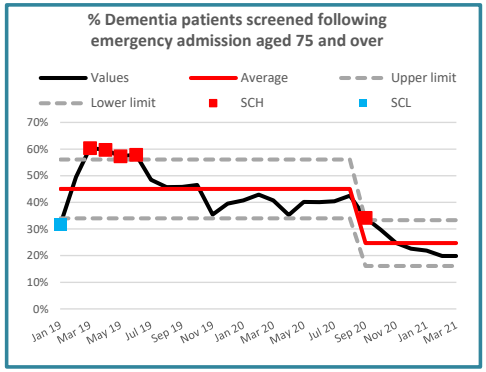
Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
Assistant	Healthcare Science Practitioner	Consultant	Advanced Practitioner
Cook	Healthcare Scientist	Foundation Year 1	Community Nurse
Driver	Manager	Foundation Year 2	Community Practitioner
Engineer	Specialist Healthcare Science Practitioner	Specialty Doctor	Director of Nursing
Gardener/Groundsperson	Specialist Healthcare Scientist	Specialty Registrar	Midwife
Housekeeper		Staff Grade	Midwife - Manager
Maintenance Craftsperson		Trust Grade Doctor - Foundation Level	Midwife - Specialist Practitioner
Porter		Trust Grade Doctor - Specialty Registrar	Modern Matron
Supervisor			Nurse Consultant
Support Worker			Nurse Manager
Technician			Sister/Charge Nurse
Telephonist			Specialist Nurse Practitioner
			Staff Nurse

Safe - SPC Charts

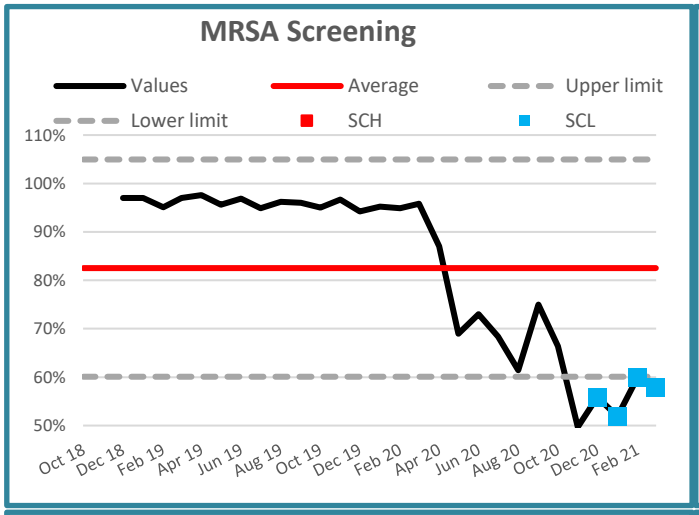


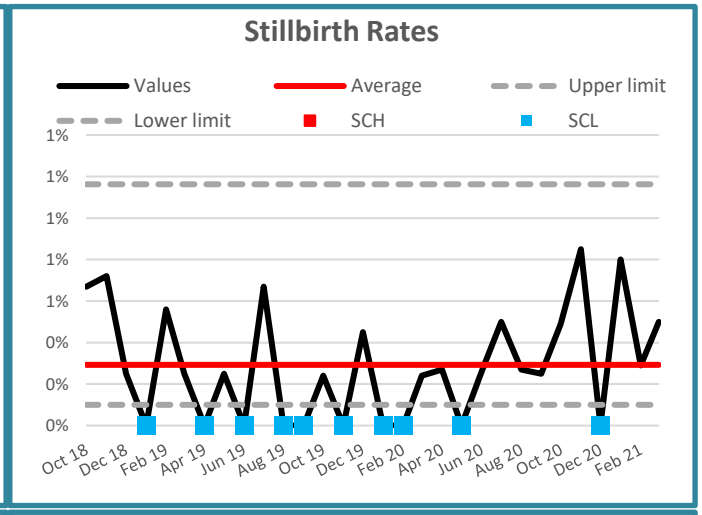
Caring - SPC Charts

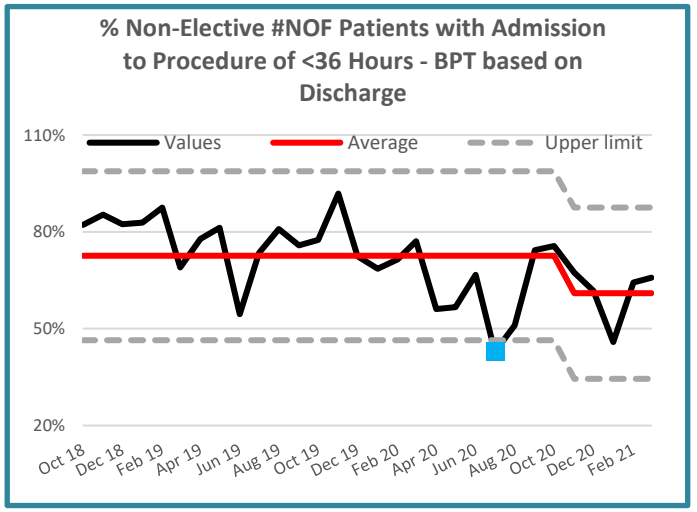


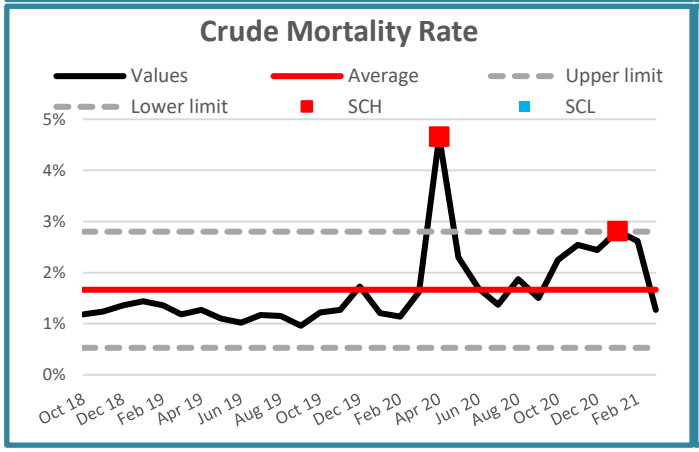


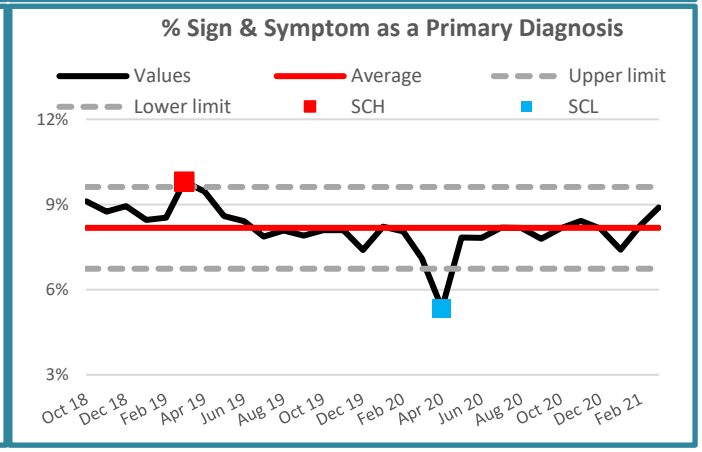
Effective - SPC Charts

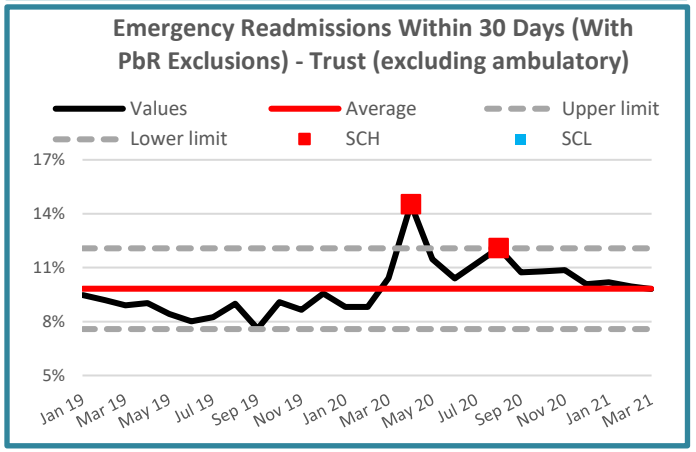




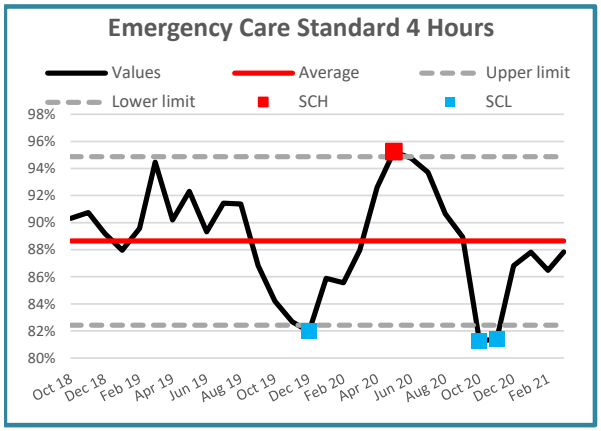


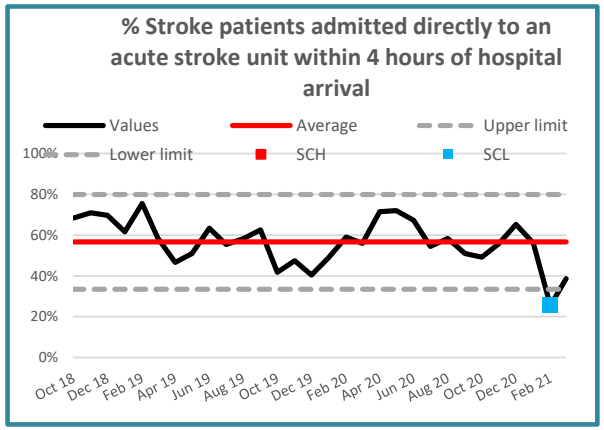


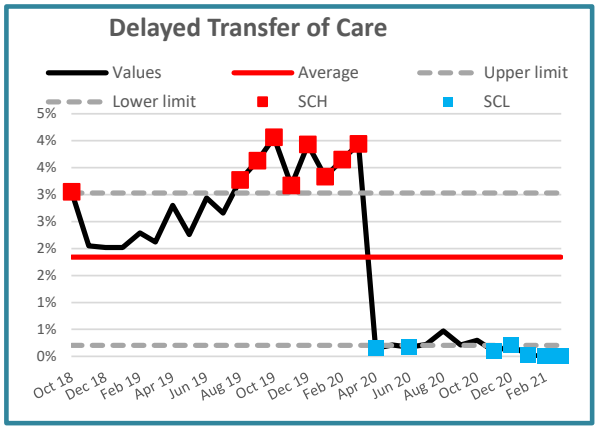


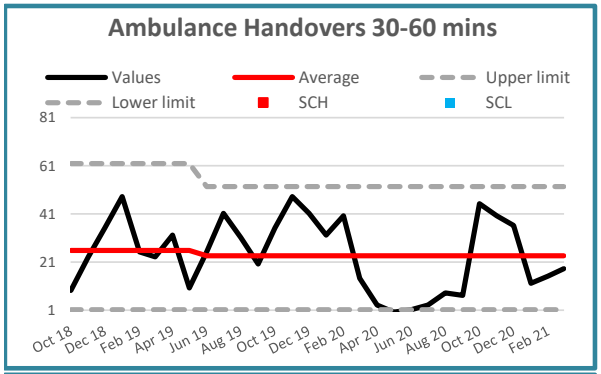


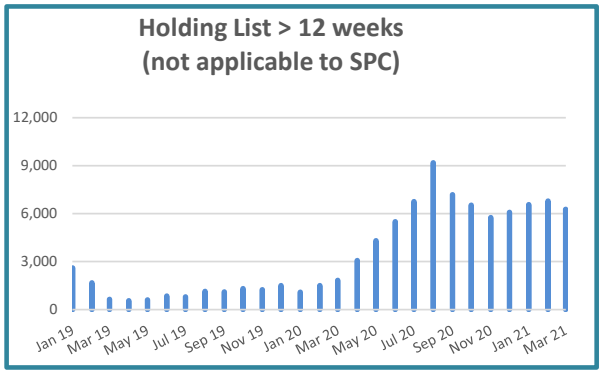
Responsive - SPC Charts

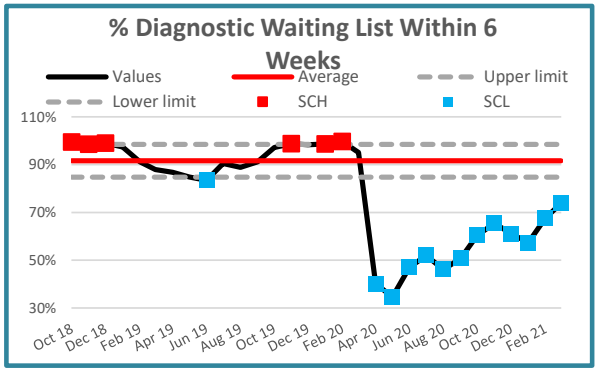


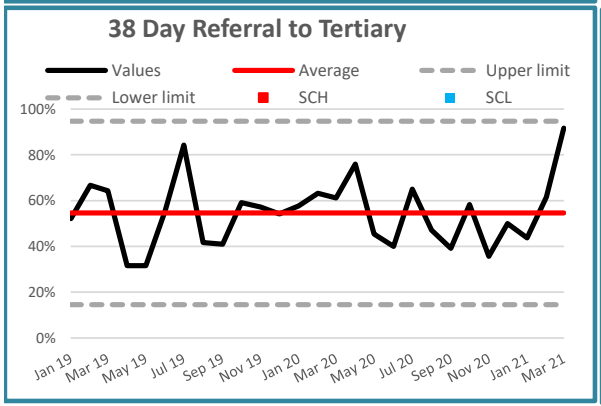


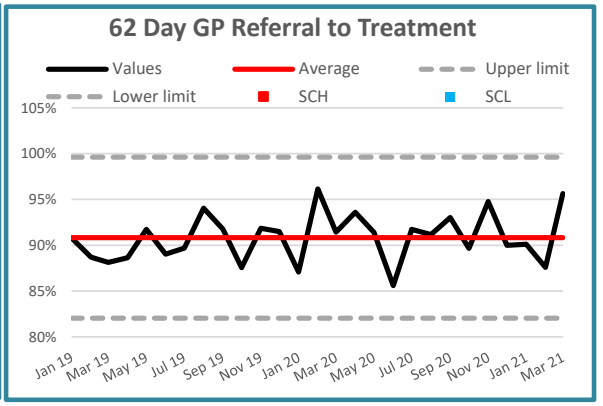












Methodology for calculating the performance score

The "key" targets are all measures included in NHS Improvement's Single Oversight Framework or measures on which the Trust is particularly focussing and are deemed more important.

Standard KPIs and "Key" targets

- Each RAG rating has a score - **red** 0 points; **amber** 2 points; **green** 4 points
- For "Key" targets, scores are weighted more heavily and are multiplied by a factor of 3 - **red** 0 points; **amber** 6 points; **green** 12 points

Calculating Domain Scores

- Add up the scores for each KPI per domain; divide by the maximum total score possible for that domain to get a percentage score.
- Apply the thresholds for the overall domain to get a RAG rating for each domain.
- Thresholds: < 50% is **red**, 50% to < 75% is **amber** and 75% and above is **green.**

Calculating Trust Performance Scores

- Calculate the overall performance score by adding up the scores for all domains; dividing by the maximum total score possible for all domains to get a percentage
- Apply the same thresholds as above to RAG rate the overall score

Glossary of acronyms and abbreviations

- **A&E** - Accident & Emergency
- **ADN** - Associate Director of Nursing
- **AED** - Accident & Emergency Department
- **ASI** - Appointment Slot Issue
- **ASU** - Acute Stroke Unit
- **BPT** - Best Practice Tariff
- **CCG** - Clinical Commissioning Group
- **CCU** - Critical Care Unit
- **CD** - Clinical Director
- **CDiff** - Clostridium Difficile
- **CDS** - Commissioning Data Set
- **CDU** - Clinical Decision Unit
- **CEPOD** - National Confidential Enquiry into Patient Outcome and Death
- **CHPPD** - Care hours per patient day
- **CIP** - Cost Improvement Programme
- **CQC** - Care Quality Commission
- **CQUIN** - Commissioning for Quality and Innovation
- **CRH** - Calderdale Royal Hospital
- **CT** – Computerised tomography
- **DH** - Department of Health
- **DNA** - did not attend
- **DSU** - Decision Support Unit
- **DTOC** - Delayed Transfer of Care
- **EBITDA** - Earnings before interest, tax, depreciation and amortisation
- **ECS** - Emergency Care Standard
- **EEA** - European Economic Area
- **EPR** - Electronic Patient Record
- **ESR** - Electronic Staff Record
- **FFT** - Friends and Family Test
- **FSRR** - Financial Sustainability Risk Rating
- **FSS** - Families and Specialist Services
- **GM** - General Manager
- **GP** - General Practitioner
- **GH** - Greater Huddersfield
- **HAI** - Hospital Acquired Infection
- **HCA** - Healthcare Assistant
- **HDU** - High Dependency Unit
- **HOM** - Head of Maternity
- **HRG** - Healthcare Resource Group
- **HR** - Human Resources
- **HRI** - Huddersfield Royal Infirmary
- **HSMR** - Hospital Standardised Mortality Rate
- **I&E** - Income and Expenditure
- **ICU** - Intensive care unit
- **IT** - Information Technology
- **KPI** - Key Performance Indicator
- **LOS** - Length of Stay
- **LTC** - Long Term Condition
- **MAU** - medical admission unit
- **MRI** - Magnetic resonance imaging
- **MRSA** - Methicillin-Resistant Staphylococcus Aureus
- **MSK** - Musculo-Skeletal
- **MSSA** - Methicillin Susceptible Staphylococcus Aureus
- **NHSE** - NHS England
- **NHSI** - NHS Improvement
- **NICU** - Neonatal Intensive Care Unit
- **NoF** - Neck of Femur
- **OD** - Organisational Development
- **PAS** - Patient Administration System
- **PbR** - Payment by Results
- **PHE** - Public Health England
- **PHSO** - Parliamentary and Health Service Ombudsman
- **PPH** - Postpartum Haemorrhage
- **PRM** - Performance Review Meeting
- **PTL** - Patient Tracking List
- **PU** – Pressure Ulcer
- **QIPP** - Quality, Innovation, Productivity and Prevention
- **RAG** - Red Amber Green
- **RCA** - Root Cause Analysis
- **RN** - Registered Nurse
- **RTT** - Referral to Treatment
- **SACT** - Systemic Anti-Cancer Treatment
- **SAU** - Surgical Admission Unit
- **SH** - Safety Huddle
- **SHMI** - Summary Hospital-level Mortality Indicator
- **SI** - Serious Incident
- **SITREPs** - Situation reports
- **SSNAP** - Sentinel Stroke National Audit Programme
- **SOP** - Standard Operating Protocol
- **SRG** - Systems Resilience Group
- **SUS** - Secondary Uses Service
- **UCLAN** - University of Central Lancashire
- **UTI** - Urinary Tract Infection
- **UoR** – Use of Resources
- **Var** - Variance
- **VTE** - Venous Thromboembolism
- **WLI** - Waiting List Initiative
- **WTE** - Whole Time Equivalent
- **YAS** - Yorkshire Ambulance Service

20. Approval of the new Performance Accountability Framework

To Approve

Presented by Helen Barker

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 6th May 2021
Meeting:	Board of Directors
Title:	Performance Management and Accountability Framework (PMAF)
Author:	Peter Keogh, Assistant Director of Performance
Sponsoring Director:	Helen Barker, Chief Operating Officer
Previous Forums:	Executive Board Finance & Performance Committee Draft has been previously circulated for comment to all Directors and Divisional teams. This has been reviewed by Cath Hill at AQUA x 2

Purpose of the Report

This is an update to the Performance Management and Accountability Framework (PMAF) originally approved in 2015 and reflects the feedback from the AQUA review.

Key Points to Note

The Performance Management and Accountability Framework (PMAF) articulates the processes, activities and controls in place to monitor the performance of our services, and to hold to account those officers responsible for delivery against forecasts, targets, standards and trajectories. It is delivered in line with the Trust's own values and behaviours as described in our mission, four pillars and Strategic objectives.

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 Trust has set out its strategy and objectives for the next five years which need to be reflected in the PMAF. These include:

- COVID stabilisation and recovery
- Prioritisation of work to reduce Health inequalities
- Achievement of compliance with regulatory standards
- Achievement of an Outstanding CQC rating
- The external landscape and new role of the Integrated Care System (ICS)
- Digital maturity
- Achieving finance balance

The refreshed framework includes an update to the Integrated Performance Report and reference to data quality alongside the development of a single combined narrative that answers the "so what" question that seeks to triangulate performance for greater Board assurance.

The above includes renewed focus on:

- Outcome based indicators
- Quality priorities
- Deep-dives into green and red indicators
- Triangulation between quality, workforce and finance
- Development of predictive analytics
- Efficiency

Areas of the Trust that are performing strongly will experience less intense performance management. Strong performance will be rewarded with autonomy. Conversely, areas of the Trust which are underperforming in key areas will be subject to rigorous performance management and will be offered greater support to make improvements. This is detailed in the CHFT framework for Earned Autonomy.

EQIA – Equality Impact Assessment

There has been consultation with representatives from the equality groups on disability, BAME and LGBTQ and feedback received is that the framework has a neutral impact from an equality perspective across all protected characteristics.

Recommendation

The Board is asked to accept the recommendation of the Finance & Performance Committee and **APPROVE** the revised PMAF.

Signed off by: H Barker

Date signed off: 27th April 2021

Calderdale and Huddersfield
NHS Foundation Trust

PERFORMANCE MANAGEMENT AND ACCOUNTABILITY FRAMEWORK

Performance Assurance

Performance Support

Learning from Performance

Calderdale and Huddersfield NHS Foundation Trust

Contents

1. Overview

The Performance Management and Accountability Framework (PMAF) will support the Trust's ambition to deliver outstanding, compassionate care to the communities we serve, through strengthening the Trust's approach to performance management and performance support alongside learning from performance. It aims to foster a culture of responsibility and accountability at all levels within the Trust. Members of staff need to know what is expected of them and what contribution they make to the success of the Trust. For example within a division all staff are responsible for Health and Safety however it is the Divisional Director who is accountable.

As we have already seen, implemented effectively, the PMAF will support delivery of national standards and the Trust's quality, financial and operational objectives.

The objective of this framework is to ensure that information is available and triangulated which enables the Board of Directors and other key personnel to understand, monitor and assess the Trust's activities. Information must be timely, accurate and complete and follow the principles set out in the Trust's Information Governance and Data Quality Policies.

We must learn from our Performance – whether that is good and is setting the benchmark whereby we are open to others learning from us, or whether we need to improve and as a result need to carry out deep-dives or thematic reviews to understand our own failings and 'go see' where necessary, seeking out best practice. Calderdale and Huddersfield NHS Foundation Trust (CHFT) has always considered it a strength to learn from other organisations who may have found success through different approaches.

The fundamental existence of our framework is to provide assurance to Board members, both Executive and Non-Executive, our governors, our partners, our patients and the public who rely on our services. The pandemic has demonstrated the strength of this organisation to respond in the most difficult circumstances and we now need to assure our key stakeholders through our response to recovery and sustainability that we can be relied upon to return to the pre-COVID high level of performance that we were consistently able to deliver.

We must also provide performance support throughout the organisation with the Executive team in particular in a position to do this via Performance Review meetings with divisions. The Trust's Governance structure shows the interfaces between committees and where Performance Review meetings are positioned. (see Appendix A)

2. Scope

The Performance Management and Accountability Framework (PMAF) articulates the processes, activities and controls in place to monitor the performance of our services, and to hold to account those officers responsible for delivery against forecasts, targets, standards and trajectories. It is delivered in line with the Trust's own values and behaviours as described in our mission, four pillars and Strategic objectives.

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 Trust has set out its strategy and objectives for the next five years which need to be reflected in the PMAF. These include:

- COVID stabilisation and recovery
- Prioritisation of work to reduce Health inequalities
- Achievement of compliance with regulatory standards
- Achievement of an Outstanding CQC rating
- The external landscape and new role of the Integrated Care System (ICS)
- Digital maturity
- Achieving finance balance

Effective performance management entails positively supporting people to excel, whilst managing and rectifying performance issues. The framework reflects this by providing a system through which good performance can be encouraged and poor performance addressed with learning recognised. It is designed to articulate the processes, activities and controls in place to monitor the performance of our services, and to hold to account those officers responsible for delivery against forecasts, targets, standards and trajectories and provide support where improvement is required.

The refreshed framework includes an update to the Integrated Performance Report and reference to data quality alongside the development of a single combined narrative that answers the "so what" question that seeks to triangulate performance for greater Board assurance.

The above includes renewed focus on:

- Outcome based indicators
- Quality priorities
- Deep-dives into green and red indicators
- Triangulation between quality, workforce and finance
- Development of predictive analytics
- Efficiency

Objectives: The Trust's strategic and operational objectives are integral to the PMAF, ensuring monitoring and focus on these priorities and key milestones at all levels of the Trust to provide alignment to the delivery of our vision and long-term strategy.

Each Division will have their own strategic and operational objectives that reflect the direction set by the Board of Directors which will form the basis of their work programme and associated performance monitoring and will be addressed via Divisional Performance Review meetings.

Accountability: Clear defined expectations of individuals and teams within the Trust, their role in managing performance and the expectation when performance drops below an acceptable level. This includes at Corporate level with each function being held to account for its financial management including efficiency programmes and human resource management.

The Trust is committed to a clinical leadership model with clear accountability through a single accountable officer principle with responsibility for delivery sitting with full time managers, in Divisions this is the Director of Operations, in associated divisions and corporate teams this will be the most senior person in the team.

The Trust has four clinical Divisions, 3 bed-holding Divisions led by Divisional Directors, managed by Directors of Operations with Associate Directors of Nursing, Assistant Directors of Finance and HR Business partners and one Community Division where the Director of Operations has single accountability and responsibility but with the same supporting infrastructure. The Divisions are further divided into Directorates who are led by Clinical Directors, managed by General Managers and Matrons.

There are 3 associated divisions, one of whom is a Wholly Owned Subsidiary, alongside our PFI partner all of whom have their performance managed through a service level agreement process with regular formal reviews.

Underpinning this is the principle of the Executive team devolving decision-making and accountability to the Divisions with delivery using the values within the four pillars of:

- Putting the patient first
- Working together to get results
- We 'Go See'
- We do the Must Do's

Transparency: Clear processes, activities and controls in place so that all staff across the Trust understand how we are performing and the process by which performance is managed.

Improvement Focused: Services/areas which are identified as underperforming will be offered support to improve performance. At all times the four pillars will be the underpinning behaviours for all performance improvement work and will be conducted using the methodology of 'Work together to get results'.

Empowerment and Delegation: Areas of the Trust that are performing strongly will experience less intense performance management. Strong performance will be rewarded with autonomy. Conversely, areas of the Trust which are underperforming in key areas will be

subject to rigorous performance management and will be offered greater support to make improvements. This is the CHFT framework for Earned Autonomy

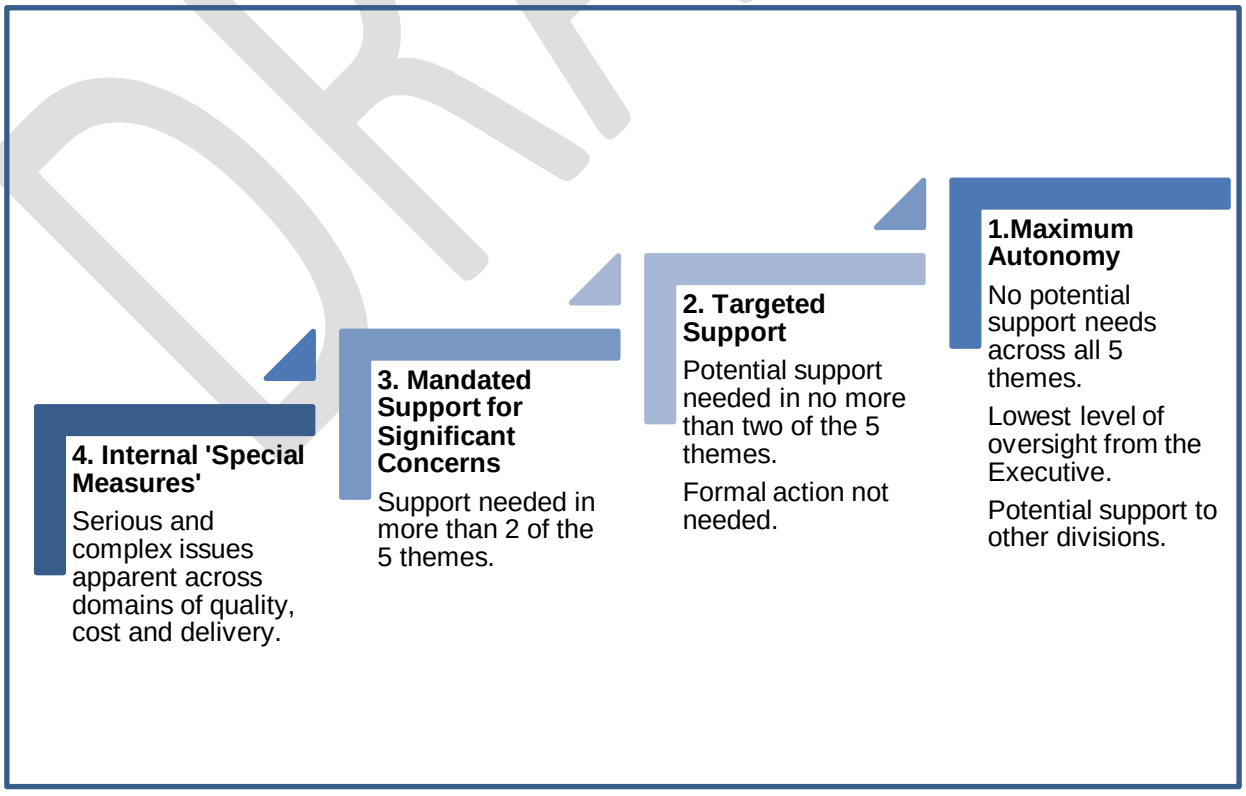
Earned Autonomy

The five themes

- Quality of care (safe, effective, caring, responsive):
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

The purpose is to:

- provide one framework for overseeing Divisions;
- help to identify potential support needs, by theme, as they emerge;
- allow the Executive team to draw on expertise from across the Trust;
- define autonomy whilst being flexible in approach, for example: the Executive team may need to respond quickly and proactively to unexpected issues in individual Divisions
- enable the ongoing development of ward to Board metrics and associated hierarchy, generating effective oversight of Divisions;
- Declare the level according to the scale of issues faced. This would be informed by data and, importantly, judgement based on Executive understanding of Divisional circumstances.



3. CHFT Strategy and Objectives for the next five years

The Trust has an agreed 10-year strategy that is reviewed and refreshed annually with a one-year plan on a page. Clinical Divisions have taken the overarching strategy and developed Divisional 10-year strategies and annual plans that contribute to the successful completion of the strategy but also reflect local priorities. These form the outline structure for the PMAF.

The framework also needs to be flexible enough to respond to the changing landscape that we are currently experiencing including the Department Health and Social Care white paper: Integration and Innovation and our recovery framework as an organisation following the COVID pandemic. Performance management and accountability refers to how we govern ourselves as an organisation and individuals must understand their roles and responsibilities within that.

COVID stabilisation and recovery

The COVID pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-COVID care.

The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure.

As a Trust and across the system we will continue to recover non-COVID services, in a way that reduces variation in access and outcomes concentrating on health inequalities. Priorities will be agreed and described in the annual objectives with performance monitored and supported accordingly

Funding decisions will be focussed on addressing treatment backlogs and long waits reflecting the principles and priorities agreed by the Board of Directors and based on reducing health inequalities. In addition, we will ensure we deliver improvements in productivity, continue with outpatient transformation and secure the agreed quality priorities.

Prioritisation of work to reduce Health inequalities

Health inequalities and what it means for us as an organisation has had an increased profile since the onset of COVID with a clear internal focus and the national identification of 8 urgent actions.

Internally we recognise the importance of this in relation to our current service models, our own stabilisation and reset plans and the strategic case for change that is guiding our reconfiguration planning. We need to make truly informed decisions and ensure that we fully understand our approach to eliminating any health inequalities, only then can we accurately analyse data and interpret feedback in a meaningful way. Once we are in this position, we will

use the PMAF and associated Integrated Performance Report to monitor our ongoing progress.

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

The four themes are:

- **The external environment**, how we connect with our communities and use this to inform our business as usual planning (Director of Transformation and Partnerships)
  As part of the Business Better than Usual programme (see appendix C), 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 lived experience**, with initial focus on families accessing our maternity service (Chief Nurse/Deputy Chief Executive and Executive lead for Health Inequalities)
  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.

- **Health inequalities data** and how we use this to compliment clinical prioritisation and our post Covid-19 delivery model (Chief Operating Officer).
  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.

- **The staff experience,** ensuring we have a workforce that reflects our local population (Director of Workforce and Organisational Development). It is essential that we have a workforce that reflects our population at all levels, that we are proactive in the planning and support provided to colleagues and that this is reflective of individual needs. Delivering a workforce and organisational development programme around Health Inequalities, diversity and inclusion and ensuring equal opportunities for all.

Health inequalities will be embedded in everything that we do. We will always view healthcare through a health inequalities lens and therefore an update on health inequalities will be a standing item at Performance Review Meetings and at the Board of Directors.

Achievement of compliance with regulatory standards

From 2020/21, the metrics for oversight and assessment purposes include the headline measures described in the NHS Long Term Plan Implementation Framework against which the success of the NHS will be assessed. These LTP measures will be used as the cornerstone of the mandate and planning guidance for the NHS for the next five years.

The future **System Oversight Framework (SOF)** proposed in March 2021 will set consistent expectations of systems and their constituent organisations and match accountability for results with improvement support, as appropriate.

This approach will recognise the enhanced role of systems. It will identify where ICSs and organisations may benefit from, or require, support to help them meet standards in a sustainable way and will provide an objective basis for decisions about when and how NHSE/I will intervene in cases where there are serious problems or risks.

The SOF introduces a new support programme to replace the 'special measures' regime. The regime was introduced in 2013 to support quality improvement in the most challenged Trusts following Professor Sir Bruce Keogh's review of trusts with high mortality rates. Subsequently, a financial special measures programme for trusts and analogous arrangements for CCGs were introduced. These separate programmes no longer provide the breadth of support required in the new system-based approach to the delivery of healthcare and therefore there is a proposal to replace with a single integrated Recovery Support Programme (RSP).

The proposed RSP will give support to the most challenged systems (in terms of quality and/or finance) to tackle their key challenges. This will enable intervention in response to CQC findings or where other regulatory action is required. This approach enables improvement action and targeted support either at organisation/provider level (with system support) or across a whole system where required and may extend across health and social care, accessing shared learning and good practice between systems to drive improvement.

Scope of the NHS System Oversight Framework for 2021/22

We expect to see greater adoption of system- and place-level measurements, which might include reporting some performance data such as patient treatment lists at system level.

Support Needs

To provide an overview of the level and nature of support required across systems, inform oversight arrangements and target support capacity as effectively as possible, ICSs, Trusts and CCGs will be allocated to one of four 'segments' as described below. There will be a phased implementation to segmentation during 2021/22 that reflects the approach to operational and financial planning set out in the 2021/22 Operational Planning Guidance.

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	This is the 'default' segment unless an ICS, trust or CCG triggers the criteria for moving into another segment. While ICSs in this segment will still be on a development journey, they will demonstrate many of the characteristics of an effective, self-standing ICS. Where performance is challenged at system, place or organisation level, plans that have the support of system partners will be in place to address this.			Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Following consultation on the approach for 2021/22, the new NHS System Oversight Framework for 2021/22 will be issued at the end of June 2021.

Achievement of an Outstanding CQC rating

As a Trust working towards the Outstanding CQC rating, the question for any Trust Framework should be one of 'Am I assured and am I confident that we know where the risks lie'.

The PMAF plays a key role in this assurance with an increased focus on the triangulation of data with softer intelligence from leadership walkrounds and discussions in associated forums. The Integrated Performance Report will continue to be formatted in line with the CQC domains and will use the Trust's Improvement Methodology of the 3Rs in its narrative.

The CQC is adapting and developing their methods of regulation by using a transitional approach to monitoring services. This focuses on safety, how effectively a service is led and how easily people can access the service.

It includes:

- a strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOEs), so they can continually monitor risk in a service
- using technology and local relationships to have better direct contact with people who are using services, their families and staff in services
- targeting inspection activity where we have concerns

CQC Strategy

CQC's new strategy was published for consultation in January 2021. The strategy is built on four themes that together determine the changes they want to make. Running through each theme is CQC's ambition to improve people's care by looking at how well health and care systems are working and how they are acting to reduce inequalities.

CQC and Compliance Group which reports to the Quality Committee will work with core service areas to set direction for the achievement of an overall rating of 'Outstanding'. The performance structures described in this framework will support the accountability of this within Divisions and at Divisional level, ensuring connectivity at Divisional level across all domains. Oversight and specific improvement activity will be managed through the CQC and Compliance Group.

CQC Insight Report

CQC Insight brings together in one place the information CQC holds about our services but is delayed in production so not suitable for inclusion in performance management. The CQC use this to decide what, where and when to inspect and provide analysis to support the evidence in their inspection reports therefore it is important to ensure the metrics within the Insight report are included in the PMAF and associated Integrated Performance Report so becoming fully integrated with core business. This will eliminate the need for separate CQC Insight reporting to Board Sub-Committees.

The external landscape and new role of the Integrated Care System (ICS)

Department Health and Social Care white paper: Integration and Innovation

The PMAF needs to be flexible and reflect the changes proposed in national guidance such as the latest ICS white paper. Details are included within Appendix B**.**

Digital maturity

To fulfil the potential of digital and data to improve patient outcomes and drive collaborative working, systems will need to:

- build smart digital and data foundations
- connect health and care services
- use digital and data to transform care
- put the citizen at the centre of their care

CHFT is already advanced in its digital journey and this includes both how we deliver services and how we monitor performance. The PMAF will continue to build on this solid foundation by working towards more predictive analysis and working across organisational boundaries to develop pathway monitoring and comprehensive outcome measures.

Achieving finance balance

CHFT will need to develop internal financial plans that connect into the wider System plan and will be expected to demonstrate how we will meet various commitments linked to the Long-Term Plan (LTP). These include:

- Plans must demonstrate how systems will meet the government's five financial tests set out in the LTP. These include: returning to financial balance; achieving cash-releasing productivity growth of at least 1.1% (with an additional 0.5% as a provider in deficit); reducing growth in demand for care through integration and prevention; reducing unwarranted variation; and making better use of capital investment. Financial recovery plans will be required for each NHS organisation not in financial balance.
- Plans should identify specialties they wish to prioritise virtual outpatient appointments.
- Activity plans should set out how systems will use the increase in their allocations to improve the volume of elective treatments year-on-year, cut long-waits and reduce the size of the waiting list. They also need to set out how digital tools will transform outpatients, removing up to a third of face-to-face outpatient visits.

Internal plans, built from the Trust 10-year strategy and local Divisional plans will be agreed annually, will be monitored in line with the PMAF. The performance structures described in this framework will support the accountability of this, ensuring connectivity at all levels and across all domains. Ensuring financial balance, including efficiency programmes, is aligned with safe and sustainable services for patients and staff.

4. Integrated Performance Report (IPR)

At the heart of the refreshed framework stands the Integrated Performance Report (IPR) which represents how we report to Board and relevant sub-committees on a monthly basis and is the reference point for how our performance has progressed over time. It has already been noted that CHFT is one of the highest achievers across regulatory standards, locally determined KPIs and that its performance has contributed to the movement from 'Requires Improvement' to 'Good' following the last CQC inspection. These are excellent achievements but there is still the need to evolve particularly with the demanding strategy and objectives that CHFT has set for the next 10 years. This, alongside the ever-changing health landscape following the impact of the pandemic and the need for recovery and stabilisation, plus the changes to the external environment and new role of the Integrated Care System (ICS).

The refreshed framework includes an update to the IPR and reference to data quality alongside the development of a single combined narrative that seeks to triangulate performance for greater Board assurance. This narrative will be driven by the re-establishment of the Deputy Directors sub-group which will meet monthly and use collective thinking to form the combined narrative needed to describe the Trust's current performance. This will also form the trigger for any deep-dives for areas of concern, highlight any areas of good practice and ensure learning is disseminated. The background context will be replaced by a SWOT analysis which will also give context and be informed by divisional level triangulation as part of their own IPRs.

With a focus on measurement for improvement, the intention is to move the IPR to have a greater Statistical Process Control (SPC) format which will better inform decision making and will also eradicate some duplication within the current IPR. There will be further emphasis on **outcome-based measures**, quite a wide range were introduced into the report in 2020/21, and this will require input at divisional and clinical level as to how we evidence outcomes; for example from the range of readmission data by condition that is already included. This will ensure we get the highest impact improvements done in relation to patient and staff outcomes.

Recovery Framework

A separate area of the IPR will be dedicated to Recovery and Stabilisation for the period of the Recovery framework. This will be for the whole of 2021/22 as a minimum and will include a trajectory for recovery of backlogs based on the agreed Board of Directors' principles and priorities. The modelling work for Outpatients, Inpatients and Diagnostics will form the basis of any trajectory and will ensure that we are clear on what success looks like and can track it as part of our performance management of Recovery. Referral rates and how activity, both elective and non-elective, and capacity are managed will be crucial to our successful delivery of this unprecedented task and CHFT's credibility in the eyes of our patients and stakeholders.

In terms of **efficiency** there will need to be trigger points that enable the gradual return to 'normality' as we move forward. We will be explicit in Recovery with a plan on improvement

and sustainability. There will be closer scrutiny through Datix around incidences of harm as a result of the backlog position and activity in general during the pandemic.

Benchmarking has been a regular part of the IPR for some time where we have compared favourably to our West Yorkshire neighbours and at England level for our key indicators. Separately we also compare performance for key indicators where the Trust has benchmarked extremely well nationally when its 2 key metrics (Emergency Care and 62-day Cancer) are considered together. This will now also be included in the IPR periodically and will incorporate the new Emergency Care and Elective Care standards as they are introduced nationally.

Getting it Right First Time (GIRFT) is a core element of performance improvement providing national benchmarking across range of standards that engages clinical colleagues. There is a well-established and comprehensive programme of support and governance for GIRFT implementation and this includes tracking of all actions required. CHFT has been recognised as a national exemplar in respect of GIRFT implementation and this will be used in triangulation of performance to ensure improvement across pathways of care, reducing variation.

Deep-dives into green and red indicators

To improve assurance around performance and data quality there is a formal programme of deep-dives across the KPIs within the Integrated Performance Report (IPR). There are currently approximately 100 metrics across the CQC domains which are reported at each Board sub-committee.

The deep-dives provide the Board with assurance on KPIs that regularly achieve target (Green RAG rating) and an understanding of the challenges of those that are currently missing their target (Red RAG rating) with a focus on learning and improvement.

A 12-month programme has been established which is refreshed annually. Audits are reported to the Executive Board via the Data Quality Board on a monthly basis with the green KPIs identified proactively based on previous performance and the reds identified on publication of the IPR.

Deep dives are further supported by the use of the 'Go See' pillar either for colleagues to visit areas under review to talk to colleagues or for visits by colleagues in those areas to learn from others either internally or externally.

Quality priorities

The NHS Five Year Forward View confirmed a national commitment to high-quality, person-centred care for all and describes the changes that are needed to deliver a sustainable health and care system.

For people who use services

Building on our existing definition of quality, the areas which matter most to people who use services:

- **Safety**: people are protected from avoidable harm and abuse. When mistakes occur lessons will be learned.
- **Effectiveness**: people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

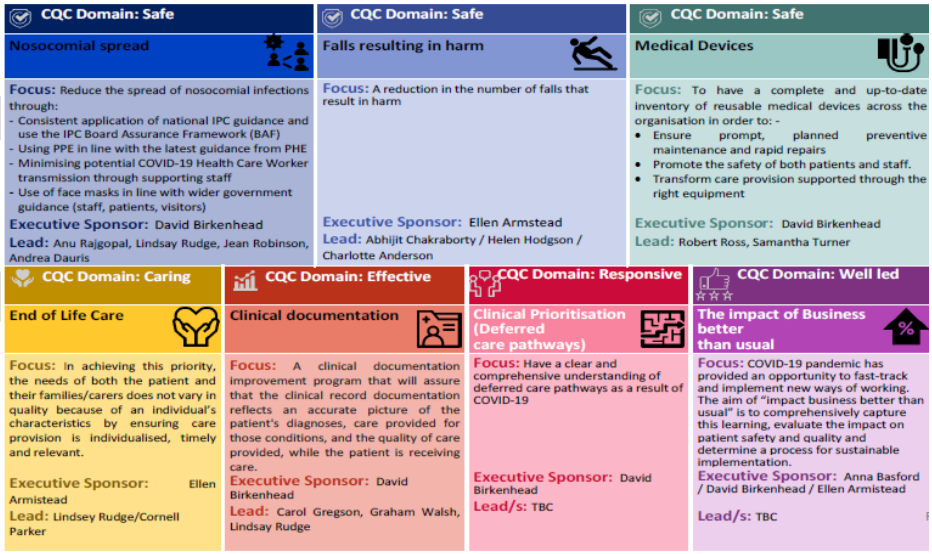
- **Positive experience**:
  Caring: staff involve and treat you with compassion, dignity and respect.
  Responsive and person-centred: services respond to people's needs and choices and enable them to be equal partners in their care.

For those providing services:
We know that to provide high-quality care, we need high performing providers and commissioners working together and in partnership with, and for, local people and communities, that:

- Are **well-led**: they are open and collaborate internally and externally and are committed to learning and improvement.
- **Use resources sustainably**: they use their resources responsibly and efficiently, providing fair access to all, according to need, and promote an open and fair culture.
- Are **equitable for all**: they ensure inequalities in health outcomes are a focus for quality improvement, making sure care quality does not vary due to characteristics such as gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy and maternity or marital or civil partnership status.

The Trust is committed to providing safe, effective and timely care to all patients and for all staff and will monitor performance across all KPIs. In addition, each year there will be specific focus on 7 key Quality priorities, drawn from learning the previous year and any externally driven changes. These will form the foundation for performance monitoring and will be standing items in any performance. These will follow the domains of the CQC and the example of the 2021/22 priorities are shown below:

CHFT



The 7 **Quality Priorities** identified in 2020/21 and refreshed for 2021/22 will be embedded at board level in terms of understanding and performance reporting and will therefore be integrated in the form of additional indicators particularly into the Caring domain with a reworking of the 'Hard Truths' element of the IPR embracing the Focused Support Framework and the implementation of the Observe and Act toolkit as an integrated module to that framework.

The key changes from the IPR have been highlighted in Appendix D

Focused Support Framework (FSF)

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

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

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

Observe and Act Toolkit

The Observe and Act tool provides a structured robust framework to view services as "a person's total experience of a service from the service user/carer perspective, learn from it, share good practice and where necessary act to make improvements".

The toolkit will assist in supporting the Trust vision and values and quality priorities for transforming patient and carer experience.

The tool has been designed and developed for use in a range of settings, including wards, departments, and clinics and contributes to service improvement by providing information about what patients and carers view as important, providing real-time feedback to staff on good practice and identifying areas where improvements can be made.

The observation team will be facilitated by a clinical lead on site and the observations will be carried out virtually by a small team of CHFT Non-Executive Directors and other volunteers as the initial cohort of observers.

5. Triangulation between quality, workforce and finance (including activity)

We expect divisions to triangulate quality, workforce and financial indicators and how they intend to use this information, particularly to improve the quality of care through the delivery of the KPIs, enhance productivity and deliver financial balance. The activity element will have even more focus during the period of recovery and stabilisation as we endeavour to return to 2019/20 levels. Within all of the above it is essential that there is proactive identification of risk and corrective actions.

In its simplest form the PMAF includes the performance management processes which collectively help deliver the strategic objectives and ultimately the vision of CHFT. Performance management within CHFT will continue to be based on the following principles:

- The Board of Directors have established clear KPIs and targets that are balanced across the CQC domains driving towards the level of performance expected of an outstanding organisation.
- KPIs will be reviewed annually then monitored regularly with performance reviews at all levels to drive performance improvement.

- Predictive reporting will be developed with a focus on looking ahead at potential risks ensuring corrective actions are implemented before any KPI fails.
- Performance conversations should focus on identifying root causes rather than symptoms, and participants should be focused on how performance can be improved.
- It is important to reinforce desirable behaviours with recognition and consequences for performance.
- Divisions operate within a devolved clinical structure remaining directly accountable for the quality of services delivered to patients within an agreed financial envelope.
- Single performance conversations that ensure delivery of a balanced set of indicators by avoiding unintended consequences of focus on single domains
- Corporate teams remain directly accountable for the delivery of financial and workforce indicators for their direct reports and will utilise their capacity to support clinical divisions in the successful delivery of their plans.

At all times the four pillars will be the underpinning behaviours for all performance improvement work and will be conducted using the improvement methodology of '3Rs'.

Within a single accountable officer structure it is essential that the role of Divisional Director/Clinical Director is clear and it is understood that this is accountability for the integrated clinical, operational, quality and financial performance of the Division/Directorate through this clinical leadership model. In conjunction with this accountability it is the responsibility of the Director of Operations to oversee the delivery of performance within and across Divisions. They will be supported in this responsibility by Divisional, Directorate and corporate colleagues. For clarity the Directors of Operations and General Managers are responsible for day-to-day delivery of performance whilst accountability falls to the Divisional Director/Clinical Director.

Decision making/levels of autonomy measures will be determined after each Performance Review Meeting (PRM) and Divisions are expected to apply the same to Directorates.

6. Roles and Responsibilities

Effective performance management relies on clear and defined responsibilities of individuals and teams within the Trust.

This also translates into objectives and the appraisal process as appropriate.

6.1. Trust Board

The Board has responsibility for assurance or is to be assured that the Trust is delivering services, corporate responsibilities and its plans. Whilst it is everyone's job to manage performance, the Board must drive a culture of performance by providing a clear vision and Trust priorities. The Board must hold the Executive Team to account for the delivery of Trust strategy and plans, including financial plans, ensuring that risks are identified and mitigated.

The Board will receive and consider the IPR at each Trust Board meeting.

The Board also delegates authority throughout the Trust's governance hierarchy for driving and monitoring delivery of objectives, and for holding to account responsible officers.

6.2. Board Members

There are seven Non-Executive Directors on the Board, which includes the Chair of the Trust. The Board also has six Executive Directors including the Chief Executive and three non-voting Directors.

The **Non-Executive directors** will assure themselves of performance by holding the Executive Directors to account for the achievement of the agreed goals, objectives, targets and measures whilst receiving adequate information and monitoring the reporting of performance. They will support this with regular 'go see' visits to areas.

Governors

As a Foundation Trust we have a Council of Governors. The three main functions of the Council of Governors are:

- Holding the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors;
- Communication with their member constituencies and the public and transmitting their views to the Board of Directors; and
- Contributing to the development of forward plans of NHS Foundation Trusts

The Council of Governors is an important link for the Trust with its local community. This is a fundamental part of being a Foundation Trust, helping us to be more responsive to local needs.

The Council of Governors, which is responsible for the appointment and re-appointment of Non-Executive directors, should take the lead on agreeing a process for the evaluation of the Chairperson and the Non-Executives, with the Chairperson and the Non-Executives.

The Council of Governors should assess its own collective performance and its impact on the NHS Foundation Trust.

6.3. Chief Executive

The Chief Executive has overall statutory responsibility for performance and how it is managed and is accountable to the Trust Board.

The Board has delegated responsibility for Performance and how it is managed to the Chief Operating Officer and to discharge this responsibility, they work with the Executive Directors to ensure effective performance management arrangements are in place across the Trust.

6.4. Executive Team

The Chief Operating Officer leads this element of the Executive agenda however all Executives have collective responsibility for the performance management of the Trust against agreed performance indicators. They are the leads for the strategic objectives and key performance indicators that link to their portfolio. The Executive Team is responsible for providing assurance that Divisions have adequate processes in place for performance delivery, provide support and guidance where there are challenges to delivery and take corrective action where required. The Executive Directors will attend regular Performance Review Meetings at Divisional level to gain assurance on delivery and facilitate performance improvement (where necessary) and

undertake go see's for added assurance. They will work as a team led by the Chief Operating Officer (for performance issues) to form the agenda for each Divisional Performance Review Meeting ensuring regular attendance to enable a consistent approach, continuity for the divisions and the agreement of improvement plans in the single meeting. This will also prevent repetition and overlapping agendas at other fora.

The Director of Transformation & Partnerships and the Managing Director of Digital Health will attend when there is a relevant agenda item required by them or a request for them by the Division.

The Board of Directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.

6.5. Medical Director

Lead for driving professional clinical responsibility in delivering key performance indicators within the Effective domain and integrating quality priorities as part of the quality and safety agenda. They are responsible for the professional application of these within the Medical workforce.

6.6. Chief Nurse

Lead for driving professional clinical responsibility in delivering key performance indicators in the Safe and Caring Domains and integrating quality priorities as part of the quality and safety agenda. They are responsible for the leadership of the CQC programme and for the professional application of these within the nursing and allied health professional workforce.

6.7. Director of Finance

The Director of Finance has clearly defined accountabilities for financial probity set out within the Trust's Standing Financial Instructions with which the PMAF has clear alignment alongside the scheme of reservation and delegation. The Director of Finance has delegated authority to ensure that there are robust systems and controls to ensure delivery of the Trust's financial forecasts and cost improvement programme plans.

6.8. Chief Operating Officer

The Chief Operating Officer has delegated responsibility from the Executive Team for ensuring effective performance management arrangements are in place across the Trust through the development, implementation and ongoing management of the PMAF. The Chief Operating Officer is responsible for ensuring robust systems are in place for monitoring performance against regulatory, contractual and internal performance indicators (including the development of the Integrated Performance Report).

They have responsibility for the professional application of these within the operational management workforce including the Divisional Directors.

6.9. Director of Workforce and OD

Leads the development and implementation of the Individual Performance Review Process that aligns the contribution made by individual staff to delivering performance.

Leads on workforce strategy and planning and organisational development including training and talent management. Leads on the Trust's response to the Full People Plan and the 'balanced scorecard' as part of the NHS Oversight Framework.

Leads on the development of the Organisational Development Strategy (The Cupboard). 'The Cupboard' is focussed on "one culture of care", providing compassionate care for everyone encompassing: Talent Management; Workforce Design; ED&I; Health and Wellbeing; WTGR; CSR; Colleague Engagement.

6.10. Managing Director – Digital Health

To ensure the provision of accurate performance data and lead on Digital Maturity developments as part of the new Digital Health Strategy.

6.11. Director of Transformation and Partnerships

Leads the development and delivery of complex transformation programmes, specifically the reconfiguration programme to the divisional Performance Review Meeting agendas. Also overseeing the implementation and progress of the 12 "Business Better Than Usual" learning themes. Plays a key role in the incorporated engagement with partner stakeholders to ensure fit with place and West Yorkshire ambitions as part of the ICS developments which will impact on performance and commissioning.

6.12. Corporate Functions

Corporate functions provide support to Divisions whilst the Executive team have collective responsibility for the performance management of the Trust including clinical divisions.

6.13. The Health Informatics Service (THIS)

External customers – THIS has an Executive Board (attended by a CHFT Non-Executive) that reviews the whole THIS position including both internal and external business. Minutes are shared with the Finance and Performance Committee.

Internal CHFT SLA – The SLA agreed is signed off through normal business planning processes and monitored bi-monthly at the Health Informatics Service Board chaired by the Director of Finance. Minutes are shared with the Finance and Performance Committee

THIS is responsible for supporting the data collection within the monthly Integrated Performance Report including the establishment of feeder systems to collate information. It will ensure timely analysis, quality assurance and interpretation of performance data for performance review and follow-up purposes.

6.14. Calderdale & Huddersfield Solutions Limited

A subsidiary of Calderdale & Huddersfield NHS Foundation Trust, CHS provides estates, facilities and procurement at the Huddersfield site. At Calderdale, ISS provide facilities and Engie provide estates services.

A quarterly Joint Liaison Committee chaired by the Director of Finance which reports to the Finance and Performance Committee has been established as a partnership arrangement between CHFT and CHS which monitors the performance of CHS against the Operated Healthcare Facility Agreement (the Contract) to ensure delivery of the agreed service specifications and approve any variations to the SLA.

6.15. PFI Partner

CHFT/PFI Quarterly Contract Meeting with PFI partner, ENGIE and ISS chaired by Director of Finance and minutes shared with Finance and Performance Committee. Performance is managed through the SLA.

6.16. Pennine Property Partnership

Pennine Property Partnership is a Joint Venture company and was established with CHFT to facilitate viable investments and better serve the local area. This alliance was initially set up to redevelop Acre Mill. This arrangement is governed via the CHFT/Pennine Property Partnership Board chaired by the Director of Finance which reports to the Finance and Performance Committee.

6.17. Huddersfield Pharmacy Specials (HPS)

HPS Management Board chaired bi-monthly by the Director of Finance which reports to the Finance and Performance Committee has an overall responsibility to oversee the operations of HPS, ensuring that the unit continues to develop, manufacture and supply unlicensed and licensed medicines meeting the requirements of Good Manufacturing Practice, while maintaining the agreed level of contribution to the Trust.

6.18. Board Committee Structure

Whilst the Board of Directors is responsible for the day-to-day management of the Trust and is ultimately accountable for the operational delivery of services, targets and performance, it delegates powers to Board Committees which report to it via Board meetings. These Committees are responsible for the effective governance of the organisation.

The Trust has the following Board Committees

- **Audit and Risk Committee** reviews the effectiveness of risk management and the system of internal control, governance and overall assurance processes across the whole of the Trust's activities that support delivery of the Trust's services and achievement of objectives. This Committee also ensures effective internal and external audit.

- **Quality Committee** provides assurance to the Trust Board and Audit and Risk Committee, via the Quality Committee Chair, that adequate controls are in place to monitor the quality and safety of care for patients across all services.

- **Finance and Performance Committee** scrutinises the financial risks and targets and monitors any significant risks to activity and performance, with oversight of operational performance targets. The Committee is responsible for ensuring that there are robust financial performance reporting systems in place and receiving reports from the Joint Liaison Committee in line with the governance framework between the Trust and senior leadership of the Trust's wholly owned subsidiary, Calderdale and Huddersfield Solutions Limited, CHS.

- **Workforce Committee** reviews workforce matters and provides assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management, recruitment and retention and health and wellbeing.

- **Transformation Programme Board** oversees the development and delivery of complex transformation programmes in the Trust, specifically the reconfiguration programme. It also oversees implementation and progress of the 12 "Business Better Than Usual" (see appendix C) learning themes identified from new ways of working implemented during the pandemic.

6.19. Data Quality Board

Underpinning data quality assurance systems have significantly developed with continued improvements to the data quality systems and processes.

The Trust has in place policies to assure the Board on a range of issues to ensure quality care is provided to patients. Systems and processes are in place to assure data accuracy and validity into the Board ensuring there is robust ward to Board assurance on the quality of care we deliver. Policies and Standard Operating Procedures to this effect are reviewed on a regular basis.

Assurance that the performance data used within the Trust and reported by the Trust is of a high standard has been via the Trust Data Quality Board, which reports to the Audit and Risk Committee with escalation into a weekly meeting of Executive Directors as appropriate. A Data Quality Group, which meets monthly and reports into the Data Quality Board, focuses on specific data quality measures from both a corporate and service position.

The recently approved Data Quality Policy relates to all areas of data produced by the Trust. High quality data is a fundamental requirement for CHFT to conduct its business efficiently and effectively. It enables the delivery of the Trust's 4 pillars and is central to the Trust's on-going ability to meets its statutory, legal, financial and other contractual requirements.

6.20. Divisional Management Teams

Divisional Management Teams are responsible for the delivery of agreed levels of performance through the monitoring and reporting of relevant indicators via a divisional Integrated Performance Report. Where delivery requires input from more than one Division there will be joint responsibility and accountability for performance.

Divisional Management Teams will ensure rigorous performance monitoring, support and

learning arrangements within their division ensuring clear triangulation of all KPIs which will inform the narrative and answer the “so what” question within the Integrated Performance Report.

Divisional Management Boards will apply the framework within Divisions to assure and support Directorates in the delivery of performance providing evidence of plans and the delivery of effective actions to improve performance.

6.21. Directorates

Directorates are responsible for the delivery of services and associated KPIs in line with Trust and Divisional plans and priorities. They will address issues to avoid undesirable impacts on all aspects of performance, escalate areas of risk with accompanying mitigations.

Clear triangulation of all KPIs with specialty/directorate context will inform a narrative around each service.

6.22. Assistant Director of Performance

Responsible for co-ordinating the criteria and maintenance of the monthly Integrated Performance Report and facilitating the bi-monthly Performance Review cycle. Also responsible for the annual review of the Integrated Performance Report.

Supports deep-dive work with divisions/services struggling to achieve sustainable high-level performance.

Works with THIS and Programme Management Office in the benchmarking of all performance indicators and any wider Benchmarking programmes

Leads the provision of the triangulation of narratives to support the Integrated Performance Report working with the Deputy Director tier.

6.23. Deputy Director Group

The Deputy Directors sub-group will meet monthly and use collective thinking to support the performance cycle and development of a single combined narrative that seeks to triangulate current performance for greater Board assurance. The group will also need divisional presence to ensure a clear interface with the divisional senior management teams.

This will also form the trigger for any deep-dives for poor performing areas and will support the SWOT analysis within the Integrated Performance Report which will also give context and be informed by divisional level triangulation as part of their own Integrated Performance Reports.

This group will ensure learning is embedded into performance delivery.

6.24. All staff

Every member of staff contributes towards effective performance management and improvement. Staff should own the data related to the service within which they work and

understand how it translates to the performance of the organisation. Good performance means patients are getting the safest service with the best experience, colleagues are well supported in the delivery of their role and the Trust balances its finances. This integrated view of performance is the foundation of success at all levels.

Individual appraisals and objectives will focus around the health, wellbeing and contribution of staff towards the overall Trust strategy.

7. Reporting arrangements

Board-level

The monthly Integrated Performance Report is provided to the Board, to support it in its role of holding Executive Directors to account for the Trust's performance. A formal Trust Board is held bi-monthly. The IPR will be accompanied by the triangulation narrative. A formal timetable will be shared with divisions and Deputy Directors to clarify their responsibilities around information and narratives to support the population of the Trust-level Integrated Performance Report.

Sub-Committees of the Board

Good corporate governance is 'the means by which boards lead and direct their organisations so that decision-making is effective, and the right outcomes are delivered'. The committees of the Board are designed to ensure that the Trust has the appropriate controls and governance mechanisms in place to deliver these outcomes with more focus on the detail. The committees should provide assurance to the Board that these mechanisms (which support effective performance delivery) are in place. The monthly Integrated Performance Report is shared with all relevant sub-committees for their agendas.

Divisional Performance Review Meetings (PRMs)

Performance review meetings will continue on the basis that they are bi-monthly with the frequency then driven by their performance rating. These are the single point for all performance related discussions with Divisions allowing for the triangulation of the various domains and the avoidance of the interdependencies of decisions being missed causing further performance issues.

The Chief Operating Officer (COO) is responsible for organising and leading the review meetings, supported by the Assistant Director of Performance. The 5 Executive Board Directors will attend all meetings with the Director of Transformation and Partnerships and Managing Director for Digital Health joining where required by either themselves or the Divisions. Deputies should only attend in exceptional circumstances.

This forum provides the Executive Team with the opportunity to gain assurance that Divisions are formally monitoring and managing all areas of performance, holding the Directorates to account for delivering all necessary corrective actions. The meetings provide a formal opportunity for Divisions to share successes, concerns, escalate risks and work through complex issues.

To enable this to happen effectively, a process for reporting exceptions is used. In summary, this requires the Performance and Information Leads to provide the Divisions with their own Integrated Performance Report at Directorate level, who will, using the 3 Rs methodology

provide the required detail and assurance of the corrective actions required to bring performance back on track. The Divisional Integrated Performance Report should be provided to the Executive team in advance of the performance meetings.

The Divisional Performance Review Meetings will enable robust discussions to take place on performance issues where assurance is a concern, with a focus on root causes and solutions (rather than symptoms). The required recovery plans, resources and support will be agreed at the performance review meetings and risks and issues will be escalated to the Board, by exception, appropriately.

It is expected that a similar performance management framework will be used within the Divisions for management of departments and services that covers the full set of domains.

Meetings with Divisions will have clear terms of reference (Appendix E) and all agendas will include:

- A review of progress against the Divisional Strategy
- Health Inequalities
- Quality priorities
- Risk profile
- Regulatory Standards including budgetary controls
- Wellbeing
- In 2021/22 – Recovery
- ICS partnership developments (internally and externally)

Additional agenda items will be requested from Divisions and all Directors 14 days before and the agenda will be finalised and circulated 10 days before the meeting. The person requesting the agenda item has responsibility to ensure the requirements from Divisions or Directors are explicit at agenda setting.

Where agenda items cross Divisions, the person requesting the agenda item will be responsible for ensuring appropriate cross-Divisional representation.

Divisions will provide a slide pack responding to each agenda item including a Position Statement to address actions from the previous meeting. These completed packs will be circulated to the Executive 3 - 5 days before the review meeting and will be discussed at the PRM pre-meeting attended by the Executive Team together with the Assistant Director of Performance.

It is expected that the Divisional Board of Divisional Director, Director of Operations, Associate Director of Nursing, Divisional Finance Manager and HR Business Partner all attend the review meetings.

The Assistant Director of Performance will connect the information from Performance Review Meetings and the Deputy Directors' triangulation meetings to ensure consistency.

The performance reviews are the core component of the accountability framework with the level of delegated autonomy and frequency of performance reviews determined by the position of the Division across the agreed metrics grouped to reflect the CQC domains. The matrix is structured to facilitate variable levels of autonomy for each domain.

Post-PRM the Executive Directors will determine the level of autonomy for each Division. The level a Division is placed in would reflect Executive judgement of the scale, seriousness and complexity of the issues it faces. This will be based on:

- considering all available information on Divisions;
- identifying Divisions with a potential support need in one or more themes;
- using Executive judgement, based on relationship knowledge and/or the findings of formal or informal investigations and/or analysis; and
- review of third-party feedback.

	Rating	**Level of Autonomy**
1	Maximum Autonomy	Quarterly performance review
2	Targeted Support	Performance Reviews every other month
3	Mandated support for significant concerns	Monthly Performance Reviews
4	Internal 'Special Measures'	Weekly Performance.

Where Divisions demonstrate effective and sustained financial balance, they will have autonomy for vacancy management working within the principles of business planning and consistent with their agreed annual plans.

Where required Divisions may move into escalation on a single domain increasing the frequency of meetings which will be with the appropriate Director lead. For such single domain escalation, the frequency of review and attendance at the meetings will be determined by the Director lead. Updates on progress will be included in the formal PRM.

Where Divisions are consistently performing on a single or collection of domains the frequency of review of these domains will be reduced in line with the levels of autonomy whilst PRMs may remain alternate months.

Clinical and corporate Divisions and/or individual services may be asked to attend a Board Sub-committee, Weekly Executive Board or the Board of Directors due to further escalation of concerns, to celebrate success or where a wider learning opportunity has been identified. This will be agreed by the Executive Directors following Performance Review Meetings.

Divisions in level 1, performing well, may be asked to receive a 'go see' from areas who can learn from them. Divisions/services in other areas may utilise the 'Go see' pillar internally or externally to learn.

Directorate level

The Divisions are expected to replicate these arrangements with all Directorates; supported by service line management reports.

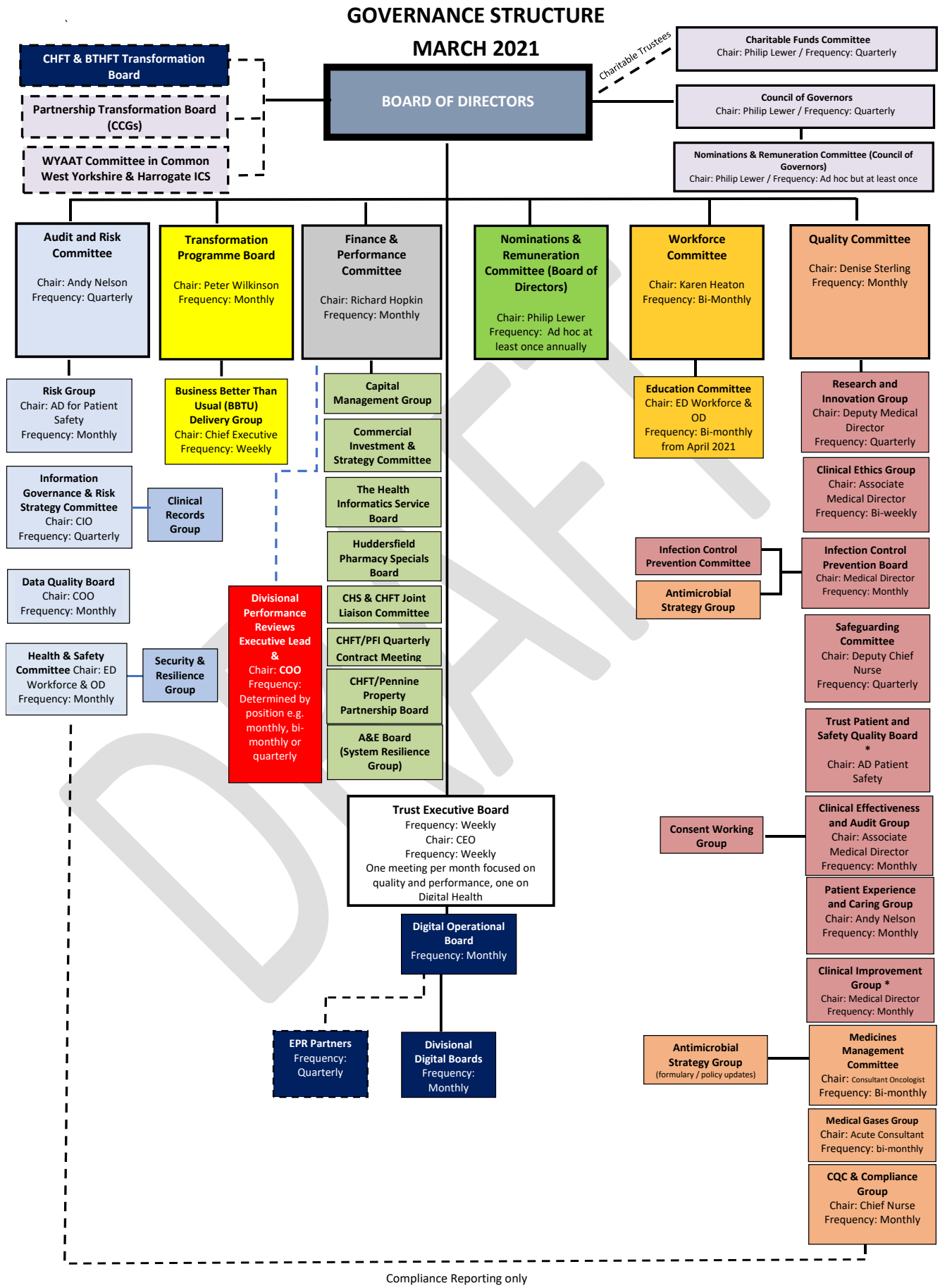
Weekly Performance Management

On a weekly basis an agreed set of KPIs are circulated and will be discussed within the 1:1s between the COO and Directors of Operations. This will be replicated at Divisional level to ensure a proactive not reactive approach to performance improvement. There will be a move to this being managed through the use of KP+ once front-end dashboards are in place.

Themes and learning from PRMs and proactive management will be collated and shared through the weekly Leadership forum, nursing forum and Medical workforce briefings.

The fora are open to all interested colleagues but as a minimum all Directorates and relevant corporate departments will send an appropriate representative to the Leadership forum who will be responsible for further communications and actions as identified.

Appendix A



Appendix B

The external landscape and new role of the Integrated Care System (ICS)
Department Health and Social Care white paper: Integration and Innovation
There are a series of practical changes which will need to be in place by April 2022 at the latest, to make a consistent transition to system working focused on further devolution to systems, greater partnership working at place and closer collaboration between providers on a larger footprint.

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) is the fourth largest Integrated Care System in the country, covering a population of 2.7 million people. It is made up of NHS organisations, councils, Healthwatch, social enterprises, charities, community and voluntary organisations, which collectively employ over 100,000 colleagues.

It is a mature partnership formed in 2016, built on strong place arrangements, mature provider collaboratives and inclusive and transparent system leadership arrangements. The 5-year plan 'Better Health and Wellbeing for Everyone' published in 2019 sets out what is collectively important to the partnership, and COVID-19 response has further strengthened relationships.

NHSE/I proposals are for ICSs to be established to include an NHS body and a Health and Care Partnership.
The Health and Care Partnership will:

- Be responsible for developing a plan that addresses the wider health, public health and social care needs of the system, with the NHS ICS board and local authorities having to regard that plan when making decisions

The NHS body will:

- Be responsible for strategic planning, taking on the commissioning functions of CCGs and be directly accountable for NHS spend and performance within the system, with its chief executive becoming the accounting officer for NHS money allocated to the NHS ICS body
- Be responsible for developing a plan to meet the health needs of the population within their defined geography; developing a capital plan for the NHS providers within their health geography; and securing the provision of health services to meet the needs of the system population.

Place level working will continue to be critical in the future.

- Place-based arrangements between local authorities, the NHS and providers of health and care will be left to local organisations to arrange.
- The statutory ICS will work to support places to integrate services and improve outcomes.
- Health and Wellbeing Boards will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.
- Strong emphasis on collaboration rather than competition as a key driver of improvement.
- Duty to collaborate – between NHS partners and NHS and local authorities
- Continued emphasis on provider collaboration – both across system and in place.
- It will be made easier for organisations to work closely together through joint committees – operating at place and system.
- There will be new powers for the Secretary of State for Health and Social Care over the NHS and other arm's-length bodies (ALBs):
    - to intervene in service reconfiguration changes at any point without need for a referral from a local authority

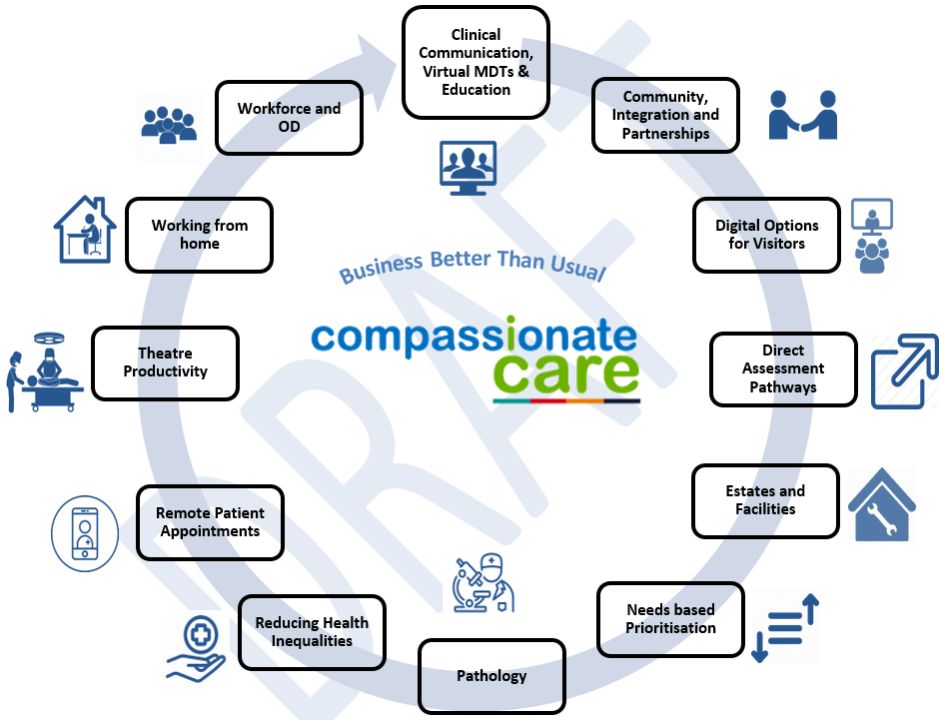
    - to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation.
- Statutory duty for Secretary of State to publish a report in each parliament on workforce planning responsibilities across primary, secondary and community care, as well as sections of the workforce shared between health and social care
- Section 75 of the Health and Social Care Act 2012 (including the Procurement, Patient Choice and Competition Regulations 2013) will be repealed and replaced with a new procurement regime.
- NHS England and NHS Improvement will be merged.

There are a number of workstreams proposed that will support the change to these new arrangements.

Appendix C

Business Better Than Usual

Through the involvement of colleagues, partner organisations and members of the public 12 learning themes were identified during the early months of the pandemic where there was agreement that new ways of working implemented during the pandemic have potential long-term benefit and should be sustained and amplified. The 12 themes are shown in the diagram below.



The learning in the first 12 months of the pandemic must inform future service delivery models to embed and sustain the examples of positive transformation and enable the future delivery of 'Business Better than Usual'. It is also important that this learning informs transformation programmes of work that were already in progress prior to the COVID-19 pandemic, such as the CHFT ten-year digital strategy and the reconfiguration of hospital services.

CHFT has established a 'Business Better than Usual (BBTU) Executive Group'. The BBTU Executive will performance manage the Trust's BBTU Programme ensuring that all agreed activity supports place-based and ICS partnership working on system wide recovery from the pandemic and achievement of the Trust's strategic goals and operating plan.

The BBTU Executive meets on a weekly basis. Membership includes all CHFT Directors and the group will be chaired by the Chief Executive. There is a named Director Sponsor for each of the BBTU learning themes who is accountable for delivery against agreed milestones. The Trust's Programme Management Office (PMO) provides support.

The BBTU Executive provides regular updates and assurance to the Trust's Transformation Programme Board on the implementation of the Business Better than Usual Programme in relation to quality and use of resources. The BBTU Executive ensures that key enabling workstreams relevant to the programme are established and supported such as informatics (business intelligence) and digital technology and infrastructure.

Appendix D

Update to the Integrated Performance Report (IPR)

The refreshed Performance Management and Accountability Framework (PMAF) references an update to the IPR which will include the development of a single combined narrative that seeks to triangulate performance for greater Board assurance. This will be informed by divisional level triangulation as part of their own directorate level IPRs. The following changes will be incorporated into the IPR for 2021/22.

Contents	**2021/22**
Performance Summary →	No Change
Key Indicators →	SPC Charts
Executive Summary →	Replaced by SWOT
Domains	**2021/22**
Safe – Quality Priorities →	Renewed Input
Caring – Quality Priorities →	Renewed Input
Caring – What our patients are saying →	Reintroduced
Effective – Readmissions by CCG →	Removed
Effective - Outcome Measures →	Appendix Quarterly
Responsive →	No Change
Hard Truths →	Reworked
Workforce →	No Change
Financial Summary →	No Change
Benchmarking	**2021/22**
Benchmarking Selected Measures →	Appendix Quarterly
Activity and Finance	**2021/22**
Efficiency →	Trigger points to reintroduce during Recovery
Activity →	Recovery

Appendices	**2021/22**
ASI/COVID/Referrals/Fast Track Cancer/A&E →	Recovery
Cancer by Tumour Group →	Removed
Performance Method/Glossary →	Reading Room

Recovery Framework

A separate area of the IPR will be dedicated to Recovery and Stabilisation for the period of the Recovery framework. This will include a trajectory for recovery of backlogs. The modelling work for Outpatients, Inpatients and Diagnostics will form the basis of any trajectory and will ensure that we are clear on what success looks like and can track it as part of our performance management of Recovery. Referral rates and how activity, both elective and non-elective, and capacity are managed will be crucial to our delivery.

Recovery	**2021/22 Detail**
Modelling trajectories	All Points of Delivery
Backlogs trajectories	All waiting list types
Activity trajectories, thresholds	Modelling and Financial
Demand	
Referrals	GP and other
Cancer Fast Track Referrals	Specialty
Non-elective	Specialty
Diagnostics	All Modalities
Capacity	
Operating sessions/theatres	Specialty
Patients per session	Specialty
Sickness	Division
Staff with HWB assessment	Division
Covid numbers	Progress
Children	
Community	
Health Inequalities	**Detail**
Continuity of Carer	
Learning Disabilities	Waits
BAME/Non-BAME	Waits
IMD	Waits
Digital Exclusion	

Appendix E

Performance Review Meetings – Terms of Reference

Performance Review Meeting (PRM) – Terms of Reference

Purpose

To Provide Assurance on the delivery of financial and non-financial performance within Divisions and to provide support to Divisions for areas of continued challenge.

Responsibilities

- To gain assurance that Divisions are formally monitoring and managing all areas of performance, holding the Directorates to account for delivering all necessary corrective actions.
- To ensure that the Trust has appropriate performance objectives and a robust strategy for delivering them.
- The required recovery plans, resources and support will be agreed at PRMs and risks and issues will be escalated to the Board, by exception, appropriately.
- It is expected that a similar performance management framework will be used within the Divisions for management of departments and services that covers the full set of domains.
- To provide a formal opportunity for Divisions to share successes, concerns, escalate risks and work through complex issues.

- In addition to the standard agenda items any additional agenda items will be requested from Divisions and all Directors 14 days before and the agenda will be finalised and circulated 10 days before the meeting.
- The divisions will provide a slide pack responding to each agenda item including a Position Statement to address actions from the previous meeting. These completed packs will be circulated to the Executive 3 - 5 days before the review meeting and will be discussed at the PRM pre-meeting attended by the Executive Team together with the Assistant Director of Performance.
- No papers will be tabled at the meeting or included under any other business unless by the authority of the COO.
- Post-PRM the Executive Directors will determine the level of autonomy for each Division as per the CHFT framework for Earned Autonomy. The level a Division is placed in would reflect Executive judgement of the scale, seriousness and complexity of the issues it faces.

Structure

Membership

- Chief Operating Officer
- Director of Finance
- Assistant Director of Performance
- Chief Nurse
- Medical Director
- Director of Workforce and OD
- Other directors where required
- Divisional Director
- Director of Operations
- Associate Director of Nursing
- Divisional Finance Manager
- HR Business Partner

Chair – Chief Operating Officer
Vice Chair - Director of Finance
Other colleagues may be invited to attend for specific agenda items.

Quorum

- Minimum of 3 Directors and 3 members of the Divisional Board
- Where Directors cannot attend a deputy must be provided
- Within Divisions Nominated Deputies should only attend in exceptional circumstances
- Members must attend at least 75% of meetings per annum

Frequency

- Bi-monthly but may change reflecting performance rating

Reporting

Decision-making: This is a decision-making forum
Authority: The meeting has authority to make decisions in line with agreed responsibilities. Decisions of significance will be presented, with recommendations to the Finance & Performance Committee
Reporting Strategy: Summary reporting into Finance & Performance Committee.
Escalation: As required into the Quality & Performance Weekly Executive Board
Admin support: All meetings will take place via teams and actions will be collated and reported back in letter format by the Assistant Director of Performance. Performance and Information Leads will provide the Divisions with their own Integrated Performance Report at Directorate level, who will provide the required detail and assurance of the corrective actions to bring performance back on track. PRM letter will be distributed within 2 weeks following the session.
Governance : The meeting provides a single forum for performance oversight across the integrated scorecard and determination of the level of autonomy for Divisions

21. Governance Report

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

b) Compliance with Licence Conditions

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

d) External Development Review of Leadership and Governance

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

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

g) Board of Directors Workplan 2021/22

h) Use of Trust Seal

i) Council of Governors – Staff Vacancies and Election Timetable

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 6 May 2021
Meeting:	Public Board of Directors
Title of report:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsor:	Owen Williams, Chief Executive
Previous Forums:	None

Purpose of the Report

This paper presents the following governance items to the Board:

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

b) Compliance with License Conditions

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

d) External Development Review of Leadership and Governance

e) Board of Directors Attendance Register – for the annual report and accounts 2020/21

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

g) Board of Directors Workplan 20212/22

h) Use of Trust Seal

i) Council of Governors – Staff Vacancies and Election Timetable

Key Points to Note

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

The Trust Constitution sets out regulations for how we operate as a Foundation Trust. It provides authority and guidance for the composition of the Board and the Council of Governors and includes Standing Orders for both the Council of Governors and the Board of Directors.

A review of the Constitution has taken place following the last review during 2019 to ensure the Constitution is current and reflects any changes across the NHS and advice received regarding any issues that have arisen. Following approval by the Council of Governors on 22 April 2021, the changes to the Constitution are detailed below for the Board of Directors for approval, with the full Constitution available in the Reading Room

Material changes to the Constitution proposed include:

- *Section 14.3* - removal of the reserve register for governors - during the Covid pandemic the Trust sought advice on use of the register and was advised by NHS Providers that the Trust should not be operating a reserve register arrangement. The option for using a reserve register to fill vacant governor posts after election is therefore proposed for removal.

- *Annexe 1 - Introduction of a Rest of England constituency* with a publicly elected governor post(s) - with an increasing focus on local health care organisations and partners working together in an integrated system, and proposed Health Bill to legislate for this in 2022, the Council of Governors have supported the proposal to introduce a "rest of England" constituency, in line with many Foundation Trusts, which allows out of area members to join the membership and be elected as a governor. Whilst this will be written into the Constitution now, work will take place to recruit members from this constituency during 2021 to enable elections for a public governor to take place in 2022, as elections are held with members of the constituency voting.

- *14.1.5 - Governor tenure* - the Trust has been reviewing the position on whether governors who have served their maximum tenure period of 6 years are eligible to re-stand for election after a gap through discussion with other Trusts and NHS Providers. There is some variation in practice amongst Trusts and, having considered the options it is proposed that publicly elected governors are able to re-stand for election after a 2 year gap.

Standing Orders of the Council of Governors

The following changes to the Standing Orders of the Council of Governors were also agreed on 22 April 2021 and are presented to the Board for approval:

- *Section 2.1* – Addition of wording that reflects meetings may be held virtually or in person.
- *Section 12* - Minutes - additions of sections 12.4 and 12.5 regarding recording of attendance and apologies.
- *Section 18* - termination of a governor - confirmation that a governor who has been terminated is not eligible to re-stand for election for a period of 2 years from the date of removal from office.
- Integrated Care System (ICS) references added.

RECOMMENDATION: The Board is asked to **APPROVE** the changes detailed above to the Trust's Constitution and Standing Orders of the Council of Governors.

b) Self-certification of Compliance with License Conditions

Each year NHS England / Improvement (NHS E/I) requires all Foundation Trusts to complete a number of self-certifications to provide assurance that the Trust is compliant with the conditions of their NHS provider licence or provide explanatory text where this is not the case.

The purpose of this paper is to seek Board approval of the enclosed self–certification schedules for 2020/21 at Appendix N2 and N3. Self -certification relates to the following three conditions:

- *Compliance with governance requirements* - condition FT4 (8) relates to compliance with systems and processes for good governance and forward compliance with the governance condition for the 2021/22 financial year and any risks. Compliance is confirmed in Appendix N2.

- *Compliance with provider licence* - the Trust is confirming compliance with condition G6 (3) which relates to effective systems to ensure compliance with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, the Health and Social Care Act 2012 and have regard to the NHS Constitution) - this is detailed at Appendix N3.

- *Available resources if providing commissioner requested services* - condition S7 (CoS7 (3)) relates to continuity of Service and having the required resources available for the next 12 months. The Trust is confirming that it has a reasonable expectation that resources will be

available for 2021/22 subject to the factors detailed in the return which is enclosed at Appendix N3. This is because the Trust remains in breach of its licence, for the availability of resources certification (CoS7) the Trust is declaring that it has a reasonable expectation to have the required resources available (declaration 3b) and the factors relating to this are stated in the return. This is consistent with the response that the Trust has given over the previous financial years whilst in breach of the licence.

The self-certification documents confirms Trust compliance with governance (FT4) and the provider licence condition G6 (3).

Condition	Description	Internal Assurance Process
FT4 (8)	Compliance with systems and processes for good governance and forward compliance with the governance condition for the 2020/21 financial year and any risks.	Confirmed - compliance is confirmed in the attached Appendix N2. Evidence of compliance with Code of Governance reviewed at Audit and Risk Committee 12 April 2021. Governor training confirmed by lead governor on behalf of the Council of Governors 26 April 2021.
G6 (3)	Trust compliance with its NHS provider licence, NHS acts and NHS constitution.	Confirmed - see Appendix N3
G6 (4) Publication	Publication of condition G6(3) self certification	To be added to Trust website by 30 June 2021
Condition CoS7(3)	Continuity of Service and having the required resources available for the next 12 months for providing commissioner requested services	Narrative by Deputy Director of Finance based on 2021/22 position and ongoing oversight of financial position by Finance and Performance Committee (see N3)

RECOMMENDATION: The Board is asked to **APPROVE** the content of the self-certification documents for the signature of declarations.

c) Delegation of authority to the Audit and Risk Committee for sign off of annual accounts 2020/21

For 2019/20 due to the Covid-19 pandemic and changes to the national annual accounts and reporting timeline the Board agreed delegation to the Audit and Risk Committee for the end of year sign off processes to the Audit and Risk Committee.

As part of continuing to work in a streamlined way it is requested that the Trust Board delegate to the Audit and Risk Committee the sign off of:

- 2020/21 audited annual accounts
- 2020/21 annual report.

The Chair will attend the meeting and the Chief Executive will attend for the Annual Governance Statement item.

The current date planned for the Audit and Risk Committee approval of the audited annual accounts, annual report is 10 June 2021, subject to Board approval for this delegation.

RECOMMENDATION: The Board is asked to **APPROVE** 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

All NHS Trusts are encouraged by NHS England/ NHS Improvement to undertake an externally facilitated well-led review of leadership and governance every three to five years using the well -led framework which has eight key lines of enquiry (KLOEs). The purpose of the review is to identify areas for further targeted development work. The KLOEs include leadership, culture, system-working and quality improvement, integrated quality, operational and financial governance.

The Trust commissioned a well-led governance development review from Aqua, (Advancing Quality Alliance) which began in 20219/20. Three phases of work took place which are now complete. The three phases were:

- Phase one - self-assessment against the well-led domains, a Board level questionnaire and key internal/external stakeholder interviews.
- Phase two - well-led mapping review and identification of developments and areas for improvement
- Phase 3 - an observation report based on the November 2020 and January 2021 Board meetings

The reviews have been shared with Board members and identified good practice and recommendations which are being progressed to enable the Board to continue to develop its leadership and governance arrangements and secure and sustain future performance. Further discussion will take place at a forthcoming Board development session.

RECOMMENDATION: The Board is asked to **NOTE** 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 are asked to check the record of attendance at the Board meetings from 1st April 2020 to 31st March 2021 and advise of any discrepancies, following which they will be published in the Annual Report and Accounts in June 2021. This is detailed at Appendix N4.

RECOMMENDATION: The Board is asked to **NOTE** the Board of Directors Attendance Register which will be published in the Annual Report and Accounts 2020/21and 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 require ratification by the Board and are therefore presented for approval.

The Standing Orders, Standing Financial Instructions and Scheme of Delegation are three important policy documents which are intrinsically linked in their application.

Standing Orders

The changes approved by the Audit and Risk Committee regarding the addition of roles and responsibilities of the Board of Directors at section 1.1 and addition in the declaration of interests and register of interests session regarding compliance with the Fit and Proper Persons requirement at section 5.

The Standing Orders of the Board of Directors are included as Annexe 8 to the Trust Constitution. Once approved the amended version will replace the existing Standing Orders of the Board of Directors within the Constitution.

Standing Financial Instructions (SFIs)

The Audit and Risk Committee approved minimal changes to the overall SFI policy, with a review of the contract and tendering procedures due to the UK leaving the European Union. The documents with tracked changes for the information of the Board are in the review room.

Scheme of Delegation

The Audit and Risk Committee approved the minimal change to the Scheme of Delegation with reference to the Drugs and Therapeutics Committee amended to reflect the name of the Committee authorising new drugs which is the Medicines Management Committee.

RECOMMENDATION: The Board is asked to **APPROVE** the changes to the Standing Orders, Standing Financial Instructions and Scheme of Delegation.

g) Board of Directors Workplan 2021/22

The business cycle for the Board for 2021/22 is attached as Appendix N5. 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.

h) Use of Trust Seal

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

RECOMMENDATION: The Board is asked to **NOTE** 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 process for elections to the Council of Governors is underway in line with the timetable below. This year there are 12 vacancies for public governors across all the constituencies, and 4 vacancies for staff governors.

Action	By
Issue nomination forms (post and e-mail) to members	Monday 19 April 2021
Publication of Notice of Election	Monday 19 April 2021
Deadline for receipt of nominations	Friday 14 May 2021
Publication of Statement of Nominations	Monday 17 May 2021
Uncontested report provided to CHFT	Monday 17 May 2021
Deadline for candidate withdrawals	Wednesday 19 May 2021
Notice of Poll/Issue of ballot packs	Tuesday 1 June 2021
Close of Poll 5.00pm	Thursday 1 July 2021
Count and Declaration of Result	Friday 2 July 2021
Reporting of results at Council of Governors meeting	Thursday 15 July 2021
Formal election results announced at Trust and Members Annual General Meeting (AGM)	Wednesday 28 July 2021

Elections are to be held for the following staff governor positions:

Constituency	Vacancies
Constituency 9 - Drs/Dentists	1
Constituency 11 – Management/Admin/ Clerical	1
Constituency 12 – Ancillary	1
Constituency 13 – Nurses/Midwives	1

A comprehensive communications strategy has been developed to generate interest in the vacancies, which has included briefing sessions for prospective staff governors hosted by the Chair during April 2021.

RECOMMENDATION: The Board is asked to **NOTE** the staff governor vacancies and timeline for governor elections.

EQIA – Equality Impact Assessment
The content of this report does not adversely affect people with protected characteristics.
Recommendation
The Board is asked to **APPROVE** the: • Changes to the Trust's Constitution and Standing Orders of the Council of Governors • Compliance with License Conditions as detailed in the self-certification schedules • Delegation of 2020/21 annual accounts and annual report approval to the Audit and Risk Committee • Standing Orders / Standing Financial Instructions and Scheme of Delegation The Board is asked to **NOTE** the following: • Completion of the external well-led governance developmental review • Board of Directors Attendance Register for the Annual Report and Accounts 2020/21 • Board of Directors Workplan 2021/22 • Use of Trust Seal • Council of Governors – Staff Vacancies and Election Timetable

APPENDIX N2 - SELF-CERTIFICATION TEMPLATE

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)

Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

APPENDIX N2 - SELF-CERTIFICATION TEMPLATE

Worksheet "FT4 declaration"

Financial Year to which self-certification relates | **2020/2021** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust monitors and reviews its systems and processes to ensure they comply with good governance, having received a CQC good rating at a well-led inspection in April 2018, with a "requires improvement" rating for use of resources. The Trust has completed an externally commissioned a well-led development governance review and is progressing recommendations from this.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Trust pays due regard to guidance when issued by NHS England / NHS Improvement and liaises through national and regional networks. NHS England / NHS Improvement guidance is also noted through the Trust's external audit technical updated reported each quarter to the Audit and Risk Committee with a similar report shared via internal auditors. Compliance with the Code of Governance is reviewed annually by the Audit and Risk Committee.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Trust has a robust Board and Board Committee governance structure. Changes were made in year to the quality governance structure and the Board established a time limited Oversight Committee to proviide Non-Executive independent review of the Executive team's decision-mkaing in relation to the Covid pandemic. Each committee has a terms of reference reviewed annually, assesses it's effectiveness on an annual basis and develops an action plan.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Board Committees give assurance to the Board that the Trust is operating effectively. These include Board Committees scrutinising the following matters: - finance and performance - quality - workforce - audit and risk The sub group reporting structure to Board committees also provide comprehensive coverage of Trust business and this has been reviewied in year, with refocusing of grops to support agendas, eg compliance role separated from Risk to ensure Risk Group can focus solely on risk, with compliance now overssen by a refocused CQC and Compliance Group+K19. The Trust's wholly owned subsidiary, Calderdale Huddersfield Solutions Ltd. has its own clear governance structure and relationships and reporting to the Trust. The Trust declared no signifcant control issues in its 2020/21 annual governance statement and detailed the Trust's risk management framework and current strategic risks.The Board Assurance Framework and risk register are reviewed regularly by the Board and it's Committees. The Trust has a clear Standing Finacial Instructions and Scheme of Delegation in place that determines the framework for financial decision-making, management and control. An independent review of the Trust's governance arrangements in response to the Covid-19 pandemic took place and provided assurance on their effectiveness. Planning was in line with national guidance, which reflected changes arising from the pandemic. The Trust continues to have a process in place that ensures business plans are developed and scrutinised.

APPENDIX N2 - SELF-CERTIFICATION TEMPLATE

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	There is an effective objective setting and performance review process in place for Board members and a Board skills competency assessment is completed and reviewed annually. A fit and proper person declarations register is maintained and reported to the Board. Quality account priorities (agreed with governors) and quality focused priorities have been agreed and reported, along with other quality metrics, to the Quality Committee and Board. The Trust has a Quality Strategy in place and engages in a wide range of quality improvement collaboratives to improve patient care.There is a robust quality impact assessment process in place for service changes.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	The Trust has in place a fomal appointment process to the Board overseen by a Nominations and Remuneration Committee which ensures that appropriately qualified Board members are recruited and appointed, with appraisal processes in place to review existing Board members. A fit and proper person declarations register is maintained and reported to the Board.

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	**Signature**
Name Owen Williams, Chief Executive	**Name** Philip Lewer, Chair

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A	N/A	**OK**

APPENDIX N2 - SELF-CERTIFICATION TEMPLATE

Worksheet "Training of governors"

Financial Year to which self-certification relates 2020/21 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where requ

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Owen Williams	**Name**	Philip Lewer
Capacity	Chief Executive	**Capacity**	Chair
Date	10 June 2021	**Date**	10 June 2021

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A N/A

APPENDIX N3 - SELF-CERTIFICATION TEMPLATE - CONDITIONS G6 AND CoS7

This template may be used by NHS foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS provider licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Calderdale and Huddersfield NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licenc
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Given the underlying deficit position and the additional financial pressure of dealing with the Covid-19 situation, the Trust has given this due consideration and notes the following:

The Trust is planning for a breakeven revenue position in the first half of 2021/22. Fixed block funding for the Trust's services will be received from commissioners in this period, incorporating additional Covid funding and Financial Recovery Funding (FRF). The Trust will work with partners across the Integrated Care System to manage elective recovery plans and access associated funding.

Further detail on the national financial funding regime and allocations for the second half of 2021/22 is awaited. This brings an element of risk to the plans for the latter half of the year. The Trust will continue to be reliant upon FRF to achieve a balanced position and maintain cash without recourse to borrowing. Pending full guidance and financial targets being released there is a level of uncertainty in the full year plans.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Philip Lewer	**Name**	Owen Williams
Capacity	Chair	**Capacity**	Chief Executive
Date	xx June 2021	**Date**	xx June 2021

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Attendance	✓	Apologies	×

APPENDIX N4

ATTENDANCE REGISTER – PUBLIC BOARD OF DIRECTORS
1 APRIL 2020 – 31 MARCH 2021

DIRECTOR	7.5.20	2.7.20	3.9.20	AGM 7.10.20	5.11.20	14.1.20	4.3.21	TOTAL
Philip Lewer, Chair	✓	✓	✓	✓	✓	✓	✓	7/7
Alastair Graham, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	7/7
Andy Nelson, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	7/7
David Birkenhead, Medical Director	✓	✓	✓	✓	✓	✓	✓	7/7
Denise Sterling, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	7/7
Ellen Armistead, Director of Nursing	✓	✓	✓	✓	✓	✓	✓	7/7
Gary Boothby, Director of Finance	✓	✓	✓	✓	✓	✓	✓	7/7
Helen Barker, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	7/7
Karen Heaton, Non-Executive Director	×	✓	×	✓	✓	✓	✓	5/7
Owen Williams, Chief Executive	✓	✓	✓	✓	✓	✓	✓	7/7
Peter Wilkinson, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	7/7
Richard Hopkin, Non-Executive Director	✓	✓	✓	✓	✓	✓	✓	7/7
Suzanne Dunkley, Director of Workforce and OD	✓	✓	✓	✓	✓	✓	✓	7/7
Anna Basford, Director of Transformation and Partnerships	✓	✓	✓	✓	✓	✓	✓	7/7
Mandy Griffin, Managing Director - Digital Health	✓	✓	✓	✓	✓	✓	✓	7/7
Stuart Sugarman, Managing Director - CHS	✓	✓	✓	✓	✓	✓	✓	7/7

APPENDIX N5

PUBLIC BOARD WORKPLAN 2021-2022

NHS
Calderdale and Huddersfield
NHS Foundation Trust

DATE OF MEETING	14 Jan 2021	4 March 2021	6 May 2021	1 July 2021	2 Sep 2021	4 Nov 2021	13 Jan 2022	3 March 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	✓	✓ R&D	✓	✓	✓	✓	✓	✓
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	✓	✓	✓	✓	✓	✓	✓	✓
COVID-19 Oversight Committee Minutes	✓	✓	✓	✓	✓	✓	✓	✓
Council of Governors Meeting Minutes		✓	✓		✓	✓		✓
STRATEGY AND PLANNING								
Strategic Objectives – 1 year plan / 10 year strategy		✓		✓ *- 2021/22 strategic*		✓		

DATE OF MEETING	14 Jan 2021	4 March 2021	6 May 2021	1 July 2021	2 Sep 2021	4 Nov 2021	13 Jan 2022	3 March 2022
				objectives year end report and 21/22 plan				
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
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)				✓ (Bi-annual)		✓ (Bi-annual)

DATE OF MEETING	14 Jan 2021	4 March 2021	6 May 2021	1 July 2021	2 Sep 2021	4 Nov 2021	13 Jan 2022	3 March 2022
(Bi-Annual report due annually in Sep; however, it will be Nov this year)								
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 and ASSURANCE								
Health and Safety Update	✓		✓		✓		✓	
Health and Safety Policy			✓					
Health and Safety Annual Report	✓						✓	
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				✓				

DATE OF MEETING	14 Jan 2021	4 March 2021	6 May 2021	1 July 2021	2 Sep 2021	4 Nov 2021	13 Jan 2022	3 March 2022
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 – TPB TBC	✓ Workforce ✓NRC BOD	✓QC	✓ F&P ✓ Transformation Programme Board	✓ Workforce	✓ARC			✓
Constitutional changes (+as required)		✓	✓					
Compliance with Licence Conditions			✓					
Huddersfield Pharmaceuticals Specials Annual Report				✓				
Health and Safety Annual Report	✓						✓	
Fire Safety Annual Report (Bev Walker/Keith Rawnsley)				✓				
Emergency Planning Annual Report (Bev Walker/Ian Kilroy/Karen Bates)					✓			
Charitable Funds Report 2019-20 and Accounts (incl Audit Highlights Memorandum)	✓							
Committee review and annual reports				✓				
Audit & Risk Committee Annual Report 2020/2021				✓				
Finance & Performance Committee Annual Report 2020/2021				✓				
Quality Committee Annual Report 2020/21				✓				

DATE OF MEETING	14 Jan 2021	4 March 2021	6 May 2021	1 July 2021	2 Sep 2021	4 Nov 2021	13 Jan 2022	3 March 2022
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)

*Extra-ordinary Board meeting date for 2020/21 annual accounts and reporting to be confirmed once national guidance issued.

22. Review of Sub-Committee Terms of Reference

a) Finance and Performance Committee

b) Transformation Programme Board

To Approve

Presented by Richard Hopkin and Peter Wilkinson

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 6 May 2021
Meeting:	Board of Directors
Title:	Annual Review of Terms of Reference – Finance and Performance Committee
Author:	Gary Boothby, Executive Director of Finance
Previous Forums:	Finance and Performance Committee – 29 March 2021

Purpose of the Report

The Terms of Reference for the Finance and Performance Committee requires that an annual review is undertaken to refresh and confirm the scope of work. This review has been undertaken the revised Terms of Reference are attached.

Key Points to Note

The Terms of Reference have been reviewed and very minor additions / changes are highlighted as tracked changes on the attached document.

EQIA – Equality Impact Assessment

Terms of reference document only. Any decisions taken by the Committee under these terms of reference will be subject to the EQIA process.

Recommendation

The Board is asked to **APPROVE** the updated Terms of Reference for the Finance and Performance Committee.

Calderdale and Huddersfield NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

Version:	1.1 - first draft circulated for review to Chair / CE / DoF / DDof 1.2 - comments received OW / CB / AH 1.3 - Amendments from the Board of Directors 2.1 – Reviewed and updated for membership and to reflect planning cycle 3.1 – Reviewed and updated to include a Performance Delivery and Assurance Section 4.1 – Reviewed and updated – March 2019 5.1 – Reviewed and updated – June 2020 6.1 – Reviewed and updated – April 2021
Approved by:	Board of Directors
Date approved:	6 May 2021 (pending)
Date issued:	Pending
Review date:	April 2022

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

1. Constitution

The Trust Board hereby resolves to establish a Committee to be known as the Finance and Performance Committee. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Purpose

The Finance and Performance Committee has delegated authority from the Board to oversee, coordinate, review and assess the financial and performance management arrangements.

The Committee will assist in ensuring that Board members have a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

3. Authority

The Finance and Performance Committee is authorised by the Board, to which it is accountable, to investigate or approve any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request for such information.

4. Role and duties of the Committee

The Finance and Performance Committee will provide the Board with assurance that finance and performance is being monitored and managed across the organisation and that progress is being made in the implementation of the Annual Plan. The Committee will also make recommendations on investment.

The duties of the Committee can be categorised as follows:

4.1. **Finance and Financial Performance**

- Provide assurance that the finances and financial performance reporting systems of the organisation are robust through detailed review of the Monthly Financial Report.
- Seek assurance from the executive that any appropriate management action has been taken to return the Trust's financial performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored.
- Provide assurance to the Board that cost improvement plans to support organisational changes are being delivered
- Review the Trust's Long Term Financial Model and any NHS Improvement submissions to test assumptions and provide assurance that the returns represent a true and fair view of the financial performance for the period under review.
- Review all significant financial risks on the high level risk register and the Board Assurance Framework.
- Review the finance elements of the Single Oversight Framework and Use of Resources metric.
- Examine any matter referred to the Committee by the Trust Board.

4.2 **Performance Delivery and Assurance**

- Provide assurance that the performance reporting systems of the organisation are robust through detailed review of the regulatory performance and other KPIs as they relate to resource utilisation and income through Integrated Board Report on a monthly basis.
- Keep the content of the Trust's Integrated Performance Report under review, ensuring that it includes appropriate performance metrics and detail of exceptions to provide assurance to the Board on all aspects of organisational performance against its Strategic Objectives.

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

- If and when necessary, seek assurance from the executive that any appropriate management action has been taken to return the trust performance to plan and that any such actions or recovery plans are in place are adequately resourced, implemented and monitored and that appropriate Equality Impact Assessment (EQIA) has been completed.
- Provide assurance to the Board that the performance of Clinical Divisions and corporate teams are in line with agreed annual plans and receive escalation where recovery plans do not resolve any adverse variance
- Review all significant operational and strategic risks as they pertain to financial and regulatory standards on the high level risk register and the Board Assurance Framework.

4.3 Business and commercial development

- Ensure compliance with the Treasury Management guidance.
- Approve and set control limit for capital
- Review the Trust's Annual Business Plan, ? and Financial Model and recommend to the Board for approval.
- Approve capital programme under discrete headings (based on high level business case proposals from divisions):
  - Equipment replacement
  - Unavoidable major schemes
  - IM&T
  - Significant strategic importance
  - Estates (maintenance/ upgrades)
- Understand and agree revenue consequences of major schemes (in line with SFIs) and monitor cash flow implications, and also ensure that appropriate EQIA has been completed.
- Receive an update from Commercial Investment Strategy Group on business case approvals ensuring that outcomes and benefits are clearly defined, are measurable and support the delivery of key objectives for the Trust. Ensuring only those below £2.5M are approved by the Group and those above £2.5M are recommended to the Board for approval.
- Periodically review the market share analysis for the Trust.
- Approve the establishment of joint ventures or other commercial partnerships/relationships including the incorporation of start-up companies. Make recommendations to the Trust Board in relation to any due diligence, warranties, assignments, investment agreements, etc. related to joint ventures, commercial partnerships or incorporation of start-up companies.
- Agree investment / dis-investment in services (with full understanding of financial and service implications of these decisions e.g. overheads)

4.4 Treasury Management

- Maintain an oversight of the Trust's Treasury Management activities, ensuring compliance with Trust's policies.
- Review borrowing arrangements and liabilities
- Review and monitor the Trust's Treasury Management Policy *(approval is through the Audit & Risk Committee)*.
- Review the activities undertaken at Cash Management Committee.

4.5 **Procurement**

- Review the activities undertaken by Procurement and the contributions made along with performance against key national metrics.

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

5. Membership and Attendees

5.1. The Committee shall consist of the following members:

- Non – Executive Director (Chair)
- Non – Executive Director (Vice Chair)
- Chief Executive
- Executive Director of Finance
- Chief Operating Officer
- Director of Transformation and Partnerships.

5.2. The Deputy Director of Finance and the Company Secretary will regularly attend. All other non-executive and executive directors will be invited to attend along with a Governor representative. Executive Directors and other senior management staff may be required to attend discussions when the Committee is discussing areas of performance or operation that are their responsibility.

6. Attendance

6.1. Attendance is required by members 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.

6.2. 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 jeopardies the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, seek a substitute or replacement.

7. Administration

7.1. The Committee shall be supported by the Secretary to the Executive Director of Finance, 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 issue to be carried forward;
- Advising the group on scheduled agenda items;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

FINANCE & PERFORMANCE COMMITTEE – TERMS OF REFERENCE

8. Meetings

8.1. Meetings will be held on a monthly basis and arranged to meet the requirements of the corporate calendar. Meetings could be held either in person or virtually using digital technology;

8.2. Items for the agenda must be sent to the Committee Secretary a minimum of 8 days prior to the meeting: urgent items may be raised under any other business;

8.3. An action schedule will be circulated 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; and

8.4. The agenda will be sent out to the Committee members one week prior to the meeting date, together with the updated action schedule and other associated papers.

9. Reporting

9.1. The minutes of the Committee meetings formally recorded by the Committee Secretary will be submitted to the Trust Board when approved.

9.2. The Chair of the Finance and Performance Committee shall, at any time, draw to the attention of the Trust Board any particular issue which requires their attention.

9.3. The Capital Management Group, the Commercial Investment Strategy Group, Cash Committee, Hospital Pharmacy Specials, Joint Liaison Committee, Strategic PFI Partner meeting, THIS Executive Board and A&E Delivery Board will provide minutes of its meetings to the Committee along with reports as agreed.

10. Quorum

A quorum is determined as being four of the members in attendance but must include the Chair or Vice-Chair and one Executive Director.

11. Review

The Terms of Reference shall be reviewed on an annual basis and ratified by the Board.

12. Monitoring Effectiveness

In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Board, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 4 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 7 days prior to the meetings;
- The action schedule was circulated within 3 working days of the meeting, on 80% of occasions

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 6 May 2021
Meeting:	Public Board of Directors
Title of report:	Annual Review of Terms of Reference - Transformation Programme Board
Author:	Anna Basford - Director of Transformation and Partnerships
Previous Forums:	Transformation Programme Board 8 March 2021

Purpose of the Report

The Terms of Reference for the Transformation Programme Board (TPB) requires that an annual review is undertaken to refresh and confirm the scope of work. This review has been undertaken the revised Terms of Reference are attached.

Key Points to Note

The Terms of Reference have been reviewed and the following additions / changes incorporated which are highlighted in red on the attached document:

1. That the purpose of the Transformation Programme Board will include leading and oversight of the "Business Better than Usual" Programme to progress learning from the Covid-19 Pandemic;
2. The Trust's Green Planning Committee will report to and provide regular updates to the Transformation Programme Board on sustainability matters;
3. Meetings of the Transformation Programme Board will be held every month;
4. The Trust's Lead Governor will be invited to attend all meetings;
5. The Transformation Programme Board will regularly review and provide assurance on the following items that are included on the Board Assurance Framework
    - Trust estate
    - Service reconfiguration
    - Digital transformation
    - Business better than usual – learning from pandemic
    - Sustainability
    - Clinical strategy

EQIA – Equality Impact Assessment

The Terms of Reference include specific responsibility of the Transformation Programme Board to ensure that assessment of the Equality and Quality Impact and Data Protection Impact of the Transformation Programme is undertaken and kept up to date and that any necessary mitigation plans are in place.

Recommendation

It is recommended that the Board **APPROVE** the updated Terms of Reference for the Transformation Programme Board.

Calderdale and Huddersfield
NHS Foundation Trust

TRANSFORMATION PROGRAMME BOARD TERMS OF REFERENCE

1. Constitution

1.1 The Trust Board hereby resolves to establish a Committee to be known as the Transformation Programme Board. The Transformation Programme Board has no executive powers, other than those specifically delegated in these Terms of Reference. The governance structure is at Appendix A.

2. Authority

2.1 The Transformation Programme Board is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference are subject to amendment by the Trust Board.

2.2 The Committee derives its power from the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. The Committee will comply with the Trust's Standing Orders and Standing Financial Instructions and schemes of delegation.

2.3 The Committee is authorised by the Trust 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 Trust 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 Transformation Programme Board is to oversee the development and delivery of complex transformation programmes in the Trust, and to provide assurance on these matters to the Trust.

3.2. The responsibilities of the Transformation Programme Board include:

- To set and ensure delivery of the key milestones for the reconfiguration of services and ensure that service delivery plans are based on new ways of working including the optimised use of digital technology;
- To set and ensure delivery of the key milestones for the capital investment and estate development at Huddersfield Royal Infirmary and Calderdale Royal Hospital to enable service reconfiguration. This will include major

capital schemes identified by the Transformation Programme Board that are high risk, high value and of significant strategic importance;

- To ensure the Trust has secured through appropriate commercial arrangements an effective supply chain with the necessary specialist skills and capacity to deliver the reconfiguration of services and associated estate development;
- To ensure that the Programme produces viable and affordable business cases that are supported by local CCGs and the West Yorkshire Health and Care Partnership and approved by NHSE&I, DHSC and HM Treasury. This includes the Strategic Outline Case, the Outline Business Case and the Full Business Case;
- To ensure the Trust's existing PFI contract for Calderdale Royal Hospital is renegotiated - and subsequently ensure there is effective dialogue and relationship management with the PFI provider to enable the required estate developments on the CRH site;
- To ensure delivery of the Programme within the agreed and available capital and revenue resource budgets;
- To ensure that the risks associated with the Transformation Programme are managed appropriately;
- To ensure that benefits realisation associated with the Transformation Programme are managed, reported or delivered. To ensure independent review of benefits realisation is undertaken through-out the programme;
- To ensure the Business Better than Usual Programme, that will progress learning from the Covid-19 Pandemic to incorporate transformational changes in future service delivery models, is led and reports into the Transformation Programme Board;
- To ensure that assessment of the Equality and Quality Impact and Data Protection Impact of the Transformation Programme is undertaken and kept up to date and that any necessary mitigation plans are in place;
- To ensure the Trust continues to engage and involve local people, key stakeholders and the Joint Health Scrutiny Committee in the Transformation Programme;
- To ensure the Programme proactively responds to climate emergency in Calderdale and Kirklees and enables an improvement in CHFT contribution to environmental sustainability. The Trust's Green Planning Committee will report to and provide regular updates to the Transformation Programme Board on these matters;
- To review and provide and assurance to the Trust Board on the following items included on the Board Assurance Framework:
    - Trust estate
    - Service reconfiguration
    - Digital transformation
    - Business better than usual – learning from the pandemic
    - Sustainability
    - Clinical strategy

4. Duties

4.1 The Programme Board will approve and manage the programme plan and sign off the key outputs and decisions at each stage of the programme. This includes:

- monitoring and ensuring delivery of the overall plan of key activity, milestones and critical path
- patient and staff communications and engagement
- procurement and commercial processes and decisions
- review of all the key deliverables and the activities required to deliver them
- the activities required to validate the quality of the deliverables
- the resources and time needed for all activities and any need for people with specific capabilities and competencies
- the dependencies between activities and any associated constraints when activities will occur
- the points at which progress will be monitored, controlled and reviewed
- the provision of regular reports, updates and assurance to CHFT Board, NHSE&I and Treasury
- maintenance of a detailed risk registers and mitigation of risk factors affecting the successful delivery of the project
- maintenance of a benefits realisation registers and monitoring of delivery
- considering and recommending to the Trust Board any changes to the project scope, budget or timescale if required
- review of serious issues, which have reached threshold level
- brokering relationships with stakeholders within and outside the project to maintain positive support for the programme
- maintaining awareness of the broader strategic perspective advising the SRO on how it may affect the project
- approving the design brief, appointment of external consultant team and approving the programme of work and the critical path.

5. Membership and attendance

5.1 The Transformation Programme Board shall consist of the following members:

- Three Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee (the Trust Board may also choose to appoint an independent Lay Chair)
- Chief Executive / Senior Responsible Officer (SRO)
- Chief Operating Officer
- Medical Director & Director of Infection Prevention and Control
- Director of Nursing
- Director of Workforce and Organisational Development
- Director of Finance
- Director of Transformation and Partnerships (Programme Director)
- Managing Director – Digital Health

- Managing Director – Calderdale and Huddersfield Solutions.

5.2 The following shall be required to attend all meetings of the Committee:

- Transformation Programme Manager
- Transformation Programme Administrator (notes)
- Associate Director of Finance

5.3 Other attendees may be co-opted or requested to attend as considered appropriate and may include external advisors. The Trust's Lead Governor will be invited to attend all meetings.

5.4 A quorum will be four members of the Committee and must include at least three board members of which one must be a Non-Executive and one an Executive Director.

5.5 Attendance is required at 75% of meetings. Members unable to attend should indicate in writing to the Committee Administrator 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.

5.6 A register of attendance will be maintained, and the Chair of the Transformation Programme Board 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 Administrator, 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
- maintaining a record of attendance.

7. Frequency of Meetings

7.1 The Committee will meet monthly. Additional meetings may be scheduled if required in relation to the Transformation Programme of work and timelines.

8. Reporting

8.1 The Transformation Programme Administrator 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 following each meeting and must be duly completed and returned to the Administrator for circulation with the agenda and associated papers.

8.3 The agenda will be sent out to the Transformation Programme Board 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 Trust Board of Directors meeting.

8.5 In considering reporting to the Trust Board, the Transformation Programme Board will consider Guidance for Reserving Matters to a Private Session of the Board of Directors

9. Review

9.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2 The terms of reference of the Committee shall be reviewed by the Trust Board of Directors at least annually.

10. Monitoring effectiveness

10.1 In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 5 working days prior to the meetings;
- The action point from each meeting are circulated within two working days, on 80% of occasions.

10.2 These Terms of reference will be reviewed after three years to determine if there is a continued need for the Transformation Programme Board.

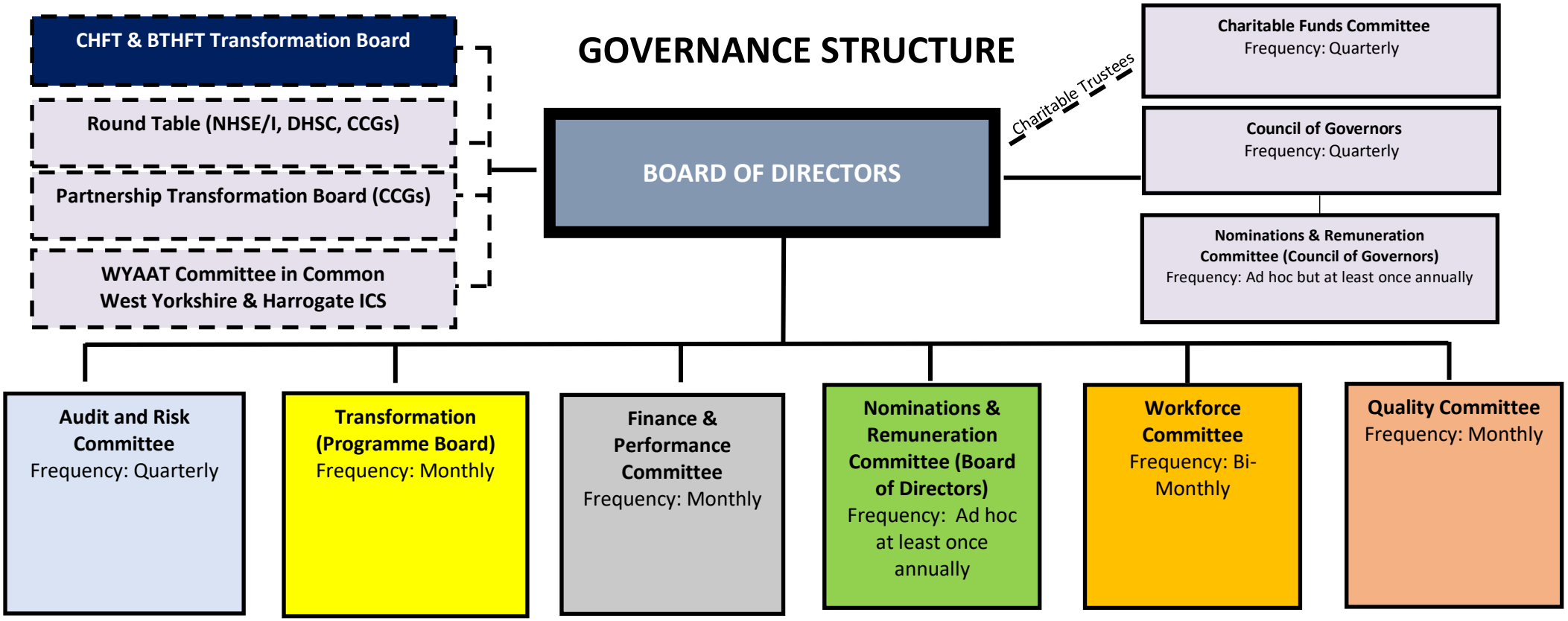
Date Approved by Transformation Programme Board: 8 March 2021

Date Approved by Trust Board: 6 May 2021

Review Date: March 2022

APPENDIX A

GOVERNANCE STRUCTURE



23. Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)

- Finance and Performance Committee
- Workforce Committee
- Quality Committee
- Covid-19 Oversight 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:	29 March 2021
Date of Board meeting this report is to be presented:	6 May 2021

ACKNOWLEDGE

- Improvement in overall IPR score in February to 68% with good performance on cancer and A&E metrics.
- Financial performance in Month 11 better than plan and on track to deliver full year 20/21 forecast.
- Continued progress with Finance team's 'Future Focused Finance' accreditation
- Health & Well Being Assessments completed for 4150 colleagues (and included 35 potential life saving interventions).

ASSURE

- Feedback on Outpatient Improvement work (carried out with Meridian consultants) reviewed – although some follow up required
- Presentation by Workforce & OD on Health & Wellbeing Strategy, including performance on Sickness Absence
- F&P Revised Terms of Reference approved
- Work Plan for 21/22 reviewed and approved

AWARE

- Challenge to achieve forecast 20/21 planned capital spend with high level of year end accruals likely
- Areas of concern arising from IPR review included SHMI, Stroke performance and Infection Control (C Diff)
- Termination of NPEx contract with Xlab during 21/22 but with additional income being negotiated to offset the required asset write offs
- Post Covid-19 reset plans outlined in presentation and detailed draft report
- (to be discussed in more detail at 6 May Board)
- Baseline budget for 21/22 approved including rollover of existing central financial regime for H1 (months 1 to 6). Further stages of plan re Developments & Elective Recovery still to be completed and ICS Funding Envelope (only just released) to be analysed.

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 8 March 2021
Date of Board meeting this report is to be presented:	Thursday 6 May 2021

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 8 March 2021.

- The positive progress being made on both the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) notably production of the Lived Experience Videos, production of Anti-bullying Week campaign, launch of the Empower programme (an inclusive personal development programme), dedicated wellbeing support for CEV staff.
- An increase in the number of sickness absence return to work interviews being undertaken.
- An assessment of the NHS People Plan against the Trust's Workforce Strategy demonstrated that despite COVID the Trust was making good progress against its Plan.

ASSURE

The Committee had expressed (as had the Board) concern over the impact of the age profile on the number of staff who may decide to take early retirement/retirement as a consequence of the impact of COVID 19. Of the 5936 employees, 929 (15.7%) are aged over 55 years. Based on the current profile approximately 25% of 51-55 age group could leave the Trust by age 60 years. The Committee were reassured that the Workforce and OD Directorate are keeping a watch on this issue and have built in mid- year career reviews giving an opportunity to gain clearer insight into individual career choices.

Further work is being undertaken to update the Trust's Workforce Strategy and the contents of "The Cupboard".

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 of meetings:	22 March 2021 and 19 April 2021
Date of Board meeting this report is to be presented:	6 May 2021

ACKNOWLEDGE

Annual Research and Innovation report

- A strong year for research focus on Covid 19 research trials
- CHFT in the top 10 recruiting trusts nationally and the highest recruiting trust across Yorkshire and Humber.
- Research nurses shortlisted for Nursing times award and were winners.

Annual Experience, Participation and Equalities Report

- Significant progress has been achieved during 20/21.

ASSURE

12 hour breaches in ED - Follow up review of the cases completed, and recommendations made to Quality Committee in Jan 2021 incorporated into an action plan. Update on the review of the final cases and progress of the action plan provided.

Children Looked After and Care Leavers Annual Report 2019-20 - The collaborative report approved and confirmation that the team have discharged their statutory and legislative responsibilities was noted.

Winter volunteering transformation project - The Quality Committee noted the progress for the project and the plans for Safety Guardians.

Focused Quality Priorities - Progress on the Quality priority received for Nosocomial Spread and Clinical Prioritisation. Focussed Quality Priorities 20/21- progress reports received and approved by the committee. Focussed Quality Priorities 21/22- Reviewed plans for the year and KPIs for each priority which will be reported into the Quality Committee and Board.

Internal Audit report on Transportation of Medicines – significant assurance that the systems and processes in place for the management of the transport of medicines are adequate.

Quality Committee Terms of Reference - Revised terms of reference approved.

Vaccination programme governance report - The report was received and approved by the Quality Committee. The Quality committee will have an ongoing oversight role regarding the Kirklees Covid-19 vaccination hub. Approval of the CHFT

Covid-19 Vaccination Programme 2020/21 Operational Policy.

The Health and Wellbeing Recovery Strategy - Committee supports the wellbeing recovery response activities.

Inaugural report Lead Medical Examiner - Service implemented December 2020 providing independent scrutiny of all deaths at CHFT, Activity Q4 20/21 56% scrutinised, committee to receive biannual reports.

Infection Prevention Control (IPC) - The oversight for IPC and the review of the NHS England / NHS Improvement Infection Prevention Control (IPC) Board Assurance Framework (BAF) action plan for CHFT.

Getting It Right First Time (GIRFT) Report – Noted the work on implementation of the national programme and CHFT's exemplar recognition and partnership with the national GIRFT team and the MDT approach to Quality improvement.

AWARE

Quality and Performance Report - Update provided on the Summary Hospital-level Mortality Indicator (SHMI) position which shows an increase. CHFT review underway, five conditions contributing to SHMI identified and deep dive to be completed.

Patient experience – Friends and Family Test (FFT), overall responses remain low, steady improvement in patient and day cases targeted work to increase response rates.

Falls – Plans to reduce falls by 10%, the committee noted the research study in collaboration with Bradford University to commence October 21.

Pressure Ulcers - Is a Focused Quality Priority with plans for a system wide approach to pressure ulcer prevention and management.

Medical Devices – Training targets of 95% is not being achieved by the majority of Divisions (legal requirement) plan in place for further work with Divisions and Wards.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Oversight Committee
Committee Chair:	Denise Sterling Non-Executive Director
Date(s) of meeting:	26 March 2021
Date of Board meeting this report is to be presented:	6 May 2021

ACKNOWLEDGE

ASSURE

Updates received:

Covid-19 Vaccination Programme - CHFT commenced 2nd dose vaccinations on 8 March 2021, good progress.

Waiting List – Clinical Prioritisation Buddying Arrangements - the arrangements have not yet been fully optimised and some modifications are required and work underway. Progress reports will be made to the Quality Committee and then to the Oversight Committee.

Learning from 12-hour Breaches - the improvements and learning to be managed through the Quality Committee.

Mixed Sex Breaches- Information requested on the current position, trends on numbers and actions taken to prevent breaches.

Mortality - There has been an increase in SHMI mortality rates for deaths out of hospital within 30 days of discharge. Work ongoing to identify the reasons, recommendations and actions taken to reverse the trend of rising SHMI scores to be brought to the Executive Board. This will then be presented to the Outer Core and the Oversight Committee.

Outer Core Register of Decisions – Received and reviewed.

AWARE

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 of meeting:	Monday 12 April 2021
Date of Board meeting this report is to be presented:	Thursday 6 May 2021

ACKNOWLEDGE

- Good progress with the actions to address 'Inappropriate access to clinical records' and new alerting tools working effectively
- The committee conducts deep dives into the work of the 4 ARC sub-committees. This meeting we had a review of the work done by the Data Quality Board showing good progress in areas such as reducing the number of incorrect encounters in EPR and capturing activity under the correct clinician

ASSURE

- Although Audit Yorkshire (AY) have been unable to complete the Internal Audit (IA) plan for 2020/21 they have been able to do the necessary audits to enable a Head of Internal Audit opinion to be provided
- Terms of reference for all 4 ARC sub-committees have been approved
- The IA plan and Counter Fraud plan for 2021/22 were approved

AWARE

- Progress report from AY showed there were 103 open recommendations of which 85 were overdue (51 of these with without a revised target date). 14 of the overdue recommendations are major but of these 9 were subject to follow-up audit activity in which the internal audit manager expected some positive progress. This situation regarding overdue recommendations is of concern ARC. It was noted this matter is receiving CEO and WEB attention which is welcomed.

24. Date and time of next meeting

Thursday 1 July 2021, 9:00 am

Venue: Microsoft Teams

To Note

Presented by Philip Lewer