Public Board of Directors

Schedule	Thursday 3 March 2022, 9:00 — 12:00 GMT
Venue	Microsoft Teams
Organiser	Amber Fox

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1. Welcome and Introductions:

To Note

Presented by Philip Lewer

2. Apologies for absence: Anna Basford

To Note

Presented by Philip Lewer

3. Declaration of Interests

To Receive

4. Minutes of the previous meeting held on 13 January 2022

To Approve

Presented by Philip Lewer

Draft Minutes of the Public Board Meeting held on Thursday 13 January 2022 at 9:00 am via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Stuart Sugarman	Managing Director, Calderdale and Huddersfield Solutions Ltd
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager
Lindsay Rudge	Deputy Chief Nurse
Devina Gogi	Guardian of Safe Working Hours **(for item 16/22)**
Karen Spencer	Associate Director of Nursing/ Head of Midwifery **(for item 08/22)**
Susan Bailey	Midwife – Home Birth Team **(for item 08/22)**
Kelly Tordoff	Patient **(for item 08/22)**
Anne Ward	Midwife – Home Birth Team **(for item 08/22)**
Kelly Brennan	Midwife – Home Birth Team **(for item 08/22)**
Amy Earnshaw	Midwife – Home Birth Team **(for item 08/22)**
Richard Hill	Head of Health and Safety **(for item 14/22)**
Nicola Hosty	Associate Director of Human Resources **(for item 12/22)**
Andrea Gillespie	Freedom to Speak Up Guardian **(for item 13/22)**

OBSERVERS

Christine Mills	Public Elected Governor
Robert Markless	Public Elected Governor
Nicola Whitworth	Public Elected Governor
Peter Bamber	Public Elected Governor
Gina Choy	Public Elected Governor
Nicola Seanor	Associate Non-Executive Director
Karen Huntley	Appointed Governor, Healthwatch
Alison Schofield	Public Elected Governor
Isaac Dziya	Public Elected Governor

01/22 Welcome and Introductions

The Chair welcomed everyone to the public Board of Directors meeting, in particular Brendan Brown and Jo Fawcus to their first Board meeting and the invited governors, Gina Choy, Robert Markless, Isaac Dziya and Nicola Whitworth.

The Chair also welcomed observers to the meeting, Karen Huntley from Healthwatch, Peter Bamber, Christine Mills, Alison Schofield and Nicola Seanor, Associate Non-Executive Director.

This Board meeting took place virtually and was not open to members of the public in light

of government restrictions. The meeting was recorded, and the recording will be published on our website shortly after the meeting. The agenda and papers were made available on our website.

The Chair wished to formally record that Richard Hopkin, Non-Executive Director has joined the meeting from Florida where it is 3:50 am.

02/22 Apologies for absence

Apologies were received from Jim Rea and Denise Sterling.

03/22 Declaration of Interests

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

04/22 Minutes of the previous meeting held on 4 November 2021

The minutes of the previous meeting held on 4 November 2021 were approved as a correct record subject to the amendments below.

- Strategic Objectives - AN asked for an action to cross reference the 10 year strategy to the one year strategy with regards to fostering a learning culture and best practice
  Action: Director of Transformation and Partnerships to contact AN to draft the additional objective into the one year strategy, cross referencing to the ten year strategy
- AN asked that a progress report is presented to the next Board meeting with clear outcome measures on the Strategic Objectives
  Action: Director of Transformation and Partnerships to present a progress report with clear outcome measures to the next Board meeting on 3 March 2022

OUTCOME: The Board **APPROVED** the minutes from the previous meeting held on 4 November 2021 subject to the amendments above.

05/22 Action log and matters arising

The action log was reviewed and updated accordingly.

OUTCOME: The Board **NOTED** the updates to the action log.

06/22 Chair's Report

The Chair informed the Board he continues to attend the West Yorkshire Association of Acute Trusts (WYAAT) meetings on behalf of the Trust alongside the Chief Executive. He also reported that he continues to attend the Integrated Care System (ICS) Chair and Leaders Advice Group. This is likely to continue until the end of June as the Health and Care Bill establishing integrated care arrangements will not go before Parliament for a further three months, after 1 April 2022.

The Chair continues to attend meetings with NHS England and other Chairs. The last meeting was attended with the Director of Nursing where the Trust was asked by NHS England to look at its recovery plans and respond to the challenge of Covid, which the Trust continues to do.

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

07/22 Chief Executive's Report

The Acting Chief Executive expressed a heartfelt thank you to all colleagues working across the Trust for their continued efforts during a challenging December and new year.

The numbers of Covid patients have increased with a more detailed update from the Chief Operating Officer later in the agenda.

The Trust is actively supporting the development of the covid medicines delivery unit. These are units being set up nationally to administer new treatments for Covid patients. This will be a community-based service and the Trust are working in partnership with Locala and Mid Yorkshire NHS Hospitals Trust (MYHT).

The Trust continue to support Leeds Teaching Hospital NHS Trust (LTHT) in the development of the Nightingale facility in response to Covid-19.

The Trust are working closely with colleagues across WYAAT to continue to support the development of sustainable services for Non-Surgical Oncology.

The building works are underway at the Huddersfield Royal Infirmary site on the new Accident and Emergency (A&E) build which is an exciting development and morale boost.

The Acting Chief Executive formally thanked the Board of Directors for their support and guidance during her short tenure as the interim Chief Executive.

The Chief Executive expressed a heartfelt thanks to colleagues for their warm welcome back to the Trust during a particularly challenging time in wave 4. He explained his focus is on our people, performance and the public. The Chief Executive stated he is impressed by the efforts of colleagues and acknowledged it will continue to be difficult for staff in a clinical or non-clinical setting as wave 4 has already surpassed the numbers seen in the first wave and the acuity and complexity of patients feels very different.

The Chief Executive explained he is keen to build on the communication process in place at the Trust and live briefings will be starting from next week, Wednesday 19 January, all colleagues are welcome to join. He thanked the Director of Transformation and Partnerships and the Communications team for their help in making this happen.

The Chief Executive handed over to the Chief Operating Officer for an update on the operational position as at 13 January 2022. The key headlines are below:

- Currently 167 covid inpatients, with 3 patients in the Intensive Care Unit (ICU)
- 26% of the bed base is currently occupied by Covid patients, this is presenting logistical challenges organising the bed base daily, including Covid contact patients
- In terms of our Operational escalation level, the Trust are at level 3 (OPEL) with level 4 being the highest
- The Trust have maintained level 3 despite the additional pressures which is a testament to the operational teams who are working hard keeping the Trust safe and steady
- The number of transfer of care patients remains at 98
- Approximately 45 care homes were shut to admissions though it is expected these will be opening within 14 days
- Staffing issues across the community and care homes means discharge will be slower
- The Nightingale facility in Leeds is currently under discussion, which will have 70 beds, of which, CHFT will gain around 5 beds; however, will need to contribute staff to use these beds
- Staffing absence levels are a concern both with the Trust and system partners

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

08/22 Patient Story – Home Birth Team

Karen Spencer, Associate Director of Nursing and Head of Midwifery introduced a patient story relating to Continuity of Carer in Maternity. Karen welcomed Kelly Tordoff and her baby, who was a patient that received her care from our home birth team and agreed to share her experience. Karen explained that midwives Susan Bailey, Amy Earnshaw, Anne Ward and Kelly Brennan were also present from the Home Birth team.

Kelly Tordoff started her story by explaining she is a service user living in Kirklees and is a Social Worker in Calderdale and has a six-week-old baby girl. Kelly wanted a home birth given that her previous birth experience at Calderdale was unpleasant, seeing at least four different midwives throughout her pregnancy. Following this experience, Kelly is now part of the Maternity Voices Partnership (MVP) to ensure no one has the same patient experience as she did.

Kelly learnt what continuity of carer meant when she met her midwife at her 16 week appointment, who explained she was her midwife, who the secondary midwife was and the midwives on the team. Kelly explained she felt able to share with her midwife details about her difficult past pregnancy experiences, and how invaluable it was knowing she only needed to share this once.

Kelly explained she had her midwives' contact details from the booking appointment and was made aware of annual leave arrangements, with the secondary midwife being the contact. This continuity was a big relief particularly during a pandemic. Kelly described how the home birth team visited her at home to familiarise themselves with the setting, met her husband, which made her feel safe and re-assured, and meant her labour and postpartum experience was much easier. Kelly expressed her heartfelt thanks to the home birth team (her home birth midwife, Susan Bailey, was in attendance) and stated the Trust should be proud of the team.

In response to Kelly encouraging the Trust to keep the home birth team, KH provided re-assurance that the Trust have no intension of disbanding home birth team and that this story is a prime example of continuity of carer and what the Trust should aspire to.

Susan Bailey, Amy Earnshaw and Kelly Brennan thanked Kelly for sharing her powerful story and commented on the incredible support from her managers, matrons and Karen Spencer for allowing the team to work in this way.

The Deputy Chief Nurse formally thanked Kelly Tordoff and colleagues in midwifery for making this a lived experience which shows the impact of continuity of carer and what this means for women, babies and the team.

OUTCOME: The Board **NOTED** the patient story in relation to Continuity of Carer in Maternity.

09/22 Health Inequalities Progress Report

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

The key points to note from the workstreams were:

- External Environment - how we connect with our communities: Signposting to support services outside the organisation and pilot work taking place
- Pilot post in place in conjunction with mental health partners looking after high intensity service users to help them navigate the system
- Social value portal action plan is being progressed
- Lived experience – maternity services were the initial area of focus – 55% of women from a BAME background are on a continuity of carer pathway, the next

project will be service users in need of mental health support (with discovery interviews by the end of February and plan by the end of March 2022)
- Following service user feedback in discovery interviews letters have now been translated into different languages
- Funding has been received nationally to support smoking cessation services
- Next lived experience
- Learning disability waiting list systems are well embedded, despite the challenges, the Trust are able to clearly identify children with learning disabilities and are currently developing a dashboard for end of life
- Workforce – Virtual event on the equality delivery system (EDS2) took place in December 2021 and the Trust was found to be achieving in all areas and outstanding on one rating

AG stated he is pleased to see pace of work regarding high intensity users and asked if the Trust have information on addresses to understand if these service users live in areas of high deprivation. He stated that frequent users of the service often live close which could be supported by outreach work. The Director of Nursing explained work is ongoing around mental health and this will be picked up in the next lived experience project. The model used for maternity services will be adopted for mental health to understand if this maps across to the index of multiple deprivation (IMD) groups.

PW explained he chairs the monthly Health Inequalities Group which has great energy. He explained the Group are starting to see if there is any alignment with the leadership framework for Health Inequalities Improvement from NHS Confederation which looks at the most deprived 20% of the community plus five clinical areas.

In response to a question from Gina Choy on what "developing the dashboard" means, the Director of Nursing explained colleagues in the Health Informatics Service (THIS) have worked closely in getting information mapped across the IMD groups. The dashboard will give a view on waiting lists in terms of IMD and the next step is to undertake this work for mental health service users and other vulnerable groups.
Action: Director of Nursing to arrange a meeting with Gina Choy and THIS to discuss this further

OUTCOME: The Board **NOTED** the progress in relation to CHFT's response to NHS expectations of providers in tackling health inequalities.

10/22 Calderdale PLACE: Partnership Working and Governance

The Director of Transformation and Partnerships presented an update on progress to develop the place based partnership agreement in Calderdale. An earlier draft of the agreement was discussed at the Board Development workshop held on 2 December 2021.

Since 2 December, the partnership agreement document has been updated to incorporate comments from CHFT and other partners. The Board is now requested to formally confirm agreement to sign up to the Calderdale Cares partnership agreement which includes the establishment of a formal sub-committee of the West Yorkshire Integrated Care Board (ICB) from July 2022. The Director of Transformation and Partnerships explained nationally the arrangements have been deferred until July 2022 and will operate in shadow form until then, when they become a formal sub-committee of the ICB.

OUTCOME: The Board **APPROVED** that CHFT sign-up to the Calderdale Cares Partnership Agreement.

11/22 Month 8 Financial Summary 2021/22

The Director of Finance presented the month 8 financial summary and highlighted the key points below:

- On plan at month 8 and continue to forecast to deliver the full year financial plan
- Efficiency programmes that are required to be delivered are behind this year; however, alternative sources of income and alternative funding have been identified which allows a forecast to deliver the plan in year
- Currently only forecasting delivery of £3.3m efficiencies which is mainly non-recurrent efficiencies against the planned £6.7m for half two (last six months of this financial year), this is adding to the financial challenge for next year
- Currently underspent on the capital programme with lots of expenditure planned in year, now reached an agreement with the ICS and NHS England /Improvement (NHS E/I) and the Trust are planning to overspend on the capital commitment in this final quarter which relieves some of the pressure

AG asked for an update on the elective recovery fund which the Trust were unable to access. He stated the 95% threshold level seems high given pressures the Trust are currently under and asked if the rules to access this funding could change in future. The Director of Finance stated the rules could change again and the Trust benefited from this fund during the first half of the financial year. He added that the Trust are planning to deliver slightly above plan for the second half of the year and should be able to access some of this funding. He explained the total fund is allocated on an ICS level basis which requires the whole ICS to deliver, which is not currently being achieved. He added that the Trust have spent a lot on insourcing to deliver additional activity which is being delivered at a cost to the Trust without receiving the income for it. The Director of Finance clarified the scale is around £150-200k.

AN recognised the £6.7m is not going to be achieved and asked whether a £5m technical adjustment needs to happen to break even. The Director of Finance reminded the Board that our plan for H2 of 21/22 was operationally to breakeven but for a £5m deficit related to a planned balance sheet transaction agreed with External Audit. If this transaction does not take place in 21/22, the overall position would be a £5m favourable variance, but relating to this technical balance sheet adjustment. This discussion has taken place at the Finance and Performance Committee. He confirmed as an ICS we are now forecasting an underspend and CHFT are the only organisation across the ICS that are struggling to achieve the breakeven position. Discussions are taking place regarding additional support from commissioners to identify funding to try and bridge the gap. Since December there is more confidence in achieving this forecast as some funding has now been agreed. He added that CHFT have been supporting MYHT in terms of non-surgical oncology which has come at an additional cost; however, MYHT have now confirmed the funding they will provide which bridges some of this gap. The Director of Finance explained the risk is that the majority of savings are non-recurrent.

OUTCOME: The Board **NOTED** the Month 8 Finance Report and the financial position for the Trust as at 30 November 2021.

12/22 Health and Wellbeing Update

The Director of Workforce and OD presented a report which updates the Board on the progress made with the wellbeing agenda, highlighting the challenges that lay ahead and asks the Board for their support to promote colleague wellbeing. She explained the Health and Wellbeing Strategy has been updated in response to the needs and wellbeing of colleagues.

KH provided assurance that health and wellbeing is discussed at the Workforce Committee, and she commended the Director of Workforce and OD, the Assistant Director of Human Resources and colleagues for all of their sustained hard work in this area.

AN asked for an update on the unusual behaviours in colleagues and if the huge pressures the Trust continue to face could see staff retiring earlier or resignations. The Director of Workforce and OD explained the Trust are witnessing behaviours like Post Traumatic

Stress Disorder from staff who are very tired and fatigued. She added that the Trust could see some uplift in retirements over the next 6-12 months and in response the Trust will need to increase succession planning and talent management.

RH stated the Trust should be looking to increase the number and coverage of wellbeing ambassadors as these seem to have a positive impact. He added the Wellbeing Leadership Programme should help to address some of the communication and management support issues that have been identified.

KH confirmed there was a national advert for recruitment and careers in the NHS and stated she is not clear what the impact of this has been locally. She added the national picture on workforce planning would be helpful, including looking at the types of roles in the NHS. The Director of Workforce and OD confirmed the Trust need the help of a national push to recruit colleagues to join the NHS.

OUTCOME: The Board **NOTED** the health and wellbeing update and supported the recommendations for 2022 activity.

13/22 Freedom to Speak Up Mid-Year Review (Themes)

The Director of Workforce and OD presented a report on Freedom to Speak Up (FTSU) activity in the Trust from 1 April 2021 to 30 September 2021. The Director of Workforce and OD introduced Andrea Gillespie, the Trust's new Freedom to Speak Up Guardian with a clinical background who started in September 2021.

KH confirmed the report has been to the Workforce Committee and highlighted that the numbers of concerns are increasing; however, raised her concern in that the majority are still anonymous which suggests people do not feel confident enough to raise these in their own name.

AN asked if the network of ambassadors covers all areas and what the trend has been over the last six months. Andrea Gillespie, Freedom to Speak Up Guardian confirmed all areas are covered, which also includes CHS; however, she is currently exploring whether CHS should have its own ambassador. She explained there are currently 26 active ambassadors from a variety of roles and areas of work across the Trust. Andrea Gillespie noted she was assured 26 is an acceptable number of ambassadors based on the number of concerns that are being received. She explained she has been impressed with the level of enthusiasm from the ambassadors to make this business as usual.

AN asked if the numbers have been rising over the last quarter. The Freedom to Speak Up Guardian explained the report includes numbers up to September 2021 and there have been 22 concerns since which shows a rise, though this could be due to increased promotion and visibility regarding Freedom to Speak Up, such as screensavers.

Robert Markless queried whether there are enough ambassadors from a range of ethnic minority backgrounds for staff to feel comfortable raising issues. The Freedom to Speak Up Guardian confirmed she had reviewed representation from each group and stated she was assured that there are enough ambassadors from different ethnic minorities.

OUTCOME: The Board **NOTED** Freedom to Speak Up activity from 1 April 2021 to 30 September 2021 and the work of the FTSU Guardian and Ambassadors.

14/22 Health and Safety Annual Report

The Director of Workforce and OD explained the Trust have been working on the foundations of health and safety over the past 18 months and several sub-committees have been set up and are now active. These sub-committees report through to the Audit and Risk Committee. The team are working very closely with the Chief Operating Officer's team on emergency planning, fire and violence and aggression. A 5 year strategy has

been developed which keeps the Trust in line with NHS workplace standards and is under a framework that the Trust may be assessed against.

KH acknowledged the very comprehensive report and asked if there are now sufficient fire aiders and fire marshals across both sites. Richard Hill, Head of Health and Safety confirmed there are sufficient first aiders with 45 additional qualified first aiders for non-clinical areas. KH further explained hybrid working can put pressure on the number of first aiders and fire marshals that are required. The Head of Health and Safety confirmed this has been considered and is factored in the numbers.

PW was pleased to see reference to the reconfiguration and building work in the 5 year strategy and stated one of the biggest risks is construction activity and expects discussions with staff to take place as construction begins.

The Chair recognised the progress with Health and Safety and stated he felt very re-assured with the excellent progress.

OUTCOME: The Board **NOTED** the progress on Health and Safety in the Annual Report.

15/22 Director of Infection Prevention Control (DIPC) Q3 Report

The Medical Director presented the Healthcare Associated Infections (HCAIs) position of performance for Q3 from 1 October to 31 December 2021. The key points to note were:

- Remains a really challenging time for the infection prevention and control team
- Clostridium difficile remains a significant challenge partly related to covid, the patient population and the use of antimicrobials to manage potential respiratory tract infections
- Guidance continues to be updated regularly in relation to covid
- New guidance around FFP3 marks and Fit testing
- Relaxed guidance on when FFP3 masks can be used to allow staff to use them more frequently at their discretion following the national approach
- New Board Assurance Framework in relation to IPC and the outcome will be brought to a future Board meeting
- Audit activity continues with IPC to provide assurance, advice, and guidance to colleagues on the wards

AG highlighted that 5 c.difficile cases were deemed preventable and asked if there are any actions out of this to try reduce chances of this happening in future. The Medical Director responded each c.difficile case has a root cause of analysis to determine if they were potentially avoidable. These could be due to antimicrobials being prescribed for longer, or not being prescribed according to policy or issues around isolation. A report will be produced for broader learning in the organisation.

AN asked if there is anything new happening in terms of the recent increase in covid cases as the Trust are seeing more hospital-based infections. The Medical Director responded that the new Covid variant is more infectious than previous variants and hospital onset infections has reflected community transmission all the way through the pandemic. The Medical Director added there is a high number of people in the organisation who came through quickly and were difficult to cohort appropriately in the time period. The number of contacts has been difficult to manage. The Trust are getting into a place with cohort wards to isolate patients as necessary. The Medical Director explained the signs and symptoms are not as closely defined as previous waves and lots of patients are attending the hospital not suffering from Covid but have Covid identifiable symptoms and transmission may already have happened.

OUTCOME: The Board **NOTED** the performance against key Infection Prevention Control targets and **APPROVED** the Q3 report.

16/22 Guardian of Safe Working Hours Q3 Report, 2021-22

Devina Gogi, Guardian of Safe Working Hours presented the Guardian of Safe Working Hours Q3 report which covers the period of 1 October 2021 to 31 December 2021. The key points to note were:

- Decrease in the number of exception reports in this quarter, usually there are roughly 30 exception reports in quarter with only 10 in this quarter
- 80% fill rate of the junior doctors posts due to rota gaps from vacancies, sickness absence, and other unplanned absence across the Trust which has reduced compared to previous quarters which is usually 90% and is as anticipated due to absences
- Junior Doctor Form was cancelled in December 2021 due to insufficient attendees and is taking place on 20 January 2022

AG asked if the Trust are providing Junior Doctors adequate access to training and education facilities. The Guardian of Safe Working Hours confirmed a meeting took place on 12 January 2022 with the Deputy Medical Director and Medical Human Resources Manager with trainees to discuss these aspects. She added they have some funds from Health Education England to try ensuring Junior Doctors can get access to training facilities. The Guardian of Safe Working Hours added that from this money she has invested in a wet lab for Ophthalmology.

The Chair thanked the Guardian of Safe Working Hours for her report and all her efforts and energy.

OUTCOME: The Board **NOTED** and **APPROVED** the Guardian of Safe Working Hours Report for quarter 3.

17/22 Quality Report (inc. Maternity Services Update)

The Interim Chief Nurse presented the Quality Report which provides the Trust with ongoing oversight of the Quality agenda and the emerging issues that need to be considered.

The report contains a maternity services update, which includes an update on stillbirths following an action at the last Board meeting. A review of the 44 cases identified that 52% of women lived in areas of highest deprivation; smoking was a risk factor in women who identified as white at booking and whilst the majority of women (34%) had no identified antenatal problems, cumulatively access to care was the greatest risk factor for stillbirth (16%).

The Deputy Chief Nurse confirmed the Trust continue to progress with the quality priorities for the coming year and updates will be provided in future meetings.

AN highlighted the good progress with the interpreter service, that the volunteer programme is now past the pilot phase and is being embedded and the Observe and Act Programme is working well. He added complaints is still an area of concern with little evidence of learning. AN added it was good to see progress in terms of pressure ulcers. He asked if the electronic monitoring for medicines management is going to mitigate the issues and if nutrition and hydration continues to be a challenging area in terms of assessment.

The Interim Chief Nurse responded further work is taking place in the clinical documentation workstream to ensure nutrition and hydration is recorded correctly. The Chief Nursing Information Officer is focused on this and a future Board workshop on the

caring domain will pick up on these aspects. The Deputy Chief Nurse added that the electronic monitoring for medicines management should help mitigate these risks such as fridge monitoring; however, the issue is freeing up staff operationally for the training. The training plan will be re-visited to implement these digital solutions.

KH raised the importance of managing dementia screening which seems to be dropping and acknowledged more training is planned, particularly for new staff. The Deputy Chief Nurse agreed and confirmed they are focusing on assessment areas and a digital white board.

The Chief Executive asked for a view on maternity services and where we are with the Ockenden review of maternity services. The Deputy Chief Nurse responded there has been really good progress with a good position against Ockenden. An external review with the regional and national team around continuity of carer took place who were very supportive of our process, particularly around the new guidance issued. The Trust now have the funding to recruit additional midwives which has been impaired with the recruitment process and the Trust are pleased with the supportive approach and additional guidance around this. As part of the Journey to Outstanding (J2O) process, a review of maternity services is taking place going forward.

The Chief Executive asked if a combined report in response to Ockenden is completed with the Non-Executive Director champion for Maternity. The Chair clarified this is covered at every Board meeting within the Quality report. KH, Non-Executive Director with oversight of maternity services, added there is still a lot of work to do in response to the Ockenden report and the recruitment of midwives is broader than the Local Maternity System and a national issue.

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

18/22 Recovery Update

The Chief Operating Officer gave a presentation updating the Board on the recovery position.

AN highlighted the focus on elective recovery despite all the Covid pressures staff are under, stating this is a credit to everyone concerned. AN pointed out the capacity in theatres and the Trust are operating at roughly 85% than pre-covid levels. The Chief Operating Officer stated theatres should be undertaking roughly 120 lists a week if fully staffed and they are currently undertaking around 85. AN asked if this was still causing a backlog issue. The Chief Operating Officer responded the Trust are using external companies to work on this backlog, patients are also being seen in the private sector and CHFT, MYHT and LTHT are assisting each other with cohorts of patients. She added that the Trust are not seeing the same uptake in terms of bank and agency staff in theatres which is a national issue. She added there has been a recent successful recruitment campaign in Theatres which should start assisting.

AN asked if there is more the Trust can do; however, acknowledging staffing remains the key issue. The Chief Operating Officer responded that the Theatre Improvement Programme is a key for this year which includes start times, finish times, productivity, key factors for turnaround in theatre. Further updates will be provided to the Board on the Theatre Improvement Programme.

OUTCOME: The Board **NOTED** the Recovery presentation.

21/22 Integrated Performance Report (IPR) – November 2021

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

- Overall performance score for November at 62% has deteriorated, with a new key challenge being in the finance domain
- Safe and effective domains remain green
- Caring domain is amber
- Responsive domain is still amber with no change in month – A&E performance for the month is still a challenged position with long waits for patients waiting for beds
- Access to beds for stroke patients remains an issue
- Cancer performance has been positive, maintaining key cancer metrics
- Workforce – one culture of care and must do action plan in place

The Director of Finance noted the finance score deteriorated due to an in month adverse variance of £50k and confirmed this has been recovered for month 9.

RH asked if there are specific initiatives being taken to address current absence rate. The Director of Workforce and OD responded to confirm there are and as of 13 January 2022, the Trust are back down to 9.1% absence with 50% related to covid absence and isolations. A more detailed update on the action plan including the Availability Strategy will be provided to the Finance and Performance Committee on 31 January 2022.

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

22/22 High Level Risk Register

The Interim Chief Nurse presented the High Level Risk Register. The key points to note during this period are the increased risk score in relation to nursing staff, fractured neck of femur and meeting the four hour emergency standards.

AN commented it was a helpful report which explained the movements and why the high risks are on the risk register. He pointed out the more recent risk relating to ICU staffing with a score of 20 is not on the matrix or in the main paper.

Action: Deputy Chief Nurse to update the High Level Risk Register report

OUTCOME: The Board **APPROVED** the High Level Risk Register.

24/22 Governance Report

The Company Secretary presented the governance items for approval and noting in January 2022.

The one item for approval in the paper is a proposed change to the Trust constitution. The Board were asked to approve an extension of the geographical eligibility criteria for Non-Executive Director recruitment to give the Trust the best chance for recruiting into these roles, given the demand in the system. The Company Secretary confirmed other Trusts have a wider geographical eligibility criteria. This change was supported by the Council of Governors.

AG highlighted that all candidates must be able to demonstrate a commitment to the Trust area or communities it serves, not just those candidates from North Yorkshire or South Yorkshire.

The Chief Executive acknowledged candidates applying from outside of the area can work remotely and it is important to understand how they invest and truly represent the communities the Trust are serving. The Chief Executive supported the change to the geographical area in the Trust constitution to test the market.

The Director of Finance asked if this could be described as a distance instead as opposed to a county boundary. The Chair explained this was debated at the Council of Governors in December and the compromise was the county; however, the points raised are valid. The Chair added that a further Council of Governors meeting is taking place this month if this needs to be brought back for debate.

The Company Secretary asked the Board to agree the geographical change in principle to be broader than West Yorkshire and Harrogate given the imminent Non-Executive Director recruitment process and agreed to share revised wording.

Nicola Whitworth expressed her support for the geographical change.

Action: Company Secretary to share the revised wording for the Trust constitution geographical eligibility criteria for Non-Executive Director recruitment for agreement.

OUTCOME: The Board **APPROVED** the amendment to section 25.4 of the Trust constitution subject to the wording being approved outside of the meeting, **NOTED** the update on the Associate Non-Executive Director appointment, extension of the Risk Management Strategy and Policy, the calendar of Board and Committee dates and membership and the Board workplan for 2022.

26/22 Board Sub-Committee Chair Highlight Reports

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

- Finance and Performance Committee
- Quality Committee
- Workforce Committee

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

27/22 Board Sub-Committee Terms of Reference

The updated terms of reference for the Organ Donation Committee were approved by the Board.

OUTCOME: The Board **APPROVED** the updated Organ Donation Committee Terms of Reference.

28/22 Annual / Bi-Annual Reports

The following annual report was available in the Review Room on Convene:

1. Charitable Funds Annual Report and Accounts 2020-2021

OUTCOME: The Board **RECEIVED** the Charitable Funds Annual Report and Accounts for 2020-2021.

29/22 Items for Review Room

- Emergency Preparedness Resilience and Response (EPRR) Core Standards Submission
- Calderdale and Huddersfield Solutions Ltd – Managing Director Update December 2021

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

- Finance and Performance Committee minutes of the meetings held 04.10.21, 01.11.21 and 29.11.21
- Quality Committee minutes of the meetings held 11.10.21, 08.11.21 and 06.12.21
- Workforce Committee minutes of the meetings held 08.11.21 and 06.12.21
- Charitable Funds Committee minutes of the meeting held 22.11.21

OUTCOME: The Board **RECEIVED** the Emergency Preparedness Resilience and Response (EPRR) Core Standards Submission, the Calderdale and Huddersfield Solutions Limited (CHS) Managing Director Update for December 2021 and the minutes of the above sub-committees.

30/22 Any Other Business

The Chair formally thanked the Board of Directors, colleagues and governors for their attendance and closed the meeting at approximately 11:08 am.

31/22 Date and time of next meeting

Date: Thursday 3 March 2022
Time: 9:00 – 12:30 pm
Venue: Microsoft Teams

5. Action Log and Matters Arising

To Note

Presented by Philip Lewer

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC) 2022

Position as at: 23.02.22

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
13.01.22 24/22	Governance Report – Trust Constitution Company Secretary to share the revised wording for the Trust constitution geographical eligibility criteria for Non-Executive Director recruitment for agreement.	AM	Completed – the updated constitution is now available on the Trust website.	03.03.22		24.01.22
13.01.22 09/22	Health Inequalities Progress Report Director of Nursing to arrange a meeting with Gina Choy and Callum MacIver, THIS to discuss the health inequalities dashboard.	EA	Callum met with Gina Choy on the 16 February 2022 to walk her through the Health Inequalities Dashboard.	03.03.22		16.02.22
13.01.22 04/22	Matters Arising - Board of Directors – 3 November 2021 Director of Transformation and Partnerships to contact AN to draft the additional objective into the one year strategy, cross referencing to the ten year strategy. Director of Transformation and Partnerships to present a progress report with clear outcome measures to the next Board meeting on 3 March 2022.	AB	On the March 2022 public Board agenda.	03.03.22		03.03.22
04.11.21 157/21	Quality Report Director of Nursing to plan and lead a caring domain session focused on patient experience for a future Board Development Session.	EA	There is a plan to arrange a 1 hour session on the caring domain topic with the Board in May or June 2022.	03.03.22		
04.11.21 155/21	Learning from Deaths Report Medical Director to explain the discrepancy in data for the initial screening reviews in future reports which is due to a time lag.	DB	This is addressed in the Q3 report at page 52 for the Board on 3 March 2022.	03.03.22		03.03.22

6. Chair’s Report

To Note

Presented by Philip Lewer

7. Chief Executive’s Report

To Note

Presented by Brendan Brown

Transforming and Improving Patient Care

8. Staff Story – ‘Engage, Support, Reenergise - Our One Culture of Care Experience.... So Far!’
Presented by - Sarah Wallwork, Eye Clinic Service Manager, Karen Lord, Sister/Charge Nurse and Natalie Rice, Healthcare Assistant, Ophthalmology

To Note

9. Health Inequalities Update

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3rd March 2022
Meeting:	Public Board of Directors
Title:	Health Inequalities Progress Report
Authors:	Ellen Armistead, Director of Nursing / Deputy CEO Anna Basford, Director of Transformation and Partnerships Suzanne Dunkley, Director of Workforce and OD
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy CEO
Previous Forums:	Health Inequalities Group

Purpose of the Report

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

Key Points to Note

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

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

External environment: how we connect with our communities: The work undertaken to conduct an internal audit to review A&E attendances and admissions for individuals from people who are homeless, asylum seekers, refugees and high intensity users has been completed. The actions suggested from the audit along with the user experience stories to improve the support available in the community has received funding from the ICS to develop a pilot project to create and implement Care Navigator roles in both our A&E departments.

A Social Value Portal (SVP) action plan has been developed using nationally approved methodology for measuring and quantifying social value in terms of economic, social and environmental impact of the Trust's planned estate investment at CRH and HRI. This action plan has quantified the expected social return that will be generated by contractors and their supply chain to support a reduction in health inequalities experienced by our local communities.

The lived experience, initial focus on maternity services: At the end of December 65% of women from a BAME background have been booked onto a Continuity of Carer pathway.

Overcoming language barriers – ESOL classes jointly run by Calderdale College and a midwife are being explored, a similar model is in place in Bradford. Mapping of multi-lingual resources at Trust, local, regional, and national level is ongoing to identify any gaps and share with colleagues.

Smoking in Pregnancy: Our plan includes:
• Introduce a new 'Smokefree Pregnancy Pathway' (SPP) which includes choice, personalisation, education and a 'menu' of support options to help families quit smoking including peer support.
• Purchase new carbon monoxide (CO) monitors to replace faulty/old equipment.
• Employ two Maternity Support Workers - Health Advisers (B3) trained as stop smoking practitioners, to pilot the SPP in targeted areas of high smoking prevalence.
Obesity and diabetes: Antenatal education A new antenatal class "Healthy Family Healthy Baby" is being developed and will be our standard offer to women with BMI >30 at booking.

Using our data to inform stabilisation and reset: Work to further narrow the health gap for those living with learning disabilities continues. Further work has been undertaken on needs of LD patients with mental health needs and cancer is being undertaking.

Further developments on the **Health Inequalities dashboard** are in the planning and are articulated within the report.

Video Consultation: Early March we are having a testing day where patients from our learning disabilities network and staff members from project search will be testing devices to see which they find easiest to use to undertake video appointments. This will help us with our work with voluntary and community organisations to enable patients to access remote appointments when they may need support.

Diverse and Inclusive workforce: CHFT Pride Network has a new Exec Sponsor Jo Fawcus, COO, focusing attention on LGBTQ History Month, LGBTQ Lunch and Learns, mystery shopper exercise with network members feeding back to the group on their experience as a patient / service user. The BAME Network has had a re-launch including reciprocal mentoring to enhance understanding of cultural differences with a view to building positive relationships.

EQIA – Equality Impact Assessment

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

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

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

Recommendation

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

HEALTH INEQUALITIES PROGRESS REPORT

3 March 2022

1. Introduction

Health Inequalities are defined as:

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

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

2. Background and Context

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

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

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

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

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

3 Workstream Updates

<u>External environment: how we connect with our communities.</u>

Partnership Working: The work undertaken to conduct an internal audit to review A&E attendances and admissions for individuals from people who are homeless, asylum seekers, refugees and high intensity users has been completed. This work included hearing

the lived experiences from refugees and asylum seekers facilitated by the St Augustine's Centre in Calderdale and the Resettlement Team in Kirklees. This learning has also been shared with the Integrated Care System (ICS) to support their aim to become an ICS of Sanctuary. The actions suggested from the audit along with the user experience stories to improve the support available in the community has received funding from the ICS to develop a pilot project to create and implement Aversity Trauma Care Navigator roles in both our A&E departments. This pilot is being developed collaboratively between the ICS and the Trust, along with wider health and care system and VCS partners.

Work has continued with the Greenwood PCN to reduce inequalities identified in emergency asthma admissions in PCN and CHFT data. A joint meeting was held in December with members of the Greenwood PCN, CHFT Clinical Leads and General Managers in the Respiratory and Paediatric Services, Locala and Kirklees Public Health. Collaborative next steps were agreed and are now being developed into a joint action plan action plan.

Social Value: The Social Value Portal (SVP) has supported the Trust in measuring and reporting the delivery of social value. An SVP action plan has been developed using nationally approved methodology for measuring and quantifying social value in terms of economic, social and environmental impact of the Trust's planned estate investment at CRH and HRI. This action plan has quantified the expected social return that will be generated by contractors and their supply chain and the Social Value assessment is based on a local needs analysis and targeted actions to support a reduction in health inequalities experienced by our local communities.

The output from this is now being used to inform our implementation plans for the estate developments to ensure the investment secures wider social benefits that are targeted to reduce health inequalities**.**

Reconfiguration Equality Impact Assessment (EQIA) & Quality Impact Assessment (QIA): As part of the process of continuous assessment in relation to the Trust's Public Sector Equality Duty and as reported previously, a refreshed assessment of the EQIA and QIA impact of the proposed service changes and estate developments at CRH and HRI has been undertaken. This was completed using the new and strengthened process to assess the EQIA and QIA impacts which included meetings with groups of people that have protected characteristics to directly inform, advise and confirm the assessment and any mitigations required.

The completed EQIA and QIA were also shared with Trust Board in October 2021 as part of the business case approval process for the Full Business Case (FBC) for the new A&E at HRI and the Outline Business Case (OBC) for the Reconfiguration Programme and have now been shared with NHSE/I and DHSC colleagues as part of the regional and national approval process for the business cases. EQIA and QIA will continue to be a refined and developed further during the next stage of detailed design work for the estate developments.

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

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

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

Continuity of carer: work continues to transition community midwifery into continuity of care teams. Our current compliance is 27% for all women and 65% for women from BAME backgrounds. The next teams to be developed will be situated in areas of high deprivation e.g. North Halifax. Over 60% of BAME women are now receiving continuity of care and compared with other trusts across the WY&H LMS, CHFT have the highest percentage.

Discovery Interviews – no recent interviews have taken place due to staffing and acuity, however a new lead for this piece of work has come forward and this will be discussed at the next Maternity HI workstream meeting.

Overcoming language barriers – ESOL classes jointly run by Calderdale College and a midwife are being explored. This model is used by Better Start Bradford to increase access to health services and knowledge around healthy pregnancy, birth and baby care. Preliminary discussions have taken place and it is felt this model would enhance the existing provision of continuity of care for BAME women.

Mapping of multi-lingual resources at Trust, local, regional, and national level is ongoing to identify any gaps and share with colleagues.

Staff Training and Cultural Awareness

Training package Two modular courses on eLfh are being trialled by members of the maternity workstream. Feedback will be discussed at the next Maternity HI Meeting.

Smoking in pregnancy: NHS Long Term Plan Funding of 93K has been received from the ICS to implement the NHS LTP to reduce smoking in pregnancy. Ringfenced funding will continue in years 2 and 3 then will be included in the overall budget allocated to CHFT.

This funding is to provide in-house stop smoking support services including the provision of nicotine replacement therapy (NRT) to women who smoke at their booking appointment, and 12 weeks support to quit. Partners who smoke will be included by offer of referral to local stop smoking services.

Our plan includes:

•Introduce a new ‘Smokefree Pregnancy Pathway’ (SPP) which includes choice, personalisation, education and a ‘menu’ of support options to help families quit smoking including peer support.

•Purchase new carbon monoxide (CO) monitors to replace faulty/old equipment.

•Employ two Maternity Support Workers - Health Advisers (B3) trained as stop smoking practitioners, to pilot the SPP in targeted areas of high smoking prevalence.

Obesity and diabetes: Antenatal education A new antenatal class “Healthy Family Healthy Baby” is being developed and will be our standard offer to women with BMI >30 at booking. This session will offer an holistic approach to health and wellbeing in pregnancy covering nutrition, activity, smoking, mental health etc with enhanced content around weight gain and healthy eating.

Using our data to inform stabilisation and reset

We continue to connect with other Trusts and ICS systems nationally, sharing our work and experience in the delivery of a Health Inequalities guided recovery framework. There remains a high level of interest around our work with Learning Disabilities and waiting lists.

The surgical waiting list for people with a learning disability continues to be monitored on a monthly basis by the surgical division and matron lead for learning disabilities. There is currently 11 adults and 2 children on the waiting list and plans are in place to meet the agreed Trust target for people with a learning disability or were out of target the team are aware of the reason behind this and it is documented on the system, for example not fit to proceed at pre assessment stage or due to the patient having COVID infection. The secretaries and theatre scheduling manager remain in frequent contact to manage this.

The learning disability flag is now on the cancer model of KP+. The lead cancer nurse and matron for learning disabilities are currently undertaking an audit of the data from 2018. Early findings are that 289 adults were referred with 19 patients been diagnosed with cancer. This is a conversion rate of 7% compared to 11% in the general population. 12 patients were referred from the screening service and none of these were diagnosed with cancer. Of the 19 patients 7 were curative and 12 palliatives of which 7 have sadly died, 1 not relating to the cancer.

The lead cancer nurse is currently looking at individual cases, reviewing the clinical pathways and whether they met the targets, and any concerns identified. What has been noted is that of the patients diagnosed with cancer with stage 3 and 4 presentation they live in supported/residential settings. Which highlights the need for further training to social care staff. The audit will be presented at the enhanced learning disability pathway task and finish group and the Trust Cancer Board.

The enhanced learning disability pathway task and finish group is now established and meets every three weeks. Terms of reference have been agreed and work is underway with the divisions and wider teams to progress the introduction of the pathway. A progress report is due to be presented to the Outpatient Transformation Board and Clinical Outcomes Board over the next month.

The lead nurse for high intensity users undertook an audit of the Emergency Department attendance with a specific presentation criterion such as self-harm or mental health as reason for presentation, comparing general population and people with learning disabilities. The timeframe was 1st January 2021-31st December 2022. There was 1315 attendance for people with a learning disability and 151 met the audit criteria compared to 4975 of general population. Within the general population mental health was the highest cause of attendance to ED where people with a learning disability presented due to physical injury. This was presented at the trauma navigator meeting. The ED attendances for patients with a learning disability will been monitored to see what the data is informing us and what actions/improvement plans are required.

CHFT held another successful COVID booster clinic for people with learning disabilities in partnership with Calderdale CCG with 41 individuals having the booster.

From 1st April 2022 data for people with learning disabilities will start to be reported on the Integrated Performance Report so the board can have oversight.

Further developments on the **Health Inequalities dashboard** including:
Information:
• Radiology and Endoscopy KP+ models are currently in development. These will enable the viewing and analysis of radiology and endoscopy activity from a HI perspective.

• Meetings being set up with divisional teams to demonstrate what HI information is available via KP+ and how to obtain it.
• Scoping work has begun in conjunction with technical partners around the delivery of a regional LD focused waiting times dashboard.
• Following the publication of a HSJ article that references the work done at CHFT I have been approached by the Hereford and Worcestershire Integrated Care System to discuss the information side of this work.

Patient Portal: The Digital Health Team and Outpatient Transformation Team are working on improving the patient portal - this will provide increased functionality supporting the organisation to meet its target. This is aligned to the organisation requirements to increase targets around Patient Initiated Follow Up. Throughout the project learning from previous engagement from patients will be considered to ensure it promotes digital inclusion.

Video Consultation: Early March we are having a testing day where patients from our learning disabilities network and staff members from project search will be testing devices to see which they find easiest to use to undertake video appointments. This will help us with our work with voluntary and community organisations to enable patients to access remote appointments when they may need support.

Diverse and Inclusive Workforce.

- Pride Network – new Exec Sponsor Jo Fawcus, COO, focusing attention on LGBTQ History Month, LGBTQ Lunch and Learns, mystery shopper exercise with network members feeding back to the group on their experience as a patient / service user.
- BAME Network – re launch reciprocal mentoring to enhance understanding of cultural differences with a view to building positive relationships.
- Carers – developing a range of podcasts / videos focus on lived experience and cultural awareness
- Disability – positive feedback regarding free permits for colleague blue badge holders
- Womens Network – Engaged Pennine Domestic Abuse partnership to speak at a womens network to discuss reducing the stigma, associated with abuse, raise awareness of support available for those impacted by domestic abuse and highlighted the fact they had specialists to support ‘everyone’ i.e. male, BAME, LGBTQ, different cultures as well as women

Summary

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

Ellen Armistead
Executive Director of Nursing/Deputy CEO
January 2022

Appendix 1

Calderdale and Huddersfield NHS
NHS Foundation Trust

Prioritised Backlog Analysis (on list - excluding surveillance/planned)

As at 18th October 2021

compassionate care

Calderdale and Huddersfield NHS
NHS Foundation Trust

Ethnicity P2 Backlog daily snapshot for 12 Mar, 19 Apr, 27 May, 18 Oct

Patient Group	12/03/21		19/04/21		27/05/21		18/10/21	
	P2 Patient Numbers	Weekly Average Waiting Time	P2 Patient Numbers	Weekly Average Waiting Time	P2 Patient Numbers	Weekly Average Waiting Time	P2 Patient Numbers	Weekly Average Waiting Time
All Patients	427	8.9	417	10.8	406	12.6	266	6.0
White	348	8.0	336	10.1	338	12.0	235	5.7
BAME	54	15.2	54	17.6	45	19.8	28	8.8
Not Stated	25	8.2	27	6.7	23	7.7	3	2.3

Source: Knowledge Portal Plus

compassionate care

Calderdale and Huddersfield NHS
NHS Foundation Trust

IMD P2 Backlog daily snapshot for 27 May, 18 Oct

Patient Group	27/05/21		18/10/21	
	P2 Patient Numbers	Weekly Average Waiting Time	P2 Patient Numbers	Weekly Average Waiting Time
All Patients	406	12.6	266	6.0
IMD 1 & 2 Only	111	17.1	70	6.4
IMD 9 & 10 Only	51	8.6	23	3.9

Source: Knowledge Portal Plus

compassionate care

Calderdale and Huddersfield NHS
NHS Foundation Trust

P2, P3, P4 Combined
27 May, 18 Oct

Patient Category	27/05/21		18/10/21	
	P2, P3, P4 Patient Numbers	Weekly Average Waiting Time	P2, P3, P4 Patient Numbers	Weekly Average Waiting Time
All Patients	5,038	33.3	4,656	28.6
White	4,152	32.7	3,939	28.2
BAME	599	37.8	573	29.8
Not Stated	287	33.7	144	35.0
IMD 1 & 2 Only	1,377	36.1	1,234	28.6
IMD 9 & 10 Only	503	30.5	460	26.4

Source: Knowledge Portal Plus

compassionate care

10. 2021/22 Strategic Objectives Update

To Note

Presented by Ellen Armistead

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title of report:	Annual Strategic Plan – Progress Report
Author:	Anna Basford, Director of Transformation and Partnerships (with input from all Executive Directors)
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None

Purpose of the Report

Provide an update on progress against the annual strategic plan for period ending February 2022.

Key Points to Note

In November 2021 the Trust Board approved an 'annual' strategic plan describing the key objectives to be progressed during the period November 2021 to March 2023 that will support delivery of the Trust's 10-year strategy. Each of the objectives has a named Director lead accountable and responsible for delivery.

This report highlights that of the 19 objectives:

0	are rated red
5	are rated amber
13	are rated green
1	have been fully completed

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to **NOTE** the assessment of progress against the 2021/23 annual strategic plan.

Calderdale and Huddersfield NHS Foundation Trust
2021-23 Strategic Plan – Progress Report for period ending 28 February 2022

Purpose of Report

The purpose of this report is to provide an update on progress made against the Trust's annual plan (appendix 1).

Structure of Report

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

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

For each objective a summary narrative of the progress and details of where the Board will receive further assurance is provided (appendix 2).

Summary

This report highlights that of the 19 deliverables:

0	are rated red
5	are rated amber
13	are rated green
1	have been fully completed

Recommendation

Note the assessment of progress against the 2021/23 objectives.

Appendix 1

Strategic Objectives (November 2021 – March 2023)

Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	**Sustainability**
	Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual' demonstrating benefits delivered. (AB)	Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleagues safety. (EA)	Develop and implement flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for clinical roles, thus retaining a turnover below 10%. (SD)	Deliver the regulator approved financial plan. (GB)
	Approval of business cases for HRI and CRH to enable construction of new A&E to commence at HRI and the development of a Full Business Case for CRH. (AB)	Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating. (EA)	Develop an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions. (SD)	Demonstrate improved performance against Use of Resources key metrics. (GB)
	Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire. (DB)	Involve patients and the public to influence decisions about their personal care, fostering a learning culture and best practice to improve patient experience : • responding to the needs of people from protected characteristics groups • implementing "Time to Care". • achieving patient safety metrics (EA)	Revise our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams through Recovery and beyond (SD)	Implement the Trust Board approved Green Plan demonstrating progress against the agreed action plan that will support reduction in the Trust's carbon footprint. (SS)
	Implement the Trust Board approved 5 year digital strategy with an agreed programme of work and milestones. (JR)	Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery. (BW/JF)	Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of our local communities. (SD)	Collaborate with partners across West Yorkshire and in place to deliver resilient system plans. (AB)
	Use population health data to inform and implement actions to address health inequalities in the communities we serve. (EA)	Deliver the actions in the Trust's Health and Safety Plan. (SD)	Develop health and wellbeing support plans for all Departments to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey. (SD)	

Goal: Transforming and improving patient care			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual'.	**BLUE** completed	In 2020 extensive engagement with colleague's, partners and members of the public about the service changes implemented during the pandemic and their aspirations for future service delivery was undertaken. The feedback identified 12 key learning themes of new ways of working where there was agreement that this could have potential long-term benefit and should be sustained and amplified. Since then a programme of work has been implemented to support continued engagement and to take forward further developments in relation to each of these themes. This work has and continues to inform operational planning and longer term strategic plans. Quarterly updates on progress have previously been reported to Trust Board sub-committees. In January 2022 Audit Yorkshire reviewed the BBTU programme and their report concluded that there was high level of assurance regarding the processes which have been put in place to ensure that positive learning from the pandemic is being embedded within the Trust. Moving forwards the Trust Board has agreed that the learning and developments from BBTU will now transition to and be further progressed through the main annual planning and longer term strategic planning processes in the Trust. The stand-alone BBTU programme will therefore be closed.	**Lead: AB** Transformation Programme Board
Trust Board approval of reconfiguration business cases for HRI and CRH.	**GREEN** on track	The Full Business for the new Accident Emergency Department at Huddersfield Royal Infirmary has been approved by NHSE. Construction has commenced and is scheduled to complete in Summer 2023. The Reconfiguration Outline Business Case has been submitted to NHSE and is progressing as expected though	**Lead: AB** Transformation Programme Board , Trust Board ICS, NHSE, DHSC

		their processes of review – Treasury approval of the OBC will be required. In anticipation of approval of the OBC work has commenced on the next stages of the programme to develop the Reconfiguration Full Business Case by Summer 2023.	
Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire.	**GREEN** on track	The Board approved clinical strategy will support future discussions within WYAAT and the ICS on the development of services into the future. Significant work progresses on the delivery of non-surgical oncology (NSO) including support into the Mid Yorkshire hospital Trust service and Bradford Teaching Hospital. An independent report on NSO by Professor Mike Richards has recommended a 2-hub model with CHFT as a hub. Work continues to secure agreement across the acute Trusts on the future service model. The Trust is engaging with partners to procure a single Chemotherapeutic prescribing system to further facilitate network development. Internal improvement work with the Stroke team has resulted in an SSNAP rating of A. The Trust is currently working on the implementation of a joint laboratory computer system across WYAAT. A WYAAT diagnostics board is being established to oversee progress of both Pathology and Radiology networks. Monthly Placed based meetings have been established in Calderdale and a partnership working group between CHFT and MYHT.	**Lead: DB** Weekly Executive Board Quality Committee Trust Board
Trust Board approval of a 5-year digital strategy supported by an agreed programme of work and milestones.	**GREEN** on track	The 5-year Digital Strategy (July 2020 – July 2025) continues to make positive progress - key activities outlined are in development. • The Infrastructure Strategy focused on moving towards the cloud is now defined. This covers how to best exploit our data supporting wider trust initiatives (i.e. PHM). • Scan for Safety developments are ongoing supporting wider trust strategies such as reconfiguration. • Capital funding for 22/23 is allocated with the Pharmacy Robot the key project for delivery.	**Lead: JR** Divisional digital boards Divisional Operational Boards Data Quality Board Digital Executive Board. Report to Board and Finance and Performance Committee by exception.

		• Digital Aspirant Programme will conclude in April 2022. Having delivered multiples projects in the 3-year programme. All necessary reporting to NHS X (now NHS E/I) delivered on time. • EPR Team structure to support optimisation team is now defined in conjunction with BTHFT. The increased capacity and capability will support the delivery of optimisation of pace. • Digital Governance at Divisional Level is now established but time is needed to fully embed Technical/project management support assigned to each divisional board to provide specialism. • Multiple Digital Funding bids have been submitted again enabling the trust to further invest in digital technology in line with Digital Strategy.	
Use population health data to inform actions to address health inequalities in the communities we serve.	**AMBER** off track – with plan	The Trust has established real time data analysis of patient waiting lists in relation to index of multiple deprivation, ethnicity, and other protected characteristics. This analysis has been considered and discussed with a range of colleagues (e.g., Patients, Doctors, Nurses, Therapists, Medical Secretaries) alongside clinical prioritisation to inform the Trust's elective recovery plans. The aim is to ensure that for people who have had their care unavoidably delayed due to the pandemic that the recovery plans are informed by clinical need and support reduction in health inequalities.	**Lead EA** Weekly Executive Board Board of Directors Learning Improvement Review Board Health Inequalities Oversight Group (England)
Goal: Keeping the base safe			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleague's safety.	**AMBER** off track – with plan	Non-elective demand has increased although hospitalisations are lower than the same period last year. We are continuing to work with all partners and communities to support increased population uptake of the Covid-19 vaccine and continue to deliver our internal winter COVID booster and flu vaccination programme. The Trust is ensuring IPC measures remain in place, so all patients and colleagues feel safe in our hospitals.	**Lead: EA** Weekly Executive Board Trust Board

		We are placing priority on reducing the backlog of patients that have had their care and treatments delayed due to the pandemic and have ensured that our recovery plans support a continued reduction in health inequalities. There has been a renewed focus on ensuring oversight of those on the waiting list to ensure we minimise incidences of clinical harm.	
Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating.	**AMBER** off track – with plan	The new style accreditation Journey to Outstanding (J20) has been tested and is being rolled out. There is a timetable of visits planned for the next 12 months. This was tested and has been rolled out. A number of areas have been assessed and improvement plans developed and actioned. The CQC continue to meet with the Trust and provide ongoing assurance to any emerging issues. We have had favourable feedback from CQC, however the monitoring visits put in place during the pandemic do not have ratings attached to them. Work in line with well-led continues. The amber progress rating reflects the gap in assurance around external validation as a result of CQC rating activity and the level of embeddedness of the J2O.	**Lead: EA** Quality Committee Weekly Executive Board
Involve patients and the public to influence decisions about their personal care fostering a learning culture and best practice to improve patient experience by: • responding to the needs of people from protected characteristics groups • implementing "Time to Care". • achieving patient safety metrics	**GREEN** on track	Work continues on a range of activities around patient engagement. Observe and Act has been introduced and plans in place for the schedule of assessments. These align to our J20 programme. The Health Inequalities group are overseeing the work plan in relation to the lived experiences that involves some discovery interviews commencing in maternity services. LD has had an increased focus across the organisation. CHFT are in the process of recruiting a Nurse Consultant for Mental Health to address the unique needs of this group pf service users.	**Lead: EA** Quality Committee Weekly Executive Board

Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery.	**AMBER** off track – with plan	Overall the structures are in place with system partners to support elective recovery with plans in place to clear the longest waiting patients by the end of March 2022. However given the size & scale of the numbers it will require further discussion as we move forward and new ways of reporting on our backlogs. The Urgent & Emergency Care Board continues to function and has supported the recent development of the Urgent Care Response Team. Aligned to this is the work on improving the delayed transfers of care and patients with a reason to reside. There are many strands of work ongoing but we are not where we need to be given the challenges of the recent Omicron wave.	**Lead: JF** Integrated Board Report Weekly Executive Board Audit and Risk Committee Finance and Performance Committee
Deliver the actions in the Trust's Health and Safety Plan.	**GREEN** on track	The health and safety management system is making good process in its development across all relevant areas of the Trust which includes a review of policies, procedures and risk assessments. Sub-groups are well established to help strengthen divisional engagement. A continued focus around COVID compliance assurance measures by improvements to risk assessments and monitoring oversight has taken place and continues. A lens has also been placed upon improving compliance across THIS, HPS to ensure they have the right local measures in place. Direct working has taken place with the Community Healthcare Division to understand their needs and expectations around lone working and violence and aggression prevention with a focus group, expanded to include all other community run services. First aid training in the non-clinical areas has been reviewed, with an uplift of 45 extra trained colleagues	**Lead: SD** Quality Committee Trust Board

		Home working display screen equipment assessment tool has been revised and planned for sharing to all relevant colleagues during 2022.	
Goal: A workforce fit for the future			
Deliverable	**Progress rating**	**Progress summary**	**assurance route**
Develop and implement flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for Nurse staffing and specialist medical roles, thus retaining a turnover below 10%.	**GREEN** on track	The Trust continues to implement actions identified through the Recruitment Strategy and progress updates are presented at Workforce Committee. This includes regular updates on both nursing and medical workforce programmes. Rolling 12 month turnover for the Trust is at 7.91% as of December 2021 and therefore achieving the target. Vacancy rate is 2.08%. The Healthcare Support Worker programme continues to achieve the national target of 0 vacancies overall in the Trust. Following on from Hard Truths in January 2022, workforce models will be rebased and a review of vacancy rates for HCSW will be undertaken. The NHS Long Term Plan has set a target of reducing Nursing vacancies by 5% by 2028 and the Trust remains committed to driving down the vacancy position at CHFT. The vacancy rate for qualified nurses has improved and stands at 59.55FTE in January 2022. We committed to recruiting 70 International Nurses before the end of Dec 2021. Despite delays due to travel restrictions and quarantine requirements to date we have managed to successfully recruit 64 nurses with the remaining 6 due to arrive in February 2022. The remaining 6 will have completed by April 2022. Significant work is being undertaken for international recruitment. 32 Nurses have undertaken the OSCE preparation programme, 22 have successfully passed their	**Lead: SD** Workforce Committee

		OSCE exam and are either now registered or awaiting NMC Pin. 10 are in the training programme and will sit the OSCE in either January or March. CHFT pride themselves on a programme of pastoral support which exceeds the expectation set out by HEE and NHSE/I and includes: • IR Facebook page for social engagement before and after arrival • Access to CHF/T's international recruitment specialist who guides recruits through the whole process from interview to taking their test. Assisting with transport, accommodation, visas, registering with GPs, shopping and the local area, booking tests including travel to Ireland. • A welcome session and booklet that includes information about the UK, the local area and also the NHS including its background and the role of a nurse in the UK today. • An open-door policy where during working hours all candidates past and present can drop in for support • Clinical support and orientation • Welcome packs and meet and greets (we are the first people recruits meet when they arrive) • Support with NMC registration During the period 2021 the impact of this approach can be measure against the attrition which represents 1 against 63 international nurse recruits. 11 apprentices successfully registered as Nursing Associates in January with a further 2 due to complete in quarter 4 following module resits. These have been allocated to vacant RN positions across the Trust. There are 3 active cohorts of Trainee Nursing Associates (TNAs) (42 apprentices in total, of which 10 are due to qualify in Dec 22, there will be no graduating June cohort in 2022 due to the pandemic and a pause of recruitment in 2020). A further 40	

		places in 2022 are anticipated pending the approval of associated business case. In addition, work is underway across WOD and clinical divisions to improve our recruitment and retention with initiatives such as Kickstart, Care Club, and we continue to work with St John's Cadets and Princes Trust "Get Into" projects. In January 2022 the budgeted establishment for Medical and Dental staff was 688 WTE. With 28 vacancies in total at that point the vacancy rate remains less than 5%. Of these vacancies 22 are at consultant level, although appointments have been made to some of these posts, with new starters expected to commence in the next few months. Turnover has decreased from just over 7% in December 2020 to 6% in December 2021 and there has been a year on year net increase of 44 more Medical and Dental staff employed (more starters than leavers). These increases are most notable in Radiology, Gastroenterology and Urology. Some of the remaining consultant vacancies are proving particularly difficult to recruit to, such as Stroke Medicine which has been advertised several times. We have also advertised in the British Medical Journal for Neurophysiology and Neurology recently to try and attract applicants from across the UK who may want to consider relocating. These are small sub-specialist departments losing long-standing colleagues due to retirement. Whilst some flexibility around the workforce model is being considered these posts will be difficult to fill. 3 areas were identified to trial workforce design processes and principles. This work has been delayed due to the impact of the pandemic however one workstream (Multi-skilled Worker in ED) has progressed. The Multi Skilled Worker project has been through an options appraisal	

		which looks at 3 different options for the workforce design. The project paper has been written up and final financial considerations for each model are being reviewed with a decision pending on how to proceed next. Through Hard Truths, further areas have been identified to use workforce design principles. Work is underway to develop an updated Recruitment Strategy which will reflect the lessons learned from Covid and will facilitate the Trust's plans for significant workforce change associated with reconfiguration and our ability to deliver on elective recovery following Covid.	
Develop an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions.	**GREEN** on track	An inclusive talent management toolkit and framework has been developed **Aim –** The starting point for all things development is enabling quality 1 to 1 conversations between managers and colleagues. The Inclusive Talent Framework & Toolkit provides colleagues/managers with a resource to support successful/supportive talent management conversations to guide and signpost colleagues with their career journey to get the best out of their people and with One Culture of Care wrapped around the conversations This Inclusive Talent Approach was launched on 1st November 2022 **Progress** – Ongoing discussions with middle/line managers across the organisation – targeting Corporate first then Divisions Outputs – the outputs from these conversations will enable colleagues and managers to understand aspirations, seek to understand challenges and opportunities and signpost colleagues to a wealth of support via our Development for all programme	**Lead: SD** Workforce Committee
Revise our Leading One Culture of Care and Management Essentials programme to support managers to successfully	**GREEN** on track	**Leading One Culture of Care** Aim : For colleagues who want to expand their learning and practically apply the tools and resources from the Leadership Development platform, role modelling One Culture of Care for our colleagues and compassionate care	**Lead: SD** Workforce Committee

lead their teams through Recovery and beyond		for our patients. This programme will enhance engagement and leadership capability. 5 key components: **Conversation** - Talent Toolkit, wellbeing conversations, one culture of care conversations, 'time for' conversations, authentic conversations **Inspiring** - role modelling, visibility, showing others you are human, humility, inclusive 'seek first to understand' **Resilience** - what have we learned from the challenges, reflection time, what made you stronger, what surprised you, what zapped your energy, importance of self-care, 'knowing you' **Problem solving** - systems leadership / balancing priorities, **Teamworking** - team and personal dynamics, knowing your team, capacity and capability 80 plus delegates 89 % female Range of ethnicities Range of grades Range of roles 3 x Cohorts All have been assigned a cross divisional network group to challenge and support one another with applying the learning from the leadership development platform **Management Essentials** This programme is currently available via the Leadership Development platform. It is the intention to expand this further via virtual 'lunch & learn' classroom sessions where discussions will be held around applying the learning into practice	
Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of our local communities.	**AMBER off track with plan**	The NHS People Plan emphasises the importance of improvement work in relation to equality and diversity and recruitment. It makes specific reference to an 'overhaul of recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.'	**Lead: SD** Workforce Committee

		A review of our practices was carried out in February 2021 identifying areas for development. A further review is currently underway to identify proposals for further addressing our inclusive approach across the Trust.	
Develop health and wellbeing support plans for all Departments to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey.	**GREEN** on track	Through focussing on Once Culture of Care for our colleagues and compassionate care for our patients we aim to embed a culture where wellbeing is at the forefront of colleague's minds Our plans have evolved throughout the pandemic, and this has demonstrated in a positive score in the staff survey relating to 'the organisation takes positive action on health and wellbeing'. Further action in 2022 will include wellbeing discussions to play a part in the Leading One Culture of Care Programme, expansion of the wellbeing partners we work with to provide specific enhanced professional support for financial and physical health, wellbeing events, improving the local environment and effective deployment of Mental Health First Aiders / Wellbeing Ambassadors The Health and Wellbeing Risk Assessment, that was first launched in June 2020, has been refreshed and will be relaunched on 14 February 2022. Colleagues will be encouraged to complete this at least once a year. The responses help us to support individual colleague needs and work through the key issues and themes by establishing health and wellbeing information directly from colleagues.	**Lead: SD** Workforce Committee
Goal: Sustainability			
Deliverable	**Progress rating**	**Progress summary**	**Assurance route**
Deliver the regulator approved financial plan.	**GREEN** on track	The Trust is forecasting to deliver the financial plan for 2021/22. The efficiency requirement for both H1 and H2 will not be delivered, and this leaves a recurrent challenge into 2022/23. Against a full year plan of £9.7m, only £6m is forecast.	**Lead: GB** Reported to Finance & Performance Committee / Estates Sustainability Committee

		Delivery of the plan has been reliant on non-recurrent support from system partners at both Place and ICS level, along with further benefit from nationally distributed monies.	Monthly regulator discussions
Demonstrate improved performance against Use of Resources key metrics.	**GREEN** on track	The finance use of resource metric is presented monthly at Finance and Performance committee. This shows improvement from when our assessment took place. Whilst the metric is no longer being collected by NHSEI we have continued to monitor. A report was published to F&P in June 2021 that demonstrated progress against other KLOE and progress against all CQC actions identified.	**Lead: GB** Reported to Finance & Performance Committee Quality Committee Monthly regulator discussions
Implement the Trust Board approved Green Plan demonstrating progress against the agreed action plan that will support reduction in the Trust's carbon footprint.	**GREEN** on track	The Green Plan was first approved by Transformation Planning Board in March 2021. Delivery is managed by the CHS and progress against the Sustainable Action Plan (SAP) is monitored through the Green Planning sub-group. The Green Plan is a Board approved document which is submitted at ICS level. Some of the key progress this year include: - 78% of CHS fleet currently ultra-low emissions vehicles; this will rise to 93.75% on delivery of 5 new vehicles by April 2022. - Successful bid for Low Carbon Skill Fund through Salix. £53,000 awarded - HRI reconfiguration scheme is on track to meet BREEAM Excellent requirements for sustainable design in new construction - 10 new secure cycle lockers and 2 Sheffield Stands with capacity for up to 8 bikes each, installed in key locations across the site at HRI - A Biodiversity Management Plan has been developed covering our estate	**Lead: SS** Transformation Programme Board Trust Board

Collaborate with partners across West Yorkshire and in place to deliver resilient system plans.	**GREEN** on track	The West Yorkshire and Harrogate Health and Care Partnership (ICS) has been progressing work to develop future governance arrangements to implement the legislative changes set out in the White Paper from June 2022. This includes the establishment of a West Yorkshire Integrated Care Board (ICB). The West Yorkshire ICS has confirmed the importance of subsidiarity. Each place across West Yorkshire has identified that a Place-Based Committee of the ICB is the preferred structure to make decisions about ICB functions and resources at place level. In Calderdale work has progressed to develop the place based working arrangements and a Memorandum(s) of Understanding to describe this. The Trust Board confirmed agreement to sign up to this in January 2022. Arrangements for place based working in Kirklees are in development and the proposed place based working arrangements will be submitted to a future Trust Board meeting. The Trust continues to work collaboratively and contribute to the West Yorkshire Association of Acute Trusts programme of work in relation to clinical support services (e.g. imaging, pharmacy, pathology, scan for safety), corporate services (e.g. workforce, procurement, health inequalities) and clinical services (e.g. vascular and non-surgical oncology). CHFT also works proactively with Trusts to provide mutual aid to support service resilience and recovery from the pandemic.	**Lead: AB** Plans reviewed by Board and WYAAT Committee in Common System Leadership Meetings with NHSE and ICS

Sustainability

11. Operational and Financial Annual Plan 2022/23

To Approve

Presented by Gary Boothby and Jo Fawcus

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title of report:	Operational and Financial Plan 2022/23
Author:	Kirsty Archer, Deputy Director of Finance
Sponsor:	Gary Boothby, Executive Director of Finance
Previous Forums:	Finance and Performance Committee

Purpose of the Report

To approve the draft operational and financial plan for 2022/23 ahead of submission to NHSI/E by the deadline of 17 March 2022. The final plan is due by 28 April 2022 and will require a further stage of approval prior to submission.

Key Points to Note

Operational plan

Operational plans align with national expectation to maximise elective inpatient and outpatient activity and reduce long waits through delivery of 104% of 2019/20 activity levels. Current plans present a challenge regarding size of follow-up backlog vs planning expectation to reduce follow-ups by 25% by the end of 2022/23.

Diagnostics backlogs are planned to be recovered in quarter 1. Continued delivery of all cancer targets and standards is assumed.

The operational plans are underpinned by the nationally advised assumption that Covid 19 levels return to Summer 2021 levels and assume the application of the latest infection prevention and control (IPC) guidance.

Financial plan

The financial plan is based upon national funding assumptions being applied at the Kirklees and Calderdale place level in line with the Integrated Care Board financial envelope. Aligned with the operational plan a level of Covid cost exit is assumed, although some cost pressure remains. It is assumed that the activity levels support receipt of the elective recovery funding in full to support investment to achieve the 104% target. A minimal level of investments are assumed, following initial review and incorporating pre-commitments.

The resultant position is a financial gap of £43m, this is partially offset by a planned £20m efficiency programme to leave a residual planned deficit of £23m at the draft stage. A number of risks and opportunities exist against this plan, notably, the scale of the efficiency challenge at 4.35% being a risk but to counter this improved productivity and staff availability could deliver elective recovery at a lower cost. Further opportunity may also exist to reduce Covid-19 associated costs subject to IPC guidance.

EQIA – Equality Impact Assessment
This paper describes the overall plan position. Any individual service changes which form part of the plans will undergo an Equality Impact Assessment and Quality Impact Assessment on a case by case basis.
Recommendation
The Board is asked to: • **APPROVE** the draft operational and financial plans and • **NOTE** the scale of potential efficiency requirement.

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Draft Operational and Financial Plan 2022/23

28 February 2022

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Annual Planning 22/23 – Timetable

Outline timetable for Planning	Date / Deadline	Approval required
Draft Annual Plan to F&P Committee		28th Feb 22
Annual Planning Workshop (Efficiency)	1st Mar 22	
Draft Annual Plan to Board of Directors		3rd Mar 22
Place leads to submit Draft Workforce/ Narrative plans to ICS	8th Mar 22	
Place leads to submit Draft Activity plans to ICS	11th Mar 22	
Draft Financial Planning Return to NHSI/E	**17th Mar 22**	
Final Plan to F&P Committee		4th April 22
Place leads to submit Final Workforce/ Narrative plans to ICS	19th Apr 22	
Place leads to submit Final Activity plans to ICS	22nd Apr 22	
Final Financial Planning Return to NHS1/E	**28th April 22**	
Final Plan to Board of Directors		5th May 22

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Operational Plan

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Draft Operational Plan

Maximise elective inpatient activity and reduce long waits

- Zero waits of over 104 weeks.
- Reduction to zero waits of over 78 weeks by the end of 2022/23.
- Improvement in waits of over 52 weeks by the end of 2022/23.
- Delivery of 104% of 2019/20 elective and day case inpatient levels.
- Delivery through increased internal capacity, improved productivity and use of Independent Sector.
- Further opportunity through changes to IPC guidelines.

Maximise outpatient activity and reduce long waits

- Current plan presents a challenge to deliver 104% of 2019/20 outpatient first activity.
- Further work required between draft and final plan to review capacity and productivity opportunities and reduction of ASI position.
- Current plans presents a challenge regarding size of follow-up backlog vs planning expectation to reduce follow-ups by 25% by the end of 2022/23.
- Continued use of insourcing for challenged specialties ENT, Ophthalmology & Neurology.
- Further opportunity through changes to IPC guidelines.
- To move/discharge 5% of outpatient attendances to PIFU pathways by March 2023.
- To deliver specialist advice requests (including advice and guidance) of 16 per 100 first attendances by March 2023.

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Draft Operational Plan

Diagnostics

- Recovery of MRI backlog by end May'22 through use of mobile scanner and installation of 2 new scanners (note risk on installation date).
- Continuation of current capacity within CT and non-obstetric US.
- Recovery of Echocardiology backlog by end Apr'22 through continued use of insourcing.

Cancer

- Continued delivery of all cancer targets and standards.

Beds

- Return to June 2021 core bed base plus additional Covid bed capacity.
- Return to Summer 2021 Covid and TOC levels assumed.
- 92% bed occupancy assumed with length of stay improvement vital in delivery of this.

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Financial Plan

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Draft Planning Assumptions

- Many assumptions still
  - Block allocations uplifted by 3.8%
  - Covid-19 funding reduced by 57% (£13m reduction)
  - Assumes Elective Recovery Funding (ERF) will flow in full to Acute Providers from local CCGs on a fair shares basis, (£14.1m assumed).
  - Assumes we deliver 104% of 19/20 levels
  - Some cost reduction assumed – IPC, beds, streaming
  - Pressures still being reviewed
  - Few developments supported

- Risks
  - Non Pay inflation
  - Elective Recovery Funding (ERF) flow
  - Enhanced pay
  - CIP Scale and acceptance of the plan

- Contingency of £1m only. No winter reserve

Bridge 1

Bridge to 22/23 Plan	Trust Bridge £'m	Trust Total £'m
Recurrent Baseline C/F into 22/23	**(69.059)**	**(69.059)**
System Top Up Funding		
System Top Up funding	**42.314**	
21/22 Growth Funding allocated non-recurrently	**3.524**	
21/22 Capacity Funding allocated non-recurrently	**3.000**	
Sub Total: Top Up Funding	**48.838**	**(20.221)**
22/23 Efficiency Impacts		
Tariff Efficiency Factor	**(5.563)**	
Convergence - System Distance from Target	**(2.352)**	
Sub Total: System efficiency / inflationary impacts	**(7.915)**	**(28.136)**
Pressures:		
Covid-19 Pressures (Non recurrent)	**(11.175)**	
Other Pressures	**(2.682)**	
Estimated Covid-19 funding (non-recurrent)	**8.901**	
Sub Total: Net Pressures	**(4.956)**	**(33.093)**

21/22 Has £72m of Non Rec support, FYE of developments and impact of 21/22 non recurrent CIP

Additional Challenge due to deficit

Assumes £5m reduction compared to 21/22 expenditure (savings TBC)

Bridge 2

Bridge to 22/23 Plan	Trust Bridge £'m	Trust Total £'m
Activity & Growth:		
Activity Changes	(0.266)	
Growth	(6.642)	
22/23 Growth Funding	8.300	
Sub Total: Growth	1.392	(31.700)
Other Planning Adjustments:		
Committed / Approved recovery costs	(0.759)	
Recovery Costs	(21.942)	
Elective Recovery Funding	14.125	
Developments - approved but not in baseline	(1.274)	
Developments	(1.510)	
Reprovide Contingency	(1.000)	
Other Non-Operating costs	(2.000)	
Vacancy Factor	2.222	
Sub Total: Other Planning Adjustments	(11.379)	(43.079)
22/23 Deficit	(43.079)	(43.079)
22/23 CIP		20.000
22/23 Deficit - Draft Plan		(23.079)

c.£7.8m required to achieve 19/20 activity levels (WLI, Insource and outsource). Assumes ERF of £14.1m would be spent in full to achieve 104%

Includes Paeds ED, IT optimisation, pharmacy spend, development in HPS

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NHS Foundation Trust

Opportunities

Opportunities:

- Spending £50m more than we were 2 years ago. CIP holiday!
- Improved productivity and staff availability could deliver Recovery at a lower cost.
- Further opportunity to reduce Covid-19 associated costs subject to IPC guidance.
- Potential to secure greater share of Place allocated Capacity Funding to support winter pressures.
- Explore opportunities to secure additional funding from non-recurrent system allocations e.g. SDF.

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ICS Early Draft Position

Provider/CCG	*Net 2022/23 planned position £m*	*Efficiency/CIP plan (% of total expenditure)* *£m*	
Airedale NHS Foundation Trust	-5.36	5.00	2.15%
Bradford District Care NHS Foundation Trust	-6.04	3.78	1.97%
Bradford Teaching Hospitals NHS Foundation Trust	-10.81	10.09	1.95%
Calderdale And Huddersfield NHS Foundation Trust	-23.10	20.00	4.35%
Leeds And York Partnership NHS Foundation Trust	0.00	7.62	3.58%
Leeds Community Healthcare NHS Trust	0.00	1.90	1.01%
Leeds Teaching Hospitals NHS Trust	-15.04	70.13	4.27%
Mid Yorkshire Hospitals NHS Trust	-20.59	12.10	1.85%
South West Yorkshire Partnership NHS Foundation Trust	-0.03	6.40	2.26%
Yorkshire Ambulance Service NHS Trust	-35.73	6.90	2.04%
Provider Total	***-116.7***	***143.9***	***2.54%***
NHS Bradford and Craven CCG	-20.47	*2.3*	0.55%
NHS Calderdale CCG	-2.06	*3.1*	2.04%
NHS Kirkless CCG	-12.29	*0.0*	0.00%
NHS Leeds CCG	0.05	*9.7*	1.82%
NHS Wakefield CCG	0.00	*2.6*	0.86%
CCG Total	***-34.8***	***17.7***	***1.06%***
ICS Total	***-151.5***	***161.6***	***0.0***

Early data collation by ICS suggests significant planning gap

CHFT highest CIP ambition but highest residual deficit

Significant challenge to Calderdale and Kirklees place (Kirklees suggesting best case £4m-5m deficit)

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Capital and Cash

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Capital Plan

- ICS allocation of CDEL to Trust level TBC – expected up to £17m
- £17m Includes ICS capital support to Multi Storey Car Park to be managed through profiling
- Internal capital plan (wave 1) agreed at £7.5m
- Further Dragon's Den process planned for September for wave 2
- National allocation of Public Dividend Capital in 2022/23 for Reconfiguration £21.8m, approved projected, e.g. Scan for Safety £0.9m and others TBC, e.g. Targeted Investment Fund (TIF) for projects in support of elective recovery (cash backed)
- ICS allocation of CDEL requires local management of cash to support investment i.e. Capital allocation is more than the cash generated in-year for capital investment

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Cash

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- Forecast 2022/23 opening cash balance £45.8m.
- Deficit position of £23m would significantly reduce this cash balance, but access to PDC revenue support is only be possible once cash reserves exhausted.
- This could impact on future Capital plans where phasing of PDC is not aligned with expenditure / internal cash resource is required to support.
- Cash balance expected to reduce further in 2022/23 as accruals unwind – e.g. annual leave.
- Aligned Payment Incentive contracts should provide a level of cash security, with payments from commissioners due on the 15th of the month.
- NHSE/I continued focus on prompt payment duties.

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Recommendations

- To approve the draft operational and financial plans.

- To note the scale of potential efficiency requirement.

12. Recovery Update

To Note

Presented by Jo Fawcus

13. Month 10 Financial Summary

To Note

Presented by Gary Boothby

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Month 10 Finance Report
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance and Performance Committee – 28 February 2022

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 10 (January 22).

Key Points to Note

Year to Date Summary

Year to date the Trust is reporting a £2.38m deficit, a £0.18m favourable variance from plan. Whilst the Trust has submitted a balanced plan for the year and has delivered a break-even position in the first half of the year (H1), the financial position remains challenging. The deficit position is driven by a combination of staffing pressures, in particular the growing cost of temporary staffing (enhanced bank rates and high cost agency) and Recovery costs. H2 includes a significant efficiency requirement of £6.7m, with only £3.9m identified of which £3.2m is currently forecast to deliver. However, the Trust has successfully bid for additional Elective Recovery+ funding in support of schemes to increase capacity and has also secured some additional funding allocations from both local Commissioners and the Integrated Care System (ICS), which between them have mitigated the additional cost pressures in the year to date position.

- Funding for H2 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H2, the Trust has been allocated £21.16m of System Top Up funding, £12.75m of System Covid funding and £1.76m of Growth funding, a total Top Up of £35.66m for H2. £2.32m of additional Capacity funding has been allocated to the Place to support winter and urgent care pressures, of which £1.5m has been agreed by the Urgent & Emergency Care Board to support Trust pressures.
- In addition the Trust continues to have access to funding for Covid-19 costs that are considered to be outside of the System Envelope and year to date has accounted for £5.86m of additional funding to cover costs incurred for Vaccinations, Covid-19 Testing, 3rd Year Student Nurse contracts and Isolation Hotels for overseas recruits. Income up to the end of M6 has now been approved and received, M7-10 funding remains subject to approval.
- In total the Trust has incurred costs relating to Covid-19 of £18.81m. Costs were driven by: Covid-19 virus testing, vaccinations (on hospital site and for local vaccination centre), the segregation of patient pathways (particularly within the Emergency Department), ICU staffing models and remote management of patients.
- Year to date the Trust has delivered efficiency savings of £5.22m, but largely on a non-recurrent basis.

- Agency expenditure year to date is £5.78m, £1.57m lower than the NHS Improvement Agency expenditure ceiling. However there has been a large increase in Bank costs that has accelerated over the last 7 months due to the enhanced pay agreement.
- Total planned inpatient activity was 97.5% of the month 10 2019/20 baseline, although within this total Elective inpatient activity was only at 89.1%. No ERF has been assumed for H2, although there are indications that some funding may be available for allocation at System level.

Key Variances

- Income is £12.98m higher than planned year to date. This includes £3.57m income to support the unplanned and backdated 21/22 pay awards. Additional income to offset outside of system envelope Covid-19 costs is £4.33m higher than planned year to date. ERF is below the planned level at £3.69m, an adverse variance of £0.62m year to date, however, this pressure is more than offset by the £2.43m additional Elective Recovery+ funding, £1m of reallocated System funding and a further £0.5m of additional CCG income to support capacity.
- Pay costs are £8.28m above the planned level year to date, although this includes £3.57m of H1 backdated pay awards which are funded, leaving an underlying variance of £4.71m adverse. £1.05m of Covid-19 costs are outside of envelope and therefore also offset by additional income. Recovery costs are £0.07m higher than planned. The adverse variance is largely driven by the agreed enhanced pay for Bank staff, an additional cost of £0.82m in month and £4.75m year to date, (£2.25m adverse variance) and growing Agency costs (£2.02m adverse variance year to date). These staffing pressures have increased over the last few months due to the spike in Covid cases and Emergency Department segregation and enhanced staffing models on Wards and in Critical Care continue to drive higher costs.
- Non-pay operating expenditure is higher than planned by £4.84m. This variance includes Covid-19 related expenditure of £3.31m for H1 vaccination costs and Covid-19 testing that were not budgeted and are offset by income and Recovery costs that are £2.46m below plan, the underlying position is therefore a £3.99m overspend driven by unidentified efficiencies, High Cost Drugs growth and a pressure on the Clinical Negligence Scheme for Trusts (CNST).

H2 (Oct-Mar) Forecast

The plan for H2 is to deliver a break-even plan, (excluding a one off non-recurrent technical accounting adjustment of £5m) and the Trust is forecasting to achieve this plan. Whilst only £3.9m of the targeted £6.7m H2 efficiency have been identified, the shortfall has been mitigated by confirmation of additional Elective Recovery+ funding and the securing of additional funding allocations from both ISC and CCG partners to support capacity. The current operational position is driving additional bank and agency costs due to increased Covid related absence which may require further mitigation to achieve the forecast position.

Attachment: Month 10 Finance Report

EQIA – Equality Impact Assessment

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

Recommendation

The Board is asked to receive the Month 10 Finance report and **NOTE** the financial position for the Trust as at January 2022.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st Jan 2022 - Month 10

KEY METRICS

	M10				YTD (JAN 2022)				Forecast 21/22			
	Plan	Actual	Var		Plan	Actual	Var		Plan	Forecast	Var	
	£m	£m	£m		£m	£m	£m		£m	£m	£m	
I&E: Surplus / (Deficit)	(£0.32)	(£0.30)	£0.02		(£2.56)	(£2.38)	£0.18		£0.00	£0.01	£0.00	
Agency Expenditure (vs Ceiling)	(£0.74)	(£0.84)	(£0.11)		(£7.35)	(£5.78)	£1.57		(£8.82)	(£7.31)	£1.51	
Capital	£3.18	£1.58	£1.60		£13.20	£9.90	£3.30		£18.99	£23.29	(£4.30)	
Cash	£41.95	£46.99	£5.04		£41.95	£46.99	£5.04		£38.75	£45.82	£7.07	
Invoices paid within 30 days (%) (Better Payment Practice Code)	95.0%	93.9%	-1%		95.0%	94.2%	-1%					
CIP	£1.32	£0.41	(£0.91)		£7.07	£5.22	(£1.85)		£9.70	£6.22	(£3.48)	
Use of Resource Metric	2	3			3	3			2	2		

Year to Date Summary

Year to date the Trust is reporting a £2.38m deficit, a £0.18m favourable variance from plan. Whilst the Trust has submitted a balanced plan for the year and has delivered a break-even position in the first half of the year (H1), the financial position remains challenging. The deficit position is driven by a combination of staffing pressures, in particular the growing cost of temporary staffing (enhanced bank rates and high cost agency) and Recovery costs. H2 includes a significant efficiency requirement of £6.7m, with only £3.9m identified of which £3.2m is currently forecast to deliver. However, the Trust has successfully bid for additional Elective Recovery+ funding in support of schemes to increase capacity and has also secured some additional funding allocations from both local Commissioners and the Integrated Care System (ICS), which between them have mitigated the additional cost pressures in the year to date position.

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Total Group Financial Overview as at 31st Jan 2022 - Month 10

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M10

CLINICAL ACTIVITY

	M10 Plan	M10 Actual	Var
Elective	3,248	3,514	266
Non-Elective	49,193	44,023	(5,170)
Daycase	39,141	38,649	(492)
Outpatient	337,500	337,479	(21)
A&E	139,159	144,729	5,570
Other NHS Non-Tariff	1,366,536	1,375,633	9,098
Other NHS Tariff	76,867	73,581	(3,287)
Total	**2,011,645**	**2,017,607**	**5,963**

TOTAL GROUP: INCOME AND EXPENDITURE

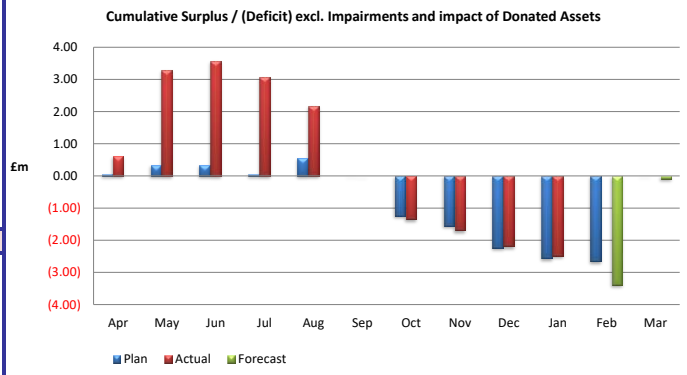
	M10 Plan	M10 Actual	Var
	£m	£m	£m
Elective	£9.46	£9.44	(£0.02)
Non Elective	£95.55	£95.56	£0.00
Daycase	£21.11	£21.10	(£0.01)
Outpatients	£28.78	£28.77	(£0.01)
A & E	£19.79	£19.79	(£0.01)
Other-NHS Clinical	£140.28	£154.58	£14.29
CQUIN	£2.83	£2.83	(£0.00)
Other Income	£43.71	£42.27	(£1.44)
Total Income	**£361.53**	**£374.33**	**£12.81**
Pay	(£249.23)	(£257.50)	(£8.28)
Drug Costs	(£35.37)	(£35.84)	(£0.47)
Clinical Support	(£32.08)	(£32.23)	(£0.15)
Other Costs	(£49.11)	(£53.33)	(£4.22)
PFI Costs	(£10.85)	(£10.85)	£0.00
Total Expenditure	**(£376.65)**	**(£389.76)**	**(£13.12)**
EBITDA	**(£15.12)**	**(£15.43)**	**(£0.31)**
Non Operating Expenditure	(£23.73)	(£23.24)	£0.48
Surplus / (Deficit) Adjusted*	**(£38.85)**	**(£38.67)**	**£0.18**
System Top Up Funding	£36.29	£36.29	£0.00
Surplus / Deficit*	**(£2.56)**	**(£2.38)**	**£0.18**

* Adjusted to exclude items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Gains on Disposal

DIVISIONS: INCOME AND EXPENDITURE

	M10 Plan	M10 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	(£75.09)	(£77.30)	(£2.21)
Medical	(£90.09)	(£98.77)	(£8.67)
Families & Specialist Services	(£71.59)	(£71.37)	£0.21
Community	(£22.02)	(£21.61)	£0.41
Estates & Facilities	£0.00	£0.19	£0.19
Corporate	(£44.08)	(£44.34)	(£0.25)
THIS	£1.32	£1.86	£0.54
PMU	£2.29	£2.25	(£0.03)
CHS LTD	£0.67	£0.61	(£0.06)
Central Inc/Technical Accounts	£299.12	£300.77	£1.65
Reserves	(£3.09)	£5.33	£8.41
Surplus / (Deficit)	**(£2.56)**	**(£2.38)**	**£0.18**

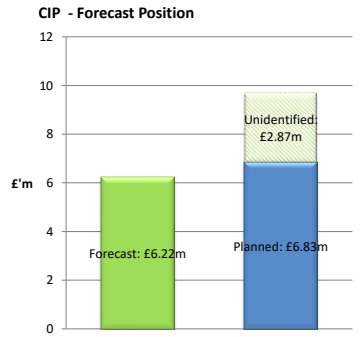
TOTAL GROUP SURPLUS / (DEFICIT)

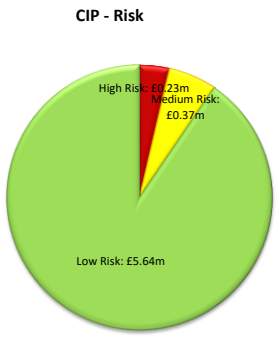


KEY METRICS

	Year To Date			Year End: Forecast			
	M10 Plan	M10 Actual	Var	Plan	Forecast	Var	
	£m	£m	£m	£m	£m	£m	
I&E: Surplus / (Deficit)	(£2.56)	(£2.38)	£0.18	£0.00	£0.01	£0.00	
Capital	£13.20	£9.90	£3.30	£18.99	£23.29	(£4.30)	
Cash	£41.95	£46.99	£5.04	£38.75	£45.82	£7.07	
Invoices Paid within 30 days (BPPC)	95%	94%	-1%				
CIP	£7.07	£5.22	(£1.85)	£9.70	£6.22	(£3.48)	
	Plan	Actual		Plan	Forecast		
Use of Resource Metric	3	3		2	2		

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £9.7m¹ **Total Forecast £6.22m**

¹ £3m target for H1 plus £6.7m target for H2

YEAR END 21/22

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	3,958	4,247	289
Non-Elective	58,213	52,503	(5,710)
Daycase	47,497	47,250	(247)
Outpatient	409,301	409,079	(222)
A&E	164,537	169,438	4,901
Other NHS Non- Tariff	1,650,603	1,657,145	6,542
Other NHS Tariff	92,256	88,637	(3,619)
Total	**2,426,366**	**2,428,301**	**1,934**

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£11.39	£11.35	(£0.04)
Non Elective	£112.76	£112.77	£0.01
Daycase	£25.29	£25.27	(£0.02)
Outpatients	£34.85	£34.83	(£0.02)
A & E	£23.16	£23.15	(£0.02)
Other-NHS Clinical	£171.08	£192.97	£21.89
CQUIN	£3.37	£3.37	(£0.00)
Other Income	£52.88	£50.85	(£2.03)
Total Income	**£434.78**	**£454.56**	**£19.77**
Pay	(£300.23)	(£312.11)	(£11.88)
Drug Costs	(£42.56)	(£43.33)	(£0.78)
Clinical Support	(£39.79)	(£39.07)	£0.72
Other Costs	(£54.13)	(£63.47)	(£9.34)
PFI Costs	(£13.03)	(£13.46)	(£0.43)
Total Expenditure	**(£449.74)**	**(£471.45)**	**(£21.71)**
EBITDA	**(£14.96)**	**(£16.90)**	**(£1.94)**
Non Operating Expenditure	(£28.38)	(£26.44)	£1.94
Surplus / (Deficit) Adjusted*	**(£43.34)**	**(£43.34)**	**£0.00**
System Top Up Funding	£43.34	£43.34	£0.00
Surplus / Deficit*	**£0.00**	**£0.01**	**£0.00**

* Adjusted to exclude forecast £5m non-recurrent accounting adjustment and all items excluded for assessment of System financial performance: Donated Asset Income, Donated Asset Depreciation, Donated equipment and consumables (PPE), Impairments and Gains on Disposal

DIVISIONS: INCOME AND EXPENDITURE

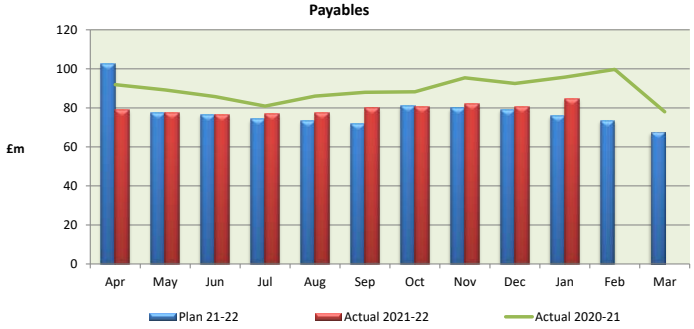
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	(£91.53)	(£95.14)	(£3.61)
Medical	(£109.88)	(£120.55)	(£10.67)
Families & Specialist Services	(£86.24)	(£86.13)	£0.11
Community	(£26.56)	(£26.08)	£0.48
Estates & Facilities	£0.00	£0.19	£0.19
Corporate	(£53.13)	(£53.32)	(£0.19)
THIS	£1.61	£1.93	£0.32
PMU	£2.60	£2.73	£0.13
CHS LTD	£0.81	£0.73	(£0.08)
Central Inc/Technical Accounts	£359.13	£361.79	£2.66
Reserves	£3.19	£13.85	£10.66
Surplus / (Deficit)	**£0.00**	**£0.01**	**£0.00**

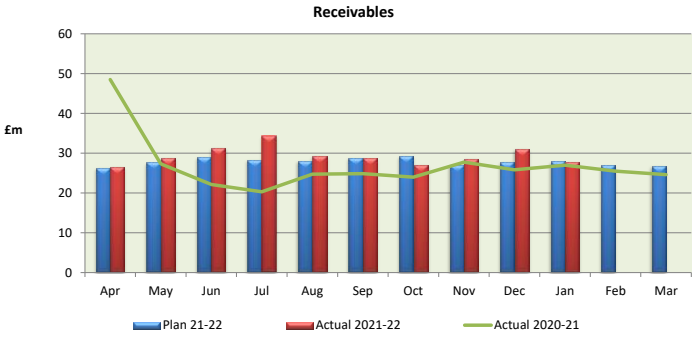
Total Group Financial Overview as at 31st Jan 2022 - Month 10

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

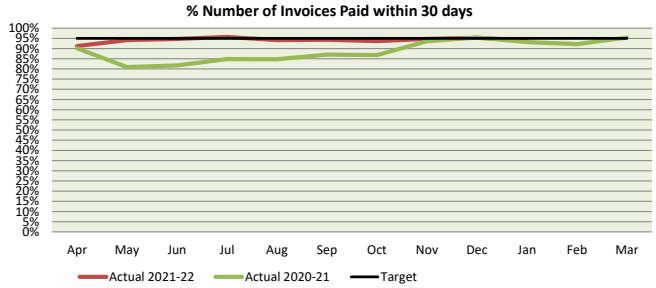
WORKING CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Payables (excl. Current Loans)	(£76.04)	(£84.59)	£8.55	
Receivables	£27.94	£27.82	£0.12	



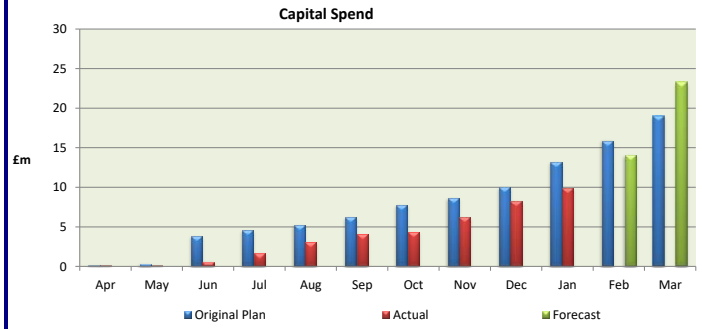


BETTER PAYMENT PRACTICE CODE



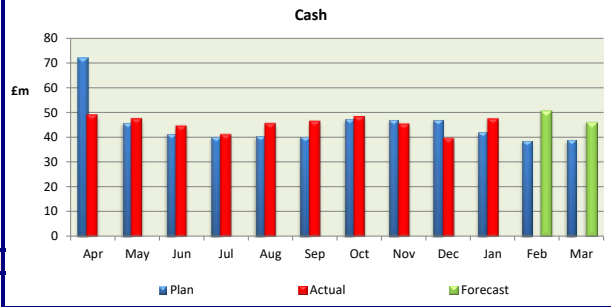
CAPITAL

	M10 Plan £m	M10 Actual £m	Var £m	M10
Capital	£13.20	£9.90	£3.30	

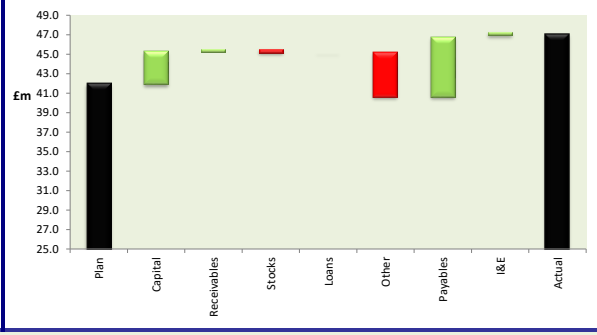


CASH

	M10 Plan £m	M10 Actual £m	Var £m	M10
Cash	£41.95	£46.99	£5.04	
Loans (Cumulative)	£17.67	£17.67	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Year to date the Trust is reporting a £2.38m deficit, a £0.18m favourable variance from plan. The deficit position is driven by a combination of staffing pressures, in particular the high cost of temporary staffing (enhanced bank rates and high cost agency) and Recovery costs, including the cost of Independent Sector support.
- Funding for H2 continues on a block contract basis, with fixed Top Up funding allocated by the ICS (Integrated Care System) to cover the Trust's underlying deficit, growth and Covid-19 expenditure. For H2, the Trust has been allocated £21.16m of System Top Up funding, £12.75m of System Covid funding and £1.76m of Growth funding, a total Top Up of £35.66m for H2.
- Total planned inpatient activity was 97.5% of the month 10 2019/20 baseline, although within this total Elective inpatient activity was only at 89.1%. No ERF has been assumed for H2, although there are indications that some funding may be available for allocation at System level.
- The Trust has incurred costs relating to Covid-19 of £18.81m, of which £5.86m are considered as 'outside of system envelope' and for which additional funding is available.
- Capital expenditure is lower than planned at £9.90m against a planned £13.20m.
- H2 includes a significant efficiency requirement of £6.7m, with only £3.9m identified of which £3.2m is currently forecast to deliver.
- NHS Improvement performance metric Use of Resources (UOR) stands at 3 against a planned level of 3.

NOTES

- The Trust is forecasting to deliver a planned break-even position for H2, although this position excludes a planned one off financial accounting adjustment of £5m.
- The forecast includes £3.98m cost of Independent Sector contracts in H2. Based on the current activity plan and initial guidance, the Trust has not planned for any ERF to offset this cost, although guidance continues to evolve and there may still be opportunities to mitigate this pressure which are being explored.
- In order to deliver the planned position, the Trust planned to find efficiencies of £6.7m. Costs have increased significantly over the last few months due to a high number of Covid patients and significant staffing shortages, and this pressure increased in Month 10. The current forecast is to deliver £3.2m of efficiencies in H2, a shortfall of £3.5m. The planned position also assumed that a remaining £1.7m funding gap could be closed.
- The shortfall has been mitigated by confirmation of additional Elective Recovery+ funding and the securing of additional funding allocations from both ISC and CCG partners to support capacity.
- The total loan balance is £18.77m as planned. No further loans are planned for this financial year.
- The Trust is forecasting to spend £23.29m on Capital programmes in this financial year, an increase of £4.30m compared to the planned value. This includes additional Capital funding bids have been approved via the Targeted Investment Fund (TIF) for elective recovery, that were not included in the Capital Plan
- The Trust has a cash balance of £46.99m, £5.04m higher than planned.

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

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

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

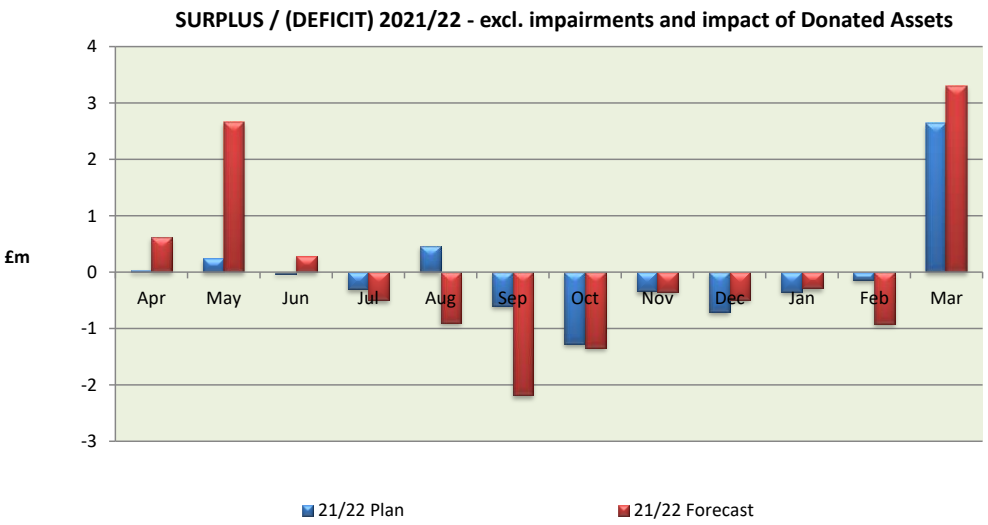
FORECAST POSITION 21/22

H2 Forecast (31 Mar 22)

Statement of Comprehensive Income	Plan[2] £m	Forecast £m	Var £m	
Income	£478.21	£498.27	£20.07	
Pay expenditure	(£300.23)	(£312.11)	(£11.88)	
Non Pay Expenditure	(£149.51)	(£159.34)	(£9.83)	
Non Operating Costs	(£28.81)	(£26.97)	£1.84	
Total Trust Surplus / (Deficit)	**(£0.34)**	**(£0.14)**	**£0.20**	
Deduct impact of:				
Impairments (AME)[1]	£0.00	£0.00	£0.00	
Donated Asset depreciation	£0.43	£0.43	(£0.00)	
Donated Asset income (including Covid equipment)	(£0.08)	(£0.38)	(£0.29)	
Net impact of donated consumables (PPE etc)	£0.00	£0.11	£0.11	
Gain on Disposal	£0.00	(£0.01)	(£0.01)	
Adjusted Financial Performance	**£0.00**	**£0.01**	**£0.00**	

Notes:
1. AME - Annually Managed Expenditure - spend that is unpredictable and not easily controlled by departments
2. Plan and Forecast excludes impact of £5m non recurrent technical accounting adjustment.

MONTHLY SURPLUS / (DEFICIT)



Forecast for H2 (Oct 21 - Mar 22)

- The H2 forecast after mitigations and efficiencies is a operational break-even position.
- This excludes the impact of a £5m non recurrent technical accounting adjustment relating to Project Echo.
- Costs have increased significantly over the last few months due to high number of Covid patients and significant staffing shortages, and this will be extremely challenging to reverse.
- Recovery costs are forecast to be higher than planned, and whilst no activity based Elective Recovery Funding (ERF) has been assumed at this stage, the Trust has been successful in 2 bids for additional funding linked to schemes to increase capacity. This funding totals £4.4m and is described as Elective Recovery+.
- The Trust planned to deliver a very challenging efficiency target of £6.7m for H2. As at month 10 the Trust forecast is to achieve £3.22m of this £6.7m target, although further schemes are still being scoped.
- The H2 plan also incorporated a further £1.7m funding gap that it was assumed would be mitigated.
- The shortfall in efficiency identification and planning gap have been offset by the Elective Recovery+ funding and the securing of further non recurrent funding allocations from the Integrated Care System and local CCGs.

Forecast Assumptions:

- The forecast assumes £8.97m of recovery costs, including £3.98m for Independent Sector contracts, this includes additional costs linked to the Elective Recovery+ bids.
- The forecast assumes that £3.22m of efficiency will be delivered versus the £6.7m target.
- The forecast reflects the fact that Bank pay enhancements of 50% are now likely to continue at the current rate until the end of the financial year, adding a further financial pressure of £3.12m compared to plan.
- No activity related Elective Recovery Funding (ERF) assumed as instructed by the ICS.
- Assumes that Covid-19 costs reduce slightly compared to those seen in the current month for the remainder of the year.
- Forecast includes a significant level of assumed non-recurrent income and other benefits that will not continue into 2022/23.
- The forecast reflects recently agreed £1.5m allocation of Capacity Funding, £0.7m lower than planned.

Risks and Potential Benefits

- The plan submitted to the ICS is a £5m deficit and includes the potential financial impact of Project Echo. If approved in this financial year by NHSI this would result in a £5m non recurrent technical accounting adjustment. There is potential that this transaction is delayed until the next financial year, resulting in a break-even position for the Trust.
- The Trust may be able to access some ERF funding if activity thresholds are exceeded at both Trust and System level.
- The forecast does not assume any change to the Annual Leave provision compared to the level assumed in March 21.

COVID-19 & Recovery

Covid-19 Expenditure YTD JAN 2022	Pay £'000	Non-Pay £'000	Total £'000
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	786	0	786
Remote management of patients	438	708	1,146
Support for stay at home models	48	0	48
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	872	237	1,109
Segregation of patient pathways	7,258	213	7,471
Existing workforce additional shifts	819	67	886
Decontamination	0	224	224
Backfill for higher sickness absence	282	2	284
Remote working for non patient activities	0	0	0
PPE - other associated costs	0	1	1
Sick pay at full pay (all staff types)	2	0	2
Other COVID-19 virus / antibody (serology) testing (not included elsewhere)	682	14	696
Enhanced PTS	0	317	317
COVID-19 virus testing - rt-PCR virus testing	206	3,106	3,312
COVID-19 - Vaccination Programme - Provider/ Hospital hubs	629	3	631
COVID-19 - Vaccination Programme - Vaccine centres	0	1,603	1,603
COVID-19 - Vaccination Programme - Vaccination of Healthy 12-15s (via SAIS)	11	70	81
NIHR SIREN testing - antibody testing only	21	3	24
COVID-19 - International quarantine costs	0	23	23
COVID-19 - Deployment of final year student nurses	182	0	182
Total Reported to NHSI	**12,237**	**6,591**	**18,827**
PPE - locally procured	0	-21	-21
Internal and external communication costs	0	1	1
Grand Total	**12,237**	**6,571**	**18,807**

Recovery Costs YTD JAN 2022	Pay £'000	Non-Pay £'000	Total £'000
Independent Sector	0	4,712	4,712
Additional Staffing - Medical	1,003	0	1,003
Additional Staffing - Nursing	348	0	348
Additional Staffing - Other	427	0	427
Non Pay	0	1,086	1,086
Enhanced Payment Model - Medical	1,054	76	1,130
Enhanced Payment Model - Nursing	1,271	0	1,271
Total	**4,104**	**5,875**	**9,978**

Covid-19 Costs

Year to date the Trust has incurred £18.81m of expenditure relating to Covid-19. Excluding Covid-19 costs that were outside of System envelope and for which funding can be claimed retrospectively, the year to date cost is £12.97m versus a plan of £10.32m. The overspend on Covid-19 is therefore £2.65m, driven by the continuation of some enhanced workforce models on wards and in ICU, a continuation of Emergency Department segregation and enhanced Bank pay rates. Outside of envelope costs are highlighted in the table to the left and total £5.86m year to date.

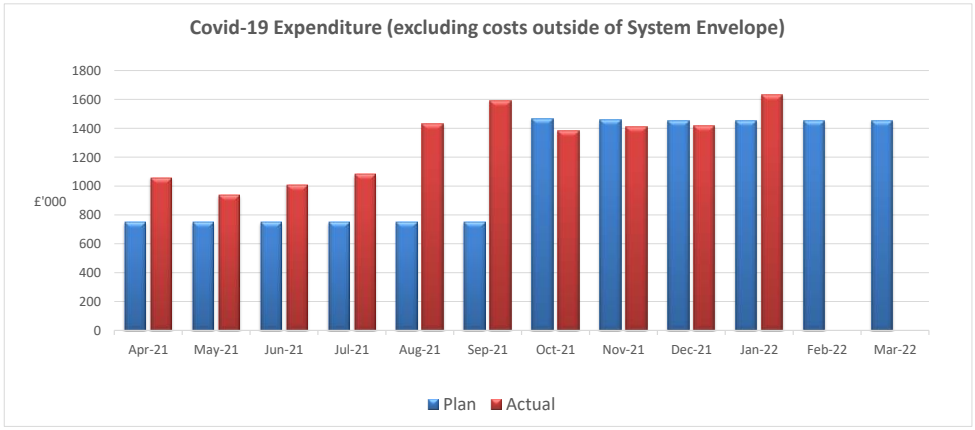
Covid-19 Funding

The Trust has been allocated block funding by the ICS to cover any ongoing Covid-19 costs and associated impacts totalling £19.79m year to date. In addition the Trust has requested retrospective Covid-19 funding of £5.86m to cover outside of envelope costs: Vaccinations, Covid-19 Testing, 3rd year student nurses and Isolation Hotels for overseas recruits.

Recovery

Recovery costs totalling £7.01m for H2 have been approved in conjunction with the Trust's activity plan. These costs are in part driving the Trust's challenging efficiency target and remaining funding gap, as no ERF in expected to be allocated to offset these costs, based on the current activity plan and existing thresholds. There does however remain a question as to whether the Trust may be able to access ERF for Independent Sector spend over and above 19/20 levels, but this will be dependent on total System Independent Sector activity against this baseline.

- Year to date Recovery costs are £9.98m.
- A significant proportion of the costs incurred related to use of the Independent Sector for outsourcing and insourcing. The Trust has agreed outsourcing contracts with Optegra, BMI, Spire and 'This Is My', as well as insourcing arrangements with Remedy, Ormis and Pioneer.
- Elective Recovery Fund (ERF) Funding is allocated at System level and only paid where the Integrated Care System (ICS) as a whole exceeds activity thresholds.
- The Trust did receive additional funding via the Elective Recovery Fund for Quarter 1 as the thresholds agreed for April, May and June activity were exceeded and £3.69m of income has been received.
- The announcement by NHS Improvement that the threshold for ERF has been increased to 95% from Month 4 has resulted in a significant reduction in forecast ERF for the Trust. No ERF has been assumed in either year to date or forecast for H2 due to the increase in the threshold.
- The Trust has been successful in two separate bids for Elective Recovery+ funding to support schemes in the Trust aimed at increasing capacity, totalling £4.42m. £2.43m of this funding has been recognised in the year to date position.



Keeping the Base Safe

14. Safeguarding Update - Adults and Children

Presented by - Andrea Dauris, Associate Director of Nursing

To Note

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Safeguarding Adults and Children Update
Author:	Andrea Dauris, Associate Director of Nursing Alison Edwards, Head of Safeguarding
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing/Deputy CEO
Previous Forums:	Safeguarding Committee 1 February 2022 Quality Committee 21 February 2022

Purpose of the Report

This report provides an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust.

The report provides assurance to the Board of Directors highlighting key performance activity and information of how its statutory responsibilities are being met, and of any significant issues or risks, and how these are mitigated.

The report provides a focus on the work and commitment to safeguarding children and adults provided by the Safeguarding Team making reference to: -

- Prevent
- Safeguarding response during the pandemic
- Hidden Harms
- Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)/ Liberty Protection Safeguards (LPS)
- Training
- Safeguarding Supervision
- Adult Safeguarding
- Children's Safeguarding
- Mental Health
- Children Looked After and Care Leavers Calderdale
- Maternity Safeguarding

Key Points to Note

As we continue to support the safeguarding agenda during the pandemic our focus continues to be on keeping the base safe.

- We have achieved 90% compliance in levels of Safeguarding Adults/ Children/ Prevent/ MCA/ DoLS training.
- Training compliance is below 90% for Female Genital Mutilation (FGM) (88%); Receipt and Scrutiny (74%).
- Safeguarding supervision is reported at 56% and work continues in partnership with the Divisions to look at how we can support to increase compliance.
- We continue to maintain a business as usual functionality continuing with day-to-day operations and attendance at multi-agency virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Calderdale and Kirklees and their sub-groups.
- Discharge quality improvement work with partner agencies (under the SAFER service improvement agenda) is ongoing to support the improvement of the quality of hospital discharges.
- The service level agreement with SWYPFT has been updated to ensure that mental health services provided to CHFT continue effectively.
- CHFT staff have continued to make Deprivation of Liberty Applications throughout this period ensuring the rights of our patients are safeguarded. These have continued to increase in 2021 showing a maintained awareness amongst staff to ensure the Human Rights of patients are protected.
- We have successfully recruited to all our vacant posts and are inducting our new team members into their roles.
- Initial and Review Health Assessments carried out by the Children Looked After Team in Calderdale have continued and a contingency plan has been implemented to address the backlog of review health assessments for children out of area placed in Calderdale.
- Calderdale Safeguarding Adults Board have recognised and commended the work in relation to the CHFT wound clinics/ sexual health clinics at the Gathering Place and High Intensity User Group that has taken place in response to the Burnt Bridges Thematic Review.

EQIA – Equality Impact Assessment

Equality impact assessment forms the basis of much of the work of the Safeguarding Team. The role of the team is to ensure that those in the most vulnerable groups are protected from harm.

Recommendation

The Board of Directors is asked to **NOTE** the key activity of the Safeguarding Team for the reporting period April 2021- September 2021.

Calderdale and Huddersfield
NHS Foundation Trust

Safeguarding Update Report
April 2021 - September 2021

Safeguarding Adults and Children Update Report for Board of Directors 3 March 2022

1. INTRODUCTION

This report is the Safeguarding Adults and Children bi-annual report to the Board of Directors, for the reporting period April 2021 – September 2021.

The report provides an overview of activity and outlines key achievements and developments on both the progress of the annual report priorities and our safeguarding strategy for 2020-22.

The report will focus upon our consistent safeguarding response during the Covid-19 pandemic and the challenges it has posed, whilst providing assurance that Calderdale and Huddersfield Foundation Trust (CHFT) has fulfilled its statutory safeguarding responsibilities.

2. PREVENT

The Counterterrorism and Security Act (2015) places a duty on CHFT to have; *'due regard to the need to prevent people from being drawn into terrorism.'*

CHFT Safeguarding Team undertakes regular patient information requests regarding potentially high risk individuals and shares these with PREVENT partner agencies. We also attend Channel panel meetings to discuss individual cases to understand their vulnerability to being drawn into terrorism activities, as well as engaging with the person and partner agencies (e.g., Child and Adolescent Mental Health Service (CAMHS), (Housing, Social Care) to support these vulnerable individuals to consider how they can make positive changes to their lives.

CHFT had previously developed a small number of PREVENT Champions to deliver PREVENT training however this ceased and is now delivered by Government PREVENT wrap training. We are working with the PREVENT lead in the local authority and the BAME network to address some issues that have been highlighted in relation to this training. Further work is required to develop a network of PREVENT Safeguarding Champions within CHFT.

CHFT have met its statutory responsibilities with the key achievements set out below: -

Key Achievements

- All staff receive the Government approved PREVENT e-learning training.
- Our training compliance has remained consistently above 90% throughout the year.
- PREVENT activity and information is shared quarterly with NHSE and our Designated Safeguarding Nurses in the CCG.
- CHFT Safeguarding Team attend Channel panel meetings where partner agencies discuss individuals in the pre-radicalisation phase to prevent them being drawn into terrorism.

Priorities 2021-2022 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Explore the role of PREVENT Champions and increase numbers if required
- Work with the BAME network and the Channel co-ordinator to explore the concerns raised with regard to the PREVENT training

3. SAFEGUARDING AND COVID

The Coronavirus Act 2020 did not suspend professionals' duties to safeguard children and adults or their responsibility to comply with the Mental Capacity Act/ Deprivation of Liberty Safeguards during this challenging time.

The Safeguarding team have consistently maintained the safeguarding service throughout the pandemic, ensuring our key statutory roles and responsibilities have been maintained. There have been several changes to the team with the recruitment of the following new team members: Named Nurse Safeguarding Children; Named Nurse Children Looked After and Care Leavers; Safeguarding Advisor Children's and Maternity services; Specialist Nurse Children Looked After and Care Leavers; Secondment post from Locala for Specialist Nurse Children Looked After and Care Leavers; Paediatric Liaison Sister.

Given the gaps in staffing arrangements the team have prioritised essential safeguarding work and updated key stakeholders/ partners of our staffing position.

Feedback regarding Adult Safeguarding initial investigations to the Local Authority, is not meeting the multi-agency agreed timeframes which are defined in the multi-agency safeguarding adult's policy. We are continuing to work with the local authority to improve this process, however due to the impact of staffing within the local authority due to the ongoing pandemic; the meetings to resolve this have temporarily been paused.

- In response to this, there has been ongoing work with the risk management team to align Trust and safeguarding processes and increase understanding between the two teams of how this can be addressed. The risk management team are meeting regularly to review incidents and the safeguarding team feed into these huddles. A dashboard has been developed to support the management of open cases.
- This risk has now been reduced from 12 to 9.

The Safeguarding Boards and Partnerships have been kept fully briefed and updated throughout this period. The Safeguarding Team have fulfilled all partnership requests for information and have contributed towards several safeguarding reviews during this period. We are working closely with the Risk Management team to ensure the SI panel have oversight of the safeguarding review process. Significantly, in Burnt Bridges, a Safeguarding Adult Review (SAR) report, the health issues of people with multiple and complex needs, including those leading street-based lives were identified. The multi-agency work streams arising from this report, along with the Making Every Adult Matter (MEAM) and trauma informed practice approaches, should improve the health outcomes of patients with such complex needs and may address some local health inequalities. Calderdale Safeguarding Adults Board have recognised and commended the work in relation to the CHFT wound clinics/ sexual health clinics at the Gathering Place and High Intensity User Group that has taken place in response to the Burnt Bridges Thematic Review.

Self-neglect has been a significant theme in SARS during this period and the self-neglect pathways and risk escalation conferences are in regular use. Other SAR reports have identified the use of the Mental Capacity Act (MCA) with patients who may have difficulties with their executive functioning (such as those with substance misuse problems, head injuries and phobias etc). We have updated the MCA policy to reflect this area and have inputted into various groups (such as the High Intensity User group) to ensure that recent case law is drawn to the attention of staff working with people with complex needs. The bespoke face to face training programme also includes this area.

We have seen several complex mental health patients (adults and children) over this period and continue to be involved pro-actively with Divisions. The team have prioritised essential

safeguarding work and continue to support the Calderdale Domestic Abuse hub with the key health practitioner role.

In line with the national trend during the pandemic there has been an increase in children admitted with non-accidental injury, particularly in the under 1's. In response to this CHFT has continued to be proactive in the roll out of the ICON programme (I-Infant crying is normal; C- Comforting methods can help; I- It's ok to walk away; N- Never shake a baby). CHFT are contributing towards a serious practice review in relation to non-accidental injury in a baby under the age of 1. The learning from this review and the National Panel Thematic Review on Non-Accidental Injury to Under One Year Olds will be help inform in safeguarding practice going forward.

Key Achievements

- We have carried out business as usual within the team and continued to maintain our operational service throughout.
- We have continued to ensure our safeguarding training is in line with restrictions in place during the pandemic, with our packages and videos being available for staff to complete on the intranet.
- We have sent our Kirklees and Calderdale partners assurances regarding our business continuity arrangements.
- We have continued to attend virtual Safeguarding Adults Board meetings and Children's Partnership meetings for Kirklees, and their safeguarding subgroups.
- Maintained our mandatory FGM and PREVENT reporting responsibilities and submissions to NHSE.
- Collaboratively our Mental Health Liaison Team (SWYPFT) has worked in partnership with CHFT to reduce prolonged waits in the Emergency Department during this unprecedented time.
- Safeguarding supervision is being delivered remotely as are our internal and multi-agency meetings.
- Worked collaboratively with Joint Security Operations Group, the security teams and the Resilience & Security Management Specialist to consider issues such as restraint of vulnerable patients, manging patients with behaviours that challenge others and to consider the Violence Protection Standards.
- Provided the CCG with Safeguarding Provider Assurance in relation to the Children Looked After and Safeguarding Inspections 2016/ 2018 through position statement mechanism.
- Supported completion for a multi-agency health audit reviewing communication between health agencies when a case has been referred to the DA Hub

Priorities 2021-2022 (including actions from 2020-2022 Safeguarding Strategy workplan

- Continue to work with Divisions ensuring that safeguarding adults and children and Domestic Abuse is part of all considerations when managing the re-introduction of Services.
- Continue to learn about the impact of the Covid 19 pandemic in relation to safeguarding children and adults at risk and how this is influencing safeguarding practice.

3.1 Hidden Harms

Crimes such as child abuse, child sexual exploitation, domestic abuse (including "honour"-based abuse), sexual violence and modern-day slavery, typically take place behind closed doors, hidden away from view. The pandemic has caused hidden harms to children and adults, and this has increased the complexity of the needs of families requiring effective

early intervention and help. The Coronavirus measures risk making these crimes more prevalent and less visible.

Key Achievements

- We continue to promote the use of the Partnership Intelligence Portal for staff to feed in soft intelligence to the Police in relation to gangs/County Lines and Modern Day Slavery.
- We continue to support local partnership meetings for children and young people at risk of exploitation.
- We flag hospital records of children/ young people at risk of exploitation.
- We have successfully used the under 18 and adults at risk CHFT bespoke proforma that has key questions in place in relation to vulnerability in gynaecology, sexual health and midwifery. This has now been built into EPR.
- We continue to link in with National Safeguarding Children Professional meetings to benchmark other regional trends in safeguarding children.
- We have monitored our safeguarding data closely throughout the year and noted increases in children on a child protection plan and those coming into care. Whilst noting these increases, we have continued to carry out safeguarding children medicals and initial and review health assessments by our Children Looked After Team.
- Reviewed the Domestic Abuse Policy

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Review the impact that the Covid 19 Pandemic has had upon the emotional wellbeing of pregnant women.
- Continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multiagency meetings to share intelligence around this
- Develop awareness and training regarding the under 18's and adults at risk safeguarding proforma.
- Raising awareness of the Making Every Adult Matter (MEAM) agenda in conjunction with partner agencies.
- Raising awareness of the Trauma Informed approach to working with patients.
- Support staff to identify and provide support for those who have multi-complex needs; are homeless or display signs of self-neglect

4. MENTAL CAPACITY ACT (MCA) AND DEPRIVATION OF LIBERTY SAFEGUARDS (DoLS)

The Department of Health and Social Care issued guidance in April 2020 emphasising that the principle of the MCA and the safeguards provided by DoLS still apply during the Covid - 19 pandemic.

Work continues to promote the principles of the MCA and in particular supporting staff in considering the importance of the executive functioning of a patient.

All CHFT DoLS applications continue to be quality assured by the adult safeguarding team providing evidence that the restrictions on the patient, that amount to a deprivation of liberty, are the least restrictive and in the patient's best interests, in addition to meeting the statutory requirement for an urgent DoLS authorisation and an application for a Standard Authorisation. Once the Standard Authorisation has been granted, the team ensure that any conditions on CHFT are complied with and that the Relevant Persons Representative (RPR)

or Paid RPR is identified in the patient's records. We continue to work closely with the Independent Mental Capacity Advocate (IMCA) service.

4.1 DoLS Data

	Number of Urgent DoLS Authorisations	Number of Standard Authorisations	Average p/month
2020-2021	187	0	15 approx
(Q1,2) 2021	155	3	25 approx

The number of Urgent Authorisations reflects CHFT staff commitment to protecting the Human Rights of their patients. Patients have not usually been assessed for a Standard Authorisations (by the Supervisory Body) as either the patient has been discharged, successfully treated or have regained the mental capacity to consent to their care and treatment arrangements. In some situations, staff have been able to use less restrictive care practices to prevent the patient being deprived of their liberty.

4.2 The Mental Capacity (Amendment) Act

The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The purpose of the Act is to provide a simplified legal framework and authorisation process which is accessible, clear, delivers improved outcomes for people deprived of their liberty and place the person at the heart of decision making. Because of the Covid-19 pandemic, the Minister for Care has deferred the implementation of the LPS, with no identified date for implementation. However CHFT must continue to work towards preparing staff and the organisation for this implementation.

Implications for CHFT

This is a significant piece of statutory work which will include several departments to ensure the implementation is effective. There will be a transition period during which existing Authorisations will remain valid.

Hospitals (the responsible body) will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager).

- Referral pathways and authorisation process will need to be considered.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
  - The person lacks capacity to consent to the care arrangements
  - The person is of unsound mind
  - The arrangements are necessary and proportionate

All 3 of the above criteria must be met

- The Authorisation can be used in a variety of settings (i.e.) those who live at home and have respite care and a day centre.
- Staff will need to be trained and aware of what the new Liberty Protection Safeguards (LPS) constitute as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP) – when the patient is objecting to the arrangements. The role of the AMCP is to carry out a pre-authorisation review and to determine whether to approve the arrangements.
- The LPS will apply to children aged 16 and 17

A paper has been submitted to WEB outlining the options in relation to:

A. Consideration as to how the Board will discharge/manage their functions as the Responsible Body in the Authorisation (signatory) process.
B. Consideration as to how CHFT will manage their responsibility in relation to section 12 doctors
C. Consideration as to how CHFT will manage their responsibility in relation to Approved Mental Capacity Practitioners.

The request from WEB was for more detail to be provided for each of these options with recommendations as to what the preferred options should be. The revised paper will be presented to WEB in March 2022.

CHFT are ensuring that the implementation of the LPS is a smooth process for staff, patients and their families. The local implementation network (LIN) is being re-established and there are regular meetings with the CCG lead and an internal draft action plan has been developed. The internal steering group is currently being set up.

Key Achievements

- Referrals during the period April 2021-September 2021 have increased showing an awareness with staff to ensure the Human Rights of our patients are maintained.
- Provided a detailed report to the Executive Board regarding the Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- We continue to quality assure all referrals made by CHFT staff.
- We have developed a digital mental capacity assessment form.
- Developed and delivered bespoke training sessions in response to identified gaps in knowledge and skills.

Priorities 2020-2021 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Develop a strategic implementation plan and continue to work towards the implementation of LPS with digitized documentation.
- Continue to update the Trust Board regarding progress in relation to LPS.
- Continue to ensure that all staff are trained in the Mental Capacity Act according to their role.
- Continue to work with our local networks and partners to ensure successful implementation of LPS.
- Audit the use of the MCA in relation to DoLS.
- Deliver bespoke MCA training to those who work with children to ensure a foundation for LPS implementation.

5. TRAINING

The Covid-19 pandemic infection control changes meant that CHFT stopped face to face training. To ensure we maintained safeguarding/ MCA/DoLS competencies with staff, it was moved to an e-learning package, available on the Safeguarding intranet pages enabling staff to complete these and self-declare their compliance. We supplemented this training through regular updates and briefings though divisional Patient Safety and Quality Board meetings, supervision sessions, and bespoke training. During this period, we have developed and worked on an alternative approach which will include e-learning and face to face training. This will ensure our compliance with the Intercollegiate documents for adults, children and children looked after and care leavers, MCA training competencies and prepare our

workforce for the implementation of Liberty Protection safeguards. This has now been approved at the Safeguarding Committee, Nursing and Midwifery Council and WEB.

Figure 1 indicates the Trust position for Safeguarding training compliance April to September 2021. Compliance data is monitored in the Safeguarding Committee.

	31.03.21					30/09/2021					
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %	% Deviation
	6063	23284	21618	1666	92.84%	6011	23418	21817	1601	93.16%	0.32%
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Key

Aspirational Target >95%
On target 90% - 94.0
ear Target 85% - 89.9%
Below Target<85%

(Figure 1)

5.1 Receipt and Scrutiny Training; Female Genital Mutilation (FGM) and Safeguarding Supervision.

Mental Health Act Receipt and Scrutiny training is delivered virtually over Microsoft teams by SWYPFT MHA administrators to CHFT senior nurses who would accept MHA section papers on behalf of the Trust.

The levels of Receipt and Scrutiny (of statutory Mental Health Act documentation) training has gradually increased from an average of Trust staff of 65.12% in March 2021 to 74.36% in September 2021 and recent data is more encouraging. Issues regarding staff completing a post training questionnaire have impacted upon training figures; however this has now been rectified**.**

There has been one Serious Incident where a patient was detained unlawfully due to the section 2 papers being incomplete. This is currently being investigated and the findings from this will inform future training requirements.

Further training dates have been planned for 2022.

Within this timeframe FGM training compliance has dropped to 88.89%. Communication across divisions has established that a contributory factor in this is due to a number of new starters who have not yet completed this training. We continue to work alongside Divisions to identify further challenges and support them in improving their compliance.

Safeguarding Supervision is delivered virtually though Microsoft teams and compliance has decreased by 8.10% since April 2021. The Safeguarding Committee has sent out compliance reports for Divisions to review and the safeguarding team will continue to work with Divisions and the challenges they may have to support improving their compliance in relation to supervision. The safeguarding team are exploring a more targeted approach to increase compliance. Additional staff have also been trained in providing safeguarding supervision with the intention of improving current levels of compliance**.** Safeguarding supervision has been available to the children's and maternity workforce for a number of years. We are also starting to embed safeguarding supervision within the adult workforce to further strengthen our approach to supporting all staff who manage safeguarding cases, and as a way of maintaining their own wellbeing in recognition of the emotional impact of this work.

Work has been completed with Maternity to ensure that all Community Midwives have an allocated supervisor. A reflective case study has been introduced into the Midwives day 2 training to capture safeguarding supervision. Compliance continues to be monitored.

Key Achievements

- We continue to engage and share training compliance with Divisions bi-monthly.
- High levels of MCA DoLS and safeguarding training have been maintained throughout the year.
- Bespoke training sessions through teams in relation to the MHA and MCA have been delivered.
- Reviewed delivery and updated the content of the Level 3 Safeguarding Training/ MCA/ DoLS packages.
- We have updated level 2 Safeguarding Families Children's and Adults combined E-learning package which includes MCA and DoLS basic awareness.
- A national E-learning package for MCA DoLS has been identified and with additional bespoke sessions it was agreed via the Safeguarding Committee that some staff groups will need to complete this further training, to ensure they are adequately equipped with the foundation for the effective implementation of the Liberty Protection Safeguards.
- Updated the Safeguarding Supervision policy.

Priorities 2021-2022 (including actions from 2020-2022 Safeguarding Strategy workplan)

- Implementation of Safeguarding Training to ensure ongoing compliance with the Intercollegiate documents and the re-introduction of face to face training.
- Continue to share compliance reports with Divisions.
- Continue to promote attendance at the Receipt & Scrutiny training delivered by SWYPFT Mental Health Act Office.

6. ADULT SAFEGUARDING

Safeguarding adults is a statutory requirement under the Care Act (2014). Safeguarding adult's means protecting a person's right to live in safety and free from harm, abuse, and neglect.

Ineffective or unsafe discharges remain an issue for safeguarding; the numbers appear to be decreasing and this will continue to be closely monitored in 2021-2022 to establish if this is a consistent trend. This position continues to be shared at Safeguarding Committee meetings which has representation from the four divisions. The Safeguarding team continue to work

with the local authority partners to ensure oversight and investigation of all these cases. Kirklees Local Authority have agreed that poorly managed discharges can be managed by a different approach to Calderdale and that some of these can be managed as quality of care concerns. This remains high risk on the risk register.

The discharge concerns include a variety of areas, including:

Lack of communication issues

- With family
- Care providers – provision not being set up in non-complex discharges
- GP- lack of information on the discharge letter
- No discharge letters being sent to care homes
- Not having the correct MHA section papers completed for discharge to another hospital
- DNACPR letters not being sent
- No referral to District Nurses/ other community staff

Lack of equipment or medication

- Not being sent home
- Arriving late
- Incorrect medication

Transport

- Confused elderly patient being discharged in the middle of the night
- Dementia patient getting out of taxi alone
- Patients being asked for/ charged for fare

Some positive responses have been introduced which included a new standard operating procedure implemented in the Emergency Departments regarding the discharge process; re-opening of the discharge lounge; reviewed arrangements with the pharmacy team. The CHFT dementia lead is now in post and is made aware of poor discharges of patients with dementia.

Chart showing ineffective discharge data for April 2021- September 2021

Overall 19/20	**33**
Overall 20/21	**105**
Overall Q1, 2	**45**

Whilst several rapid actions have already been implemented, further work is required and will be overseen by the SAFER quality improvement team which will include representation from the Safeguarding team.

Key Achievements

- Management of Patients Not Brought for Appointments Policy now includes adults with vulnerabilities/ adults at risk.
- Missing Persons Policy has been reviewed.
- Adult Safeguarding continue to work closely with Kirklees Local Authority to agree that the increased number of ineffective discharges could be managed internally by CHFT

via the Discharge Improvement Group as opposed to formal individual Care Act (2014) Section 42 investigations.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- Streamline safeguarding processes and investigations.
- Systems approach to embed learning (i.e. Multi Agency Audit programmes)
- Working with the new Lead Nurse Children to progress the embedding of the Transition Policy.
- To contribute to support Divisions and the work of the Discharge Improvement Group to drive quality improvements in relation to hospital discharges.
- To work alongside and support Divisions with regard to providing timely feedback to the local authority.

7. CHILDREN SAFEGUARDING

CHFT is fully committed to the principles set out in the Government guidance 'Working Together to Safeguard Children - 2018',the Children Act 1989/2004 and to joint working with both the Calderdale and Kirklees Safeguarding Children Partnerships. The Trust works within the West Yorkshire Safeguarding Children Policies and Procedures for the protection of all children who attend CHFT.

CHFTs' safeguarding responsibilities are effectively discharged by the provision of day to day advice, supervision, support and promoting good professional practice. This includes identifying the training needs of all staff and volunteers in relation to safeguarding children and delivering a comprehensive mandatory programme of training, which includes key safeguarding messages from research, safeguarding incidents, and child practice safeguarding/learning lessons reviews.

The Management of Patients Not Brought to Medical Appointments Policy has been approved and the following case scenario highlights its impact:

A young man with learning disabilities and epilepsy 17 years old failed to attend his first adult clinic over a 12 month period. Several letters were sent to the GP and to the home of the young man. The Epilepsy nurse followed the policy and contacted the Matron Lead for Learning Disability for advice. The safeguarding team were contacted and found an updated mobile phone number on the GP record. The epilepsy team contacted mum and made an appointment and updated her mobile number on the patients EPR record. He is due to be reviewed in January and his mum is aware of the appointment. The epilepsy service has embraced the policy and proactively monitors and review patients who fail to attend their appointments in particular those with learning disabilities.

Key Achievements

- Process established for identifying where 16 to 17 year olds are admitted, training undertaken and SOP developed to support.
- Safeguarding Supervision being offered to departments where young people aged 16 to 17 are admitted with presentations of concern.

- Developed a pathway with Locala (Community Services) for direct referral into Paediatric/ED services for children requiring hospital assessments.
- Introduction of the electronic ED Paediatric Liaison Notification form.
- Paediatric Sit Rep embedded into core safeguarding work, children and young people reviewed and supported by the team.
- Developed a Children Mental Health Policy with CAMHS and Paediatric services
- Robust oversight of paediatric patients who have mental health concerns and closer working with the paediatric department. MDT meetings established, with safeguarding representation to support paediatric department. Ongoing utilisation of the Children Mental Health Policy and documentation.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- Paediatric Liaison Sister and Safeguarding Advisor to establish links with newly appointed care navigator.
- Ongoing training to support teams to undertaken safeguarding supervision within own departments via the safeguarding champions arena and safeguarding team members.
- ED bespoke training to be updated to include ICON. Sessions to be recommenced in April 2022 and include safeguarding supervision.
- Map other areas that may need review of safeguarding supervision processes and include establishing robust safeguarding children's champions.
- Continue to support inclusion of the child's voice/lived experience of the child in safeguarding practice.

8. MENTAL HEALTH

CHFT works in partnership with SWYPFT formally through the service level agreement and the clinical working protocol. We are using the values described in our 4 pillars in developing a mental health strategy with our partners though the Mental Health Operational Group. There are reciprocal representatives and papers shared at SWYPFT's Mental Health Act Committee and CHFT's Safeguarding Committee meeting, and we continue to work in close partnership to meet the needs of our patients.

The Mental Health Liaison Team (MHLT) support and work with CHFT trust staff to ensure that all patients who are referred are reviewed and supported in a timely way.

An adult safeguarding team representative attends the Mental Health Operational Group and also the multi-agency Suicide Prevention Action Group.

Key Achievements

- The Department of Health and Social Care (DHSC) and NHS England (NHSE) have provided guidance to professionals on the use of the Mental Health Act during the pandemic. The Court and Tribunals Department instructed the MHA office to carry out their functions remotely during the Coronavirus period Mental Health Act Tribunals and Hospital Managers hearings have been carried out remotely on our wards co-ordinated by the MHA Office (SWYPFT).
- The MHA office took a similar position in relation to the hospital managers' hearings. This has effectively ensured our patients' rights to appeal have been discharged throughout this period.
- The Safeguarding Team have continued to support the MHA Office with their scrutiny and reporting mechanism.
- The Service Level Agreement between SWYPFT and CHFT has been re-reviewed and signed for a further 12 months.

- There are honorary contracts in place for Consultants who work for SWYPFT and based in the Mental Health Liaison Team.
- Additional training dates provided to improve compliance with Receipt and Scrutiny training.
- The Joint Working Protocol has been reviewed in line with changes to the working arrangements in the Mental Health Liaison Team.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- 'Reforming the Mental Health Act' White Paper Consultation took place and the Government has now published its response to the Consultation. When more information becomes available, CHFT will consider the proposals and ensure that policies and procedures are updated accordingly. There may be changes to the Mental Capacity Act policy and procedures that will need to be implemented.
- Embedding of new processes for electronic submission of forms related to detaining and serving of MHA papers.
- Ongoing promotion of MHA receipt and scrutiny training to improve compliance.

9. CHILDREN LOOKED AFTER AND CARE LEAVERS (CALDERDALE)

Our Children Looked After Team, work in partnership with Calderdale Metropolitan Borough Council (CMBC) to ensure that the health needs of children who are looked after (CLA) and young people in Calderdale are met. The team provides advice and support to health and social care practitioners to improve health outcomes for CLA and young people. A Looked After Child is subject to a care order (placed into the care of local authorities by order of a court), and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live in foster homes, residential placements or with family members (connected carer's).

The Children Looked After Team in Calderdale provide support and guidance to children and young people who are the most vulnerable in society. Developing professional relationships are key in engaging with young people to make positive health changes in their life to improve their health outcomes which improves other aspects of their life.

There were significant vacancies within the team during this period (1.75 WTE vacancies) and this impacted on the capacity of the team in relation to completing review health assessments for externally placed children in Calderdale. This was placed on the risk register with a contingency plan to address this and ensure these were up to date by the end of December 2021.

Key Achievements

- A template has been developed for all CLA who move into Calderdale from an external LA. This is to be completed by the LAC health team in the placing authority to provide Calderdale with an overview of the child or young person's health needs and any identified risks.
- New appointment of two Specialist Nurse's to replace existing positions. One to commence in November 2021 and a further Nurse to start March 2022
- Audit to review children placed in Calderdale from out of area and impact this has on their unmet health needs, Calderdale Health Service provision and to highlight any gaps.
- We are working with the fostering team to deliver training and health updates to foster carers.
- 31 Initial Health Assessments were completed in Q1 (94% in timescale) and 100 Review Health assessments (95% in timescale). 28 Initial Health Assessments were completed in Q2 (79% in timescale) and 70 Review health Assessments (94% in timescale).

Priorities 2020-21 (including actions from 2020-22 Safeguarding Strategy workplan)

- Continue to develop support links for care leavers over 18years of age.
- Explore use of continued virtual assessments if this is the preference of the young person or if Covid restrictions do now allow a home visit.
- Working with Calderdale Children's Services to develop a pathway improve completion of SDQ's (Strengthening Difficulties Questionnaire) and information sharing with Calderdale CLA health team.
- To develop support links with Calderdale GP surgeries/Safeguarding Lead GP's to ensure a GP's contribution is part of the IHA & RHA.
- To start to collect data for CLA who have been placed in Calderdale from an external LA.

10. Maternity Safeguarding

Within maternity services, safeguarding from early intervention to child protection is a key factor. The main issues are: mental health where this may impact on the parenting ability, domestic abuse, teenagers and substance abuse. Where it has been identified that the woman or her family may be a complex case and more detail is required, practitioners document this information within the confidential element of Athena. This allows all maternity staff to have a clear overview of the concerns within the pregnancy as well as the plan for the unborn if the case is open to children's social care.

To assist and support with the maternity service, there is a specialist midwife panel that meets once a week. The purpose of this panel is to review complex cases and ascertain if the pregnant woman would benefit from the additional support of the complex needs midwife or specialist midwife for substance abuse and alcohol. The panel has an overview of the complex cases that have been identified from community maternity and allow closer MDT working to assist in better risk assessment plans for the unborn.

Key Achievements

- Ensured that mandatory FGM reporting responsibilities are maintained with the submissions to NHSE.
- Ensured processes in place for the Trust to ensure all female children born to FGM survivors records are flagged with the female genital mutilation information sharing (FGM-IS) flag.
- CHFT is continuing to participate with the children partnership board within Calderdale and Kirklees in relation to FGM. This is to represent health and help to reduce the risk to children in our local area.
- Provided external FGM training with Karma Nirvana.
- Reviewed MAPLAG and SWANS process to ensure enhanced risk assessment process are in place within the multi-agency arena.
- We have successfully used the under 18 and adults at risk CHFT bespoke proforma that has key questions in place in relation to vulnerability in gynaecology, early pregnancy assessment unit (EPAU). This has been built into EPR.
- New appointment of the Safeguarding Children and Maternity Advisor commenced September 2021.
- Developed a pathway with Locala for direct referral into Paediatric/ED services for children requiring hospital assessments.
- Delivered ICON training.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- To work with both local authorities in developing a robust pathway for referring female children/new-born babies into children's social care.

- To update CHFT FGM policy.
- To audit FGM cases ensure that the Department of Health risk assessment tool is included in the Athena records to demonstrate clear discussion with families around the illegal aspect of FGM.
- To appoint Health Independent Domestic Violence Advocate (Kirklees) with specific remit towards Pakistani and Muslim heritage.
- To ensure a think family approach is embedded in Maternity to include robust risk assessments into partners/fathers and significant others.
- Maternity services to include details and known risk factors of fathers/significant others in all cases heard in the Specialist Midwifery Panel.
- To review the SOP to include the referral criteria of cases to be heard in the Specialist Midwifery Panel.
- CHFT to review training to all relevant staff groups regarding hidden males/significant others.

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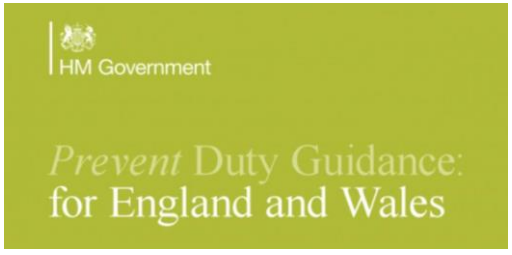
Prevent

Prevent is about safeguarding people and communities from the threat of terrorism

Key Achievements

- Our training compliance has remained consistently above 90% throughout this period.
- Prevent activity and information is shared quarterly with NHSE and our Designated Safeguarding Nurses in the CCG.
- CHFT Safeguarding Team attend Channel panel meetings where partner agencies discuss individuals in the pre-radicalisation phase to prevent them being drawn into terrorism.

- **Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)**
- Further explore the role of Prevent Champions.
- Explore concerns raised by the BAME network relating to training through joint working with Chanel co-ordinator



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Safeguarding and Covid

The Coronavirus Act 2020 did not suspend safeguarding duties and responsibilities

Key Achievements

- Continue to work closely with and support the work of the Safeguarding Boards/ Partnerships virtually.
- Delivered virtual safeguarding supervision/ safeguarding training in line with covid restrictions.
- Continued to update and further develop the safeguarding contingency plan to support staff to maintain their safeguarding responsibilities

Priorities 2021-2022 (including actions from 2020-22 Safeguarding Strategy workplan)

- Continue to work with Divisions ensuring that safeguarding adults and children. including domestic abuse is part of all considerations when managing the re-introduction of services.
- Continue to learn from the effects of the pandemic on families, influencing safeguarding practice with what we have learned.
- To work alongside and support Divisions with regard to providing timely feedback to the local authority

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Hidden Harms

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Hidden Harms take place behind closed doors or away from view eg domestic abuse, sexual abuse, child sexual abuse and modern slavery.

Key Achievements

- Continue to raise awareness of the Police Partnership Intelligence Portal.
- Under 18/ adults at risk proforma built into EPR
- Monitored safeguarding data and continue to see an increase in children subject to a child protection plan and those coming into care.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy work plan)

- Review the impact that the Covid 19 Pandemic has had upon the emotional wellbeing of pregnant women.
- Raising awareness of the Making Every Adult Matter (MEAM) agenda in conjunction with partner agencies.
- Raising awareness of trauma informed care

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MCA and DoLS/ Liberty Protection Safeguards

The MCA protects and restores power to vulnerable people who may lack capacity to make decisions

Key Achievements

- Provide detailed report to the Executive Board regarding the Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- Developed a digital mental capacity assessment form
- Developed and delivered bespoke training sessions in response to identified gaps in knowledge and skills base.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- Update the Board in relation to appraisal of the options for the implementation of liberty protection safeguards
- Review Trust Safeguarding Team resources to implement the new LPS scheme including staff recruitment, training across the Trust, new processes and expertise.
- Continue to ensure that all staff are trained in the Mental Capacity Act according to their role/ Audit the use of MCA in relation to DoLS

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Training Compliance

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On target 90% - 94.0
ear Target 85% - 89.9%
Below Target<85%

The chart above indicates the year end Trust position for Safeguarding training compliance. Compliance data is monitored in the Safeguarding Committee. As of September 2021, overall compliance was at 93.16%.

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Adult Safeguarding

Is protecting a person's rights to live in safety, free from abuse and neglect

Key Achievements

- Management of Patients Not Brought for Appointments Policy now includes adults with vulnerabilities/ adults at risk – available on the intranet
- Reviewed Missing Persons Policy
- Adult Safeguarding worked closely with Kirklees Local Authority to agree that the increased number of ineffective discharges could be managed internally by CHFT via the above group as opposed to formal individual Care Act (2014) Section 42 investigations.

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- Systems approach to embed learning (i.e. Multi Agency Audit programmes).
- To contribute to support Divisions and the work of the Discharge Improvement Group to drive quality improvements in relation to hospital discharges
- To work alongside and support Divisions with regard to providing timely feedback to the local authority

Kirklees Safeguarding Adults Board
Partners in preventing abuse and neglect

Calderdale Safeguarding Adults Board

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Safeguarding Children

Working together to protect the welfare of children and protect them from harm

Key Achievements

- Process identified to identify where 16-17 year olds are cared for, training undertaken with staff and development of a SOP to support.
- Safeguarding supervision is now being offered to departments where 16-17 year olds are admitted with presentations of concern
- Developed a pathway with community services for direct referral into Paediatric/ ED services for hospital assessments

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- Ongoing training to support teams to undertake safeguarding supervision with own departments via the safeguarding team champions and safeguarding team
- Map other areas that may need review of safeguarding supervision process and include establishing robust safeguarding children's champions
- Continue to support the inclusion of the child's voice/ lived experience of the child in safeguarding practice

Kirklees Safeguarding Children Board

Calderdale Safeguarding Children Partnership

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Mental Health Act

The Mental Health Act covers the assessment, treatment and rights of people with a mental health disorder.

Key Achievements

- Service level agreement between SWYPFT and CHFT reviewed and signed
- Additional training dates provided to improve compliance with Receipt and Scrutiny training
- Joint Working Protocol has been reviewed in line with the changes to the working arrangements in the Mental Health Liaison team

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy) work plan

- Review policy and procedure in response to the proposals following the consultation process reforming the Mental Health Act
- Embedding of new processes for electronic submission of forms related to detaining and serving of MHA papers.
- Ongoing promotion of MHA receipt and scrutiny training to improve compliance.

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Children Looked After (CLA)

Children and Young people in the care of the Local Authority. The CLA team works with Calderdale Council to ensure the health needs of looked after children in Calderdale are met

Key Achievements

- Development of a template for all CLA who move into Calderdale from an external local authority
- Audit to review out of area children placed in Calderdale – impact on health needs; gaps in Calderdale service provision
- Collaborative working with the fostering teams to train and support health updates to foster carers

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- Continue to support links for care leavers over 18.
- Working with Calderdale Children's Services to improve completion of SDQ's (Strengthening Difficulties Questionnaire).
- Commence data collect for CLA placed in Calderdale from an external local authority

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Maternity Safeguarding

Within maternity services, safeguarding from early intervention to child protection is a key factor in keeping the unborn and pregnant women safe

- **Key Achievements**
- Process in place to ensure flags are in place for all babies at risk of FGM
- Reviewed Multi Agency Pregnancy Liaison Advice Group (MAPLAG) and Supporting Women in Ante Natal Services (SWANS) process to ensure enhanced risk assessment processes are in place
- Delivered ICON training

Priorities 2021-22 (including actions from 2020-22 Safeguarding Strategy workplan)

- Collaborative working with the local authorities in developing a robust pathway for referring female children/ new born babies into children's social care
- Appoint Health IDVA with specific remit towards Pakistani/ Muslim heritage
- Criteria for cases to be reviewed at the specialist midwifery panel to be included in the SOP

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Safeguarding is Everyone's Responsibility

15. Nursing and Midwifery Staffing Hard Truths Requirement

Presented by - Andrea Dauris, Associate Director of Nursing

To Note

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Nursing and Midwifery Safer Staffing Report
Author:	Andrea Dauris, Associate Director of Nursing
Sponsoring Directors:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	Workforce Committee - 15 February 2022

Purpose of the Report

The purpose of this report is to provide the Board of Directors with an overview for Nursing and Midwifery staffing capacity and compliance within Calderdale and Huddersfield NHS Foundation Trust in line with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Workforce Safeguards guidance.

This is supported by an overview of staffing availability over the reporting period and progress with assessing acuity and dependency of patients on ward areas. This data collection has been used to inform the Nursing and Midwifery establishment reviews for 2021-2022.

This report provides an update regarding safer Nursing and Midwifery staffing and an overview of measures being taken to address risk within Calderdale and Huddersfield NHS Foundation Trust.

Key Points to Note

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

- The current reality, in the context of the ongoing pandemic response and the recovery agenda.
- The Nursing and Midwifery workforce recruitment and retention strategy which in its proactive and innovative approach is having a positive impact on the vacancy position
- The continued focused leadership to support this agenda.
- The actual and planned CHPPD position, in particular the gap in the Registered Nurse (RN) staffing group.
- The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas.
- CHFT compliance against the Appraisal of the *Winter 2021 preparedness: Nursing and midwifery safer staffing* (NHS Nov 2021). (compliance against 3 out of the 4 domains providing assurance that the approaches within CHFT are reflective of the recommended processes to safer nursing and midwifery staffing
- The summarised identified next steps

EQIA – Equality Impact Assessment

Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non-English speakers and being a member of a social minority (e.g., migrants, asylum seekers, and

travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing staff required to provide safe care.

Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the scoping document.

Evidence shows us a direct correlation between quality, safety and patient experience and nurse staffing levels. Failure to have staffing in place that meets the care needs of patients means there is a potential risk of poor outcomes for all service users. Should this be the case then people from protected characteristic groups could have been disproportionally impacted given the evidence to suggest a less favourable experience for people from these groups across all NHS services.

Recommendation

The Board of Directors is asked to **NOTE** the content of the report for assurance.

CONTENTS	
1.0	Introduction
2.0	Safer Staffing
3.0	Sickness and Absence levels
4.0	Hard Truths data
5.0	Strengthening the escalation and reporting arrangements for Quality and Safety
6.0	Recruitment and Registered Nurse Trajectory
7.0	Nursing and Midwifery Workforce
8.0	Summary
9.0	Recommendations
	Appendix 1 Safer Staffing OPEL cards.

1.0. INTRODUCTION

The purpose of this report is to provide an overview for Nursing and Midwifery capacity and compliance with the NICE Safe Staffing, National Quality Board (NQB) Standards and the NHS Improvement Workforce Safeguards guidance. Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with the Care Quality Commission (CQC) regulation and Nursing and Midwifery Council (NMC) recommendations.

This is supported with an overview of staffing availability over the previous six months and progress with assessing acuity and dependency of patients on ward areas. This data has supported the review of the Nursing and Midwifery establishment reviews for 2021/2022 in addition to providing a cumulative oversight of CHPPD and fill rates.

It is well documented that there is an established relationship between higher Registered Nurse (RN) staffing levels and improved patient outcomes and care quality (Griffiths et al 2020).

Developing Workforce Standards (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and built on the National Quality Board (2016) guidance. The standards provide a framework for the approach taken to determine safe staffing processes which includes three components:

- Evidence base tools and data
- Professional judgment
- Outcomes

It is this framework that has used to determine CHFT's safe staffing processes and the recent safer staffing review.

Within Midwifery Services, a baseline assessment was commissioned using BirthRate Plus, which continues to inform the recent safer staffing review.

This report describes CHFT's position in response to the national guidance for the reporting period August 2021 to January 2022.

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

CHFT's Reality

2.0 SAFER STAFFING

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

Whilst the vacancy rate at CHFT has remained static over previous years running with circa 150 qualified vacancies, January 2022's vacancy position has reported an improvement with a vacancy position of 59.55 FTE.

During the reporting period the Hard Truths review process commenced in November with Safer Care Nursing Tool (SNCT) data collection, followed by four divisional panels presented to the Executive Director of Nursing during the month of January.

This included an appraisal of the proposed workforce models, in additional to identification of the right skills, in the right place at the right time, supporting any divisional training plans. Decision making was premised on the principles as set out in the Developing Workforce Safeguards guidance (2018) which drew together SNCT data analysis, professional judgement, and a suite of metrics such as: sickness/absence data, nurse sensitive indicators and complaints to inform recommendations.

Except for services listed below the workforce models were approved with some fine tuning based on the triangulation of service data:

- Emergency Departments continue to operate with partial segregation across both sites, involving enhanced workforce models.
- Acute floor at CRH was approved based on an interim surge model.
- Respiratory Wards – approval of a 10 bedded Acute Respiratory Care Unit
- Midwifery services (detailed below)
- Neonatal Intensive Care Unit – additional external funding received to support the service in providing a nurse in charge role across all shifts.

2.1 Maternity Services

Birthrate Plus was commissioned to undertake a full baseline assessment for the period 1st April 2019 – 31st March 2020, which was reported on in November 2020. Birthrate Plus methodology is consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and has been endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists. A current maternity workforce gap analysis was also a requirement within the 7 immediate and essential actions in response to the Ockenden Report.

The review highlighted a requirement for 226.84 wte clinical and non-clinical staff of which 20.81 wte could be suitable qualified support staff at agenda for change Bands

3 or 4. The current funded establishment for maternity services is 186 wte qualified midwives (clinical and non-clinical), 11.37 wte band 3 Midwifery Support Workers and 39.58 band 2 Health Care Assistants. To note Birth Rate Plus does not include band 2 support staff within their review.

A gap of 20 wte registered midwives (226.84-20.81= 206.06 vs current establishment 186 wte) and 9.44 wte band 3 support staff (20.81-11.37).

In April 2021 NHSE/I invested a further £95.9 million to support maternity services to meet the 7 immediate and essential actions of the Ockenden Report with organisations submitting bids to fill the staffing gaps evidenced by their workforce gap analysis. CHFT maternity services therefore submitted a bid for 20 wte registered midwives based on the November 2020 Birth Rate Plus report and were allocated funding for 10.9 wte.

The last report highlighted a risk in recruitment of these posts, which despite a programme of rolling adverts for midwifery posts at CHFT, these posts remain unfilled.

The senior midwifery team are considering alternative registrant roles that could be utilised in maternity services to release midwives to undertake midwifery functions, however it is important to recognise that these posts would be in place of and not in addition to the number of midwives required.

The Integrated Care System (ICS) has confirmed that the funding will be made available in the next financial year. Therefore, the plan would be to fill these posts and any current vacancies from the next cohort of student midwives achieving registrant status. The recruitment process is likely to commence in spring 2022 and will be a collaborative recruitment process across the Local Maternity System (LMS), however, to note the successful applicants would not come into post until September 2022.

Local midwifery metrics informed this current round of establishment reviews as part of the establishment review within the midwifery service. During the reporting period the below position was described based on the acuity and demand of the patients against the midwifery workforce position:

Week	%census periods RAG rated Red	%census period RAG rated Amber	%census periods RAG rated Green
6.12.21	7%	52%	40%
13.12.21	15%	54%	32%
20.12.21	12%	43%	45%
27.12.21	0%	31%	69%
3.1.22	7%	62%	31%
10.1.22	6%	36%	58%

Definition:

- Red more than 3 midwives short in the census period
- Amber up to 3 midwives short in the census period
- Green number of midwives available meets the acuity

It is this metric that the senior maternity leadership team use to deploy midwives to match the acuity, this period of deployment can range from a whole shift to a few hours as the acuity changes.

In context of the current Covid -19 surge the total unavailability (includes annual leave, maternity leave, sickness and isolation (headroom is set at 22%) for inpatient maternity services for the same timeframe was:

Week	Total Unavailability
6.12.21	36%
13.12.21	38.5%
20.12.21	37.5%
27.12.21	26.5%
3.1.22	63.5%
10.1.22	38.5%

In response to this position the service described a robust escalation policy reported via the incident reporting system with periods of escalation are reviewed at the weekly maternity governance meeting.

1:1 Care in labour

One of the most important metrics in maternity care is the provision of 1:1 care for women in labour. There is no fixed definition of what “in labour” means and these can range from a midwife having responsibility for only 1 woman in active labour to a woman having a midwife available to her when she needs it. At CHFT the 1:1 care in labour metric is reported on the maternity dashboard that is shared both internally and across the local maternity system (LMS).

6 month data for CHFT

Month	July	August	September	October	November	December
% women received 1:1 care in labour	98.2%	98.9%	98.8%	98.4%	96.6%	98.1%

Quarterly LMS and Yorkshire and the Humber data for 1:1 care in labour

1:1 care in labour	Q1 21/22	Q2 21/22
CHFT %	98.5%	97.2%
West Yorkshire and Harrogate LMS	95.38%	94.6%
Yorkshire and The Humber %	91%	94.3%

The service presented additional metrics related to NHS Resolution’s Maternity Incentive Scheme which states that the midwifery coordinator in charge of labour ward must have supernumerary status, which is defined as having no caseload of their own during their shift to ensure there is an oversight of all birth activity within the service. For the period 6.12.21 to 16.1.22 there were a possible 252 census periods, of these

there was only 1 census period (a time span of 4 hours) where the labour ward coordinator was not supernumerary.

In summary the review of maternity services workforce models in line with CHFT's nursing and midwifery hard truths review focused on the services plans for Continuity of Carer being the default model of care in line with the NHSEI paper published in October 2021 the focus being on the provision of safe staffing across the service, and ensuring staff have the training and support necessary to work within the model of care.

3.0 SICKNESS AND ABSENCE LEVELS

Figures 1 - 5 show the sickness level at the Trust during the reporting period. Data has also been included from "Covid-19 related absence" which is coded differently within the electronic staff records, however, is an impact of the pandemic which directly affects the availability of the nursing and midwifery and nursing support workforce.

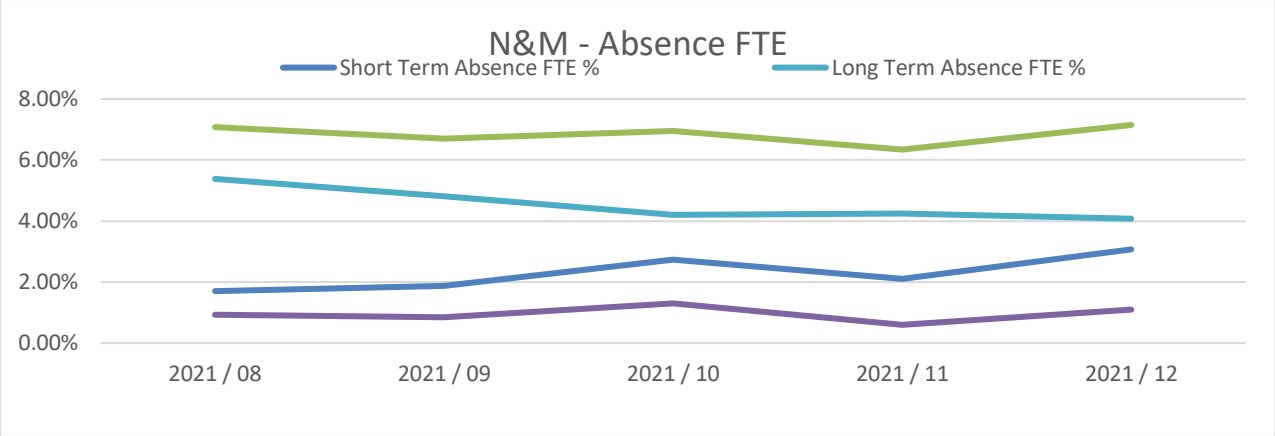
During the reporting period total absence continued to be a challenging position with peaks in October and December for both workforce groups. This position is attributable to COVID positive colleagues as well as other absence such as stress, anxiety, and depression.

Whilst these findings are not peculiar to nursing and midwifery, CHFT recognises that support for colleague wellbeing is vital pre, during and post the pandemic. The health and well-being support available at CHFT continues to be refined and tailored to support the diversity of our people and continues to be a critical response to supporting the health and well-being of nursing and midwifery colleagues.

Qualified Nursing & Midwifery

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2021 / 08	850.65	2,688.07	3,538.72	49,968.18	1.70%	5.38%	7.08%	462.96	0.93%	8.01%
2021 / 09	910.97	2,329.77	3,240.75	48,394.42	1.88%	4.81%	6.70%	408.65	0.84%	7.54%
2021 / 10	1,409.87	2,168.03	3,577.89	51,494.11	2.74%	4.21%	6.95%	669.93	1.30%	8.25%
2021 / 11	1,062.61	2,146.76	3,209.37	50,605.39	2.10%	4.24%	6.34%	302.68	0.60%	6.94%
2021 / 12	1,612.11	2,140.42	3,752.54	52,500.46	3.07%	4.08%	7.15%	579.11	1.10%	8.25%

(Figure 1)

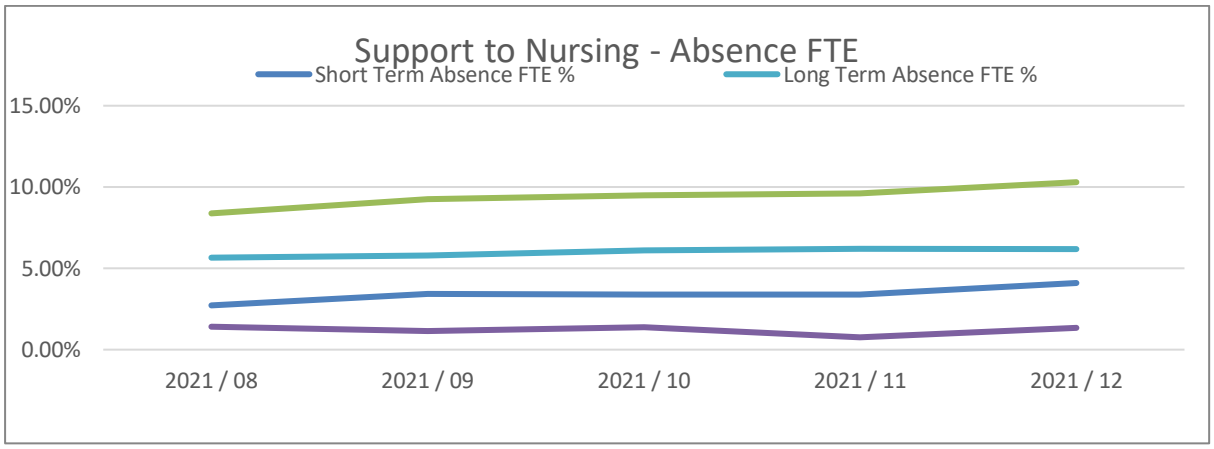


(Figure 2)

Nursing support

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2021 / 08	728.87	1,514.24	2,243.11	26,771.27	2.72%	5.66%	8.38%	377.73	1.41%	9.79%
2021 / 09	883.40	1,490.75	2,374.15	25,687.99	3.44%	5.80%	9.24%	297.09	1.16%	10.40%
2021 / 10	905.47	1,624.39	2,529.85	26,636.26	3.40%	6.10%	9.50%	363.15	1.36%	10.86%
2021 / 11	879.71	1,607.99	2,487.70	25,927.00	3.39%	6.20%	9.60%	196.47	0.76%	10.35%
2021 / 12	1,089.67	1,647.72	2,737.39	26,583.79	4.10%	6.20%	10.30%	355.75	1.34%	11.64%

(Figure 3)



(Figure 4)

The impact of the combined actual RN wte and average sickness absence position has been further modelled across the four divisions to give context to the workforce challenges.

	Medicine	Surgery	FSS	Community
Budgeted RN WTE	488.76	426.08	263.41	114.18
Actual RN wte	460.02	410.23	239.55	114.25
RN vacancy wte	28.74	15.85	23.86	0
RN % vacancy gap	5.89%	3.72%	9.06%	0
Average absence above budgeted headroom (22%)	10.60%	5.29%	7.37%	6.77%
Total combined vacancy and average absence position above headroom.	16.49%	9.01%	16.42%	6.77%

*Data source- Healthroster budgeted vs actual position 31/01/2022 (***Figure 5)**

This position is further compounded by the actual RN workforce supporting additional capacity which has included Ward 14, 6AB, 4d, 11 and 15. As an example, to support the 27 beds on Ward 15 requires an additional 22.48 wte registered nurses.

4.0 HARD TRUTHS DATA

As indicated earlier safe staffing is one of the essential standards that all health care providers must meet. NHS England and the Care Quality Commission (CQC) issued guidance in 2014 detailing their ongoing commitment to publishing staff data, referred to as “Hard Truths.”

Hard Truths is a commitment to greater openness and transparency and is achieved by publishing staffing data regarding nursing, midwifery and care staff levels.

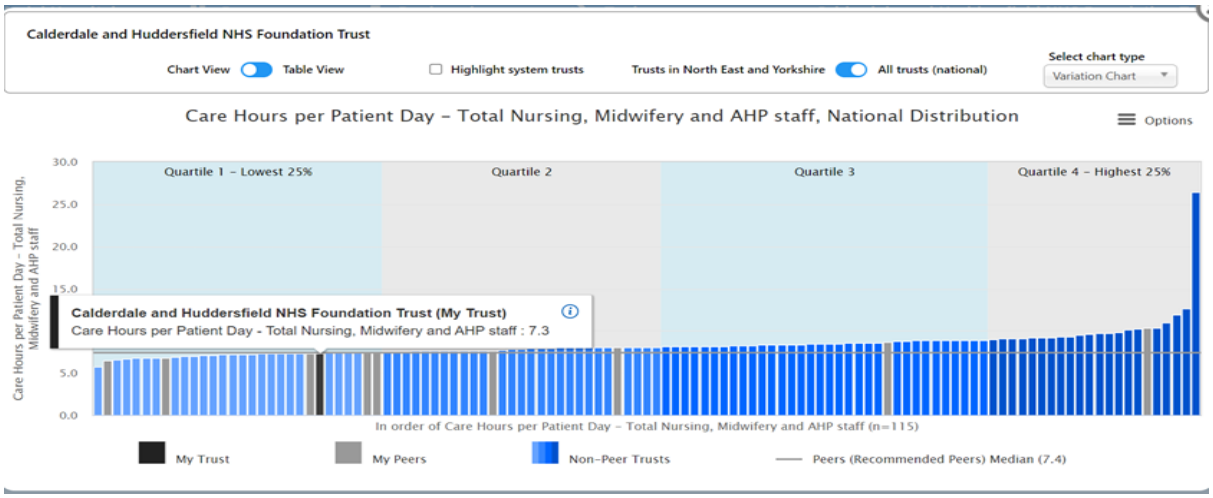
This is provided through the Trust reporting nursing and midwifery staffing numbers including registered and unregistered to NHS England and Improvement (NHSE/I) via a monthly nursing and midwifery staffing return. The data includes oversight of care hours per patient day (CHPPD) which is now seen as a national measure for safer staffing. NHSE/I began collecting CHPPD formally in 2016 as part of the Carter Programme and data at Trust and ward level for all acute Trusts is now published on NHS Model Hospital.

CHPPD provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units.

It is calculated by adding together the total number of registered nurses, nursing associates, and in some cases allied health professionals, along with healthcare assistant hours on each ward and dividing by the number of patients on the ward each day at midnight. The aim of this is to enable national benchmarking, reduce variation and increase efficiency. Given the way it is calculated, actual CHPPD is influenced not

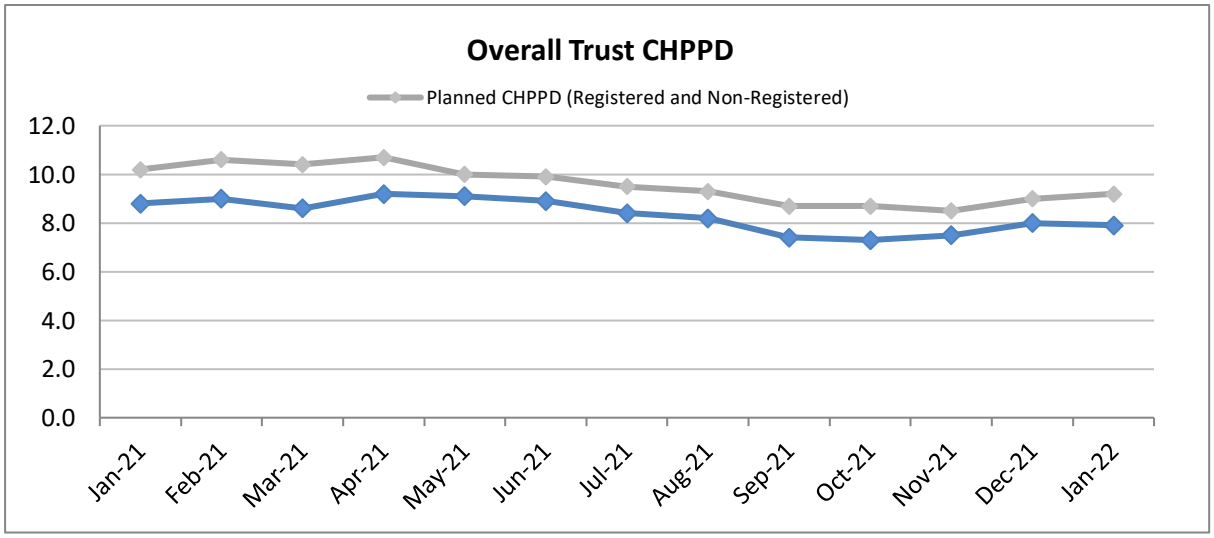
only by numbers of staff on duty, but also the bed occupancy, with wards with fewer patients, or with high numbers of day-case patients who are discharged prior to midnight, demonstrating significantly higher CHPPD.

Information obtained from the Model Hospital platform identifies CHFT to be in the lower quartile of CHPPD provision by nurses, midwives and AHPS at 7.3 CHPPD. (Data from October 2021) This compares to an average of 7.4 CHPPD for peers and a national median of 8.1 CHPPD provided by registered professionals. This represents the significant challenges faced by CHFT during the latter part of quarter 2 in 2021 when significant numbers of new registrants were still in their supernumerary period.



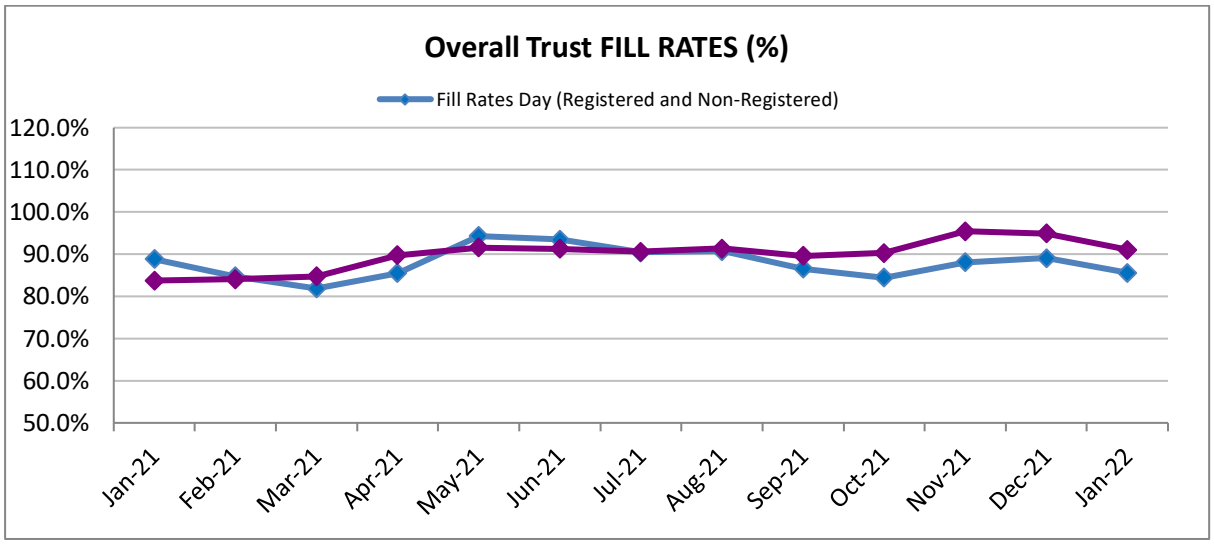
(Figure 6)

<u>CHPPD</u>



(Figure 7)

Fill rates



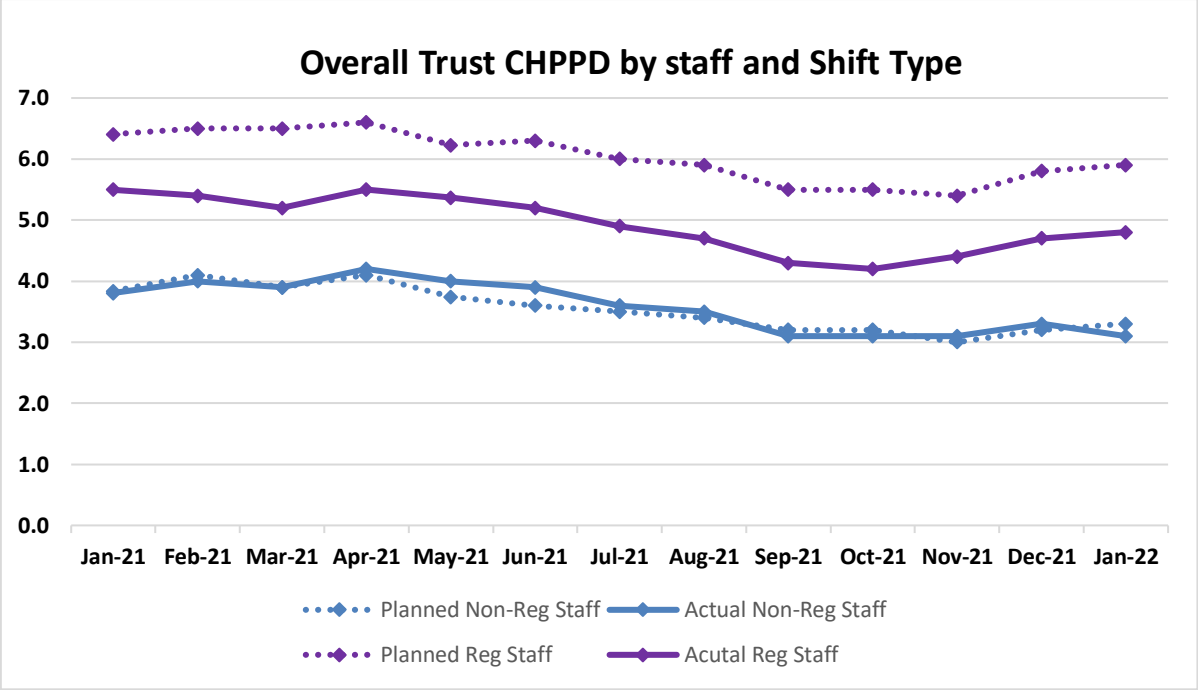
(Figure 8)

Whilst fill rates are no longer a reporting requirement to NHSE/I they continue to be a useful measure for analysis. Fill rates are calculated by comparing planned hours against actual hours worked for both RN and HCSW. Factors affecting fill rates include:

- Sickness (lower if not filled)
- Vacancies (lower if not filled)
- Enhanced Care Support Worker requirements, otherwise known as 1:1 observation (when additional staff above agreed WFM are rostered on to support)

Trust overall fill rates have not regained the pre pandemic position which trended around the 90-95% position. For the reporting period, August reported a fill rate position of 91.4% which dipped to its lowest position in October at 84.5% (Figure 8). These impacts can be seen on the overall trust CHPPD position with an ongoing shortfall reported between planned and actual care hours during the reporting period (Figure 7). This is reflective of the ongoing challenging sickness/absence position, restarting of services to a pre-pandemic position, in addition to supporting enhanced service delivery in some areas.

In recognising the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), Figure 9 breaks down the CHPPD by staff groups, which highlights the most challenging gap can be seen within the RN workforce.



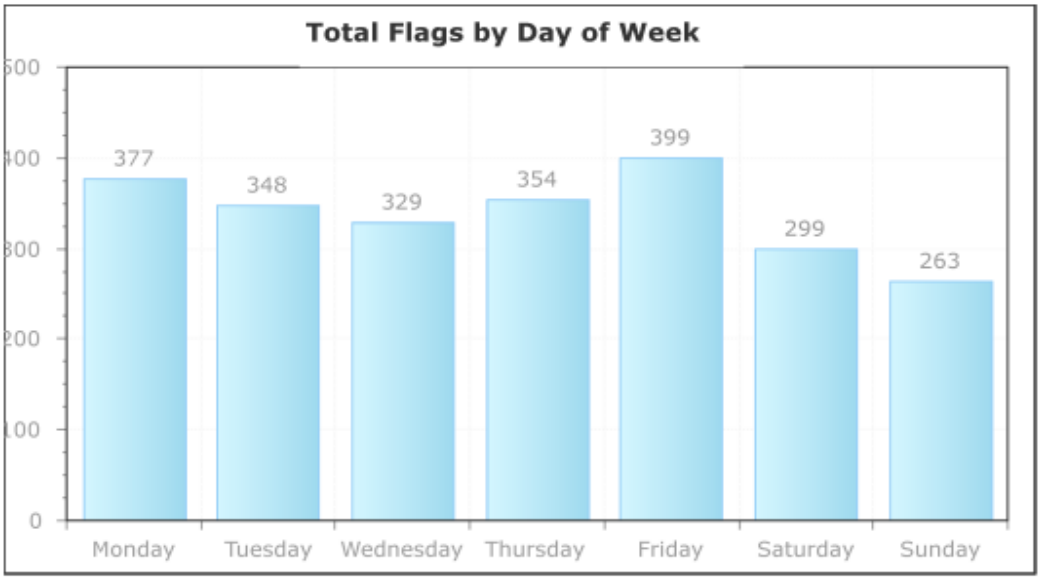
(Figure 9)

4.1 Red Flag Escalation

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

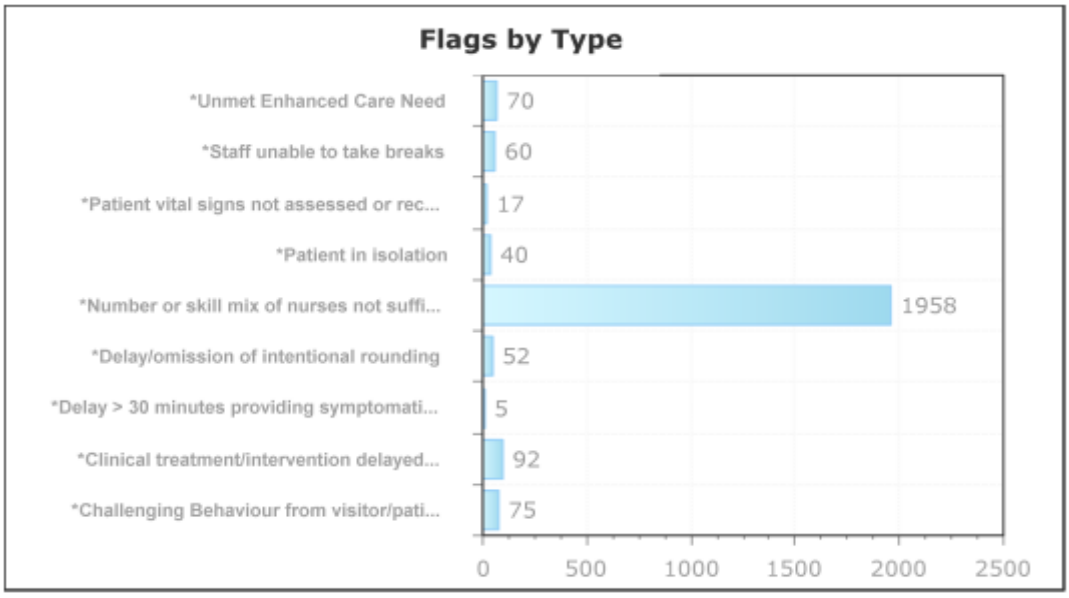
During the Covid-19 pandemic given the significant staffing challenges there would be an expectation of escalation via the Red Flag process which forms a key part of the governance arrangements and ongoing monitoring of the staffing position.

Figure 10 provides a breakdown of red flags for the reporting period 1st August 2021 – 31st January 2022.



(Figure 10)

Figure 11 provides a further breakdown of the category of Red Flag.



(Figure 11)

In isolation this data does not provide a clear understanding of the actual impact upon patient experience or the workforce in delivering patients' care. Thus, this information should be considered within the context of the CHPPD and fill rate position and the quality agenda in section 4.2 of the report. Alongside the additional bed capacity which has been opened during the reporting period.

4.2 Quality

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

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

In addition, since the last report, work has progressed on the development of an integrated dashboard accessible by clinical teams through Knowledge Portal+. This dashboard provides close alignment of the fill rates, CHPPD and several quality metrics to facilitate professional curiously and initiate deep dives into service areas.

This is further supported by the development of an Enhanced Dashboard Metric which is now embedded into clinical practice and reported into the Nursing and Midwifery Safer Staffing meeting. The data within this report is further analysed through divisional teams to determine the actions required to respond to data triangulation, and mitigation against any impacts. Data from this dashboard was also used by divisional teams to inform the establishments reviews.

4.2.1 Friends and Family Test (FFT)

The performance data reported below is a combined rating of all 5,571 FFT responses submitted between 01/09/2021 – 20/01/2022.

The main FFT question asks patients**: Thinking about your stay in hospital overall, how was your experience of our service?** With options ranging from very good to very poor. The breakdown of positive vs negative results is a useful barometer to monitor performance through a patient feedback lens.

All	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Don't know
% of Total	84%	12.40%	1.80%	0.23%	0.28%	0.70%
Combined	**Positive: 93%**			**Negative: 0.51%**		

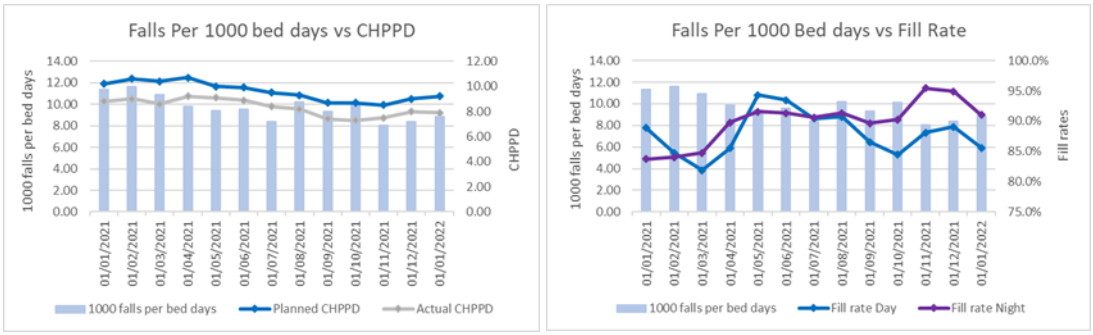
The overall positive FFT score of 93% is a positive position which is against a national position of 95%.

4.2.2 Falls and Pressure Ulcers

The charts below provides an overview of the reporting of incidents related to falls per 1000 bed days (Figure 12) and ulcers per 1000 bed days (Figure 13).

Falls

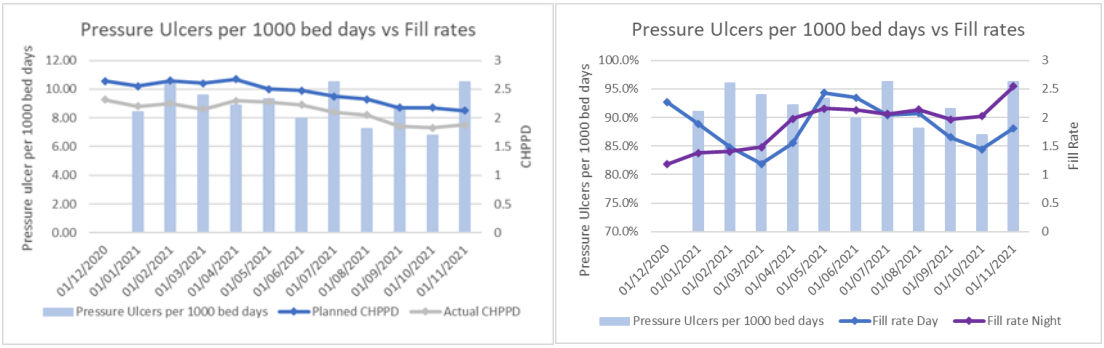
Falls remained at their highest period during the months of August – October 2021 which reflects a challenging fill rate position which drops to its lowest point in October to 84.5%. This is consistent against the CHPPD which is at its broadest gap between planned and actual also between August – October 2021, followed by an additional dip in January which identifies a further upward trend in falls in the same month.



(Figure 12)

Pressure Ulcers

Due to validation processes for the purpose of the reporting period of this report pressure ulcer data is only available for the months August – November. Data for pressure ulcers per 1000 bed days demonstrates a fluctuating position with the highest incidence identified in November where fill rates were 88.1% and CHPPD demonstrated an overall gap between planned and actual of 1.0.



(Figure 13)

Analysis of the data indicates an increasing incidence of the two nurse indicators that may be attributable to the deteriorating fill rate and CHPPD position.

Given the established relationship between higher registered nurse staffing and improved patient outcomes and care quality (Griffiths et al 2020), and the gap in CHPPD continues to be identified as the most challenging for the RN workforce (Figure 8).

It is reasonable to suggest the impact of the recovery agenda, ongoing enhanced delivery of some services, additional capacity, current vacancy position and the impact of increasing staff sickness absence has impacted upon the patient experience.

4.2.3 Incident reporting

During the reporting period 149 Nursing and Midwifery staffing related incidents were reported through the Datix reporting system. 146 of these incidents were reported as no harm and 3 as minor harm. There was appropriate escalation when the incidents occurred, and this is recorded within the incident records. There is a strong theme

around staff being redeployed to support other areas and the impact of this. There were also incidents related to additional patient areas being open. It is apparent from the incidents that support was offered to staff and there was no significant harm to patients. There is ongoing work to link incidents with activity levels in the trust which will help triangulate information. The quality and risk team safety huddles are established and have oversight of all incidents. This provides the opportunity to immediately escalate any incidents and seek assurance about the outcome for any patients (if relevant) or the wellbeing of staff involved.

4.2.4 Further points for consideration

Whilst red flags and incident reporting are established methods of escalation, it should equally be noted that these approaches may not be fully utilised by a workforce that is challenged by the current staffing position. Under reporting is an ongoing concern and reiterates the importance of ensuring forums are available for concerns to be raised.

A recurring theme raised by staff side at the Staff Partnership Forum, relates to the movement of staff across clinical areas to address shortfalls. Consideration has been given to this issue; however, it remains a challenge given the current levels of sickness that are further compounded by the additional capacity areas that have been opened.

CHFT'S RESPONSE

Short-term strategies

5.0 STRENGTHENING THE ESCALATION AND REPORTING ARRANGEMENTS FOR QUALITY AND SAFETY

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

- The senior nurse leadership rota established earlier this year continues supported by the Executive Director of Nursing, Deputy Director of Nursing and Associate Directors of Nursing to provide ongoing visibility and dialogue across clinical areas, and support staffing escalations across the 7 days.

In addition to providing ongoing visibility and dialogue across clinical areas, the senior nurse leadership rota also supports delivery of the welfare packs.

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

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

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

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

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

- The twice daily nursing and midwifery safer staffing meetings have a direct escalation into the Nursing and Midwifery Workforce Safer Staffing Group chaired by the Executive Director of Nursing.

- An enhanced dashboard has been established to provide clear visibility on the workforce position and impacts on the patient experience, quality and safety agenda. This dashboard now includes several metrics that sit across all four divisions, in addition to divisional specific metrics which will enable true triangulation of the datasets.

The enhanced dashboard provides weekly visibility on a suite of metrics enabling a rapid appraisal of each metric and determination of a response where impacts can be seen on the patient experience.

- During the reporting period triggered by the ongoing critical workforce challenges Gold meetings have been established chaired by an Executive Director with representation from internal colleagues and system partners. This provided a forum for closer monitoring and oversight of the Nursing and Midwifery workforce position including several key interdependencies including: - workforce metrics, safer staffing quality metrics, patient flow and infection prevention and control.

- The Safer Staffing OPEL cards have revised to include additional responses that were enacted (see Appendix 1).

- Appraisal of the *Winter 2021 preparedness: Nursing and midwifery safer staffing* (NHS Nov 2021) identified compliance against 3 out of the 4 domains providing assurance that the approaches within CHFT are reflective of the recommended processes to safer nursing and midwifery staffing.

5.1 Staff Health and Well-Being

The nursing and midwifery workforce recognise the ongoing impact of the Covid-19 pandemic on NHS staff well-being. This continues to remain an area of significant focus with ongoing support from colleagues within workforce and organisational

development departments (WOD). Recognising the ongoing exceptional circumstances colleagues are working under a suite of services continued to be refined to respond to those ongoing needs

These include:

- The Wellbeing Hour is actively encouraged and supported
- Leader/Manager Resource Kit to support wellbeing to be at the heart of conversations with colleagues
- Freedom to Speak up - Guardian,
- Trauma / PTSD therapy offered by Socrates Psychological Services
- Money Advice Service -the NHS has partnered with the Money and Pensions Service to bring financial wellbeing support
- Ongoing daily coaching/debrief for critical care staff
- Ensuring staff feel safe and protected
- Ensuring safe spaces for rest and recuperation
- Appraisal of flexible working
- Ongoing promotion and completion of the Trusts health and well-being risk assessment
- Duty Matron rota established 7 days a week
- 7-day senior nurse leadership rota
- Weekly Leadership Assurance audit (including staff health and well-being)
- Listening events

Medium-long term strategies

6.0 RECRUITMENT AND REGISTERED NURSE TRAJECTORY

The NHS Long Term Plan has set a target of reducing Nursing vacancies by 5% by 2028 and the Trust remains committed to driving down the vacancy position at CHFT. This will be addressed by a comprehensive, multi-pronged recruitment strategy with ongoing alignment to the NHS People Plan and government mandate. This includes specific commitments around:

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

We continue our local approach of 4 rolling adverts out (Staff Nurse Medicine, Staff Nurse Surgery, Nursing Associate, Return to Practice and Staff nurse student), and maximising opportunities to attract the next cohort of new graduates. Below is further detail surrounding our recruitment strategy:

6.1 International Nurse Recruitment

We committed to recruiting 70 International Nurses before the end of Dec 2021. Despite delays due to travel restrictions and quarantine requirements to date we have managed to successfully recruit 64 nurses with the remaining 6 due to arrive in February 2022. Despite working to a small delay, we are confident that the remaining 6 will have completed by April 2022. Our IR recruitment numbers are complimented by 2 internal HCSW recruits who had the accepted qualifications to join the OSCE preparation programme. They don't contribute to the project of 70 as they were recruited directly from the UK but are additional nursing recruits and contribute to reducing the vacancy gap.

During this reporting period 32 Nurses have undertaken the OSCE preparation programme, 22 have successfully passed their OSCE exam and are either now registered or awaiting NMC Pin. 10 are in the training programme and will sit the OSCE in either January or March.

All nurses are supported to transition into life within the UK, in addition to a robust training package and wrap around pastoral support that has seen positive results with 0.64% attrition during the 2021 programme.

Pastoral support has been at the centre of this project since its inception and recognised by (Health Education England) HEE and NHSE/I as imperative to making IR recruitment work. CHFT pride themselves on a programme of pastoral support which exceeds the expectation set out by HEE and NHSE/I and includes:

- IR Facebook page for social engagement before and after arrival
- Access to CHF/T's international recruitment specialist who guides recruits through the whole process from interview to taking their test. Assisting with transport, accommodation, visas, registering with GPs, shopping and the local area, booking tests including travel to Ireland.
- A welcome session and booklet that includes information about the UK, the local area and also the NHS including its background and the role of a nurse in the UK today.
- An open-door policy where during working hours all candidates past and present can drop in for support
- Clinical support and orientation
- Welcome packs and meet and greets (we are the first people recruits meet when they arrive)
- Support with NMC registration

During the period 2021 the impact of this approach can be measure against the attrition which represents 1 against 63 international nurse recruits.

We are now working towards an ambitious target of 80 recruits during 2022. Recruitment has commenced and initial interviews have taken place with 9 in the pre travel onboarding stage, we expect the first arrivals in March. We are adopting a varied approach to securing applicants including the use of agencies and a new international nurse specific job advert in which nurses can apply direct to Trust via our recruitment

system - TRAC. There is pre-planned interview schedule across the year to support this strategy.

6.2 Recruitment of Newly Qualified Nurses

Following the success of the 2020/21 recruitment campaign 83 new graduates joined the Trust across the months of Sep-Nov. They have been enrolled in role specific induction and preceptorship programmes which will enhance competence and in turn confidence with the aim of retaining those recruited. Our preceptorship package was shortlisted for a National Nursing Times award in November, and we benchmark and appraise our programme regularly against local counterparts and nationally recognised frameworks.

Our graduate recruits are an increase on the previous year and reflects efforts to enhance our learning experiences and opportunities for students and the continuation of this into their transition to graduate nurse.

Due to the ongoing pandemic and covid restrictions there will continue to be a strong emphasis on virtual and digital materials in our 2022 recruitment strategy. Attracting our final year students remains a priority and a virtual recruitment event is planned for February with the hope of small face to face workshops and fairs later in the academic year. We are working closely with Workforce and Organisational Development and local Universities to create digital and promotional materials which will be used from initial recruitment/adverts through to onboarding and start.

January is our second graduate recruitment point and there are a further 9 new graduate nurses planned to take up employment across January and February.

6.3 Nursing Associate Apprenticeships (TNAs)

11 apprentices successfully registered as Nursing Associates in January with a further 2 due to complete in quarter 4 following module resits. These have been allocated to vacant RN positions across the Trust.

There are 3 active cohorts of Trainee Nursing Associates (TNAs) (42 apprentices in total, of which 10 are due to qualify in Dec 22, there will be no graduating June cohort in 2022 due to the pandemic and a pause of recruitment in 2020). A further 40 places in 2022 are anticipated pending the approval of associated business case.

As our Nursing Associate numbers grow attention has started to turn to professional development opportunities and revalidation support. This is integral in ensuring we have a valued and supported workforce. Various workforce planning events have also taken place with divisions to consider utilisation, governance and how the role can be embedded further into our clinical teams and services.

6.4 Registered Nurse Degree Apprenticeships

The 2 apprentices on the full 3-year apprenticeship have successfully moved into their second year (qualifying in January 2024).

Our first cohort of 7 Nursing Associates on the 2-year shortened RN apprenticeship have also moved into their second year and will complete and qualify as registered Nurses in January 2023.

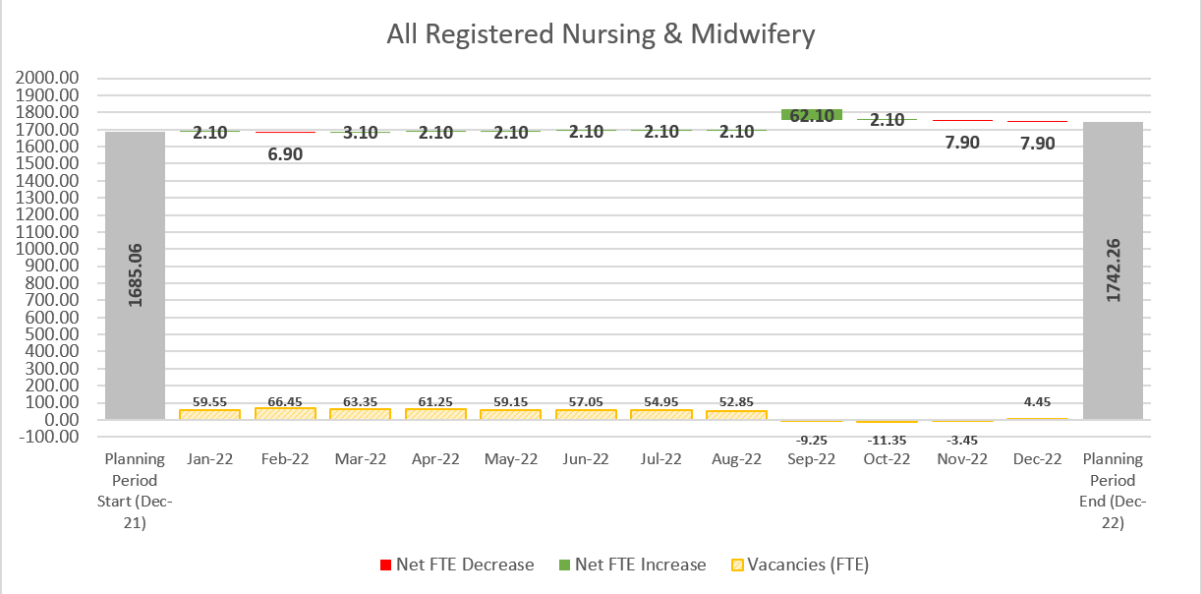
The 2nd cohort of Nursing Associates started their RN apprenticeship in October 21 with a view to qualifying in October 23.

Projected numbers and cohort start dates for 2022 are being finalised within Trust and with partner Universities. Is it expected that recruitment will commence in the Spring.

6.5 Return to Practice Nurses:

1 nurse returned to practice in September 21 and has now completed the course and is awaiting pin. 2 had been recruited for a February 22 cohort but unfortunately one has withdrawn.1 nurse will now start in the medical division. The next cohort is September 2022. In response to reduced applicants across 2020-2021, a review of our strategy is required to address this and improve 2022/23 numbers. New recruitment materials, opportunities for other professional groups and new ways of completing the training need to be explored with Workforce and Organisational Development, HEE project team and local course providers.

Based on the current Nursing and Midwifery recruitment strategies, January's vacancy position sits at 59.55 FTE with projections indicating a further improving position towards the end of 2022.



(Figure 14)

6.6 Health Care Support Workers (HCSW)

The national 'Zero HCSW Vacancy' campaign has been extended in to 2022, the aim of the programme is to meet a zero HCSW vacancies and have procedures in place

to ensure this is maintained. An increased funding investment in to welcoming recruits with no prior experience has been pressed as a priority, this is to avoid destabilising existing services and to grow our HCSW workforce nationally in line with demand. We are currently exploring how this investment can be utilised to the best effect, implementing a long-term process to widen access and stabilise HCSW position fill.

At present there are only 2 entry routes into band 2 vacancies at CHFT which are advertised separately:

- Apprenticeship pathway for individuals with little or no experience who can demonstrate the academic ability required to successfully complete the programme, currently only available on a full-time basis. This is paid at 20% below band 2.
- Direct access at band 2 for those with significant experience and relevant qualifications.

This very rigid system means we lose some good applicants who fall short of one or the other entry point. Some don't quite meet the criteria to enter at band 2 but are already at a higher level than the apprenticeship on offer.

In response to this, it is proposed that we expand employment routes as follows:

- Secondment to apprenticeship – for current staff members in other roles wishing to progress into the HCA role. Secondment would protect their salary whilst affording them the opportunity to progress.
- Trainee roles – For applicants who have relevant qualifications higher than those within the apprenticeship (and therefore don't qualify for apprenticeship funding) but do not meet the experience requirements for direct entry at band 2 OR applicants who have significant customer service experience and strong GCSEs. A 3-6-month training post to include completion of the care certificate. Recruits attain a substantive Band 2 post on completion.

In addition to available HEE funding there may also be a requirement for CHFT investment to implement and deliver a trainee programme.

Having an HCSW Recruitment Team in place has allowed for future planning of ward changes, as an example the Acute Floor at HRI will become 2 wards from January 31st, 2022. Liaising with clinical leads and the recruitment has allowed for pre planning of 12.03 WTE vacancies.

In previous months, a relationship has been built with the HCSW Recruitment Team and the ward areas to overcome resistance to generic recruitment. Administrative time has been reduced for Clinical Leads as the weekly triangulation report is used to identify vacancies and recruits placed accordingly. In addition to this new starter requirements are completed by the recruitment team for uniforms and IT access. This ensures the recruits receive a more streamlined induction into the trust and delays across recruitment have been minimised by having a central service that advertise, shortlist, interview and appoint.

6.7 Employability at CHFT

Since August 2020, The Employability Team have been developing a range of entry pathways into the Trust supplemented with targeted employability interventions that seeks to support additional recruitment into clinical and nonclinical areas. Guiding principles within employability focuses on leveraging local talent, supporting internal CHFT colleagues and removing barriers to entry for applicants in accessing development opportunities at CHFT which includes:

Care Club Volunteering

The Employability team made a successful bid in November 2021 to NHS England and NHS Improvement for £25K enabling the successful recruitment of a Band 5 Volunteer Coordinator in January 2022. One of the main outputs for this project includes the recruitment of an additional 75 x Ward Helper Volunteers and 20 x Volunteer Mentors before funding ends in August 2022, targeting local young adults who have been disproportionally affected by the pandemic. Volunteer mentors will come from existing volunteers and current apprentices with the aim to improve the overall volunteer experience and general support for all stakeholders.

The role of a "ward helper" was developed in partnership with clinical teams as part of an organisational response to the workforce challenges. It is seen as crucial in enabling the Trust to free up clinical staff time and to support other ward colleagues in helping to improve the patient experience by being that "extra pair of hands". In return, volunteers will be able to access employability and progression workshops which will enable CHFT to prioritise recruitment from this volunteer pool into other pathways such as NHS cadet schemes, traineeships, apprenticeships, and band 2 roles.

The Care Club in general is currently being relaunched and rebranded to incorporate existing volunteers, the recruitment of "internal" CHFT colleagues and to scale up the recruitment of new external "ward helper" volunteers into the Trust.

A recent recruitment campaign for Internal staff to join Care Club as a ward helper has also resulted in an additional **15 x internal non-clinical CHFT colleagues** who have stepped forward to help support ward areas at key pressure points (mealtimes, visiting etc).

Kickstart

A Kickstart pathway for both nonclinical and clinical applicants was established in September 2020 working in partnership with the DWP, JCP+ and C+K Careers to support local unemployed young adults in receipt of Universal Credit. Where appropriate the aim is to progress applicants from Kickstart onto Apprenticeships or Band 2 roles. The employability team has worked closely with ward and clinical leads to present "work ready" candidates and provide pastoral support throughout the applicants' journey at CHFT.

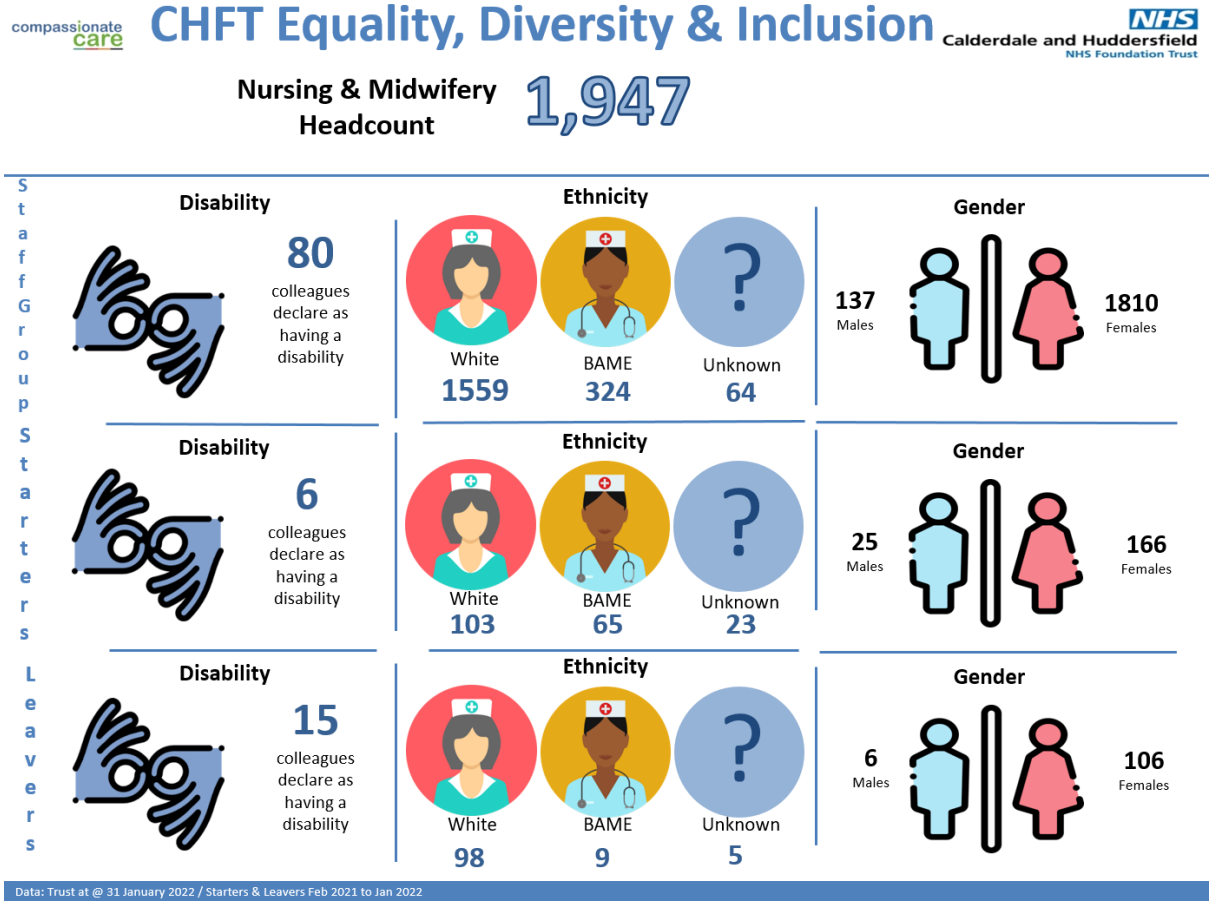
This partnership has so far supported 18 x local young people (10 x nonclinical administrative and 8 x clinical ward helpers with 2 more candidates to recruit) across a variety of roles including ward areas with acute pressures. Over the course of this

project, it will provide an additional 13,000 working hours and over £115K in salary subsidy but more importantly provide additional resource to help improve patient experience and contributing positively to the current N&M workforce challenges.

New for 2022; St John's Cadets and Princes Trust "Get Into" projects
Working in partnership with St John's Ambulance and the Princes Trust, from January 2022 CHFT have recruited **70 local young people**, aged 14-18 to access personal development and employability workshops including access to care club ward helper volunteering roles where appropriate. These additional pathways will help support ward areas further, support wider apprenticeship and entry role recruitment activities within the Trust and provide another potential pipeline for future talent.

7.0 Nursing and Midwifery workforce

7.1 Equality Diversion and Inclusion



(Figure 15)

The current qualified nursing workforce comprises of 1947 staff, 80 (4.1%) of which have declared a disability, comparable to CHFT as a whole at 4.2%.

324 (16.6%) of all RNs at CHFT are of BAME ethnicity, this is below the reported overall CHFT figure of 20.4%, while just over 3% have not declared their ethnic origins.

The majority (93%) of RNs are female, this is above the Trust whole workforce gender split of 81.5% female, 18.5% male.

Over the reporting period there has been a net…

…decrease of 9 disabled staff.
…increase of 5 white staff.
…increase of 56 BAME staff.
…increase of 18 staff of unknown ethnic origins.
…increase of 19 males.
…increase of 60 females.

7.2 Revalidation

Revalidation is the process that all nurses and midwives in the UK and nursing associates in England need to follow to maintain their registration with the Nursing and Midwifery Council (NMC). Revalidation promotes continual development and reflection in practice and is a requirement to undertake every three years.

In 2021 approximately 733 nurses, midwives and nursing associates revalidated (based on 2024 projections), with 543 due to revalidate during 2022.

The NMC provides a comprehensive suite of resources which support registrants through the process of revalidation. This is signposted through CHFT intranet page which also provides additional information to support the process.

As part of the 2022 Nursing and Midwifery workplan additional resources will be developed including an update of the associated intranet pages.

7.3 Nursing and Midwifery Council (NMC) referrals

During 2021/2022 there are 8 active cases that have been referred to the with a further 4 that have been closed.

8.0 Summary

- During the reporting period an establishment reviews have been undertaken which continues to focus upon the recovery agenda and returning many services to pre-covid workforce models.

- The impact of the combined actual RN wte and average sickness absence position modelled across the three divisions is creating a deficit and impacting upon the ability to meet the actual CHPPD, which describes an unmet patient need.

- Close monitoring of nurse sensitive indicators and red flag escalations also demonstrates a trend which corresponds to the RN shortfall position.

8.1 Next Steps

The below identifies the key next steps: -

- Ongoing work focused against the delivery of a robust recruitment and retention strategy
- Increase in student nurse placements through an expansion of clinical placements areas
- A drive on supporting the ongoing Health and Well-Being of colleagues
- Delivery against the Nursing and Midwifery Time to Care “Dream Team” Strategy
- A review of the Matron’s role against the Chief Nursing Officer’s Matron handbook

9.0 Recommendations

The Board is asked to: -

- **NOTE** the content of this report, progress in relation to key work streams and key next steps

- Gain insight and assurance regarding the daily processes to monitor and manage nurse and midwifery staffing levels at ward level, including the proposal to refine this approach going forward, which includes tracking of impacts related to the nursing and midwifery workforce position

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Appendix 1 Safer Staffing OPEL cards. (Review date January 2023)

Safer Staffing Levels of Escalation and Recommended Mitigations

Escalation Level	Acute Trusts	Community Care	Action
OPEL 1	**No staffing issues identified** **Use of specialist units/beds/wards have capacity** • Demand for services within normal parameters • There is capacity available for the expected emergency and elective demand. • No technological difficulties impacting on patient care • Good patient flow through ED and other access points. Pressure on maintaining 4-hour Emergency Care Standard • Infection control issues monitored and deemed within normal parameters	**No staffing issues identified** Community capacity available across system. Patterns of service and acceptable levels of capacity are for local determination	• Monitor current situation (daily staffing meetings) • Where surplus staff to patient care needs identified, feed into staffing meetings to support other areas. • Ensure changes to staffing are reported accurately with safe care. • Review actual staffing levels, understanding the gaps and the actions required to close them. • Ensure breaks and annual leave is taken as planned (working within Annual Leave Policy) • Ensure live recording of Safe Care describing service area acuity and professional judgement • Divisional Confirm and Challenge meetings • Regular staffing meetings should be adhered to. • Effective roster management - ensuring safer staffing planning reflects the principles of good health roster management and KPI's, including adherence to headroom. • Send shortfalls in WFM to Flexible Workforce Department in a timely manner • Daily safety huddles • *Identify what activity can be brought forward

*Community Specific Actions

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Escalation Level	Acute Trusts	Community Care	Action
OPEL 2	**Lower levels of staff available but appropriate mitigation to maintain services** **Opening of escalation beds likely (in addition to those already in use)** **Capacity pressures on PICU, NICU, and other intensive care and specialist beds** • Anticipated pressure in facilitating ambulance handovers within 60 minutes • Insufficient discharges to create capacity for the expected elective and emergency activity • Infection control issues emerging • Lack of beds across the Acute Trust • ED patients with DTAs and no action plan	**Lower levels of staff available, but are sufficient to maintain services** • Patients in community and / or acute settings waiting for community care capacity • Lack of medical cover for community beds • Infection control issues emerging	• All appropriate actions at Level 1 completed • Liaise with buddy wards to source any additional support (this may be a 2-3 hours etc) • Escalate concerns through safe care • Ensure clear communication of expectations of what the escalation beds require from a workforce model. • Refer to local action cards that are established for clinical areas • Ensure communication with health roster teams to initiate the builds to proposed escalations. • If required, offer additional hours at agreed enhanced payments & volunteers to rearrange annual leave to provide extra capacity • Consider additional support from ward clerk role to support patient flow (admissions and discharges) • Chase reviews and diagnostics to expedite discharges • Nurse in charge on ward areas to acknowledge and act on right to reside data • *Consider stopping accepting referrals for patients on the Practise Nursing caseloads – weekends and annual leave • *Inform CCG of any change to service provision and/or requests made to other providers for support/mutual aid

*Community Specific Actions

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Escalation Level	Acute Trusts	Community Care	Action
OPEL 3	**Actions at OPEL Two failed to deliver capacity** **Significant unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas** **Serious capacity pressures escalation beds and on PICU, NICU, and other intensive care and specialist beds** • Significant deterioration in performance against the 4-hour Emergency Care Standard (e.g. a drop of 10% or more in the space of 24 hours) • Patients awaiting handover from ambulance service within 60 minutes significantly compromised • Patient flow significantly compromised • Unable to meet transfer from Acute Trusts within 48-hour timeframe • Awaiting equipment causing delays for a number of other patients • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that cannot be rectified within 2 hours	**Significant unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow** Community capacity full	• All appropriate actions at Level 2 completed • Daily sit-rep reporting of position by affected services • Where appropriate, cancel/defer all meetings not immediately required for the provision of safe services • Consider cancelling all non-essential training (risk assessed within divisional areas and oversight by ADN's for consistency of approach) • Implementation of daily Nursing and Midwifery Safer Staffing meeting (this will receive escalations from staffing meetings) • Band 7 visibility on the clinical area – leading from the front, supporting staff to take breaks • Staff on days off or annual leave contacted to see if available to support. • Visible senior leadership walk rounds to clinical areas • Maximising the opportunity for the right staff, with the right skills are in the right place and at the right time (Prompt:- consideration of multi-professional response) • Mobilise ward helper support (e.g from care club or volunteers) to support clinical services • Non-essential procedures postponed where clinically indicated. • Undertake reviews of specialist nursing roles and risk assessment of ability to release nursing capacity to clinical areas (mobilisation will be activated in OPEL 4) • Organise 'Buddy Matron' roster to ensure coverage on both sites 7 days per week. (Implement at OPEL 4) • Depending on where the pressures lie within the system, ensure attendance at the • *Suspend District Nursing clinics • *Consider declining new OPAT referrals • Offer additional hours at agreed enhanced payments • *Community Matrons to cancel non urgent visits to support District nurses and Quest Team • Review all patients due for discharge to assess whether discharge can take place sooner

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Escalation Level	Acute Trusts	Community Care	Action
OPEL 4	**Actions at OPEL Three failed to deliver capacity** **Unexpected, reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety** **Severe capacity pressures on PICU, NICU, and other intensive care and specialist beds.** **Infectious illness, Norovirus, severe weather, and other pressures in Acute Trusts (including ED handover breaches)** • No capacity across the Acute Trust • Severe ambulance handover delays • Emergency care pathway significantly compromised • Unable to offload ambulances within 120 minutes • Problems reported with Support Services (IT, Transport, Facilities Pathology etc.) that cannot be rectified within 4 hours	**Unexpected reduced staffing numbers (due to e.g. sickness, weather conditions) in areas where this causes increased pressure on patient flow is at a level that compromises service provision / patient safety** No capacity in community services	• All appropriate actions at Level 3 completed • Staffing ratios will be reduced outside national guidance. The staffing position will be assessed at twice daily meetings chaired by the ADN. Professional Judgement will be used to mitigate risk on shift-by-shift basis, the risk of which will be escalated through Gold Command. • Matrons will be deployed to clinical shifts as determined by the ADN. • 'Buddy Matron' rota will be implemented to ensure presence on both sites 7 days per week. • Daily Huddles will be undertaken by the Outpatient departments to provide support where possible to other clinical areas. • Consider deferring essential safety training • If required, defer appraisals and 1:1s unless high risk • Mobilisation of deployment of specialist nurses as identified in OPEL 3 planning stage • Admission avoidance – consider only accepting hospital discharges • Use of other staff within CHFT (not including core services) with correct skill set to meet presenting need where appropriate • All colleagues with a clinical registration to be available to support essential services and critical functions if required. • *Consider providing essential visits only • *Where possible, suspend non-core services to support core services • *Contact other healthcare providers to provide support for essential service delivery

compassionate care

NHS
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NHS Foundation Trust

Board of Directors

NURSING & MIDWIFERY

SAFER STAFFING REPORT

Reporting period: August 2021 – January 2022

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Introduction

- The purpose of this report is to provide an overview for Nursing and Midwifery capacity and compliance with the NICE Safe Staffing, National Quality Board (NQB) Standards and the NHS Improvement Workforce Safeguards guidance.

- Demonstrating safe staffing is one of the essential standards that all health care providers must meet to comply with the Care Quality Commission (CQC) regulation and Nursing and Midwifery Council (NMC) recommendations.

- There is a breath of research that has long demonstrated that staffing levels are linked to the safety of care delivery and that staff shortfalls increase the risks of patient harm and poor-quality care.

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The Reality

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

- Whilst the vacancy rate at CHFT has remained static over previous years running with circa 150 qualified vacancies, January's vacancy position has reported an improvement with a vacancy position of 59.22 FTE.

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The Reality

Sickness / Absence position

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Qualified Nursing and Midwifery

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2021 / 08	850.65	2,688.07	3,538.72	49,968.18	1.70%	5.38%	7.08%	462.96	0.93%	8.01%
2021 / 09	910.97	2,329.77	3,240.75	48,394.42	1.88%	4.81%	6.70%	408.65	0.84%	7.54%
2021 / 10	1,409.87	2,168.03	3,577.89	51,494.11	2.74%	4.21%	6.95%	669.93	1.30%	8.25%
2021 / 11	1,062.61	2,146.76	3,209.37	50,605.39	2.10%	4.24%	6.34%	302.68	0.60%	6.94%
2021 / 12	1,612.11	2,140.42	3,752.54	52,500.46	3.07%	4.08%	7.15%	579.11	1.10%	8.25%

Nursing Support

	Sickness Absence							Isolation Absence		Sickness + Iso
Month	ST FTE Lost	LT FTE Lost	Total FTE Lost	Available FTE	Short Term Absence FTE %	Long Term Absence FTE %	Total Absence FTE %	Isolation FTE Lost	Total Iso Absence FTE %	Total Absence
2021 / 08	728.87	1,514.24	2,243.11	26,771.27	2.72%	5.66%	8.38%	377.73	1.41%	9.79%
2021 / 09	883.40	1,490.75	2,374.15	25,687.99	3.44%	5.80%	9.24%	297.09	1.16%	10.40%
2021 / 10	905.47	1,624.39	2,529.85	26,636.26	3.40%	6.10%	9.50%	363.15	1.36%	10.86%
2021 / 11	879.71	1,607.99	2,487.70	25,927.00	3.39%	6.20%	9.60%	196.47	0.76%	10.35%
2021 / 12	1,089.67	1,647.72	2,737.39	26,583.79	4.10%	6.20%	10.30%	355.75	1.34%	11.64%

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The Impact

	Medicine	Surgery	FSS	Community
Budgeted RN WTE	488.76	426.08	263.41	114.18
Actual RN wte	460.02	410.23	239.55	114.25
RN vacancy wte	28.74	15.85	23.86	0
RN % vacancy gap	5.89%	3.72%	9.06%	0
Average absence above budgeted headroom (22%)	10.60%	5.29%	7.37%	6.77%
Total combined vacancy and average absence position above headroom.	16.49%	9.01%	16.42%	6.77%

*Data source:- Healthroster budgeted vs actual position 31/01/2022

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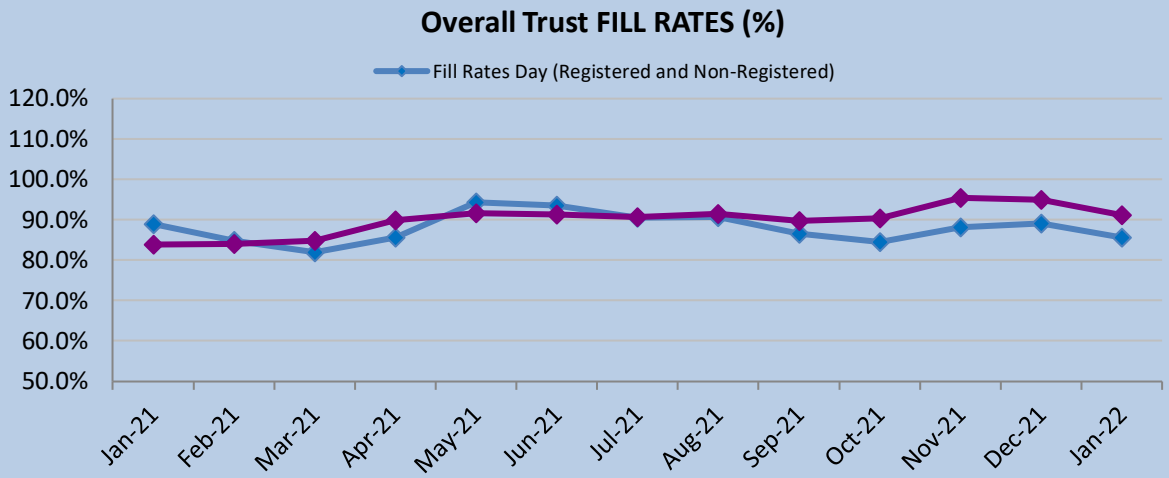
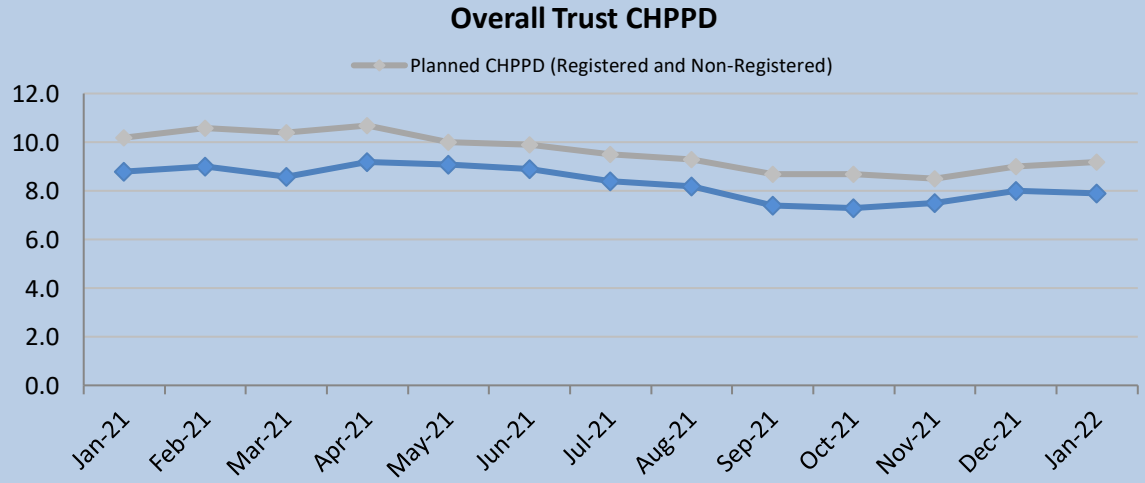
Hard Truths Data





Summary

- For the reporting period, August reported a fill rate position of 91.4% which dipped to its lowest position in October at 84.5% (Figure 8). These impacts can be seen on the overall trust CHPPD position with an ongoing shortfall reported between planned and actual care hours during the reporting period

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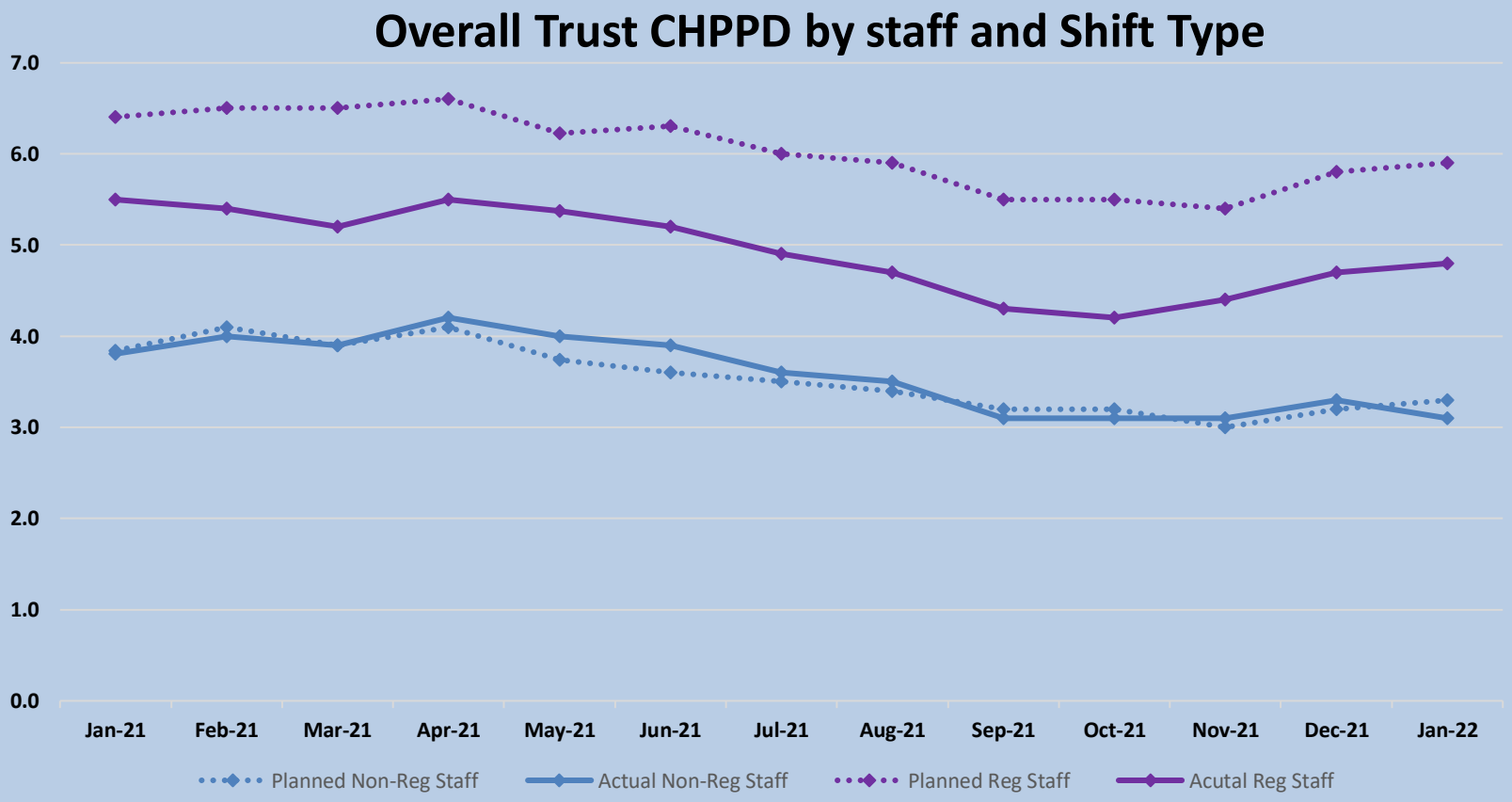

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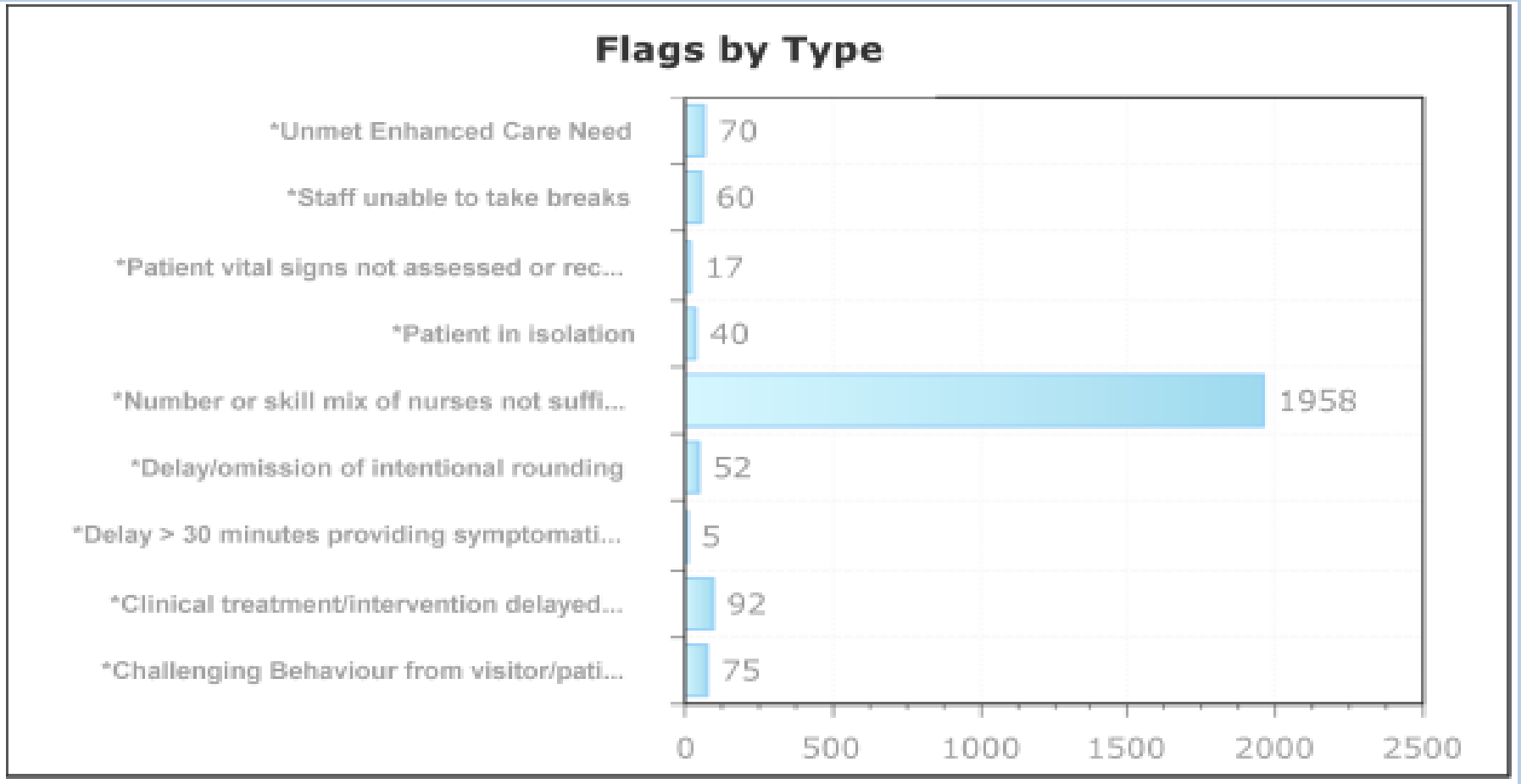
Red Flag escalation



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Quality

Developing Workforce Standards (2018) was established from safe staffing work when system leaders identified a gap in support around workforce and built on the National Quality Board (2016) guidance. The standards provide a framework for the approach taken to determine safe staffing processes which includes three components:

- Evidence base tools and data
- Professional judgment
- Outcomes

For this report three recognised nurse sensitive indicators have been used: Friends and Family Test, falls and pressure ulcer data.

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Friends and Family test

The performance data reported below is a combined rating of any FFT responses submitted between August 2021 and January 2022.

The main FFT question asks: ***Thinking about your recent stay in hospital... Overall, how was your experience of our service?*** With options ranging from very good to very poor. The breakdown of positive vs negative results is a useful barometer to monitor performance through a patient feedback lens.

All	Very Good	Good	Neither Good nor Poor	Poor	Very Poor	Don't know
% of Total	84%	12.40%	1.80%	0.23%	0.28%	0.70%
Combined	**Positive: 93%**			**Negative: 0.51%**		

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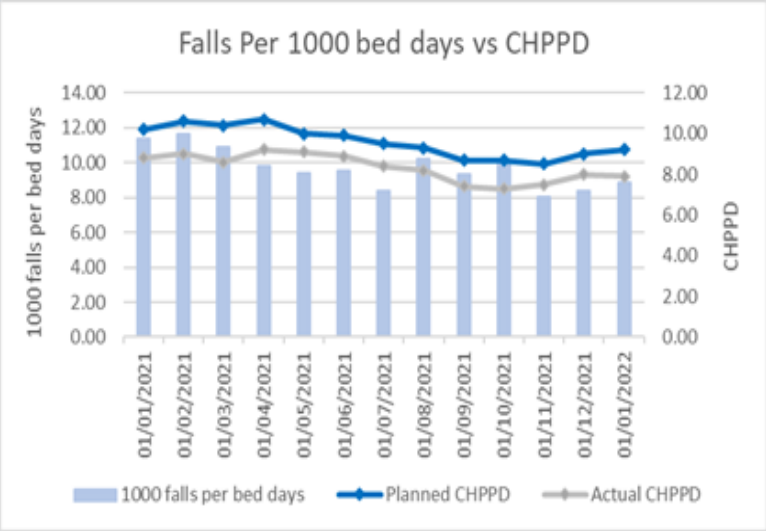
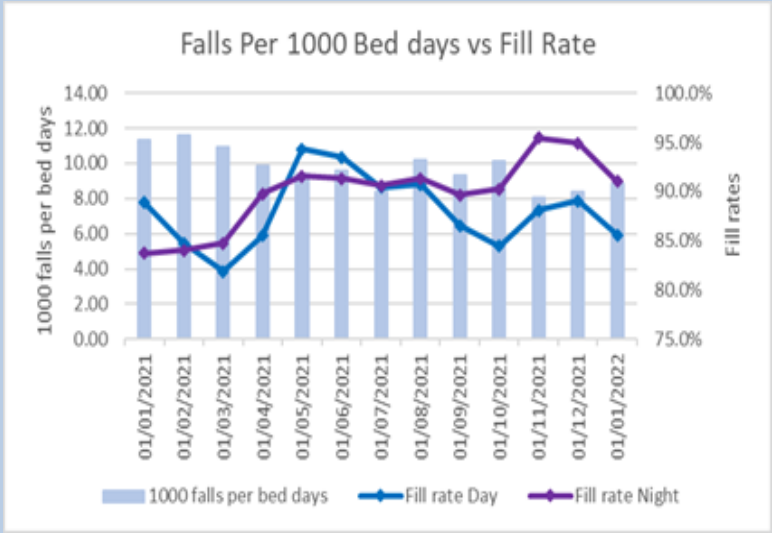
Falls

Falls remained at their highest period during the months of August – October 2021 which reflects a challenging fill rate position which drops to its lowest point in October to 84.5%. This is consistent against the CHPPD which is at its broadest gap between planned and actual also between August – October 2021, followed by an additional dip in January which identifies a further upward trend in falls in the same month.





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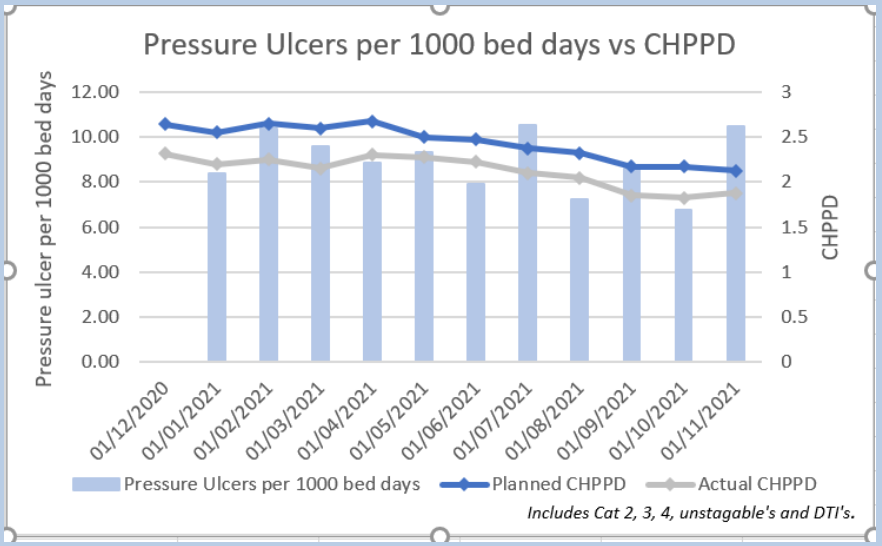
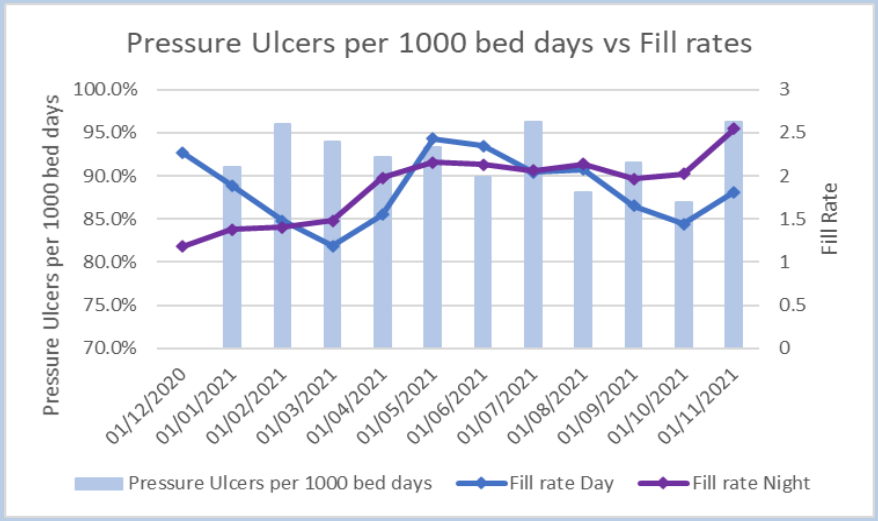
Pressure Ulcers

Data for pressure ulcers per 1000 bed days demonstrates a fluctuating position with the highest incidence identified in November where fill rates were 88.1% and CHPPD demonstrated an overall gap between planned and actual of 1.0.





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Points for consideration

- During the reporting period 149 Nursing and Midwifery staffing related incidents were reported through the Datix reporting system. 146 of these incidents were reported as no harm and 3 as minor harm. There was appropriate escalation when the incidents occurred, and this is recorded within the incident records.
- A recurring theme raised by staff side at the Staff Partnership Forum, relates to the movement of staff across clinical areas to address shortfalls. Consideration has been given to this issue; however, it remains a challenge given the current levels of sickness that are further compounded by the additional capacity areas that have been opened

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CHFT response – Short Term

- The senior nurse leadership rota established earlier this year continues supported by the Executive Director of Nursing, Deputy Director of Nursing and Associate Directors of Nursing to provide ongoing visibility and dialogue across clinical areas, and support staffing escalations across the 7 days.
- Twice daily nursing and midwifery staffing meetings chaired by the Associate Director of Nursing (Corporate) are now in operation 7 days a week, operating with a revised term of reference.
- The twice daily nursing and midwifery safer staffing meetings have a direct escalation into the Nursing and Midwifery Workforce Safer Staffing Group chaired by the Executive Director of Nursing
- An enhanced dashboard has been established to provide clear visibility on the workforce position and impacts on the patient experience, quality and safety agenda. This dashboard now includes several metrics that sit across all four divisions, in addition to divisional specific metrics which will enable true triangulation of the datasets.

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CHFT response – Short Term

- During the reporting period triggered by the ongoing critical workforce challenges Gold meetings have been established chaired by an Executive Director with representation from internal colleagues and system partners. This provided a forum for closer monitoring and oversight of the Nursing and Midwifery workforce position including several key interdependencies including: - workforce metrics, safer staffing quality metrics, patient flow and infection prevention and control.
- The Safer Staffing OPEL cards have revised to include additional responses that were enacted
- Appraisal of the *Winter 2021 preparedness: Nursing and midwifery safer staffing* (NHS Nov 2021) identified compliance against 3 out of the 4 domains providing assurance that the approaches within CHFT are reflective of the recommended processes to safer nursing and midwifery staffing.

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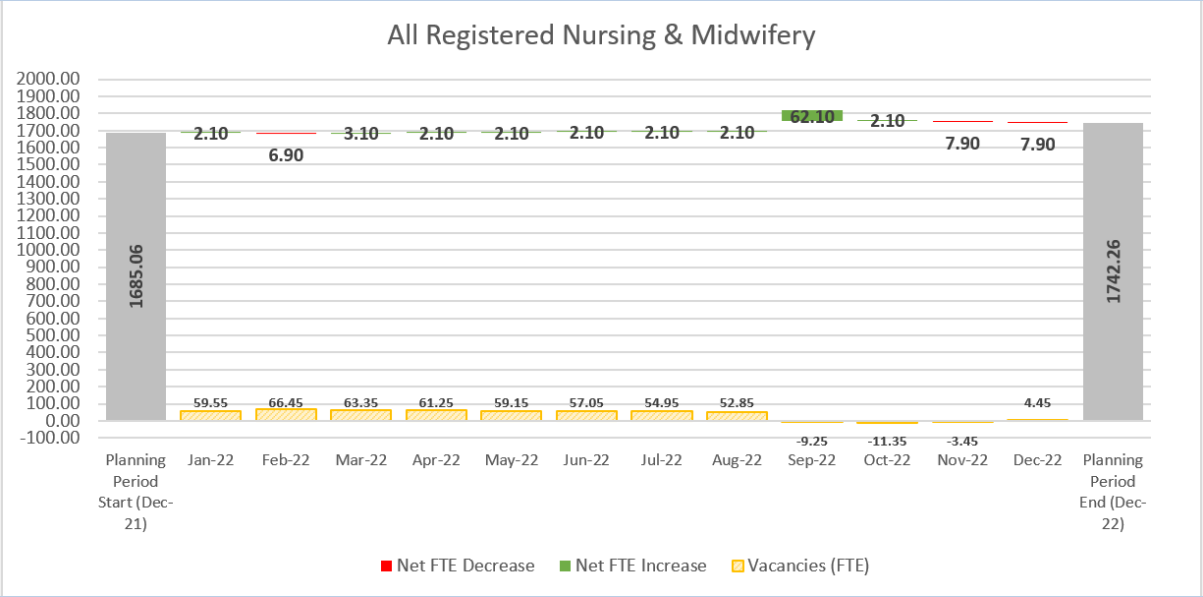
CHFT response – Medium Term



- International Nurse Recruitment programme
- Recruitment of newly quality nurses
- Health Care Support Worker programme
- Trainee Nursing Associates
- Clinical apprenticeship scheme
- Employability @ CHFT

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Next Steps

- Ongoing work focused against the delivery of a robust recruitment and retention strategy
- Increase in student nurse placements through an expansion of clinical placements areas
- A drive on supporting the ongoing Health and Well-Being of colleagues
- Delivery against the Nursing and Midwifery Time to Care “Dream Team” Strategy
- A review of the Matron’s role against the Chief Nursing Officer’s Matron handbook

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Summary

- During the reporting period an establishment reviews have been undertaken which continues to focus upon the recovery agenda and returning many services to pre-covid workforce models.
- The impact of the combined actual RN wte and average sickness absence position modelled across the three divisions is creating a deficit and impacting upon the ability to meet the actual CHPPD, which describes an unmet patient need.
- Close monitoring of nurse sensitive indicators and red flag escalations also demonstrates a trend which corresponds to the RN shortfall position.

16. Learning from Deaths Q3 Report

To Note

Presented by David Birkenhead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Learning from Deaths Q3 Report
Authors:	Cornelle Parker, Deputy Medical Director Mandy Hurley, Clinical Governance Support Manager
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	Quality Committee 21 February 2022

Purpose of the Report

To provide the Board with assurance of the Learning from Deaths (LfD) mortality review process and an update against agreed recommendations in relation to LfD approved in the annual report July 2021.

Key Points to Note

In Quarter 3 (Oct – Dec 2021), there were 499 adult inpatient deaths.

31% of all in-hospital deaths have been reviewed using the initial screening tool (ISR). This is an improvement on previous months:

	Q1	**Q2**	**Q3**
Number of deaths	351	344	499
Reviews	65	28	153
%	**18%**	**8%**	**31%**

This falls short of the 50% target for mortality reviews. Recovery plans have been agreed with the Respiratory & Acute Mortality Leads, the specialities with the largest number of deaths, to achieve the 50% standard.

Extra capacity for completion of ISRs has been offered by our Trust core trainees. Trainees will be provided with confirmation of completion for their portfolios once they have undertaken 10 completed ISRs.

A total of 24 structured judgement reviews (SJRs) were requested in the 2nd Quarter (July to Sept) of 2021/22 of which 24 have been completed.

3 SJRs undertaken in Q2 of 2021/22 have been escalated to divisions via the Datix reporting process and taken through orange panels for further investigation.

EQIA – Equality Impact Assessment
Equality impact in relation to the impact of mortality on our local population in respect of gender, age and ethnicity is examined in detail in the Learning from Deaths Annual Report. Additional aspects of EQIA include: Deaths of those with learning difficulties aged 4 and upwards: managed through the national LeDeR programme (learning disabilities mortality review). All deaths in patient with learning disabilities will be reported externally and reviewed, regardless of the cause of death or place of death. This process runs alongside our internal mortality reviews and does not replace out internal process. All deaths are reviewed internally using a SJR. These reviews are collated and an annual report is provided by the Matron for Complex Care and presented to the Mortality Surveillance Group. Child deaths: Whilst all deaths are notified to the Child Death Overview Panel and a core data set collected, not all deaths will be reviewed in detail and are therefore considered for SJR review. Particular consideration is given to the review of sudden unexpected deaths in infancy and childhood; accidental deaths; deaths related to maltreatment; suicides; and any deaths from natural causes where there are potential lessons to be learnt about prevention. Maternal deaths are reported to the National MBRRACE-UK, to allow confidential review and wider learning dissemination. Maternal deaths are normally notified to the woman's area of residence. These cases are also reported on Datix to ensure local governance and risk management structures are followed. All cases of maternal death are discussed at the weekly maternity governance meeting and reported to the Patient Safety Quality Board. Quarterly reports are presented to the Mortality Surveillance Group. Stillborn and perinatal deaths are reported to the National MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) to allow confidential review and wider learning dissemination. These cases are also reported on Datix to ensure local governance and risk management structures are followed. Stillbirths and neonatal deaths are reviewed by a multidisciplinary team and reported nationally via the Perinatal Mortality Review Tool.
Recommendation
The Board is asked to **NOTE** the Learning from Deaths Q3 Report.

Learning from Deaths Report Quarter 3 2021/2022

In Quarter 3 (Oct – Dec 2021), there were 499 adult inpatient deaths at CHFT recorded on Knowledge Portal. This report was generated on 1st February 2022

Initial Screening Reviews (ISR)

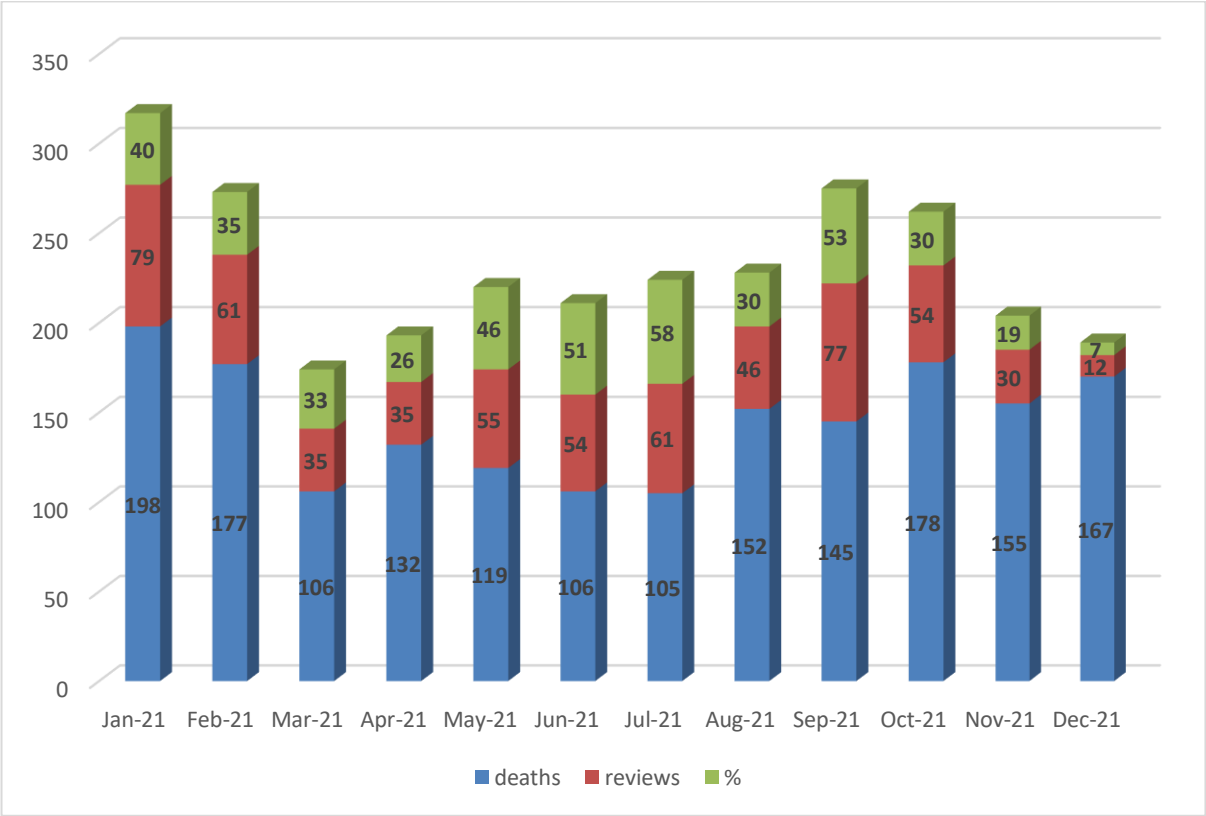
The online initial screening review tool focuses primarily on initial assessment, ongoing care, and end of life care. Reviewers are asked to provide their judgement on the overall quality of care. Specialities have been given the opportunity to identify additional specific questions to enhance the information they have around death. The tool now includes speciality specific questions for Gastroenterology, Critical Care, Haematology, Oncology and Respiratory Medicine.

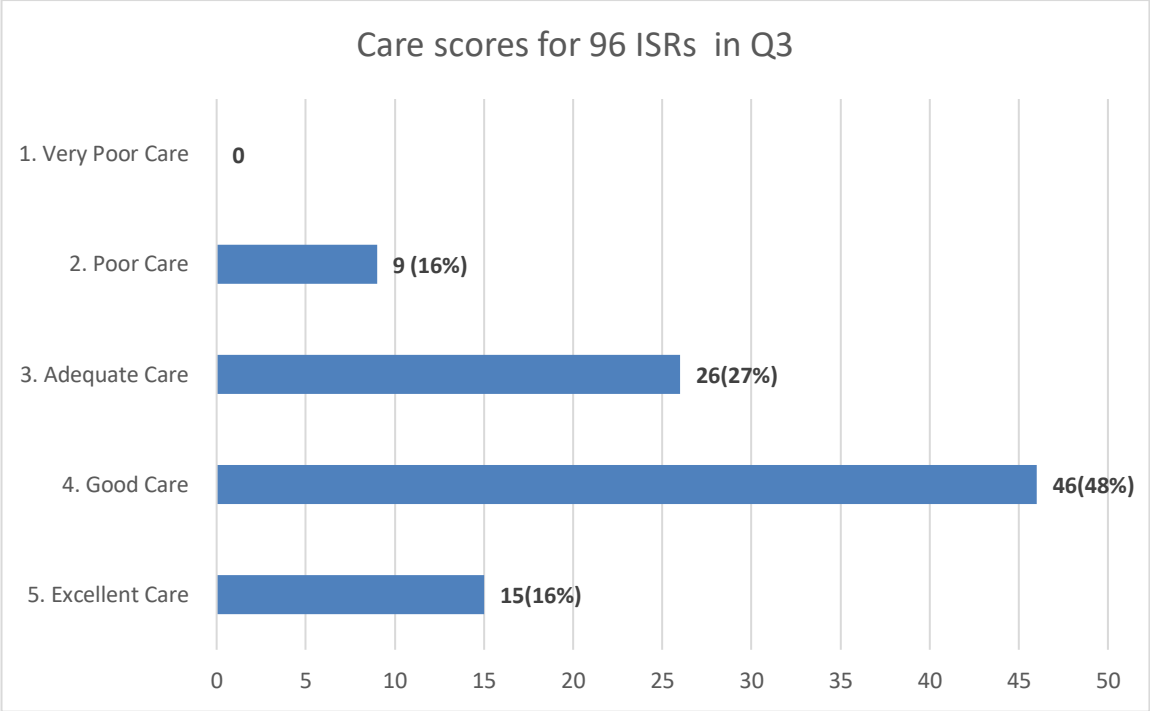
Of the **499** adult inpatient deaths recorded in Quarter 3 of 2021/2022, **153** (**31%**) have been reviewed using the initial screening tool (ISR). This falls short of the 50% target; however, this represents a small increase from 28% demonstrated in the Q2 report.

The committee is reminded of the lag between issuing cases for review and completion of the reports. By comparison in the Q2 report, June mortalities demonstrated a review rate of 32%. The chart below demonstrates that this figure has now risen to a 51% completion rate.

ISR recovery plans have been agreed with Acute Medicine, Respiratory and Elderly Medicine Mortality Leads. These are the specialities with the greatest number of deaths. We recognise these are clinical areas with some of the greatest operational pressure currently and we are conscious of the time pressures this scrutiny creates.

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





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

Structured Judgement Reviews

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

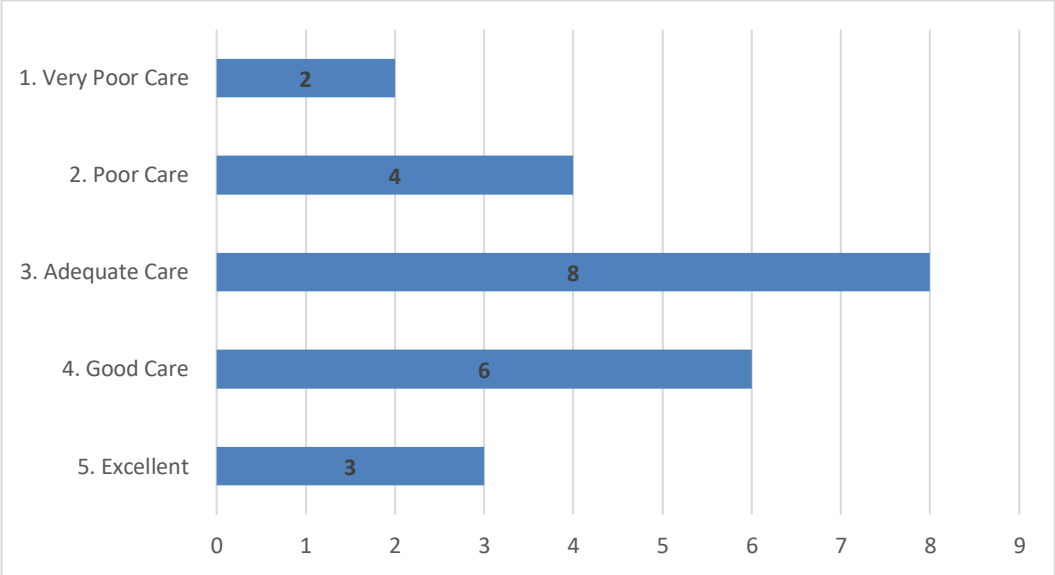
	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Total
Escalated from ISR	2	3	0	1	0	0	2	1	1	0	4	1	**15**
Escalated by ME	1	0	2	6	0	2	10	3	8	6	1	3	**42**
Complaint	0	1	0	1	0	0	0	0	0	0	0	0	**2**
SI Panel	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Elective	1	0	0	0	0	0	0	2	0	0	0	0	**3**
LD	0	3	2	2	0	1	1	0	0	1	1	1	**12**
2nd Opinion SJR	2	2	0	3	2	3	4	0	2	0	6	1	**25**
Coroner	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Other	0	0	6	1	18	0	2	0	0	0	0	0	**27**
Total Requested	**6**	**9**	**10**	**14**	**20**	**7**	**19**	**6**	**11**	**7**	**12**	**6**	**127**

127 SJRs were requested in the last 12 months. An increasing proportion of SJR's have been requested through the Medical Examiner's Office. This is to be expected and is a positive development. Early case

review by an experienced medical practitioner which is intrinsic to the process, flags clinical concerns more promptly.

A total of 24 SJRs were requested in the 2nd Quarter (July to Sept) of 2021/22 of which 24 have been completed. The findings from SJRs are shared with the speciality mortality leads and appropriate Clinical Directors.

Quality of Care score distribution for 24 completed SJRs



Of the 24 SJRs completed in Quarter 2 2021/2022 the following learning themes and concerns were identified:

- Ongoing care, care during this time was good
- Good documentation of conversations with family regarding patient's religious beliefs and offer of Chaplaincy input made.
- Excellent MDT working and communication in the critical care setting despite pressures on resource and COVID-19 restrictions
- Good senior decision making from Consultants & Heart Failure Nurse with evidence of good liaison with next of kin
- Evidence of good skin care undertaken by tissue viability nursing staff
- Evidence of excellent nursing care e.g. mouth care, positioning, skin care
- Good documentation at end of life
- Timely review of patients with escalation to senior colleagues appropriately communicated

The following poor practice was identified:

- Several examples of poor attention to the Mental Capacity Act
- Two examples relating to VTE prophylaxis
- Missed doses of prescribed meds in a patient with deteriorating heart failure

- Documentation for the ascitic tap procedure is very poor. No reference is made as to whether asepsis was adhered to or whether local anaesthetic/analgesia was given or indeed, whether Ultrasound imaging was used
- Poor documentation around an invasive procedure
- Delayed recognition of a deteriorating patient and lack of prompt intervention

3 of the SJRs undertaken in Q2 of 2021/22 have been escalated to divisions via the Datix reporting process and taken through orange panels for further investigation. The outcomes of these are as follows:
Case 1 – Respiratory patient.
Plan - this incident is currently with medicine leads for their clinical opinions. Awaiting feedback.
If deemed necessary, this will lead to a full investigation, alternatively, learning will be identified

Case 2 – SI investigation within Division of Surgery, incorrect patient identification – awaiting RCA

Case 3 - Reviewed at Surgical orange panel. A 72-hour panel review was conducted. Downgraded to yellow as panel felt that all appropriate actions had been taken and multi-disciplinary decisions taken. Learning points shared with division

Recommendations in relation to LfD for 2021/22 proposed in 2020/21 annual report

- **50% of all in-patient deaths to be reviewed by June 2021:**
  - SJR's reviews are completed to target. As described above, the pandemic still presents challenges with regards to ISR capacity.
  - Action: To increase the capacity for LfD reviews we have developed a process for all CT trainees to review 10 cases, have clinical supervision and have this recognised in their training portfolios.

- **Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities:**
  - Aligning SJR themes with improving quality in Care of the Acutely Ill Programme
  - SJR findings are shared with speciality mortality leads and clinical directors
  - The next step is to develop a process for the specialities to feedback their responses to SJR findings in their annual updates to the Mortality Surveillance Group.

- **To work alongside the new Medical Examiner (ME) team and align the LfD processes:**
  - Lead Medical Examiner now attends Mortality Surveillance Group
  - Medical Examiner team is scrutinising all medical certificate of cause of death and identifying certification errors. This will result in an improvement in completing the medical certificate of cause of death.
    Medical Examiner office is now escalating quality of care issues identified on initial review for SJR and this number is increasing

Recommendation to the Board

The Board is asked to **NOTE** the Learning from Deaths Quarter 3 report.

17. Risk Management Strategy and Policy

To Approve

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Risk Management Strategy and Policy
Author:	Kim Smith, Assistant Director for Patient Safety
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing
Previous Forums:	Audit and Risk Committee – 25 January 2022

Purpose of the Report

The purpose of this report is to provide the Trust with the revised and refreshed Risk Management Strategy and Policy. It provided assurance that CHFT has in place effective risk management system designed to ensure the proactive identification, assessment and mitigation of risks for CHFT to achieve its Strategic Objectives.

This process will help the organisation maintain the safety of its staff, patients, services users and visitors.

Risk management is an integral part of CHFT's management activity and is a fundamental pillar in embedding high quality, sustainable services for the people CHFT serves. As a large and complex organisation delivering a range of services to a diverse population in a challenging and ever-changing health landscape, it is accepted that risks are an inherent part of the day-to-day operation of CHFT.

Key Points to Note

The Strategy has been revised and refreshed, they key changes to note are:

Section 7, (pg. 8) Rephrased definition of Risk and Risk Management as well as outcomes of successful risk management added
Section 9 (pg.13) Assistant Director Quality and Safety role added
Section 11, (pg. 19) Risk Management Process refreshed
Section 12 (pg. 21), Describing a risk and communicating risk explicit
Risk Appetite Statement (pg.29) updated to September 2021 Version

Appendix 3 (pg. 30) updated to include the revised Governance Structure from January 2022.

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.

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

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

Recommendation

The Board is asked to **APPROVE** the Risk Management Strategy and Policy.

Calderdale and Huddersfield NHS Foundation Trust

RISK MANAGEMENT STRATEGY AND POLICY

Version 5

2022 - 2023

Document Summary Table		
Unique Identifier Number		
Status	Final	
Version	5	
Implementation Date	3rd March 2022	
Current/Last Review Dates	January 2022	
Next Formal Review	January 2023	
Sponsor	Executive Chief Nursing and Deputy CEO	
Author	Assistant Director of Quality and Safety	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Board of Directors		3rd March 2022
Executive Board		
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Risk Group	Assistant Director of Quality and Safety	9 February 2022
Audit and Risk Committee	Non-Executive Director (outside of formal meeting)	18 January 2022
Other Stakeholders Consulted		
N/A		
Does this document map to other Regulator requirements?		
Regulator details		
CQC	Regulation 12: Safe care and treatment Regulation 13: Safeguarding Regulation 15: Premises and Equipment Regulation 16: Complaints Regulation 17: Good Governance Regulation 19: Fit and Proper Persons	

NHS Improvement	Single Oversight Framework
Document Version Control	
Version no	
1	Risk Management Strategy incorporating Raising Concerns / Freedom to Speak Up
1.1	Minor amendment made to section 9.5 to include additional information in relation to compliance registers following internal audit report
2.1	Changes to titles, removed Head of Risk & Gov, added Assistant Director Patient Safety, Assistant Director Patient Experience Updated App 3 Governance Structure, App 2: Risk Appetite statement
3.1	Updated the Risk Management Strategy as part of its planned review
3.1.1	Updated the Risk Management Strategy as part of its planned review and merge with Risk Management Policy
4	Updated the Risk Management Strategy as part of its planned review
5	Added to section 7, Rephrased definition of Risk and Risk Management and added Outcomes of successful risk management Added Section 11, Risk Management Process Changes to title on section 12, Describing a risk and reworded Step 5 Changes to titles, Assistant Director Patient Safety, Assistant Director Patient Experience to Assistant Director Quality and Safety Updated Appendix 3 - Governance Structure Updated Risk Appetite Statement to September 2021 Version

CONTENTS

1. Overview

The Calderdale and Huddersfield NHS Foundation Trust (CHFT) recognises that the principles of good governance must be underpinned by an effective risk management system designed to ensure the proactive identification, assessment and mitigation of risks for CHFT to achieve its Strategic Objectives. This process will help the organisation maintain the safety of its staff, patients, services users and visitors.

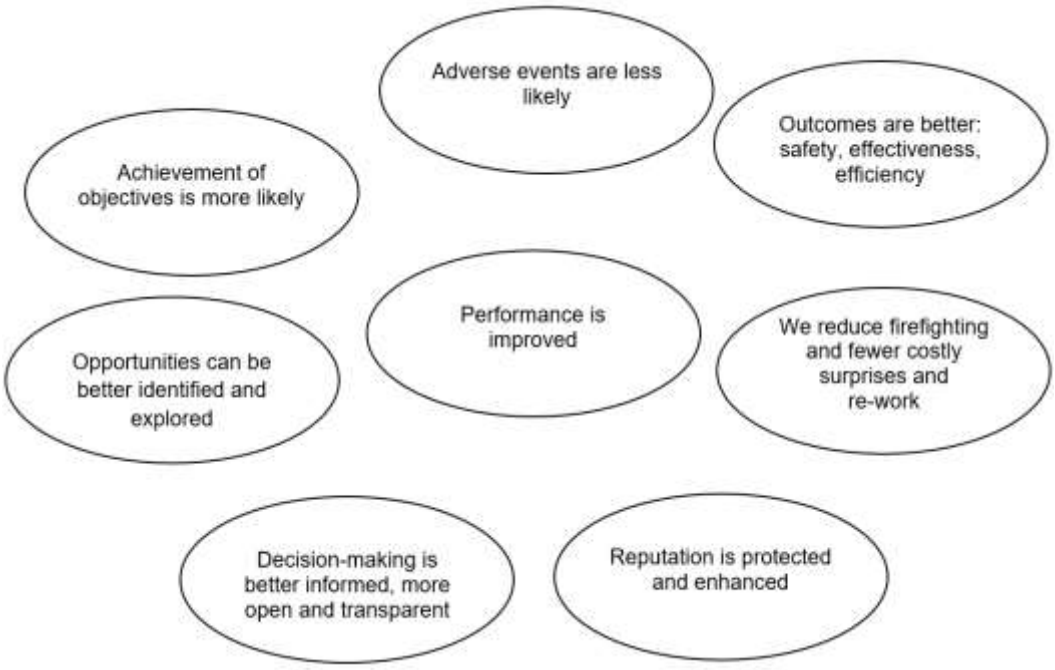
Risk Management is an integral part of CHFT's management activity and is a fundamental pillar in embedding high quality, sustainable services for the people CHFT serves. As a large and complex organisation delivering a range of services to a diverse population in a challenging and ever-changing health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

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

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

2. Benefits of Managing Risk

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



3. Scope

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

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

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

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

4. Vision and Statement of Intent

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

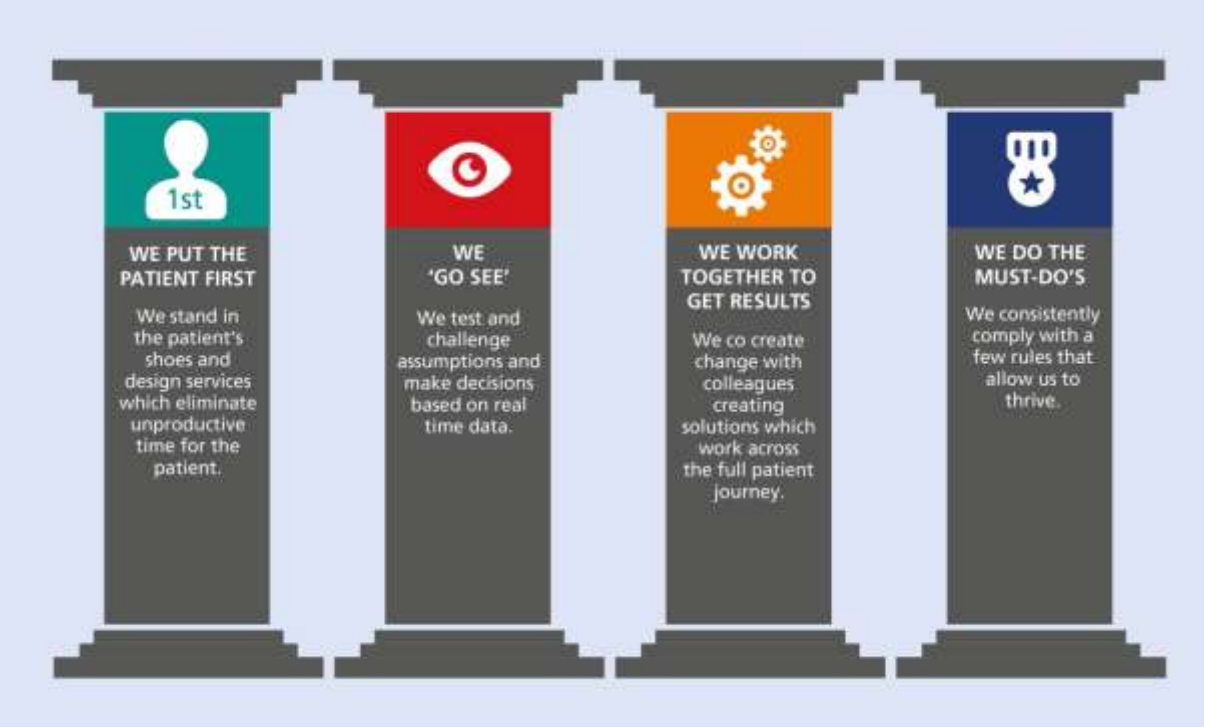
"Together we will deliver outstanding compassionate care to the communities we serve".

Our strategic objectives to deliver this aim are to:

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

The way we work

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



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

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

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

To ensure the effectiveness of CHFT's risk management processes, the Board and senior management team will rely on 'Three lines of defence', including the monitoring and assurance governance arrangements within the organisation. Details on how CHFT will implement its 'Three lines of defence' can be found in Section 13 – Assurance.

5. CHFT's Risk Management Strategy

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

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

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

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

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

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

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

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

- **Provide training to support risk management**

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

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

  CHFT will enable decision-makers to understand risks in any proposal and the degree of risk to which CHFT can be exposed or extent to which an opportunity can be pursued. The Board and its Committees need to ensure that they consistently apply the risk appetite to drive decisions made. The Board will annually review and approve a risk appetite statement which will assist decision makers to understand the level of risk the Trust is willing to tolerate (See Appendix 2).

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

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

6. CHFT's Risk Management Objectives

In support of CHFT's Risk Management Strategy and Policy the following objectives have been devised and CHFT will endeavour to ensure that they are applied through its risk policies, procedures and systems. CHFT will also ensure that it monitors compliance with its Risk Management Strategy and Policy (See Section 15 Monitoring and Audit). The objectives are:

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

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

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

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

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

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

7. Policy

Risk Management

Definitions of Risk and Risk Management

A risk is an uncertain event or set of events that should it happen will have an effect on the achievement of objectives. It is measured by a combination of the probability of the perceived threat or opportunity (likelihood) occurring and the magnitude of its impact (consequence) on objectives.

Risk Management is the systematic application of principles, approach, and processes to the tasks of identifying and assessing risks, and then planning and implementing risk responses. See Appendix 1 for further definitions that relate to this strategy and policy.

Principles and outcomes of successful Risk Management

It is the role of the CHFT Board to lead and support risk management across the organisation.

The principles of successful risk management are:

- to embrace an open, objective and supportive culture
- to acknowledge that there are risks in all areas of work
- for all staff to be actively involved in recognising and reducing risk

- to communicate risks across the Trust through escalation and de-escalation processes
- to learn from mistakes.

The outcomes of successful risk management are:

- Fewer sudden shocks and unwelcome surprises
- More efficient use of resources
- Reduced waste
- Reduction in management time spent fire fighting
- Better service delivery
- Increased likelihood of change innovations being achieved
- More focus internally of doing the right things properly

Responsibilities and accountabilities for Risk Management

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

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

8. Organisational Structure for Risk Management

Organisational Structure

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

Roles and responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. Management Accountabilities, Roles and Responsibilities for Risk Management

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

The Chief Executive has overall accountability and responsibility for:

- ensuring CHFT maintains an up-to-date Risk Management Strategy and Policy, is committed to the risk management principles in the CHFT statement of intent and has a risk appetite endorsed by the Board
- promoting a risk management culture throughout the organisation
- ensuring an effective system of risk management and internal controls are in place with a framework which provides assurance to CHFT management
- ensuring that the Annual Governance Statement contains the appropriate assurance requirements for risk management
- ensuring priorities are determined and communicated, risk is identified at each level of the organisation and managed in accordance with the Board's appetite for taking risk.

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

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

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

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

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

Lead Executive Director	Risk Area

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

Executive Directors

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

Director of Transformation and Partnerships	

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

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

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

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

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

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

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

Assistant Director of Quality and Safety

The Assistant Director of Quality and Safety is a key member of the Quality Directorate Team. They are responsible for providing quality, risk management, governance and compliance leadership and advice to the Director of Nursing and Medical Director. The Assistant Director holds a Trust-wide portfolio for safety and quality improvement. The post holder will provide effective leadership, co-ordination and management of patient experience and patient and public involvement strategies and outcomes. This role is accountable for the development and delivery of quality governance strategies that will support the achievement of organisational objectives. The role will lead our Patient Safety and Experience strategies ensuring that patient outcomes remain at the centre of all that we do. The Assistant Director for Quality and Safety is also responsible for quality management and quality improvement (effectiveness, experience, and safety). Specific responsibilities include ensuring quality improvement and risk management strategies and plans are in place to support the Trust's vision and delivery of the Trust's objectives, overseeing the Complaints/ PALS, Patient/ Carer Experience and Legal functions, developing greater public participation /co production within CHFT, and working with the

The Assistant Director of Quality and Safety will support and be working with: -

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

- **Executive Director of Nursing / Deputy Chief Executive** to understand the health inequalities in our communities and identify ways to close inequality gaps.

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

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

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

All Staff
- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that are affected by Trust business.
- Be aware of, identify and minimise risks, taking immediate action to reduce hazards or risks.
- Identify, assess, manage and control risks in line with Trust policies and procedures.
- Be familiar with local policies, procedures, guidance and safe systems of work
- Be aware of their roles and responsibilities within the risk management strategy, policy and supporting policies, e.g., comply with incident and near miss reporting procedures.
- Be responsible for completing essential safety training and other training necessary to safety undertake their role.
- Undertake risk assessments within their areas of work and notify their line manager of any perceived risks which may not have been addressed.

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

Role	Responsibility
Caldicott Guardian – Deputy Medical Director Senior Information Risk Owner (SIRO) Information Governance Manager	Information Governance Risks
Company Secretary	Strategic Risks Foundation Trust risks
Executive Director of Nursing / Deputy Chief Executive	Clinical Risk
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening

	programmes
Head of Midwifery	Maternity Risks
Emergency Preparedness	Emergency Planning and business continuity risks
Fire Officer Head of Health and Safety Local Security Management Specialist (LSMS) Director of Estates and Facilities Director of Security	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability Security Management
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Assistant Director of Quality and Safety Legal Services Manager Complaints	Patient Experience Risks
Assistant Director of Quality and the Safety, Quality Governance Leads Clinical Governance Leads	Central alert systems risk Risk Management Systems, tools, training Quality and safety risks
Local Counter Fraud Specialist	Fraud Risks
Head of Safeguarding / Safeguarding Team	Safeguarding Risks

Contractors and Partners
It is the responsibility of the Trust, that staff who employ contractor and their partners, ensure they are aware of the 'Estate Policy – Management' and 'CHS Management of Estate Policy' or for CRH the Equans Estates Policies. Contracted work would normally procure via the Estates Team at either CRH or HRI and requires, as a minimum, induction and supervision of contractors. This will ensure that all contractors working on behalf of CHFT are fully conversant with CHFT's health and safety rules and the staff member responsible is fully aware of the contractor's activity for which they are engaged and, if applicable, are in possession of the contractor's risk assessment and method statement for their activity.

10. Risk Management Systems

Policies
There are several key policies which support the effective management of risk. These supporting policies are detailed in Section 16.

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

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

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

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

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

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

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

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

Board Assurance Framework (BAF)

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

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

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

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

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

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

Risk Registers

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

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

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

It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure risks with a current score of 15+ feed into the high-Level Risk Register which is reviewed on a monthly basis and forms an integral part of CHFT's system of internal control.
Risks of 15+ are reviewed monthly by the Risk Group and through the governance cycle to CHFT Board three times a year.

Adding risks to the High-Level Risk Register
The Quality Governance Leads or other non-clinical divisional leads for risk management, are responsible for flagging risks from the division with a current score of 15+ or above that require a review by the Risk Group for consideration on the high-level risk register and alerting the Senior Risk Manager to this.

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

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

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

Where it is decided that the risk should not be added to the high-level risk register this will continue to be monitored within the divisional risk management processes. Whilst risks are on the high-level risk register, actions to address the risk may remain with the division and as such, the risk will continue remain on the divisional risk registers at a score of 15 or above register – e.g. specific staffing issues in a specialty.

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

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

All additions and removals from the high-level risk register and changes in scores will be highlighted to the Trust Board via high level risk register reports. The Board, in reviewing the high-level risk register at Board meetings, will check, challenge, and recommend closure of risks.

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

11. Risk Management Process

Risk Management Systems - West Yorkshire and Harrogate

The Trust is a key system partner in the West Yorkshire and Harrogate Integrated Care System. The governance arrangements for the system are evolving, including those for management of system risk. Once these risk management systems are in place the Trust will then consider how it incorporates system level risks within its risk management processes, for example gauging the proportion of risk relevant to the Trust in the system within the Board Assurance Framework.

Within the West Yorkshire Associate of Acute Trusts (WYAAT) risk registers are maintained for individual programmes. The oversight of programme delivery and assurance that risks are being managed is via Committee in Common meetings, attended by the Chair and Chief Executive, minutes of which are shared with the Trust Board. Risks are also managed within specific programmes of work. Further details on the WYAAT governance structure and management of risks can be found within the WYAAT Governance Framework

12. Describing a Risk

Risk identification involves examining all sources of potential risk that CHFT may be exposed to from the perspective of all stakeholders throughout the organisation. The process is divided into four primary steps: Identify, Assess, Plan and Implement.

Step 1: Identify Risk

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

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

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

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

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

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

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

Step 2: Assess the Risk

All risks must be assessed in an objective and consistent manner. Risks are assessed on the probability, i.e., the likelihood of a risk happening and on what would happen (impact/consequence) should the risk occur.

The magnitude of a risk can be estimated by multiplying the severity of impact by the likelihood of the risk occurring using a standard 5x5 risk scoring matrix to score likelihood and impact of a risk.

CHFT has a risk appetite which details the amount of risk that the organisation is willing to take in pursuit of its strategic objectives. The risk appetite can be found in Appendix 2 of this Strategy and Policy and on CHFT's intranet.

CHFT procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed without existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured
- **Current risk score -** this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target/residual risk score as action plans to mitigate risks are developed and implemented. However, there are instances where the current score may increase.
- **Target/residual risk score -** this is the score that is expected after the action plan has been fully implemented. It is the amount of risk that the organisation/service is willing to live with.

Staff should use the risk scoring matrix guidance (Appendix 6) and be realistic in the quantification of severity and likelihood. A guide to calculating target/residual risk and risk scoring matrix guidance is provided at Appendix 6.

Step 3: Respond to the Risk

There are a number of different options for responding to a risk. These options are referred to as risk treatment strategies. The main options most likely to be used include:

Action	Definition
Eliminate	Appropriate remedial action by the organisation will result in the elimination and subsequent closure of the risk. E.g., by doing things differently we could remove the risk immediately or by implementing counter measures, where it is feasible to do so, this could prevent the threat or problem from occurring or prevent it having any impact on the activity
Reduce	Appropriate remedial action will result in the severity and/or likelihood of the risk being reduced to a level where: ▪ The risk has been reduced to its inherent or natural level and can now be managed through CHFTs normal operational activity and procedures. ▪ The risk has not been reduced to its inherent or natural level and now CHFT must Tolerate or Accept this risk.
Tolerate	Remedial action has reduced the severity and/or likelihood of the risk to a rating of 'Moderate' or 'High'. Further remedial action by is not possible without additional resources in terms of effort, time or cost, or it requires remedial action is the responsibility of a Third Party (e.g., another Trust or a Commissioner). The risk will continue to be monitored to ensure the controls remain effective and that the risk is being reported/escalated to the relevant Third Party.
Accept	Remedial action has reduced the severity and/or likelihood of the risk to a rating of 'Low'. Further remedial action is now no longer practical in terms of effort, time or cost, the risk will continue to be monitored to ensure that the controls remain effective.

Step 4: Develop an Action Plan

Key aspects to consider when developing an action plan to mitigate/reduce the risk are summarised below.

- What are the existing controls?
- Are there any gaps?
- What further controls are practical and sustainable? (Check with staff who work in the area)

- Is the design of the control right? Is it helping you achieve your objectives?
- What further actions are needed to manage the risk?
- By when will the action be completed?
- How will you assure that the control measures implemented will remain effective and not result in the risk re-emerging?

Action Plans should be focused on gaps in controls and should include the following:

- A list of any actions that are needed to manage the risk indicating the agreed time scale for each action
- A designated person who is responsible for each action.
- Each action identified should be SMART (**S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely).
- Action plans must be proportionate to the level of the current risk.

Action target dates and risk review dates should be set in accordance with the level of risk, and compliance with these must be monitored appropriately through the directorate / divisional review and monitoring meetings prior to submission for assurance to the relevant committee.

Further Actions recorded on the register must be dated with the most recent date to the top

Step 5: Communicate Risk

All risks must be recorded on the Risk Register. It is the responsibility of each division to maintain and monitor their risk registers. The Trust's exposure to risk is never static. Effective communication is key to identification of new threats or changes to existing risks.

An integral part of effective risk management is ensuring that risks are escalated through the organisation in line with the relevant governance committee structures. This will ensure visibility of risks throughout the organisation, the appropriate level of management and prioritisation of resources.

Risks are escalated according to the risk score as summarised in the table below.

Risk Rating	Risk Level	Level of approval, escalation and management
1 - 6	Low Risk	– Managed at ward / office level – Approved by Divisional PSQB – If meeting target/residual, only need reviewing annually atRisk Group on business plan by division. – If not at target/residual risk, then reviewed at directorate meetings
8 - 12	Medium Risk	– New Medium Risks reviewed by Risk Group which can either: approve, escalate or de-escalate and include explanation. – Divisional PSQB report to the Risk Group and an explanation for increase or decrease in risk. – Risk Group may decide in exceptional circumstances to add 12 rated risks to HLRR – Risk Group may decide if risk trust-wide – Existing medium risks reviewed every other month by Risk Group.

15-16	High Risk	– Risk Group report must include statement for increase and or escalation in risk. – Initial Risk rating or increased risk rating can only be approved by Risk Group who can either: approve, escalate or de-escalate and include explanation – Record on HLRR and notify Company Secretary to consider effect on the BAF – Monitor monthly in sequence by Risk Group / Executive Board / Subcommittee of Board / Board
20 - 25	Very High	

NB Staff/Health and Safety risks are reported and managed via Health and Safety related Sub-Groups and Health and Safety related specialist leads. The Health and Safety Committee provides the same functions as the Risk Group towards Health and Safety Risks as shown above, however, Health and Safety risks which need to be considered for the High-Level Risk Register still require going through the Risk Group.

Risks which score 15 or higher must be brought to the attention of the Senior Risk Manager for escalation to the appropriate committee for consideration and potential inclusion on the high-level risk register. In exceptional circumstances the Risk Group will also consider for inclusion on the high-level risk register risks scored at 12 as highlighted by the divisions. The high-level risk register prioritises risks populated from risk assessments carried out both at a strategic and operational level.

The Risk Group, on behalf of the Audit and Risk Committee and Board, oversees the high-level risk register (i.e. mainly risks with scores 15 and above), together with identified Board Committees or groups overseeing the management of BAF risks on behalf of CHFT.

Key outputs from the risk management system will be reported to relevant staff/committees depending on the residual risk score.

The **Risk Group**, which **is a sub-committee of the Audit and Risk Committee**, will receive reports to monitor the quality, completeness and utilisation of risk registers, and oversee the extent / levels of risk across CHFT. Reports will cover the risk description, the residual risk (exposure after control), main controls, date of review and risk owner.

The Quality Committee has a specific role for clinical risks, it receives the High-Level Risk Register on a monthly basis.

Risk registers from divisions are overseen and scrutinised through their Patient Safety Quality Boards and every two months by the Risk Group. They are reviewed to ensure that risks within the division and their directorates are captured. Each division reports on their risk registers on a quarterly basis to the Quality Committee.

The Executive Team will be informed by the Executive Director of Nursing (or relevant Executive Director) of any new significant risk arising at the first meeting opportunity.

Step 7: Risk Closure

A risk can be closed and moved to the closed section of the electronic risk register system for audit purposes when:

i. There is a change in practice which removes the hazard
ii. Where the risk/event has passed
iii. Where it is clear that the action taken to treat the risk eliminates all reasonably foreseeable exposure to that risk.

Completion of actions does not necessarily mean that a risk can be eliminated and closed.

Each division will have governance arrangements (does this approach does not introduce inconsistences) which define a clear process for authorising the closure of risks by managers/through appropriate directorate/department or divisional meeting and ensure that all staff are aware of this. The reason for closure must be stated on the risk register.

It is good practice to periodically audit closed risks to be assured that the risk is no longer present. It should be noted that risks removed from the high-level risk register may continue to be managed on a divisional risk register at a risk score of 12 or below, so will not necessarily be closed.

Compliance

To ensure that CHFT manages risks and response to issues highlighted in external reviews, each division and corporate services maintain a Register of Compliance

This enables a systematic approach to recording details of all external assessments, inspections and accreditations and provides an overview of compliance with regulatory standards (financial, performance, quality) in line with CHFT External Agency Visits, Inspections and Accreditations Policy. Guidance is provided to divisions on the content of the compliance section of the risk register to ensure consistency of content and this is enclosed at Appendix 8.

The register of compliance details the date and type of assessment, level of compliance, actions required, consequence of non-compliance and any associated risks. It also includes the date the next assessment is due, whether any recommendations from previous visits are outstanding and identifies any risk areas. The compliance section of the risk registers are reviewed at divisional Patient Safety Quality Board meetings and by the CQC Response Group.

13. Assurance

CHFT's approach to risk assurance is based on the widely adopted Three Lines of Defence model as endorsed by professional bodies such as the Chartered Institute of Internal Auditors, the Chartered Governance Institute, and the Institute of Risk Management. Appendix 9 presents a high-level diagram to show how the Three Lines of Defence model operates in CHFT.

The first line of defence contains operational functions that directly own and manage risks. CHFT's first line of defence constitutes teams and managers in operational or service delivery functions and in support functions.

The second line of defence contains 'corporate' or 'central' functions that oversee, assure, or specialise in risk management or related control and compliance activities.

The second line of defence provides the frameworks, policies, procedures, guidelines, tools, techniques, and other forms of support to enable first line operational managers and staff to manage risk well. The second line also carries out quality assurance, monitoring and reporting activities relating to risk management.

The third line of defence contains functions that provide independent and objective assurance regarding the integrity and effectiveness of risk management and related controls in CHFT. Internal audit is the key function in CHFT's third line of defence. Reporting to CHFT Board via the Audit Committee, internal audit provides risk-based evaluation of the effectiveness of risk management, governance, and internal control in the organisation. The third line of defence has interfaces with other external providers of independent and objective assurance, including external audit, regulators (such as the Care Quality Commission) and commissioners (such as NHS England / Improvement - NSHEI).

14. Ris

Risks may be identified pro-actively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:

a) Risk Register

The Risk Register provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto the risk register.

b) Risk Management Training

Training is required to effectively manage risks in line with the process set out above. Regular Risk Register training sessions are offered on a monthly basis with dates available published on the Quality and Safety intranet page. Bespoke risk management training will be available to teams, tailored to their specific needs. This could include sessions on:

- Operational use of the electronic risk register system and guidance on how to articulate a risk, controls and actions (group or individual)
- Advice and guidance on management of risk in their area
- Peer review of risk registers
- Support with the development of risk registers.

c) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive training and/or briefings on the risk management process by staff from the Risk Management team. In addition, supplementary briefings will be provided as required following publication of new guidance or relevant legislation.

d) Divisional, Ward and Departmental managers will have further detailed risk management process training incorporating how to use the Risk Register database before access to the database is enabled.

15. Monitoring and Audit

The following indicators will form the Key Performance Indicators (KPIs) by which the effectiveness of the Risk Management Process will be evaluated:

- All relevant significant risks are discussed at the appropriate group depicted in the Governance

structure (see Appendix 3) and formal meetings of Committees of the Board
- Risks of ≥15 are reviewed by the Risk Group, with risks of 12 also reviewed when requested by divisions
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and >80% of risks are within review date, and none are overdue for review by 6 or more months

Compliance with the above process will be monitored by the Company Secretary, Assistant Director of Quality and Safety and reviewed by the Executive Director of Nursing and reported within an annual report submitted to the Audit and Risk Committee.

16. Associated Documents / Further Reading

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

- Incident Reporting, Management and Investigation policy
- Handling Concerns and Complaints Group policy
- Claims Group policy
- Being Open/Duty of Candour policy
- Major Incident Group Plan
- Blood Transfusion policy
- Procedure for handling concerns regarding medical and dental staff conduct and capability
- Central Alerting System Group Policy
- Control of Substances Hazardous to Health (COSHH) Policy
- Consent policy
- Domestic Abuse policy
- Emergency Preparedness, Resilience and Response Strategy
- Fire Safety Group Policy
- Freedom to speak up: Raising Concerns (whistleblowing) Group policy
- CHFT Health and Safety policy
- Induction Group policy
- Infection Prevention and Control arrangements Group Policy
- Information Governance Group Policy and Strategy
- Inquest policy
- External Agency Visits, Inspection and Accreditation policy
- Maternity Services Risk Management Strategy
- Medical Device Management
- Mental Capacity Act and Deprivation of Liberty Standards Group Policy
- Moving and Handling policy
- Patient Identification policy
- Policy Management
- Policy for the implementation of national guidance and other high-level reports
- Contractors' Group Policy – Safe Management
- Safeguarding Adults Policy
- Safeguarding Children Group Policy
- Security policy
- Slips, trips and Falls Group Policy
- Waste management policy

All operational policies, procedures and guidance also support the effective management of risk.

17. Trust Equalities Statement

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

APPENDIX 1

Glossary of Terms used within Policy

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

Board Assurance Framework	The BAF - Risks which impact upon the Trust achieving its strategic objectives	**Risk**	Effect of uncertainty on objectives
Control	An intervention used to manage risk	**Risk Acceptance**	Informed decision to take a particular risk
Exposure	Extent to which the organisation is subject to an event	**Risk aggregation**	Process to combine individual risks to obtain more complete understanding of risk
Hazard	Anything that has potential for harm	**Risk analysis**	Process to comprehend the nature of risk and to determine the level of risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	**Risk appetite**	Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate
Inherent risk	Exposure arising from a specific risk before any intervention to manage it	**Risk assessment**	Overall process of risk identification, risk analysis and risk evaluation
Level of Risk	Overall magnitude of a risk. It can be Very high, high, moderate, low or very low.	**Risk avoidance**	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Material Risk	Most significant risks or those on which the Board or equivalent focuses	**Risk management**	Coordinated activities to direct and control the organisation with regard to risk
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	**Risk owner**	Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
Operational Risk	The risk of loss or gain, resulting from internal processes, people and systems or from external events	**Risk Register**	A record of information about identified risks.
Programme Risk	Risk associated with transforming strategy into solutions via a collection of projects	**Significant Risk**	A risk that has a high probability with significant harm which requires recording on the HLRR.
Residual risk	Current risk. The risk remaining after risk treatment	**Target Risk**	A level of risk being planned for

APPENDIX 2

Risk Appetite and CHFT Annual Risk Appetite Statement

No organisation can achieve its objectives without taking risks. The Board will determine and continuously assess the nature and extent of the principal risks that CHFT is exposed to and is willing to take to achieve its objectives – known as the CHFT's risk appetite. The Board should also ensure that planning and decision-making reflects the level of risk with which CHFT aims to operate.

The risk appetite provides a structure for CHFT to work within, by enabling the organisation to take decisions based on an understanding of the risks involved. The organisation will communicate expectations for risk taking to managers.

CHFT uses the risk appetite matrix for NHS organisations developed by the Good Governance Institute (Board guidance on risk appetite, May 2020) to express its risk appetite.

The risk appetite will be agreed by the Board and reviewed at least annually or as needed, as risk appetite levels may change.

Risk Categories

Risks need to be considered in terms of both opportunities and threats and are not usually confined to clinical risk or finances – they are much broader and impact on the capability of CHFT, its performance and reputation. The risk appetite is also influenced by the overall objectives set by CHFT.

CHFT will agree categories of risk and will publish these, which will cover the over-arching areas of:

- Quality, innovation and improvement, safety
- Financial
- Commercial
- Regulation
- Reputation
- Workforce

The risk appetite statement will be communicated to relevant staff and risks throughout CHFT should be managed within the CHFT's risk appetite. Where this is exceeded, action should be taken to reduce the risk.

The Risk Group and Quality Committee will review the high – very high risks on the HLRR to ensure that risks are acceptable within CHFT risk appetite and that the CHFT's overall portfolio of risk is appropriate, managed, balanced and sustainable.

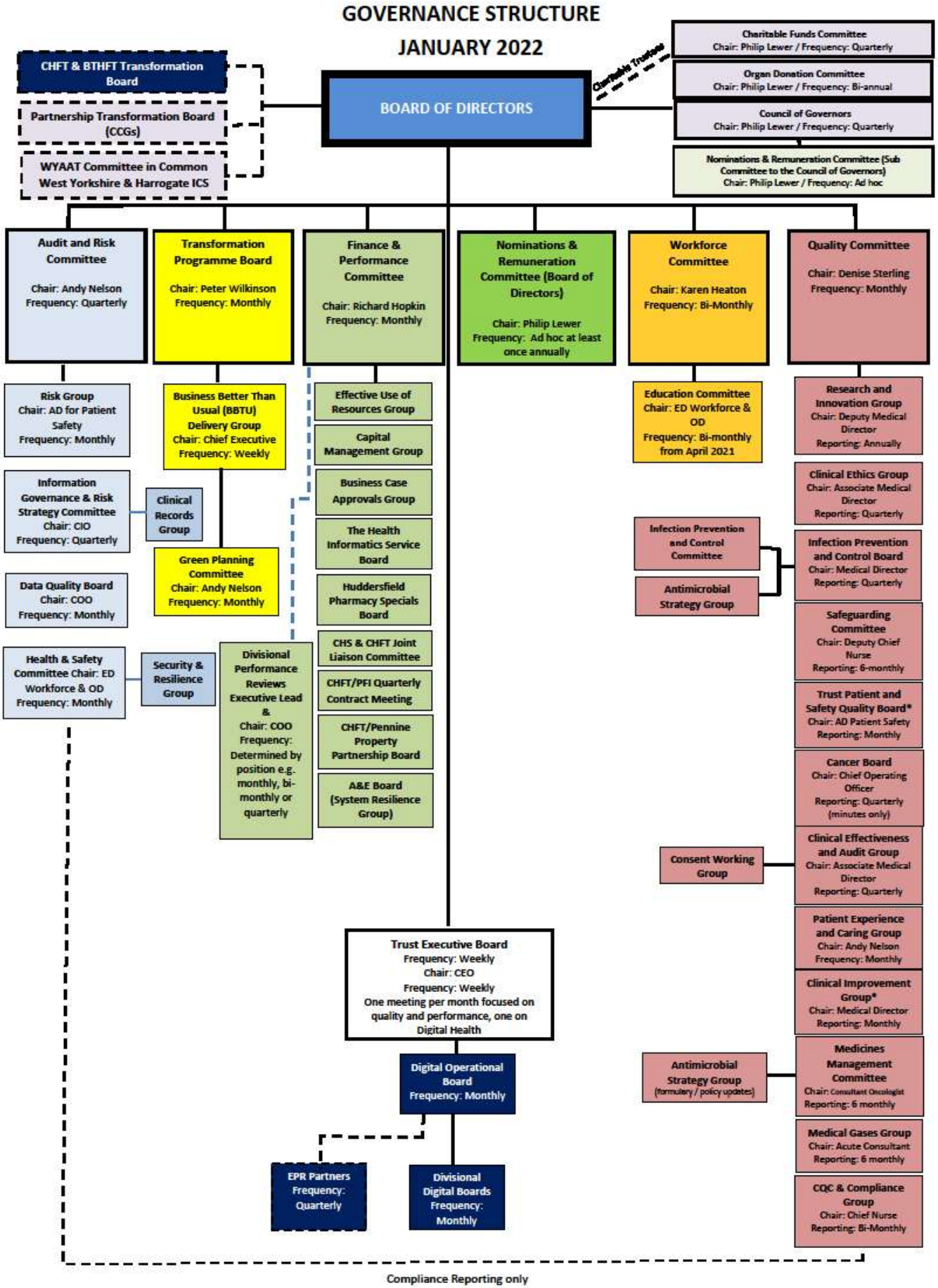
The Audit and Risk Committee will ensure that the CHFT risk appetite through its auditing and reporting process is being appropriately implemented to provide assurance to the Board

CHFT RISK APPETITE STATEMENT - September 2021

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 not shy away from making difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**

Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, aiming to deliver our services within our financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commercial	We will always explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients safe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety and promoting the well-being of our staff.	**LOW**
Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery.	**SIGNIFICANT**

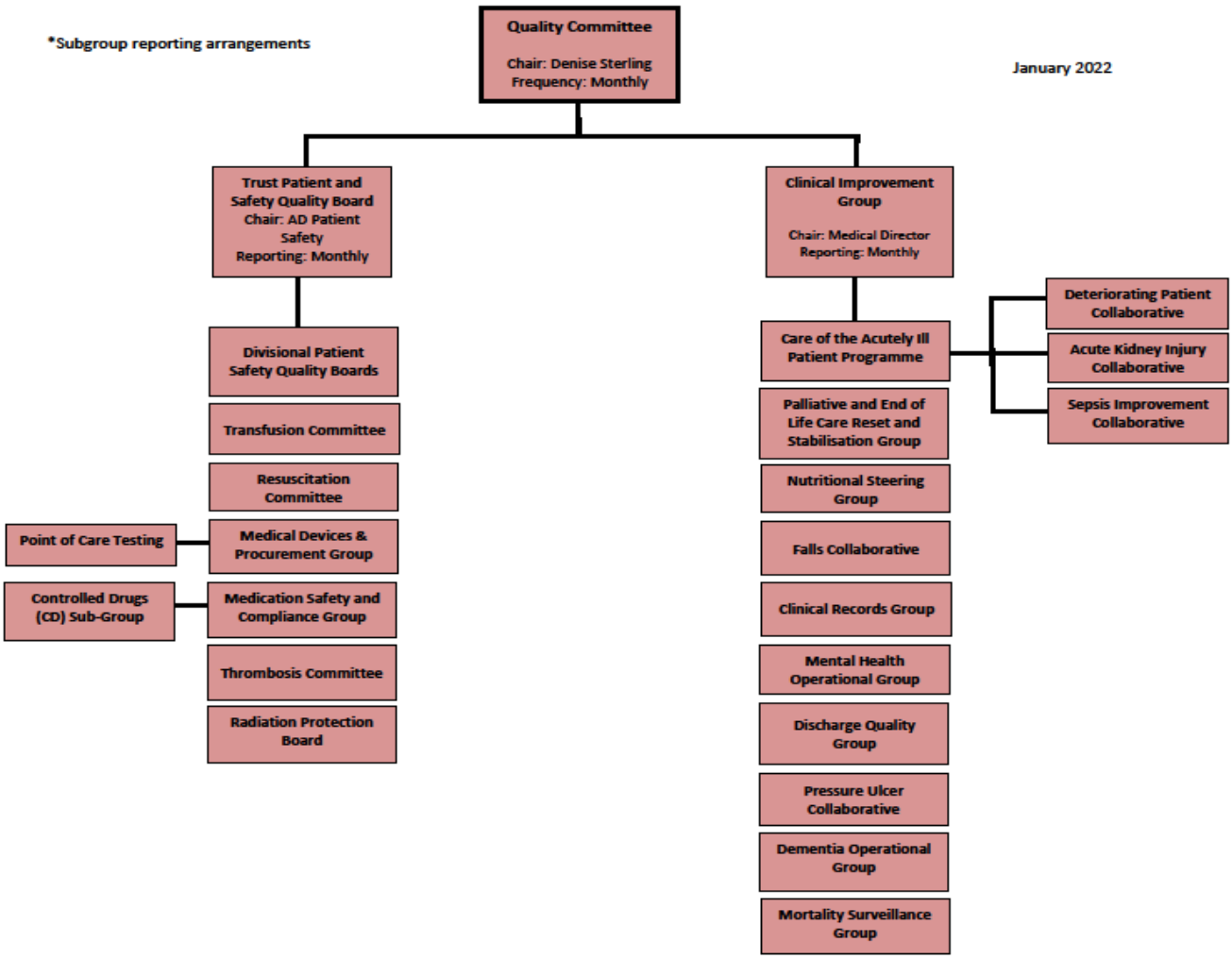
APPENDIX 3


GOVERNANCE STRUCTURE
JANUARY 2022
CHFT & BTHFT Transformation Board
Partnership Transformation Board (CCGs)
WYAAT Committee in Common West Yorkshire & Harrogate ICS
BOARD OF DIRECTORS
Corporate Trustee
Charitable Funds Committee
Chair: Philip Lewer / Frequency: Quarterly
Organ Donation Committee
Chair: Philip Lewer / Frequency: Bi-annual
Council of Governors
Chair: Philip Lewer / Frequency: Quarterly
Nominations & Remuneration Committee (Sub Committee to the Council of Governors)
Chair: Philip Lewer / Frequency: Ad hoc
Audit and Risk Committee
Chair: Andy Nelson
Frequency: Quarterly
Transformation Programme Board
Chair: Peter Wilkinson
Frequency: Monthly
Finance & Performance Committee
Chair: Richard Hopkin
Frequency: Monthly
Nominations & Remuneration Committee (Board of Directors)
Chair: Philip Lewer
Frequency: Ad hoc at least once annually
Workforce Committee
Chair: Karen Heaton
Frequency: Bi-Monthly
Quality Committee
Chair: Denise Sterling
Frequency: Monthly
Risk Group
Chair: AD for Patient Safety
Frequency: Monthly
Business Better Than Usual (BBTU) Delivery Group
Chair: Chief Executive
Frequency: Weekly
Effective Use of Resources Group
Capital Management Group
Business Case Approvals Group
The Health Informatics Service Board
Huddersfield Pharmacy Specials Board
CHS & CHFT Joint Liaison Committee
CHFT/PFI Quarterly Contract Meeting
CHFT/Pennine Property Partnership Board
A&E Board (System Resilience Group)
Education Committee
Chair: ED Workforce & OD
Frequency: Bi-monthly from April 2021
Research and Innovation Group
Chair: Deputy Medical Director
Reporting: Annually
Information Governance & Risk Strategy Committee
Chair: CIO
Frequency: Quarterly
Clinical Records Group
Green Planning Committee
Chair: Andy Nelson
Frequency: Monthly
Data Quality Board
Chair: COO
Frequency: Monthly
Health & Safety Committee Chair: ED Workforce & OD
Frequency: Monthly
Security & Resilience Group
Divisional Performance Reviews Executive Lead & Chair: COO
Frequency: Determined by position e.g. monthly, bi-monthly or quarterly
Clinical Ethics Group
Chair: Associate Medical Director
Reporting: Quarterly
Infection Prevention and Control Committee
Antimicrobial Strategy Group
Infection Prevention and Control Board
Chair: Medical Director
Reporting: Quarterly
Safeguarding Committee
Chair: Deputy Chief Nurse
Reporting: 6-monthly
Trust Patient and Safety Quality Board*
Chair: AD Patient Safety
Reporting: Monthly
Cancer Board
Chair: Chief Operating Officer
Reporting: Quarterly (minutes only)
Consent Working Group
Clinical Effectiveness and Audit Group
Chair: Associate Medical Director
Reporting: Quarterly
Patient Experience and Caring Group
Chair: Andy Nelson
Frequency: Monthly
Clinical Improvement Group*
Chair: Medical Director
Reporting: Monthly
Trust Executive Board
Frequency: Weekly
Chair: CEO
Frequency: Weekly
One meeting per month focused on quality and performance, one on Digital Health
Digital Operational Board
Frequency: Monthly
Antimicrobial Strategy Group
(formulary / policy updates)
Medicines Management Committee
Chair: Consultant Oncologist
Reporting: 6 monthly
Medical Gases Group
Chair: Acute Consultant
Reporting: 6 monthly
CQC & Compliance Group
Chair: Chief Nurse
Reporting: Bi-Monthly
EPR Partners
Frequency: Quarterly
Divisional Digital Boards
Frequency: Monthly
Compliance Reporting only
January 2022

Compliance Reporting only

*Subgroup reporting arrangements

January 2022



APPENDIX 4

Risk Management Specialists

Caldicott Guardian
The Caldicott Guardian is a senior health professional who oversees all procedures affecting access to person-identifiable health data, protecting the confidentiality of patient and service user information.

Senior Information Risk Owner
As CHFT Senior Information Risk Owner (SIRO), the Chief Information Officer is responsible for ensuring that CHFT creates and manages its information risks, through the development of a network of Information Asset Owners (IAOs) and Information Assess Administrators (IAAs).

Information Governance Manager
The Information Governance Manager is responsible for ensuring that CHFT has robust strategies, policies and procedures for the management of CHFT's information, both corporate and clinical/patient.

The Information Governance Manager liaises with CHFT's Caldicott Guardian and Senior Information Risk Owner to ensure that CHFT meets and complies with the standards set out in the Data Security and Protection Toolkit.

Data Protection Officer – the Data Protection Officer is responsible upholding standards for the protection of personal data and ensures CHFT follows the law and appropriate regulations.

Company Secretary
The Company Secretary is responsible for ensuring the strategic risks for the organisation are captured in the Board Assurance Framework and that there are effective processes in place for managing central alerts. The role also ensures that the supporting Committee structure of the Board and their terms of reference reflect the Committee risk responsibilities system. This role also ensures that CHFT is aware of any compliance issues, i.e. via the Single Oversight Framework from NHS Improvement, and that any risks associated with new business or service change which may impact on CHFT ability to adhere to the Single Oversight Framework are appropriately reported throughout the organisation.

Executive Director of Nursing / Deputy Chief Executive
The Executive Director of Nursing is the Executive lead for risk management and patient safety in partnership with the Medical Director, ensuring organisational requirements are in place which satisfy the legal requirements of CHFT for quality and safety, patients and staff, including delivery of processes to enable effective risk management and clinical standards.

Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) has the following role and responsibilities: oversee local control of infection policies and their implementation; responsibility for the Infection Prevention and Control Team within the healthcare organisation; report directly to the Chief Executive and the Board; challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions; assess the impact of all existing and new policies and plans on infection and make recommendations for change; be an integral member of the organisation's clinical governance structures.

Medical Director
The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the and leads the quality improvement strategy. The Medical Director is responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation.

The Medical Director is also responsible for managing safety incidents in NHS screening programmes where CHFT is involved.

The Director of Workforce and Organisational Development has executive responsibility for health and safety.

The Director of Finance's responsibilities includes management of the PFI provider and Calderdale Huddersfield Solutions to manage estates risks.

The Chief Operating Officer has responsibility for security management and Trust resilience.

Head of Midwifery
The Head of Midwifery is the professional and management lead for midwives and is responsible for the co-ordination of clinical risk, providing expert advice for risk management within maternity services and responsible for supporting and embedding the implementation of risk management within maternity services. A Maternity Risk Management Strategy supports the continual improvement of the quality of clinical care through effective management of clinical risks and details roles and responsibilities for maternity risk management.

Fire Officer
This includes the provision of a fire safety strategy and fire training for all staff in terms of prevention, fire precautions and safe evacuation. The role also includes ensuring each area has a current fire risk assessment. The Fire Officer provides specialist advice to design consultant/architects in respect of statutory structural fire safety incorporating the requirements of health technical memorandum 05 Fire Safety requirements.

Head of Health and Safety
The Head of Health and Safety is responsible for providing advice and supporting the development, implementation and monitoring of the relevant policies in order to meet the requirements of legislation

Resilience & Security Manager
The overall objective of CHFT Resilience and Security Management Specialist is to serve two separate functions as a designated Emergency Planning/Business Continuity Manager and the Local Security Management Specialist (LSMS) is to identify the work programs required to comply with both the Civil Contingencies Act (2004) and the NHS Protect Security Management Standards, as dictated by national service provision contract standards. The associated corporate work programs will form the basis of ongoing developmental work and an implementation plan to deliver compliance against legislation and standards.

Controlled Drugs Officer
The Clinical Director of Pharmacy is the controlled drugs accountable officer for CHFT (CDAO) in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006) and has responsibility for all aspects of controlled drugs management within CHFT, including standard operation procedures for controlled drugs, procurement and storage arrangements and oversight of the safe practices for prescribing and administration of controlled drugs, investigation of medication incidents.

The Clinical Director of Pharmacy is also the Chief Pharmacist and is responsible for policy and strategy in respect of medicines management.

Medication Safety Officer
CHFT has a Medication Safety Officer who oversees medication error incident reporting and learning to improve medication safety.

Radiation Protection
CHFT has a Radiation Protection Board chaired by the Divisional Director, with specialist and technical advice on radiation provided by the Radiology department and external radiation protection advisors.

Freedom to Speak Up Guardian
The Guardian acts as an independent and impartial source of advice for staff on raising concerns and will signpost staff to other sources of advice where necessary. In addition, the Guardian will help to support CHFT to become a more open and transparent place to work.

Head of Risk and Compliance - has day-to-day responsibility for risk management process, quality governance and safety management including:

- Challenging, grading and development of risks

- The development of risk management strategy and policies
- Administration of risk management systems
- Oversight of risk exposures facing the business
- Provision of risk management training and support to divisions
- The maintenance of the corporate service risk register
- Support the development of local risk registers
- Lead in triangulating and sharing lessons for learning from adverse events
- Liaise with the Company Secretary with regards inclusion of risks in the HLRR and/or BAF
- Involvement in internal and external audits related to risks

The Head of Risk and Compliance and Risk Manager also provide advice and support on risk management to staff.

Head of Safeguarding - has day to day responsibility for ensuring risks relating to safeguarding adults and children are managed in line with local policies and through collaborative working with other agencies and safeguarding practitioners.

APPENDIX 5

Risk Register Guidance - Risk Description

Describing Risk and Assigning Controls

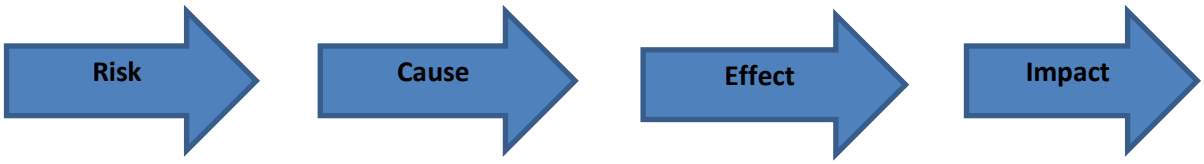
Risks are described in a clear, concise and consistent manner to ensure common understanding by all (including the public) with acronyms spelt out in the first instance. Describing risk in this way enables effective controls, actions or contingency plans, to be put in place to reduce the likelihood of the risk materialising.

Staff should carefully consider the wording of risks as risk registers are subject to Freedom of Information requests i.e., copies of risk registers can be requested and be disclosed to individuals / organisations. Where risk assessments concern specific patients or employees and contain confidential information, they must not be added to the Risk Register in order to avoid breaching patient or staff confidentiality. Such risk assessments must be stored in the patient's health record, or employee personnel folder.

When wording the risk, it is helpful to think about it in four parts. For example:

"There is a risk of/that..... This is caused/due to by ..... and would result in.... leading to an impact upon....."

The Trust's standard for recording risks is to define risks in relation to:



- A **Risk** is described as something uncertain that may happen and could prevent us from meeting its objectives.
- The **Cause** is the problem or issue that 'could' cause the risk to happen.
- The **Effect** is the result of something that will happen if we do nothing about the risk
- The **Impact** is the wider impact of the risk on the objectives if we do nothing

An example of describing risk in the Trust standard is detailed below:

Objective: Keep the base Safe

Risk: Risk of failure to maintain safe staffing levels

Cause:
- High staff sickness rate
- Difficulties in recruiting clinical staff

Effect: Inability to maintain the safety of patients

Impact:
An increase in the number of pressure ulcer/falls incidents

APPENDIX 6

Assessing Risk and Calculating Residual Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence

using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring, i.e. multiplying the consequence / severity score by the likelihood score.

CHFT procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured

- **Current risk score -** this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target / residual risk score as action plans to mitigate risks are developed and implemented

- **Target / residual risk score -** this is the score that is expected after the action plan has been fully implemented and refers to **the amount of risk remaining after treatment**.

CHFT uses a standard 5 x 5 scoring matrix set out at Appendix 7

APPENDIX 7

Risk Grading Matrix

1. Impact

Impact is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select (from the Impact score matrix) whichever description and domain best fits.

2. Likelihood

Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment and using relative frequency where this is appropriate

3. Impact Score

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Injury (physical / Psychological)	Minimal injury requiring no/minimal intervention or treatment.	Minor injury or illness, first aid treatment needed Health associated infection may/did result in semi-permanent harm Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Moderate injury or illness requiring professional intervention to resolve the issue RIDDOR / Agency reportable incident (7- 14 days lost) Adverse event which impacts on a small number of patients Increased length of hospital stay by 4 – 15 days	Incident leading to avoidable death Multiple permanent injuries or irreversible health effects
Environmental Impact	Potential for onsite release of substance Minimal or no impact on the environment	Onsite release of substance but contained Minor impact on the environment Minor damage to Trust property – easily remedied <£10K	On site release of substance Moderate impact on the environment Moderate damage to Trust property	Offsite release of substance Major impact on the environment Major damage to Trust property – external organisations required to remedy	Onsite /offsite release with catastrophic effects Catastrophic impact on the environment loss of building / major piece of equipment vital to CHFT business continuity
Staffing & Competence	Short term low staffing level (<1 day) – temporary disruption to patient care Minor competency	On-going low staffing level - minor reduction in quality of patient care Unresolved trend relating to competency	Ongoing low staffing resulting in moderate reduction in the quality of patient care Late delivery of key objective /	Loss of key staff Uncertain delivery of key objective / service due to lack of staff Serious error due to ineffective	Loss of several key staff Non-delivery of key objective/service due to lack of staff Critical error

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
	related failure reduces service quality <1 day	reducing service quality 75 % staff attendance at mandatory / key training	service due to lack of staff Error due to ineffective training / competency 50% - 75% staff attendance at mandatory / key training	training and / or competency 25%-50% staff attendance at mandatory / key training	leading to fatality due to lack of staff or insufficient training and / or competency Less than 25% attendance at mandatory / key training on an on-going basis
Business/ Service Interruption	Loss/Interruption of >1 hour; no impact on delivery of patient care / ability to provide services	Short term disruption, of >8 hours, with minor impact	Loss / interruption of >1 day Disruption causing impact on patient care Non-permanent loss of ability to provide service	Loss / interruption of > 1 week. Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked Temporary service closure	Permanent loss of core service / facility Disruption to facility leading to significant 'knock-on' effect across local health economy Extended service closure
Inspection/ Regulatory Compliance/ Statutory Duty	Inspection/ Regulatory Compliance/ Statutory Duty Small number of recommendations which focus on minor quality improvement issues Minimal breach of guidance / statutory duty Minor non-compliance with standards	Single failure to meet standards No audit trail to demonstrate that objectives are being met (NICE; HSE; NSF etc.)	Challenging recommendations which can be addressed with appropriate action plans Single breach of statutory duty Non-compliance with > one core standard	Enforcement action Multiple breaches of statutory duty Improvement Notice Trust rating poor in National performance rating Major non-compliance with core standards	Multiple breaches of statutory duty Prosecution Severely critical report on compliance with national standards Zero performance rating Complete systems change required
Adverse Publicity / Reputation	Rumours Potential for public concern	Local Media – short term – minor effect on public attitudes / staff morale Elements of public expectation not being met	Local media – long term – moderate effect – impact on public perception of Trust & staff morale	National media <3 days – public confidence in organisation undermined Use of services affected	National / International adverse publicity >3 days. MP concerned (questions in the House) Total loss of public confidence
Financial	Small Financial loss < £1K	Loss <£1k - £50K	Loss of £50K - £500K	Loss of £500K - £1M	Loss > £5M

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Fire Safety/ Security Management	Minor short term (<1day) shortfall in fire safety system. Security incident with no adverse outcome	Temporary (<1 month) shortfall in fire safety system / single detector etc (non-patient area) Security incident managed locally Controlled drug discrepancy – accounted for	Fire code non-compliance / lack of single detector – patient area etc. Security incident leading to compromised staff / patient safety. Controlled drug discrepancy – not accounted for	Significant failure of critical component of fire safety system (patient area) Serious compromise of staff / patient safety Loss of vulnerable adult resulting in major injury or harm Major controlled drug incident involving a member of staff	Failure of multiple critical components of fire safety system (high risk patient area) Infant/young person abduction Loss of vulnerable adult resulting in death
Complaints/ Claims	Informal / locally resolved complaint Potential for settlement / litigation <£0.1 million	Overall treatment / service substandard Formal justified complaint (stage 1) Minor implications for patient safety Claim >£0.1 million	Justified complaint (stage 2) involving lack of appropriate care Potential for independent review Moderate implications for patient safety Claim(s) between £10K - £500K	Multiple justified complaints Findings of Inquest suggesting poor treatment or care Non-compliance with national standards implying significant risk to patient safety Claim(s) between £500K - £1M	Multiple justified complaints Single major claim Ombudsman inquiry Totally unsatisfactory level or quality of treatment / service Claims >£1M

4. Likelihood score

What is the likelihood of **the impact / consequence** occurring?

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to occur within a year	Expected to occur at least annually	Expected to occur at least every 6 months	Expected to occur at least monthly	Expected to occur at least weekly
Probability	Less than 10%	11 – 30%	31 – 50%	51 – 70%	Greater than 70%

Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst-case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register**

Risk Grading

Risk grading makes it easier to understand the Division/Directorate/Trust risk profile. It provides a systematic framework to identify the level at which the risks must be managed and overseen in the

organisation, prioritise actions and resources to address risk and direct which risks should be on the HLRR register.

Having assessed and scored the risk using the 5x5 risk scoring matrix, use the table below to grade the risk as low, moderate, high or very high.

Table 3

Risk scoring = Impact / Consequence x likelihood

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

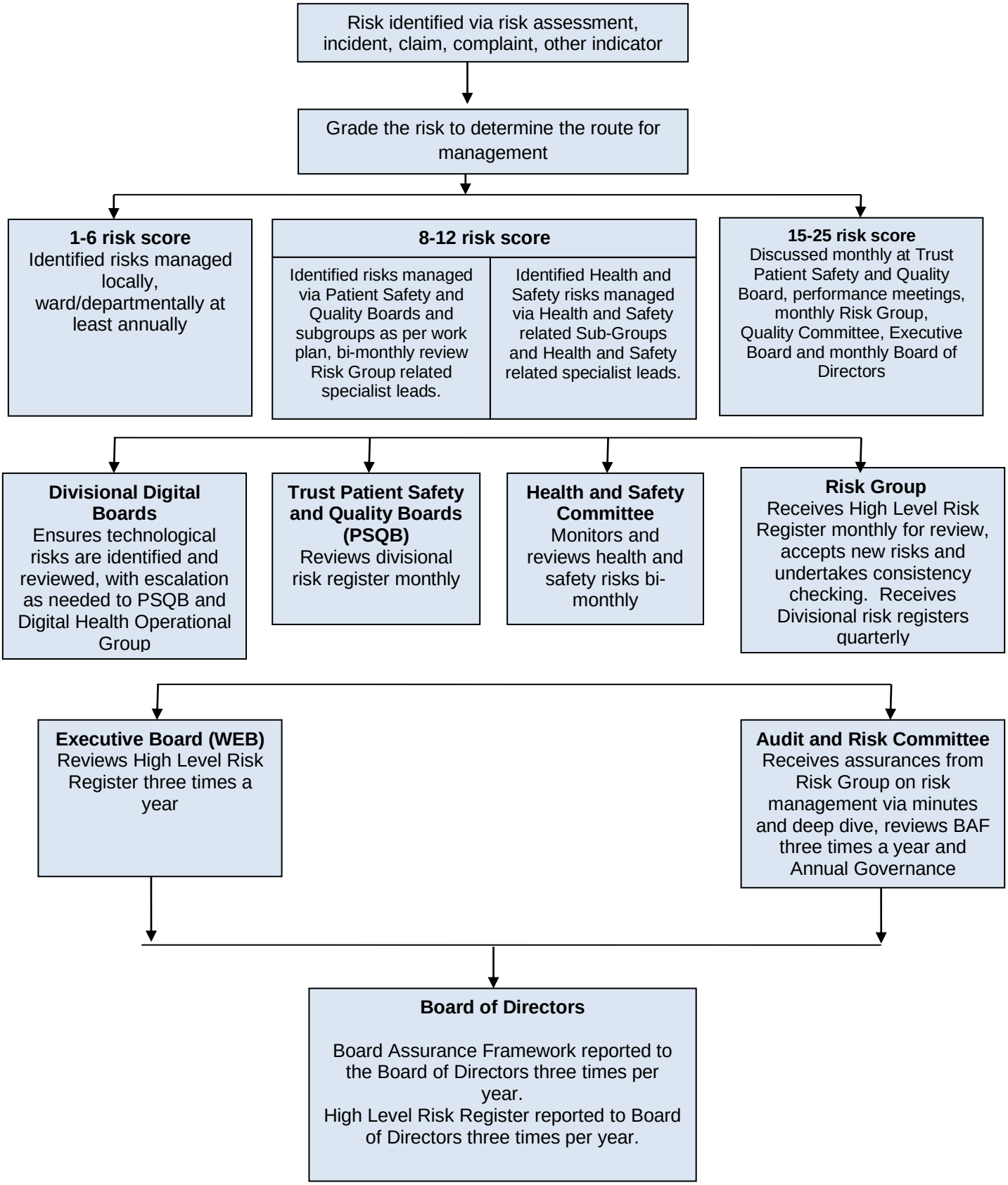
1 - 6	Low Risk	
8 - 12	Medium Risk	
15-16	High Risk	Significant Risks to be included in the High-Level Risk Register
20 - 25	Very High	

APPENDIX 8

Compliance Section of the Risk Registers Content Guidance: External inspections / reviews

CQC must do actions which are a failure to meet regulatory standards	CHFT position will be captured in the corporate service register, any that relate to a specific core service to feature on the associated divisional register. Actions not driven by compliance register, acknowledge they are monitored elsewhere
Quality surveillance programme (previously cancer peer review):	Self-assessments or visits
Other peer review programmes	Include national, regional, local networks
Health & safety executive NHS Improvement /NHS England NHS Digital Health Education England GMC	Outcome of any specific assessment of CHFT
National audits	Capture any audits where CHFT services are significant outlier – high level messages
NICE guidance	Include any guidance where CHFT services will remain non-compliant, not those where we are working towards compliance. These can be listed as one entry referencing that they feature on CHFT NICE database and are monitored through Clinical Audit and Effectiveness Group and Divisional PSQB Reference should be made to the specific recommendation relating to the non-compliance
NCEPOD	Include any recommendations of significant non-compliance. These can be listed as one entry referencing that they feature on CHFT NCEPOD database and are monitored through Clinical Audit and Effectiveness Group and Divisional PSQB Reference should be made to the specific recommendation relating to the non-compliance
Service reviews: - National screening programmes - Accreditations (mandatory and voluntary) - Quality Assurance - Royal college	Outcome of any specific assessment of CHFT
Ofsted inspections (health aspects)	Main inspection will sit with lead organisation
Internal audits	Limited assurance reports
Invited service reviews: - Clinical Non-clinical / corporate services (e.g. ISO standards)	

APPENDIX 9


Risk identified via risk assessment, incident, claim, complaint, other indicator
Grade the risk to determine the route for management
1-6 risk score
Identified risks managed locally, ward/departmentally at least annually
8-12 risk score
Identified risks managed via Patient Safety and Quality Boards and subgroups as per work plan, bi-monthly review Risk Group related specialist leads.
Identified Health and Safety risks managed via Health and Safety related Sub-Groups and Health and Safety related specialist leads.
15-25 risk score
Discussed monthly at Trust Patient Safety and Quality Board, performance meetings, monthly Risk Group, Quality Committee, Executive Board and monthly Board of Directors
Divisional Digital Boards
Ensures technological risks are identified and reviewed, with escalation as needed to PSQB and Digital Health Operational Group
Trust Patient Safety and Quality Boards (PSQB)
Reviews divisional risk register monthly
Health and Safety Committee
Monitors and reviews health and safety risks bi-monthly
Risk Group
Receives High Level Risk Register monthly for review, accepts new risks and undertakes consistency checking. Receives Divisional risk registers quarterly
Executive Board (WEB)
Reviews High Level Risk Register three times a year
Audit and Risk Committee
Receives assurances from Risk Group on risk management via minutes and deep dive, reviews BAF three times a year and Annual Governance
Board of Directors
Board Assurance Framework reported to the Board of Directors three times per year.
High Level Risk Register reported to Board of Directors three times per year.

18. Board Assurance Framework

To Approve

Presented by Andrea McCourt

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Board Assurance Framework – Update 3 2021/22
Author:	Andrea McCourt, Company Secretary
Previous Forums:	Audit and Risk Committee - 25 January 2022

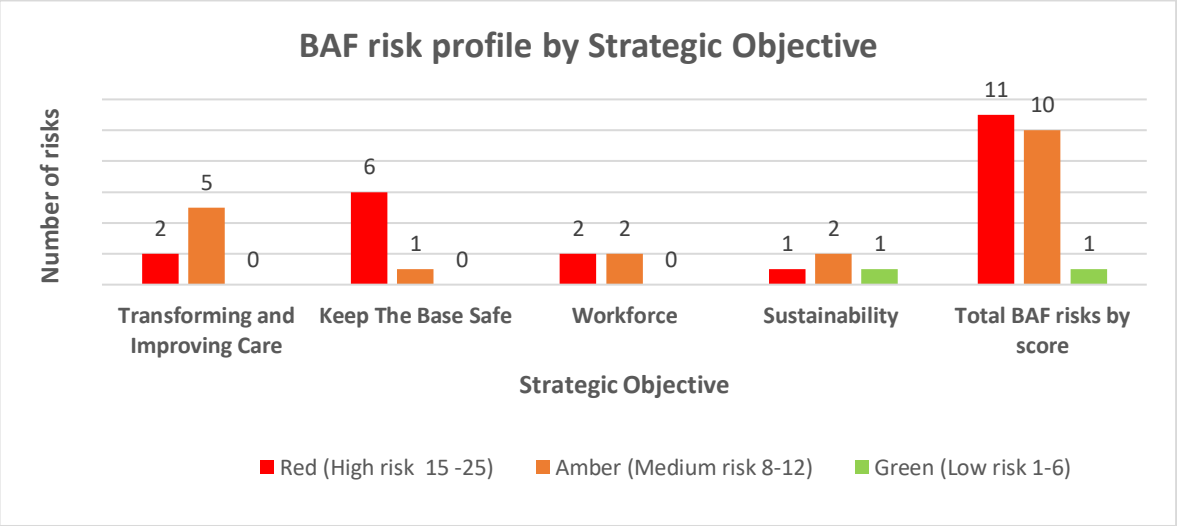
Purpose of the Report

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

This report presents the third update of the Board Assurance Framework (BAF) for 2021/22 and last of the financial year for approval and is for review and approval.

Key Points to Note

Risk Profile
The Trust has the following risk profile for risks to its strategic objectives as at 18 February 2022. The Keeping The Base Safe strategic objective has the greatest number of high (red) risks, at 6 of the 22 risks on the BAF.



There are no new risks for addition to the Board Assurance Framework (BAF). The Audit and Risk Committee reviewed a proposed new risk regarding workforce reduction due to the requirement for mandatory vaccination for frontline staff, however this has been removed given the regulations making vaccines a condition of deployment for health and social care staff are set to be revoked, subject to public consultation and Parliamentary approval.

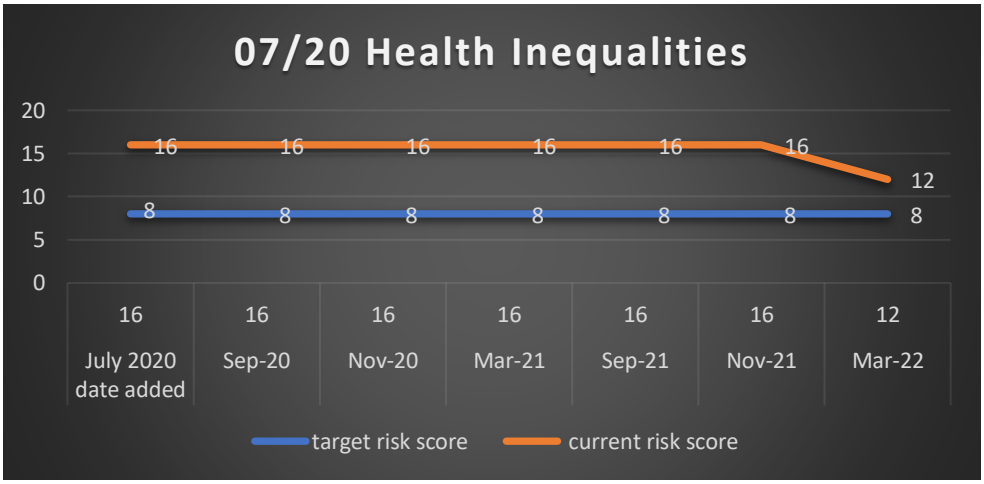
One risk is proposed for removal, risk 03/20 Business Better Than Usual Service Transformation as it has met its target risk score (further details below). With this risk removed the total number of risks on the BAF will be 21.

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

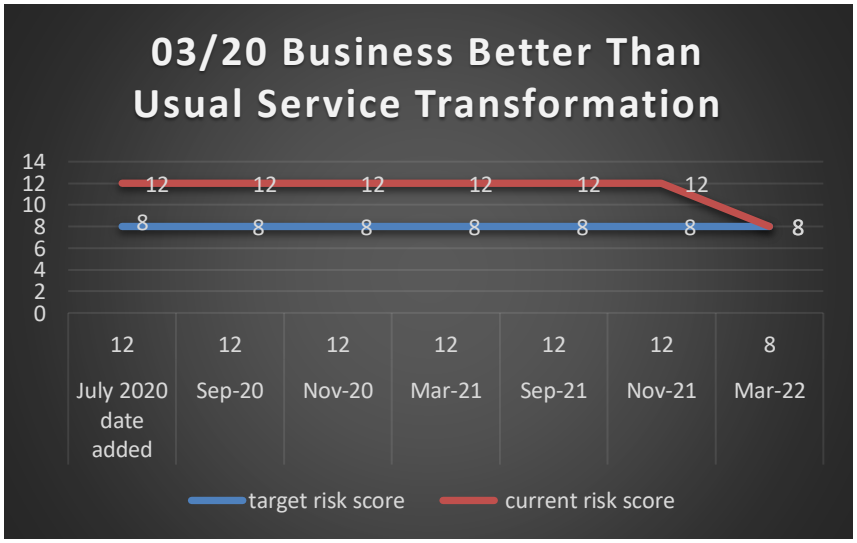
Risk Score Movement
There have been reductions in three risk score shown below. Rationale for this movement in risk score is given below.

Risk score movement	BAF Risk reference and score
↓ 16 to 12	7/20 Health Inequalities
↓ 12 to 8	03/20 Business Better Than Usual Service Transformation
↓ 16 to 12	14/19 Finance: capital funding

- *7/20 Health Inequalities* - score reduced from 16 to 12 to reflect the significant activity and progress made on waiting lists and waiting times for BAME service users in more deprived neighbourhoods based on Index of Multiple Deprivation (IMD) and progress on lived experience of patients, with plans to further expand this to include mental health service users. As the risk appetite for this risk is low it had previously been identified as an area of risk exposure, with a reduction in score this risk is now removed as an area of risk exposure



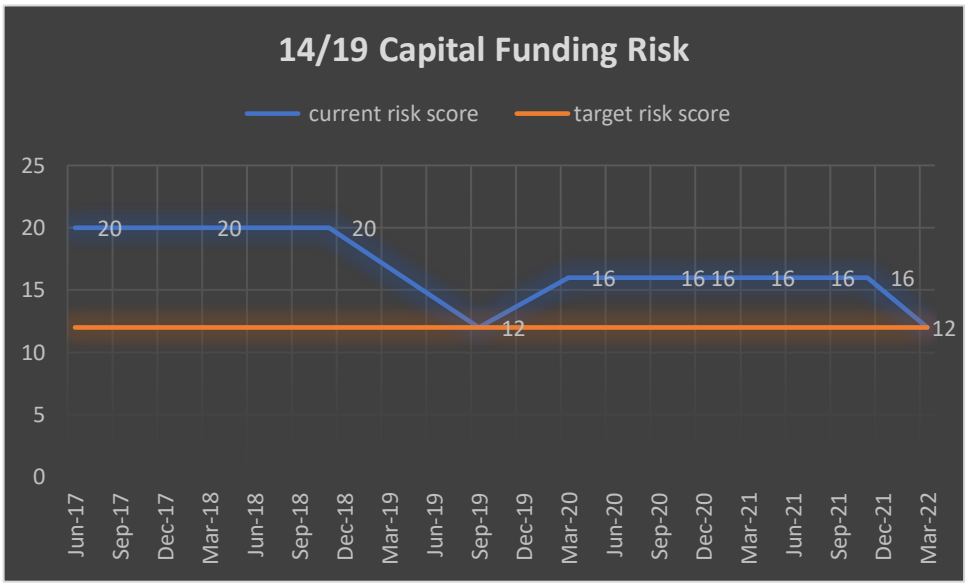
- *03/20 Business Better Than Usual (BBTU) Service Transformation* - score reduced from 12 to 8 (impact of 4, likelihood of 2) reaching target risk score of 8. It is proposed that this risk be removed from the Board Assurance Framework.



In January 2022 Audit Yorkshire reviewed the BBTU programme and their report concluded that there was a high level of assurance regarding the processes that have been put in place to ensure that positive learning from the pandemic is being embedded within the Trust across the 12 learning themes.

Going forward this programme of work will be sustained / embedded in the Trust's main annual planning and longer term strategic planning processes. This will integrate and ensure learning from the pandemic is not a stand-alone initiative and is an integral part of the Trust's drivers for strategic planning and transformation. Discussion with Board members regarding this took place on 3 February 2022 who agreed with this way forward and closure of the BBTU programme.

- *14/19 capital funding* - score reduced from 16 to 12



Following Joint Investment Sub Committee approval in December 2021, funding has been secured for the Emergency Department at Huddersfield Royal Infirmary of £15m. Additionally, and conditional of this support, the Integrated Care System have agreed to support the identified funding shortfall of £6.2m plus the Multi Storey Car Park at Calderdale Royal Hospital of £15m. Overall, £36.2m has been secured which reduces the risk. With a reduction in score this risk is now removed as an area of risk exposure.

Although the risk has reached its target risk score it was agreed at the Finance and Performance Committee on 6 January 2022 that the risk should remain on the BAF as there is an expectation that the risk score may rise in the future.

Risk Exposure

Where a BAF risk score is higher than the risk appetite (e.g. risk score of 15 or above where risk appetite is moderate or low) this has been identified as a breach of the risk appetite.

In considering risk exposure the Trust needs to assess whether any further mitigating actions are needed and review the adequacy of information and assurance on the management of risks with risk exposure.

As at 18 February 2022 the Trust has eight areas of risk exposure summarised below, a reduction of two due to the risk score reduction for health inequalities (07/20) and capital (14/19).

Strategic Goal: Transforming and Improving Care	Risk Score	Risk Appetite category	Risk Appetite
4/19 Patient and Public Involvement	16	Regulation	Moderate

Strategic Goal: Keeping the Base Safe			
6/19 Quality and Safety (newly added)	15 =	Regulation	Moderate
4/20 CQC rating	16 =	Regulation	Moderate
7/19 NHS Improvement Compliance	20 =	Regulation	Moderate
8/19 Performance targets	16	Regulation	Moderate
5/20 Service capacity due to Covid-19	20 =	Harm and safety	Low
Strategic Goal: Workforce			
12/19 Colleague engagement	12 =	Workforce	Low
Strategic Goal: Sustainability			
18/19 Long term financial sustainability	16=	Financial/Assets	Moderate

These areas of risk exposure are shaded in grey in the summary sheet of risks in the enclosed BAF.

EQIA – Equality Impact Assessment

The BAF has a specific risk, risk 07/20, which relates to the Trust making slow progress addressing health inequalities in the 20% of the most deprived patients in our communities.

The Trust has a regular report on progress with health inequalities actions at Board meetings.

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

Recommendation

The Board is asked to **APPROVE** the updated Board Assurance Framework as at 18 February 2022, the removal of risk 03/20 Business Better Than Usual and **NOTE** the movement in risk scores and areas of risk exposure.

Update 3 - 3 March 2022
2021/22

Calderdale and Huddersfield NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2021/22 Update 3

Contents:

compassionate care

CHFT RISK APPETITE STATEMENT - Revised September 2021

Risk Category	This means	Risk Appetite
Strategic / Organistional	We seek out innovation to deliver higher quality patient care, accepting this brings risk.	**SIGNIFICANT**
Reputation	We will not shy away from making difficult decisions in the best interests of patient safety but appreciate this may attract scrutiny / interest from stakeholders.	**HIGH**
Financial / Assets	We will invest resources to enable us to deliver improvements in care ensuring rigorous impact assessments. We will resource opportunities and always consider price, value and benefits, aiming to deliver our services within our financial plans, retaining flexibility to capitalise on opportunities.	**MODERATE**
Regulation	We will make every effort to comply with regulation and will explain our approach.	**MODERATE**
Legal	We will comply with the law.	**LOW**
Innovation / Technology	We change how we deliver care to meet the challenges of the future by actively pursuing digital innovation, while providing safe, effective and efficient care for patients.	**HIGH**
Commercial	We will always explore new opportunities which will enhance and support our core business and reputation for providing patient care.	**HIGH**
Harm and safety	We take as little risk as possible when it comes to harm and safety to keep our patients safe and achieve the best clinical outcomes.	**LOW**
Workforce	We have one Culture of Care with colleagues looking after each other as well as the people we care for, ensuring patient safety and promoting the well-being of our staff.	**LOW**
Quality innovation and improvement	We seek innovation in the way we deliver services and employ staff as a key enabler for improving quality, patient safety and experience.	**SIGNIFICANT**
Partnership	We accept a level of risk in working with partners to support service transformation and operational delivery.	**SIGNIFICANT**

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

REF	RISK DESCRIPTION	Initial Score	Current score	Target Score	Lead	Link to High Level Risk Register	Risk Category	Risk Appetite
Transforming and Improving Patient Care								
01/19	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.	25	**15 =**	10	AB	2827, 5806,7413,7414	Strategic/ Organisational	Significant
03/19	Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	15	**9=**	4	DB	None	Regulation	Moderate
04/19	Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a a meaningful way to patient and service user feedback resulting in services not designing services using patient recommendations.	12	**16 =**	4	EA	None	Regulation	Moderate
01/20	Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.	15	**12 =**	10	DB	None	Strategic/ Organisational	Significant
02/20	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.	12	**12 =**	9	JR	None	Innovation/ Technology	High
03/20	Risk the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation, resulting in the Trust not being able to stabilise the future delivery of services and missing opportunities for improvement in the quality, experience and efficiency of service delivery.	12	**8 ↓**	8	AB	None	Strategic/ Organisational	Significant
07/20	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	16	**12 ↓**	8	EA	None	Harm and safety	Low
Keeping the base safe								
06/19	Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.	15	**15=**	10	EA	see individual sheet	Regulation	Moderate
07/19	Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement resulting in enforcement action.	25	**20 =**	10	GB	None	Regulation	Moderate
08/19	Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.	16	**16 =**	12	JF	7615	Regulation	Moderate
09/19	Risk of failure to maintain current estate and equipment and to develop future estates model resulting in patient harm, poor quality patient care or regulatory enforcement.	16	**15 =**	8	GB	5806	Strategic/ Organisational	Significant
16/19	Risk of not being compliant with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.	9	**9 =**	4	SD	7413, 7414 , 7474	Regulation	Moderate
04/20	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation.	12	**16=**	6	EA	None	Regulation	Moderate
05/20	Risk that services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand and non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is a potential for an adverse impact on health inequality.	20	**20=**	8	JF	7689, 7683, 7809, 7834, 7634	Harm and safety	Low

SUMMARY BOARD ASSURANCE FRAMEWORK RISKS BY TRUST STRATEGIC GOAL

A workforce fit for the future								
10a/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**16 =**	9	DB	2827,7078, 5747	Quality/Innovation & Improvement	Significant
10b/19	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.	16	**20 =**	9	EA	6345	Quality/Innovation & Improvement	Significant
11/19	Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.	16	**12 =**	9	SD	None	Quality/Innovation & Improvement	Significant
12/19	Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to a lack of robust engagement mechanisms.	12	**12=**	4	SD	None	Workforce	Low
Sustainability								
14/19	Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.	20	**12** ↓	12	GB	None	Financial/Assets	Moderate
15/19	Risk that the Trust will not deliver external growth for commercial ventures resulting in potential lost financial contrbution.	**9 =**	6	6	GB	None	Commercial	High
18/19	Risk re: longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit with the growing level of debt and reliance on borrowing.	25 =	**16=**	12	GB	None	Financial/Assets	Moderate
06/20	Risk of climate action failure resulting in adverse impacts on public health, patients, natural environment and reputation denotes risk with risk exposure.	16	**12=**	9	SS	None	Strategic/ Organisational	Significant

Area of risk exposure

HEAT MAP

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

= no change to risk score

Assessment is Likelihood x Consequence

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2022
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE									
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022 Risk category: Strategic Risk appetite: Significant**	
1/19	Board of Directors / Transformation Programme Board	Director of Transformation and Partnerships	Risk that the Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC) from NHSI, DHSC, Ministers and HM Treasury and as a result the Trust is unable to progress changes that will improve the quality of care, workforce resilience and mitigate estate risks **Impact** Trust unable to improve long term clinical quality and deliver compliance with statutory, regulatory and accepted best practice.	Formal governance structures established: - Transformation Programme Board, formal sub-committee of the Trust Board oversees service transformation and reconfiguration plans. - Quarterly review meetings with NHSE&I, and DHSC colleagues to advise on planning assumptions used in business cases to ensure compliance with HM Treasury and DHSC requirements and facilitate future approval(s). External professional and technical capacity and expertise procured with design partner appointed in March 2020. Turner Townsend have been appointed to provide a Project Director. Close working with: - Joint Health Scrutiny Committee, wider stakeholders and colleagues to ensure full involvement in the development of the plans and business cases. - West Yorkshire & Harrogate Health & Care Partnership and commissioners to ensure alignment of the reconfiguration plans with their strategic objectives to facilitate the ICS and CCGs ability to provide formal letters of support for the business cases. A local system Partnership Transformation Board that has members from CCGs, ICS, YAS, and the Trust meets monthly to ensure system alignment and support for business case planning assumptions and development.	First line Transformation Programme Board-oversight of governance and content of business case development including relationship management with Stakeholders and NHSE/NHSI, DHSC Second line Trust Board approval of business cases (SOC approved, March 2019). Reconfiguration OBC and FBC for new A&E at HRI approved by Trust Board in October 2021. Third line ICS and NHSE/NHSI review and approval of business cases prior to submission to DHSC. SOC approved by DHSC in November 2019. FBC for new A&E at HRI approved by NHSE Joint Investment Committee in December 2021.Consideration of Reconfiguration OBC by NHSE Joint Investment Committee (JIC) scheduled for 25th February 2022. Subject to support from JIC the OBC will be submitted for approval by Treasury.	• See below for further detail. 1. Her Majesty's Revenue and Customs (HMRC) advice on preferred procurement route 2. Agreement for development on the CRH site.	Moving forward, subject to approval of OBC, the Trust will need to review the technical and other skills capacity and capability to progress the next stages of the programme to FBC. Work has been undertaken to define the skills and capacity needed for next stage of the programme to develop the FBC and is being considered by the Transformation Programme Board in January 2022.	**Initial** 5x5 = 25	**Current** 3x5 = 15	**Target** 2x5 = 10

Gaps in Control	**Timescales**	**Lead**
1.Trust and CCGs need to agree clinical protocols with Yorkshire Ambulance Services to ensure patients are transported to the hospital that provides the services that will meet their clinical needs – whether this is in Halifax, Huddersfield or other specialist providers, such as Leeds. 2. The Trust must obtain advice from Her Majesty's Revenue and Customs (HMRC) regarding the preferred procurement route through the Trust's wholly owned subsidiary (Calderdale & Huddersfield Solutions Ltd). 3. The Trust will have concluded discussions with the PFI Special Purpose Vehicle (SPV) to enable the development on the CRH site. 4. Provision of aditional car parking at CRH and a hospital travel plan is required.	1. Discussions have taken place with YAS and activity modelling and clinical protocols have been agreed. 2. The Trust has written to HMRC regarding the preferred procurement route through Calderdale and Huddersfield Solutions. 3. An agreement with the PFI Special Purpose Vehicle has been drafted and is progressing to completion -this will require Treasury approval. 4. The Trust has submitted a planning application for the mutli-storey car park to Calderdale Council in July 2021. The Trust's Travel Plan and Green Plan have been developed. The Travel Plan has been approved by the TPB and the Green Plan by the Trust Board. Determination on the Car Park Planning Application is provisionally scheduled for 8th March 2022.	AB for all actions

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

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2022
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022 Risk category: Regulation Risk appetite: Moderate**		
3/19	Quality Committee	Executive Medical Director	**Risk** Risk that the Trust will be unable to deliver appropriate services across seven days due to staffing pressures resulting in poor patient experience, greater length of stay and reduced quality of care **Impact** - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Governance systems and performance indicators in place, Learning from Deaths group and Care of the Acutely Ill Programme re-established, reports to Clinical Outcomes Group and Quality Committee. Quality Comittee oversight of SHMI / HSMR. • Rosters focussed on managing Covid-19 providing extended cover- regular staffing meetings held to endure cover for key services/ movement of staff should staffing levels drop to unacceptable levels • Radiology staffing has improved with a number of recent Consultant appointments. Increased demand for acute imaging has somewhat diminished the impact of these posts, however the service overall is more robust and better able to respond to pressures including increased staff absence due to COVID. • Early implementer to trial new NHSE methodology of Board assurance and sign off. Survey completed twice yearly (Spring/ Autumn) • Programme to extend 7 day working across medical specialities - now includes elderly medicine, respiratory, cardiology, gastro, stroke, haematology, acute medicine, diabetes with discussions progressing in palliative care • Reconfiguration of medical services: elderly medicine, cardiology, respiratory, gastroenterology has facilitated the introduction of speciality on-call rotas to expand provision of 7 day speciality cover	First line HSMR better than expected, SHMI increasing though remains within expected range largely as a result of out of hospital mortality. Second line Deep dive report on this risk to Quality Committee 30.12.20. minor amend to risk description Second Line Integrated Board report with SHMI/HSMR reporting. Annual Learning from Deaths report to Board July 2021. Quartelry Learning from Deaths report to Board (4 March 2021, 1 July 2021, 4.11.21.) Third line Positive feedback from NHSI/E, NHSE-led, WYAAT-wide implementation scheme Benchmarking exercise against remaining 6 non-priority standards to report to WEB	Workforce plan being developed for managing Covid Lead: Cornelle Parker, Deputy Medical Director COVID continues to place strain on delivering all services across 7 days due to staff sickness. Enhanced Consultant Physician and Middle Grade cover is in place in areas under highest capacity and staffing pressures. Staffing pressures have exceeded capacity pressures during the current COVID 4th wave. Improved staffing in Accident and Emergency, however remains insufficient to deliver extended Consultant presence in accordance with National Guidance. Challenging to meet this standard until reconfigured service in place. Diagnostic capacity in Radiology and Endoscopy limited by requirements of Covid-19 IPC. Endoscopy waiting lists are challenging - action: plan additional internal activity as part of Recovery response; in -sourcing and outsourcing under consideration : COO. Limited resource to audit the 4 key standards Action:Audit to commence in March 2022, led by Terry Matthews in Governance. -Governance facilitators will collect data from 30 patients from each division and analyse this. -Divisions will prvide clinical input as required. -Plan to feedback results in April/ May 2022.	• Scope for futher implementation limited without service reconfiguration or additional investment NHS I suspended collection of reports on seven day service standards due to Covid-19 in March 2020 Local audit planned for March 2022- Lead: AMD Future response to Covid-19 may impact delivery of 7 days services in some specialities as a result of changes to both medical and nursing rotas. In principle aim to meet seven day standards(7DS) but these have not been measured; position variable depending on Covid situation and escalation and impact	**Initial** **5x3 = 15**	**Current** **3x3= 9 =**	**Target** **2x2 = 4**

Action	**Timescales**	**Lead**
Ongoing review of staffing pressures A&E Develop Workforce Plan for managing Covid Plan additional diagnostic capacity as part of Recovery response, including focus endoscopy Local audit of 4 key seven day standards commnce March 2022 by Governance / Audit team and divsions	Ongoing Ongoing March 2022 May 2022	DB/CP Deputy Medical Dirctor,CP Chief Operating Office, JF EL/ Governance Audit team & divisions

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

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2022
TRANSFORMING AND IMPROVING CARE

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE									
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4/19	Quality Committee	Executive Director of Nursing / Deputy Chief Executive	**Risk** Risk that the Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of , capacity and capability to respond in a meaningful way to patient and service user feedback resulting in not designing services using patient recommendations **Impact** - poor patient experience Non delivery of improvements in services - inequitable service / care for patients - Risk of legal challenge - Reputational impact	• Patient Experience Group (PEG) in place which mandates the workplan and oversees progress and audit activity for public invovlement and patient experience Dedicated senior leadership post for patient experience, equality and diversity and matron for complex care needs Patient and Service User Engagement Strategy approved by Quality Committee • Patient engagement in Outpatient Transformation Programme • Patient Engagement champions in clinical areas to support staff in engaging with patients and service users • Nursing and Midwifery Strategy which enables staff time to care for patients • Health Inequalities group established and developed workplan with a focus on the experience of BAME services users and people living with learning disabilities BAME Community Engagement Advisor Engagement appointed to work alongside the CHFT BAME network group and create engagement opportunities with local BAME communities • Matron assigned to Reconfiguration Team to lead on patient experience	First line Patient Experience Group, areas of good practice with service users identified eg co design and development of children's community hub, continuity of carer maternity teams supporting greater engagement in decisions about personal care (BAME / areas of deprivation), engagement on relocation of Rainbow Child Development Service, project to improve access to healthcare for disadvantaged groups focused in ED, new Clinical Nurse Specialist post for transition of young people with neruo-disability. Introduced Observe and Act observation tool initiative to "see through the patient eyes". Regular review by Quality Committee Second line Patient Story to Board meetings Governor attends PEG PEG reporting to Quality Committee quarterly, CCG membership at Quality Commitee. Board quality report inlcudes a section in relation to service users involvement.Governor attends Health Inequalities Group as lay member Third line Quality Account to NHS Improvement, CCGs and other stakeholders, CQC rating of Good - report referenced positive examples of patient engagement Healthwatch reports (Outpatients post Electronic Patient Record, Syrian Refugees)	Lack of central system for patient engagement and involvement data - lead Assistant Director for Patient Experience, March 2022 Lack of mechanism for systematic involvement of members of BAME communities. Action: Implementation of Patient and Service User Engagement Strategy , Assistant Director Patient Experience, review March 2022 Current operational pressures are impacting on the pace of progression of some workstreams.	Mapping complaints to IMD groupings - lead: Calum MacIver,THIS, timescale 31 March 2022. Review and refresh of this BAF PPI risk (4/19) Lead: Ellen Armistead and patient experience colleagues Timescale: Q1 2022/23	**Initial** **3x4 = 12** **Current** **4x4 = 16 =** **Target** **1x4 = 4**

Action	**Timescales**	**Lead**
Implementation of Patient and Service User Engagement Strategy Mapping of complaints to IMD groupings Refresh of this PPI/PPE Board Assurance Framework risk (4/19)	March 2022 March 2022 June 2022	Quality Directorate / L Rudge THIS Calum MacIver Ellen Armistead/ Patient Experience colleagues

Links to risk register:
No risks on the high level risk register

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2022
TRANSFORMING AND IMPROVING CARE

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Ref: 01/20 Added July 2020	Transformation Programme Board (TPB)	David Birkenhead, Medical Director	Risk of not delivering the ambitions described in the Trust clinical strategy due to lack of collaboration across the West Yorkshire system to enhance the quality and resilience of clinical services due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce NB: See 1/19 reconfiguration risk which has signifcant overlap with this risk and 3/20 Business Better Than Usual risk .	Refreshed Clinical Strategy - describes Trust position on service development across West Yorkshire (WY) Transformation Programme Board - clinical strategy informing decisions made to reconfigure services and ensure that the redesigned hospital model is fit for purpose ICS - member of the WY& H Partnership Board which agrees service direction, strategy and financial allocations and controls. More effective working relationships with partners and establishment of networked approaches to Pathology and Vascular Surgery. Transformation Programme Board ensures estate is aligned with the clinical strategy. Recently established Planned Care Alliance to co-ordinate and plan phased approach to reset, including redesign to planned care Member of WYAAT which identifies, agrees and manages programms of work targeted to improve services and patient experience across West Yorkshire. WYAAT governance framework with specific forums for acute Trusts including Chief Exec forum, Committeee in Common and programme office with oversight. Recruiting for additional Oncology staff to strengthen capacity	**First Line** Clinical strategy developed and shared with WEB (23.5.19.) **Second Line (Board / Committee)** Clinical strategy - Board 4 July 2019 (private), refreshed Clinical Strategy July 2021 Board approved Board Business Better Than Usual report to 2 July 2020 Board describing learning from Covid-19 will help to inform any necessary adaptation of the Clinical Strategy ICS clinical forum 7 July 2020 discussed Planned Preventative Care post Covid-19 Response to COVID-19 has by necessity driven enabling work for the strategy, including remote working, developments in community care, and virtual outpatients. **Third Line** Vascular network established with Bradford WYAAT Pathology Board established. Common LIMS procured now being rolled out	Non-Surgical Oncology (NSO) - acute system pressures across WY require additional support from CHFT. Working with LTHT, MYHT to ensure short term service support in place, whilst sustainable WY solution identified. Independent reivew report (Dec 2021) recommends two site service model for NSO. Action: Report is being considered by WYATT Oncology Board, will recommend a future service model for agreement by the WYAAT Commitee in Common (April 2022). Any service model will be subject to ICS support and will require formal public consultation West Yorkshire and Harrogate Clinical Strategy under development Action: Following pause during Covid, WYAAT clinical lead restarting clinical strategy work,including refresh of workforce data, linking with fragile services work add timeframe WYAAT and ICS system-wide approaches to reset. Performance of CHFT in relation to Covid recovery programme may reduce ability to deliver new services Consideration to be given to primacy of PLACE v system. Action: Develop further as ICS is formally established in July 2022.	None at present	**Initial**	**Current**	**Target**
								3x5=15	3x4=12	2x5=10
Action					**Timescales**			**Lead**		
NSO - WYAAT to agree future service model informed by in independent review report WYAAT - refresh of West Yorkshire Clinical Strategy, incorporating work on fragile services Collaboration with ICS / PLACE partners to agree identification of respective PLACE / system responsibilities					April 2022 WYAAT to confirm July 2022 (expected formal ICS establishment date)			David Birkenhead, Medical Director WYAAT clincial lead / WYAAT Chief Executives Brendan Brown/ David Birkenhead / Anna Basford		
Links to risk register: None See 1/19 reconfiguration BAF risk and 3/20 BBTU risk										

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2022
TRANSFORMING AND IMPROVING CARE

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02/20 July 2020	Transformation Programme Board	Managing Director - Digital Health	Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience	5 year Digital Strategy and continued review by Weekly Executive Board and annually to Board which will meet the needs and build the foundation for the 10 year digital strategy Digital Aspirant and Scan for Safety funding for next 2 years to March 2023 and committed capital funding from the Trust which will enable progression along the national Digital Aspirant Programme Dedicated Digital Transformation Director co-ordinating digital programmes and providing leadership Governance via Digital Health Forum and Digital Operations Board. Digital Operations Board chaired by Managing Director Digital Health, with reviewed terms of reference Monthly meetings with Managing Director Digital Health and Director of Finance reviewing progress with digital investment strategy - Divisional Digital Boards which report into the Digital Operations Board with revised terms of reference which will ensure clarity of purpose of group and consistent approach	**First Line:** Digital Health Forum meeting bi-monthly, programme of work and progress presenned at each meeting **Second Line** Board approved Digital Strategy and associated investment plan (2 July 2020) provides direction . Additional funds for digital capital expenditure for 2021/22 secured.. 2 September 2021 Board approved THIS Commercial Strategy confirms the Trust contribution target and allows for re-investment into THIS Spring 2022 new portfolio management process and redefinition of demand management, prioritisation, return on investment and governance Redefine digitial governance in line with DoF mandate and Business Cases Approval Group (replaces CISG, meets from 17.2.22.) **Third Line:** Digital Aspirant Trust Scan for Safety Programme in progress.	Lack of prioritisation process for digital projects: Action: Redefine digiial governance in line with DoF mandate and changes to CISG (now Business Cases Approval Group) Lead: Managing Director - Digital Health and Director of Finance Timescale: In place for March 2022 Review of digital health team capacity and capability Action: Redefine scope of digital health programme in line with EPR optimisation, reconfiguration and cross -organisational partnerships Lead: Managing Director - Digital Health Timescale: October 2022	Difficulties defining effective governance process to be reviewed and actioned in Winter 2022. Prioritisation process lacking across divisions to be reviewed in Winter 2022. Business case rationalisation and strategic alignment of projects to be reviewed via new governance process in Winter 2022.	**Initial** **4x3 = 12**	**Current** **4x3 = 12**	**Target** **3x3=9**
Action					**Timescales**			**Lead**		
Create formal prioritsation process for digital projects at Business Cases Approval Group (formerly CISG) Review of digital health team capacity and capability and redefine scope of digital health programme Define effective digital governance process Monitoring via Finance and Performance Committeee					March 2022 October 2022 Winter 2022 Ongoing			Jim Rea, MD - Digital Health Jim Rea, MD - Digital Health im Rea, MD - Digital Health Gary Boothby		
Links to risk register see linked 1/19 reconfiguration risk										

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2022
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								Initial	**Current**	**Target**
03/20 July 2020	Transformation Programme Board	Director of Transformations and Partnerships	**Business Better Than Usual (BBTU)** There is a risk that the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation. As a result the Trust may not be able to stabilise the future delivery of services and will miss opportunities for improvement in the quality, experience and efficency of service delivery.	CHFT has engaged colleagues, patients and partners across the Calderdale and Greater Huddersfield health and social care system to capture learning from experience of their responses to the COVID -19 pandemic. The findings from this were presented to the Trust Board on 2nd July 2020 and 12 key learning themes of transformational changes that should be sustained and amplified were agreed by the Board. Governance and management arrangements to provide assurance on the implementation of this have been agreed by the Trust Board and have been implemented. This includes: - appointment of theme leads - establishment of BBTU Delivery Group - oversight by Transformation Programme Board Business Better Than Usual - Results - shared with Transformation Programme Board, Quality Committee, Workforce Committee and Finance and Performance Committee	**First Line** - BBTU Delivery Group chaired by the CEO includes membership of a named Lead for each learning theme. The Delivery Group leads implementation and provides progress reports to the Transformation Programme Board. (8.7.21.) **Second Line** - the Transformation Programme Boardl provides oversight of the BBTU programme of delivery and and updates on progress to the Trust Board. Board discussion 3.2.22. agreed closure of BBTU programme and move to integrate through the Effective Resources Group **Third Line**. High level of assurance confirmed by Internal Audit independent review on adequacy of governance arrangements for a strategic programme of transformation based upon learning from Covid-19 pandemic through the Business Better than Usual (BBTU) project (January 2022) The Trust evidenced " positive learning from the pandemic is acting as a driver for positive transformation" External - collaboration with external stakeholders (e.g.CCGs, acute and mental health Trusts, community providers, hospices, voluntary sector, social care, the West Yorkshire ICS, and NHSE) to progress and provide regular updates on actions to respond to learning from the pandemic.		Final BBTU progress report to Board Committees February / March 2022 advising of Trust Board agreement of BBTU programme closure and that learning from the pandemic through BBTU will be taken forward through the Trust's Effective Resources Group and longer term strategic planning. .	**3x4=12**	**→ 4x2=8**	**4x2=8**

Action	**Timescales**	**Lead**
Work to clarify the impact of BBTU on operating costs and efficiency is on-going. Close this risk and integrate BBTU programme via Effective Resources Group	31 March 2022	AB/GB AB

Links to risk register:None

BOARD ASSSURANCE FRAMEWORK
FEBRUARY 2022
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Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022 Risk category: Harm and Safety Risk appetite: low**		
								Initial	**Current**	**Target**
07/20 Added July 2020	Trust Board	Director of Nursing / Deputy Chief Executive	Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete population health and patient ethnicity data, healthcare service delivery not matching patient needs in the most deprived areas, lack of quality priorites to advance health equity, lack of resource allocation and programmes for health prevention, ineffective partnership working and lack of sustained focus on actions to address ill health and prevention, resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.	Director of Nursing named Board Executive providing accountable leadership for tackling health inequalities. Chief Executive expertise in health inequalities. Actively addressing the urgent actions for health inequalities set out by NHS E/I. Health Inequalities Group, chaired by NED, ensures oversight of all Trust workstreams in relation to health inequalities. Equality impact assessment (EQIA) process for service and policy changes. Health Inequalities is reported formally into Trust Board. Board development sessions include deep dives on issues relating to health inequalities to increase knowledge of Board members on why addressing health inequalities is important and provide insight to local health inequality issues Diversity - 1 Non-Executive BAME members of the Board brings lived experience to help tackle health inequalities. Trust Diversity and inclusion networks and 5 year plan for inclusion (Staff).The ethnicity of the Trust Board reflects its workforce and local communities. BAME representative on interview panels. West Yorkshire and Harrogate Healthcare Partnership (ICS) - Trust plays a full part in Health and Well-Being Boards and place-based partnerships, where reducing inequality is an ICS goal and exemplified in the Professor Dame Donna Kinnair DBE review. CHFT part of the Health Inequalities Academy to share best practice and agree workstreams. Nominations and Remuneration Committee (Board of Directors) agreed actions to improve Board diversity as part of succession planning and Inclusive Recruitment Strategy for Director vacancies 12.2.21.	**First Line** - developing data and performance information to enable greater activity analysis of access and outcomes through routine performance monitoring. Project in Maternity Services underway to look at outcomes and experiences of those from most deprived areas in the community. **Second Line** - Board development session 3 June 2021 re health inequalities locally and the imapct of becoming an anchor organsiation. Restoration service activity performance monitoring to include deprivation data (index of multiple deprivation) for patients from 20% most deprived neighbourhoods and communitties: Regular updates to Board by Health Inequalities Group leads (6.5.21., 1.7.21. 2.9.21, 4.11.21.,13.1.22.) with workstream updates. Approved Board succession plan seeks to ensure clear talent pipelines for each Executive and non Executive role in the Trust, including actions to ensure inclusive recruitment, and actions to ensure that the Board reflects the gender make up of local communities. EQIA referenced in all Board paper front sheets **Third Line** WYAAT Committee in Common report by Trusts on impact of inequalities on patients, elective recovery and waiting times 27.7.21	Health Inequalities Academy workstreams yet to be defined An action plan to support a move to a more diverse Board and senior staffing group that is consistent with the local community. Discussions about succession planning for Board level and senior posts across the organisation is ongoing. Steps to publicise Board level posts more widely and to under represented groups are being taken in respect of vacant posts and/or future opportunities. The Trust is working to deliver NHS wide high impact actions in respective of equality and diversity.	There are no expectations on reporting externally, however Trust working with and reporting to the ICS and WYAAT. Health Inequalities Group to review use of the Health Inequalities Leadership Framework Tool (NHS Confederation) locally. Lead: Health Inequalities Chair Timescale: 30 June 2022.	4x4=16	→ 4x3=12	2x4=8

Action	**Timescales**	**Lead**
Action Plan for more diverse Board and senior staffing consistent with local community	TBC	Suzanne Dunkley
Health Inequalities Group to review use of the NHS Confederation Health Inequalities Leadership Framework Tool	30/06/2022	Peter Wilkinson

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
KEEPING THE BASE SAFE

TRUST GOAL: 2 KEEPING THE BASE SAFE

Ref	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2022 Risk category: Regulation Risk appetite: Moderate
06/19	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Enforcement notices with regulators - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - Poor staff morale	• Quality governance arrangements monitor quality and safety Quality and Safety Strategy - each clinical division reports into performance review meetings on delivery of the ambitions of the strategy • SI investigation process identifies recommendations to improve care with strong governance in place • Strengthened risk management arrangements at divisional level, including compliance registers Strengthened quality section within performance review meetings more in depth analysis of quality and safety priorities • Programme of ward assurance visits in place - clinical area quality dashboard in place reviewed at Gold Command (weekly) and weekly at Nursing and Midwifery Workforce meeting. Process in place for reviewing quality metrics at ward and department level, reviewed and aligned to CQC key lines of enquiry • Consistent mandatory and essential training compliance Care of the Acutely Ill Patient programme in place to improve mortality outcomes • Risk management strategy. • Learning and Improving: Quality and Safety Strategy agreed and rolled out Refresh and relaunch of Nursing and Midwifery Strategy (8 October 2021) which reinforces importance of real time monitoring of quality of care.	First line Assessment of compliance with NICE guidance Ward accreditation - J2O Jouney to outstanding in early phases of roll out. Performance against saferty must dos reviewed at ward / matron level HSMR & SHMI Mandatory training compliance Improved real time assurance on impact of safety staffing and quality - Nursing Midwifery Workforce Group Second line Clinical audit plan reviewed Bi-monthly Quality Report to Quality Committee and Board KPIs in Integrated Performance Report PSQB reports to Quality Committee Infection Prevention and Control report to Board IPC Board Assurance Framework approved at Board 2 July 2020, progress with IPC BAF recommendations regularly report to Board via Quality report and reviewed through governance structures Serious incident report to Quality Committee Safer Staffing Hard Truths report to Board 4.11.21. Refreshed Nursing and Midwifery Strategy (2021) approved by Quality Committee and Board Third line CQC rating of Good CQC In patient Childrens and Young Peoples survey 2021 Quality Account reviewed by stakeholder bodies Independent assurance on clinical audit strategy Feedback through ongoing relationship with arms length regulatory bodies CQC TMA visits have taken place in ED, Maternity and Vacciniation centre. Independent Service Reviews (ISR) and accreditations. Health Services Investigation Branch reports	• Investigator capacity to support Si investigations and standard of serious incident investigations needs further improvement Alternative model for investigators to Quality Committee Children and Young Peoples Improvement Plan being developed Timescale 28.2.22, lead ADN Family & Specialist Services	• CQC assessed the Trust as requires improvement for safe domain • There has been a move away from non essential activity by relevant regulators in response to the pandemic. • Regular leadership assurance visits not being undertaken regularly due to operational pressures.	Initial: 3x5 = 15 Current: 3x5= 15 = Target: 2x5 = 10

Action	Timescales	Lead
Develop alternative model for serious incident investigtaors and present to Quality Committee	June 2022	EA
Develop Children and Young Peoples Improvement plan	28 February 2022	AD Quality & Safety

Links to risk register:
7809 theatre and clinical capacity, 7689 waits for diagnostics, operations and outpatients, 7683 isolation facilities, 7474 Medical devices, 7834 Elective orthopaedic inpatient theatre capacity, 6453 delay of surgical repair of #NOF, 2827 ED middle grade medical staffing capacity, 7615 emergency care delays not meeting the 4 hour emergency care standard, 6715 inconsistent completion EPR documentation

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2022 Risk category: Regulation Risk appetite: Moderate
7/19	Finance & Performance Committee	Director of Finance	**Risk** The Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement (NHS E/I) **Impact** - Risk of further regulatory action - Reputation damage - Financial sustainability	• Board approved 10 Year Strategic Plan • Board member participation in Place based system meetings with NHS E/I(1 Kirklees, 1 Calderdale) with ICS feedback letter • ICS system financial regime • Standing Financial Instructions and budget management • Strategic outline case (SOC) approved by Board and accepted by commissioners and Integrated Care System (ICS) • Transformation project support in place • Use of Resources work steered by Finance and Performance Committee • Executive leads assigned for 5 Use of resources areas with working groups reporting to Executive leads • Post project evaluation reported at Capital Management Group for capital schemes and Commercial Investment Strategy group for revenue investment Effective use of Resources Group now established, chaired by Chief Executive, to plan and deliver effective resource use to support delivery of the Trust's financial plans Board workshop in December 2021 detailing the underlying financial challenge	First line Transformation project support Monthly monitoring of performance and Covid spend Minutes from Capital Management Group and Commercial Investment Strategy Group, reporting into Finance and Performance Committee. Second line Integrated Board report monitoring of key regulatory standards to every Board public meeting and Finance and Performance Committee, most recent F&P discussion UoR update provided to F&P on 1.6.21 that detailed actions taken from last inspection and provided evidence of where discussions take place and where further improvement remains in focus. A repository of information is available with evidence of discussions and actions along with updated metrics. On a control total basis the Trust has delivered a surplus financial position (£360k) for the 2nd year running and this has also resulted in a revised external audit VFM assessment that reflects the progress made. Third line Current use of resource score was a 2 from April to August 2020 which was an improvement from 3. However, due to loan repayments in September 2020 the capital service cover element of the score became a 4, and overall rating defaulted to a 3. This was a technical anomaly and was discussed in detail at Finance and Performance Committee and with NHS E/I. A decision was taken to adjust the score to report a score more reflective of current performance. This improved the score to a 2. The Trust closed 20/21 with a score of 2. Further autonomy granted from NHS E/I as result of performance and delivery of the 2019/20 control total from NHSE/I.	Effective Resources Group established but the 2021/22 efficiency target has not been fully identified and not identified recurrently Action: Effective Resources Group to identify both in year efficiency plus 5 year approach towards efficiency by 31.3.22. Lead: Director of Finance Maintain awareness of financial challenge at Board level and across the Trust Action: Use Trust communications channels, awareness raising via business planning day with leadership team (1.3.22.) Action: Consider development and promotion of Finance Strategy Finance and Performance Committee May 2022	• Performance against key targets • Use of Resources rating of requires improvement. Use of Resources external assessment has not been completed as benchmarking data is not available and no external capacity to provide a valued assesment.	Initial: 5x5 = 25 Current: 4x5 =20 = Target: 2x5 = 10

Action	Timescales	Lead
Effective Resources Group to identify both in year efficiency plus 5 year approach towards efficiency. Raise and maintain awareness of financial challenge Consider development and promotion of Finance Strategy	31.3.22. 1.3.22. and ongoing May 2022 (paper to Finance and Performance Committee)	Director of Finance Director of Finance Director of Finance /Chief Executive

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022 Risk category: Regulation Risk appetite: Moderate**		
8/19	Finance and Performance Committee	Chief Operating Officer	**Risk** Risk of failure to achieve local and national performance targets due to a needs-based stabilisation and reset plan **Impact** - deterioration of patients waiting longer for treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders Clinician dissatisfaction	Clinical prioritisation of all patients on waiting lists to identify current priority status and a process for regular review of clinical need. Increased number of outcome metrics within performance reporting monitored through performance framework . WYAAT system approach to capacity management. Urgent Care System Board and discharge focus Board with social care providers to plan / consider options, supplemented with Reason To Reside Work Performance Management and Accountability Framework to support delivery of national standards and Trust quality,financial and operational objectives. Current Covid-19 management and governance arrangements in place to oversee the delivery of needs-based care. Daily escalation of performance issues from divisional hubs into Covid-19 tactical (daily meetings) with daily Gold reflecting increased pressures. Weekly review of KPIs with Directors of Operations (D Ops), Assistant Directors of Nursing, plus 1:1 with COO and D Ops. Local triggers for Omicron variant remain in place, monitored by Recovery Oversight group, recovery plan for 104 week waiters for completion by 31.3.22. Daily touchpoint meeting with Divisional teams for timely escalation, action and joint visibility. Planned care backlogs collated & presented to Finance & Performance Committee trajectories and tracking included in IPR. Outcome metrics included quarterly in IPR. Acute Respiratory Care Unit (ARCU) business case approved to build in greater resilience for managing pressures without the requirement to redeploy theatre and endoscopy staff; the provision of an ARCU will aid recruitment & retention. Clinical Reference Groups for Modelling and Health Inequalities supporting the shaping of capacity. Clinical prioritisation/holistics needs assessment matrix. Waiting time modelling completed,with parameters, and shared with regulators along with needs based focus; Continue to utilise external capacity for backlogs, internal enhancement scheme being reviewed to try and secure further additionality and joint deployment team in place with CCGs to ensure opportunities managed at pace.	First line Gold meetings (3 x per week) including escalation of risks, incidents, complaints and staff concerns. Gold attended by CCG colleagues and system silver in place with wider engagement. Risk registers reviewed at Divisional PSQBs & PRMs. Weekly review of KPIs by COO and senior divisional teams Integrated Performance report focus of one WEB each month for detailed scrutiny with wider representation from divisions. Regular monitoring of waiting time past due date for clinically prioritised Second line Board sub committee detailed appraisals of position & actions. Integrated Performance Report discussed at each Board sub committee and Board of Directors. Clinical Prioritisation agreed as a key Quality Indicator, led by Medicl Director reporting via PRMs and into Quality Committee Detailed review of backlog position across planned care through Finance & Performance Committee. Third line Modelling for Omicron variant and scenario planning Positive assurance from NHS E/I Intensive Support Team following review of process for managing P5/P6 patients.(December 2021)	1. Insufficent elective capacity across the system for current and future waiting lists. Non-elective impact on community - workforce issues resulting in a significant deficit of care hours in the community which will result in delayed transfers of care (DTOC) and increased presure on urgent care • Action: Review Urgent Care System Board and discharge focus Board in April 2022 2. Improvement Programmes reporting to Financeand Performance Committee for theatre transformation to improve prdoductivity and Emergency Department to ensure consistency opf service delivery Lead; COO Time frame: 2022/23 3 MRI Capacity - plan for further mobile scanning capacity to manage backlog and demand lead COO	Development of further outcome metrics for IPR. Lead: Chief Operating Officer Timescale: March 2022 Timeframe for ARCU provision to be confirmed: Lead: Chief Operating Officer Timescale: TBC	**Initial** 4x5 = 20	**Current** 4x4 = 16 =	**Target** 4 x 3 = 12
Actions					**Timescales**			**Lead**		
Performance reporting - development of further outcome metrics DTOC/ Urgent Care - review Urgent Care Systems Board / Discharge Focus Board ARCU provision to be confirmed: Improvement Programmes - Theatres and Emergency Department Further mobile scanning capacity to manage backlog and demand					March 2022 April 2022 TBC April 2022 - March 2023 Q1 2022/23			Chief Operating Officer all actions		
Links to risk register: 7615 - 4 hour Emergency Care standard										

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TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
9/19	Transformation Programme Board	Executive Director of Finance	Risk of failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• Governance arrangements and SLAs with CHS monitored at CHS Board, monhtly contract and performance meeting with quarterly CHS / Trust Joint Liaison Committee,overseeing estate, facilities and medical engineering risks • Governance arrangement and performance contracts with PFI monitoring at monthly Contract & Performance meetings in place. • Systematic review of Divisional and Corporate compliance, • Medical device and maintenance policies procedures, Planned Preventive Maintenance (PPM) Programme - improvements made to PPM and end of life service contracts •Premises Assurance Model (PAMs) illustrates to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe • CHS Medical Engineer in post • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Independent audit of medical devices • Health Technical Memorandum (HTM) compliance structure in place including external Authorsing Engineers (AE's) who independantly audit both CRH and HRI Estates against statutory guidance. • Authorising engineer for fire •Concordat with West Yorkshire fire authority * Quarterly PFI Liaison Committee established Oct 2020 with PFI & CHFT to receive assurance against compliance, Plans in place to demolish DATs building to reduce backlog maintenance. CHS now attend the Risk Group to align Trust and CHS risk registers	First line • Close management of service contracts to ensure planned maintenance activity has been performed. Audit plan in place for both PFI and CHS and regular audits completed by Service Performance. Risk register reports. Joint HTM Meetings in place with Trust,PFI & CHS Review of CHS SLAs (Quantitive KPIs & Qualitative Performance) carried out Q4 2020 Learning Centre, Nurses Residence & Saville Court are now demolished (all had significant backlog maintenance). Audits of routine checks, estates * Trust Health & Safety Manager with oversight of H&S across Trust & between partners Second line Estates strategy (revised) approved at Board 2.9.21.H&S Update to Board: January 2022. Priorities shared with Service Performance to implement with CHS/PFI Board review of feasibility study for development of HRI which mitigates known estates issues (5 March 2020 private Board) Health and Safety Committee monitors medical devices training and escalates concerns to Audit & Risk Committee (Audit & Risk to approve newly developed H&S Committee TORs) Medical Engineering Committee monitors medical devices action plan, new equipment and addresses risk analysis of devices Review of PFI arrangements, via Service Performance Audits / Reports Assurance provided by HTM Compliance reports via external Authorised Engineers inspections against HTM standards. WEB reports on medical devices July 2019 H&S Training 90% target achieved, 93% as at 10.2.22. 6 Facet estate condition survey presented to Board 4 July 2019 is informing estates investment plan for HRI Third line PLACE assessments *1, CQC Compliance report.PAMS. HSE review of water management. Familiarisation visits by local operational Fire and Rescue teams. External assurance from authorising engineers for high voltage/ low voltage systems.	* Funding agreed at Joint Investment sub Committee in December 2021 to support the HRI ED business case worth £15m. Support was conditional on ICS support of an overall shortfall on the reconfiguration programme of £6m plus ICS support of £15m for CRH MSCP. The ICS has offered this support so in summary £36m was secured in December 2021. • Whilst additional funds have been secured, 6their remains a backlog maintenance issue at HRI including funding for cladding solution. A bid has been made into the ICS long term capital bidding process that covers the cladding issue. Capital bids have been submitted for consideration against the 22/23 internal capital allocation and these are to be agreed in February 2022 and then agreed to Board as part of the annual plan approval process. lead Director of Finance	*1 PLACE inspections not taken place since 2020	4x4 = 16	5x3= 15	2x4 = 8

Action	Timescales	Lead
Ongoing discussions regarding funding Need for Funding for cladding flagged to ICS - need to decide how to prioritise future capital allocation	Ongoing April 2022	Director of Finance /CHS Director of Finance

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

BOARD ASSURANCE FRAMEWORK
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TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
16/19 9/1/20	Audit and Risk Committee	Director Champion - Executive Director of Workforce & OD	Risk of not being compliant with the Health and Safety at Work Act (1974) and supporting regulations and healthcare safety and welfare standards due to lack of clarity on roles in Health and Safety Policy between CHS and the Trust and health and safety resource, resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage Internal audit review of H&S action plan underway	•Board approved 5 year H&S strategy with 6 key elements, NHS Workplace Safety Standards provides framework for H&S activity, relevant policies reviewed and shared with stakeholders specific to roles and responsibilities. •Health and Safety Policy (revised 2021) clearly highlights the overarching roles and responsibilities from Director level right to front-line colleagues. The roles and responsibilities clearly set-out expectations so that CHFT can be confident of meeting its legal obligations • Process and document describing process for monitoring 12 H&S specific regulatory policies (eg slips, trips and falls, asbsetos) with lead per policy developed and being implemented • SLA in place for CHS to provde Health and Safety Induction Training for CHFT colleagues • Director and Non-Executive Director Health and Safety Champion identified as well as Director responsible for Fire Safety Operational responsibility for H&S across sites sits with CHS for HRI and our PFI partners at CRH - recently appointed interim technical advisor in CHS. • Proactive Health & Safety Committee. • Head of Health and Safety involved in all new sub committees to H&S committee. 8 H&S subgroups formed - maintains traction upon stakeholder responsibilities • Health & Safety action plan in porgress • Annual report on Health and Safety to Board, • Health and Safety action plan with updates to Board, Audit and risk Committee oversight. • Health and Safety mandatory training for staff (3 years). • Health and Safety training on staff induction. • COSHH training. • Risk assessment training design and implementation under review	First line Minutes of Health and Safety Committee evidence good level of engagement by all partners. Review of Health and Safety Committee by members confirmed good sharing of current information, monitoring of trends, review of policies, sharing of health and safety incidents and learning, medical devices training & monitoring, fire and security information . Second line Board joint responsibility for risk understood. WEB reports on mandatory training, health and safety training compliance currently at target levels 9 January 2020 external Health and Safety review presented to Board • 2019/20 Annual Health and Safety report and action plan to Board - 9 January 2020 and 2020/21 Annual Health and Safety action plan to Board - January 2021 and 1 July 2021 • Health and Safety Strategy approved by Board 1 July 2021 • Lead Persons nominated and appointed as chairpersons of health and safety sub-groups. Updates to Board on H&S 3 September 2020, 14 January 2021, 1 July 2021, 13 January 2022 Third line External health and safety review (Quadriga) 2019. Progress monitored at Health and Safety Committee. Audit and Risk Committee and Board.	Implementation of policy monitoring document and process for 12 regulatory policies, including policy revision and detailed review of individual roles and responsibilities working with sub groups (Stage 1). Lead: Head of H&S Timescale: March 2022 Stage 2:Monitoring of 12 regulatory policies compliance via auditing and dashboard reporting to H&S Committee Lead: Head of H&S Timescale: December 2022	Lead for COSHH to be established to chair COSHH sub committee. CHS are currently chairing the COSHH sub committee. Exploring nominated representative from the Trust to take on the responsibilities for COSHH lead.	3x3 = 9	3x3 = 9	2x2 = 4

Action	Timescales	Lead
Stage 1 Implementation of H&S Policy Monitoring Document for 12 key regulatory policies	March 2022	Head of H&S
Stage 2: Monitoring of Compliance of H&S Policy Monitoring Document	December 2021	Head of H&S
Plan to identify nominated representative for COSHH through joint working with CHS	January 2022	Ian Rawson, Corporate

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

BOARD ASSURANCE FRAMEWORK
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KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

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								Initial	Current	Target
04/20 July 2020	Quality Committee	Director of Nursing / Deputy Chief Executive	Risk of not maintaining the Trust CQC overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of qualiy of servies to patients and an impact on reputation See BAF risk 6/19 - quality of care and poor compliance with standards	CQC & Compliance group meets monthly, oversses divisional compliance with regulatory standards/ compliance registers and reports to Quality Committee and Audit and Risk Committee for compliance. Regular engagement meetings with CQC Process for internal assessment against CQC standards (Journey to Outstanding) Dedicated CQC lead Independent Well-led Governance development review completed. CQC resource centre portal for staff with information on CQC reports, standards, self assessment documentation. Ward accreditation processes (Journey to Outstanding) reveiwed and updated, piloted and being rolled out	**First Line:** Reports to CQC & Compliance Group from divisions Journey to Outstanding results and action plan and findings shared with wards and presented to CQC & Compliance Group **Second Line:** Quality Committee reports from CQC Group Quality update report to each Board 6 May, 1st July 2021 Review by Quality Committee and Board of progress with CQC action plan . Quality report to January, March and July Board . CQC well-led governance phase 2 report shared at Board workshop July 2021 Board Development Session 7 October 2021 on CQC effective domain. **Third Line:** Quarterly formal engagement meetings with CQC Current CQC rating of "good" including well-led governance	CQC preparation visits and Trust preparation had been scaled back in response to Covid priorities, Uncertainty of direction of future CQC inspection and rating regime. CQC focus on high risk organisations with targeted inspections . Scaled back inspection regime due to IPC risk of on-site infections. Action: Risk and Compliance team have regular updates CQC and attend update meetings. Developments identified from well-led governance review deferred due to operational pressures. Action: Review of KLOEs for well-led governance assessment by Executive leads. External assessment to look at well-led preparedness. Q1 2022/23 Lead: Executive Team / Ellen Armistead	Journey to Outstanding (J20) in early phases of implementaiton, as such there is little available data to assure. Action: Timetable of J2O visits for next 12 months agreed. Lead: Ellen Armistead CQC new regulatory framework not yet implemented nationally - on hold because of pandemic. Action: Regular updates of CQC plans Lead: Ellen Armistead	4x3=12	4x4=16	3x2=6

Action	Timescales	Lead
Liaison with CQC to understand position on CQC plans for inspections Journey to Outstanding implementation underway via rolling programme Repeat audit of 2 recently closed CQC actions (Critical Care Anaesthetic cover, ED Consultant cover) with report CQC and Compliance Group Review of KLOEs for well -led governance assessment	Ongoing 12 month programme to December 2022 June 2022 June 2022	ADN Quality and Safety and Deputy Director of Nursing Director of Nursing Executive Leads

Links to risk register:
None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
KEEPING THE BASE SAFE

TRUST GOAL: 2. KEEPING THE BASE SAFE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2022 Risk appetite: Low (Ham and Safety) Initial	Current	Target
05/20 July 2020	Finance and Performance Committee	Chief Operating Officer	Risk that: - services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand. - non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is a potential for an adverse impact on health inequality. See also BAF 08/19 re performance targets and BAF 7/20 health inequalities	Surge plan in place across Divisions to support recovery whilst maintaining capacity and triggers for future surges. Bed plans and flow arrangements reflect the risk of increased non elective demand.Review of surge plan for Omicron. IPC pathways amended to reflect national guidance, cross checked with Board of Directors principles on patient and staff safety. Maintaining separation of elective and non elective bed capacity. Continuing to utilise the Independent sector, commissoining activity for H2. Retained additonal diagnostic capacity to supplement reduced internal capcaity or provide additional capacity for backlog clearance and non elective demand increases All inpatient waiting lists clinically reviewed and priority status identified. Criteria for outpatients agreed and clinical review ongoing. Reviewing waiting lists and cross referencing with deprivation index, overssen by Health Inequalities Group. Regular reporting at IMD level now available showing progress in closing the 'waits gap' since March 2021. This is also available for BAME/Non-BAME patients. Working with system partners on referral pathways Health & Well-Being risk assessment of staff Scenarios modelled for various configurations of covid activity.	**First Line:** Daily review of Covid-19 activity and weekly review of all other waiting list data Submission of national data sets. Daily tactical meetings chaired by senior Operational manager monitoring demand and bed capacity All admitted waiting lists clnically prioritised with consistency checking process in place and monitoring of waiting time against priority score **Second Line** Finance & Performance Committee oversight of activity and backlogs with new IPR that includes a Recovery section Performance reports to relevant Board Sub-Committees (Finance and Performance, Quality Committee, Workforce Committee) Discussion on key elective recovery metrics.	1. Reset plans have interdependency risks on workforce availability that will limit capacity. Action: Oaily monitoring of workforce availability 2. Clinical Review of out patient activity ongoing Lead: Medical Director 2. Review and refocus of this risk in light of Covid becoming business as usual and national guidance on tackling Covid-19 elective care backlog. Lead: Chief Operating Officer June 2022		4 x 5 - 20	4 x5= 20 =	2x4=8

Action:	Timescales	Lead
1. Monitoring of workforce availability 2. Clinical review for out patient activity - changing national IPC guidance to faciltate recovery of elective services 3. Review and refocus of risk	Daily Ongoing June 2022	Chief Operating Officer, Jo Fawcus Medical Director David Birkenhead

Links to risk register:
7689 out patient waits, 7683, isolation capacity, 7809 theatre and clinical capacity, 7834 elective orthopaedic in patient theatre capacity, 7634 theatre list cancellation due to vacancies

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref & Date added	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING FEBRUARY 2022 Risk Category: Quality, Innovation & Improvement Risk appetite: Significant
10a/19	Workforce Committee	Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to inability to attract, recruit, retain, reward and develop clinical workforce. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Trust vaccination programme for staff Consultant Succession planning -divisional workforce planning including discussions with Consultants over age of 55 and "Grow our own" approach • CESR programme to increase Consultant workforce in appropriate specialties, Emergency Medicines scheme for oversease doctors with Royal College (Hybrid International Emergency Medicines) supports recruitment and retention. Global fellows in Radiology, Guardian of Safe Working ensures safe working hours for junior doctors. • E -job planning in place for all Consultants ensures efficient use of medical staff workforce and visibility of Consultant workforce activity • Revisions to rotas for Consultants, registrars,trainees with clincians & medical HR to support training, staff and activity backlog • Recruitment and retention success, continued use agency and well-established bank medical staff for shortage specialties, agency spend within control totals, use current staff effectvely - all new employees opted in to a bank contract (unless opt out) • Mitigate shortages in specialties nationally,eg Radiology by network working, explore advanced practitioner to support Consultant workforce, use external reporting for Radiology • WYAAT networking approach to pressured specialties, eg Non- Vascular Interventional Radiology, supporting MYHT with Non Surgical Oncology • ED business continuity plan in place; ED Clinical Fellows with 30% education time to provide succession planning • Ongoing recruitment -segmentation approach & vacancy tracker (maps medical workforce to establishment, tacks vacancies, pipeline, retention) ensures focus on clinically high risk and likelihood of appointment. Focus on alternative workforce models, allied health care professional roles – Physician Associates and Advanced practitioner. Recruit to FY3 posts,Radiology Global Fellowship posts • Medical Workforce Programme Steering Group meetings provides overview of the programme. Meeting monthly with highlight reports from workstream leads. Recruitment through external agencies for posts which are difficult to recruit to (eg Interventional Radiology) New national contract launched for specialty doctors and specialist doctors enbaling appointments at specialist level with more independence. Junior doctor awards.Adopted SAS (Staff and Associat Specialists) doctor charter , recruitment udnerway for SAS advocate role	First line Staffing levels, training & education compliance and development reported to WEB, Divisional business meetings and PSQBs consider staffing levels as part of standard agenda, IPR with key KPIs shows slight decrease in sickness levels, and reduction in agency spend Aim to keep agency expenditure under control though for patient safety may need to breach agency cap where necessary with Executive Direcor sign off. Weekly meeting on agency spend. Additional PA posts recruited to, work with Deanery to develop those in post, additional 6 PAs, some of which are in ED. Weekly divisional medical staffing meetings to optimise fill rates Bimonthly executive led meetings on medical agency spend - reduction in medical agency spend based on forecast. Vacancy tracker broadly shows improvement in some medical specialties. Turnover reduced from 12% in June 202 to 6% in 2021. Low vacancy rate 3.3% Dec 2021 (22 Consultants). Medical workforce programme steering group meetings reinstated monthly. Second line Monthly performance meetings review workforce reports Workforce Committtee - continued reduction in medical vacancies – net recruitment gain of 35 medical and dental posts from July 2020 to June 2021. Deep dive of risk to Workforce Committee 15.2.22. Recruited to 9 Radiology posts (6 Consultant, 3 Global Fellows. Emergency Department middle grade remains challenging. Medical Appraisal and revalidation report to Board, demonstrates high quality workforce. Guardian of Safe Working annual and quartetly report (2.9.21., 7.12.21., 13.1.22.) on working hours to Board - investing in improved facilities for trainees. PSQB reports to Quality Committee. 9 August 2021 Deep dive review of risk by Workforce Committee. Workforce Strategy approved by the Board Third Line Plans discussed with NHS I Assurance process with CQC colleagues - feeback from relationship with arms-length bodies, GMC Report on Junior Doctor Experience	Medical E-rostering only partially implemented for doctors -Implementation of NHSE/I Medical Deployment systems project 2023 – Phase 1 completion. Pensions rules remain a concern and affect willingness of medical staff to deliver additional work Dependence on HEE allocation of trainees across the patch. Sickness absences are unpredictable and contribute to rota gaps. Unknown impact of Covid on existing medical staff who may take early retirement or reduce job plans as a result of pressures of having worked through Covid-19 Consultant co-ordinator vacancy for e-rostering and vacancies in e roster team Accumulated annual leave from Covid-19 may pressure clinical service delivery.	Unpredictability of staff availability due to Omicron variant and impact on services at short notice, background of increasing staff fatigue impacting on staff health and well being Short term sickness absence may be under-reported by medical staff. Action: Implementation of e-rostering to record sickness absence (2023), resources for e-rostering significantly impacted by Covid related work . Neuro-physiology, neurology niche specialty vacancies expected and stroke vacancies - all difficut to recruit to posts. Work with Integrated Medical Services Clinical Director, advertising roles in BMJ, explore use of new specialist grade role	Initial: 4 x 4= 16 Current: 4 x4=16 Target: 3 x 3 = 9

Action	Timescales	Lead
E-rostering being rolled out to medics- implementation expected 2023,subject to change depending on Covid operational pressures. Objectives 100% Consutlant & SAS (Associate Specialists) doctors have electronic job plans /85% junior doctors electronically rostered, 55% Consultants electronically rostered Work with Integrated Medical Specialties (IMS) Clinical Director re recruitment to Stroke, Neurology and Neurophysiology vacancies and explore use of specialist grade role	2023 (may slip due to Covid-19 priorities) 2022	Lisa Cooper, Medical Workforce with Jackie Robinson, Dr Sree Tumula, Associate Medical Director Dr S Tumula, Clinical Director IMS

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

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10b/19 2021/22	Workforce Committee	Executive Director of Nursing	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues. **Impact on** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff - ambition to demonstrate the Trust is an "outstanding" organisation by CQC standards	• Senior nurse leadership rota provides ongoing visibility and dialogue across clinical areas, supports staffing escalation • Twice daily staffing meetings, Workforce meetings increased in areas of greatest need - senior nurse staffing meetings twice a week •Daily and weekly nurse staffing escalation reports • Staffing Command links to availability, OPEL level escalator, senior medical and nursing leadership oversight and directly links to tactical meeting Gold Command meeting routinely reviews staffing pressures with monitoring via staffing dashboard identifying areas of concern. • Strengthened escalation and reporting arrangements for quality and safety (short term and medium/long term), including enhanced dashboard which provides clear visibility on workforce and impacts on patient experience, quality and safety, revised Safer Staffing OPEL action cards • Nursing and Midwifery Strategy- implementation of "Time to Care" - relaunch 8 October 2021 • Ongoing recruitment programme in place, including international recruitment • Utilisation of bank, agency and overtime staff in place, managed and escalated through a Standard Operating Procedure with bank enhancements introduced to encourage uptake of shifts. • E-roster system in place and linked Safer Care IT system being used to match staffing levels to patient acuity. • Ward assurance process for identifying 'at risk' wards which are under resourced or under performing in place including Hard Truths processes • Risk assessments in place • Nursing and Midwifery Group, monthly meeeting reviews operational issues, strategy and seeks assurance	First line Gold Command meetings review of nurse staffing shortages Divisional business meetings and PSQBs consider staffing levels as part of standard agenda Bi-annual review of ward nursing levels Trust recruting to fill all HCSW vacancies Embarking on international recruitment programme Second line Monthly performance meetings (PRM) review workforce reports Workforce Commitee receives updates on recruitment and retention issues. 15.2.22. Nursing and Midwifery Safer Staffing report shows improved position on qualified nursing vacancies (from 150 to 59 January 2022) though absences affecting availability). Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board September 2020 KPIs embedded in Integrated Performance Report. PSQB reports to Quality Committee Review of impact of bank pay enhancements in addressing shortages at WEB (23.9..21, 3.2.22.). From 1 April 2022 revert to previous arrangements. Third Line Performance reported into NHSE/I Assurance process with CQC colleagues - feeback from relationship wth arms-length bodies	Despite the controls in place and increased scrutiny there are occasions where capacity does not meet demand , eg managing staff sickness, managing covid positive and negative patients, increase in non elective, elective recovery and a decrease in staff undertaking bank shifts is significantly impacting on safe staffing levels. Pace of embedding all elements of the Nursing and Midwifery Strategy has been impacted by Covid response **Action:** To refocus nursing workforce on key deliverables of Time to Care **Lead:** Andrea Dauris **Timescale: Ongoing - Q4 2021/22**	Filling shifts is significantly challenging. Ward accreditation process updated Journey to Outstanding) which will include an assessment of staffing levels. Rolling out across all clinical areas over next 12 months. Plan to discusse safe staffing at the Quality Committee lead:Andrea Dauris, Associate Director of Nursing (Corporate)Q4 2021/22	Initial: 4x4 = 16 Current: 4x5 = 20 Target: 3x3 = 9

Action	Timescales	Lead
To refocus nursing workforce on key deliverables of Time to Care	Q4 2021	Andrea Dauris

Links to risk register:
Risk 6345 - nurse staffing risk

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

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11/19	Workforce Committee	Executive Director of Workforce and Organisation Dewvelopment	Being an employer of choice means we can attract, retain and develop colleagues to deliver one culture of care. Risk of not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues due to a lack of clear OD strategy and focus on development for current and aspiring leaders means that we will not be able to deliver the Trust's objectives and sustainable services for the future **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale.	• Board agreed Succession Planning approach in place for Board, being rolled out by division which links to co-ordinated talent management pipeline programme including Empower programme and Enhance talent approach -Inclusive Leadership is one of the modules within our core Leadership Development programme. Each module is a three hour education session with action to implement practical application of the learning. Check in sessions will then be held to collate evidence of the application which will enable the organisation to monitor the growth of inclusive leadership. • Workforce Committee seeks assurance on recruitment, retention and reviews key workforce indicators • New recruitment website now in place -Focused recruitment and retention work through medical, nursing and AHP workstreams provides an opportunity to review traditional methods of recruitment which includes looking at alternative roles • Work together get results to Improve programme in place provides a link to the Trust journey to being an outstanding Trust and how we will use our own internal methodology to improve patient and colleague care. -•Specific behavioural statements developed to support our values and underpin One Culture of Care • Clinical Director review complete with induction proramme developed and now in place • Development of new roles across professional groups, eg physicians associates.AHP, and widenining access programme rolled out July 2021 development of five new career ladders for apprentices alongside new strategy for Apprenticeships • Strategy for Equality, Diversity and Inclusion which will attract a wider and more diverse workforce that will understand the differing needs of our patients. • Development of specific behavipours to support 4 pillars by BAME network Development of 24/7 helpline for colleagues to receive support with their mental health including specialist psychological help if required Well being hour and appointment of 150 well being Ambassadors • Health and Well Being assistance in place for staff via bespoke psychological and mental	First line Clinicians leading of transformation programmes Recruitment to key Consultant roles across the Trust - see BAF risk 10a Workforce Committee reviews key workforce indicators at its meetings•CHuFT Awards Recognition programme, 130+ nominations from a range of grades, divisions and specialisms colleague to colleague nomination •Second line Integrated Performance Report and Workforce Committee reports show turnover of 7.98% Revalidation report to Board Workforce Committee approval of Enhance (Talent Management Pipeline) 30.9.21. Third line Investors in People (IIP)Silver Accreditation to 2021 based on assessment of the IIP principles of leading, improving and supporting. Very positive feedback from reviewer in June 2021. GMC survey of trainees is positive, with CHFT having no negatively outlying results in comparison with other WYAAT trusts. Annual staff survey saw an increase in response rate to 50.1% and a 1% increase in our overall score.	•Review medical colleague turnover following issue of annual pension statement in October 2021, action survey of consultants early November to assess impact. •lack of comparative workforce data for medical and AHP staff groups compared to nursing, due to the delayed implementation of e-rostering.	Review medical colleague turnover following issue of annual pension statement in October 2021 Lead SD Action survey of Consultants by end February 2022 to assess impact	Initial: 4x4 = 16 Current: 3x4 =12 Target: 3x3 = 9

Actions	Action, Lead, Timescales	Lead
Consultant survey re: impact of pension statements	Feb-22	Suzanne Dunkley

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
A WORKFORCE FOR THE FUTURE

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022** **Risk Category: Workforce** **Risk appetite: Low**		
12/19	Workforce Committee	Executive Director of Workforce and Organisational Development	**Risk** Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to lack of robust engagement mechanisms. **Impact** - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / Quarterly Pulse Survey	• Workforce and OD Engagement Team in place with a defined role and iterative activity programme. • Clear responsibility for colleague engagement in Assistant Director of HR portfolio. •Colleague engagement focused on listening events, friendly ear and supportive events to engage colleague offering over difficult last 18 months. • Trust appointed 150 HWB ambassadors to engage with colleagues across all services areas. • Engagement events carried out by divisions focused on services and coping with enormous challenges related to elective recovery and increasing volume and activity across the Trust. • Leadership visibility / walkarounds carried out by senior colleagues who have moved to 7/7 day working • Weekly Communication to staff by Chief Executive with Q&A session: operational update(Mondays), CHFT LIVE meeting (Wednesdays), Chief Exeutive Update (Fridays) • Freedom to Speak Up (FTSU) resource - appointed clinical FTSU guardian so that colleagues who want to raise safety concerns feel more able to do so • FTSU Ambassador network is established. • Medical CHFT's Got Talent Awards • CHuFT awards • Colleague engagement groups, now expanded to include following networks: Women's Voices, Armed Forces, Carers, International Colleagues in addition to BAME network, Colleague Disability Action Group, LGBTQ+. Network chairs meet regularly to share best practice. • Community engagement post established in engagement team works with patients and communities and links to BAME network, balancing colleague and patient experience	First line Monthly workforce monitoring meeting reviews all workforce data sets • Apprenticeship services assessed as GOOD with one area of OUTSTANDING in July 2021 Second line Workforce Committee reviews progress with colleague engagte,ent with health and well being activities / programmes. PRMs monitoring roll out of staff survey actions. Third line Quarterly People Pulse survey/ national staff survey Investors in People accreditation - Silver award to 2021. CQC rating of Good for well-led domain	Hot House events temporarily paused due to colleague unavailability (September 2021) Action: 2022 programme of hot house events in place commencing March 2022 Lead: Suzanne Dunkley Staff survey results to be shared at March 2022 Board. An action plan to respond to the required improvements and build on good practice is to be tabled. Lead: Suzanne Dunkley Timescale: 3 March 2022 Pandemic response limiting visibility of and access for leaders and managers in service areas and contact with service teams. Action: Clarity about leadership and manager visibility Lead: Executive Team Consistent understanding, appreciation and deployment of one culture of care. Action: Refresh of one culture of care principles and practices, agree actions to communicate and engage with staff	NHS Quarterly Staff Survey results (Q1 2021/22) awaited. 2021 Annual Staff survey results will be presented to Board in March 2022.	**Initial**	**Current**	**Target**
								3x4 = 12	**3x4 =12 =**	**1x4 = 4**

Action to address gap in control	**Action and timescale**	**Lead**
2022 programme of hot house events with topics identified in place. Board approved staff survey action plan. Clarity about leadership and manager visibility led by executive team. Increased awareness through enhanced communication / publicity for one culture of care	4 scheduled events, commencing March 2022. March 2022 February 2022 March 2022 onwards	Suzanne Dunkley all actions

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

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022** Risk Category: Financial / Assets **Risk appetite: Moderate**		
								Initial	**Current**	**Target**
14/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention. **Impact** - financial sustainability - inability to provide safe high quality services - inability to invest in patient care or estate	Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Prioritised capital programme. Historic delivery of the plan. Contingency set within annual plan Transformation Programme Board established with oversight of significant strategic investment, chaired by Non-Executive Director with relevant commercial experience	<u>First line</u> Oversight at Finance and Performance Committee and Board Capital Management Group reports Transformation Programme Board minutes <u>Second line</u> Business case for reconfiguration continues to progress through NHS E/I approval process <u>Third Line</u> Monthly reporting to Transformation Programme Board, Finance and Performance Committee and Board Monthly report to ICS	The long term capital spend required for HRI is in excess of internally generated capital funds. The long term plan for HRI requires additional funds from a combination of regulator approved business case, emergency capital and ICS capital. This is widely recognised and accepted by the regulators. Actual costs for cladding are not yet confirmed Lead: Director of Finance	5 year capital plans submitted to ICS but allocation process is still to be agreed. Lead: Director of Finance, Backlog maintenance costs will remain in excess of planned capital spend. No firm agreement reached with ICS for prioritisation of funds to cover cladding Price not yet agreed for CRH and remains subject to change	**4x5 = 20**	**4x3 = 12 →**	**3x4=12**

Action	**Timescales**	**Lead**
Ongoing monitoring of financial position through Finance &Performance Committee and Board Continued pursuit of agreed ICS prioritisation of cladding	Ongoing Ongoing	Director of Finance

Links to risk register: None

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022 Risk Category: Commercial Risk appetite: Moderate**		
								Initial	**Current**	**Target**
15/19	Finance and Performance Committee	Executive Director of Finance	**Risk** Risk that the Trust will not deliver external growth for commercial ventures within the Trust. (Health Informatics Service, Huddersfield Pharmacy Specials (HPS), Calderdale and Huddersfield Solutions) **Impact** - potential lost contribution	Board reporting in place for all ventures. Commercial strategies in place: THIS Commercial Strategy approved by Board September 2021 HPS Commercial Strategy approved annually at HPS Board Health Informatics Service (THIS) contract income for all customers approved and monitotred via quarterly contract review meetings Director of Finance monitors monthly budget performance Joint Liaison Committee for CHS - reviews overall CHS financial performance and reporting on commercial ventures, review of CHS commercial strategy	**First line** Individual boards (THIS, HPS, CHS) and report on performance against targets into Finance and Performance Committee **Second Line** Successful bid for digital aspirant funds to support both digital development and ongoing capital requirements. Further digital funding allocated during 2021/22 by NHS E/I.	HPS requires further capital investment to continue to grow. Exploring future commercial options. Director of Finance has written to national Director of Finance to highlight the challenge. National strategic direction for Pharmacy Manufacturing Units to be finalised and impact for HPS to be considered. Meeting, chaired by national Director for Pharmacy being established to approve next steps nationally. Lead: Director of Finance The 2021/22 financial plans for THIS and HPS are reliant on lower contributions than previous years based on known reductions in activity and trading.	HPS requires capital investment to meet its ambitious growth plans. This was discussed in Private Board workshop in December 2020. Recognised that investment is needed to deliver the commercial strategy and increased revenue returns. Further work agreed with a review at Board in 2021. External advisers appointed and report received. Awaiting decision on national direction and funding. Lead: Director of Finance	**3x3 = 9**	**3x2 = 6**	**3*2= 6**

Action		**Lead**
Ongoing monitoring of financial position through F&P and Board	Ongoing	Director of Finance
Explore future commercial options	Ongoing	Director of Finance
Consider impact for HPS once NHS E/I confirms national strategic direction for Pharmacy Manufacturing Units	NHS E/I to confirm plans and timescales	Director of Finance
Links to high level risk register: None		

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022 Risk Category: Financial / Assets Risk appetite: Moderate**		
								Initial	**Current**	**Target**
18/19 March 2020	Finance and Performance Committee	Executive Director of Finance	Risk of failure to secure the longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit –and reliance on cash suppport. Whilst the Trust is developing a business case that will bring it back to unsupported financial balance in the medium term. this plan is subject to approval and the release of capital funds **Impact** - financial sustainability - loss of financial recovery funding (FRF) - increased regulatory scrutiny - Reduced ability to meet cash requirements - inability to invest in patient care or estate	Working with partner organisations across WYAAT and ICS to identify and implement system savings and opportunities Budgetary control process with increased profile and ownership Business better than usual forum established to support-more efficient pathways. Accurate activity, income and expenditure forecasting Development of: - 25 year financial plans in support of Business Case - 5 year Long Term Financial Plan forms part of ICS financial plan Standing Financial Instructions set authorisation limits Finance and Performance Committee in place to monitor performance and steer necessary actions. Transformation Programme Board to monitor delivery of key capital schemes.	<u>First line</u> Reporting on financial position, cash and capital through divisional Boards and Performance Review meetings and WEB monthly Capital Management Group meeting receives capital plan update reports <u>Second line</u> Scrutiny at Finance and Performance Committee and Board Reports on progress with strategic capital to Transformation Programme Board (monthly) Board Finance reporting ICS have a balanced ~~H1~~ plan for 2021/22 <u>Third line</u> Monthly return to NHS E/ I Strategic Outline Business Case submitted April 2019 and 5 year plan submitted October 2019. H2 Financial plan agreed by Board and ICS.	Efficiency process for 2021/22 is in place but has not identified the efficiencies required. This has implications for future years. Competing ICS priorities for resources Progression of transformation plans are reliant on external approval and funding Impact of national workforce shortages eg. qualified nurses and A&E doctors. Key enablers to reconfiguration, e.g. Project Echo reliant upon external approval to progress. Limited additional revenue costs have been included for the development of the Reconfiguration Business Case.	Efficiency process in place but not yet identified the 2021/22 target and the savings identified are non recurrent.	**5x5 = 25**	**4x4 = 16**	**3x4=12**
Action					**Timescales**			**Lead**		
Efficiency process being developed					31.3.2022			G Boothby		
Links to high level risk register risks: None										

BOARD ASSURANCE FRAMEWORK
FEBRUARY 2022
FINANCIAL SUSTAINABILITY

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref & Date added	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING FEBRUARY 2022 Risk Category: Strategic Risk appetite: Significant**		
								Initial	**Current**	**Target**
06/20 July 2020	Transformation Programme Board	Executive Director of Finance	**Risk** Risk of climate action failure including not reducing carbon emissions across the organisation and not reducing the impact of climate change across Huddersfield and Calderdale due to a lack of behaviour change (eg travel, waste, procurement) and not embedding climate and environmental considerations in decision-making. Resulting in adverse effects on natural environment, public health, vulnerable patients, energy costs, waste disposal fees, non-compliance costs and also creating a negative impact on reputation.	CHS is rolling out Carbon Literacy Training for its senior management team and this will be cascaded to all colleague by the Environment Manager. Energy - 100% energy bought from green sources and installation of LED lighting to reduce energy consumption Signed up to NHS pledge to reduce plastic usage in hospital Leadership on climate change managed by CHS's Environment Manager and sponsored by the MD of CHS who is the Trust's lead for climate and sustainability. Green Planning Committee chaired by a NED within CHFT has been established to oversee delivery of sustainbility action plan which will report to Transformation Programme Board on quarterly basis. The Committee is attended by a range of internal and external partners and we continue to expand the membership. Reconfiguration design and build principles led by a Sustainability design brief and overseen by Transformation Programme Board. The Green Planning Committee (with approved terms of referennce) meets monthly, monitor progress against sustainability action plan, focusing on idea generation and initiatives to reduce carbon emissions, eg re-usable items. Quarterly update to Transformation Programme Board Funding successfully awarded through Salix Low Carbon Skills Fund for the development of the Trust's Heat Decarbonisation Plan. External controls - Environment Manager and MD of CHS connected into a range of West Yorkshire sustainability groups involving the WYCA, WYATT, Kirklees & Calderdale Councils. QIA procedure to be reviewed along with business case applications to ensure that a standing section for sustainability is featured and addressed in Board paper submissions.	First line Monthly monitoring of the Trusts energy consumption Quarterly Update on progress with Green Plan and Sustainability Plan to Transformation Programme Board Second line 1. Monitor against our Green Plan and Sustainability Action Plan (SAP) approved at 6 May 2021 Board meeting, following reviewed by Transformation Programme Board 8 March 2021 2. Annual Board paper on sustainability/climate change Climate change sustainability brief for the reconfiguration agreed and taken to Board 5 November 2020 Third line Working towards ISO14001 accreditation as a means of assuring environmental management systems across the CHFT	Further funding being sought for implementaiton of engineering solutions. Bid for Public Sector Decarbonisation Fund sumbitted.	CHS MD will produce an annual report to Board on climate change and progress with actions based on the action plan contained in the Green Plan.	4x4 = 16	4x3 = 12	3x3=9
Action					**Timescales**			**Lead**		
Further funding being sought for implementaiton of engineering solutions. Bid for Public Sector Decarbonisation Fund sumbitted					TBC			Stuart Sugarman		
No related risks on high level risk register										

ACRONYM LIST

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

	New risk
	Breach of risk appetite
1-6	Low risk
8-12	Medium risk
15-25	High risk

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
SD	Suzanne Dunkley, Executive Director of Workforce and OD
DB	David Birkenhead, Executive Medical Director
GB	Gary Boothby, Executive Director of Finance
JF	Jo Fawcus, Chief Operating Officer
JR	Jim Rea, Managing Director of Digital Health
AM	Andrea McCourt, Company Secretary
CP	Cornelle Parker, Deputy Medical Director
SS	Stuart Sugarman, Managing Director CHS (Seven day service lead)
BB	Brendan Brown, Chief Executive
EA	Ellen Armistead, Director of Nursing / Deputy Chief Executive
KA	Kirsty Archer, Deputy Director of Finance
ALL	All Board members

19. Ockenden Review of Maternity Services – End of Year Progress Report Presented by – Karen Spencer, Head of Midwifery

To Note

Presented by Ellen Armistead

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title of report:	Ockenden review of maternity services – one year on
Author:	Karen Spencer, Head of Midwifery
Sponsor:	Ellen Armistead, Chief Nurse, Executive Maternity Safety Champion
Previous Forums:	None

Purpose of the Report

On 25 January 2022 Sir David Sloman, Chief Operating Officer NHS England and NHS Improvement and Ruth May, Chief Nursing Officer England wrote to trusts asking them to discuss progress with the implementation of the 7 Immediate and Essential Actions outlined in the Ockenden report, the plan to ensure full compliance, and maternity service workforce plans at their public Board before the end of March 2022.

Following this progress should be shared with the Local Maternity System (LMS) and Integrated Care System (ICS.)

Key Points to Note

- During the initial self- assessment maternity services felt assured that they met all the elements of the 7 Immediate and Essential Actions (IEA's), other than those that were a new action from the Ockenden report, for example the plan to implement the Perinatal Quality Surveillance Model.
- In June 2021 maternity services were asked to submit specific evidence to provide assurance of compliance and received feedback in November 2021.
- The ensuing action plan has identified two areas for significant improvement, a coproduced work plan with the Maternity Voices Partnership (MVP) and ensuring that personal care and support plans are in place for each patient.
- Close working with the MVP has proved challenging due to the Covid pandemic though there is a new chair in place and regular meetings have been reinstated.
- Personal Care and Support Planning has been added to the electronic maternity record allowing regular audits to take place.
- The action plan to ensure full compliance will be monitored through maternity forum to PSQB.

- Maternity services remain committed to recruitment to all vacant posts.
- A gap analysis of the Strengthening Midwifery Leadership document has been undertaken, there are plans in place to recruit to a Director of Midwifery post, and whilst there is no Consultant Midwife in post there is an innovative joint appointment with Huddersfield University of a Professor of Midwifery Practice who will support operational teams to support midwifery strategy and quality improvement priorities.

EQIA – Equality Impact Assessment

Maternity services at CHFT provide care to a diverse mix of women and families. 30% of women come from a BAME background and 40% of all women reside in the areas of highest deprivation.

There is significant evidence which demonstrates that the experiences and outcomes of mothers and babies from BAME groups and those from the areas of highest levels of deprivation are more likely to be poor.

Recommendation

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

Ockenden Review of Maternity Services One Year On

Background

In December 2020 the Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust (the Ockenden report) was published. This was quickly followed by the request for maternity services to self-assess against the Maternity Services Assurance and Assessment Tool; the 7 Immediate and Essential Actions in the Ockenden Report.

In June 2021 maternity services submitted evidence for independent assessment against the 7 Immediate and Essential Actions and received feedback of the independent review on the 26th November 2021. The feedback confirmed compliance based on the evidence submitted against the evidence requested.

In January 2022 Sir David Sloman, Chief Operating Officer NHS England and NHS Improvement and Ruth May, Chief Nursing Officer wrote to trusts asking that progress against the Assurance and Assessment tool including plans to ensure full compliance with the 7 immediate and Essential Actions, and maternity service workforce plans be discussed at public Boards and shared with the Local Maternity System LMS) and Integrated Care System (ICS).

7 Immediate and Essential Actions (IEA)

During the initial self assessment maternity services were assured that with their local knowledge they met all elements of the Immediate and Essential Actions other than those which were as a direct response to the Ockenden Report. These were specifically:

- A plan to implement the Perinatal Clinical Quality Surveillance Model – the model was released on the 8th December 2020 and regular monthly meetings are now in place.
- Trusts must create an independent senior advocate role which reports to both the trust and LMS Boards – this post remains in development nationally.
- Support the development of maternal medicine specialist centres – this work continues to be developed across the ICS and maternity services remain involved in this work.
- Dedicated Lead Midwife and Lead Obstetrician for fetal wellbeing with allocated time in job plans. The roles were in place but job plans did not make specific reference to time allocated for the roles.
- Strengthening Midwifery Leadership: a manifesto for better maternity care -areas of non-compliance with the Royal College of Midwives: Director of Midwifery, Consultant Midwife.

In June 2021 maternity services were asked to submit specific documents to evidence compliance with each element of the 7 Immediate and Essential Actions. The service took the decision to be stringent in its submission taking the decision for example that if an audit was requested but not currently in place no submission would be made. The findings of the independent review were shared with maternity colleagues on the 26th November and following that an action plan was developed to meet the identified gaps.

The table below shows the percentage compliance for CHFT and the LMS as of the 26th November:

Immediate and Essential Action	CHFT % compliance	LMS % compliance
IEA1 Enhanced Safety	56%	73%
IEA2 Listening to Women and Families	41%	69%
IEA3 Staff Training and Working Together	61%	71%
IEA 4 Managing Complex Pregnancy	50%	58%
IEA 5 Risk Assessment Throughout Pregnancy	73%	68%
IEA6 Monitoring Fetal Wellbeing	56%	54%
IEA 7 Informed Consent	56%	36%

The action plan has identified two areas which require significant improvement. These are:

- Evidencing that personal care and support pans are in place for each woman – this has now been added to the Athena electronic maternity record allowing regular audits to be carried out to ensure compliance with this element.
- Coproduced work plan with the local Maternity Voices Partnership (MVP) – work with the MVP has proved challenging throughput the pandemic but there is a new MVP chair and regular meetings have been reinstated. It is hoped that MVP colleagues will be able to return to site in the very near future to support initiatives such as the 15 steps challenge and our patient feedback processes.

Other areas of non compliance related to a number of Standard Operating Procedures (SOP) and on-going audits required. Maternity services historically have used guideline documents extensively but recognise that an SOP on a page is often easier for staff to use; the audits are all in the process of being instigated.

The senior midwifery leadership team meet monthly to review the action plan and receive updates on any outstanding actions.

Maternity Service Workforce Plans

Maternity services commissioned a Birth Rate Plus Workforce Planning review and received the final report in November 2020. The review evidenced a deficit of 20wte midwives against the current budgeted establishment of 186 wte midwives required to deliver the current model of care.

In May 2021 maternity services were allocated additional funding non recurrently for 10.9 wte additional midwives. This was in acknowledgement of the deficit evidenced in the Birth Rate Plus report.

As posts become vacant the service instigates an active recruitment process however the reality is that the majority of vacant posts are recruited to annually from the cohort of soon to be graduating student midwives. This recruitment process commences in Spring of each year with all posts under offer subject to successful entry to the Nursing and Midwifery

Council Register. As a result of this the 10 additional midwifery posts funded by NHSEI remain unfilled, as are other substantive vacant midwifery posts. As of February 2022 the service currently has 20 wte substantive vacant midwife posts and the additional 10 wte externally funded midwifery posts.

A gap analysis against the RCM document Strengthening Midwifery Leadership; a manifesto for better maternity care has been undertaken by the Head of Midwifery. The document describes trusts having:

A Director of Midwifery in every Trust

The service does not currently have a Director of Midwifery; however, plans are in place for the role to replace that of the Head of Midwifery within the Families and Specialist Services Division.

More Consultant Midwives

The service does not currently have a Consultant Midwife; however, there is a joint post in conjunction with Huddersfield University of a Professor of Midwifery Practice. The post holder supports the midwifery leadership team through:

- working collaboratively with the operational teams to support the midwifery strategy and develop initiatives of translating research into practice.
- working with the operational teams to develop service orientated research and quality improvement portfolio that reflects local, regional and national priorities for maternity care

Specialist Midwives in every Trust

The maternity service has a range of specialist midwife posts in the service providing specialist support in terms of Antenatal Screening, Bereavement, Substance Misuse, Perinatal Mental Health, Early intervention and Support for Vulnerable women, Public Health and Health Inequalities, Breastfeeding, Practice Development, and Risk and Governance.

A commitment to fund on-going midwifery leadership development.

In terms of leadership development all Band7 Midwives and above have access to CHFT's online Leadership Development Programme.

Conclusion

Maternity services have an action plan in place to ensure compliance with the 7 Immediate and Essential Actions. The action plan is reviewed by the midwifery leadership team on a monthly basis and will be monitored through maternity forum, with escalation to the divisional Patient Safety and Quality Board (PQSB).

The midwifery leadership team are committed to a programme of full recruitment in order to continue to work towards Continuity of Carer being the default model of care form women.

The gap analysis evidences that the Trust is committed to a Director of Midwifery and staff leadership development. Whilst there isn't a Consultant Midwife in post, the joint appointment of a Professor of Midwifery Practice is an innovative approach to a senior midwifery role focusing on midwifery strategy and quality improvement.

20. Quality Report

To Note

Presented by Ellen Armistead

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Quality Report (Reporting period December 2021 & January 2022)
Author:	Kim Smith, Assistant Director for Patient Safety
Sponsoring Director:	Lindsay Rudge, Deputy Director of Nursing
Previous Forums:	Quality Committee – 21 February 2022

Purpose of the Report

The purpose of this report is to provide the Trust with ongoing oversight of the Quality agenda and the emerging issues for consideration.

It is to ensure that the Quality Committee and Board of Directors is provided with a level of assurance around key quality and patient experience outcomes. The report provides confirmation that during the COVID pandemic and as the Trusts implements its recovery programme in response to the pandemic, the processes and systems within the Trust to ensure quality and safety are fit for purpose.

To provide high level updates on the Trust's preparedness for relevant regulatory scrutiny.

Key Points to Note

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

Care Quality Commission (CQC)

CQC Inspection Actions – The Trust continues to demonstrate substantial assurance regarding the one outstanding CQC "Must Do" action. This has progressed, despite the impact of COVID-19 on all services. Planning for the next financial year is underway to ensure the actions will be address as part of the quality and financial forward view of the Trust.

Partnership Working - The Trust continues to work in partnership with the CQC by means of regular update meetings and has been able to provide assurance in relation the current position regarding Staff Health & Wellbeing, Winter Must Do's and the Trusts Recovery Plan as well as responding to CQC enquires.

Journey 2 Outstanding Reviews (J2O) - The full review programme is due to relaunch from February 2022. However, nine Journey 2 Outstanding Reviews have taken place to date. All visted wards have action plans in place to ensure progress is made against any non-compliance, with monthly meetings established to ensure that there is senior oversight and scrutiny of all action plans by regular reporting into the CQC and Compliance Group.

CQC Insight report - The most recent CQC Insight Report was published in January 2022

with the previous report published in November 2021. The report indicated that CHFT remains an outlier in relation to Central Alert System (CAS) alerts, however, the Risk Team have now implemented a revised process resulting into alerts completed within timeframes and the Trust receiving positive feedback from the Clinical Commissioning Group. The insight report indicators and outliers continue to be monitored via the CQC and Compliance Group and to ensure action plans are in place to address any concerns.

Dementia Care and Screening

CHFT has been working closely with colleagues in Bradford to develop comprehensive care plans for colleagues to follow for patients with a diagnosis of dementia. Separate delirium care plans are also being developed. This will be link with dementia screening compliance to ensure a robust process in place as well as additional training and guidance being implemented for new medical staff.

There has been a decline in dementia screening compliance and therefore, this has been added onto the risk register to ensure there are clear action plans and an explicit process for oversight and scrutiny. Actions to address this so far are educational packages developed for medical colleagues to support them to understand the importance of dementia screening and impact on patient experience, as well as daily communication regarding any overdue dementia screens shared with senior clinicals to prompt completions of dementia screening tool. The Dementia Operational Group is reviewing the Dementia Strategy in line with the quality priorities.

Patient Experience, Participation, Equalities

A Quality Improvement Manager was appointed in January 2022 who is implementing focused Friends and Family Test (FFT) 'Target Days' during February and March. The aim of this work is to increase number of patients completing the FFT, advise patients and colleagues how the data from the FFT is used and increase staff confidence in asking patients to review the care they received at CHFT. The outcome of this will be reported to Patient Experience Group to identity lessons learnt.

As part of the implementation plan of The Carers Strategy for CHFT, an action plan has been developed which will be submitted to the Patient Experience Group in March 2022. The key areas it addresses are: -

- Raising the profile of Carers
- Education, training and Information
- Service Development
- Person Centred Well-coordinated care
- CHFT the employer

The Carers Passport will also be launched in June 2022 (Carers Week).

Patient Advice and Complaints Service (PACS)

The Making Complaints Count (MCC) steering and operational groups have been reviewed to ensure effective use of colleagues' input across both groups. A Task and Finish Group has been established and six sessions have been scheduled to focus on Quality, Performance and Learning. Outcomes from this so far are the implementation of a training needs analysis, and a specific intranet page is underway which will contain "how to guides" to support teams with completing complaint responses, which also include patient centred standard statements to ensure consistency of approach.

The role of patient experience and quality support leads have been revised to increase the 'improvement' element of the role, an action learning set approach is in place for these colleagues with support from the Head of Complaints and the Patient Advice and Liaison Service (PALS).

A review of the complaints team has also taken place with an additional interim band 7 role now in place to provide additional oversight and scrutiny.

Legal Services

Considerable work has been undertaken by the team to reduce the inquest portfolio (total down from 179 to 76); however, this has been impacted by some of the approach within the Bradford Coroner's Office. The Acting Head of Legal, Executive Medical Director and Executive Director of Nursing will be meeting with the Senior Coroner in March 2022 to establish a line of communication with the Coroner's Office and agree a more productive and efficient working relationship moving forward.

A new process has been agreed with the divisions to ensure that they are aware of any new claims or inquests requesting a statement (for information and appropriate escalation), to enable them to respond in a timely manner.

The team are looking to incorporate learning from Inquest and Claims and GIRFT (Getting It Right First Time) into the new processes. Legal Services are planning to link in with speciality GIRFT Leads and divisions across the Trust on a quarterly basis in relation to claims and inquests. Whilst there are already established links in some areas, the aim is to standardise this engagement to ensure a constant approach.

Incidents

There have been 927 incidents total reported in January 2022, which is an increase from 812 reported in December 2021. 10 incidents resulted in severe harm or death in January 2022 compared to five incidents in December 2021, with one incident meeting the threshold for reporting externally on StEIS (Strategic Executive Information System) and two in January 2022 meeting the threshold.

The Risk team have reviewed the management of serious incidents and is focusing on historic serious incidents which have outstanding actions. This is being undertaken alongside work within the divisions to manage outstanding actions.

There is recognition of the operational pressures and the impact this is having on the management of serious incidents. The risk team continue to provide support to clinical teams. The risk team have good oversight of serious incidents and continue to work closely with the divisions to support a consistent process across the Trust and ensure all actions are responded to in a timely manner, with robust evidence.

No further Never Events have been reported during December 2021 and January 2022.

Lesson Learnt from Serious Incidents

Specific themes and trends from serious incidents are identified as:

Some of the policies and procedures required a refresh to ensure they were explicit regarding roles, for example the Standard Operating Procedure for the Frailty Coordinator has been redistributed to all colleagues for clarity, and adherence to the Standard

Operating Procedure for escalation to avoid 12-hour trolley has been reiterated and included as part of Safety Huddles.

Clinical risk assessment tools are implemented and actioned by colleagues, with adherence to best practice guidelines to support this. This is monitored on daily board rounds.

The handover of care between teams is effective and patient centred by ensuring use of the SBAR (Situation, Background, Assessment, Recommendation) tool.

Medicine Safety

The Medication Safety and Compliance Group (MSCG) continue to raise awareness of the importance of safe storage, prescribing and administration of medication. The priority MSCG work streams are development of an electronic recording solution for controlled drug (CD) registers to improve CD documentation and compliance with legislative requirements. Final version has been released which is due to go live across in all areas March 2022.

Phase 1 of installation of electronic medication storage cabinets has taken place. This first phase is to install cabinets in the Emergency Departments (EDs) to ensure robust storage facilities, reduce risk of medication error selection, reduce risk of medication diversion and free up nursing time to care. Omnicell cabinets have been installed in the ED at HRI and due to be installed at CRH in March 2022.

Active temperature monitoring for medication stored in fridges (phase 1) went live on 17th January 2022, with the expansion of system to include ambient temperature monitoring (phase 2). Ward-based staff will be trained on the new Stanley system and once over 70% of colleagues have completed the training in a clinical area, the manual monitoring system in that area can be stepped down.

It has been noted that there has been reduced compliance with the Trust mandatory medicines management training. A deep dive of this highlighted that not all colleagues who should be completing the training are registered to do so. This requires urgent review to provide assurance that the relevant training can take place. The Quality Committee is asked to provide oversight and scrutiny of this.

Lack of quoracy at MSCG, due to gaps of divisional / cancellation of last meeting due to operational pressures continues to be of some concern. Assistant Directors of Nursing (ADNs) have been asked to ensure a deputy is nominated to attend if they are unable to do so, to ensure consistency of approach.

Maternity Services

Ockenden report - The service continues to work through the action plan developed as a result of the independent review of the evidence the service submitted against the seven Immediate and Essential Actions.

Year 4 of the NHS Resolution Scheme was suspended for a period of three months in December 2021 in response to the ongoing challenges in healthcare. However, the service has continued to work towards the 10 safety actions.

There are currently six open Healthcare Safety Investigation Branch (HSIB) investigations, the service is awaiting the final reports from these.

In relation to the Perinatal Mortality Review Tool Quarter 3 report, it notes that there have been seven stillbirths in the reporting period. Of these, two women were unbooked for

pregnancy care; two neonatal deaths in the reporting period; one baby had known congenital abnormalities which were incompatible with life; one baby had anomalies highlighted on ultrasound scan and further abnormalities identified at birth.

Maternity staffing remains challenging, however, CHFT compare favourably with other Local Maternity System (LMS) maternity services. This is reported by quarter on the maternity dashboard.

Quality Priorities

The Trust has continued to focus on its quality priorities. There remain several priority indicators with limited assurance as progress has been limited due to the pressures within teams. However, a review of the evidence to support all quality priorities has commenced by the Assistant Director of Quality and Safety to ensure that effective reporting arrangements remain in place and that divisions are supported to ensure that the underpinning evidence is in place. The following updates are provided: -

- In relation to reduce waiting times for individuals in the Emergency Department, a new incident report format for 12-hour length of stay has been implemented by the Risk team. A surge and escalation standard operational procedure in now in place, ensuring wide communication between all on-call elements and tactical leads.

- There has been a reduction in the incidence of hospital-acquired pressure ulcers from November to December 2021. During December, the Trust witnessed high patient acuity and frailty, high numbers of patients with pressure ulcers at end of life and high levels of moisture-associated skin damage, which places an individual at greater risk of pressure damage. Actions to address this are: -

  - Divisional Associate Directors of Nursing are reviewing all pressure ulcers acquired on enhanced ward dashboards on a weekly basis.
  - Surgery and Anaesthetic services division linking with Continence service to improve bladder and bowel care.
  - The Trust has submitted a bid for an additional £65k for alternating pressure mattresses to ensure patient need is met and allow for decommissioning of old mattresses.
  - The new Policy for the Prevention and Management of Pressure Ulcers is currently being ratified.
  - The Medical division are 'releasing time to care' to Matrons enabling closer monitoring of quality standards at ward level. Matrons will be allocated clinical, patient-facing time each day.
  - 'Minimise Moisture' awareness week to be held in March 2022 to improve standards of care in the prevention and management of moisture damage.

- Falls prevention intervention care plans have been created and will be disseminated across the wards. The falls collaborative are currently working with the Communications team to create this. This care plan will eventually be uploaded onto the Electronic Patient Record (EPR) so that all colleagues can access this. The Falls policy has been updated to reflect specific timeframes for assessments and learning from Serious Investigations will be disseminated through the Falls Collaborative.

- In relation to Hospital-acquired Infections (HAIs), CHFT are compliant with the minimal national patient testing regime and also include additional tests as part of local guidance and COVID-19 testing compliance is 92%, an improvement of 6%. Specialised clinics have been established to support people with a learning disability to receive their

vaccines and will be included in future planning.

- In relation to the recognition and timely treatment of sepsis, category 2 patients in the emergency department have now been seen in rapid assessment area at HRI rather than waiting for a cubicle. This has improved treatment times for patients. Sepsis trollies have been moved into Resuscitation area of the Emergency Department (ED) to assist in speeding up administration of intravenous antibiotics as the sickest patients are treated there and the Sepsis nurse is delivering training to ED staff on teams twice weekly.

- A 7-day service has been implemented working across community services for End-of-Life Care Patients and the Bereavement Service recently won Overall Winner at the Patient Experience Network National Awards (PENNA), plus a win in the personalisation of care category and runner up in the staff engagement and improving the staff experience category.

EQIA – Equality Impact Assessment

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

This report considers the impact on all 'protected` groups under the Equality Act 2010 including parents/carers and/or socio-economic groups.

It is not anticipated that the contents within this report will have a detrimental impact on any of the protected characteristics but seeks to give the assurances that as a Trust we are doing everything in our power to reduce risk and ensure high quality and safe care for all to include improvements for dementia screening for our patients aged 75 and over.

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

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

Recommendations

The Board of Directors are 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

Bi-monthly reports *(December 2021 and January 2022 data)*

1. Introduction

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

The paper seeks to brief the Quality Committee and 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 and assurance required.

This report provides an update on assurances against several quality measures for December 2021 and January 2022: the progress updates for the Quality Account Priorities and the Focussed Quality Account Priorities for 2021/2022.

The Quality Committee continues to provide the scrutiny, monitoring and assurance on the quality programmes that are in place within the Trust. The Committee has and continues to recognise the challenges that has been placed upon the Trust during the COVID-19 Pandemic and continues to acknowledge the hard work from all colleagues to continue to provide one culture of care for patients and colleagues. As we implement the recovery programme it is more than ever important that as a Trust, we are sighted on the quality agenda and any associated risks.

2. Care Quality Commission (CQC) workstreams

During December and January 2021, the CQC workstreams have continued to be guided by the continuous engagement with the Trusts CQC Relationship Mangers, Trust's recovery plan, and national guidance.

2021/22 CQC Exceptions Action Plan – Update on 'Must Do' & 'Should Do' Actions

Of the outstanding actions from the 2018 CQC inspection, the Trust now has one action to complete.

In brief the one 'must do' action is not yet embedded in the Trust and remains incomplete pending further consideration of the quality and financial position of the Trust as set out in Table 1.

The outstanding action is due to be presented at the March 2022 for consideration to be closed.

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

Table 1

Compliance	Current Position	Further Actions	Assurance
MD1 - The trust must improve its financial performance to ensure services are sustainable in the future	The Trust's submitted draft financial plan for 20/21 was in line with the required five-year Financial Improvement Trajectory, this plan was overridden subsequently due to Covid-19. The Month 5 reported position was break-even, based upon the temporary financial regime in place to support Covid pressures. Very long-term strategic recommendation, the plans linked to this were around reconfiguration. We continue to progress but due to current environment we are breaking even on a month-on-month basis to support Covid activity. Planning for the next financial year is taking place	This action is a long-term action which continues to progress a further update is scheduled to be received at the March 2022 CQC & Compliance Group.	**Substantial Assurance**

CQC Engagement Meeting

Regular catch-up meetings between CQC and CHFT have continued to take place throughout the COVID-19 pandemic with both the Acute and Community Healthcare Services. These catch ups are scheduled to continue quarterly with the last full engagement meeting taking place on 10th December 2021.

The interim Director of Nursing and Chief Operating Officer updated CQC with assurance and current position in relation to, Staff Health & Wellbeing, Winter Must Do's and the Trusts Recovery Plan.

Updates were shared regarding current position with all open enquiries as set out below:

13 Enquiries closed in the reporting period.
Currently 3 Open Enquiries.

1 x Serious Incident
1 x Safeguarding Concerns
1 x HSIB Reportable Incidents

CQC informed CHFT Colleagues that the organisation would be getting a new Inspection Manager & Relationship Manager from February 2022. The change is due to team changes in portfolios at CQC.

Wendy Dixon will be the new Inspection Manger; she will also be the inspection manager for all NHS Trusts with the West Yorkshire Integrated Care System. The new Relationship Manager will be Stephen Purvis who we have been informed is new to CQC.

An informal meeting with the new CQC team is scheduled to take place 16th February 2022 with the next planned full engagement meeting due March 2022.

Journey 2 Outstanding Review

One Journey 2 Outstanding (J2O) Review was undertaken in December 2021. Due to the operational and staffing pressures during January 2022 a decision was made to suspend the scheduled J2O reviews. The full review programme is due to relaunch from February 2022.

- **Reviews to Date**

Nine Journey 2 Outstanding Reviews have taken place to date on, Appendix 1 sets out the overall compliance on each Ward visited.

All visted wards have action plans in place to ensure progress is made against any non-compliance. Monthly meetings have been initiated within the division of Medicine to ensure Ward Managers and Ward Matrons are held accountable for all action plans.

Divisional Associate Directors of Nursing are scheduled to give bi-monthly updates regarding action plan progress and compliance against recommendations at the CQC & Compliance Group.

- **Challenges**

There have been ongoing challenges to ensure medical colleagues are involved in the J2O reviews both from a review team perspective and to be interviewed as part of the inspection. This is mainly due to operational pressures.

This is to be discussed at the next Clinical Directors forum in February 2022.

- **J2O Review Next Steps**

Now the Ward based J2Os are established across the organisation plans are in place to develop the J2O toolkit to fit other services across the trust. Priority areas for Q4 2021-22 include:

- Children & Young Peoples Services – pilot scheduled February 2022
- Community Services (Health Centres) – pilot scheduled March 2022

CQC Insight Report

The most recent CQC Insight Report was published in January 2022 with the previous report been published in November 2021. The insight report indicators and outliers continue to be monitored via the CQC and Compliance Group.

CHFT Performance Summary:

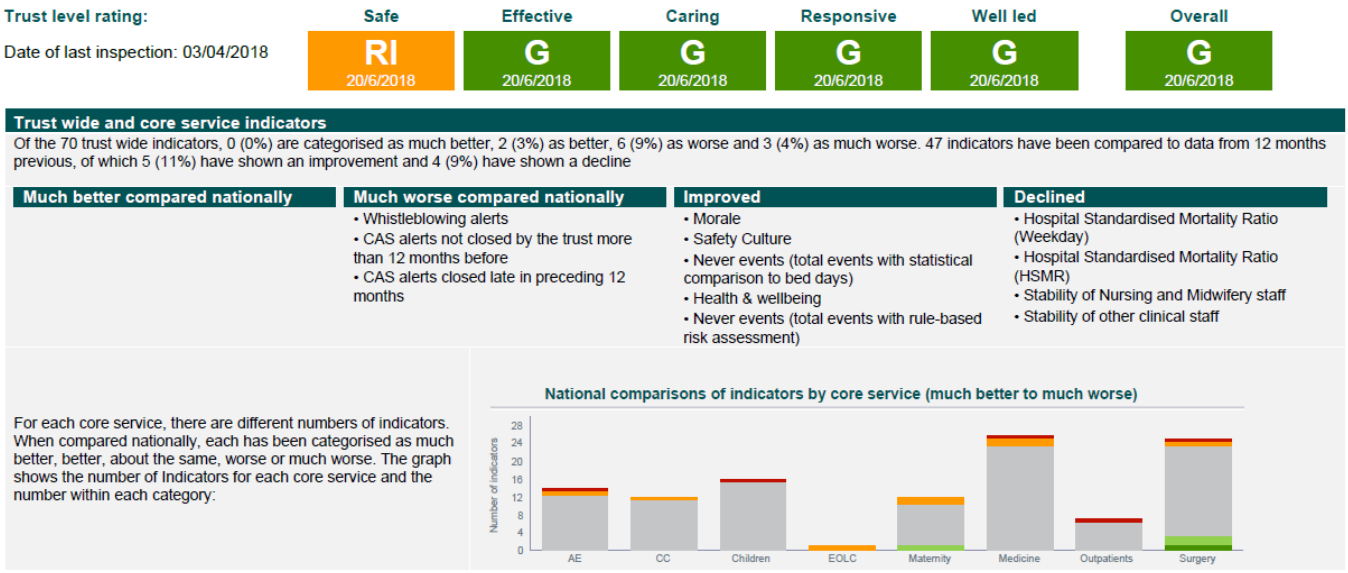
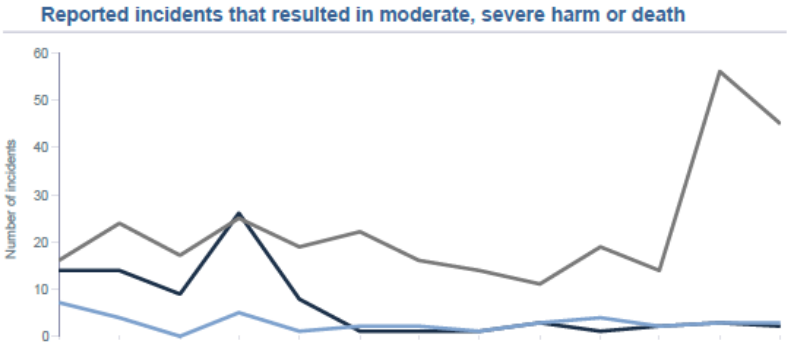


Table 2 sets out the key points to note within the published CQC Insight Report. Bi-monthly assurance updates continue to be received at the CQC & Compliance Group.

Table 2.

CQC Insight Report Indicator	Key points to Note
A&E Attendances admitted – 12 months to August 2021 - +70%	Significant increase of +70% attendees in A&E from August 2020 – August 2021. This shows the increase in demand within the department during the pandemic period.
CAS Alerts Outlier	Jan 22 published report still shows CHFT as an outlier. This should improve from next report due to the extensive which has been undertaken by the risk team to close overdue and open CAS alerts within timeframe.
Whistleblowing January 2022	Report states that one or more whistleblowing concerns have been raised to CQC in January 2022. These have not been reported to CHFT from CQC therefore query has been raised with CQC.
Emergency Readmissions Acute and Unspecified Renal Failure – 12 months to June 2021 – 142.4	100 is national average. CHFT is reporting 142.2 readmissions with renal failure. Further assurance needed to ensure this has been followed up by appropriate team.
Emergency Readmissions Septicaemia – 12 months to June 2021 – 136.8	100 is national average. CHFT is reporting above at 136.8. Further assurance needed to ensure this has been followed up by the appropriate team.
Incidents with moderate harm increased September/October	Moderate harm incidents increased in September & October 2021 see figure 1.
SHMI 105 – 100 more deaths than expected 12 months to June 2021	100 more deaths than expected in 12 month reporting period. Cornelle aware and actioning.
HSMR 93.26 – 88 less deaths to June than expected 12 months to June 2021	Less than 100 but gradually increasing.

Figure 1.



	Year-month	2020-10	2020-11	2020-12	2021-01	2021-02	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	2021-09	2021-10
	1. Death	14	14	9	26	8	1	1	1	3	1	2	3	2
	2. Severe	7	4	0	5	1	2	2	1	3	4	2	3	3
	3. Moderate	16	24	17	25	19	22	16	14	11	19	14	56	45
	4. Low	163	168	149	164	148	136	120	103	169	170	158	164	185
	5. No Harm	856	845	739	839	782	852	735	827	809	690	649	822	931
	6. Total	1,056	1,055	914	1,059	958	1,013	874	946	995	884	825	1,048	1,166

CQC & Compliance Group

The CQC & Compliance Group continues to meet monthly, in recent months the meeting has had poor attendance. The meetings terms of reference are now due for annual review giving the opportunity to relook at the meetings attendees, purpose, reporting and function within the CHFT governance structure.

The review of the groups terms of reference links to two other key workstreams to review the organisations Divisional Compliance Registers and External Inspection & Review policy.

The plan is to review the three workstreams as a whole to ensure robust processes, reporting and governance are in place to ensure Compliance and Assurance is embedded across the organisation. This workstream will commence from February 2022.

Appendix 1.

Traffic Light Score
GREEN - 90% and above
AMBER - 80- 89%
RED - 79% and under

	Ward 8B CRH	Ward 5 HRI	Ward 17 HRI	Ward 20 HRI	Ward 22 HRI	Ward SAU HRI	Ward 6C CRH	Ward 18 HRI	Ward 19 HRI
	Surgical Head & Neck	Medicine Elderly Care	Medicine Gastro	Medicine Elderly Care	Surgery Urology	Surgery SAU	Medicine Cardiology	Medicine Isolation Acute	Surgery Orthapedics
	Date: 17th to 21st May	Date of J20: 14th to 18th June	Date of J20: 5th to 9th July	Date of J20: 27th Sep to 1st Oct	Date of J20: 4th to 8th Oct	Date of J20: 11th to 15th Oct	Date of J20: 8th to 12th Nov	Date of J20: 22nd to 26th Nov	Date of J20: 6th to 10th Dec
Pre-Inspection Data Review	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Onsite Observations	87%	77%	70%	96%	87%	88%	89%	95%	90%
Night Matron Observations	N/A	N/A	N/A	N/A	N/A	100%	95%	98%	N/A
Medicine Management Audit	88%	75%	94%	97%	83%	89%	95%	93%	93%
Ward Manager Engagement	73%	89%	91%	89%	85%	86%	93%	99%	90%
Medic Engagament	58%	73%	77%	N/A	N/A	N/A	N/A	N/A	N/A
Staff Engagement 1	84%	77%	71%	93%	93%	94%	90%	100%	98%
Staff Engagement 2	N/A	97%	65%	94%	89%	91%	95%	99%	82%
Patient Record Audit	91%	80%	72%	83%	75%	92%	84%	85%	88%
Observe & Act	Good	Requires improvement	Requires improvement	Good	Good	Good	Good	Good	Good
Overall Compliance Score	80%	81%	77%	92%	85%	91%	92%	96%	90%

3. Dementia Screening

Dementia Screening Compliance

Month	Jan-21	Dec-21	Nov-21	Oct-21	Sep-21	Aug-21
Trust %	23.08%	28.74%	37.6%	44.15%	46.32%	36.90%
FSS %	0%	-	-	-	-	-
Medicine %	24.93%	29.27%	39.18%	45.68%	49.10%	39.70%
Surgical %	13.24%	25.93%	27.87%	37.35%	35.96%	22.78%

There has been a decline in screening compliance; however, this may link to the new rotational medics starting and plans are in place to increase compliance these include:

- A Standard Operating Procedure (SOP) has been circulated to the new rotational medical colleagues and has been added onto Padlet for medics to review in their own time.
- A daily email of the list of patients with an overdue dementia screen is sent out to consultants/ward managers/ward sisters and matrons of the assessment units to prompt medical staff to complete.
- A "Dementia Screening – What is it and why do we do it?" educational package has been developed for medical colleagues to support them to understand the importance of dementia screening and impact on patient experience. This has been presented at the induction for all new rotational medics and is uploaded on the Intranet for colleagues to view.

Dementia screening has been added onto the risk register (risk no 8093). As screening compliance is improving, the risk will be reviewed accordingly. However, risk remains as compliance not yet achieving the 90% target. Working with the matron for the Acute Floors to improve screening compliance.

Dementia / Delirium Care Plan:

Have met with Bradford Dementia Lead to create a more in-depth care plan for staff to follow for patients with a diagnosis of dementia. Separate delirium care plan also in process of being developed. Aiming for care plans to be triggered through Dementia, Delirium and Depression screen. This is ongoing as it needs to be linked with dementia screening compliance.

Dementia Training Compliance – Target 95%

	December 2021	January 2022
Community	97.87%	97.42%
Health Informatics	98.68%	99.57%
Pharmacy Manufacturing	100%	98.53%
Corporate	97.85%	98.97%
Families & Specialist Services	97.25%	97.82%
Calderdale & Huddersfield Solutions Ltd	97.96%	98.20%
Medical	95.01%	95.28%
Surgery & Anaesthetics	95.33%	95.79%
Central & Technical	92.86%	87.50%
Grand Total	**96.59%**	**96.88%**

Dementia Operational Group:

Last meeting January 2022 – developing links with South West Yorkshire Trust and Yorkshire Ambulance Service. Next meeting planned February 2022. The Dementia Operational Group is reviewing the Dementia Strategy in line with the quality priorities.

Dementia Lead Role:

Reviewing patients daily on elderly care wards who have delirium and dementia in relation to their care needs, Deprivation of Liberty Safeguards (DoLS), capacity assessments and discharge planning, providing advice and guidance to staff where required. I have noted an increased number of referrals through which is positive. Feedback received so far has been positive, aiming to increase the number of referrals received. In process of developing a dementia specific care plan with Bradford Dementia Lead, this is ongoing.

Person-Centred Dementia training:

This is currently placed on hold whilst a review is undertaken. Working with Clinical Lead for Enhanced Care to develop ward-based person-centred care training. This is ongoing.

4. Patient Experience, Participation and Equalities Programme

<table>
<tr><th>Project</th><th>Summary</th><th>Current position January</th><th>RAG rating</th></tr>
<tr>
<td>1. Friends and Family Test (FFT) changes:

Project leads: Quality Improvement Manager and FFT divisional leads

Evidence for change: Revised question and restart following suspension</td>
<td>• The national FFT question was due to change on 1st April 2020, with the question being revised from a one which asked whether patients would recommend the service to friends and family to one which asks how patients would ‘rate’ the care they received.
• However, notification was received 30th March 2020 to advise that in order to reduce the burden and release capacity to manage the COVID-19 pandemic that the submission of FFT data to NSHE&I was to be suspended from all settings until further notice.
• Where SMS messaging was used to capture responses (OPD and ED) this could be continued. In these areas, useful feedback was received to indicate whether changes implemented to address the pandemic were providing an experience that met patient needs
• Notification was received from NHSE&I that the submission of FFT data was to recommence with effect from December 2020
• The reporting format has moved away from response rates with a greater focus on driving improvement, supporting comments of what went well and what can we do better will help to inform the improvements
• Numbers of responses have been low for inpatient, community and maternity services, low figures relate to staffing pressures and priorities, along with adapting to new processes; higher numbers achieved in the ED and OPD where SMS messaging is the main method of response</td>
<td>The Quality Improvement Manager will undertake some FFT ‘Target Days’ During February and March. The purpose of this is to increase the number of patients completing the FFT, advice patients and staff how the data from the FFT is used and increase staff confidence in asking patients to review the care they received at CHFT. Findings will be shared with Patient Experience and Caring Group (PEG) and at Patient Safety and Quality Board (PSQB) meetings.

Target FFT target days:
• Maternity
• Community Midwife
• Gynaecology
• Urology

Increasing the numbers of patients completing the FFT and learning from the feedback will continue to be a priority for 2022/2023

Positive Response Rates:
<table>
<tr><th></th><th>November</th><th>December</th><th>January</th></tr>
<tr><td>In-Patients</td><td>97.4%</td><td>97%</td><td>97.2%</td></tr>
<tr><td>Outpatients</td><td>92.5%</td><td>93%</td><td>92.3%</td></tr>
<tr><td>A&E</td><td>82.3%</td><td>84.4%</td><td>86.3%</td></tr>
<tr><td>Maternity</td><td>93.6%</td><td>97.2%</td><td>96.1%</td></tr>
<tr><td>Community</td><td>96.5%</td><td>94.4%</td><td>96%</td></tr>
</table>
% of Patients Completed Responses
<table>
<tr><th></th><th>November</th><th>December</th><th>January</th></tr>
<tr><td>In-Patients</td><td>4%</td><td>3.6%</td><td>3.2%</td></tr>
<tr><td>Outpatients</td><td>3.7%</td><td>3.3%</td><td>3.7%</td></tr>
<tr><td>A&E</td><td>7.6%</td><td>7%</td><td>4.4%</td></tr>
<tr><td>Maternity</td><td>0.9%</td><td>0.6%</td><td>2%</td></tr>
<tr><td>Community</td><td>0.6%</td><td>1%</td><td>0%</td></tr>
</table>
</td>
<td>Reasonable Assurance</td>
</tr>
</table>

2. Reducing noise at night (from staff): ***Project leads:*** Janette Cockroft / Felicity Astin ***Evidence for change:*** National inpatient survey, Exemplar ward audit, Joint research project with university of Huddersfield	The results of the 2020 inpatient survey (patients discharged in July 19) identified the following question about noise at night as scoring low, when benchmarked with other Trusts was 'Were you ever bothered by noise at night by hospital staff' The Trust had previously collaborated with the University of Huddersfield on a joint research project to explore the characteristics of night-time noise levels and in-patients' self-reported sleep. An opportunity was taken to use this knowledge to develop an improvement package, which included: • Educational online resource • Presentations at key meetings • Posters for wards • Ward based 'sleep champions' • Resources promoted through Trust 'comms' • Clinical waste bin selection (soft-close) • Looking into use of noise metre • Adding information to elective surgery letters about ear plugs The Professor of Nursing leading the research influenced a revision to the National survey question, changing to one that is more focused on sleep: Were you ever prevented from sleeping at night by any of the following? • Noise from other patients • Noise from staff • Noise from medical equipment • Hospital lighting • Something else • None of these **Plans for 2021/22** • Work with individual ward managers and the nominated sleep champions to fully embed the improvement package, to include measurement of compliance and impact	**12.1.22 Update from JC** Bin Evaluation: At both hospital sites to obtain feedback from clinical staff regarding 3 different models of bins, that are improved design than the current Wybone bins that are widespread within the trust and not the bin of choice. The Business Case for Commercial Investment Strategy Group (CISG) meeting 27 January 2022. There does appear to be an issue with procurement and the option appraisal but not yet sure of an update. Next meeting for working group 13.1.22 **Ongoing Improvement Work**: Louise Taylor (night matron) will meet with ward 12 staff to talk about next steps. Actions: • Pilot the bins on ward 12-issue has arisen with the standards size of orange offensive waste bags not fitting the pilot bins this is still with procurement • Collection of patient baseline data using paper surveys at ward level: • Improvement interventions: Ensure Posters - Reducing noise at night are on display and the team have read them; aim to get all staff to view the 8-minute educational video over next 2 months and encourage them to email pledges as instructed in the video.	**Reasonable Assurance**

3. Volunteer work - Front of House – meet and greet service and safety guardian (NHSEI funded projects ***Project leads:*** to be revised due to new accountability structure with the Quality and Safety Team ***Evidence for change:*** Patient feedback	• Successful bids made to the NHSE&I 'winter and covid 19 volunteering programmes', has created an opportunity to fund temporary co-ordinator project posts within the Quality Directorate. • The purpose of the NHSE&I funding is to support the use of volunteer services in order to reduce pressure on NHS staff and services. • The project incorporates a detailed induction and on-boarding programme in line with the Trust's additional governance requirements for voluntary services to maintain safety of the volunteers. This includes monitoring progress, evaluating impact, and identifying emerging volunteer leaders. Volunteer roles that form part of the project are: - Establishing and embedding a robust front of house / meet and greet service (to include monitoring of covid 19 requirements (use of hand gel, wearing a face covering, maintaining social distancing). This role will also support the 'Belongings to Loved Ones' service, once a full rota is in place - Exploring how the service can maximise the opportunities to support patients and carers on discharge from hospital - Introducing ward based 'safety guardians' to work as part of the clinical team to provide 'eyes on' support • The pilot Front of House rotas have now commenced, running over four mornings, the volunteers are providing feedback after each session based on reflection at the end of their shift re their observations of good practice, along with any concerns they encountered / noted	The Volunteers have made a significant improvement to the front of house at both HRI and CRH. Evidence has shown us that volunteers help on average 100 patients per shift. **Volunteers have helped with:** • Helping patients navigate around the hospital grounds to their appointments • Reminding patients and visitors about the importance of wearing masks • Signposting patients • Conveying patients in their wheelchairs to their appointments (this is following training) freeing up porting staff. • Collecting equipment for wards **Insight shared from Volunteers**: • If department moves/ closures happen, this information is not always cascaded onto volunteers and/or reception staff • Appointment letters do not always make it clear where a patient should go on their appointment, this could result in patients arriving late for appointments • Changes in relation to Covid visiting arrangements should be made clear to volunteers The Volunteer programme has now been completed and handed over to Workforce & Development.	**Substantial assurance**

8a. **Volunteer bid – Ward Volunteers** ***Project leads:*** Liam Whitehead ***Evidence for change:*** Staffing levels / workforce data	The role of the 'Ward Volunteers" s' has been explored with ward managers to gain an agreement of suitable tasks, these include answering telephones, sitting with patients, supporting mealtimes and being involved in the 'time to clean' sessions **Plans for 2021/22:** • Commence a recruitment campaign for new volunteers, along with revisiting the readiness for existing volunteers who are currently not back in the Trust to return as government restriction are relaxed. All placements are based on an advanced safety check and Occupational Health agreement. • Align the services with the existing volunteering services in the trust, embedding and sustaining the volunteer role – develop processes that will enable the project co-ordinators to walk away from the project with the volunteer positions functioning effectively within the trust and being recognised as an essential part of the ward's workforce model	Workforce & Development have commenced the full roll out of the Ward Volunteer Programme. Since commencing this pilot 37 ward volunteers have commenced the posts, with an additional 40 due to commence from St John's Ambulance. Assistance Volunteers have provided: • Support with nutrition and hydration: - Under supervision offering support to serve meals refreshments and snacks, offering support or prompting patients to eat (for example helping to ensure food is cut up, opened and accessible). Keep patient and staff water jugs filled and provide tea and coffee. Making drinks for staff. Supporting in the 7 drinks a day round. • Befriending/patient support: - Offering support to patients – talking to, and interacting with patients to promote their wellbeing, recovery, safety and comfort on the ward. Reading to patients or supporting them with individual activities, where appropriate. Alert staff when buzzers need answering • Cleaning and restocking of areas: - helping to restock equipment, Personal Protective Equipment and supplies, 2 hourly touchpoint cleaning.	**Substantial assurance**

4. Making complaints count ***Project leads:*** Emma Catterall/ Divisional complaint leads ***Evidence for change:*** Local reviews / PHSO standards	**Plans for 2021/22** Initial project milestones are focused on: • Gathering user experience and feedback • Capturing a wider data set of patient characteristics – to better understand the differing needs of our communities • Improving data quality, including a staff education programme, improved internal communications, and improving the quality of complaint responses • Developing a standard operating procedure for the complaint's pathway in line with the Parliamentary and Health Service Ombudsman (PHSO) standards	The trust has now reached 200 open complaints. Task and finish groups have set up to help address the following: • Quality • Learning • Performance Divisional representatives have attended the sessions, which are due to end in March 2022.	**Reasonable Assurance**
5. Commitment to Carers ***Project leads:*** Quality Improvement Manager ***Evidence for change:*** National guidance	An assessment of the NICE guidance - supporting adult carers, has been used to direct the priorities for the Trust, which includes developing processes to involve carers more fully and for them to be seen as partners in care: • Identifying unpaid carers • Referring carers to 3rd sector carer support organisations (who will take responsibility to refer for formal carer assessments and signpost carers to information and support • Recognising carers in the Trust (via a lanyard and ID card) and providing them with support such as reduced parking rates, refreshments, discounted meals and access to the ward. Also agreeing involvement in care and treatment discussions (with patient consent) Contacts have been made from within the local community to explore more effective ways of working together: - West Yorkshire and Harrogate Health and Care Partnership carers leads	Our Carers Action Plan is in its final stages. This will be submitted through our next PEG meeting in March 2022. The Action Plan addresses: • Raising the profile of Carers • Education, training and Information • Service Development • Person Centred Well-coordinated care • CHFT the employer The Carers Passport will be launched in June 2022 (Carers Week) The Carers Lanyard will be ready for April 2022.	**Reasonable Assurance**

	- Local Authority carer leads and commissioners - Local 3rd sector service providers **Plans for 2021/22** • Set up a carers collaborative group, with champions from services such as Frailty, End of life care, Discharge, Dementia, Learning Disability, Cancer, Stroke • Review the involvement of carers post covid • Identify test wards for the project • Increase awareness in the Trust • Co-design a carers charter		
6. Caring for patients with visual impairments ***Project leads:*** Janette Cockroft / Disability Partnership Calderdale ***Evidence for change:*** Feedback from Disability Partnership Calderdale, Learning from patients and carers, SI	Group established and met via Teams – Ophthalmic colleagues, Disability Partnership Calderdale, Halifax Society for the Blind. Creating links with Kirklees visual impairment network. Propose as core project 2021/22 We started this collaborative working with Disability Partnership Calderdale, after they shared a story with us about an experience of one of their visually impaired members. We have had one meeting with them, following which they have undertaken some further engagement with visually impaired members and also with Halifax Society for the Blind. They are bringing feedback from this engagement to a meeting this Thursday (happy for someone to join if they are free (12 – 1:30 via Teams) Our aim is to identify where improvements can be made, prioritise issues raised and work together on solutions. From the Trust we have myself, one of our corporate Matrons (Janette), Sister and Matron for eye clinic and eye clinic liaison officer Also got Kirklees Visual Impairment Network attending the meeting	**CRH main hospital building and pedestrian access** Awaiting written feedback from Julie re visit to CRH site who visited with a service user (that happened a few months ago) with the verbal feedback provided, some actions were able to be undertaken in the interim ie decluttering signage, approved template (agreed with visiting team) that estates can use for changes of ward location (instead of using size 12 font on white paper which has been widespread throughout the site) Other external signage from the roadside requires funding approval. **HRI visit to Acre mill**, Sue from Kirklees visited with her guide dog to look around the site with a particular focus on the ophthalmic clinic. Julie kindly filmed the visit, and this is going to be shared with the Kirklees forum and again awaiting some feedback.	Work ongoing

7. Observe and Act ***Project leads:*** Janette Cockroft / Andy Nelson ***Evidence for change:*** Capturing real time feedback from patient perspective	• Project work commenced in 2020 to introduce 'Observe and Act' within the trust. This national 'through the patient eyes' observation / improvement tool is to be utilised virtually as part of the focussed support framework approach. • CHFT is currently testing this approach using virtual mechanisms and is the first trust in the country to test this approach. • This module will be predominately supported/ delivered by volunteers, governors, members and non-executive directors. • One of the key elements of this module relates to observing how our patients and carers with accessibility, inclusion and diversity needs are cared for. • Key findings at each observation then drives local improvement at ward level in the trust. **Plans for 2021/22** Following the initial Train the Trainer training the aim is to build capacity and capability within the trust. Further recruitment of volunteers and governors to support will be happening. Ongoing evaluation is informing implementation in the Trust and this learning is being shared nationally.	Virtual visits are still in place. Themes feedback to CQC complaints group. Positive patient experience feedback. Observe and Act / Journey to Outstanding (J2O) actions for improvement reviewed by divisions at monthly meetings.	**Substantial assurance**
Arts council	Working with communities to coproduce a solution that enables communities and individuals to tell their story in a way that meets their cultural background / preferred medium for storytelling. The people that will be supporting the storytelling to happen practically will be from our local communities e.g. local students, local businesses. Focus On: health inclusion communities **Next steps:** Meet with Arts & Health Programme Manager – South West Yorkshire Trust to scope the project	Funding has been secured to complete this. Areas to develop further: End of Life Carers Choir Children & Young People We have undertaken 5 scoping exercises. Awaiting next stages and South West Yorkshire Trust decision moving forward, but all engagement requirements have been fulfilled by CHFT to date.	**Reasonable Assurance**

5. Patient Advice and Complaints Service (PACS)

CHFT views any complaint as an extension of our service user's care and the Trust is committed to moving towards a user centric service. Effective processes and procedures for handling concerns, feedback, stories, compliments, and complaints is pivotal to organisational learning success.

Key Objectives

The Patient Advice and Complaint team's main objectives are:

Objective	Current level of assurance	Comments
1. Working with the divisions effectively to deliver strong complaints performance and user centric service	**REASONABLE Assurance**	Ongoing work with the divisions continues with a view to improving complaint responses. The Patient Experience Lead is working with the complaints team to share examples of good complaint responses.
2. Making Complaints Count & Working Together to Get Results: Delivering on collaborative action plan/ quality priority	**REASONABLE Assurance**	Good progress.

Progress against key objectives

Complaints and Patient Advice and Liaison Service (PALS) Performance Summary

	December	January
Complaints received	39	43
Complaints closed	41	30
Complaints closed outside of target timeframe	16	19
% of complaints closed within target timeframe	37%	37%
Complaints reopened *1	5	6
*1 Work is ongoing to validate this figure due to informal methods of handling further contacts on Datix		
PALS contacts received	249	259
Compliments received	79	75
PHSO complaints received	0	0
PHSO complaints closed	0	1
Complaints under investigation with PHSO (total)	6	

An increase in PALS contacts, and in compliments, is noted compared to the previous 2 months.

The percentage of complaints closed within the target timeframe continues to be an area of concern.

Making Complaints Count Collaborative

The Task and Finish Groups have commenced. The first 2 meetings have taken place: Quality of complaint response was the focus of these meetings. (Performance and Learning from Complaints to follow).

Barriers to effective completing timely and effective responses were discussed by the divisions: The complaints team have offered to meet with any staff who require support in completing their responses.

There has been further discussion about ongoing training being provided to complaint writers about quality of complaints by the legal team, and about arrangements for legal services to support in complaint response writing: Discussions about this are ongoing.

The Making Complaints Count (MCC) steering and operational groups have been reviewed to ensure effective use of colleagues input across both groups. A Task and Finish Group has been established and six sessions have been scheduled to focus on Quality, Performance and Learning.

Outcomes from this so far are the implementation of a training needs analysis, a specific intranet page is underway which will contain “how to guides” to support teams with completing complaint responses. which also includes patient centred standard statements to ensure consistency of approach.

The role of patient experience and quality support leads has been revised to increase the ‘improvement’ element of the role – an action learning set approach is in place for these staff members with support from the Head of Complaints and Patient Advice and Liaison Service (PALS).

A review of the complaints team has also taken place with additional interim band 7 role now in place to provide additional oversight and scrutiny.

6. Legal Services

Introduction

Calderdale and Huddersfield NHS Foundation Trust is committed to:

1. Promoting the highest possible standards of care for patients in an environment that is safe and effective for staff and visitors.
2. Dealing with claims that arise in a competent and consistent manner, in a culture of openness between the parties to facilitate early resolution, and thereby minimise the financial loss to the Trust / NHS Resolution (NHSR)
3. Using learning arising from claims and inquest investigations to promote improvements to the quality of care provided to patients.

Synopsis / Present position

Sarah Mather has joined the Trust as a secondee from Weightmans LLP (NHS Panel Solicitors) as Acting Head of Legal Services until June 2022. This secondment will allow the Trust time to make permanent arrangements and will provide support and leadership to the Legal Services Team in the interim.

The Legal Services Team continue under operational pressure due to the departure of the part-time Claims Handler in the team, who left the Trust in October 2021. A new legal restructure has been proposed and is to be reviewed however, a secondment is being explored in the interim for short term assistance. The proposed framework with allow for additional support and structure in both the Claims and Inquest portfolio which are experiencing high volumes of work (to handler ratio) and a considerable backlog in the Coroners Officer.

Whilst considerable work has been done by the team to reduce the inquest portfolio (total down from 179 to 76), this has been complicated by ongoing operational pressures within the Trust at every level and irregularity within the Bradford Coroner's Office. The Acting Head of Legal, Executive Medical Director and Executive Director of Nursing will be meeting with the Senior Coroner in March 2022 to establish a line of communication with the Coroner's Office and agree a more productive and efficient working relationship moving forward. It is hoped HM Coroner will agree to a monthly meeting, together with the Senior Coroner's Officer to encourage a greater and more consistent working relationship with the Coroner's Office.

Recent Data

This report covers the period **1 December 2021 – 1 January 2022**.

Clinical Negligence

- 169 active clinical negligence claims
- 11 new clinical negligence claims were received.
- 8 clinical negligence claims were concluded.
- Damages totalled £116,500

Employers' and Public Liability (EL/PL) Claims

- 22 active EL/PL claims
- 2 EL/PL claims were received

- 2 EL/PL claims were concluded
- Damages totalled £5000

Lost Property

- 14 active lost property claims
- 7 lost property claims were received
- 3 lost property claims were concluded
- £1,198.49 paid in respect of lost property claims

Inquests

- 77 active inquests
- 14 inquests were opened
- 99 inquest files were closed

Objective	Quarter 2	Quarter 3	Quarter 4	June and July 2021	Aug and Sept 2021	Dec 2021 and Jan 2022	Assurance
System in place to ensure effective communication within the Legal Services Department	KPIs set and implemented	98% compliant with department KPIs	100% compliant with department KPIs	At the end of 2019/20 98% of KPI were met. During Covid-19 report on KPIs has ceased to all staff with the department to help support clinical colleagues; therefore, figures not available for this period. Reporting will be reviewed as part of wider review.	Snapshot service review completed. New Head of Legal Services to review further on commencement.	**Acting Head of Legal to incorporate communication and sharing procedures within new Legal SOP. This is to be implemented by March 2022.** **An escalation process has been agreed with the Divisions for triangulation and efficiency.**	**Reasonable assurance**
Datix Module for Legal Services reviewed and updated	Not implemented	Datix reviewed with Trust Datix Lead, stages streamlined, and actions set up for Inquests. Further work required in Q4.	Legal Services Department together with wider Governance Department moved offices and sites during Q4. Work on Datix module was paused during this time to focus on the move.	Not implemented	New Head of Legal Services to review further on commencement.	**This has stalled in the absence of a Datix Manager. It is noted steps have been taken to recruit for this role.** **Acting Head of Legal to incorporate into SOP to be implemented by March 2022.** **Case Plans have already been implemented in the Inquest**	**Reasonable assurance**

Objective	Quarter 2	Quarter 3	Quarter 4	June and July 2021	Aug and Sept 2021	Dec 2021 and Jan 2022	Assurance
						portfolio to record salient information. This is to be rolled out in Claims shortly.	
Audit of Legal Services files on Datix	Not implemented	Not implemented	Not implemented	Audit of Legal services files continues to take place as part of quarterly reporting. At present audit feedback sheet has been designed and feedback is given to handlers on an individual basis. Quarterly basis has been deemed a reasonable period of time for audits to take place.	File audit continues in association with quarterly and bi-monthly reporting, plus ad hoc sampling, therefore more regularly than quarterly.	**File audit continues in association with quarterly and bi-monthly reporting, plus ad hoc sampling, therefore more regularly than quarterly.** **This is supported by the introduction of Case Plans to ensure accurate and up to date information is maintained on file.**	**Reasonable assurance**
SOP for DP7 requests	SOP set up	In Q3 the role and responsibility for managing all DP7 requests was given to Legal Services. Currently no SOP in Trust for handling these.	Confirmed that DP7 requests from the Police that relate to Trust staff or incidents that have happen on Trust property. All other requests will be handled through Access to Data DP7 requests have been added to Datix as a type in claims module and managed under the SOP for legal disclosures.	Confirmed that DP7 requests from the Police that relate to Trust staff or incidents that have happened on Trust property should be referred to Legal Services.	Access to Health Data is updating the main Access to health records policy, of which this forms a part.	**A finalised SOP from Access to Health Data has been received.** **The Medical Records disclosure process is currently being reviewed. This has been added to the Risk Register given the operational, financial and reputational risk.**	**Limited assurance**.
Disclaimers for personal property on EPR	Not implemented	Not implemented, discussions being undertaken	The Digital Health Team are looking into how disclaimers	The Digital Health Team are looking into how disclaimers	NB Disclaimers have only limited benefit; they cannot avoid	**As previous.**	**Limited Assurance**

Objective	Quarter 2	Quarter 3	Quarter 4	June and July 2021	Aug and Sept 2021	Dec 2021 and Jan 2022	Assurance
		with EPR Team in relation to this.	can be added to EPR. There has been little movement as claim handler for lost property is on sick leave.	can be added to EPR. There has been little movement as claim handler for lost property only returned to work in July 2020 and has had a phrased return to work	responsibility or liability where it is present and are not valid when the patient lacks mental capacity to sign them.		

Legal Services and Divisional Engagement

As detailed above, a review of the Legal Standard Operating Procedure (SOP) and escalation process is underway. Given the increasing operational pressures, it is important that Legal are making the Divisional Leads and Directors etc aware of any additional requests being made of their staff in terms of coronial and litigation involvement and that they are supported. This process should also be utilised where there are delays or potential operational risk.

A new process has been agreed with the Divisions to notify the Clinical and Divisional Director / Matron / General Manager aware of any new claims or inquest requesting a statement (for information and appropriate escalation). Any operational risk will be escalated to the Divisional Director / Associate Director of Nursing by the Head of Legal.

Legal Service Learning- Sharing Learning from Inquest and Clinical Negligence Claims

Legal are looking to incorporate learning from Inquest and Claims and Getting It Right First Time (GIRFT) into the new processes. Legal Services are planning to link in with Speciality GIRFT Leads and Divisions across the Trust on a quarterly basis in relation to claims and inquests. Whilst there are already established links in some areas, the aim is to standardise this engagement so that no clinical/divisional areas are excluded.

There will be two strands to this engagement. The first will be to ensure that all Divisional and Speciality Leadership, as well as individual clinicians involved in providing care, are sighted on all claims and inquests at the relevant stages. As above, this has been implemented.

The second strand of improved engagement will be with Speciality Leadership. Legal Services will arrange to meet with each Speciality, once a quarter, to review their new, on-going, and closed claims and inquests. We are currently exploring appropriate forums; however, this will be aimed at lower to senior levels and clinical forums. This will ensure oversight and awareness by the Speciality and improve identifying and acting on any learning in real time, rather than when a claim has concluded, which traditionally has been the case. This will also ensure that the 5 Point Action Plan recommended by GIRFT can be achieved on a continual basis, rather than once a year with the release of the Data Pack.

CHS Claims

Calderdale & Huddersfield Solutions (CHS) are a wholly owned subsidiary of Calderdale & Huddersfield NHS Foundation Trust. The Trust Legal Team have a Service Level Agreement (SLA) to manage CHS insurance claims on their behalf.

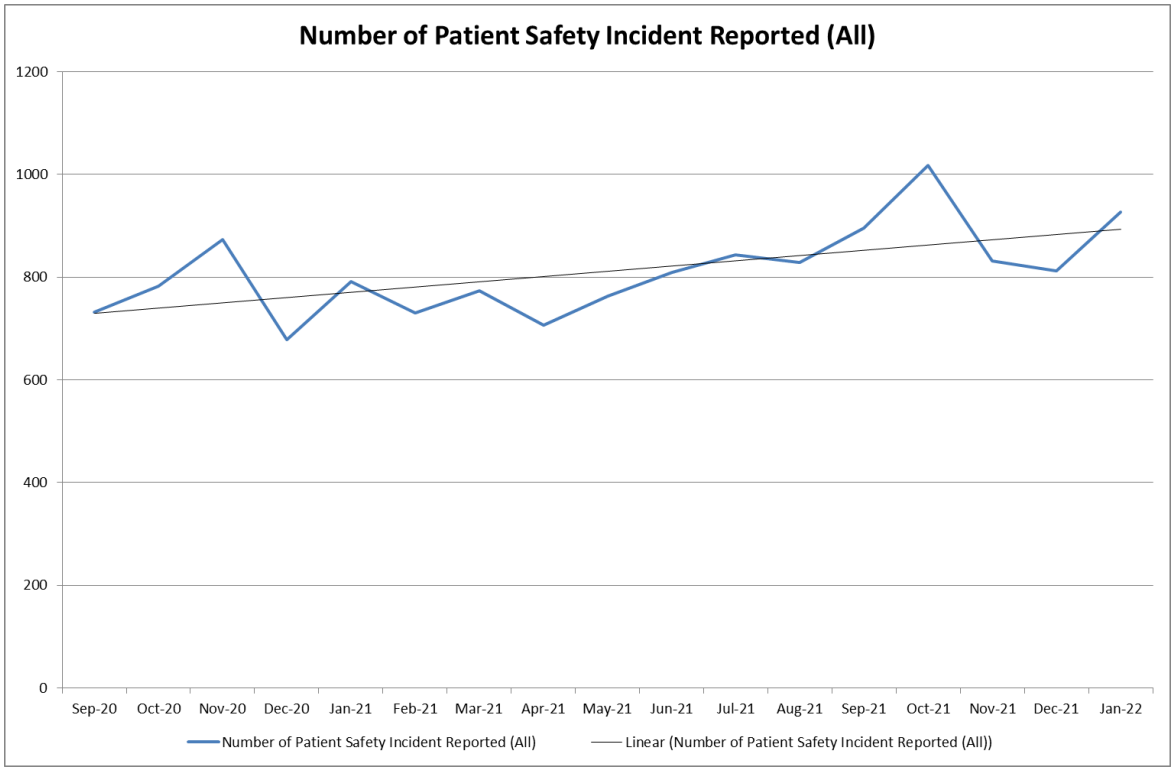
A SOP and escalation process has been created and is in the process of being agreed by CHS to streamline the internal processes to ensure CHS cases are being dealt with correctly and efficiently. Legal are also to provide a Quarterly Report to CHS (by 1st March, June, September, December) with the Head of Legal or representative to attend the CHS Patient Safety Quality Board on a quarterly basis.

7. Incidents

Below is a summary of patient safety incidents and incidents with severe harm or death, for the year September 2020 to January 2022, and number of serious incidents (SIs) reported by month.

Following review, the number of incidents resulting in severe harm or death during the period reported has been amended to reflect the current position, post investigation.

Month reported	Number of Patient Safety Incidents reported (all)	Number of Patient Safety Incidents of severe harm or death	Serious Incidents by the month externally reported on StEIS
Sept 2020	732	5	4
Oct 2020	783	6	2
Nov 2020	874	25	1
Dec 2020	679	11	3
Jan 2021	791	30	5
Feb 2021	730	18	2
Mar 2021	774	3	2
April 2021	707	4	4
May 2021	763	6	2
June 2021	809	8	5
July 2021	843	4	3
Aug 2021	829	8	2
Sept 2021	896	12	4
Oct 2021	1018	11	4
Nov 2021	832	13	7
Dec 2021	812	5	1
Jan 2022	927	10	2



Never Events

No further Never Events have been reported during December 2021 and January 2022.

Summary of Progress with Serious Incident Actions

- The Risk team has reviewed the management of serious incidents and has closed historic serious incidents which had outstanding actions dating back to 2019. This was done working alongside the divisional manages and evidencing outstanding actions that could be closed.

- There is recognition of the operational pressures and the impact this is having on the management of serious incidents. The risk team continue to provide support to clinical teams. The risk team have good oversight of serious incidents and continue to work closely with the divisions to support a consistent process across the trust and ensure all actions are responded to in a timely manner, with robust evidence.

- A total of 3 StEIS (Strategic Executive Information System) incidents were reported; 2 for December 2021 and 1 in January 2022.

Learning from Serious Incidents

Specific themes are trends from serious incidents are identified as: -

- Some of the policies and procedure required a refresh to ensure they are explicit regarding roles, for example the Standard Operating Procedure for the Frailty Coordinator has re distributed to all staff for clarity and adherence to Standard Operating Procedure for escalation to avoid 12-hour trolley has been reiterated and included as part of Safety Huddles,

- Clinical risk assessments tools are implemented and action by staff, with adherence to best practice guidelines to support this. This is monitored on daily board rounds.

- The handover of care between teams is effective and patent centred by ensuring use of the SBAR (Situation, Background, Assessment, Recommendation) tool

Serious incident reports submitted to the Clinical Commissioning Group (CCG) in December 2021 and January 2022 are as follows:

Incident Summary	Learning Need and Organisational Learning
Patient Fall resulting in injury	• The Standard Operating Procedure for the Frailty to be redistributed with the Frailty Team for clarification. • Staff to be reminded where next of kin contact details are recorded on EPR. • Review of the visiting policy in line with COVID restrictions. • Falls Lead to work on promoting the falls prevention • Dementia Lead Practitioner to continue to develop a Dementia Care Plan.

Incident Summary	Learning Need and Organisational Learning
Pressure area care.	• Comprehensive risk assessment tools support identification of potential risk and in the planning to mitigate this risk • Best practice guidance and national guidelines give us an evidence-based upon which to align care planning and documentation • Effective handover is supported by SBAR and safety huddles, ward and board rounds • Providing a comprehensive resume of the patient's clinical condition to relatives to support the understanding the patient's treatment and care planning
Incident Summary	**Learning Need and Organisational Learning**
Orthopaedic cast pressure sore development following delays in follow up	• For orthopaedic outpatients, to review process when care home residents are not brought to appointments. • Vulnerable patients need to be followed up if their fail to attend appointments • Handovers are required for patients who require carers. . • Patient information regarding care of casts/backslaps should be sent home with patients regardless of whether they at home or in a care/nursing home as they can be used to support care plans. • Staff education to include a reminder that any cast can potentially cause a pressure ulcer,
Incident Summary	**Learning Need and Organisational Learning**
Deteriorating patient in Emergency Department, with increased length of stay	• The Emergency Department Team should have responsibility for patients in Emergency Department Resus even if those patients have been 'accepted' by another team • When a patient has been in resus for 4 hours a conversation should take place between the Emergency Department Consultant and a Consultant from any other team involved in the patients care in order to confirm that an appropriate management plan is being undertaken and an appropriate clinical area is identified for the patient to transfer to • Patients who have been in Emergency Department Resus for 4 hours should be escalated to the next Tactical Meeting. • There should be a structured handover between the resus team and the receiving team prior to the transfer of a patient from resus
Incident Summary	**Learning Need and Organisational Learning**
Child Safeguarding Incident	• It is essential that all information is obtained at the antenatal booking regarding father of the baby including any previous children • All children admitted with Safeguarding concerns should have a strategy meeting prior to discharge and discussion should be documented in the child's medical notes. • Any disagreement amongst professionals on outcomes from the strategy meeting should be escalated within their organisation

Incident Summary	Learning Need and Organisational Learning
Still Birth after prolong pregnancy	• Raised awareness of risk of pronged pregnancy associated with age over 35 years. • Ensure appropriate escalation when best practice is not able to be facilitated • Raise awareness of the importance of reduced fetal movements at term as a risk for poor outcome and the recommendation to offer immediate IOL if presenting over 40 weeks' gestation with reduced movements. • Increase understanding/awareness of the limitations of CTG monitoring as a predictor of fetal wellbeing over a period of time.
Incident Summary	**Learning Need and Organisational Learning**
Critically unwell patient in the ED for 12 hours. Patient later died	• The SOP for escalation to avoid 12-hour trolley waits should be followed even when the delay is due to a clinical reason. • Clarity on the overall responsibility of patients in ED resus, and the role of the ED Consultant and OCM. • Documentation and verbal communication of the rationale behind decisions regarding Critical Care admission should be comprehensive and clear as well as further escalation triggers.
Incident Summary	**Learning Need and Organisational Learning**
Missed diagnosis in ED resulting ineffective discharge arrangements and follow up	• Effective communication with relatives as part of discharge planning and follow up of care • An abnormal ECG should be further investigated to understand the cause of symptoms
Incident Summary	**Learning Need and Organisational Learning**
Deteriorating patient during diagnostic intervention	• Implementation plan for policies and procedures to ensure all staff are aware of key messages • All staff to ensure that documentation is contemporaneous • Effective Handover at all times to ensure that patients that any change in their condition is shared with all staff • A review of the patient's condition prior to transferring to any other department for diagnostic tests or assessments to of support for safe transfer
Incident Summary	**Learning Need and Organisational Learning**
Undiagnosed breech delivery	• Any discrepancy between the EDD by LMP and the growth measurements on the ultrasound scan the women should be referred for a consultant decision as to which EDD should be used. • Staff to be reminded that a holistic risk assessment should be undertaken at each antenatal contact • Staff to be reminded that the decision to admit a baby to the Neonatal Unit should be made by the Neonatal Medical Team.

8. Medicines Safety

The Medication Safety and Compliance Group (MSCG) continue to raise awareness of the importance of safe storage, prescribing and administration of medication.

The priority MSCG work streams are:

- Development of an electronic recording solution for controlled drug (CD) registers to improve our CD documentation and compliance with legislative requirements. Final version has been released to the sandpit environment and is currently being tested by CHFT project team. Due to go live across in all areas March 2022.
- Phase 1 of installation of electronic medication storage cabinets. This first phase is to install cabinets in our Emergency Departments (ED) 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. Omnicell cabinets have been installed in ED at HRI and due to be installed at CRH in March 2022.
- Go live on 17th January 2022 for active temperature monitoring for medication stored in fridges (phase 1) and then expansion of system to include ambient temperature monitoring (phase 2). Ward staff need to be trained on the new Stanley system and once >70% of staff have completed the training in a clinical area; the manual monitoring system of that area can be stepped down.
- Review of Medicines management training; both course content and compliance

Main concerns / escalations:

- A new issue has been highlighted, the poor compliance with the Trust mandatory medicines management training. A deep dive of this issue highlights that not all staff that should be completing the training are registered to do so and that the current training programme is not fit for purpose. This requires urgent review.
- Lack of quoracy at MSCG due to gaps of divisional / cancellation of last meeting due to operational pressures continues to be an issue. Pharmacy leading on all current medication safety work streams. Associate Directors of Nursing have been asked to ensure a deputy is nominated and attends if they are unable to do so.
- The Training burden for ward staff for use of electronic CD registers and Active temperature systems

Issue	Update	Risks	Mitigations	Next steps	Assurance
Non-compliance of the medicines management 'must do's **Ongoing objective requiring continual monitoring**	Bi-annual pharmacy audits continue to be completed and highlight both areas of good and poor practice. Electronic meds management audit tool developed. Spot checks have not demonstrated improvements To add to MSCG workstreams a review of current Medicines management training module. We need to ensure key safety messages and medicine governance standards are included. Only 1612 staff are registered for this training and 1251 have completed it. 1612 does not equate to the total number of RNs/RMs/ODPs/NAs, Prescribers and AHPs who handle medicines.	Audits only give a snapshot of routine practice It appears there is a difference in the results seen on planned visits when the ward is informed in advance they are being audited compared to ad hoc/ unannounced visits indicating the planned audits may not be seeing the true picture As the current medicines management training does not reflect our medication safety issues, we risk staff not being aware of the required standards and how to mitigate these risks.	Ward managers and senior nurses reminded of the core standards and their professional responsibility to adhere to them Pharmacy teams supporting wards to alert senior nurses if standards aren't being met. To offer support when capacity to do so in terms of emptying returns bin/ putting deliveries away/ removing expired medication from fridge Training to be reviewed and updated. Divisions to be made aware of which staff need to complete this training.	Where spot checks have highlighted issues / concerns, reported to ward manager and action plan agreed. Areas with poor medication storage facilities e.g paeds being considered for installation of electronic cabinets to support with medication storage compliance Some areas ; ED and the ward 6's asking for additional pharmacist support due to medication governance issues in those areas. Whilst short term support is being provided (where possible), a long term solution i.e. business case needs to be considered. Discuss with the Web team about building bespoke CHFT medicines management training that is reflective of current local and national medication safety issues. Review if which staff require this training and how compliance can be improved.	**LIMITED ASSURANCE**

Issue	Update	Risks	Mitigations	Next steps	Assurance
Annual medication fridge temperature monitoring audit highlighted only 39% of all areas 100% compliant. Repeated audits continue to show poor compliance. **Go live for Stanley Active temperature monitoring system- target completion date delayed from Aug to Dec 21**	SOP for how to access and update active temp system approved and circulated. Go live of Stanley system on 17th Jan. Some staff still need to complete the training in order that they can correctly access temperature deviation alerts, Once 70% of staff in an area have been trained, they can step down the daily manual monitoring.	Audits show that staff are not acting on temperature deviations Staff may tamper with new temperature devices as they may not know what they are Staff have turned off current' traditional' fridge thermometer alarms (reliant on for manual monitoring of fridges until the active system go live). This results in no audible alarm i.e., when fridge door left Once Go Live for fridge monitoring, aim go live with ambient temperature monitoring and there is a financial risk for any areas whose temperature is consistently above 25 degrees Celsius as they may need air con installing	Screensaver and comms issued to clinical staff showing pictures of monitoring devices including instruction stating not to tamper with devices Daily manual recording of fridge temperatures continues until active system Go Live Pharmacy audits continue to check 'traditional' fridge monitor alarm correctly switched on and daily monitoring of temperatures is recorded For any areas storing meds at higher than recommended temperatures, there is a pharmacy led process of reducing expiring dates (depending on exposure length and temp reached). This carries the added risk of increased waste of medication/ cost	Ward managers reminded of must do's /manual fridge temperature monitoring requirements (until Go live with active temperature monitoring system) Comms to nursing teams of active temp system, Go Live date and requirement to complete training Relevant staff to complete training	**Reasonable assurance**

Issue	Update	Risks	Mitigations	Next steps	Assurance
To improve medical gas training to ensure compliant with HTM requirements	SWAY oxygen training package completed. Training being rolled out Designated Nursing Officer (DNO) virtual group formed – holding bi-annual meeting at which updates on relevant oxygen and medical gas information shared Progress Feb 22: no further updates since last report	Not all clinical staff may be up to date with training	Completion of Datix reports when any incidents relating to medical gases including poor practice occur	Promotion of the training would include posters, bite size info on the monthly newsletters, block emails to managers, etc, and their ESR would be put on red until it completed Await national updates to HTM and Medical Gas Group Terms of Reference (as per Healthcare Safety Investigation Branch (HSIB) report recommendations) Continue to roll out SWAY training	**Reasonable assurance**

9. Maternity Services

Ockenden report

The service continues to work through the action plan developed as a result of the independent review of the evidence the service submitted against the seven Immediate and Essential Actions. The review highlighted areas where Standard Operating Procedures (SOPs) are required, areas which require on-going audits to provide assurance and a gap analysis and action plan to meet the recommendations of the Royal College of Midwifery document Strengthening Midwifery Leadership.

The review also highlighted gaps in the visibility Maternity Voices Partnership (MVP) colleagues within the service in terms of supporting service development however given the ongoing challenges of COVID-19 face to face site visits do not take place.

The Perinatal Quality Surveillance Meetings continue to be held monthly with attendance from CHFT maternity safety champions CCG and Local Maternity System (LMS) colleagues. The agenda for the meetings is continuing to be revised and developed following each meeting. This monthly meeting has superseded the previous bimonthly maternity safety champion's meetings.

Better Births – Continuity of Carer (COC)

As described previously the service submitted to the Executive Board its plans for achieving the ambition of Continuity of Carer being the default model for all women.

In February and March a series of open meetings with staff will be held to share the plans for CHFT to achieve this ambition. These meetings will be followed up by 1:1 meetings with staff to undertake individual training needs analyses to ensure that staff are supported to provide this model of care.

In recognition of the fact that safe staffing levels in all areas is integral to achieving COC as the default model the Community Midwifery Matron and Managers are reviewing the current caseload and size of teams delivering a traditional model of community antenatal and postnatal care to ensure that midwives are supported to deliver antenatal and postnatal continuity in preparation for a move to providing COC throughout the pregnancy continuum.

NHS Resolution Maternity Incentive Scheme

In response to the on- going COVID-19 pandemic and the pressures currently being experienced across all areas of healthcare NHS resolution suspended year 4 of the Maternity Incentive scheme in December for a period of three months initially. The service however continues to work towards the current trajectories and have not paused any internal on-going work to meet year 4 of the scheme.

Healthcare Safety Investigation Branch (HSIB)

As of 10th January 2022, the maternity services position is:

Cases to date	
Total referrals	33
Referrals / cases rejected	9
Total investigations to date	24
Total investigations completed	18
Current active cases	6

Of the current cases the position is:

HSIB case number: MI-003979
HSIB criteria: HIE/Cooling
Trust site: Calderdale Royal Hospital
Incident date:06/08/21
Referral date: 09/08/21
Lead MI: Olivia Newman
Support MI: Amanda Abbott

Update:

- Factual accuracy review comments received from Trust.

Next steps:

- Maternity Investigator to take comments to factual accuracy review meeting (FARM) 13/01/22.

Key lines of enquiry:

- the management of the Baby's growth in pregnancy.
- the management of the mother's attendances to the emergency department.
- the management of fetal monitoring during the mother's admission and labour.
- the management of labour and birth.

HSIB case number: MI-004024
HSIB criteria: HIE/ Cooling
Incident date: 18/08/21
Referral date: 19/08/21
Lead MI: Amanda Abbott
Support MI: Sharon Perkins
Update:

- Draft report with the Trust for factual accuracy review (due back 18th January).

Next steps:

- To review any factual accuracy comments made by the Trust.
- To share the draft report with the family for factual accuracy review.

Key lines of enquiry:

- Management of care when the mother opts for care outside local guidance.
- Management of latent phase of labour.
- Management of a waterbirth.
- Management of the third stage of labour with a history of PPH.
- Use of emergency call bell/escalation on the BC.
- Decision for therapeutic cooling.

HSIB case number: MI-004095
HSIB criteria: Intrapartum Stillbirth
Incident date:07/09/21
Referral date: 07/09/21
Consent date: 09/09/21
Update:

- 10/01/22: HSIB report panel to consider the draft Maternity Investigation report.

Next steps:

- Prepare and share the report with the Trust for factual accuracy review.
- Respond to the Trust comments and prepare the draft investigation report to be shared with the family.

HSIB case number: MI-004891
HSIB criteria: HIE / Cooling
Incident date: 03/11/21
Referral date: 11/11/21
Consent date: 16/11/21
Update:

- Chronology completed.
- Meeting with the mother took place on 16/12/21.
- SMART 1 meeting took place 5/1/22.
- Neonatal meeting scheduled for 26/1/22.

Next steps:

- Share terms of reference with Trust and family.
- Arrange staff interviews

HSIB case number: MI-005708
HSIB criteria: Neonatal Death
Incident date: 15/12/21
Referral date: 29/12/21
Consent date: 31/12/21
Update:

- Family contacted to arrange family interview
- Additional records requested from Leeds Teaching Hospitals NHS Trust
- Chronology underway

Next steps:

- Arrange first HSIB clinical panel review.

Key lines of enquiry: To be confirmed

HSIB case number: MI-005739
HSIB criteria: Maternal death
Incident date: 31/12/21

Update:

- Awaiting further details from the Trust to assess whether the case meets HSIB criteria
- Update 17.1.22 this case does not meet the criteria for a HSIB investigation

Perinatal Mortality Review Tool Quarter 3 Report

Quarter 3 PMRT reportable cases

Date	Gestation	Stillbirth (SB) or Late fetal Loss (LFL)	Brief Summary
13.10.21	27	SB	Unbooked pregnancy received no antenatal care
16.10.21	40+6	SB	Antenatal bleed ? placental abruption. Awaiting Postmortem report. Ongoing open incident
20.10.21	28	SB	Baby with known congenital abnormalities
6.11.21	41+2	SB	Complex social history no engagement with services

12.11.21	25+6	SB	Unbooked pregnancy , congenital abnormalities noted at birth
18.12.21	36+5	SB	Attended for routine growth scan, =no fetal heart noted on scan
28.12.21	37	SB	Attended with a history of reduced fetal movements for 48 hours No fetal heart on admission.

Neonatal Deaths in Quarter 3

Date of death	**Gestation/Age**	**Brief Summary**
15.12.21	37+6	Known echogenic bowel transferred to Leeds
29.12.21	29+5	Known congenital abnormality

Maternity Incidents

Maternity incidents reviewed at weekly maternity governance MDT meeting. All incidents are reported via Datix and coded as maternity incidents. The data for January is described below.

	Total
PPH- no adverse outcome	7
Shoulder Dystocia	0
Unexpected admission to the Neonatal Unit	8
2nd Theatre opened	1
3rd or 4th Degree perineal tear	8
Delay in Emergency Caesarean Section	10
Total	34

Maternity Complaints

Maternity services currently have 7 open complaints as of 29th January 2022 under investigation all of these within timescale.

Maternity Staffing

In line with nursing at CHFT midwifery staffing allocation is managed through the Allocate e-rostering system and Safecare safer nursing care acuity and dependency tool. However, to note Safecare is not a recognised tool for maternity acuity so the Birth Rate Plus acuity tool is used in both LDRP and the Birth Centre

Local Midwifery Metrics

The LDRP coordinator completes the Birth Rate Plus acuity tool every 4 hours. The tool assesses each patient on the ward at the time of the census against specific criteria relating to their pregnancy risk and status, whether they are antenatal, in labour or postnatal. The number of midwives on duty is also taken into account. The tool assesses the number of midwives available against the acuity and demand of the patients and calculates the excess or deficit of midwives available in that time period.

This is then RAG rated:

- Red more than 3 midwives short in the census period
- Amber up to 3 midwives short in the census period
- Green number of midwives available meets the acuity

In the time frame 6.21.21 to 16.1.22 (6 completed weeks) the acuity was:

Week	% Census periods RAG rated Red	% Census period RAG rated Amber	% Census periods RAG rated Green
6.12.21	7%	52%	40%
13.12.21	15%	54%	32%
20.12.21	12%	43%	45%
27.12.21	0%	31%	69%
3.1.22	7%	62%	31%
10.1.22	6%	36%	58%

Whilst the table above describes the weekly position it is important to note that the acuity fluctuates as activity on the labour ward ebbs and flows therefore the daily review of acuity is a more sensitive metric as it captures the peaks and troughs directly related to the number of women in labour at any one time and their individual acuity. It is this metric that the senior maternity leadership team use to deploy midwives to match the acuity, this period of deployment can range from a whole shift to a few hours and the acuity changes.

In context of the current COVID-19 surge the total unavailability (includes annual leave, maternity leave, sickness and isolation) within the inpatient maternity services for the same timeframe was:

Week	Total Unavailability
6.12.21	36%
13.12.21	38.5%
20.12.21	37.5%
27.12.21	26.5%
3.1.22	63.5%
10.1.22	38.5%

1:1 care in labour is reported both internally and externally on the maternity Dashboard. The previous six months data for CHFT is:

Month	July	August	September	October	November	December
% Women received 1:1 care in labour	98.2%	98.9%	98.8%	98.4%	96.6%	98.1%

Quarterly LMS and Yorkshire and the Humber data for 1:1 care in labour

1:1 care in labour	Q1 21/22	Q2 21/22
CHFT %	98.5%	97.2%
West Yorkshire and Harrogate LMS	95.38%	94.6%
Yorkshire and The Humber %	91%	94.3%

Labour Ward Coordinator Supernumerary

NHS Resolution's Maternity Incentive Scheme describes that the midwifery coordinator in charge of labour ward must have supernumerary status, which is defined as having no caseload of their own during their shift to ensure there is an oversight of all birth activity within the service.

The assessment of supernumerary status is a subjective assessment undertaken by the coordinator and recorded each census period within the Birth Rate Plus acuity tool. For the period 6.12.21 to 16.1.22 there were a possible 252 census periods of these there was only 1 census period (a time span of 4 hours) where the labour ward coordinator was not supernumerary.

10. Quality Priority updates

Set out below is the first report in relation to the Quality Account Priorities for 2021/2022. The report details each priority and the measures to be monitored and reported into the Quality Committee this coming year.

Quality Account Priorities

CQC Domain: Effectiveness	CQC Domain: Safety	CQC Domain: Experience
Recognition and timely treatment of Sepsis 	**Reduce the number of Hospital Acquired Infections including COVID-19** 	**Reduce waiting times for individuals in the Emergency Department (ED)** 

Focussed Quality Priorities

CQC Domain: Caring	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Responsive	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Effective
Reducing the number of Falls resulting in harm 	**End of Life Care** 	**Increase the quality of clinical documentation across CHFT** 	**Clinical Prioritisation (Deferred care pathways)** 	**Nutrition and Hydration for in-patient adult and paediatric patients** 	**Reduction in the number of CHFT acquired pressure ulcers** 	**Making complaints count: Implement ation of the national regulations & PHSO standards (phased introduction)** 

10.1 **Recognition and timely treatment of Sepsis** (Quality Account Priority)

Operational Leads – Dr Rob Moisey and Paula McDonagh

We will this year undertake quality improvements to - Improve the recognition and timely treatment of Sepsis.

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
QP1. Increase our concordance with the administration of intravenous antibiotics in the emergency depts. within 60minutes of recognition of sepsis to 80% for the severely septic patient. This will be measured by using the Red Flag Criteria for severe sepsis recognition. Concordance is captured by the timing from the earliest suspected sepsis alert to the administration of the first intravenous antibiotic through the electronic patient record system.	**1) All patients coded with sepsis-December 2021- 62.5%** **January 2022-69.7 %** **2) Red flag patients- December 2021- 52.5%** **January 2022- 41.9%** The above percentages are based on 1) all patients coded with suspected sepsis in the Emergency Department (ED) at both sites.2) all patients admitted to EDs with Red Flag sepsis. **Progress work** - Sepsis trollies moved Into Resus to assist in speeding up administration of intravenous antibiotics as the sickest patients are treated there. - Macoset device introduced to assist with mixing the antibiotic Pip Tazocin - Mobile phones now ordered for the ED Registrars to carry 24/7, this is so they can be contacted quickly to review patients and any escalations can be discussed. ED team have suggested we trial this. - A clinician has met with informatics and have discussed how the red flag data can be pulled from the electronic patient record (EPR); this has now been actioned for trial so we can now report red flag sepsis compliance from EPR going forward. - Sepsis nurse delivering training to ED staff on Teams twice weekly. - ED sepsis lead clinician updating actions from red flag data at daily handovers. **Risks and mitigation's** - Sepsis trolleys require further attention relating to stocking up and consistent usage though improvements noted in month. **Action-** ED sepsis champions to continue communicating usage guidelines and process for re stocking. - Not all staff using Macoset device to mix Pip Tazocin ED HRI so further communication re usage given, **Action** sepsis nurse will monitor, and check stock levels are sufficient. Sepsis nurse overseeing commencement of trial of device in ED at CRH. Use of Macoset device introduced to acute floors and Frailty due to success in ED, positive feedback on reducing preparation times and support of good practice re ANTT. - ED consultant continuing to analyse red flag patient (sickest sepsis patients) data, we have looked back at	**Reasonable Assurance**

What do we aim to achieve?	December 2021 and January 2022 Update		Progress rating
	2021 up to month 11 and the average % for antibiotics administered under 1 hour is 56% rising to 87% administration under 2 hours. - Compliance of sepsis training reduced due to staffing shortages and vacancies. **Action-**Sepsis nurse delivering Team's training to both Emergency depts with aim to complete all staff (RNs and HCAs) by March 2022. education for Clinicians is being provided. - Staffing shortages have been affecting patient reviews and treatment times. **Action –** ED teams initiated cross site staffing support lead by lead nurse each site, use of flexible workforce and extra duty payments. **<u>Successes</u>** Category 2 patients in the emergency dept are been seen in rapid assessment at HRI rather than waiting for a cubicle. This has improved treatment times for patients with sepsis. Recruitment of sepsis champions in both EDs. Agreed that further purchase of sepsis trolleys required as part of reconfiguration plan.		
QP2. Compliance of all elements of the sepsis 6 (BUFALO) to be improved to 50% **single elements to be improved to 90%**	**December 2021**	**January 2022**	
Blood cultures	74.8%	81.9%	**Reasonable**
Urine output	55.5%	73.6%	**Reasonable**
Fluids	98.3%	98.6%	**Substantial**
Antibiotics	98.3%	100%	**Substantial**
Lactate	Unable to add Lactate to EPR		
Oxygen	93.3%	95.0%	**Substantial**
TOTAL %	**43.7%.**	**41.9%**	
Each element will be measured (with exception of Lactate) from the sepsis screening tool and power plan within the electronic patient record.	**<u>Progress work</u>** - Element for blood culture has been confirmed as being measured accurately, audit of Oct/Nov patients identifies that the non-compliant patients are mostly ward based. - Recognition that drop in compliance in some elements e.g., fluids and antibiotics is affected by data pull not working with Athena for maternity patients. Effects 1 to 2 patients per month. Maternity EPR midwife is working on sepsis screening tool for Athena, progressing well. - Point of Care Testing Business case funding now agreed and waiting next stage to initiate the reporting of blood gas and urinalysis results from Lab to EPR. Aim is for this to be completed by 31/03/2022. Working groups in place.		

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
	Risks and mitigation's - Not all Red flag sepsis patients are receiving blood cultures when sepsis six care bundle requests this, this is more prevalent in ward areas. **Action-** sepsis collaborative members to media the requirement through their work channels, sepsis nurse to visit clinical areas and remind clinicians, action group to be set up by sepsis nurse, article added to sepsis press re importance of this element measure. Additionally, sepsis 6 education now on junior doctors induction training. Noted that nurses within ward based areas do not take blood cultures so added to agenda on IV working group for discussion/action. - Data pull not working from Athena into KP+ this is affecting compliance figures of septic maternity patients. **Action-** sepsis bundle will be available in Athena but date not available. This will then allow information to be present in the knowledge portal meaning maternity patient sepsis treatment compliance will be reported accurately. In meantime informatics are actioning a manual data pull to maintain accuracy. **Successes** Target of total (50%) compliance achieved in Sept 55.9% Oct 56.3% and Nov 51.7%. Oxygen element changed to measure target saturation compliance resulting in more accurate recording. Consistent month on month substantial progress reporting fluid and antibiotics. PCOT funding agreement to report arterial and venous blood gas results (Lactate).	
QP3. Establish sepsis skills training as part of essential safety training and achieve 40% concordance for eligible staff in year 1. This will be measured by training compliance records extracted from ESR and Lead Sepsis Nurse presentations.	Business intelligence have now provided the training numbers: - Consultants (except Obstetrics and Gynaecology) 250 - Foundation years (except Obstetrics and Gynaecology) 82 - CT (except Obstetrics and Gynaecology) 31 - ST (except Obstetrics and Gynaecology) 69 - Clinician Total **432** - Registered Nursing Total **672** **Progress work** - Sepsis training continuing on Teams and face to face with 20 eligible staff being trained in last 4 weeks. **Total so far 260** - Sepsis presentation now separated into clinician and registered nurse. RN approved at January's sepsis collaborative meeting now to be approved at nursing and midwifery group. Clinician training requires addition of questions before WEB approval. - Sepsis champions supporting the training of registered nurses in clinical areas. **Risks and mitigations** - Sepsis recognition and treatment not currently part of essential safety training. **Action-** agreed at sepsis collaborative that training should be mandatory and with a 3-year update. - Access to training staff proving difficult at times due to ward/dept pressures and movement of staff to support staffing shortages particularly in last 2 months. **Action-** sepsis nurse providing access to training evening and weekends and utilising sepsis champions to assist where possible.	**Limited assurance**

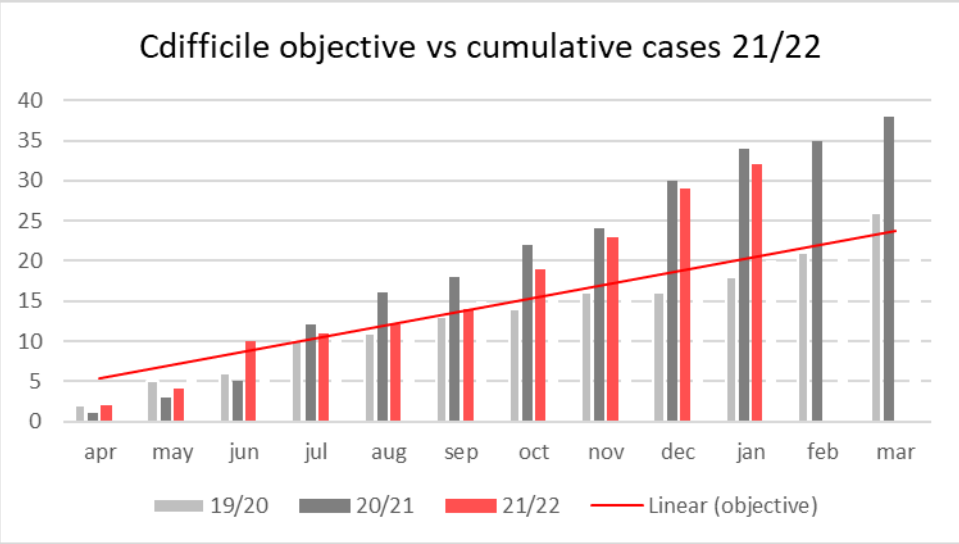
10.2 Reduce number of Hospital Acquired Infections including COVID-19 (Quality Account Priority)

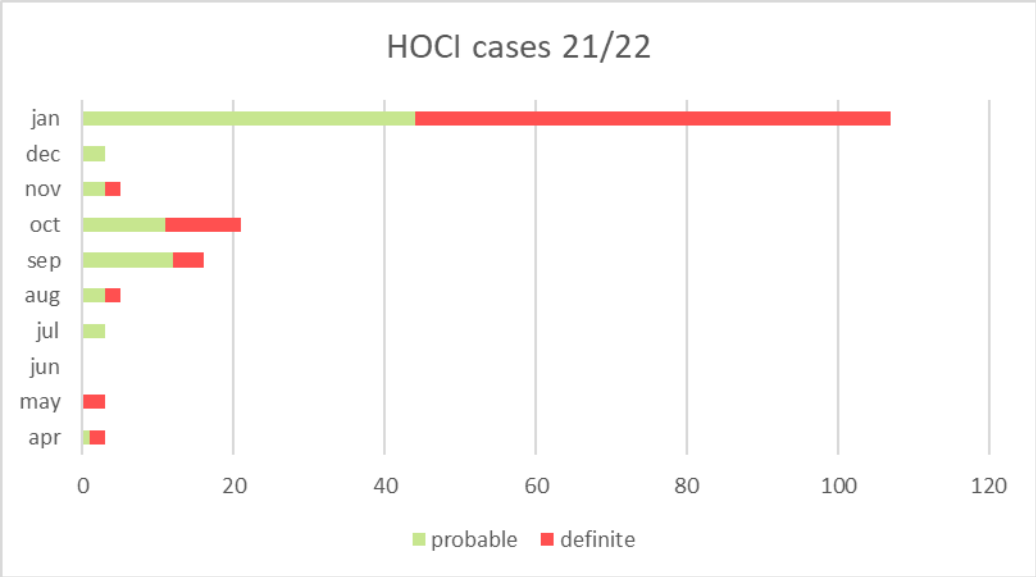
Operational Leads – Dr David Birkenhead, Dr Vivek Nayak and Gillian Manojlovic

We will this year undertake quality improvements to - Reduce the number of Hospital Acquired Infections including COVID-19

What do we aim to achieve?	December 2021 to January 2022 Update	Progress rating
QP1. Through the testing workstream we will ensure that all CHFT patient and colleague testing strategies are compliant with National and Local guidance. This will be measured by performance against patient testing regimes.	CHFT are compliant with the minimal national patient testing regime and also include additional tests as part of our local guidance	**Full assurance**
	Covid testing compliance stands at 92%, an improvement of 6%	**Reasonable Assurance**
	Lateral Flow Device (LFD) testing is in place as per national guidance for staff. This is to be encouraged with staff but is not mandated. We are no longer able to track this data due to staff being instructed to upload results onto the National portal. Continuing actions taken to promote LFD uptake include communication via leadership briefings and the MUST Do messages.	**Limited Assurance**
QP2. Support a system wide approach to Covid-19 vaccination programme through CHFT vaccine centres and support to the national programme.	Sessions planned for second vaccines for outstanding staff.	**Substantial assurance**
2a Establish specialised vaccine clinics for people with Learning Disabilities (LD)	Specialised clinics have been established to support people with a learning disability to receive their vaccines and will be included in future planning	**Substantial assurance**

What do we aim to achieve?	December 2021 to January 2022 Update	Progress rating
2b Establish clinics for people with allergies	Specialised clinics for patients with multiple allergies and/or previous anaphylaxis were undertaken, again outside of the routine clinics, supported by a Consultant Anaesthetist, senior nursing, and administration staff. A total of 17 allergy patients have been through the clinics. The final allergy clinic session was on the 28 June 2021 for the administration of second doses. All future allergy referrals for the whole of West Yorkshire where there is the need to administer the vaccine in an acute setting will be managed at Airedale Hospital.	**Full Assurance**
2c Through our community teams support the vaccine programme across Calderdale	The community healthcare division has proactively supported the vaccination programmes across Calderdale place and has included this in the system wide winter planning.	**Substantial assurance**
2d Through our partnerships support the vaccine programme across Kirklees	CHFT have remained an active partner on the Executive Partnership meeting for Kirklees and have contributed both in leadership activities and resource support to the programme	**Substantial assurance**
This will be measured as a narrative against the indicators and numbers of people vaccinated where data is available	ImmForm report for staff immunisation at the end of Jan 2022 showed an overal Covid Booster uptake of 62.7% and flu uptake of 57.8% for frontline HCWs. VCOD activity by HR colleagues suggests aproximately 260 unvaccinated Frontline HCWs for covid at CHFT. Covid immunisation history is remaining part of routine pre employment health checks. Flu campaign remains live to the end of February with a final push being supported by the Trust peer immunisers. A covid clinic will be set up in March 22 to support administration of the second dose of covid vaccine for heathcare workers who had a first dose recently due to VCOD pressure.	**Reasonable Assurance**

What do we aim to achieve?	December 2021 to January 2022 Update	Progress rating
QP3. Reduce the number of preventable Clostridium Difficile infections This will be measured by ensuring we do not exceed the threshold of 22 cases set in 20/21	The 21/22 objective for C.Difficile is 22 cases which is a reduction of one case based on the 2019 data of 18 HOHA cases plus 5 COHA cases. This will be monitored in the Integrated Performance Report (IPR). The objective was breached in November 21, and there have been 32 cases year to date. 	**Limited assurance**
QP4. Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection (HOCI) This will be measured by the rate of HOCI each month.	COVID patient pathways are in place to minimise the risk. Any Hospital-Onset COVID-19 Infections (HOCI) identified are reported immediately and a rapid RCA completed. HOCIs are currently reported weekly to Infection Prevention and Control (IPC) Gold and monthly to IPC Performance Board. Every action count tools are being used to support alongside the updated IPC guidance Lessons learnt from HOCI are shared to support organisational learning. The IPC Board Assurance Framework (BAF) is reviewed within the governance structures.	**Reasonable Assurance**

What do we aim to achieve?	December 2021 to January 2022 Update	Progress rating
	There was a extensive increase seen in January associated with the Omicron variant and associated outbreaks. A further review of the Trusts management of HOCI cases was undertaken by NHSEI and no additional actions were advised. The CHFT experience of the Omicron variant has not been different to that of other Trusts. 	

10.3 **Reduce waiting times for individuals in the Emergency Department** (Quality Account Priority)

Operational Leads – Jason Bushby, Dr Amjid Mohammed and Jayne Robinson

We will this year undertake quality improvements to - Reduce waiting times for individuals attending the Emergency Department

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
QP1. Implement and monitor effectiveness of the standard operating procedure to prevent any 12-hour breaches within the Emergency Department (ED) This will be measured by: • Number of (NHSE/I) reportable 12-hour breaches	Presented to Digital Quality Board in June that new reporting mechanism (on discharge) implemented April 2021 ensures that all length of stay (LOS) in the ED are captured and reported accurately. **No change still capturing any LoS >12 hours however 4 reportable >12 LOS have ensued**	**Reasonable Assurance**
• Internal standard: Number of patients who waited >12 hour within the department from time of arrival	Zero tolerance as reportable. There were two patients over 12-hour breaches last month discharged home non-reportable. **This has reduced to 132 patients having a LoS over 12 hours non-reportable in November all patients have been risk assessed and RCA completed on datix. ADN Medicine working with risk to develop a rapid review of all patients.**	**Limited assurance**
• Training delivered for on call teams to support implementation of the SOP	Surge and escalation document in use ensuring wide communication between all on call elements and tactical leads. **ED OPEL escalation tool now in place and accepted at trust level this now works with the trust OPEL scoring mechanism. Further work on actions on ED escalation**	**Limited assurance**
QP2. To align reporting systems with Cerner and the DATIX incident reporting system. This will be measured by • Establishment of >12hr DTA breach report from Cerner that matches incident reporting	New datix format for 12-hour LOS implemented by risk	**Substantial assurance**

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
QP3. Improved documentation of Intentional care rounds to ensure patients are receiving effective pressure area care, nutrition and hydration. This will be measured through: • No of colleagues who undertake training for intentional care rounds	Documentation audit in place to provide assurance to lead nurses that standards are met. Requires further monitoring to establish success. **Ongoing**	**Reasonable Assurance**
• Monthly audit of patient cases to review compliance with clinical documentation	Care is reviewed via datix	**Reasonable Assurance**

10.4 **Reducing the number of falls resulting in harm** (Focused Quality Priority)

Operational Leads – Dr Abhijit Chakraborty, Lauren Green and Charlotte Anderson

We will this year undertake quality improvements to - Reduce the number of inpatient falls and those resulting in harm by 10%, by the end of 2021 / 2022

What do we aim to achieve?		Progress rating

Reduce the total number of falls.
Reduced number of harms falls by 10%.
	- Falls Collaborative continues to meet every 6 weeks.
	- Patient and carer falls leaflet has been updated – was due to be agreed at Feb Falls Collaborative, however this has been delayed until March.
	- Flowchart of Bed rail assessment process – reviewing comments from safeguarding. This will be reviewed and agreed at Falls Collaborative in March. See flowchart attached
	- Audit completed of harm falls across trust. Identified themes and generated an action plan following audit:
	  ○ Mapping floors to identify high risk areas. Utilising ward staff and remote laptop stands
	  ○ Developing a risk assessment to support nursing staff with their decision making as to where patients are placed on a ward upon admission depending on their level of falls risk.
	- Falls prevention intervention care plan has been created and will be disseminated across the wards. Currently working with Communications team to create this. This care plan will eventually be uploaded onto EPR however until then the wards will be informed via their matrons, ward managers and senior nurses. In process of working with Bradford's falls leads to finalise the care plan.
	- Working with Bradford's falls leads to review falls assessment tool on EPR.
	- Falls and Fragility Fracture Audit Programme (FFFAP) Quality Improvement project underway. Identified area: Lying and Standing Blood Pressures on HRI Acute Floor.
	- Compliance with the SureFalls devices has significantly improved – all wards are now at level of compliance to order their devices.
	- Falls policy has been updated to reflect specific timeframes for assessments.
	- Learning from Serious Investigations will be disseminated through the Falls Collaborative. Recent SI from ward 6 has identified a number of areas that need actioning. This will be presented in next falls collaborative.
	- Falls Link Practitioners – Falls Leads are in process of developing the initial learning/education session. Names are still being collected and a role specification has been drafted. This is to be agreed in March Falls Collaborative
	- Meeting with Matron for Acute Floors monthly to develop action plan for falls. Recently have mapped out the
		Reasonable Assurance

<table>
<tr><th>What do we aim to achieve?</th><th></th><th>Progress rating</th></tr>
<tr><td></td><td>ward to identify the high risk areas and where staff should be stationed with their laptops. This work is ongoing

<table>
<tr><th>Month</th><th>Jun-2021</th><th>Jul-2021</th><th>Aug-2021</th><th>Sep-2021</th><th>Oct-2021</th><th>Nov-2021</th><th>Dec-2021</th><th>Jan-2022</th></tr>
<tr><td>No. of Falls</td><td>158</td><td>152</td><td>189</td><td>167</td><td>197</td><td>146</td><td>164</td><td>174</td></tr>
<tr><td>No. of Harm Falls</td><td>1</td><td>4</td><td>3</td><td>6</td><td>3</td><td>3</td><td>3</td><td>7</td></tr>
<tr><td>Falls per 1000 bed days</td><td>9.5</td><td>8.3</td><td>9.9</td><td>8.8</td><td>10.0</td><td>7.6</td><td>8.3</td><td>8.8</td></tr>
</table></td><td></td></tr>
<tr><td>Slip trip policy to include measurable falls assessment risk target</td><td>This is still in progress in line with the falls EPR workstream and review of the multifactorial risk assessment and Falls care plan on EPR with Bradford’s Falls Lead. This is ongoing.</td><td>Limited Assurance</td></tr>
<tr><td>Implement audits to check progress against targets</td><td>Audits on lying and standing blood pressures, mobility assessments and medication reviews currently being collected on W6.
Challenges have been identified with auditing accurately on EPR due to staff documenting in areas that cannot be audited. Work is being undertaken with Bradford’s falls leads to review the multifactorial falls risk assessment on EPR to include lying and standing blood pressures, mobility assessments and medication review sections to be fully audited.
The Falls Leads are in process of drafting up the falls link practitioner roles, they will support with auditing on their wards.
FFFAP QI project has been launched and is focussing on improving lying and standing blood pressure readings to be completed within 48 hours of admission into hospital.</td><td>Reasonable Assurance</td></tr>
</table>

10.5 **End of Life Care** (Focused Quality Priority)

Operational Leads – Mary Kiely, Christopher Roberts and Christopher Button

We will this year undertake quality improvements to:

- Ensure the needs of both the patient and their families/carers does not vary in quality because of an individual's characteristics by ensuring care provision is individualised, timely and relevant.
- Ensure improved resources for relatives and carers relating to breaking bad news relating to End of Life (EoL) care

What do we aim to achieve?	December 2021 and January 2022 update	Progress rating
QP1. Implement a 7-day service across community services Measure impact of 7 day working across the Key Performance Indicators EoL dashboards (Abbie Thompson)	We now have an established 7-day service and are collating prospective 6-month audit data which will need review next month. We had previously presented evidence from audited a 7-day working trial, which was present to Community PSQB.	
QP2. Implement a 7-day service within the in-patient areas Measure impact of 7 day working across the Key Performance Indicators EoL dashboards (Mary Kiely)	Staff sickness/shortages hindering service. 2 full time B6 posts have been recruited to. Maternity cover being advertised, closes 20th Jan. A trial of a 7 day service did take place but was stood down due to staff shortages.	
QP3. Improve access to ePaCCs across the for patients within Frailty service This will be measured through an audit of records every quarter (Renee Comerford)	Improve access to EPaCCs – Currently there is limited staff within the acute trust who have access to see or document on EPaCCs template through system one Project underway to increase the number of people to have access to systmone and training on EPaCCs.	Update required from RC
QP4. Introduce a standard(s) that will improve a person's experience pre and post bereavement delivered by the ward teams This will be measured by qualitative narrative quarterly by EoL care facilitator. (Gill Sykes)	The bereavement service will feed back qualitative narrative and improvements to the End-of-Life Care Steering Group quarterly. (Unfortunately, the EOLC steering group isn't running at the moment to provide this feedback).	Awaiting funding decision at end of Jan 22 re

What do we aim to achieve?	December 2021 and January 2022 update	Progress rating
	The bereavement service as highlighted in QP5 will act on negative and positive person's experience gained from the bereavement telephone service. Currently the EOLC Facilitator and colleague work with wards and groups to improve overall care but specific areas are targeted based on feedback from the bereavement service where necessary. The Bereavement service is now also recording compliments/concerns via Datix to enable the team to monitor areas of need and excellence to ensure suitable support is available. CHFT Charitable funds have funded the bereavement support service for 12 months to employ a Band 6, 5 and 3 to enable increase in bereavement calls and also in reach into ward areas.	permanent funding
QP5. Review the Bereaved relatives telephone support service This will be measured by a qualitative and quantitative review of the service established during the pandemic (Gill Sykes)	Ongoing review and development of the bereavement support service. We now work closely with the medical examiners team to prioritise relatives for a call that they feel may need extra support. We also forward concerns/compliments to Datix to enable us to look at trends and implement changes. 12-month funding has been approved through charitable funds to continue the award-winning bereavement support service and employ a Band 6,5 and 3. A business plan has also been prepared for the next CISG meeting for substantive	Awaiting funding decision at end of Jan 22 re permanent funding

What do we aim to achieve?	December 2021 and January 2022 update	Progress rating
	funding of the service. We have overwhelmingly positive feedback from the relatives we speak to. We have also set up data to capture the number of calls undertaken. The Bereavement Service has recently won Overall Winner at the Patient Experience Network National Awards (PENNA) plus a win in the personalisation of care category and runner up in the staff engagement and improving the staff experience category. It was also a finalist in the Nursing Times Awards in the team of the year category and won the CHuFT 4 pillars team of the year award.	
QP6. Review Visitors guidance in line with national guidance and monitor compliance This will be measured by a Quarterly audit of the guidance in relation to EoL patients (Alexandra Keaskin)	All visiting has been suspended with exceptions around end-of-life care. National recommendation is 1 person visit but each case is assessed on a individual basis by ward managers. Visiting reviewed at Trust Gold meetings on a weekly basis.	Visiting currently suspended

10.6 **Clinical Documentation** (Focused Quality Priority)

Operational Leads – Lindsay Rudge, Louise Croxall and Mr Graham Walsh

We will this year undertake quality improvements to: Measure this piece of work is to ensure that the clinical record gives an accurate picture of the patients diagnoses, the care provided to that individual, that it reflects the standards laid down by the Trust and that information is recorded consistently.

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
QP1. Optimise the Clinical Record 1a. Complete the in-depth analysis	Company identified – stuck in the procurement process at the moment. July 21 – Meeting arranged with company 20.07.21 Sept 21 – Meeting took place with the company new Chief Nursing Informatics Officer (CNIO) needs to become up to date with background and then drive this forward to bring a plan back to next meeting. Dec 21- New CIO looking at ways of optimisation currently the external review has been paused. Feb 22- New CIO has assessed the original optimisation plan in conjunction with colleagues and a new plan has been put in place to base line re- education and a separate technical silver service. Nursing documentation is being looked at alongside Bradford CNIO.	**Reasonable Assurance**
1b. Benchmark	Subject to the outcome of the in-depth analysis	**Reasonable Assurance**
1c. Set local standards	Subject to the outcome of the benchmarking	**Reasonable Assurance**

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
QP2. Trial the use of the Digital White Board Identify areas to trial over a 4-week period - implement the white boards identifying data that can be pulled and measured to determine progress and future planning.	Trial period commenced – end date 15th June 21. July 21 – evaluation of the trial underway. Sept 21 – trial completed and CNIO and Chief Clinical Informatics Officer (CCIO) to meet to review feedback and discuss future innovations with Cerner. Dec 21- Further meetings taken place with Cerner re: White board and working with Director of Operations (DOP) for medicine to configure the white boards to CHFT needs and work alongside plan for every patient. Task and finish group taken place and electronic patient record (EPR) team building a mock board in cert to review and start a trial. Feb 22- Meetings have taken place with the DOP for medicine, QI manager and EPR workstream lead to map out what the board needs to include and how the board will work in clinical practice. Needs to go to Change and Prioritisation board and CNIO and CCIO have asked for a project manager to be assigned to the project to drive and coordinate the implementation.	**Substantial assurance**
QP3. Carry out a full review of the Ward Assurance within the KP+. 3a. Look at current data captured with service users	This will be reviewed by the subject matter experts (SMEs) and Ward Managers following the Work Together Get Results (WTGR) piece. Work to commence July 202. July 21 – Task and Finish Groups to be formed now WTGR completed to look at data capture. Sept 21- Task and finish groups under way. All first ones undertaken and SME's reviewing the documentation to bring back to next meeting. Dec 21- Task and finish groups completed and CNIO and corporate matron meeting with Robert Cox and team to make sure all areas are pulling from the correct place. Feb 22- Task and finish groups complete.	**Substantial assurance**

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
3b. Assess whether data relevant	Full review of data to be carried out regarding not only relevance, but also how staff can make it more meaningful to them in addressing shortfalls. July 21 – Task and Finish Groups to be formed now WTGR completed to assess whether data relevant. Sept 21 – SME's reviewing documentation bring back to task and finish groups. Dec 21- All key metrics have been agreed by SME's and are all in line with national guidance. Some questions modified and removed. Feb 22- As Above	**Substantial assurance**
3c. Agree metrics for collection	Metrics already agreed upon – review of data being extracted. Sept 21- Metrics may change according to task and finish group decisions. Dec 21 – As above meeting with data team and ward assurance team to improve data collection. Feb 22- Awaiting all data quality messages to be completed to pull information from relevant and correct areas within EPR. This should be completed by 14th Feb.	**Substantial assurance**
QP4. Ensure Ward Managers and Matrons own their own ward data using KP+ 4a. Ensure that all Ward Managers and Matrons have access to KP+	Staff groups contacted already – awaiting feedback. Aim to complete this by end of June 2021. July 21 – engaged with Matrons and Managers – access arranged for those who did not have access. Sept 21- This has been put on hold until task and finish groups complete there woke to train all staff the correct way. Dec 21- Meeting with CNIO and data quality team to make sure all the data is pulling correctly in ward assurance to give the wards the correct data. Feb-22 All ward managers have been issued with the individualised care document to issue to all nurses in ward areas of what assessments are expected.	**Substantial Assurance**

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
4b. Provide training in the use of KP+ for Ward Managers and Matrons	This was carried out in November 2020 – further engagement with staff on the 6th August 2021 through Chief Nurse's briefing. Sept 21- All ward managers have been asked to make sure they have access to KP+ Dec 21- Plan to roll out in January 2022. Feb 22- All ward managers should have access this needs to be managed in divisions to make sure ward managers are using and providing assurance.	**Reasonable Assurance**
4c. Embed review of KP+ into daily practice	This will be an action from the WTGR – start end of July 2021. July 21 – further training 6th August 2021 at Chief Nurse's briefing. Sept 21- Once task and finish groups completed this will be a session on Chief Nurse's briefing. Dec 21- Review of KP+ and to work with senior nursing leaders to improve dashboards for ward managers/ Matrons Feb 22- Strategy to be formed on how this can be achieved and completed and reviewed within divisions.	**Reasonable Assurance**
QP5. Audit clinical records using an audit tool. Audit 5 sets of records per week by Ward Manager reporting and act upon findings.	Audit to be carried out by Matrons – one per month per each of their wards – to start end of July 2021. July 21 – roll out delayed due to delay in completion of WTGR Sept 21- As above. Dec 21- Individualised care document to be updated and distributed to Matron's and ward managers. Changes implemented on feedback from ward 5 pilot making it easier for staff to access certain areas of the notes. This then needs to be driven by Associate Directors of Nursing (ADN) Feb 22- Sat within divisions.	**Reasonable Assurance**

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
QP6. Identify and establish a project team that can drive the improvement of data entry into EPR across the Trust. 6a. Identify the team	This will include Associate Director of Nursing, Matron and Ward Managers across the Trust.	**Substantial assurance**
6b. Identify outcomes wanting to achieve	Working Together Get Results completed at the end of July, face to face to ensure optimum engagement obtained. Action Plan to be completed from the results of the WTGR. Sept 21- Task and finish groups have been established. Which are being led by the subject matter experts Dec 21 – Clinical Records and Optimisation group will drive this forward in the future alongside ward Assurance tool. Feb 22- Clinical Records group will continue to drive forward and ward assurance will be covered in quality committee and through WEB.	**Reasonable Assurance**
6c. Agree defined goals and action plan that reflects this	Outcome of the WTGR will determine the action plan – aim for this to be available by the end of July 2021. July 21 - Sessions completed end of July – working towards action plan middle of August 2021. Sept 21-. Subject matter experts leading the review of assessment documentation within EPR. Amendments can then be made to extract data at the backend of EPR Dec 21- Review of the ward assurance will continue. Feb 22- Review of ward assurance continues.	**Reasonable Assurance**

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
QP7. Ensure training in the use of EPR reflects the standards laid down by the Trust and that it reflects training needs of the staff 7a. Support the Training team to ensure training meets the needs of the service user – fully aligned to roles and responsibilities	Task and Finish Group set up 2/12 ago to review the training plans for medical, nursing and HCA groups as a priority. Some representation from nursing but not medical teams – seeking support from them. July 21 - Progressing well with projected completion by the end of August 2021. Sept 21- Training team for digital health are attending ward areas also with set goals to achieve. CNIO working with Matrons and ward manager for the area to make sure correct goals are set. Ward 5 identified as first ward. Dec 21- Supporting the training team to introduce working again in the trust from being at home throughout the pandemic. Further areas identified for them to work in in coming months. Feb 22- Review and working alongside training team and looking at how can support the clinical groups working everyday supporting the teams. Review of training material planned with EPR team and training team.	**Reasonable Assurance**

What do we aim to achieve?	December 2021 and January 2022 Update	Progress rating
7b. Encourage Training Team to explore ways in which service users can be supported e.g. online, face to face, digitally	This is being reviewed within THIS. Initial plans e-Learning developer starting in post on 21.06.21 with an immediate action to create e-Learning modules for medical, nursing and HCA roles for August 2021. July 21 – E Learning Developer now in post and e learning sessions already underway. Sept 21- Training team attending ward areas for 3 weeks at a time working with nurses on the ward making sure EPR is being used to its most effective and documentation is all in the correct place. Dec 21 –New E-Learning modules have been produced and are currently in the testing phase. Feb 22- Training teams have been supporting the CNIO with ward visits supporting nurses and student nurses. Monthly meetings have been set up between the CHFT digital health team and the training lead to make sure expectations are laid out and key deliverables achieved. Also reviewing the training and different ways to support clinical staff across all roles.	**Substantial assurance**

10.7 Clinical Prioritisation (deferred care pathways) (Focused Quality Priority)

Operational Leads – Divisional Directors, Directors of Operation and Katharine Fletcher

We will this year undertake quality improvements to:

- Maintain a clear and comprehensive understanding of deferred care pathways as a result of COVID 19

No update received for this report, the Assistant Director of Quality and Safety will work with operation leads to provide an update the next report

10.8 Nutrition and Hydration for in-patient adult and paediatric patients

Operational Leads – Vanessa Dickinson, Jonathan Wood, and Dr Mohamed Yousif

We will this year undertake quality improvements to: Deliver safe and high-quality nutrition and hydration care for all in-patients at CHFT.

No update received for this report, the Assistant Director of Quality and Safety will work with operation leads to provide an update the next report

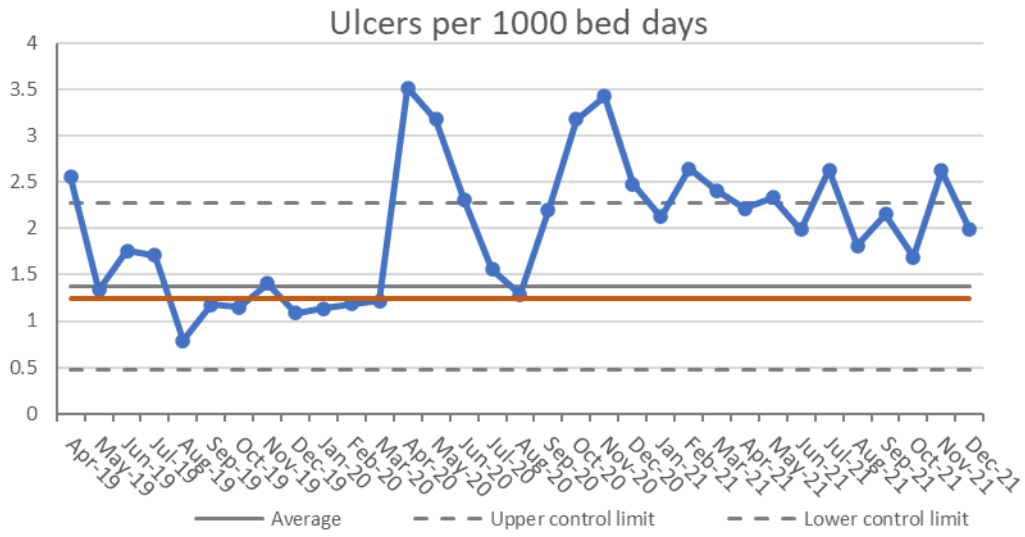
10.9 Reduction in the number of CHFT acquired pressure ulcers (Focused Quality Priority)

Operational Lead – Judy Harker

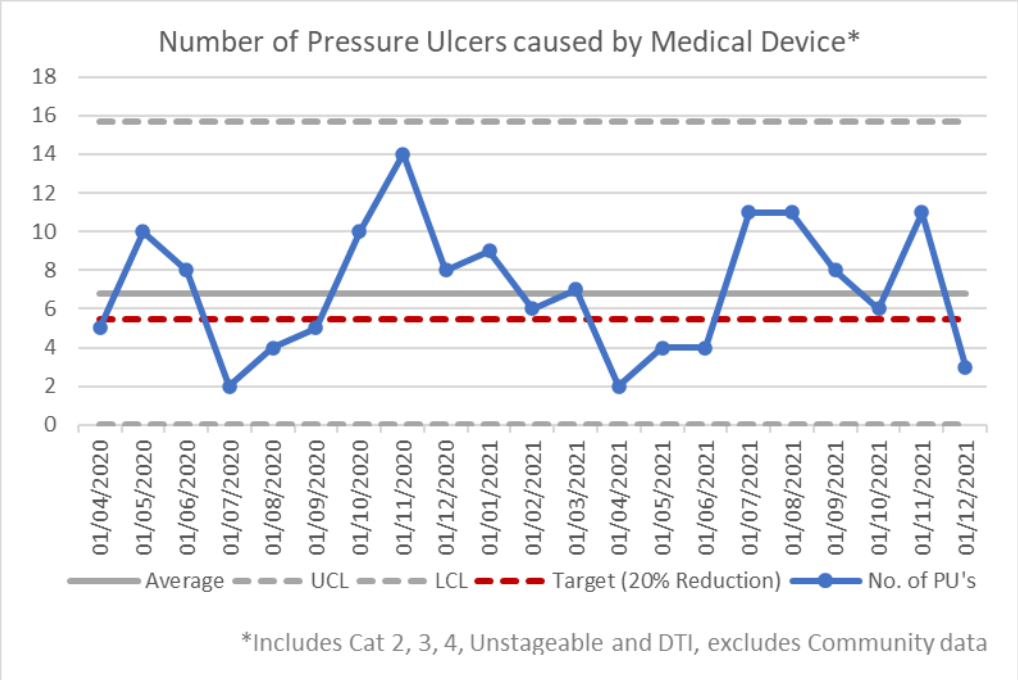
Incidence of hospital acquired pressure ulcers remains within target including heel and medical device pressure ulcers. Good progress has been made with ward assurance metrics which have been aligned to NICE quality standards and EPR as part of record keeping quality priority. Community pressure ulcer KPI has been agreed with data to follow in the next Quality Priority update. The Trust has witnessed an increasing trend in red pressure ulcer incidents. Learning from pressure ulcer investigations continues to be a key focus for the collaborative.

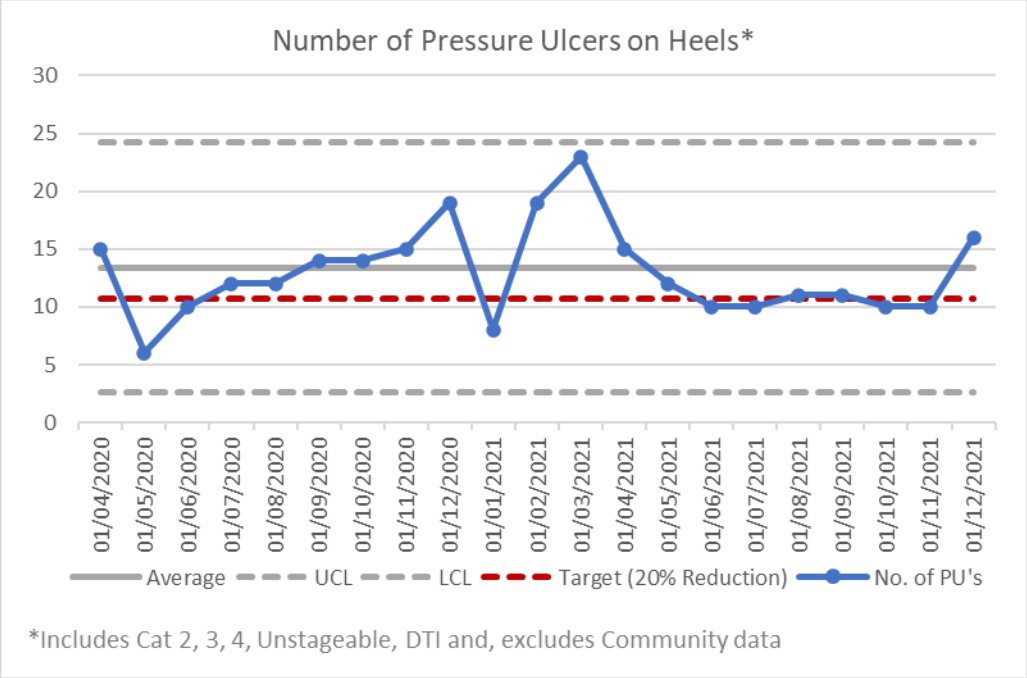
We will this year undertake quality improvements to:

- Reduce the occurrence of pressure ulcers and improve healing rates for existing pressure ulcers. In doing so we can reduce harm and spend, while improving the quality of healthcare experience of our most vulnerable patients.

What do we aim to achieve?	Current Update – November / December 2021	Progress rating	Next period
Reduction in the Incidence* of hospital-acquired pressure ulcers by 10%. This will be measured by incident data		**Reasonable assurance**	Continue to monitor and validate January data Launch of new pressure ulcer policy

What do we aim to achieve?	Current Update – November / December 2021	Progress rating	Next period
	There has been a reduction in the incidence of hospital acquired pressure ulcers from November to December 2021. November and December have been very challenging months for pressure ulcers. The Trust has witnessed high patient acuity and frailty, high numbers of patients with pressure ulcers at end of life and high levels of moisture associated skin damage which places an individual at greater risk of pressure damage. **Risk** There have been instances where wards have failed to Datix hospital acquired pressure ulcers. There is a risk that the pressure ulcer data may be incorrect. **Mitigation** Datix training delivered by Quality and Safety Team. Divisions to ensure that Datix reporting is included in Quality Priority action plans. Divisional ADNs are reviewing all pressure ulcers acquired on enhanced ward dashboards on a weekly basis SAS division linking with Continence service to improve bladder and bowel care. The Trust has submitted a bid for an additional £65k for alternating pressure mattresses to ensure patient need is met and allow for decommissioning of old mattresses. The new Policy for the Prevention and Management of Pressure Ulcers is currently being ratified. The Medical division are 'releasing time to care' to Matrons enabling closer monitoring of quality standards at ward level. Matrons will be allocated clinical, patient-facing time each day. 'Minimise Moisture' awareness week to be held in March 2022 to improve standards of care in the prevention and management of moisture damage.		

What do we aim to achieve?	Current Update – November / December 2021	Progress rating	Next period
Reduction in the incidence* of hospital-acquired medical device related pressure ulcers by 20%. This will be measured by incident data	 There has been a decrease in the number of device related pressure ulcers from November to December 2021. Devices causing pressure damage in December 2021 included endotracheal tubes, urinary catheters and NG tubes. **Risk** Lack of sustained reduction in medical device related pressure ulcers.	**Reasonable assurance**	Continue to monitor and validate January data.

What do we aim to achieve?	Current Update – November / December 2021	Progress rating	Next period
	Mitigation Medical device related pressure ulcers featured as a bite-sized training event during Stop the Pressure week November 2021. Recording available on Tissue Viability webpage and shared with Critical Care staff. Implementation of daily checklists of patients with casts, looking into the feasibility of orthopaedic practitioners completing a daily ward round of patients with high risk casts (cylinder) Materials Management are keeping key preventative dressings and gel pads on ICU top up.		
Reduction in the incidence* of hospital-acquired heel pressure ulcers by 20%. This will be measured by incident data		**Reasonable assurance**	Continue to monitor and validate January data Remaining wards will receive Off-loading devices on top up via Materials Management Heel Device Selection Guide to be devised by Podiatry Team Explore feasibility of

What do we aim to achieve?	Current Update – November / December 2021	Progress rating	Next period
	Hospital acquired heel pressure ulcers have increased sharply in December 2021. 75% of the Trust adult wards have inflatable heel devices on top up via Materials Management. Training video disseminated widely.		using QR codes on plaster casts to provide pressure ulcer information Spread QI from Orthopaedic OPD to Orthopaedic wards in relation to heel pressure ulcer prevention
Reduction in the number of Orange harm pressure ulcers by 50%	18 moderate / orange harms in November and 12 in December 2021. **Risk** Assurance required that all pressure ulcer incidents are coded correctly. **Mitigation** There is a need to understand the journey of an incident and identify who is responsible for updating Datix at different stages of an investigation. Medical division is developing a SOP for Orange Panel to improve attendance, quality of investigations and learning. Once completed this will be shared across the organisation.	**Reasonable assurance**	Work to commence on reviewing Datix build and have capability to extract pressure ulcer contributory factors to support system wide learning.
No Red serious pressure ulcer incidents	There has been a further red serious incident in December 2021. This is a category 4 pressure ulcer to the sacrum. Themes from red incidents have been very similar. They include gaps in skin inspection and repositioning, provision of incorrect pressure redistributing equipment, inconsistent documentation and incorrect or late risk assessment. These all constitute the fundamentals of pressure area care.	**Limited assurance**	

What do we aim to achieve?	Current Update – November / December 2021	Progress rating	Next period
95% or more of patients in hospital will have a pressure ulcer risk assessment within 6 hours of admission to Trust / transfer to ward. This will be measured by ward assurance	In December 2021 30% of patients in hospital received a risk assessment within 6 hours of admission/transfer. There has been no improvement on this measure. **Risk** Data would indicate that 98% of patients have received a risk assessment within 7 days. Analysis of data would suggest that whilst risk assessments are being carried out in ED, they are not consistently being repeated once a patient has transferred to a new ward. This results in a failure to implement or delayed implementation of preventative interventions. **Mitigation** Audit support provided for this quality priority. Identification of barriers to completing risk assessments will be focus of enquiry. New PURPOSE T risk assessment tool EPR proposal is being reviewed at Digital prioritisation Board in February 2022. Guidelines for Documenting Individualised Care through EPR now published and circulated to clinical areas. Informatics are building a live dashboard on KP+ to help identify patients who have not received necessary risk assessments. Bite-sized pressure ulcer training to be rolled out to wards starting 28.2.22. There will be a strong focus on skilling up Health Care Support Workers who we acknowledge provide the bulk of pressure area care.	**Limited assurance**	
95% or more of at-risk patients in hospital will have a sskin bundle identified and completed. This will be measured	Data incomplete. **Risk** Gaps in skin bundles poses risk for pressure ulcer development. **Mitigation**	**Limited assurance**	Skin bundle fields on EPR being reviewed jointly with BHFT. Changes to

What do we aim to achieve?	Current Update – November / December 2021	Progress rating	Next period
by ward assurance	Guidelines for Documenting Individualised Care through EPR now published and circulated to clinical areas. Informatics are building a live dashboard on KP+ to help identify patients who have not received necessary risk assessments. Bite-sized pressure ulcer training to be rolled out to wards starting 28.2.22. There will be a strong focus on skilling up Health Care Support Workers who we acknowledge provide the bulk of pressure area care. ED to initiate skin bundles on patients with an extended stay in department beyond 8 hours.		EPR to require ED to initiate skin bundles. Meeting with ED staff to understand how sskin bundles will fit with patient pathways on EPR.
95% or more of at-risk patients in hospital will have a pressure ulcer care plan initiated. This will be measured by ward assurance	All patients with a Waterlow of 10 > had a pressure ulcer prevention care plan initiated. Joint work underway with BHFT in developing a new suite of pressure ulcer care plans. Guidelines for Documenting Individualised Care through EPR now published and circulated to clinical areas.	**Substantial assurance**	Finalise revisions to BHT / CHFT care plan.
95% or more of patients will have a completed Waterlow pressure ulcer risk assessment within 7 days of admission to	50% of patients with a Waterlow pressure ulcer risk assessment completed within 7 days 82% of completed Waterlows done within 7 days Risk Difficulties in extracting data from Systmone due to diverse patient caseload and activity. Early data needs to be interpreted with caution. Mitigation	**Limited assurance**	

What do we aim to achieve?	Current Update – November / December 2021	Progress rating	Next period
District Nursing caseload. This applies to patients who have been on caseload for more than 28 days. This will be measured by SystmOne audit.	Data to be interrogated further for next report. Risk assessments are reviewed in Orange Panel.		
95% of relevant staff (RNs, Nursing Associates and HCAs) will have completed React To Red Pressure or equivalent Pressure Ulcer training in last 2 years. This will be measured by Essential Safety Training (EST) compliance data	81% of staff have completed React To Red Training. Additional virtual and ward-based training has been provided on pressure ulcer prevention to support staff. Deep dive in SAS division to ensure compliance data is capturing correct staff. Improved traction with divisional quality improvement pressure ulcer leads to address non-compliance of staff with regards to training. National pressure ulcer e learning tool will replace Trust's e learning resource once the new pressure ulcer risk assessment tool is implemented across the organisation. Bite-sized training to be delivered across the Trust. Physiotherapists and Occupational Therapists are receiving pressure ulcer training in March 2022. Tissue Viability Nursing Associates continue to deliver bedside training to wards experiencing increased incidence of pressure damage,	**Reasonable assurance**	Divisions to continue to address non-compliance Screensaver to raise awareness of training.

10.10 Making complaints count: Implementation of the national regulations and Parliamentary and Health Service Ombudsman (PHSO) standards (phased introduction)

Operational Leads – Head of Complaints

Our focus for this quality priority is to: Demonstrate an incremental improvement / compliance over the year against the national regulations and standards. Our implementation success measure will be a shift change in the assurance from red to green over the year. Improvements will be noted via performance reporting and within this bi-monthly report.

The Making Complaints Count (MCC) steering and operational groups have been reviewed to ensure effective use of colleague input across both groups. A Task and Finish Group has been identified and 6 sessions have been scheduled to focus on Quality, Performance and Learning, these will commence early January. Training needs analysis is part of this process. An intranet page is currently underway which will contain how to guides. Standards statements are also underdevelopment which will be shared with all of the team to ensure consistency of approach. The investigation training as been revised and will apply to staff involved in all types of investigation not just incident investigation.

The Head of Head of PALS & Complaints came into post in August 2021 and the Assistant Director of Quality and Safety commenced in post in January 2022 with a key responsibility for Monitor performance against the key complaint's quality indicators, taking action where the standards are not being met, ensuring the delivery of the Complaint Improvement Action. A review of the team has begun take place with additional interim band 7 role now in place to provide additional oversight and scrutiny.

Making Complaints Count and quality priority actions from this are: -

- The role of patient experience and quality support leads has been revised to increase the 'improvement' element of the role – an action learning set approach is in place for these staff members with Head of Complaints
- An investigation training programme is ongoing - the focus for this is serious incident investigation, but the theory is transferable to a complaint investigation.
- Complaint Electronic Staff Record (ESR) learning module in place and a review the 'Quality check' of draft complaint responses tool previously used by Divisional managers has taken place. This will support identification of which staff require additional / focussed support

Appendix 1 – Report BRAG rating assurance table

RAG RATING	Evidence of fulfilling RAG rating
WHITE	• Not yet started
Substantial assurance	• Progressing to time, evidence of progress • Full assurance provided over the effectiveness of controls. • No action required • This would normally be triggered when performance is currently meeting the target or on track to meet the target. • No significant issues are being flagged up and actions to progress performance are in place.
Reasonable Assurance	• Evidence available at the time of assessment shows that the outcome is mostly met or there is insufficient evidence to demonstrate the outcome is met. • Impact on people who use services, visitors or staff is low. • Action required is minimal • Some assurances in place or controls are still maturing so effectiveness cannot be fully assessed at this moment but should improve. • There are a set of actions in place that is expected to result in performance coming closer to meeting the target by the end of the target or reporting period. • Delayed, with evidence of actions to get back on track.
Limited assurance	• Evidence available at the time shows that the outcome is not being met or there is no available evidence that the outcome is met. Impact on people who use services, visitors or staff is high/significant. Action is required quickly • Cause for concern. No progress towards completion. Needs evidence of action being taken • Close monitoring or significant action required. This would normally be triggered by any combination of the following: • Performance is currently not meeting the target or set to miss the target by a significant amount. • Actions in place are not believed to be enough to bring performance fully back on track before the end of the target or reporting period. • The issue requires further attention or action
Full assurance	• Completed with documented evidence • Evidence of compliance with standards or action plans to achieve compliance.

21. Integrated Performance Report – January 2022

To Note

Presented by Jo Fawcus

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Quality and Performance Report
Authors:	Peter Keogh, Assistant Director of Performance, Kirsty Archer Deputy Director of Finance, Andrea Dauris Associate Director of Nursing, Jason Eddleston Deputy Director of Workforce and OD
Sponsoring Director:	Jo Fawcus, Chief Operating Officer
Previous Forums:	Quality Committee, Finance & Performance Committee

Purpose of the Report

To provide the Board of Directors with a single combined narrative that seeks to triangulate current performance for the month of January 2022.

Key Points to Note

Trust performance for January 2022 was 61% which is actually its lowest position in this financial year with the RESPONSIVE domain (now red) and the WORKFORCE domain impacting most on this overall deterioration.

The **SAFE** domain is now the Trust's only green domain. The **CARING** domain remains amber with 4 of the 5 FFT areas now green but performance in Complaints has dipped again following improvement last month. Dementia screening is now at its lowest level this financial year at 20%. The **EFFECTIVE** domain has become amber as a further couple of targets have been missed and SHMI and HSMR values have increased further. #Neck of Femur is still struggling to improve its position at 60%. The **RESPONSIVE** domain is showing as red for the second month this year with a couple of 31-day cancer targets being missed to add to those areas that have been struggling to maintain performance. Stroke indicators alongside the underperformance in the main planned access indicators and ED are the main challenges. **WORKFORCE** remains amber but has deteriorated with a significant increase in Covid related absence and as a result we have seen a peak in the 12-month running total for both long-term and short-term sickness. Return to Work Interviews are still below 60%. **FINANCE** domain is still amber and has improved a little although the Use of Resource Metric is now red.

Due to operational pressures IPR (Integrated Performance Report) only contains narratives for Key Indicators that are not achieving target.

EQIA – Equality Impact Assessment

The IPR does not report performance with a breakdown of Protected Characteristics either for workforce or patient data. Workforce equality monitoring is conducted at Workforce Committee via WRES, WDES and Staff Survey. The Public Sector Equality Duty annual report is presented to Board annually, as well as our gender pay gap report.

Recommendation

The Board of Directors is asked to **NOTE** the narrative and contents of the report and the overall performance score for January 2022.

Calderdale and Huddersfield NHS Foundation Trust

Performance
January 2022

National Comparative Performance
Although CHFT has had a difficult few months in terms of performance we need to recognise the comparative performance of the organisation for its key metrics across England as a whole to fully appreciate how well the Trust is still managing to operate at the highest levels.

Cancer 62-day referral to treatment – for the cumulative 8-month position April to November 2021 CHFT was 2nd best out of 127 Trusts nationally with performance at 91.5% (England 70.9%), an outstanding achievement.

Emergency Care standard 4 hours - for the cumulative 9-month position April to December 2021 CHFT was placed 14th out of 111 Trusts nationally with performance at 80.4% (England 67.9%), best in West Yorkshire and with only 2 smaller Trusts in the North performing better for Type 1 EDs. Again, a fantastic effort.

If these 2 metrics are combined, then CHFT performs better than any other organisation nationally.

Elective Care
Although CHFT is in a good position for P2s and 104 week waits we need to bear in mind the impact of switching on referrals early and not treating electives for longer than other Trusts in Yorkshire during the early stages of the pandemic. Our 18 weeks referral to treatment position stands at 55.3% as at December 2021 (we do not monitor as we are one of the field-test Trusts for the new Elective Care standard) which places us at 99 out of 113 Trusts nationally.

Quality, Workforce and Finance
We have looked at our main headlines from a Trust overview perspective and considered the impact that these areas are having on service performance.

The number of ED attendances for both hospital sites has increased since Christmas with significant numbers of Covid cases from 26th December through to 19th January where they peaked at 189 Covid positive inpatients. Acuity/dependency is still significantly high and has led to some very challenging operational issues. We have seen the impact on the 4-hour ECS performance over recent months although still often better than other Trusts in West Yorkshire. We have continued to see long waits in both emergency departments which is an extremely poor patient experience, and we know increases risk for patients in terms of outcomes.

We have seen significant numbers of Hospital Acquired Covid due to the transmissibility of the Omicron variant, as well as this there was a Norovirus outbreak which lasted approximately 4 weeks on one ward area reducing patient flow within Frailty and Elderly Care and gave the need to keep some extra capacity areas open.

The Covid numbers have reduced significantly, however there are approximately 100 patients on the Transfer of Care list which means keeping the extra capacity areas open and using discharge lounge at HRI and Ambulatory at CRH as inpatient ward areas.

Year to date the Trust is reporting a £2.09m deficit, a £0.15m favourable variance from plan. Whilst the Trust has submitted a balanced plan for the year and has delivered a break-even position in the first half of the year (H1), the financial position remains challenging. H2 includes a significant efficiency requirement of £6.7m, with only £3.9m identified of which £3.3m is currently forecast to deliver. The deficit position is driven by a combination of staffing pressures, in particular the high cost of temporary staffing (enhanced bank rates and high cost agency) and Recovery costs, including the cost of Independent Sector support.

Pay costs are £6.69m above the planned level year to date, although this includes £3.57m of H1 backdated pay awards which are funded, leaving an underlying variance of £3.12m adverse. The adverse variance is largely driven by the agreed enhanced pay for Bank staff, an additional cost of £0.76m in month and £3.93m year to date, (£2.01m adverse variance). Covid pressures have also increased over the last few months; Emergency Department segregation and enhanced staffing models on Wards and in Critical Care continue to drive higher costs.

Whilst both Trust and Integrated Care System (ICS) have not delivered elective activity above the required threshold in order to access the Elective Recovery Fund (ERF) in H2, the Trust has successfully bid for additional Elective Recovery+ funding in support of schemes to increase capacity. This has mitigated the additional cost pressures in the year to date position and similarly the Trust is forecasting achievement of the full year financial plan, but this is reliant upon non-recurrent mitigation.

We continue to monitor One Culture of Care Must-Do's to support colleagues. This focuses on colleague rest and recuperation for wellbeing, health and wellbeing risk assessments, clear access points for our internal Listening Ear service and external psychologist-led employee assistance programme provided by CareFirst, refreshed leader/manager guides and ensuring there is an understanding of the opportunities to raise concerns through our Speak Up processes. Absence levels have increased in January, principally as a consequence of the Omicron Covid variant. The 12-month rolling absence rate is at 5.43%, the rate for January was exceptionally high at 8.74% driven by a 3.66% Covid related absence rate. This has created a significant pressure on frontline services with a greater reliance on bank and agency covered shifts and a greater likelihood of 'on the day' moves for substantive colleagues. We are now seeing a reduction in absence as the Omicron variant impact subsides.

A review of January 2022 data indicates that the combined RN and non-registered clinical staff metrics resulted in 24 of the 27 clinical areas having fewer CHPPD than planned, with a total deficit of 1.1 CHPPD across the Trust. The gap in CHPPD is at its broadest with the RN workforce representing 1.1 deficit and HCSW 0.2 deficit. This position demonstrates a deterioration from the November and December figures across fill rates and CHPPD. This deficit is managed through twice-daily staffing meetings which are chaired by the Associate Directors of Nursing and supported by mitigations reported within the Safecare system and the use of professional judgement to redeploy staff on a shift basis and establish the safest staffing possible in all areas.

A review of the nurse sensitive indicators demonstrates a reduction in the number of falls and pressure ulcers across both the Medical and Surgical divisions.

The use of the enhanced metrics dashboard is embedded in the weekly senior safer staffing review meeting. Areas with less than 85% shift fill rate are scrutinised with a suite of nurse-sensitive indicators. Specific action plans are generated by the ADNs and reported through the Gold Command structure.

In response to the changing situation as a result of the emergence of the Omicron strain of Covid, activity has completed to plan for any surge in clinical demand and/or significant staffing challenges as a result of staff absence. This includes a review and update of the OPEL Safer Staffing Actions cards and service specific action cards which are all available on the intranet.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Integrated Performance Report

January 2022

Report Produced by : The Health Informatics Service

Data Source : various data sources syndication by VISTA

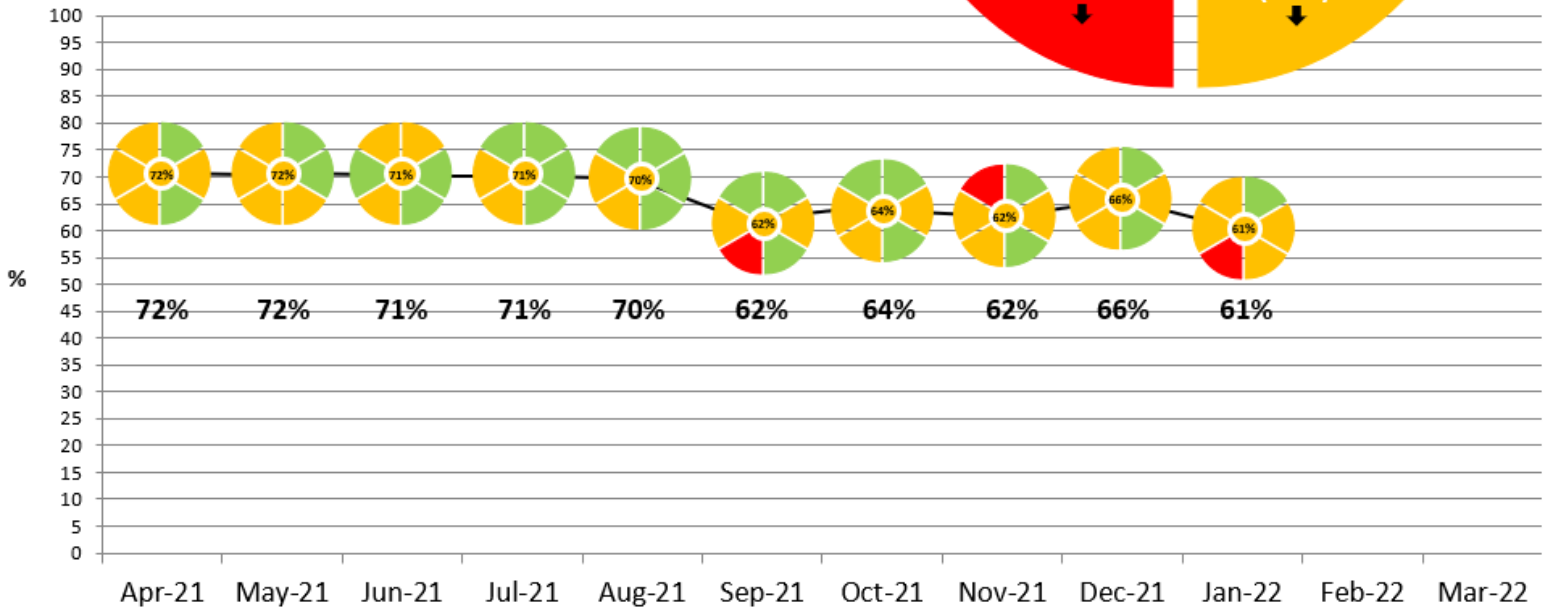
Performance Summary

January 2022

OVERSIGHT FRAMEWORK

SAFE	
VTE Assessments	Never Events
CARING	
Mixed sex accommodation breaches	% Complaints closed
FFT Inpatients FFT Outpatients FFT A&E FFT Community	FFT Maternity
EFFECTIVE	
MRSA	Preventable Cdiff
HSMR	SHMI

RESPONSIVE	
Diagnostics 6 weeks	ECS 4 hours
Cancer 62 day Screening to Treatment	Cancer 62 day Referral to Treatment
FINANCE	
Variance from Plan	Use of Resources
WORKFORCE	
Proportion of Temporary Staff	Sickness
Staff turnover	Executive Turnover



Key Indicators

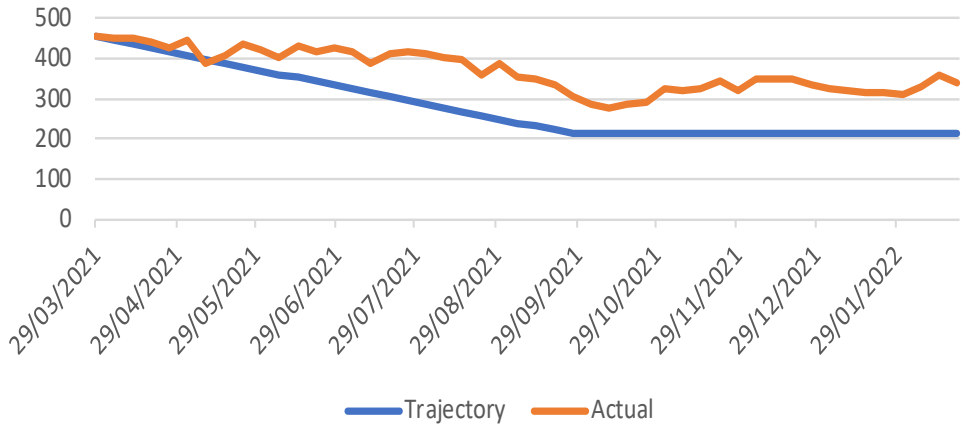
	20/21	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	YTD	Performance Range		
SAFE																									Green	Amber	Red
Never Events	2	0	1	1	0	0	0	0	0	0	0	0	0	**0**	0	1	0	0	0	0	0	0	**0**	**1**	0		>=1
CARING																									Green	Amber	Red
% Complaints closed within target timeframe	60.07%	93.8%	81.8%	80.0%	69.6%	71.4%	53.9%	44.1%	50.0%	41.7%	63.0%	52.9%	60.00%	100.00%	87.50%	100.00%	69.44%	55.10%	71.43%	58.82%	94.29%	70.73%	**in arrears**	**74.17%**	100%	86% - 99%	<=85%
Friends & Family Test (IP Survey) - % Positive Responses	91.09%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.63%	93.46%	88.32%	96.82%	96.75%	95.62%	97.00%	96.38%	96.61%	97.33%	98.26%	97.47%	97.35%	**in arrears**	**96.98%**	>=90% / >=95% from		<=79%
Friends and Family Test Outpatients Survey - % Positive Responses	93.27%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	93.37%	93.10%	93.28%	92.38%	92.45%	92.20%	92.29%	91.88%	91.77%	91.49%	91.51%	92.45%	93.02%	**in arrears**	**92.10%**	>=90% / >=93% from		<=79%
Friends and Family Test A & E Survey - % Positive Responses	90.16%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	90.38%	90.91%	89.37%	90.48%	85.13%	85.90%	82.98%	78.53%	81.33%	80.85%	81.01%	82.39%	84.40%	**in arrears**	**82.50%**	>=80% / >=85% from		<=69%
Friends & Family Test (Maternity) - % Positive Responses	98.86%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	98.00%	100.00%	100.00%	91.89%	85.71%	90.00%	91.23%	97.53%	95.19%	97.69%	93.98%	93.20%	98.33%	**in arrears**	**95.41%**	>=90% / >=95% from		<=79%
Friends and Family Test Community Survey - % Positive Responses	100.00%	COVID	COVID	COVID	COVID	COVID	COVID	COVID	COVID	100.00%	100.00%	100.00%	100.00%	99.50%	93.80%	93.37%	87.74%	92.52%	94.27%	91.12%	95.86%	93.68%	**in arrears**	**92.85%**	>=90% / >=95% from		<=79%
EFFECTIVE																									Green	Amber	Red
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0**	0		>=0
Preventable number of Clostridium Difficile Cases	6	1	1	2	2	0	0	0	0	0	0	0	0	0	1	0	1	0	1	0	0	1	**0**	**4**	4		3.4
Local SHMI - Relative Risk (1 Yr Rolling Data)	100.94	98.4	98.68	99.05	99.74	100.88	101.31	102.27	102.71	100.94	104.11	103.15	102.26	104.83	104.78	105.07	105.49	105.91	105.39	106.60				**106.60**	<=100	101 - 109	>=110
Hospital Standardised Mortality Rate (1 yr Rolling Data)	90.49	91.32	91.56	92.39	91.88	92.85	93.32	93.3	92.98	90.32	90.49	90.76	89.46	88.24	88.99	90.00	90.56	92.19	93.78	95.20	97.00			**97.00**	<=100	101 - 109	>=111
RESPONSIVE																									Green	Amber	Red
Emergency Care Standard 4 hours	88.81%	92.59%	95.24%	94.76%	93.72%	90.65%	88.93%	81.25%	81.42%	86.82%	87.82%	86.48%	87.83%	88.22%	86.70%	86.16%	78.59%	79.57%	78.29%	75.97%	76.81%	72.95%	**75.70%**	**79.96%**	>=95%	81% - 94%	<=80%
% Stroke patients admitted directly to an acute stroke unit within 4 hours of arrival	65.30%	71.43%	71.93%	67.24%	54.41%	58.33%	50.94%	49.18%	55.90%	65.30%	56.06%	25.42%	38.60%	61.02%	49.06%	54.90%	42.29%	43.14%	42.00%	33.87%	33.33%	23.19%	**16.67%**	**40.00%**	>=90%		<=85%
Two Week Wait From Referral to Date First Seen	98.74%	98.24%	99.02%	98.52%	98.92%	99.65%	97.85%	99.04%	98.50%	98.91%	98.55%	98.80%	98.76%	98.31%	99.02%	97.84%	97.87%	98.46%	98.62%	98.59%	99.21%	97.79%	**98.39%**	**98.42%**	>=93%	86% - 92%	<=85%
Two Week Wait From Referral to Date First Seen: Breast Symptoms	97.86%	100.00%	100.00%	97.70%	95.87%	100.00%	99.27%	100.00%	94.78%	98.70%	97.35%	96.45%	97.34%	98.28%	98.04%	100.00%	98.68%	100.00%	97.96%	98.45%	96.86%	96.00%	**93.20%**	**97.75%**	>=93%		<=92%
31 Days From Diagnosis to First Treatment	98.08%	99.42%	97.37%	98.26%	97.83%	97.69%	100.00%	98.67%	96.23%	96.71%	96.82%	98.55%	99.22%	99.45%	99.41%	97.63%	98.94%	97.92%	95.88%	94.89%	99.01%	99.35%	**98.14%**	**98.07%**	>=96%		<=95%
31 Day Subsequent Surgery Treatment	90.99%	96.88%	96.00%	69.57%	86.84%	91.30%	100.00%	96.30%	96.30%	86.21%	73.91%	92.31%	100.00%	97.14%	100.00%	100.00%	97.78%	94.44%	84.78%	100.00%	92.59%	100.00%	**92.59%**	**95.41%**	>=94%		<=93%
31 day wait for second or subsequent treatment drug treatments	99.15%	100.00%	100.00%	97.87%	97.83%	100.00%	100.00%	100.00%	100.00%	100.00%	96.55%	100.00%	98.04%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	**95.00%**	**99.55%**	>=98%		<=97%
38 Day Referral to Tertiary	54.64%	76.00%	45.45%	40.00%	65.00%	47.06%	39.13%	58.33%	35.71%	50.00%	43.75%	61.54%	91.67%	50.00%	63.16%	50.00%	72.73%	44.44%	54.55%	57.89%	53.85%	28.00%	**41.67%**	**50.30%**	>=85%		<=84%
62 Day GP Referral to Treatment	91.47%	93.61%	91.41%	85.59%	91.72%	91.16%	93.03%	89.67%	94.76%	90.00%	90.10%	87.58%	95.65%	93.14%	90.09%	91.97%	91.30%	91.48%	89.35%	91.51%	93.43%	87.32%	**88.73%**	**90.87%**	>=85%	81% - 84%	<=80%
62 Day Referral From Screening to Treatment	63.98%	72.22%	37.50%	0.00%	0.00%	33.33%	0.00%	83.33%	81.82%	85.19%	83.33%	73.91%	100.00%	75.00%	57.89%	48.48%	32.14%	55.26%	32.00%	55.56%	76.19%	78.57%	**53.85%**	**55.21%**	>=90%		<=89%
Faster Diagnosis Standard: Maximum 28-day wait to communication of definitive cancer / not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	79.84%	70.98%	85.89%	73.70%	80.21%	83.19%	82.94%	82.52%	80.91%	81.48%	71.76%	82.50%	80.21%	73.05%	67.44%	69.00%	73.38%	69.32%	70.67%	76.20%	78.29%	76.99%	**76.43%**	**73.07%**	>=75%		<=70%
WORKFORCE																									Green	Amber	Red
Sickness Absence rate (%) - Rolling 12m	4.52%	4.12%	4.23%	4.25%	4.25%	4.24%	4.24%	4.30%	4.41%	4.46%	4.53%	4.59%	4.52%	4.37%	4.35%	4.44%	4.61%	4.76%	4.89%	5.00%	5.01%	5.12%	**5.43%**	-	<=4%	<=4.5%	>4.5%
Long Term Sickness Absence rate (%) -Rolling 12m	3.07%	2.61%	2.69%	2.72%	2.73%	2.73%	2.73%	2.78%	2.86%	2.93%	2.99%	3.07%	3.07%	3.01%	2.99%	3.07%	3.17%	3.29%	3.36%	3.39%	3.38%	3.38%	**3.40%**	-	<=2.5%	<=2.75%	>2.75%
Short Term Sickness Absence rate (%) -Rolling 12m	1.45%	1.51%	1.54%	1.53%	1.52%	1.51%	1.52%	1.52%	1.55%	1.52%	1.54%	1.52%	1.45%	1.36%	1.35%	1.38%	1.44%	1.48%	1.53%	1.61%	1.63%	1.74%	**2.04%**	-	<=1.5%	<=1.75%	>1.75%
Overall Essential Safety Compliance	94.90%	93.61%	94.11%	94.24%	95.85%	94.42%	95.28%	95.51%	95.18%	95.16%	95.02%	94.86%	94.90%	94.85%	94.68%	95.64%	95.48%	93.93%	93.81%	93.22%	93.01%	93.28%	**92.50%**	-	>=90%	>=85%	<85%
Appraisal (1 Year Refresher) - Non-Medical Staff	95.15%									95.15%	95.15%	95.15%	95.15%											-	>=95%	>=90%	<90%
Appraisal (1 Year Refresher) - Medical Staff (Rolling 12mth)	41.05%																							-	>=95%	>=90%	<90%
FINANCE																									Green	Amber	Red
I&E: Surplus / (Deficit) Var £m YTD	2.27	(0.00)	0.00	0.00	0.00	0.00	0.00	0.95	0.16	-1.00	0.41	0.58	1.18	0.55	2.39	0.28	-0.22	-1.40	-1.62	0.00	-0.05	0.17	**0.02**	**0.18**			

SWOT Analysis

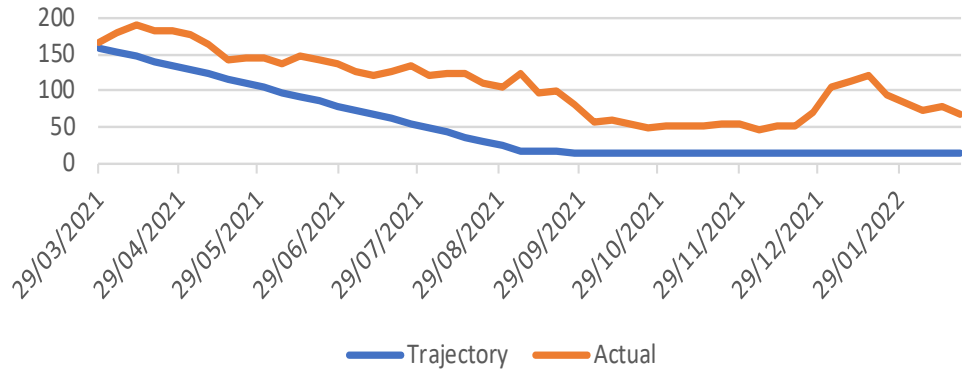
Strengths	• Agreed Recovery Framework. • Continuing to focus on Trust agreed priorities for elective patients, e.g. ensuring we prioritise patients with learning disabilities, P2s and long waiters (104 weeks). • Ongoing comprehensive theatre staff engagement and workforce development programme. • Community Pharmacist roles continue to add significant value in Quality Improvement (identifying and managing medication incidents), supporting effective assessment and care planning across nursing and therapy services and helping manage some of the discharge based risks and issues with handover of medicines management. • Continue to support Mid Yorkshire Hospital Trust with Non-Surgical Oncology care for Breast and Lung cancer and also now providing some in-reach support to Bradford. • The Tytocare trial has now completed the initial period of 6 weeks in the Emergency Department following clinical safety sign-off and sign-off by the Divisional senior management team. The aim of the trial was to utilise new technology to enable virtual consultant presence in the emergency department; this should reduce the overall length of stay in the department and increase the number of patients who have a decision within one hour. The trial is currently being evaluated in Medicine and next steps confirmed with a formal review scheduled for early January. • Focus on recruitment in both clinical and admin roles to support Recovery. Using alternative roles and thinking differently for hard to recruit areas. Also exploring risks and benefits to over recruitment to minimise bank and agency spend. • Have introduced a locally developed acuity and complexity score for District Nursing caseloads which is adding value in weighting caseload management but also evidencing increased acuity in demand. • Insourcing arrangements in place for ENT (OP & Surgery), Orthopaedics (CHOP LLP) and Ophthalmology (OP, diagnostics & Surgery) to help tackle elective backlogs. • Automated medicine cabinets installed at HRI and pharmacy robot business case approved. • CMDU programme started 17th January in collaboration with Locala and Mid Yorkshire to reduce hospital attendances. • Urgent Community Response 0-2 hour service started 6th December and is being well received and utilised with 120 referrals in December primarily from CHFT services, other HCP's GP's and YAS. • Community 7-day on-call manager rota in operation to respond to and support pressures in the system. • Continue to respond to a challenging Covid Vaccination Programme 12-15 yr old requirements including planning for new 2nd dose and 5-12 yr old requirements.
Weaknesses	• Bed pressures continue to be significant. Continued sustained pressure on ICU (Covid and non-Covid demand). • The staffing position continues to be extremely challenging across all divisions in particular among nursing teams and is being closely monitored and managed on a daily basis through the Gold meetings. • Ward 11 is now a 24/7 medical ward but with an establishment only for Monday-Friday • High levels of staff having to isolate leading to low levels of staffing across clinical areas. • Staffing shortages in theatres leading to continued reduced capacity to operate on patients. • Having to pull outsourced patients back from BMI and Spire due to not being dated within current local waiting time targets. • Issue retaining Community Pharmacists in Quest due to conflicting demands with PCN Pharmacists. • MRI downtime in Radiology due to equipment issues. ED and IP prioritised to ensure flow was not compromised. • Trust Estate and dual site configuration reduces flexibility.
Opportunities	• The SAFER programme continues to pull together existing workstreams and those stopped during the Covid period. • The Plan for Every Patient roll-out programme is underway with further resource allocated to increase pace and buy-in. • Medicine is enacting plans to effectively use allocated face to face clinic capacity to ensure this is used effectively across all specialties to ensure patients with the highest priority are seen. • Pilot Urgent Care Hubs have been established at both HRI and CRH staffed by CHFT colleagues. These are operational Monday-Friday 08.00-18.00 with the service reverting ` to Local Care Direct outside of these hours. The pilots have been extended until the end of December and a joint business case with the CCGs is now in draft format. We have managed to secure a significant increase with GP shifts in the hubs. Demand going through the UCHs has now increased to 18% of attendances. • Developing SOP to stop mandatory 3-day isolation for low-risk pathways - will help reduce health inequalities and help backfill late notice cancellations. • From December weekend Endoscopy insourcing will focus on tackling surveillance backlog which will also help the Trust's 52-week position. • Using Myosure in Gynaecology to see and treat patients in an ambulatory setting where previously they would have needed theatre. Supports capacity and improved patient experience. • Development of workforce plan including ODP apprentices, Nurse Associate role. • Opportunity to work with NHSE as a part of the pathfinder pilot looking at hospital patient transport (HTCS) for both inpatients and outpatients. • Money received from HEE for Allied Health Professions Workforce Supply Strategy Planning project work started and planned to be undertaken between December 2021 and April 2022. • Recruitment in process for Clinical Educator role (Nursing). Will support development of competencies and aim to improve performance against key quality KPIs i.e. medication incidents.
Threats	• We continue to see the significant and sustained increase in demand for both our emergency departments which continues to create pressure at the front door and driving ongoing increased staffing. • Staff being stretched due to increased number of Delayed Transfers of Care and increased Covid bed base. • Community services are increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and Long Term Condition (LTC) management. • Patients are presenting with increased acuity and complexity which is resulting in a longer length of stay and challenges around timely discharge into the community. • Staff fatigue due to ongoing pressures and frustration due to prolonged changing and increasing workloads. • Cost pressures increasing dependencies on overtime and bank. • Winter pressures. • Amendments to pay enhancement scheme for elective recovery could risk losing more theatre capacity • Potential stopping of some elective services to a) move RNs to support medical wards, or b) move staff from Endoscopy or theatres in the event of increased ICU demand - significant health and wellbeing implications to these staff as well as the risk they resign from CHFT. • Increasing number of complaints due to prolonged waits and poor patient experience. • Significant cost pressure within Community due to Private Ambulance costs over and above CCG YAS commissioned service. • Health and safety risks due to ageing estate across the Trust. Working with stakeholders to mitigate risks and explore permanent solutions that align with wider Trust reconfiguration plans.

INPATIENT WAITING LIST - P2

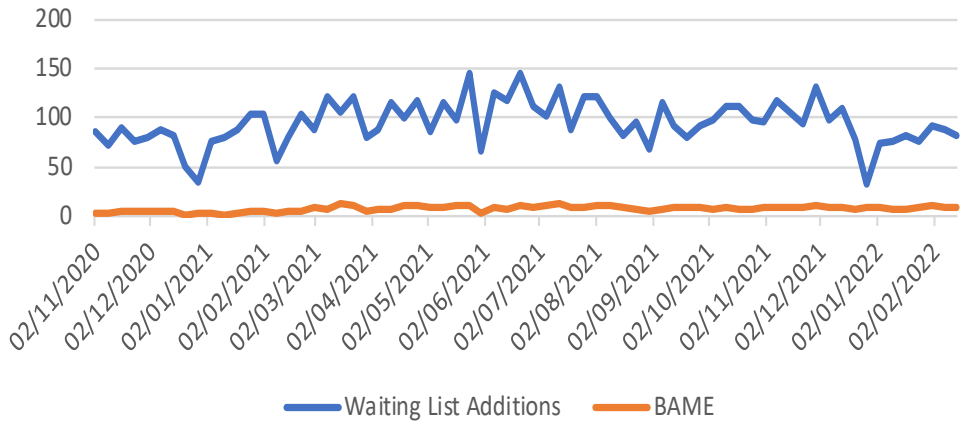
Trajectory vs Actual - Total P2s on Waiting List



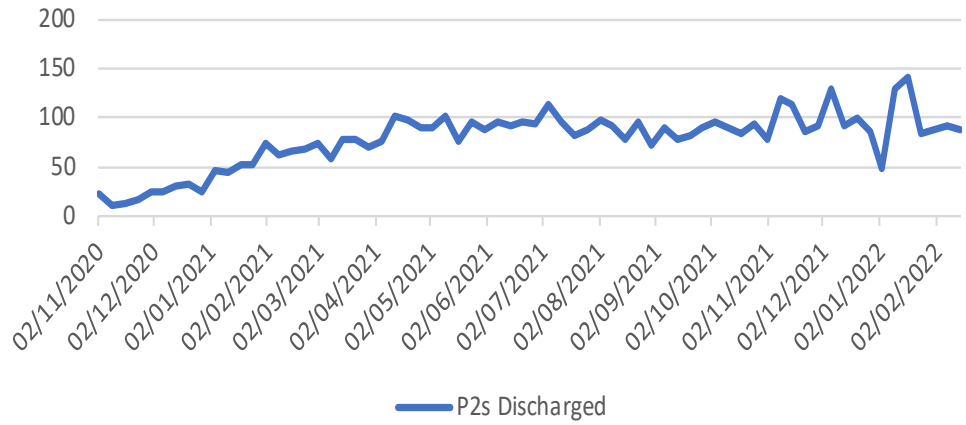
Trajectory vs Actual - Total P2s on Waiting List Over 1 month



P2 waiting List Additions

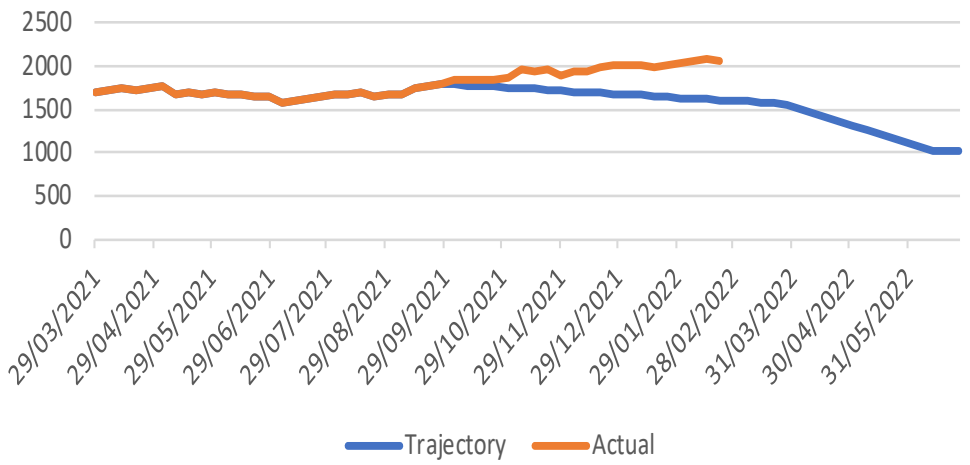


P2 Surgery done in the week

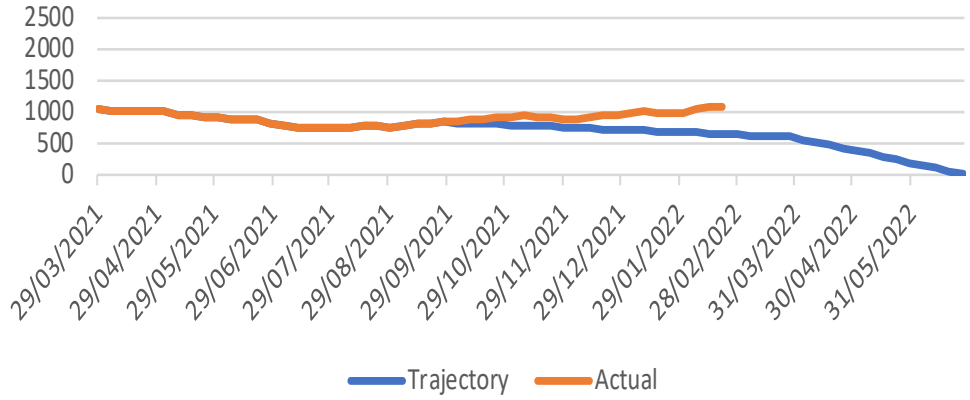


INPATIENT WAITING LIST - P3

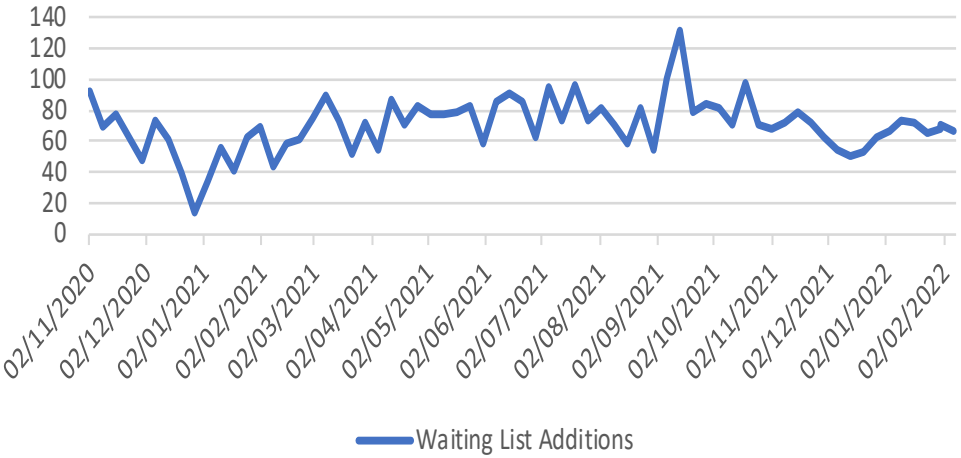
Trajectory vs Actual - Total P3s on Waiting List



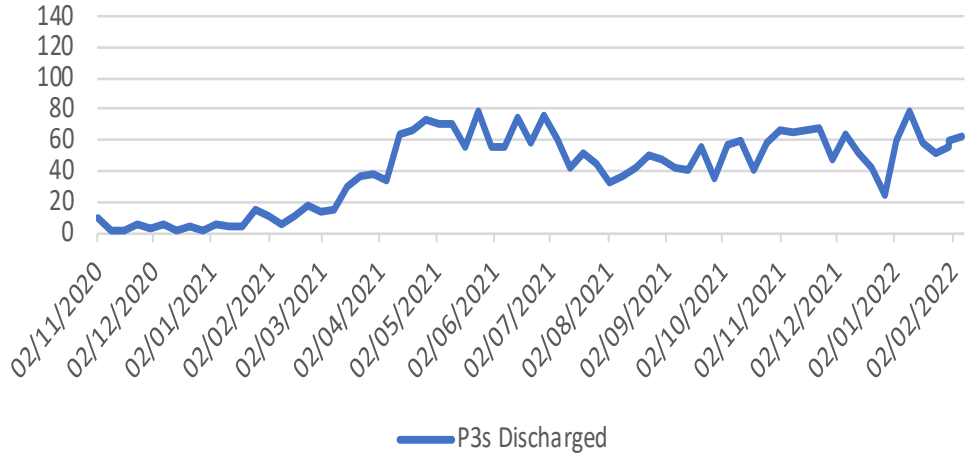
Trajectory vs Actual - Total P3s on Waiting List Over 3 months



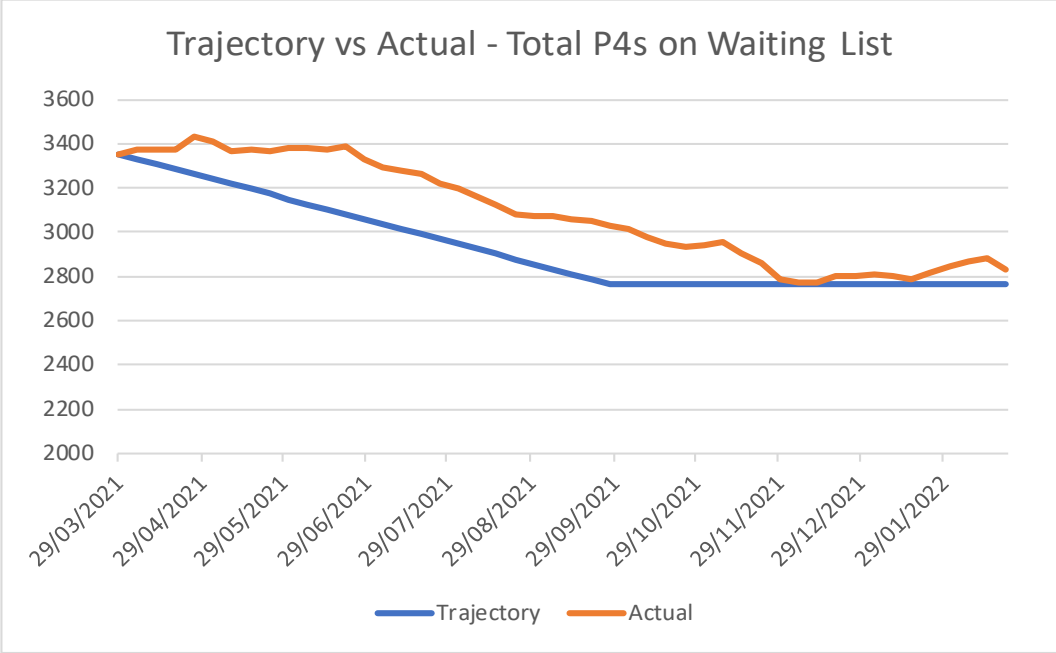
P3 waiting List Additions

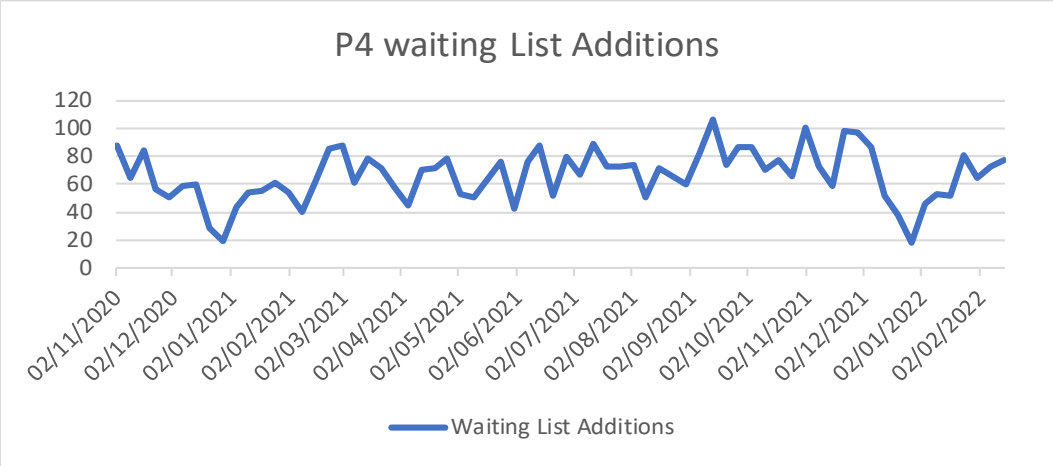


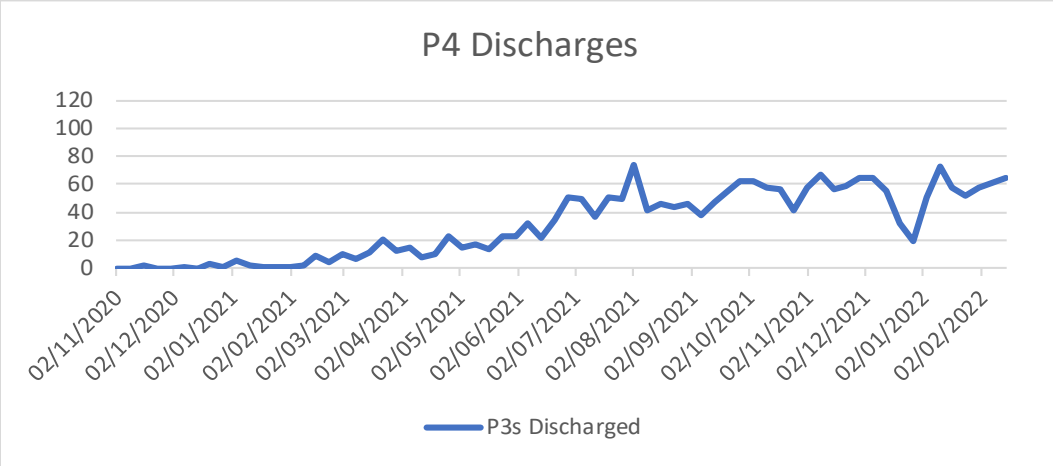
P3 Discharges



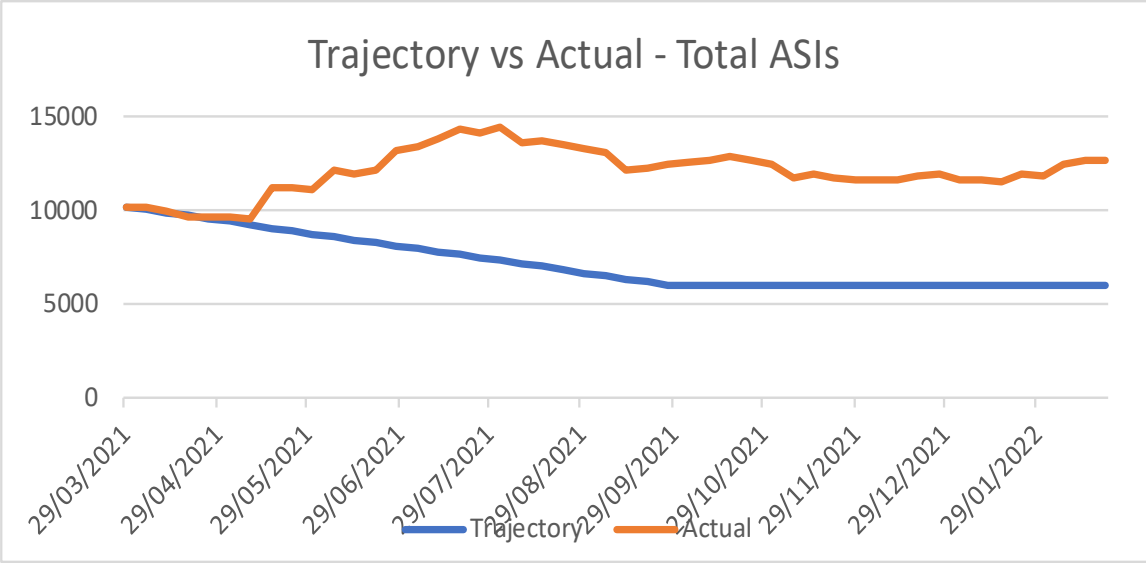
INPATIENT WAITING LIST - P4

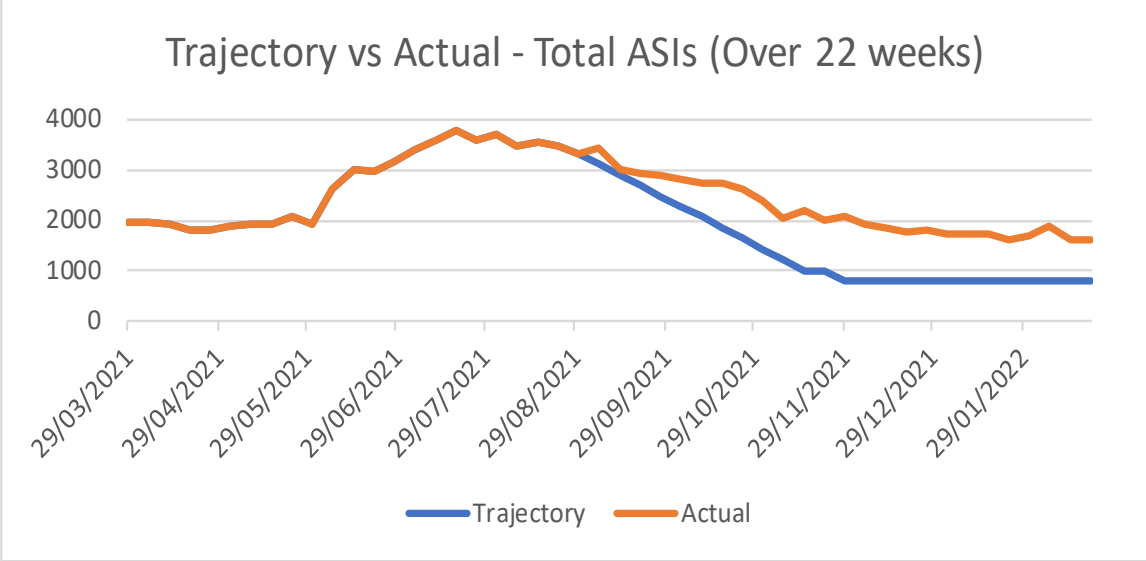




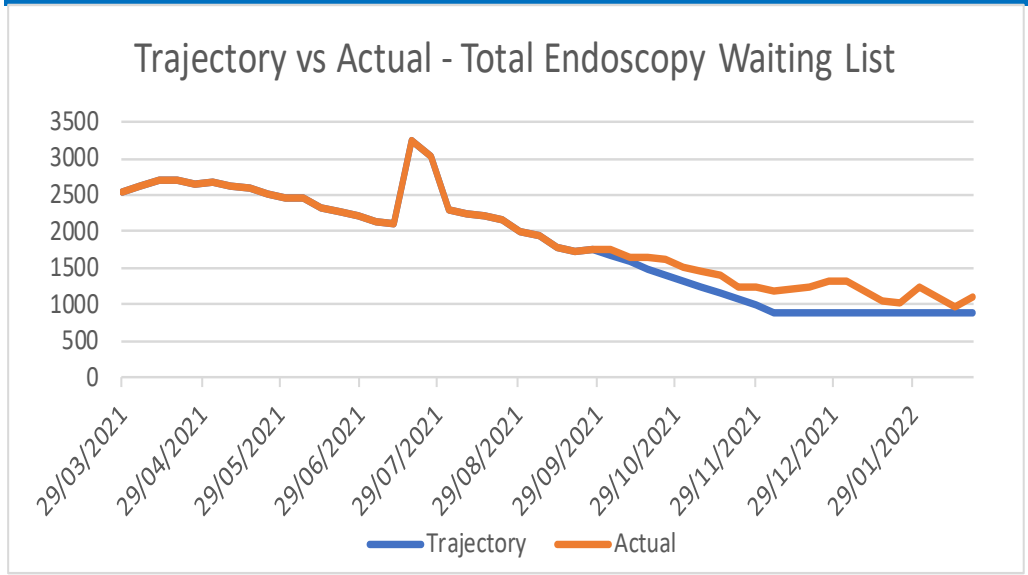


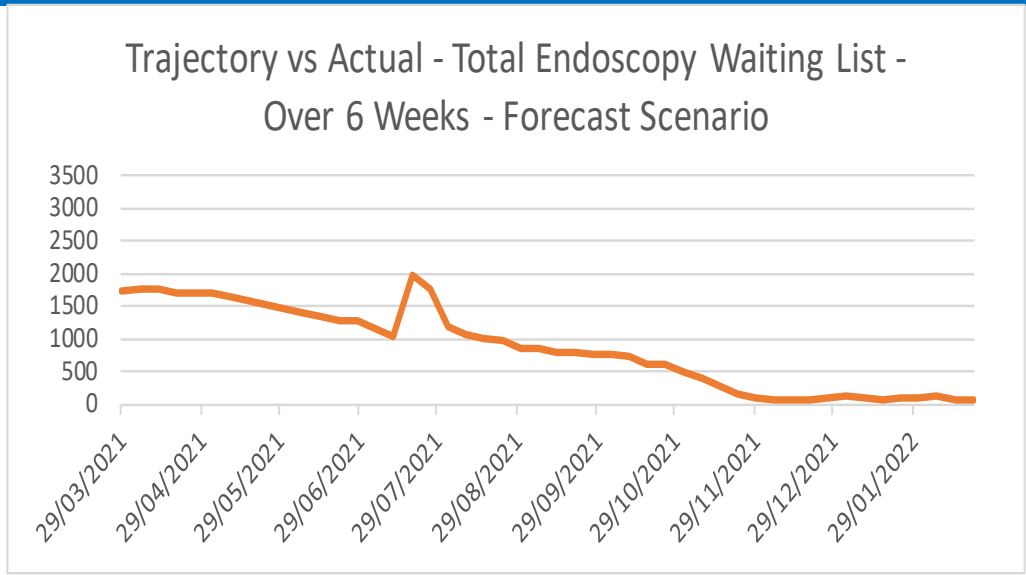
ASIs

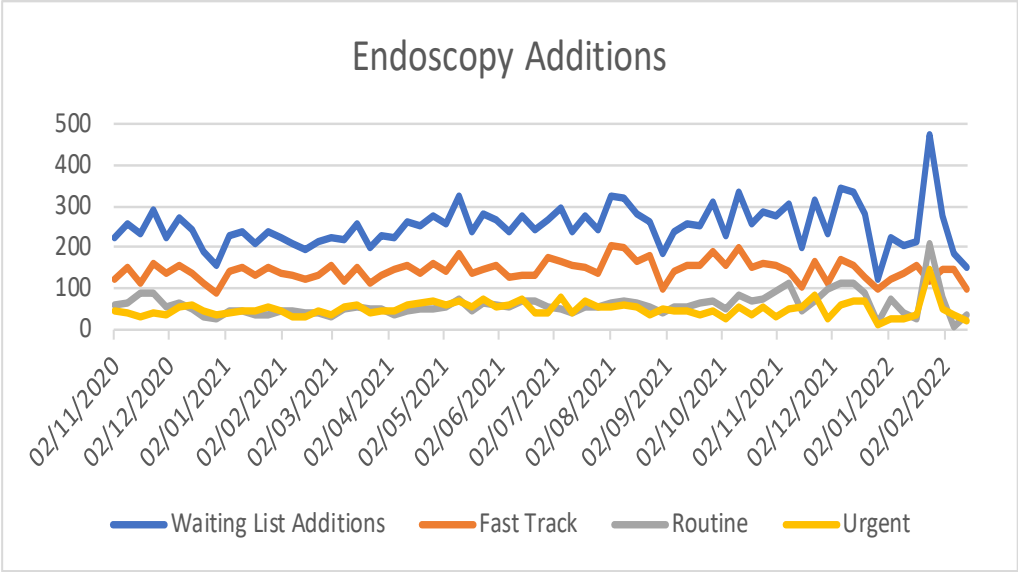

Trajectory vs Actual - Total ASIs
15000
10000
5000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
29/12/2021
29/01/2022
Trajectory
Actual

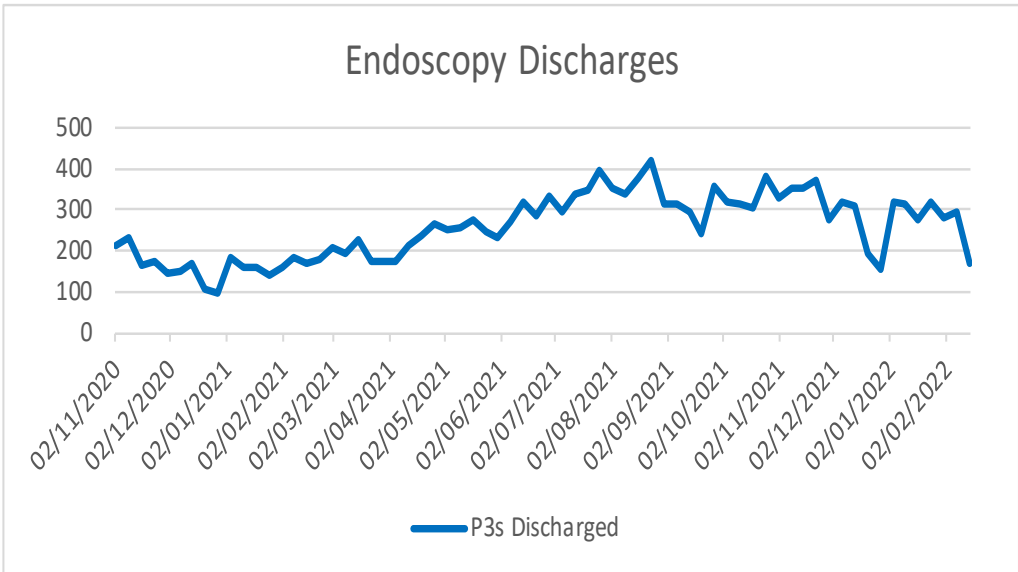

Trajectory vs Actual - Total ASIs (Over 22 weeks)
4000
3000
2000
1000
0
29/03/2021
29/04/2021
29/05/2021
29/06/2021
29/07/2021
29/08/2021
29/09/2021
29/10/2021
29/11/2021
29/12/2021
29/01/2022
Trajectory
Actual

Endoscopy Waiting List



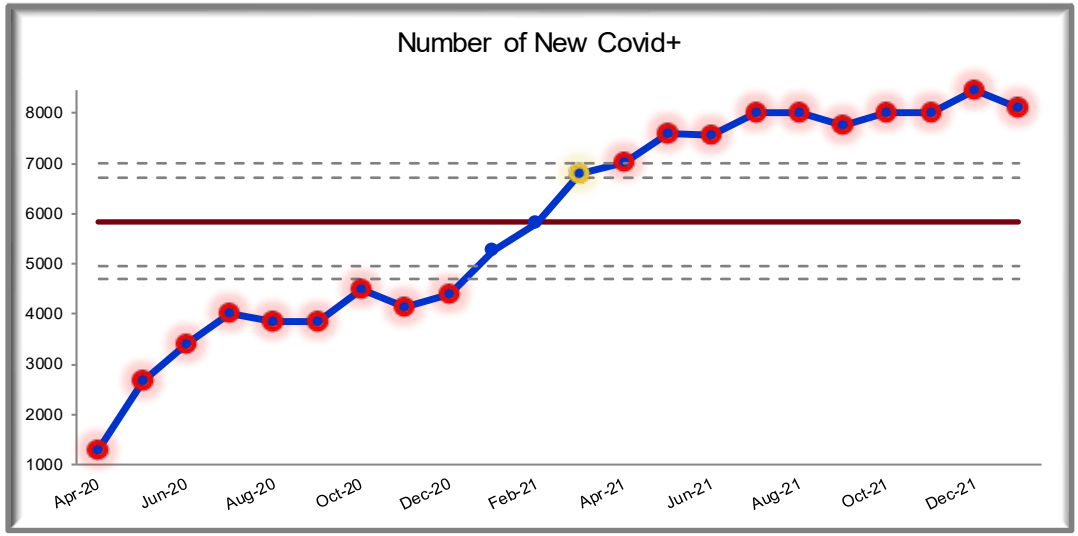


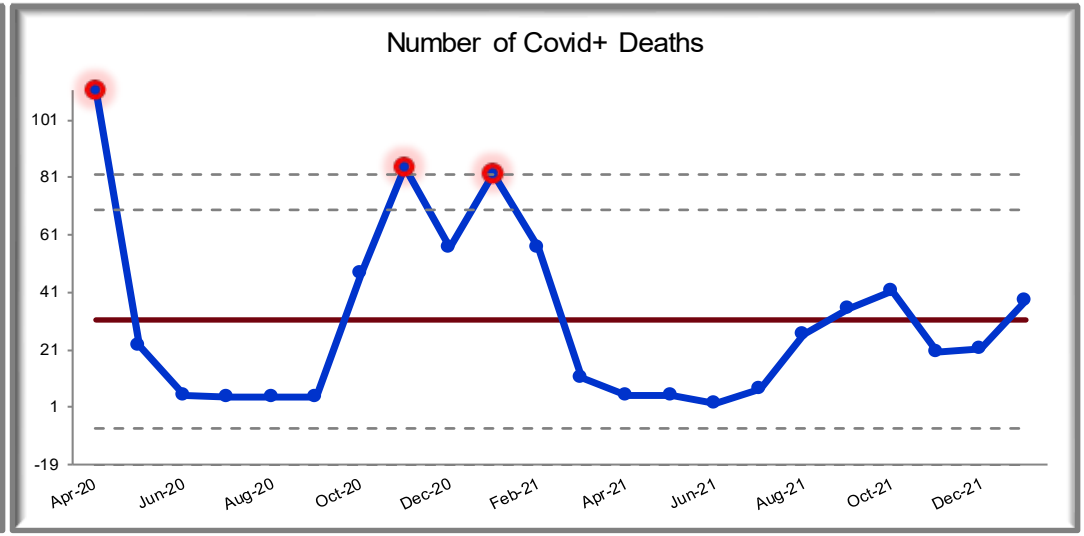


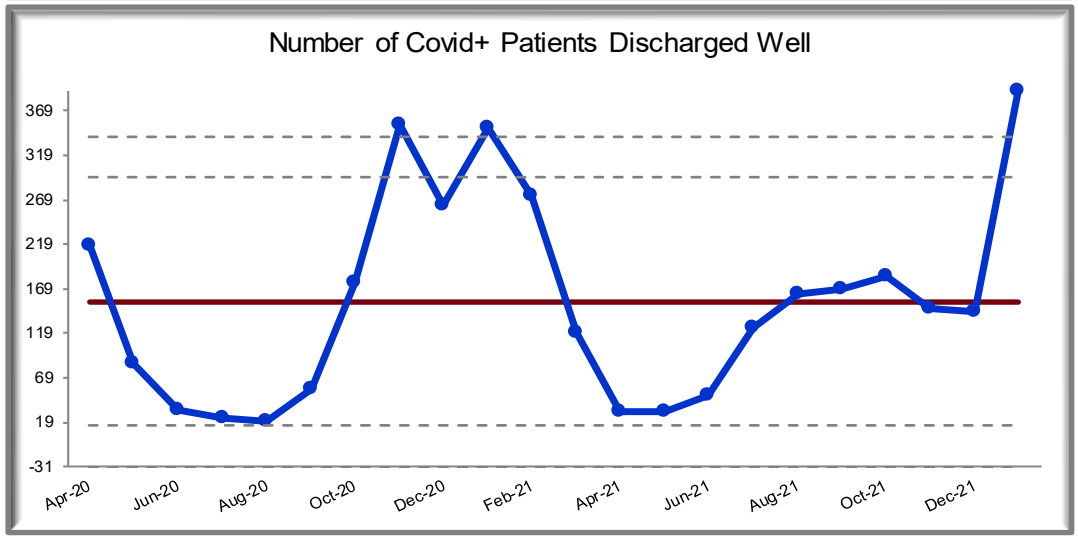


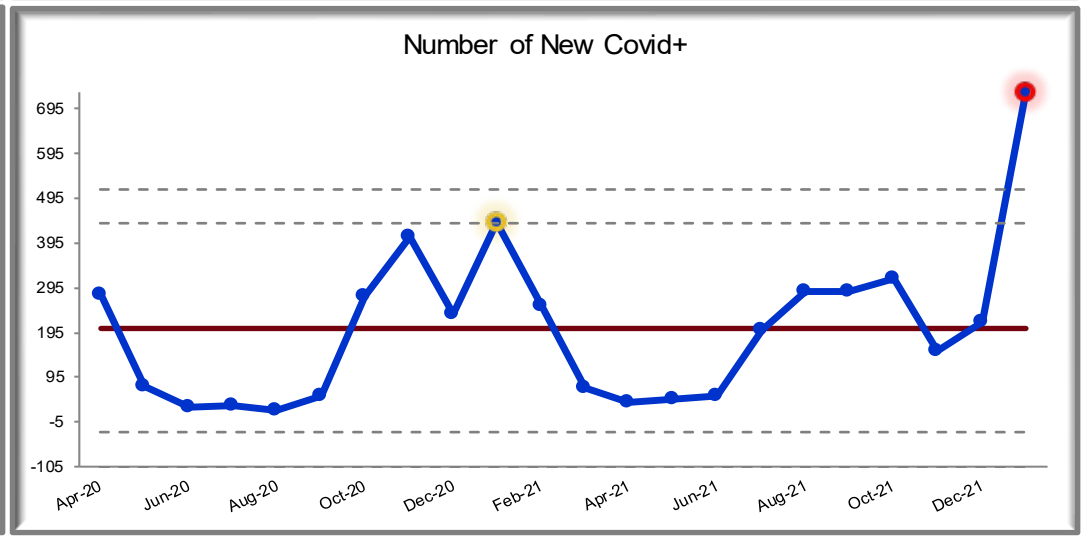
Covid-19 - SPC Charts

Average | Values | Target | Control Limits | Warning | Critical | Trend | Good Over Target / Good Below Target



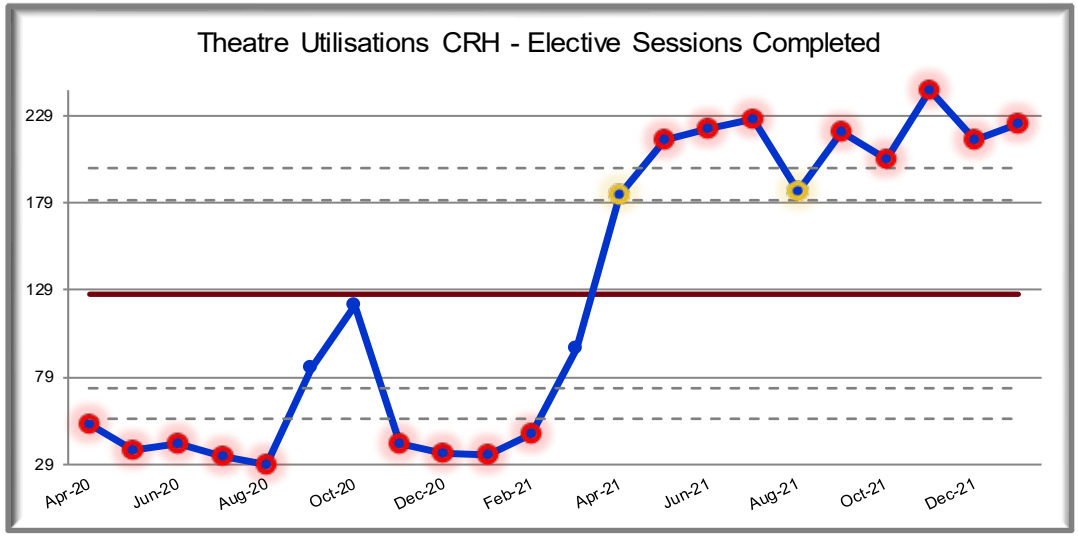


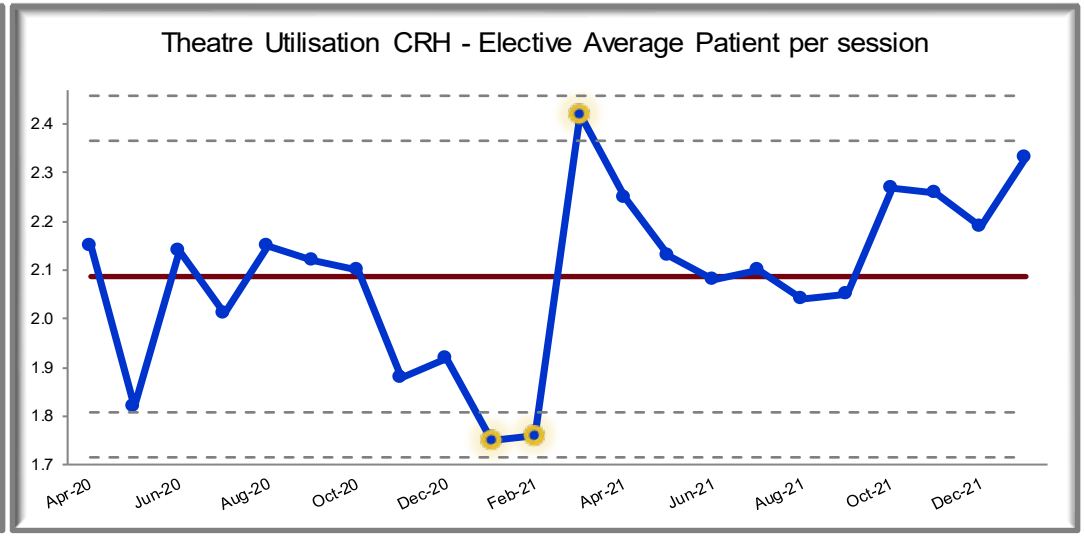


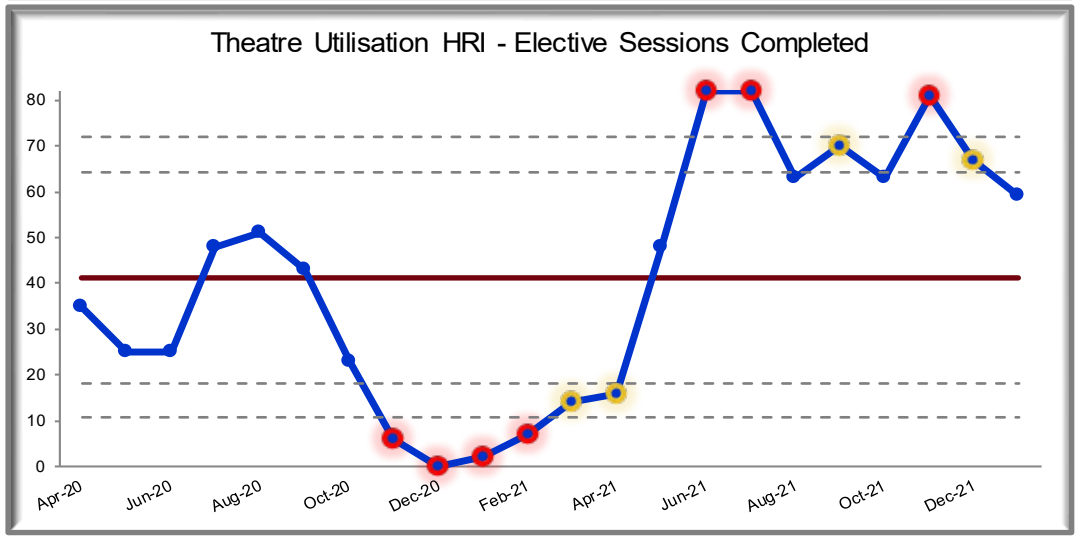


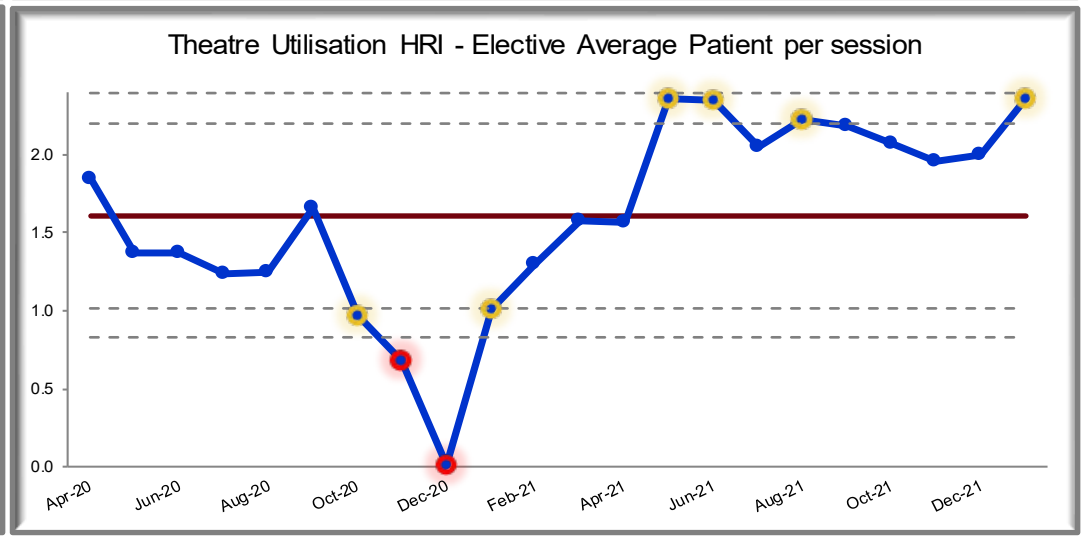
Theatres - SPC Charts

Average — Values — Target — Control Limits — Warning — Critical — Trend — Good Over Target / Good Below Target

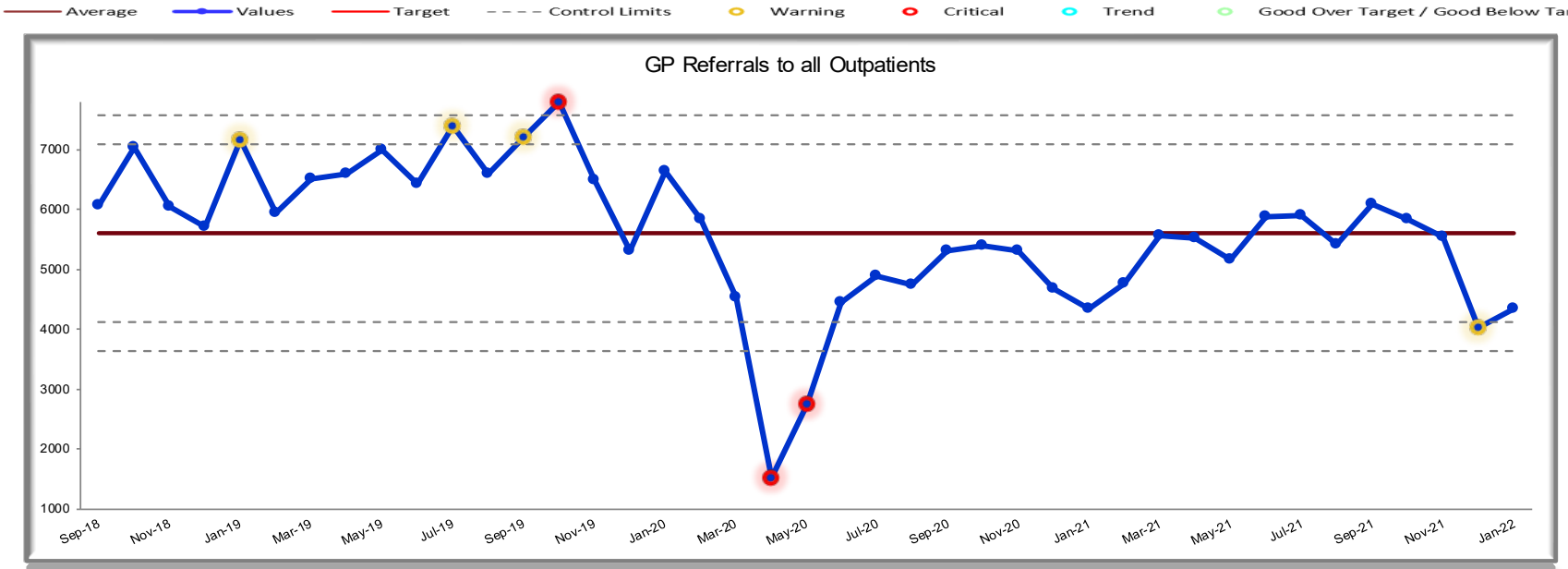


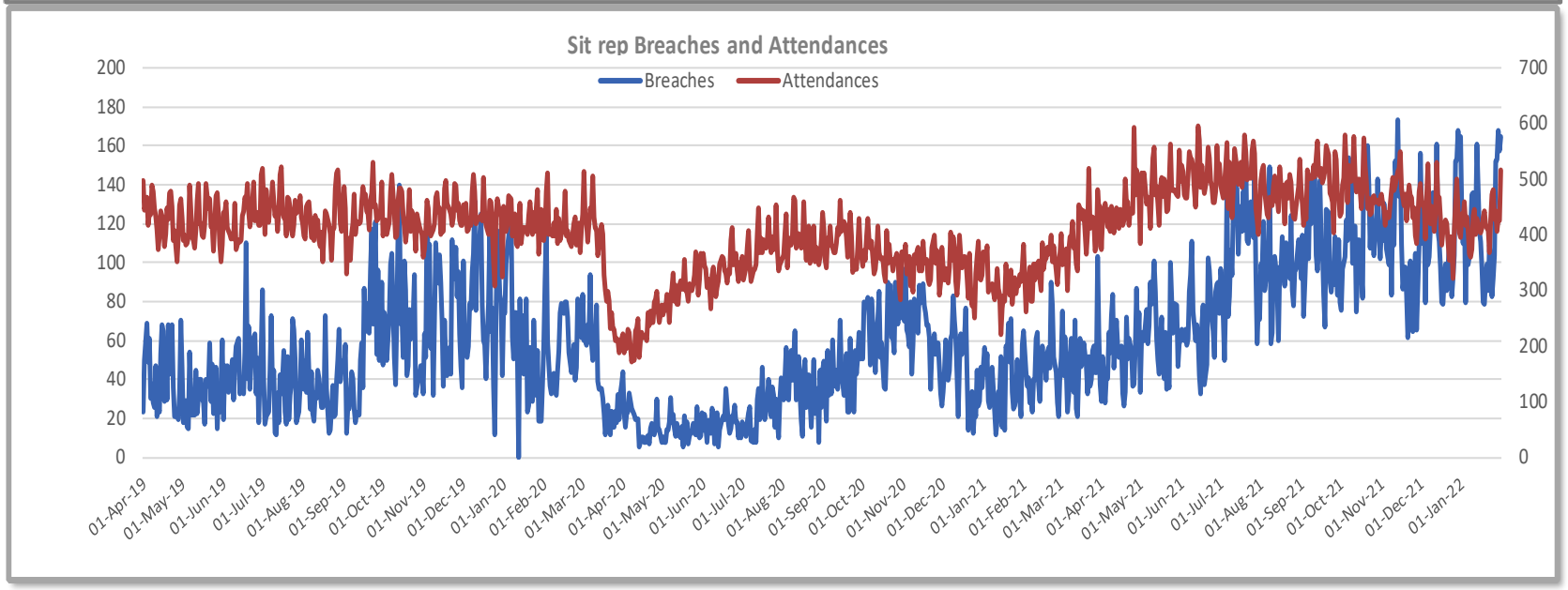






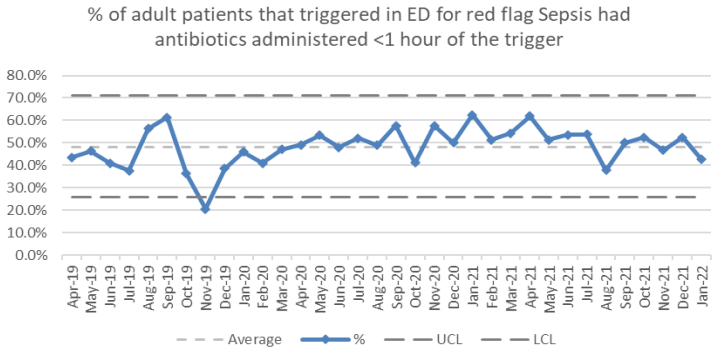
Capacity and Demand

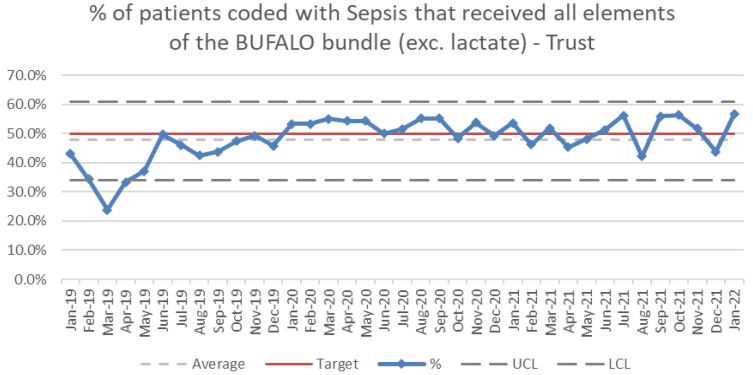




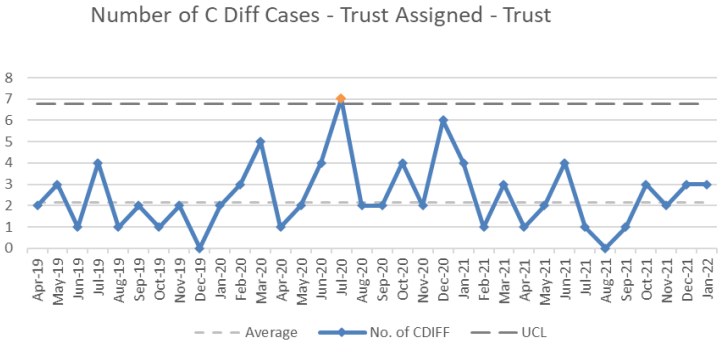
Quality Priorities - Quality Account Priorities

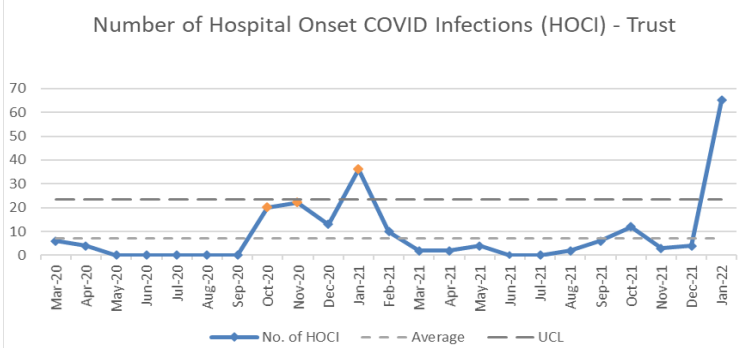
1. Recognition and timely treatment of Sepsis



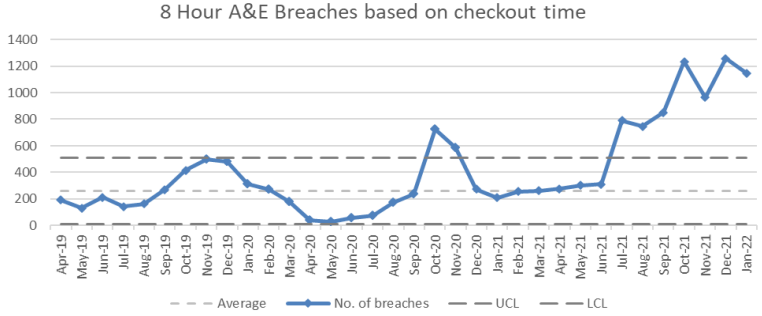


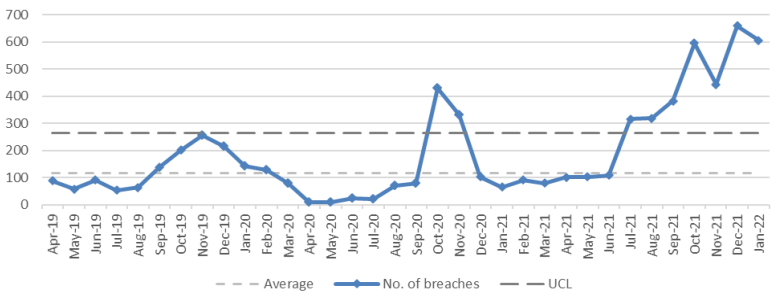
2. Reduce number of Hospital Acquired Infections including Covid 19





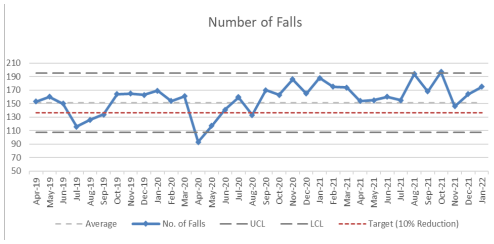
3. Reduce waiting times for individuals attending the ED



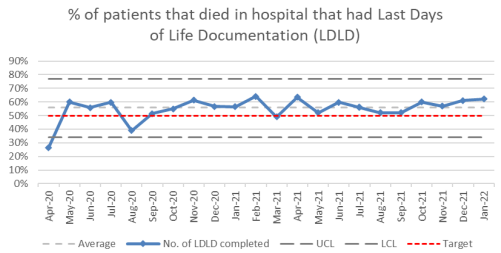


Quality Priorities - Focussed Quality Priorities

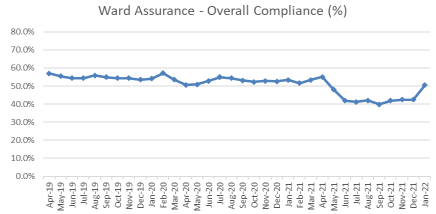
1. Falls Resulting in Harm



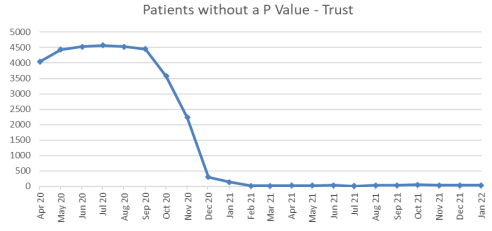
2. End of Life Care



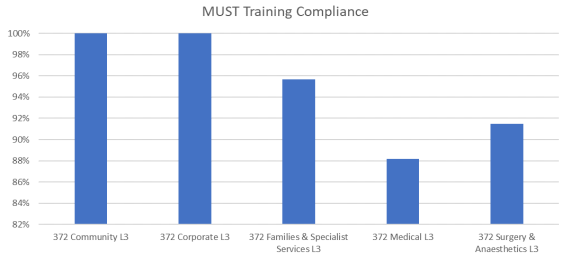
3. Clinical Documentation

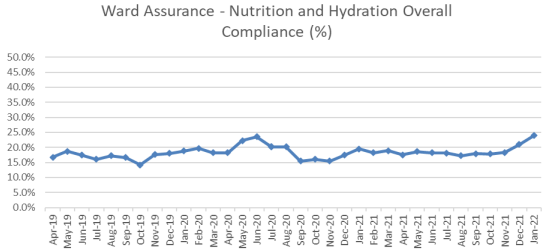


4. Clinical Prioritisation (Deferred care pathways)



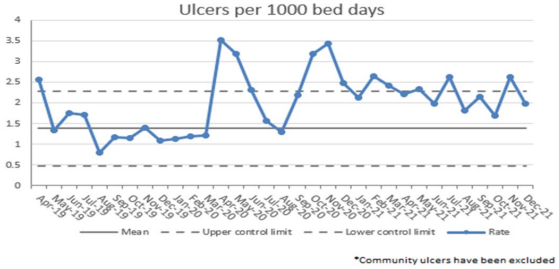
5. Nutrition and Hydration

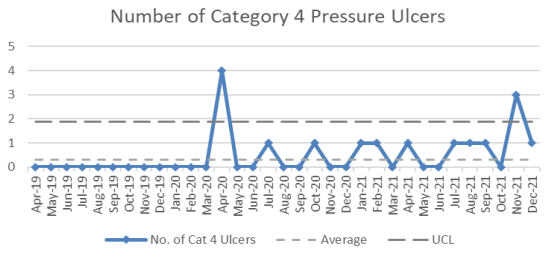




6. Pressure Ulcers

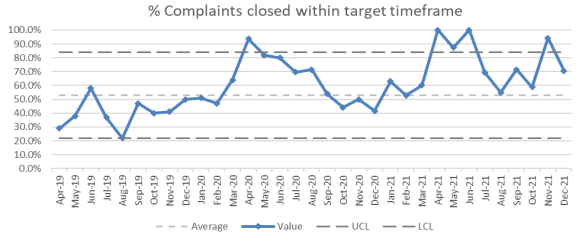
(Reported a month in areas)





7. Making Complaints Count

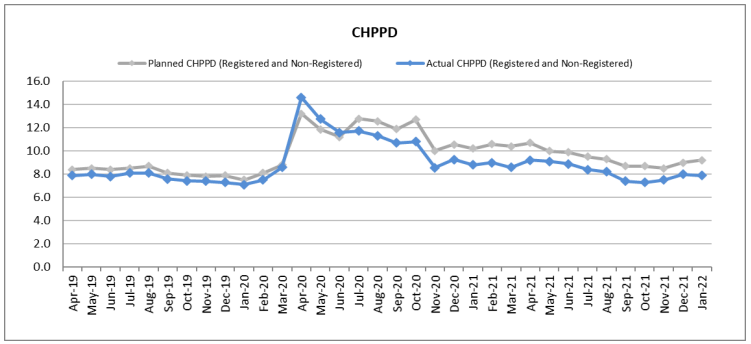
(Reported a month in areas)



Hard Truths: Safe Staffing Levels

TRUST - CHPPD & FILL RATES (REGISTERED & NON REGISTERED CLINICAL STAFF)

	Nov-21	Dec-21	Jan-22
FILL RATES - DAY (REGISTERED & NON REGISTERED CLINICAL STAFF)	88.1%	89.1%	85.6%
FILLRATES - NIGHT (REGISTERED & NON REGISTERED CLINICAL STAFF)	95.5%	94.9%	91.0%
PLANNED CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	8.5	9.0	9.2
ACTUAL CHPPD (REGISTERED & NON REGISTERED CLINICAL STAFF)	7.5	8.0	7.9

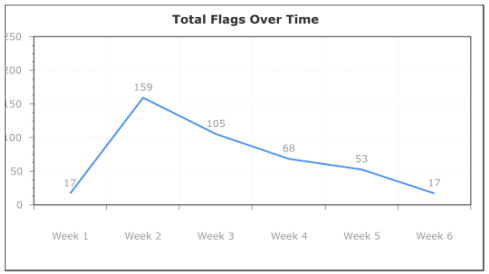


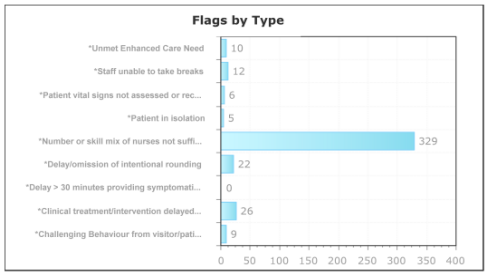
CHPPD provides a single, consistent and nationally comparable way of recording and reporting deployment of staff to provide care on inpatient wards. CHPPD is not a stand alone measure and should be used alongside clinical quality and safety outcome measures.

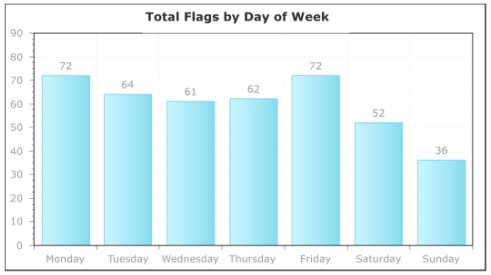
A review of January 2022 data indicates that the combined RN and non-registered clinical staff metrics resulted in 24 of the 27 clinical areas having fewer CHPPD than the planned, with a total deficit of 1.1 CHPPD across the Trust. The gap in CHPPD is at its broadest with the RN workforce representing 1.1 deficit and HCSW 0.2 deficit. This position demonstrates a deterioration from the November and December figures across fill rates and CHPPD. This deficit is managed through twice daily staffing meetings which are chaired by the Associate Directors of Nursing and supported by mitigations reported within the Safecare system and the use of professional judgement to redeploy staff on a shift basis and establish the safest staffing possible in all areas.

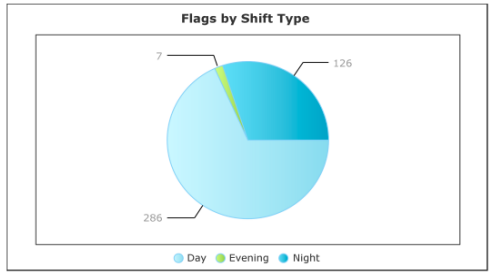
A review of the nurse sensitive indicators demonstrates a reduction in the number of falls and pressure ulcer across both the medical and surgical divisions.

STAFFING RED FLAG INCIDENTS









A Red Flag Event occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015). As part of the escalation process staff are asked to record any staffing concerns through safe care live. These are monitored daily by the divisions and monthly through the Nursing workforce strategy group.

January saw an elevated number of Red Flags reported in comparison to previous months which reflects the ongoing challenging staffing position.

The Red Flags are reviewed as part of the daily staffing meetings and immediate mitigate put in place as required.

Hard Truths: Safe Staffing Levels (2)

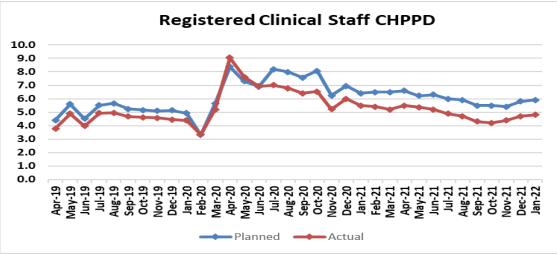
Aggregate Position | Trend | Result

CHPPD BY STAFF TYPE

Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 5.9 for planned and 4.8 For actual for Registered Clinical Staff

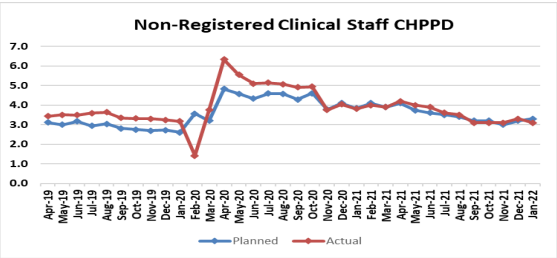


Overall there is a shortfall of 1.1 CHPPD against an overall requirement of 5.9 CHPPD for registered staff. Professional judgement informs decision-making at the twice daily staffing meetings to mitigate the risk across the clinical areas, and staff are redeployed to optimise safety. A suite of nurse sensitive indicators have also been incorporated into this section of the report to monitor for any correlations alongside the CHPPD in line with national recommendations. For those indicators reported there has been a reduction in the number of falls. This position may be reflective of a targeted piece of work aimed at improving the falls sensors training compliance across all inpatient areas.

Non Registered Clinical Staff

Monthly hours (day and night combined) divided by average patient count at midnight

CHPPD was 3.3 for planned and 3.1 for actual for Non Registered Clinical Staff



Overall there is a shortfall in the CHPPD of 0.2 for non-registered clinical staff. This is reflective of an increasing demand for 1:1 care and a skill-mix response to mitigate the risk to meet the needs of patients due to the shortfall in Registered Clinical Staff CHPPD.

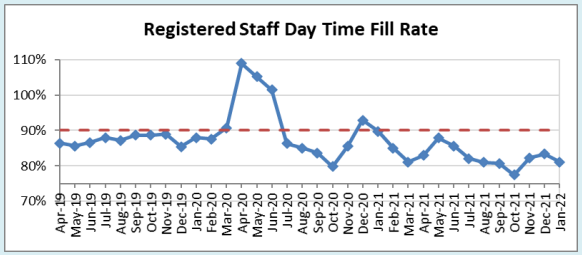
The fill-rate percentage of non-registered clinical staff (table below) shows a drop due to an increased demand in the requirement for 1:1 care needs and the need for additional staff due to the increased bed base capacity, rather than an inability to staff established workforce model shift requirements for this workforce.

FILL RATES BY STAFF AND SHIFT TYPE

Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

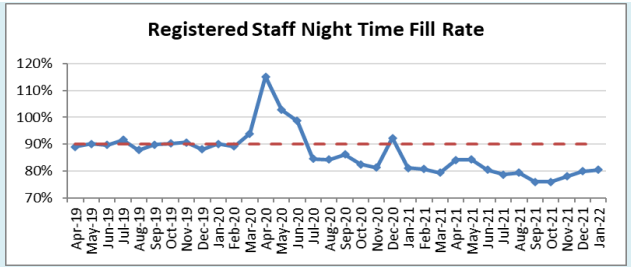
81.12% of expected Registered Clinical Staff hours were achieved for day shifts.



Registered Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

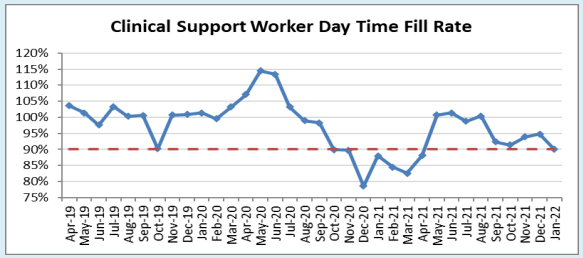
80.51% of expected Registered Clinical Staff hours were achieved for night shifts.



Non-Registered Clinical Staff Day

Monthly expected hours by shift versus actual monthly hours per shift only. Day shift only.

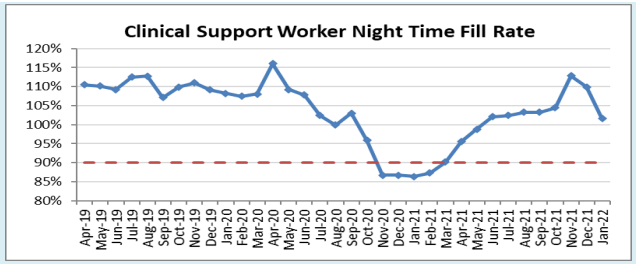
90% of expected Non-Registered Clinical Staff hours were achieved for Day shifts.



Non-Registered Clinical Staff Night

Monthly expected hours by shift versus actual monthly hours per shift only. Night shift only.

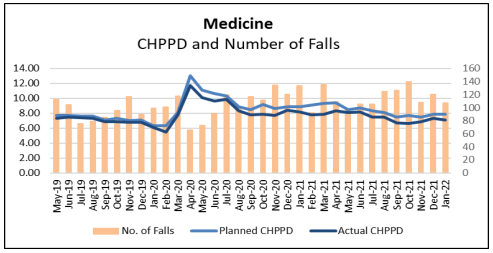
101.56% of expected Non-Registered Clinical Staff hours were achieved for night shifts.

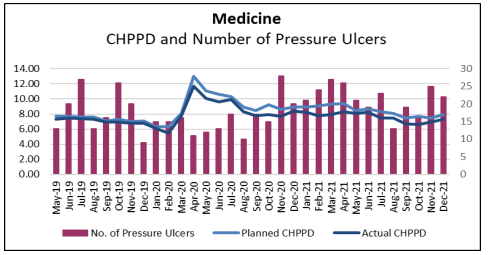


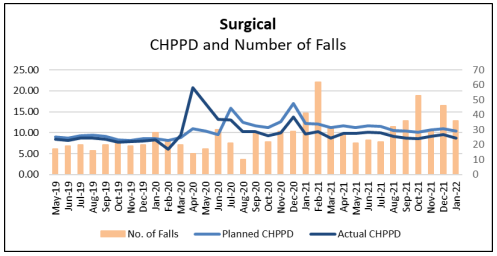
Hard Truths: Safe Staffing Levels (3)

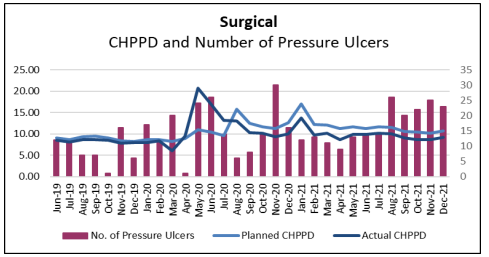
NURSING QUALITY INDICATORS AND FILLRATES BY WARD AND DIVISION

Ward	Average Fill Rates				Care Hours Per Patient Day		Nursing Quality Indicators					Safecare	
	DAY - Registered Clinical Staff (%)	DAY - Non Registered Clinical Staff (%)	NIGHT - Registered Clinical Staff (%)	NIGHT - Non Registered Clinical Staff (%)	Total PLANNED CHPPD	Total ACTUAL CHPPD	MRSA Bacteraemia (post cases)	Pressure Ulcer (Month in Areas)	Falls	Staffing Red Flags	Ward Assurance	Number of red shifts	Number of amber shifts
Medicine	**85.7%**	**94.6%**	**82.1%**	**104.2%**	**7.9**	**7.1**	**0**	**22**	**107**	**251**	**52%**	**606**	**85**
CRH ACUTE FLOOR	105.4%	100.5%	96.8%	96.4%	7.1	7.1		8	13	30	55.0%	80	7
HRI ACUTE FLOOR	90.4%	82.3%	92.3%	82.7%	8.1	7.1		6	24	25	56.2%	60	10
RESPIRATORY FLOOR	71.2%	83.6%	77.3%	68.1%	8.8	6.6		2	8	20	49.7%	70	7
WARD 5	67.8%	79.5%	77.4%	112.4%	7.4	6.1		2	5	23	46.4%	46	6
WARD 6	80.9%	68.7%	102.8%	106.5%	4.6	4.0			9	12	59.5%	21	9
WARD 6C	86.7%	82.6%	87.9%	106.6%	13.1	11.9			1	4	44.8%	10	1
WARD 6AB	86.7%	82.6%	87.9%	106.6%	6.7	6.1		1	12	28	50.5%	49	6
WARD CCU	75.2%	69.5%	74.6%		8.7	7.2				5	55.1%	17	6
STROKE FLOOR	152.1%	119.0%	82.9%	117.7%	8.1	9.7			14	37	44.1%	6	2
WARD 12	81.3%	98.3%	99.9%	125.8%	7.6	7.4		2	4	6	43.8%	13	2
WARD 15	69.9%	103.8%	57.8%	125.9%	7.6	6.8			9	23	55.5%	64	10
WARD 17	63.2%	107.0%	73.4%	108.3%	7.4	6.1			3	13	50.3%	47	10
WARD 18	61.5%	190.2%	68.9%	185.6%	8.8	9.6				12	60.6%	50	4
WARD 20	67.7%	85.8%	69.7%	106.4%	7.8	6.4		1	5	13	52.6%	73	5
Surgical	**79.8%**	**79.3%**	**81.6%**	**100.4%**	**10.4**	**8.7**		**25**	**36**	**73**	**47.1%**	**224**	**104**
WARD 21	73.0%	79.5%	77.7%	94.0%	8.4	6.7		3	4	1	54.3%	29	11
WARD 22	83.0%	90.8%	83.3%	128.5%	7.0	6.4		1	9	10	48.6%	52	11
ICU	83.8%	69.5%	84.6%	77.3%	36.4	29.8		7		2	61.9%		
WARD 8AD	76.5%	61.6%	71.9%	98.3%	10.9	8.0			4	5	52.4%	11	5
WARD 8B	100.9%	79.6%	100.0%	112.6%	8.5	8.1			1		56.3%	21	8
WARD 10	65.0%	90.4%	75.4%	90.7%	10.9	8.5					60.2%	33	4
WARD 11	65.6%	71.0%	77.5%	96.4%	8.2	6.2		4	9	29	39.4%	6	53
WARD 19	71.8%	95.0%	83.4%	107.5%	7.7	6.8		4	7	5	54.3%	11	1
SAU HRI	96.8%	85.6%	80.8%	116.2%	7.6	6.9		6	2	21	43.9%	61	11
FSS	**75.4%**	**89.6%**	**77.6%**	**85.3%**	**12.9**	**10.1**	**0**	**0**	**0**	**11**	**13.7%**	**21**	**7**
WARD LDRP	72.1%	70.2%	72.2%	84.2%	29.9	21.8				4	14.2%		
WARD NICU	80.5%	71.0%	84.7%	71.0%	13.0	10.5					12.0%		
WARD 3ABCD	75.3%	107.3%	78.4%	90.2%	13.1	10.5					15.3%	21	7
WARD 4ABC	75.3%	107.3%	78.4%	90.2%	7.9	6.3				7	13.4%		
TRUST	**81.12%**	**90.00%**	**80.51%**	**101.56%**	**9.2**	**7.9**							









Hard Truths: Safe Staffing Levels (4)

Conclusions and Recommendations

Conclusions

The Trust remains committed to achieving its nurse and midwifery staffing establishments. The January position remains below the required level, but is an improvement on the December position as anticipated.

On-going activity:
1.The use of the enhanced metrics dashboard is embedded in the weekly senior safer staffing review meeting. Areas with less than 85% shift fill rate are scrutinised with a suite of nurse sensitive indicators. Specific action plans are generated by the ADNs and reported through the Gold Command structure.
2. The Nursing and Midwifery Workforce Steering Group agenda has been incorporated into the twice weekly Senior Nurses' Staffing Meeting and is progressing work to understand the detail of the vacancy position and potential leavers and aligning this to the recruitment/training strategy in partnership with the local HEI.
3. A review of the current Nursing and Midwifery workforce plans is underway and supported by Workforce Business Intelligence, reviewing directorate specific pressures to inform recruitment.
4. Work is ongoing to maximise the use of HealthRoster and the confirm and challenge process, to ensure a reduction of planned variability of shift fill across weekdays and weekends, as well as ensuring Annual Leave and Study leave is planned within agreed headrooms.
5. The International recruitment project continues to progress well with 64 nurses recruited as of December 2021, whilst delays have been experienced due to travel restrictions and quarantine it is anticipated that the goal of 70 international nurses will be achieved by February 2022. Plans for further International Recruitment in 2022 are being implemented with a commitment from WEB to support a further 80 International Recruits in 2022.
6. CHFT was successful in a bid to secure funding from HEE to support a band 6 project lead for 6 months to improve the use of health roster to facilitate student placements. This will enable improved experience by removing the peaks and troughs of student presence in an area by allocating across the 7-day week and 24hr shift patterns. This will enable closer working patterns aligned to practice supervisors and assessors. It will also allow for an increase in student placement capacity by approximately 20%.
7. In response to the changing situation as a result of the emergence of the Omicron strain of Covid, a revision of the Safer Staffing OPEL cards were completed which resulted in mobilisation of the Level 4 actions to support service pressures as a result of the increasing staff sickness/absence position. activity is underway to plan for any surge in clinical demand and/or significant staffing challenges as a result of staff absence. Mobilisation of this action further mitigated the workforce position.

22. Non-Executive Director Champion Roles

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Non-Executive Director Champion Roles
Author:	Andrea McCourt, Company Secretary
Sponsoring Director:	Brendan Brown, Chief Executive
Previous Forums:	None

Purpose of the Report

This report is for the Board to note the new approach to Board oversight by Non-Executive Director Champion roles and to approve the changes to the Quality Committee Terms of Reference to provide assurance to the Board.

Key Points to Note

Context and Summary

Nationally there has been a growing number of lead/champion roles defined for NHS Non-Executive Directors (NEDs) across quality, finance and workforce, making it difficult for Trusts to discharge them all effectively, with Non-Executive Directors typically having a time commitment of two to three days per month. These individual roles contradict the collective role of a unitary Board of joint responsibility and decision-making and Directors' duties under the Company's Act.

Following a detailed review by NHS England / Improvement (NHS E/I) guidance was issued in December 2021 setting out a new approach to ensuring Board oversight of important issues. This new approach is that oversight of important issues will best be achieved through discharging the activities and responsibilities held by NED champion roles through existing Board Committees rather than through individual NED champion roles. This approach is endorsed by the Care Quality Commission.

The NHS England / Improvement guidance can be reviewed at: B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf (england.nhs.uk)

NED Champion Roles

The guidance recommends that five NED champion roles be retained because they are either:

- A statutory requirement
- The function requires a named individual to discharge
- NHS E/I considers that having an individual NED is the most effective way of delivering the changes that are needed

The five NED champion roles to be retained are shown below, with the origins / rationale for each role detailed at Appendix 1:

Roles to be retained				
Maternity board safety champion	Wellbeing guardian	Freedom to speak up	Doctors disciplinary	Security management

For the Trust the following NEDs are confirmed as undertaking these roles:

Maternity Board Safety Champion **Karen Heaton**	Well-Being Guardian **Richard Hopkin**	Freedom to Speak Up **Karen Heaton**	Doctors Disciplinary **All Non-Executive Directors**	Security Management **Andy Nelson**

Further details of each of these retained NED Champion roles can be found at Appendix 1.

Going forward when the above NEDs report to the Board or a Committee in the capacity of their defined NED Champion role this title should be referenced within reports and minutes by the author.

Issues to be overseen through Board Committee Structures

There are 13 roles referenced in the guidance, shown below, that are to be overseen by Board Committees or the Board in line with the national guidance, meaning these will no longer have a named NED Champion.

Roles to transition to new approach				
Hip fracture, falls and dementia	Learning from deaths	Safety and risk	Palliative and end of life care	Health and safety
Children and young people	Resuscitation	Cybersecurity	Emergency preparedness	Safeguarding
Counter fraud	Procurement	Security management-violence and aggression		

Below are the respective Committees that will provide assurance for these 13 areas. The national guidance contains further information on each of these areas.

The national guidance emphasises that safety and risk should be integral to all Committees as a key part of being a well-led organisation, with health and safety being viewed broadly to include patient safety, employee safety, public safety and system leadership. The remit for this will cut across all Committees.

Quality Committee

- Hip fracture, falls and dementia
- Learning from Deaths (requirement for this to be reported in the public domain)
- Palliative Care & End of Life Care
- Safeguarding (reports to Board annually)
- Resuscitation (reports to Quality Committee via Trust Patient Safety Quality Board)
- Children & Young People - the CQC Core Service Inspection Framework for Children and Young People refers to an interview with the NED in the Board with responsibility for Children and Young People, this is by a NED member of the Quality Committee
- Health & Safety - e.g., patient safety

Audit and Risk Committee

- Health & Safety
- Security (via Health and Safety Committee)
- Counter Fraud
- Procurement (and Finance and Performance Committee for commercial matters)

Workforce Committee

Security Management – Violence & Aggression - currently this is via the Health and Safety reporting into Audit and Risk Committee. Plan to present paper to 12 April 2022 Workforce Committee outlining de-escalation training and plans to support colleagues.

Board

Emergency preparedness (annual report of Core Standards presented to Board)
Cyber security (and via Senior Information Responsible Officer, i.e., Managing Director - Digital)

Recommendation

The Board is asked to:

a) **NOTE** the new approach to Board oversight by Non-Executive Director Champion roles
b) **APPROVE** the changes to the Quality Committee Terms of Reference at section 4.8 in Appendix P2 which confirm the additional areas of responsibility for the Committee in line with the national guidance.

Appendix 1

NON-EXECUTIVE DIRECTOR CHAMPION ROLES

(extract from Enhancing Board Oversight, NHS England /Improvement)

Maternity Board Safety Champion

In response to the Morecambe Bay Investigation (2015), this role was established through Safer Maternity Care 2016, which stated that "Senior trust managers will want to ensure unfettered communication from 'floor-to-board' by appointing a board level maternity champion". The role is in line with recommendations from the Ockenden Review (2020) and while not a statutory requirement, for trusts providing maternity services having a named NED maternity board safety champion is recommended.

The champion should act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal), service users, local maternity system (LMS) leads, the regional chief midwife and lead obstetrician and the trust board to understand, communicate and champion learning, challenges and successes.

The named champion could be the chair of the quality and safety committee and the requirements of the role could be discharged through the appropriate committee provided Trusts ensure that the clinical director and director of midwifery are integral to these Committee meetings. NEDs should use appreciative inquiry approaches and the Maternity Self-Assessment Tool to provide assurance to the board that the best quality maternity care is being provided by their trust. Trusts may also wish to note that the NSR maternity incentive scheme safety actions refer to the maternity board safety champion role under Safety Action 9. Along with other recommendations contained in the Ockenden Review, this role will be reviewed nationally in 2-3 years' time to gauge its effectiveness.

A Trust role description is in place for this NED for Oversight of Maternity Services and is scheduled for review in June 2022.

Wellbeing Guardian

This role originated as an overarching recommendation from the Health Education England 'Pearson Report' (NHS Staff and Learners' Mental Wellbeing Commission 2019) and was adopted in policy through the 'We are the NHS People Plan for 2020-21 – action for us all'. The NED should challenge their trust to adopt a compassionate approach that prioritises the health and wellbeing of its staff and considers this in every decision.

The role should help embed a more preventative approach, which tackles inequalities. As this becomes routine practice for the Board, the requirement for the wellbeing guardian to fulfil this role is expected to reduce over time. The Guardian community website provides an overview of the role and a range of supporting materials.

Freedom to Speak Up Champion (FTSU)

The Robert Francis Freedom to Speak Up Report (2015) sought to develop a more supportive and transparent environment where staff are encouraged to speak up about patient care and safety issues. In line with the review, it is recommended that all NHS trusts should have this functional FTSU guardian role so that staff have a clear pathway and an independent and impartial point of contact to raise their concerns in the organisation. The role of the NED champion is separate from that of the guardian. The

NED champion should support the guardian by acting as an independent voice and board level champion for those who raise concerns. The NED should work closely with the FTSU guardian and, like them, could act as a conduit through which information is shared between staff and the board (p.146, Francis FTSU report). All NEDs should be expected to provide challenge alongside the FTSU guardian to the executive team on areas specific to raising concerns and the culture in the organisation. When an issue is raised that is not being addressed, they should ask why. A full description of NED responsibilities can be found in the NHS E/I FTSU supplementary information July 2019 which can be accessed via this link.

https://www.england.nhs.uk/wp-content/uploads/2021/05/ftsu-supplementary-information.pdf

Doctors disciplinary NED champion/independent member

Under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005 there is a requirement for chairs to designate a NED member as “the designated member” to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS Foundation Trusts as advice only.

Security Management NED Champion

Under the Directions to NHS Bodies on Security Management Measures 2004 there is a statutory requirement for NHS bodies to designate a NED or non-officer member to promote security management work at board level. Security management covers a wide remit including counter fraud, violence and aggression and also security management of assets and estates. Strategic oversight of counter fraud now rests with the Counter Fraud Authority and violence/aggression is overseen by NHS England and NHS Improvement.

While promotion of security management in its broadest sense should be discharged through the designated NED, relevant Committees may wish to oversee specific functions related to counter fraud and violence/aggression. Boards should make their own local arrangements for the strategic oversight of security of assets and estates.

Reference:

B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf (england.nhs.uk)

QUALITY COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1. The Trust Board hereby resolves to establish a Committee to be known as the Quality Committee. The Quality Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Authority

2.1. The Quality Committee 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.

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 Quality Committee is:

- To provide assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care
- To ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

3.2. The Quality Committee is responsible for:

- Reviewing proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account.
- Seeking assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.
- The ongoing monitoring of compliance with national quality standards and local requirements.

4. Duties

The duties of the Committee, given below, cover quality improvement, governance and risk, quality and safety reporting and audit and assurance.

Quality improvement

4.1. To review proposed quality improvement priorities and monitor progress and compliance against defined quality priorities.

4.2. To maintain a focus on patient experience through a number of data sources including stories; friends and family test; national surveys and seek assurance that the Trust is learning from experience.

4.3. To oversee the development of the Quality Accounts to ensure accuracy of data and compliance with timescales for publication and review progress against these.

4.4. To review the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding progress with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

4.5. To receive, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

4.6. To establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessments, standards or criteria.

Governance and risk

4.7. Ensure all quality risks are appropriately managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the high-level risk register and Board Assurance Framework

4.8. In response to the publication to redefine the NED Champion roles NHS England , Enhancing board oversight: a new approach to non-executive director champion roles, the Committee will consider and review on behalf of the Board the following;

- Hip fracture, falls and dementia
- Learning from Deaths (assuring published information on the Trust's approach, achievements and challenges via a report to the public Board)
- Palliative Care and End of Life Care
- Safeguarding (annual report to Board)
- Resuscitation (requiring Resuscitation Policy sign off on behalf of the Board)
- Children & Young People (Core Service Inspection Framework for Children and Young People refers to an interview with the NED in the Board with responsibility for Children and Young People, noting oversight – NED on Quality Committee
- Health and Safety (aspects include patient safety, employee safety and system leadership)
- Safety and Risk

4.9. Promote a just and open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

4.10. Seek assurance on the process for reviewing and reporting incidents and serious incidents and sharing the learning from these.

4.11. Seek assurance against compliance with NICE guidelines / guidance and any rationale for non or partial compliance

4.12. Seek assurance that there are effective systems of governance, performance and internal control in relation to clinical services, research and development through an annual governance review.

4.13. Review performance against the quality and safety aspects of the Integrated Performance Report

4.14. Undertake an annual review of the quality impact assessment process to gain assurance that the risks to any impact on quality arising from proposed cost improvements have been managed and mitigated.

4.15. Ensure any procedural, policy or strategy documents which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with the Policy for Development and Management of Procedural Documents (Policy for Policies) and any key national standards and best practice

4.16. Receive a quarterly report from each of the sub-groups to the Committee.

4.17. Establish an annual work plan which the Committee will review quarterly

4.18. Produce an annual report against delivery of the terms of reference of the Quality Committee.

Quality and safety reporting

4.19. In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

Audit and assurance

4.20. To approve and oversee delivery of the clinical audit plan and a review of its findings.

4.21. To receive all reports regarding the Trust produced by the Care Quality Commission and other external bodies, e.g. Royal Colleges, and seek assurance on the delivery of actions to address recommendations

4.22. Receive reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions

4.23. To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken to address these.

4.24. Gain assurance from divisions that they implement the activity required to achieve compliance with service quality and governance standards.

4.25. To receive internal audit reports (with a quality element) and seek assurance on recommendations

5. Membership and attendance

5.1. The Committee shall consist of the following members:

- Non-Executive Director **(Chair) (DS)**
- Non-Executive Director **(Deputy Chair) (KH)**
- Executive Director of Nursing **(EA)**

- Medical Director **(DB)**
- Deputy Director of Nursing **(LR)**
- Chief Operating Officer **(JF)**
- Deputy Director of Workforce and Organisational Development **(JE)**
- Assistant Director of Patient Safety **(KS)**
- Clinical Director of Pharmacy / Trust Controlled Drug Accountable Officer **(ES)**
- Head of Risk and Compliance **(LC)**
- Governance administrator (minutes) **(MA)**

5.2. The Chair of the Board of Directors will appoint a representative of the Council of Governors to attend each meeting as an observer. The appointment will be reviewed each year **(GC and JK)**

5.3 The following shall be required to attend the meetings to present their sub-group report, as required:

- Representative from Medicines Management Committee **(Annually)**
- Representative from Safeguarding Committee **(6-monthly)**
- Representative from Clinical Ethics Group **(6-monthly)**
- Representative from Clinical Effectiveness and Audit Group **(Quarterly)**
- Representative from Medical Gases Group **(Quarterly)**

5.4 The following minutes shall be received on a quarterly basis:

- Cancer Board

5.5 Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.6 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.

5.7 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.

5.8 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, 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 every month and at least nine times per year.

8. Reporting

8.1. The Committee 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 Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4. Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next Trust Board of Directors meeting.

8.5. A summary report will be presented to the next Trust Board meeting.

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

Version Control	
1.1	first draft circulated for review to Chair / Director of Nursing
1.2	Amendments prior to Trust Board
1.3	Amendments after submission to Quality Committee
1.4	Further amendments
1.5	Further amendments
2	Amendments made: ▪ Director of Workforce and Organisational Development added to section 5.1; ▪ Section 5.2 added ▪ Divisional attendance amended in section 5.4 ▪ Quorum amended at section 5.6 ▪ Medication and Safety Compliance Group and Cancer Board added to sub-groups at appendix 2 ▪ Medication and Safety Compliance Group and Cancer Board added to reports at appendix 3
3	Amendments made: ▪ Chief Operating Officer removed from membership ▪ Executive Director of Planning, Estates and Facilities removed from membership ▪ Two non-executive directors instead of three ▪ Purpose added in relation to internal audits
3.1	Amendments made (with Chair) (June 2019) ▪ Organ Donation Committee and Cancer Board added to sub-groups at appendix 2 ▪ Frequency of sub-group meetings amended at appendix 2 ▪ Frequency of meetings amended at appendix 3
4	Amendments made (Jan 2020) ▪ Organ Donation Committee removed from sub-groups at appendix 2 ▪ Addition of named NED at appendix 2 ▪ Frequency of Medication Safety and Compliance Group changed from quarterly to monthly at appendix 2 and 3
4.1	Amendments made (June 2020) ▪ Clinical Director of Pharmacy added to membership ▪ Executive Director of Workforce and Organisational Development amended to Deputy Director of Workforce and Organisational Development
5	Amendment made (January 2021) ▪ Assistant Director of Patient Experience added to membership
5.1	Amendment made (April 2021) ▪ Medicines Management Committee added as a sub-group ▪ CQC and Compliance Group added as a sub-group ▪ Clinical Effectiveness and Audit Group added as a sub-group ▪ Clinical Ethics Group added as a sub-group ▪ Medical Gases Group added as a sub-group ▪ Serious Incident Review Group removed as a sub-group ▪ Medication Safety and Compliance Group removed as a sub-group ▪ Cancer Board removed as a sub-group
5.2	Amendment made (July 2021) ▪ Cancer Board reinstated as a sub-group, to receive minutes only ▪ Amendment Oct 2021 – CM no longer public elected governor
5.3	Amendment made (November 2021) ▪ Chief Operating Officer added to core membership
5.4	Amendment made (January 2022) ▪ Removal of Assistant Director for Patient Experience from core membership
5.5	Amendment made 3 March 2022 Additional areas of responsibility in light of B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf (england.nhs.uk)

Appendices	**1.** List of members **2.** Subgroups **3.** Reports aligned to CQC domains
Issued by Quality Committee	April 2021
Due for Review	April 2022
Approved by Board of Directors	TBC

23. Governance Report

a) Board of Directors Declarations of Interest Register

b) Fit and Proper Persons Self-Declarations Register

c) Board of Directors Terms of Reference

d) Board of Directors Workplan 2022/23

e) Governance Documentation Changes regarding Associate Non-Executive Director

f) Non-Executive Director Recruitment

g) Delegation of 2021/22 Annual Report and Accounts Report approval

To Approve

Presented by Andrea McCourt

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title of report:	Governance Report
Author:	Andrea McCourt, Company Secretary
Sponsor:	Brendan Brown, Chief Executive
Previous Forums:	None

Purpose of the Report

This paper presents the following governance items to the Board:

a) the formal and updated declaration of interests of members of the Board of Directors via the Declarations of Interest Register which the Trust is required to maintain and the Board is requested to note

b) the compliance position for the Fit and Proper Persons Regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 following an annual update which the Board is requested to note.

The above items are presented to the Board in line with the Trust Constitution, Standing Orders (section 5.2 Register of Interests and 5.3 Fit and Proper Persons Regulations) and the Code of Governance**.**

c) Board of Director terms of reference - the annual review of the terms of reference of the Board of Directors which describes the role and work of the Board of Directors is presented for approval.

d) Board of Directors workplan 2022/23

e) Governance Documentation Changes regarding Associate Non-Executive Director

i. Board of Directors Standing Orders
ii. Constitution

f) Non-Executive Director Recruitment

g) Request for delegation of 2021/22 Annual Report and Accounts approval

Key Points to Note

a) Board of Directors Declarations of Interest Register

The Board of Directors is committed to openness and transparency in its work and decision-making.

Schedule 7 of the National Health Service Act 2006 and Section 32 of the Trust's Constitution requires all Board directors (including Non-Executive Directors) and any other officers nominated by the Trust to declare interests which are relevant and material to the Board of Directors of which they are a member. A register of these interests must be kept by the Trust.

In addition, the Trust has in place a Conflicts of Interest and Standards of Business Conduct Policy which notes the duty to ensure that dealings are conducted to the highest standards of integrity and helps staff and Non-Executive Directors manage conflicts of interest effectively.

On an annual basis the interests of members of decision-makers in the Trust, including the Board members are required to be updated.

The Board of Directors Declarations of Interests Register as at 23 February 2022 is attached at Appendix Q2. The Board declarations of interest register is available to the public on the Trust website at the following address: https://www.cht.nhs.uk/publications/

Any changes in interests must be made using the online declarations system as soon as is practicable and notified to the Company Secretary. Changes in interests shall be officially declared at the next Trust Board meeting following the change occurring and be recorded in the minutes.

RECOMMENDATION: The Board is asked to **NOTE** the Board of Directors Declarations of Interests Register as at 23 February 2022.

b) Fit and Proper Person Self-Declaration Register

The fit and proper persons regulation (FPRR) requirements came into effect for all NHS Trusts and Foundation Trusts in November 2014 to ensure greater regulation of NHS Board level Directors. Regulation 5 of the Health and Social Care Act 2008 provides for the CQC to monitor and assess how well Trusts discharge their responsibility to comply with the fit and proper persons requirements for Directors.

The regulation requires NHS Trusts to seek the necessary assurance that all Executive and Non-Executive Directors (or those in equivalent roles) are suitable and fit to undertake the responsibilities of their role. The CQC holds Trusts to account in relation to FPPR through their well-led domain assessments and inspections.

The Board of Directors Fit and Proper Person Self-Declaration Register as at 23 February 2022 is attached at Appendix Q3. The following groups of staff are required to complete a Fit and Proper Persons declaration annually:

- Executive Directors (including the Chief Executive)
- Directors
- Non-Executive Directors (including the Chair)
- Deputy Directors (Finance, Medical, Nursing, Operations and Workforce and organisational Development)
- Company Secretary

RECOMMENDATION: The Board is asked to **NOTE** the Fit and Proper Persons Self-Declaration Register and that all current Directors satisfy the Fit and Proper Persons Requirements.

c) Board of Directors Terms of Reference

The Board of Directors terms of reference are attached at Appendix Q4 which describe the role and work of the Board. An annual review of the terms of reference has taken place. The changes include:

- section 5, role of the Chair - addition of deputy Chair arrangements, reference to the Trust governance documents confirming Board composition and confirmation that Associate Non-Executive Directors, a new role, may attend meetings of the Board of Directors
- section 7, Accountability to the Council of Governors - arrangements for sharing agendas and Board minutes with the Council of Governors has been added
- section 8, frequency of meetings and procedures - reference to convening of urgent meetings added
- section 9, confirmation of the position regarding non-quorate Board meetings

All changes are highlighted in red font for ease of reference.

As a recommendation from an external well-led governance review of the Board, an assessment of the Board effectiveness will take place annually, commencing December 2022.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors Terms of Reference.

d) 2022/23 Board of Directors Workplan

The Board workplan provides the basis for the preparation of Board agendas for the coming year. Ad-hoc items and reports will be included on meeting agendas as necessary. The 2022/23 workplan at Appendix Q5 is presented for approval.

RECOMMENDATION: The Board is asked to **APPROVE** the Board of Directors workplan for 2022/23.

e) Governance Documentation Changes

In late 2021 the Trust agreed to pilot the use of an Associate Non-Executive Director role. The appointment was overseen by the Nominations and Remuneration Committee of the Council of Governors. The terms of reference of this Committee were revised to incorporate the appointment and removal of the Associate Non-Executive Director in December 2021 and this was ratified by the Council of Governors on 27 January 2022.

The Trust now needs to reflect the Associate Non-Executive Director role in key governance documents, the Standing Orders of the Board of Directors and the Trust Constitution, which is proposed below.

i. Standing Orders of the Board of Directors

The Board of Directors Standing Orders detail the composition, appointment and terms of office of the Board. To incorporate the role of Associate Non-Executive Director the Board is requested to approve the additions to the extract from Board of Directors Standing Orders enclosed at Appendix Q6i which has proposed additions (in red font) relating to:

- section 1.2, Composition of the Board of Directors
- section 1.3 Appointment and Removal
- section 1.4 Terms of Office.

ii. Constitution

The Trust Constitution also needs to incorporate the role of Associate Non-Executive Director and the Board is requested to approve the additions in Appendix Q6ii detailing this at the following sections:

- Section 24 - Board of Directors composition - addition of 24.7
- Section 25 - Appointment and removal of Chair, Deputy Chair and other Non-Executive Directors
- Section 27 - Board of Directors - tenure of Non-Executive Directors

RECOMMENDATION: The Board is asked to **APPROVE** the following:

Standing Orders of the Board of Directors - addition to sections 1.2, 1.3 and 1.4 of the relating to Associate Non-Executive Directors

Constitution - addition to sections 24,25 and 27 of the Constitution relating to Associate Non-Executive Directors, subject to the approval of the Council of Governors.

f) Non-Executive Director Recruitment

As part of the Trust's succession planning for Non-Executive Directors, recruitment is currently underway for three Non-Executive Director posts, those of Chair, Non-Executive Director with

financial experience and Non-Executive Director who chairs the Trust's Calderdale and Huddersfield Solutions Board.

The Council of Governors is responsible for the appointment of the Chair and Non-Executive Director appointments. The Trust is working closely with governors on the Council of Governors Nominations and Remuneration Committee on the recruitment process, which is being supported by a recruitment agency. Ratification of appointments will take place by the Council of Governors. The recruitment process for all three posts is expected to be completed by early April 2022. There will be a period of handover between departing Non-Executive Directors and the new appointments to support them in undertaking the role.

RECOMMENDATION: The Board is asked to **NOTE** the recruitment process for the Chair and two Non-Executive Directors.

g) Delegation of 2021/22 Annual Report and Annual Accounts approval

For the past two financial years the Board has 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:

- 2021/22 audited annual accounts
- 2021/22 annual report.

The current date planned for the Audit and Risk Committee approval of the audited annual accounts, annual report is 20 June 2022, 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 20 June 2021, the 2021/22 audited annual accounts and annual report.

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EQIA – Equality Impact Assessment

An Equality Impact Assessment has been completed on the Conflicts of Interest and Standards of Business Conduct policy to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

The content of this report does not adversely affect people with protected characteristics.

Recommendation

The Board is asked to **NOTE** the following:

- Board of Directors Declarations of Interest Register
- Fit and Proper Persons Self-Declaration Register
- Recruitment Process for the Chair and two Non-Executive Directors

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

- Board of Directors Terms of Reference
- Board of Directors workplan for 2022/23
- Board of Directors Standing Orders - additions at sections 1.2, 1.3, 1.4
- Constitution - additions at sections 24, 25 and 27
- Delegation to the Audit and Risk Committee for the approval of the 2021/22 Annual Report and Annual Accounts.

DECLARATION OF INTERESTS – BOARD OF DIRECTORS
AS AT 23 FEBRUARY 2022

Calderdale and Huddersfield NHS Foundation Trust

Date of Declar-ation	Name	Designation	Directorships, including Non-Executive Directorships held in private companies or public limited companies	Ownership/ Part Ownership of private companies and businesses	Controlling Share holding	A position of authority in a charity or voluntary organisation in the field of health and social care including membership of Partnership Meetings	Any connection with a voluntary or other organisation contracting for NHS services	Other Employment (paid or non-paid) with a third party
EXECUTIVE DIRECTORS								
18.1.22	Brendan Brown	Chief Executive				Chair of West Yorkshire and Harrogate People Board Member of NHS People Plan Delivery Board Member of NHSE/I North East & Yorkshire Regional People Board Honorary Professor University of Bradford Member of Bradford City of Culture Board		
21.02.22	Dr David Birkenhead	Executive Medical Director	Benson Medical Services	Nil	Nil	Member of YHW Diagnostics Board Member of the WYAAT Medical Directors Group.		

						Chair of the WYAAT LIMS Procurement Group.		
21.02.22	Ellen Armistead	Director of Nursing	Trustee Kirkwood Hospice	Nil	Nil	Member of WYATT Chief Nurse group	Nil	Nil
04.11.21	Joanna Fawcus	Chief Operating officer				Chair of West Yorkshire Cardiac Clinical Network		
03.01.22	Gary Boothby	Executive Director of Finance	Director of Pennine Property Partnerships	Nil	Nil	Member of the West Yorkshire Association of Acute Trusts Finance Group Member of Integrated Care System Directors of Finance Forum Member of the Partnership Transformation Board Finance Lead WYAAT Aseptics Project Board WY Finance Representative for Supply Chain Northern Customer Board	Nil	Nil
02.11.21	Suzanne Dunkley	Executive Director of Workforce & OD	Nil	Nil	Nil	Nil	Nil	Nil
CHAIR AND NON-EXECUTIVE DIRECTORS								
20.9.21	Philip Lewer	Chair	Nil	Nil	Nil	Member of: West Yorkshire Association of Acute Trusts (WYAAT) – Committee in	Nil	Nil

						Common West Yorkshire NHS Chairs meeting Partnership Transformation Board		
21.09.21	Richard Hopkin	Non-Executive Director	Capri Finance Ltd – own consultancy company.	Nil	Nil	Finance Director (part time) for Age UK Wakefield and District		Other project work through consultancy company Capri Finance Limited for the Onside Foundation
15.02.22	Karen Heaton	Non-Executive Director	Nil	Nil	Nil	Nil		Nil
18.02.22	Andy Nelson	Non-Executive Director	Nil	Nil	Nil	Nil	Nil	
17.02.22	Peter Wilkinson	Non-Executive Director	Leeds Grand Theatre and Opera House Ltd – independent member of the Board and Trustee. A company limited by guarantee and a registered charity. Non-Executive Director Decipher Consulting UK Ltd. Consultancy business based in Manchester/Macclesfield	PW Advisory Ltd – own consultancy company based in Holmfirth	Nil	Nil	Nil	Nil
6.10.21	Denise Sterling	Non-Executive Director	Nil	Nil	Nil	Board Member for Race Equality Network (REN) Trustee Board Member Bradford Diocesan Academies Trust	Nil	
19.09.21	Alastair Graham	Non-Executive Director	Director and Chair of Calderdale and Huddersfield Solutions Limited	Nil	Nil	Nil	Nil	Nil

ATTENDEES AT BOARD OF DIRECTORS								
23.02.22	Anna Basford	Director of Transformation & Partnerships	Nil	Nil	Nil	Member of WYAAT Directors of Strategy Group Member of Calderdale Health and Wellbeing Board	Nil	Nil
06.09.21	Stuart Sugarman		Managing Director – Calderdale and Huddersfield Solutions Limited, wholly owned subsidiary of CHFT	Nil	Nil	Nil	Nil	Nil
06.09.21	Jim Rea	Managing Director – Digital Health	Nil	Nil	Nil	Nil	Nil	Nil
21.01.22	Andrea McCourt	Company Secretary	Nil	Nil	Nil	Appointed Governor of South West Yorkshire Partnership Foundation Trust	Nil	Nil
15.12.21	Nicola Seanor	Associate Non-Executive Director	Nil	Nil	Nil	Trustee Paladin NSAS Charity	Nil	Lead Health and Justice Commissioning Support at North of England Commissioning Support (NHS)

All the above Board of Directors have confirmed that they continue to comply with the Fit and Proper Person Requirement.

FIT AND PROPER PERSON SELF-DECLARATION REGISTER FEBRUARY 2022

Calderdale and Huddersfield NHS Foundation Trust

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK / RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
EXECUTIVE DIRECTORS										
16.02.22	**ARMISTEAD**	Ellen	Executive Director of Nursing/ Deputy CEO	RGN PIN 83G1353E	June 2019	15.09.21	Owen Williams	01.07.19	Clean 17.02.22	Clean 17.02.22
17.02.22	**FAWCUS**	Jo	Chief Operating Officer	-	August 2021	n/a		08.11.21	Clean 17.02.22	Clean 17.02.22
28.01.22	**BIRKENHEAD (Dr)**	David	Executive Medical Director	GMC 3280122	October 2018	26.10.21	Owen Williams	01.12.99	Clean 17.02.22	Clean 17.02.22
27.01.22	**BOOTHBY**	Gary	Executive Director of Finance	Assoc CMA 8659790 CIPFA 41612-CIP	December 2021	16.08.21	Owen Williams	07.03.16	Clean 17.02.22	Clean 17.02.22
16.02.22	**DUNKLEY**	Suzanne	Executive Director of Workforce & OD	FCIP 31049644	December 2021	12.10.21	Owen Williams	01.02.18	Clean 17.02.22	Clean 17.02.22
16.02.22	**BROWN**	Brendan	Chief Executive	RGN PIN 88IO16E	December 2021	n/a	n/a	04.01.22	Clean 17.02.22	Clean 17.02.22
DIRECTORS & COMPANY SECRETARY										
15.02.22	**BASFORD**	Anna	Director of Transformation & Partnerships	-	28.06.16	03.09.21	Owen Williams	15.7.13	Clean 17.02.22	Clean 17.02.22
31.01.22	**REA**	Jim	Managing Director – Digital Health	-	13.05.21	n/a		02.08.21	Clean 17.02.22	Clean 17.02.22

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
27.01.22	**SUGARMAN**	Stuart	Managing Director - CHS	Solicitors	September 2021	July 2021	Alastair Graham	30.09.19	Clean 17.02.22	Clean 17.02.22
01.02.22	**MCCOURT**	Andrea	Company Secretary	-	April 2015	15.10.21	Owen Williams	18.05.15	Clean 17.02.22	Clean 17.02.22
NON-EXECUTIVE DIRECTORS										
28.01.22	**GRAHAM**	Alastair	Non- Executive Director	N/A	December 2017	11.08.21	Philip Lewer	01.12.17	Clean 17.02.22	Clean 17.02.22
01.02.22	**HEATON**	Karen	Non- Executive Director	Member of the Chartered Institute of Personnel and Development (10344496)	12 May 2016	19.08.21	Philip Lewer	01.03.16	Clean 17.02.22	Clean 17.02.22
31.01.22	**HOPKIN**	Richard	Non- Executive Director (Deputy Chair / SINED)	FCA (membership number 7311370)	14 December 2017	16.08.21	Philip Lewer	01.03.16	Clean 17.02.22	Clean 17.02.22
09.02.22	**LEWER**	Philip	Chair	-	April 2018	July 2021	Board / Council of Governors	01.04.18	Clean 17.02.22	Clean 17.02.22
28.01.22	**NELSON**	Andy	Non- Executive Director	-	9 October 2017	10.08.21	Philip Lewer	01.10.17	Clean 17.02.22	Clean 17.02.22
02.02.22	**STERLING**	Denise	Non- Executive Director	Health and Care Professionals Council OT10114	October 2019	17.08.21	Philip Lewer	01.10.19	Clean 17.02.22	Clean 17.02.22
14.02.22	**WILKINSON**	Russell Peter	Non- Executive Director	Member of the Royal Institution of Chartered Surveyors (MRICS) Ref No 0085230	September 2019	13.09.21	Philip Lewer	01.01.20	Clean 17.02.22	Clean 17.02.22

DATE OF DECLA-RATION	SURNAME	FIRST NAME	JOB TITLE / ROLE	PROFESSIONAL REGISTRATION	DATE OF DBS CHECK/ RE- CHECK	DATE OF LAST APPRAISAL	NAME OF APPRAISER	DATE COMMEN-CED IN CHFT	INSOLVEN-CY REGISTER CHECK	DISQUAL-IFICATION FROM DIRECTORS REGISTER
17.02.22	**SEANOR**	Nicola	Associate Non-Executive Director	-	12 November 2021	n/a		15.12.21	Clean 17.02.22	Clean 17.02.22
DEPUTY DIRECTORS										
27.01.22	**ARCHER**	Kirsty	Deputy Director of Finance	Chartered Management Accountant, ACMA (CIMA)	17 October 2021	18.05.21	Gary Boothby	01.08.08	Clean 17.02.22	Clean 17.02.22
11.02.22	**EDDLESTON**	Jason	Deputy Director of Workforce and OD	MCIPD 10327459	Post does not fall within the legal provisions that govern the processing of a DBS standard or enhanced check	22.07.21	Suzanne Dunkley	08.02.1999	Clean 17.02.22	Clean 17.02.22
31.01.22	**PARKER**	Cornelle	Deputy Medical Director	GMC 3286582	May 2017	10.02.21	Dr Rob Moisey	08.05.17	Clean 17.02.22	Clean 17.02.22
16.02.22	**RUDGE**	Lindsay	Deputy Chief Nurse	NMC 90E0076E	23 October 2021	13.10.21	Ellen Armistead	12.07.93	Clean 17.02.22	Clean 17.02.22

Calderdale and Huddersfield NHS Foundation Trust

BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTITUTION

In accordance with its Constitution, the Trust has a Board of Directors, which comprises both Executive Directors, one of whom is the Chief Executive and Non-Executive Directors, one of whom is the Chair.

As set out in Annex 8 of the Constitution, the Trust has Standing Orders for the Board of Directors which describe the practice and procedures for the business of the Trust. Those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, information for the Trust as a whole and serve as the basis of the terms of reference for the Board's own committees.

2. PURPOSE

The principal purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the Council of Governors and some decisions of the Board of Directors require the approval of the Council of Governors.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, which is a unitary Board, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, the Integrated Care System, PLACE level partner organisations including local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients, service users, and carers;
- To ensure that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision, strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the Trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

4.3. Quality

The Board:

- Ensures that the Trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:

- Sets, maintains and oversees the implementation of the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Monitors and reviews management performance to ensure the Trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.
- Ensures that national policies and strategies are effectively addressed and implemented within the Trust.

4.5. Culture

The Board:

- Is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction;
- Ensures that high standards of corporate governance and personal integrity are maintained in the conduct of foundation Trust business;
- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:

- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by NHS England/ NHS Improvement from time to time) and appropriate codes of conduct, accountability and openness applicable to Foundation Trusts;
- Ensures that the Trust operates in accordance with its Constitution;
- Ensures that all elements of the Trust's licence relating to the Trust's governance arrangements are complied with;
- Ensures the Trust protects the health and safety of Trust employees and all others to whom it has a duty of care;
- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements;
- Review and approve the Trust's Annual Report and Accounts
- Review and approve the annual Quality Account or equivalent
- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account the lived experience of patients and carers;
- Ensures that all required returns and disclosures are made to the regulators and complies with all relevant regulatory, legal and code of conduct requirements, including Care Quality Commission fundamental standards for all regulated activities;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation Trust business;
- Agrees the schedule of matters reserved for decision by the Board of Directors;
- Ensures that the statutory duties of the Trust are effectively discharged;
- Acts as a corporate trustee for the Trust's charitable funds.

4.7. Risk management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities;
- Ensures that there are sound processes and mechanisms in place to ensure

effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services;
- Ensures there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining committees of the Board of Directors with delegated powers as prescribed by the Trust's standing orders and/or by the Board of Directors from time to time:

4.9. Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its Governors, members, staff and the local community;
- Meets its engagement obligations in respect of the Council of Governors and members and ensures that governors are equipped with the skills and knowledge they need to undertake their role;
- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publicly, primarily via the Trust's website;
- Publishes an annual report and annual accounts.

4.10. Finance

The Board:

- Ensures that the Trust operates effectively, efficiently, economically;
- Agrees the Trust's financial objectives and approve the financial plan;
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensures that the Trust achieves the targets and requirements of stakeholders within the available resources;
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and Council of Governors and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole plays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Council of Governors.

The Deputy Chair, a Non-Executive Director, will chair the Board in the absence of the Chair.

The composition of the Board is set out in the Constitution of the Trust (section 24) and the Standing Orders of the Board of Directors (Annex 8). Associate Non-Executive Directors may also attend meetings of the Board of Directors.

The Board may invite non-members to attend its meetings on an ad-hoc basis, as it considers necessary and appropriate, and this will be at the discretion of the Chair.

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chair and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and Council of Governors.

7. ACCOUNTABILITY TO THE COUNCIL OF GOVERNORS'

The agenda of the Board of Director meetings held in public shall be forwarded to the Council of Governors prior to the meeting.

After each Board meeting held in public, the Board of Directors will send a copy of the minutes to the Council of Governors.

The Non-Executive Directors are accountable to the Council of Governors for the performance of the Board of Directors. To execute this accountability effectively, the Non-Executive Directors and Associate Non-Executive Director will need the support of their Executive Director colleagues. A well-functioning accountability relationship will require the Non-Executive Directors to provide Governors with a range of information on how the Board has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the Trust. The Non-Executive Directors will need to encourage questioning and be open to challenge as part of this relationship. The Non-Executives also should ensure that the Board as a whole allows Council of Governors' time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS AND PROCEDURES

The Board of Directors will meet at least six times a calendar year in public on dates agreed with the Chair. Dates of forthcoming meetings held in public shall be posted on the Trust's website. Board meetings may be conducted virtually and, where this is the case, a recording of the Board meeting will be made available on the Trust website as soon as is practically possible after the meeting.

Agendas and papers for forthcoming meetings of the Board to be held in public, and minutes of previous meetings held in public, shall be posted on the Trust's website.

Urgent meetings shall be convened in accordance with section 2.4 of the Standing Orders of the Board of Directors in Annex 8 of the Trust's Constitution.

Additional meetings of the Board may be held in private for consideration of confidential business.

Further details on the practice and procedure of the Board of Directors, including voting, can be found in Annex 8 of the Constitution, Standing Orders of the Board of Directors.

9. QUORUM

Seven directors including not less than three executives, and not less than three Non-Executive Directors shall form a quorum.

If an Executive Director is unable to attend a meeting of the Board, an alternative may be appointed to attend that meeting or part of it, if so requested by the Chair. Any such alternative shall not be counted as part of the required quorum unless they have been formally been appointed by the Board as an Acting Director.

Non-quorate meetings may go forward unless the Chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the Company Secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the Chair and Chief Executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the Council of Governors and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all Directors and others as agreed with the Chair and Chief Executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

The Board will review its effectiveness in the following ways:

Annual assessment of Board effectiveness
Review of attendance records

Calderdale and Huddersfield NHS Foundation Trust

Annual reports from Board Committees
Board of Director Strategy Sessions
Outputs from any Well-Led Governance Reviews

Date drafted: 18 February 2022

Date approved: 3 March 2022 TBC

Review Date: February 2023

PUBLIC BOARD WORKPLAN 2022-2023

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Date of agenda setting/Feedback to Execs	4 April 2022	1 June 2022	TBC	TBC	TBC	TBC
Date final reports required	22 April 2022	24 June 2022	19 August 2022	21 October 2022	30 December 2022	17 February 2023
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓
Patient/Staff Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
Recovery Update	✓	✓	✓	✓	✓	✓
Financial Update	✓	✓	✓	✓	✓	✓
Health Inequalities	✓	✓	✓	✓	✓	✓
Quality Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Finance and Performance Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Workforce Committee Chair's Highlight Report & Minutes	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓
Council of Governors Meeting Minutes	✓	✓	✓		✓	
STRATEGY AND PLANNING						
Strategic Objectives – 1 year plan / 10 year strategy		✓ *- 2021-2023 Strategic Objectives Progress Report*		✓		✓
Digital Health Strategy		✓				

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Workforce OD Strategy	✓					
Risk Management Strategy						✓
Annual Plan	✓	✓				✓
Capital Plan					✓	
Winter Plan			✓			
Green Plan (Climate Change)	✓					
QUALITY						
Quality Board update	✓	✓	✓	✓	✓	✓
Director of Infection Prevention Control (DIPC) quarterly report	✓Q4		✓Q1	✓Q2	✓Q3	
DIPC Annual Report		✓				
Learning from Deaths Quarterly Report		✓Q4 (Annual Report)	✓Q1	✓Q2		✓ Q3
Safeguarding update – Adults & Children			(Annual Report)			✓
Safeguarding Adults and Children Annual Report			✓			
Complaints Annual Report			✓			
WORKFORCE						
Staff Survey Results and Action Plan	✓	✓				✓
Health and Well-Being			✓			
Nursing and Midwifery Staffing Hard Truths Requirement			✓ Bi-Annual			
Guardian of Safe Working Hours (quarterly)	✓Q4		✓Q1	✓Q2	✓Q3	
Guardian of Safe Working Hours Annual Report	✓					
Diversity						✓
Medical Revalidation and Appraisal Annual Report			✓ Annual Report			
Freedom to Speak Up Annual Report			✓ Annual Report		✓ 6 month report FTSU themes	

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Workforce Committee Annual Report	✓ 2021/2022					
Public Sector Equality Duty (PSED) Annual Report						✓
GOVERNANCE & ASSURANCE						
Health and Safety Update	✓	✓			✓	
Health and Safety Policy	✓					
Health and Safety Annual Report					✓	
Board Assurance Framework		✓ 1		✓ 2		✓ 3
Risk Appetite Statement			✓			
High Level Risk Register	✓		✓		✓	
Calderdale Huddersfield Solutions Managing Directors Report	✓	✓	✓	✓	✓	✓
Standing Orders/SFIs/SOD review	✓					
Non-Executive appointments				✓		✓
Annual review of NED roles			✓			
Board workplan	✓	✓	✓	✓	✓	✓
Board meeting dates		✓				
Use of Trust Seal		✓		✓		✓
Council of Governor elections						✓ timetable
Declaration of Interests – Board of Directors (annually)						✓
Attendance Register – (annually)	✓					
Fit and Proper Person Self-Declaration Register						✓
Seek delegation from Board to ARC for the annual report and accounts 2021/22						✓
BOD Terms of Reference						✓
Sub Committees Terms of Reference	✓ QC ✓ F&P ✓ TPB	✓ Workforce	✓ARC			✓QC ✓ NRC BOC

DATE OF MEETING	5 May 2022	7 July 2022	1 Sep 2022	3 Nov 2022	12 Jan 2023	2 Mar 2023
Constitutional changes (+as required)	✓					✓
Compliance with Licence Conditions	✓					
Huddersfield Pharmaceuticals Specials (HPS) Annual Report				✓		
Fire Safety Annual Report		✓				
Fire Strategy 2021-2026 and Fire Policy Update						✓
Emergency Planning Annual Report (Bev Walker/Ian Kilroy/Karen Bates)			✓			
Charitable Funds Report 2021-22 and Accounts (Audit Highlights Memorandum)					✓	
Committee review and annual reports		✓				
Audit & Risk Committee Annual Report 2021/2022		✓				
Finance & Performance Committee Annual Report 2021/2022		✓				
Quality Committee Annual Report 2021/22		✓				
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)

Appendix Q4i.

Extract from the Standing Orders of the Board of Directors - Proposed Additions regarding Associate Non-Executive Director

1.2 Composition of the Board of Directors

In accordance with the 2006 Act, Terms of Authorisation and the Constitution, the Board of Directors of the Trust shall comprise both Executive and Non-Executive Directors as follows:

A Non-Executive Chair

Up to 6 other Non-Executive Directors (one of who shall act as the SINED)

Up to 6 Executive Directors including:

- *the Chief Executive (the Chief Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *a medical or dental practitioner*
- *a registered nurse or midwife*

The Non-Executive Directors and Chair together shall be greater than the total number of Executive Directors.

Other Directors may be appointed to the Board of Directors from time to time but shall have no voting rights.

Associate Non-Executive Directors: Associate Non-Executive may be appointed to the Board on terms and conditions to be specified by the Board to provide additional advice and expertise to the Board and / or its Committees. Associate Non-Executive Directors will not be Directors of the Trust for the purposes of the National Health Service 2006 Act and thus will be non-voting appointees without executive or delegated executive functions or any power to bind the Trust.

1.3 Appointment and removal of the Chair, Non-Executive Directors and Associate Non-Executive Directors

The Chair, Non-Executive Directors and Associate Non-Executive Directors are appointed and may be removed by the Council of Governors in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution.

1.4 Terms of Office of the Chair, Non-Executive Directors and Associate Non-Executive Directors

The Chair and Non-Executive Directors are appointed for a period of office in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution. The terms and conditions of the office are decided by the Council of Governors.

The terms and conditions relating to the office of Associate Non-Executive Directors are decided by the Council of Governors.

Appendix Q4ii.

Extract from the Trust Constitution - Proposed Additions regarding Associate Non-Executive Director

24. Board of Directors – composition

24.1 The Trust is to have a Board of Directors. It is to consist of executive and non-executive directors.

24.2 The Board of Directors is to comprise:

24.2.1 a non-executive Chair;
24.2.2 up to 6 other non-executive directors;
24.2.3 up to 6 executive directors.

24.3 One of the executive directors shall be the Chief Executive who shall be the Accounting Officer.

24.4 One of the executive directors shall be the finance director.

24.5 One of the executive directors is to be a registered medical practitioner.

24.6 One of the executive directors is to be a registered nurse or a registered midwife.

24.7 The Board may appoint associate non-executive directors to provide additional advice and expertise to the Board or its Committees. These are non-voting appointments.

25. Board of Directors – appointment and removal of the Chair, Deputy Chair and other non-executive directors, including associate non-executive directors

25.1 The Council of Governors shall appoint a Chair of the Trust.

25.2 The Board of Directors will appoint one non-executive director to be Deputy Chair of the Trust. This individual may, through agreement with the Chair, take on the role of Senior Independent Non-Executive Director (SID).

25.3 The Chair and Deputy Chair will be the Chair and Deputy Chair of both the Council of Governors and the Board of Directors.

25.4 To be eligible for appointment as a non-executive director or associate non-executive director of the Trust the candidate must demonstrate a

commitment to the Trust are and the communities it serves and live within reasonable travelling distance.

25.5 The Council of Governors at a general meeting shall appoint or remove the Chair of the Trust and the other non-executive directors and associate non-executive directors.

25.6 Non-Executive Directors and Associate Non-Executive Directors are to be appointed by the Council of Governors using the following procedure:

25.6.1 The Board of Directors will work with the external organisations recognised as expert in non-executive appointments to identify the skills and experience required

25.6.2 Appropriate candidates will be identified by the Board of Directors who meet the skills and experience required

25.6.3 A sub-committee of the Council of Governors (not exceeding four persons) including the Chair, will interview a short list of candidates and recommend a candidate for appointment by the Council of Governors.

25.7 Removal of the Chair or other non-executive director shall require the approval of three-quarters of the Council of Governors.

25.8 The Board of Directors shall appoint one non-executive director to be the Deputy Chair of the Trust.

27. Board of Directors – tenure of Non-Executive Directors and Associate Non-Executive Directors

a. The Chair and the Non-Executive Directors are to be appointed for a period of three years.

b. The Chair and the Non-Executive Directors will serve for a maximum of two terms.

c. In exceptional circumstances a Non-Executive Director (including the Chair) may serve longer than six years (two three-year terms). Any subsequent appointment will be subject to annual re-appointment. Reviews will take into account the need to progressively refresh the Board whilst ensuring its stability. Provisions regarding the independence of the Non-Executive Director will be strictly observed.

d. The tenure of Associate Non-Executive Directors will be determined on a case by case basis and will be no longer than that stipulated at 27b above.

24. Annual / Bi-Annual Reports

1. Public Sector Equality Duty (PSED) Annual Report

To Approve

Presented by Suzanne Dunkley

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	Thursday 3 March 2022
Meeting:	Public Board of Directors
Title:	Public Sector Equality Duty Annual Report – January to December 2021
Author:	Adam Matthews, Workforce and OD Business Manager Nikki Hosty, Assistant Director of Human Resources
Sponsoring Director:	Suzanne Dunkley, Executive Director of Workforce and OD
Previous Forums:	Previous Annual Report - Board of Directors, 4 March 2021

Purpose of the Report

To present the annual report as required by the Public Sector Equality Duty. The annual report highlights the activities CHFT have been working on to address the needs of patients and colleagues who fall under the nine protected characteristics as outlined in the Equality Act 2010. The report will be published following review by the Board of Directors.

Key Points to Note

The Public Sector Equality Duty Report aims to eliminate discrimination, advance equality of opportunity and foster good relations between people. The duty applies to the public sector, including the NHS and also to others carrying out public functions.

Whilst planned patient and workforce equality and diversity activity for 2021 was impacted by the response to COVID 19, opportunities arose for CHFT to identify any health inequalities that may impact on our patients, including our future reconfigured services, and also improved the breadth of our engagement and communication with colleagues.

Actions for 2021 are identified in section 5 of the report.

Appendix 1 provides details about the equality of our workforce in 2021.

EQIA – Equality Impact Assessment

All equality groups have been consulted on the Equality, Diversity and Inclusion approach we are taking in the Trust. Many colleagues have been involved in the activities delivered for patients and colleagues. We are raising awareness of difference, integrating difference and identifying barriers and removing them for patients and colleagues.

Recommendation

The Board is asked to **APPROVE** the Public Sector Equality Duty Annual Report for 2021.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Public Sector Equality Duty Annual Report

January 2021 to December 2021

CONTENTS

1 Introduction

This equality report for the period January to December 2021 provides assurance to the Board that Calderdale and Huddersfield NHS Foundation Trust (CHFT) continues to meet its responsibilities under the Equality Act 2010 and in particular that it meets the requirements of the Public Sector Equality Duty.

The report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the general equality duty. The report also contains the Equality in our Workforce Report, at Appendix 1.

Our Trust is committed to ensuring equality, diversity and inclusion are central to the way we deliver compassionate healthcare services to our service users and how we wrap One Culture of Care and support around our colleagues.

We are a progressive organisation that promotes equality, celebrates diversity and is working towards building inclusive and compassionate environments where our colleagues provide services that are delivered with kindness, dignity, and respect.

This report highlights our approach and work to address any additional needs of those patients or colleagues who identify with a range of protected characteristics. Examples of what we have been doing at CHFT to address these needs are included in the report. The examples are, however, only a sample of the work going on overall to improve services for patients and colleagues from protected groups.

NHS Employers defines Equality, Diversity, and Inclusion in the following way:
"Equality is about creating a fairer society where everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Inclusion is about an individual's experience within the workplace and in wider society and the extent to which they feel valued and included."

By adopting this definition, we can be clear with both patients and colleagues about what we mean by equality, diversity and inclusion and therefore develop a shared understanding of what we are trying to achieve.

2 The Legal and Compliance Framework

2.1 Equality Act 2010

The Equality Act came into force from October 2010 providing a modern, single, legal framework with clear, streamlined law to more effectively tackle disadvantage and discrimination. On 5 April 2011, the public sector equality duty came into force. The equality duty was created under the Equality Act 2010.

The equality duty consists of a general equality duty, with three main aims (set out in section 149 of the Equality Act 2010) and specific duties for public sector organisations. The Equality Act requires public bodies like CHFT to publish relevant information to demonstrate their compliance with the duty.

The Act applies to service users and Trust employees who identify with the following protected characteristics:

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy or maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The **general equality duty** means that the Trust must have due regard to the need to:

- Eliminate unfair discrimination, harassment, and victimisation.
- Advance equality of opportunity between different groups; and
- Foster good relationships between different groups

By:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The **specific duties** are legal requirements designed to help the Trust meet the general equality duty. These require the publication of:

- Annual information to demonstrate our compliance with the general equality duty published on our website by 30 March each year.

- Equality Objectives (which are specific and measurable) published for the first time by 5 April 2012, reviewed annually and re-published at least every four years.

2.2 Care Quality Commission Requirements

The Care Quality Commission (CQC) expects to find evidence that the Trust is actively promoting equality and human rights across all its services and functions. Equality and diversity considerations are specifically addressed as part of its key line of enquiry around a Trust's responsiveness to patient needs. The CQC asks "Are services planned and delivered to meet the needs of people?" and "Do services take account of needs of different people, including those in vulnerable circumstances?"

The Trust was rated as 'Good' at the last inspection in April 2018.

3 Our progress in 2021

3.1 Health Inequalities

The link between poor health outcomes and social deprivation has long been established and has been the subject of several significant independent reviews and research studies over many years. The Covid 19 pandemic exposed and exacerbated long standing inequalities particularly among the Black, Asian and Minority Ethnic (BAME) communities.
The NHS commissioned a review of the impact of Covid 19, reporting in July 2020 the report made clear there are 8 urgent actions that needed to be progressed namely:

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

In response to this the Trust has set up a Health Inequalities Working Group to oversee progress and activity. Its work is guided by four themes, each led by a senior director to help shape our response and disseminate any learning across our organisation and wider Health and Social care system in Calderdale and Huddersfield.

- The external environment, how we connect with our communities and use this to inform our business-as-usual planning
- The lived experience, with initial focus on families accessing our maternity service

- Health inequalities data and how we use data to compliment clinical prioritisation and our post Covid-19 delivery model
- The staff experience, ensuring we have a workforce that reflects our local population

Progress on the key objectives for 2021 – 2025 that we set out in 2020 includes:

Development of a mechanism for systematic involvement of BAME communities from community groupings with known health inequalities

The Trust appointed a BAME Community Engagement Advisor Engagement to work alongside the Trust's BAME network group and create engagement opportunities with the local BAME communities, following are examples of initiatives she is involved in: -

- Developing links with community centres in Huddersfield and Calderdale e.g., Women's Activity Centre (organisation which supports women from South Asian backgrounds exposed to social isolation and deprivation)
- Raising awareness of Root Out Racism and how the Trust supports the movement
- Carrying out walk arounds at both Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) speaking with patients around care and experience

Development of a transformation programme: Focus On: addressing inequalities in health, participation and experiences for patients and carers

The Trust is improving access to healthcare for disadvantaged groups (homeless, refugees, asylum seekers). This work is being led by the Transformation team and focused within the Emergency Department (ED), as this is where individuals attend at a point of crisis. The aim is to create a directory of services for ED staff to provide acute signposting and safety netting for individuals to ensure continuity of care and so that the ED is a safe and empathic environment.

Community colleagues are working with St Augustine's Centre which supports asylum seekers and refugees. After an initial assessment of health needs and assessing what support is required, Community Matrons now attend to support health needs, prescribing and access to GPs.

District Nurses are working alongside the "Gathering Place" (drop in for the homeless) in Halifax targeting hard to reach patients. The nurses are running drop-in clinics twice a week. The number of services attending has grown, Sexual Health now run a weekly clinic and Podiatry are attending when the nurses identify a need for their input for foot ulceration / footwear.

Development of a learning portal for staff. Focus On: Learning from complaints and incidents.

The impact of the pandemic has led to the development of a learning portal being delayed until 2022.

Develop a deep understanding of complaints service access inequalities by strengthening relevant monitoring and reporting to drive improvements and engaging with service users on specific complaints service codesign projects

A dashboard has been developed in our Knowledge Portal Plus (KP+) tool which maps complaints to Index of Multiple Deprivation (IMD), strengthening our monitoring mechanisms. The tool is still in its infancy, but early analysis of the data indicates that there is a higher level of advocacy amongst the BAME community than the non-BAME community when it comes to making complaints.

We also use data to compliment clinical prioritisation and our post Covid-19 delivery model. A Health inequalities dashboard enables a review of patients awaiting access to outpatient, diagnostic and inpatient services in terms of their clinical priority, alongside other risk factors:

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

Reviewing the waiting list data in this way has enabled a more holistic profile of 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 Trust has also strengthened processes for conducting and reviewing Equality Impact Assessments (EQIA), recent examples that have been completed include:

- Children's Community Hub Elland as part of the reconfiguration of the Child Development Service
- Children's Community Nursing, Children's Epilepsy and Diabetes services, some therapy services
- Children's Emergency Department Business case

The EQIA of the clinical model for reconfigured services has also been refreshed which involved engagement with groups representing protected characteristics. The Trust engaged Calderdale Disability Group, Youth Forum, Equality Network, Chaplains, BAME Network, and Learning Disability Networks.

Alongside this we've also seen progress in the following areas:

Pregnancy/Maternity and Race

Maternity services now have two Continuity of Carer teams which are based in areas of high deprivation. They focus on the provision of Maternity care for women from black, minority ethnic groups/areas of deprivation, supporting greater engagement in decisions about their personal care. Engagement initiatives are being carried out to gain a better understanding of experiences and needs of these women, which will help to direct the development of the service provided by these teams. We also

hosted face to face discovery interviews with women to share their experience of maternity services.

Given the link with clinical outcomes and service user engagement, the maternity service is undertaking some anonymous interviews with staff to gain insight into the challenges of caring for service users from vulnerable groups and different ethnic backgrounds. The Trust is part of a Maternity Services Community Action Network which captures insight on specific topics from teen mums, refugees and asylum seekers, poverty and deprivation (including homeless), English not a first language, BAME population groups, women in prison or detention centres, and addiction. Through a co-production session, the main findings have been discussed to identify any required change or support.

Learning Disabilities

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

The Trust now has a project manager for health inequalities in post whose main focus is the development of the enhanced care pathway for people with learning disabilities.

Visual Impairment

Working with representatives from Disability Partnership Calderdale, Halifax Society for the Blind and Kirklees Visual Impairment Network, the team are leading on developing awareness raising messages for sharing across the Trust. These are being informed by local patients with visual impairments. Members of all organisations have been involved in reviewing the signage internal and external, sharing views and recommendations as part of the Transformation programme.

Children

There has been engagement with service users and families who access the Rainbow Child Development Service (currently at CRH) regarding the relocation of the service into a community facility. This included contact being made with 800 families in relation to the future development of a Children's Community Hub. Families from a range of IMD and ethnic backgrounds have been encouraged to be involved in the design work for the new facility. Interactive puppets - Star, Thunder and Sunny have been used as a communication aid for to facilitate children and young people having a voice in this project.

3.2 EDS2 (Equality Delivery System 2)

The EDS2 helps the Trust to meet and respond to the Public Sector Equality Duty as set out in the Equality Act 2010. Giving 'due regard' is a legal duty – it means proactively and consciously engaging and considering the impact of our decisions – which helps to provide better health outcomes for diverse groups. It will assist to

meet the general duty to eliminate discrimination, harassment, and victimisation; advance equality of opportunity; and foster good relations.

The Trust worked in partnership with local organisations including Clinical Commissioning Groups (CCG) and Locala to host a joint EDS2 virtual forum to share progress and hear from local Calderdale and Kirklees service users. We believe that everyone in our community deserves the opportunity to lead a healthy, happy life and our differences, our diversity should not lead to disadvantage. Delivering compassionate care is at the heart of what we do.

The events were well received, and we received 'Good' score at both the Kirklees and Calderdale events.

3.3 Membership and Engagement

As a Foundation Trust, CHFT has a Council of Governors, which is actively engaged through divisional reference groups and corporate sub-groups with members and service users about quality improvement and service change.

We strive to ensure that we have a diverse membership that represents the people we serve and our community. This table shows how representative our membership community was, compared with our local populations, as at 31 December 2021:

	CHFT members as % of total members	CHFT members as % of eligible** members
Age		
0-16	0.03%	n/a
17-21	0.5%	8.2%
22+	99.5%	90.2%
Ethnicity		
White	85.3%	83.3%
Mixed	2.1%	1.5%
Asian/Asian British	9.3%	12.6%
Black/Black British	2.8%	1.6%
Other	0.5%	0.6%
Gender		
Female	65.6%	51.4%
Male	34.4%	48.6%
Transgender	0.01%	Not available

The data shows that our membership community is under-represented in three sectors: younger people; those from Asian/Asian British backgrounds; males.

In 2021 we put plans in place to establish a Membership and Engagement Working Group through which we will develop strategies for encouraging membership from under-represented sectors of our communities. The group will have its first meeting in March 2022.

In 2021 we reviewed the make-up of the Council of Governors in order to broaden its diversity, as a result of which the Equality and Diversity Manager from one of our local CCGs is now invited to attend our public Council of Governors meetings as an observer.

We held governor elections in 2021 and were successful in broadening the diversity of the Council of Governors further through the election of one governor from a BAME background and another with a declared disability. In addition, the age profile of our governors reduced over 2021, with 83% of governors aged 60 or over in January 2021, compared with 69% in December 2021.

We continue to focus on efforts to engage with as wide a range of service users and stakeholders as possible and during 2021 we have made progress against the priorities in our Membership and Engagement strategy despite the restrictions placed on our work by the COVID-19 pandemic.

The Trust continues to focus on efforts to engage with as wide a range of service users and stakeholders as possible. In 2019 the Trust's Membership and Engagement Strategy for the three-year period 2020-2023 was reviewed and a number of priorities were identified for the next 12 months. These were:

We will analyse our membership on a regular basis, and have targeted campaigns to recruit members from any group that is under-represented	We will actively promote membership and raise the profile of our governors and the Council of Governors in a variety of settings and forums	We will have a Patient Panel through which members and members of the public can feed back on service changes and forward plans
Within our public membership body, we will have a youth membership constituency	Our governors will have opportunities, and the necessary skills, to actively seek out the views of members and the public on material issues or changes being discussed at the Trust	
We will have established links with local organisations through whom we can recruit members		

4 Strengthening Equality, Diversity, and Inclusion – Workforce

4.1 Why Equality, Diversity and Inclusion was even more important to us in 2021

As with 2020, 2021 was significantly impacted by the Trust's response to COVID 19.

However, rather than pausing the activities identified in our Inclusion Strategy, we took the opportunity to progress several high level activities that have improved our approach to Equality, Diversity and Inclusion.

The Trust's vision is to provide compassionate care to the populations of Calderdale and Kirklees. To do this we adopted 'One Culture of Care', focusing on caring for ourselves and each other so that we can offer outstanding care to our patients.

Our COVID Health and Wellbeing Strategy was launched as soon as the nation went into lockdown in March 2020. At its helm was a 'friendly ear' service, focused on mental health - which disproportionately affects BAME people and LGBTQ groups. In designing the Health and Wellbeing Strategy it was important to understand the different needs of our workforce and what compassionate care looked like to them. By understanding our colleagues' different needs, we were then able to adapt our wellbeing services to better suit them.

4.2 The benefits of Equality, Diversity, and Inclusion

We aim to create an inclusive culture where all employees feel engaged, valued, and included. Leadership will be inclusive and compassionate in order that colleagues feel supported by their line managers. Greater accountability and engagement from senior managers in the equality, diversity, and inclusion (EDI) agenda, taking ownership of the issues affecting different diverse groups of staff.

A diverse and inclusive work environment will help the Trust better understand and meet different patient expectations and improve their experience. As ~80% of our workforce live in the communities the Trust serves, harnessing the insight and views of our colleagues also enabled us to understand the needs of our communities. Moving forward, it will also help us to attract and retain a whole range of people from different walks of life, with different experiences.

This plan embraces our values and vision (our four pillars) , and explains what we are working towards, our goals, commitments and activities, as well as mechanisms and timescales for reporting our progress.

Our approach will be to 'seek to understand' and to 'stand in the shoes' of our colleagues to better understand their needs and differences.

Our Inclusion Strategy identifies 4 key aims:

- We will have a workforce that champions and celebrates our diverse communities. Our board and senior clinical and non-clinical teams will be fully inclusive
- We will support current and future colleagues and enable them to make the most of their skills and talents
- We will engage a whole range of colleagues to create an inclusive culture where all staff feel engaged and valued
- We will engage and work with our partner organisations to share best practice, learn from one another, build relationships, and work together for the benefit of colleagues and the communities we serve

4.3 Equality and Diversity Training

We will provide a high-quality service for all of our patients and be an employer of choice in the local area.

We will fulfil our legal obligation under the Equality Act 2010 to provide services and employment in a manner that eliminates discrimination, advances equality, and fosters good relationships between protected groups.

The Trust's workforce development approach centres on leadership, personalised learning, building networks, experiential learning and focussing on unlocking talent for all. Our colleagues are placed at the centre of our programme. This inclusive approach helps the organisation, and our colleagues define the skills and capabilities needed for the future; to provide our colleagues with the tools they need to deliver positive outcomes and identify key gaps in the current workforce; and create innovative strategies and programs to apply those capabilities.
Ultimately our aim is to build a resilient, emotionally intelligent, and inclusive workforce that can bounce back, express compassion, promote positive relationships with One Culture of Care at the heart of everything we do.

Formal Programmes include:

- Enhance – Inclusive Talent Framework and Toolkit
- Empower – Inclusive Personal Development Programme
- Elevate – stepping into leadership
- Leadership Development Programme
- Management Essentials

Equality, Diversity & Inclusion is threaded into all formal learning programmes

4.4 Equality, Diversity & Inclusion Activity

The Trust has a number of Equality Networks to offer colleagues a safe place to receive support, advice and encouragement. The networks provide an open forum to exchange views, experiences and raise concerns. All colleagues at the Trust are welcome to join the Networks. Each Network has an Executive Sponsor and a member of the Executive team, who actively champions the protected characteristic, attends Network meetings, and supports the Networks with their respective work programmes.

BAME Network

The BAME Network has continued to meet over Microsoft Teams and hosted a variety of events to support BAME colleagues during the pandemic. 2021 highlights for the network included celebrating Windrush Day with the flying of the Windrush flag outside HRI, positive BAME representation in the Freedom to Speak up Ambassadors team, Workforce Race Equality Standard (WRES) monitoring and

action planning, championing and challenging change and supporting the Root out Racism campaign.

Pride Network

The Pride Network meets bi-monthly. Achievements include: -

- Flying the Progress Pride flag outside HRI in June 2021
- Attending Happy Valley Pride with members of the sexual health team
- Celebrating Pride in the NHS week in September with charity Just Like us providing an information session on trans access to healthcare
- Virtual social events including quiz nights
- Pride network representatives supporting inclusive recruitment panels
- Participated in the lived experience series (podcasts / videos)
- Facilitated a LGBTQ+ History Month lunch and learn
- Hosted a World Aids Day stall with support from our Sexual Health team.

Colleague Disability Action Group

The Colleague Disability Group has continued with peer support meetings throughout the pandemic, offering regular slots for colleagues to engage with each other and exchange advice.
It meets quarterly with achievements in 2021 including free colleague car parking agreement for blue badge holders, participating in the lived experience series (videos/podcasts), promoting importance of person-centred decision making, inclusive recruitment panellists and Workforce Disability Equality Standard (WDES) monitoring and action planning.

Women's Voices

As an outcome of International Women's Day session, a group of colleagues in the organisation formed Women's Voices. This is a community where colleagues come together quarterly to discuss women's issues (topics include as domestic abuse, career pathways and menopause), share lived experiences and have the opportunity to network. This network contributes to Gender Pay Gap Action Plan, supports inclusive recruitment and our lived experience series.

These discussions led to the development of a separate menopause wellbeing group, highlights of which include the development of an 8-point workforce wellbeing plan to support colleagues going through the menopause and management advice and guidance.

We also have four further employee led networks:

- Carers Network
- Armed Forces Network
- BAME Nursing and Midwifery Group
- International Network

Black History Month

Black History Month aims to celebrate the culture, history and achievements of black communities and promote knowledge of black history, culture, and heritage. Celebrating Black History Month has raised awareness and the importance of equality and equity for our colleagues, patients, carers, and communities.

We launched the Root Out Racism campaign during Black History Month where all the Executive team signed a Root out Racism pledge. The Root out Racism movement was launched by West Yorkshire and Harrogate Health and Care Partnership and the West Yorkshire Violence Reduction Unit. The Trust joined several other local organisations to join together to root out racism and signed a commitment agreement at the Piece Hall in October.

Project SEARCH

Project SEARCH is a transition to work programme committed to transforming the lives of young people with learning disabilities and autism. The Trust works with the local college in Calderdale to provide offer a 12-month work experience programme for 10 - 15 interns per year. This programme enables transformative change, supporting and helping young people with autism and learning disabilities into the world of work.

Health and Wellbeing Risk Assessments

At the start of the pandemic, we launched our Health and Wellbeing Risk Assessment to give colleagues the opportunity to tell us about the factors that impact their health and wellbeing, their experiences at work, how they are feeling and highlight any concerns they might have.

The assessment covers three main areas: physical health, mental health, and personal circumstances. The responses help us to support individual colleague needs and work through the key issues and themes by establishing health and wellbeing information directly from colleagues.

In 2021, 833 risk assessments were completed.

Inclusive Recruitment

Volunteers from our Equality Networks have been trained by the Workforce and Organisational Development team to participate in recruitment processes. The training included gaining the confidence to challenge decision-making on the panel and how to reduce bias in the process.

Inclusion Week

An opportunity for everyone to work together and design and deliver a range of events to highlight that ‘everyone is welcome at the Trust.
Activities in 2021 included:

- Mental Health First Aid sessions
- Jerusalama dance
- Root out Racism Pledge
- Women's voices lived experience event
- Andy's Man Club presented at Wellbeing ambassador meeting
- Virtual Quiz
- Inclusion Schwartz round – Pride and Prejudice

Wellbeing

Employee wellbeing has become a particular concern throughout the pandemic. Mental ill health rates are rising; the Office for National Statistics (2021) reports the number of adults diagnosed with depression has more than doubled since before the pandemic. Many people have suffered loss, isolation, illness, and stress during this time, as an inclusive employer the need for an understanding, compassionate, and flexible approach to work is more critical than ever.

The Trust has significantly increased their attention on the wellbeing offer / strategy to support the diverse needs of our colleagues with One Culture of Care at the heart of the programme.

Events and networks include: -

- Long Covid network
- Mental Health Network
- Menopause Network
- Danny Sculthorpe, State of Mind, delivering a presentation to the wellbeing ambassador network
- A programme of Schwartz round sessions

Through focussing on Once Culture of Care for our colleagues and compassionate care for our patients we aim to embed a culture where wellbeing is at the forefront of colleagues' minds, and we aim to become an inclusive employer of choice.

5 Conclusions/Looking ahead to 2022

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

We will continue to build on the progress made against the key objectives for 2021 – 2025 which are as follows:

- Development of a mechanism for systematic involvement of BAME communities from community groupings with known health inequalities

- Development of a transformation programme: Focus On: addressing inequalities in health, participation and experiences for patients and carers
- Development of a learning portal for staff. Focus On: Learning from complaints and incidents.
- Develop a deep understanding of complaints service access inequalities by strengthening relevant monitoring and reporting to drive improvements and engaging with service users on specific complaints service codesign projects

We will help colleagues feel confident and competent when caring for or dealing with people with any of the protected characteristics, and to ensure that equality and diversity considerations are an everyday, intrinsic part of being a valued Trust colleague and of delivering excellent, compassionate care.

6 Contacts and Enquiries

If you have any questions or comments on this report, or would like to receive it in alternative formats, e.g., large print, braille, languages other than English, please contact Nikki Hosty at Nicola.hosty@cht.nhs.uk

APPENDIX 1

EQUALITY IN OUR WORKFORCE REPORT

1. Introduction

Equality and diversity related to the workforce is led by the Director of Workforce and Organisational Development. This report provides information about equality in the Trust's workforce. It is based on data that is held about the workforce as at 31 December 2021. In accordance with the Equality Act 2010, we have a duty to "publish information relating to persons who share a relevant protected characteristic who are its employees."

The Trust published its Workforce Race Equality Standard (WRES) in October 2021. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES became operational from 1 April 2015. The standard has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for BAME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust also published its Workforce Disability Equality Standard (WDES) in October 2021. Again, the WDES is a national equality standard for employment against which all NHS organisations are assessed.

2. Staff profile

The staff profile shown in the graphs below are based on a 'snapshot' of all the staff working for the Trust as at 31 December 2021 against the same date in the previous four financial years.

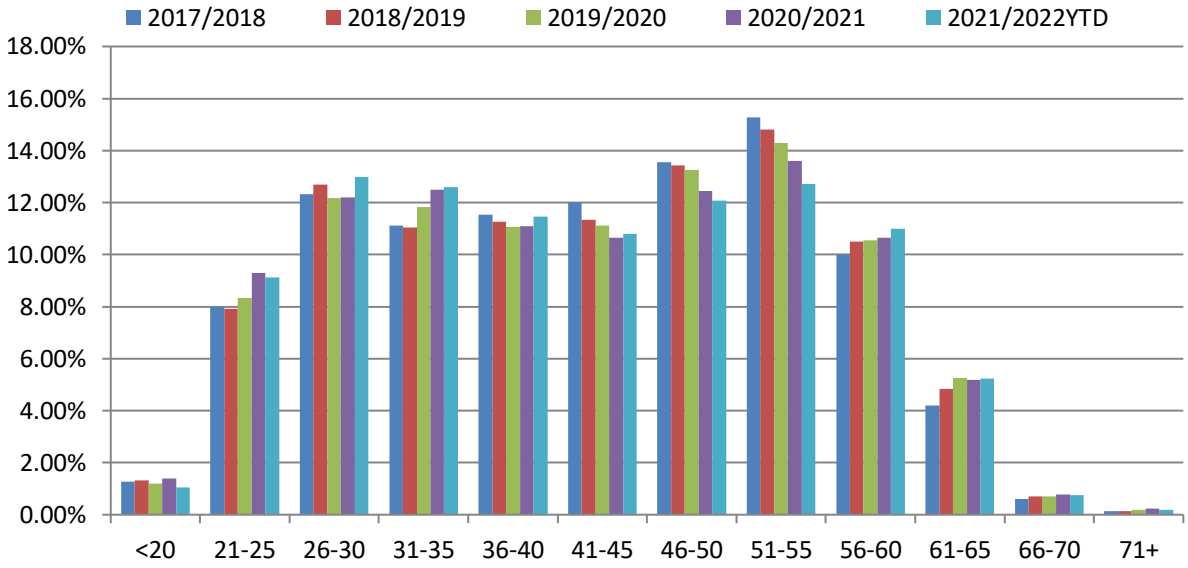
Following good practice in data protection and to ensure personal privacy, some categories have been combined. This helps to protect the anonymity of staff.

We have analysed the Trust's workforce information from the last four years using key equality and diversity indicators to try and identify any significant trends in the data. The categories used are:

- Age
- Disability
- Ethnicity
- Gender
- Religious Belief
- Sexual Orientation

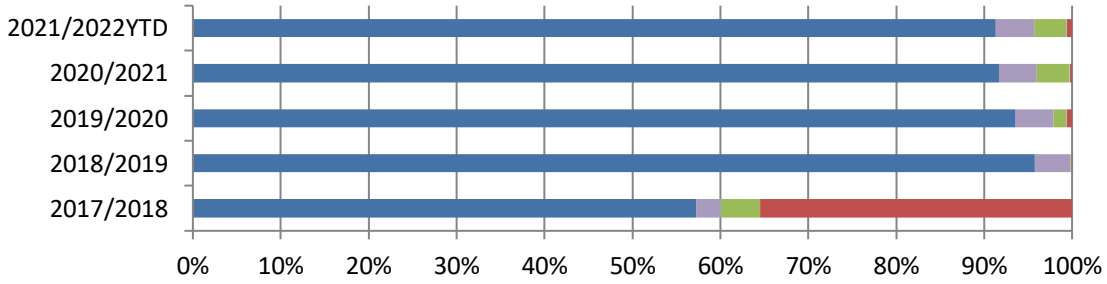
Age Profile

The highest proportion of Trust employees (12.99%) are in the age bracket 26-30.



Disability

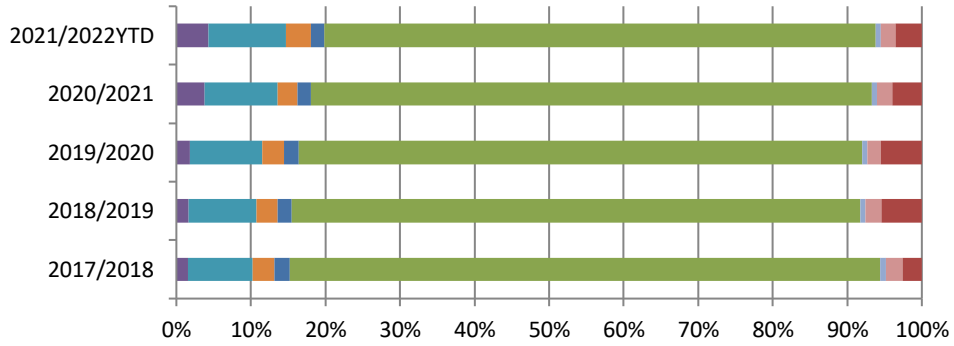
Information on the profile of the Trust's workforce in terms of disability is not sufficiently clear in order to provide a valid analysis of the data. Data quality has improved over the last 5 years, with a significant data quality exercise taking place in 2018; however, detail level data on type of disability is currently not available. This data is reviewed on an on-going basis and continuous improvements made.



	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022YTD
No	57.30%	95.75%	93.61%	91.68%	91.30%
Yes	2.80%	4.05%	4.26%	4.30%	4.39%
Not Declared	4.44%	0.07%	1.48%	3.70%	3.64%
Prefer not to say	0.00%	0.07%	0.05%	0.06%	0.11%
Unknown	35.52%	0.07%	0.60%	0.26%	0.57%

Ethnicity

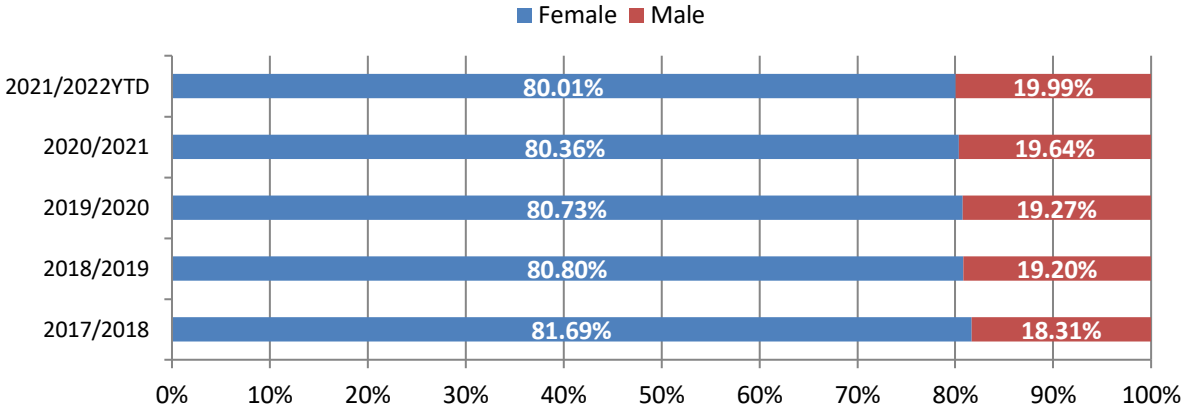
The ethnicity profile of the Trust has seen gradual increases within the Asian and 'Any Other' ethnic groups, however the largest profile remains White - British (73.94%).



	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022YTD
Any other ethnic group (including Chinese)	1.54%	1.61%	1.79%	3.82%	4.26%
Asian and Asian British	8.65%	9.15%	9.71%	9.74%	10.42%
Black and Black British	3.00%	2.79%	2.91%	2.70%	3.36%
Mixed Race (dual heritage)	2.06%	1.89%	1.98%	1.83%	1.84%
White - British	79.20%	76.30%	75.61%	75.17%	73.94%
White - Irish	0.75%	0.70%	0.67%	0.75%	0.71%
White (not British or Irish - includes White unspecified)	2.23%	2.13%	1.84%	2.04%	1.93%
Not Known	2.57%	5.43%	5.50%	3.95%	3.54%

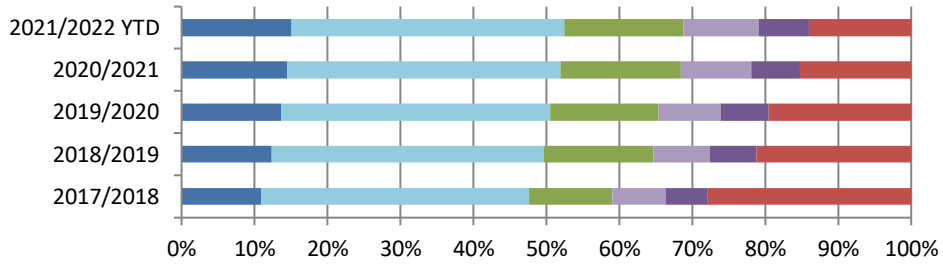
Gender

The gender split in the Trust has not shown much change over the reporting period, with the proportion of men significantly lower than the national workforce average. However, the health and social care sector traditionally employs more women than men.



Religion & Belief

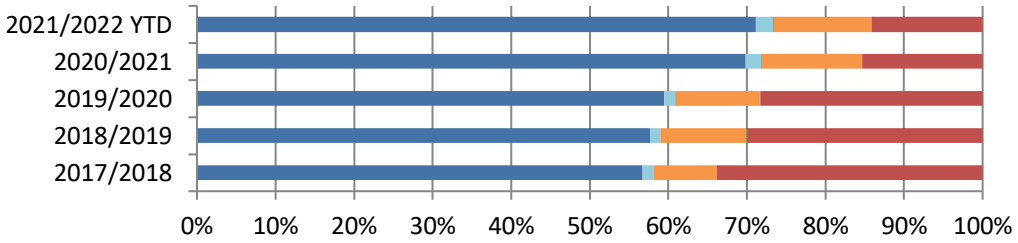
Data quality has continued to improve; however, at the time of reporting 14% of the workforce has not recorded their religious belief. (an improvement of 1% points on the previous year)



	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022 YTD
Atheism	11%	12%	14%	14%	15%
Christianity	37%	37%	37%	37%	37%
I do not wish to disclose my religion/belief	11%	15%	15%	17%	16%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	7%	8%	9%	10%	10%
Other	6%	6%	7%	7%	7%
Not Known	28%	21%	20%	15%	14%

Sexual Orientation

Data quality on Sexual Orientation has continued to improve. At the time of reporting 14.08% of the workforce has an unknown sexual orientation, a decrease of 1.26% from the end of the previous year.



	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022 YTD
Heterosexual	61.69%	64.77%	66.60%	69.84%	71.13%
Lesbian, Gay or Bisexual	1.51%	1.46%	1.66%	1.95%	2.22%
Other Sexual Orientation	0.00%	0.00%	0.02%	0.06%	0.09%
I do not wish to disclose	8.81%	12.31%	11.97%	12.73%	12.41%
Undecided	0.00%	0.07%	0.07%	0.08%	0.06%
Not Known	36.80%	33.70%	31.66%	15.34%	14.08%

3. Staff joining the Trust

This section shows demographic data for the recruitment of staff and has been broken down using equality and diversity indicators. All information in this section is sourced from TRAC, an online recruitment tool used by Calderdale and Huddersfield NHS Foundation Trust.

The charts below reflect all recruitment activity for the period 1 January 2021 to 31 December 2021, and provide a breakdown (%) of applicants, applicants shortlisted, and applicants recruited.

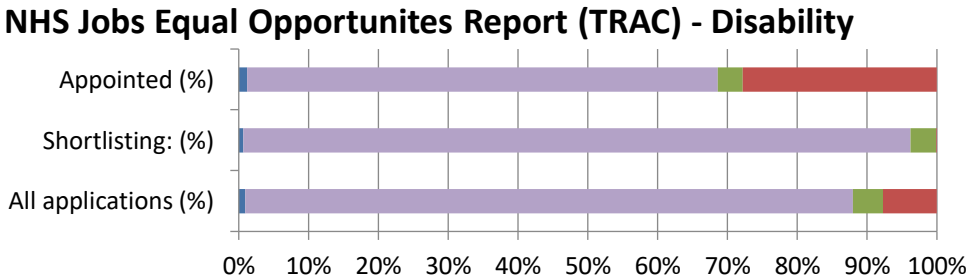
Age Profile

Most applications (24.5%) come from the 25-29 age group. This group is also the most likely to be shortlisted (27.6%) and appointed (21.5%).

Age Group	Applications	%	Shortlisted	%	Appointed	%
Under 20	411	3.1%	212	3.0%	49	2.5%
20 - 24	2234	16.7%	1213	17.3%	359	18.4%
25 - 29	3264	24.5%	1938	27.6%	418	21.5%
30 - 34	2693	20.2%	1545	22.0%	319	16.4%
35 - 39	1697	12.7%	910	13.0%	225	11.6%
40 - 44	1000	7.5%	460	6.6%	181	9.3%
45 - 49	760	5.7%	328	4.7%	145	7.4%
50 - 54	591	4.4%	218	3.1%	108	5.5%
55 - 59	419	3.1%	136	1.9%	98	5.0%
60 - 64	154	1.2%	49	0.7%	38	2.0%
65+	37	0.3%	11	0.2%	7	0.4%

Disability

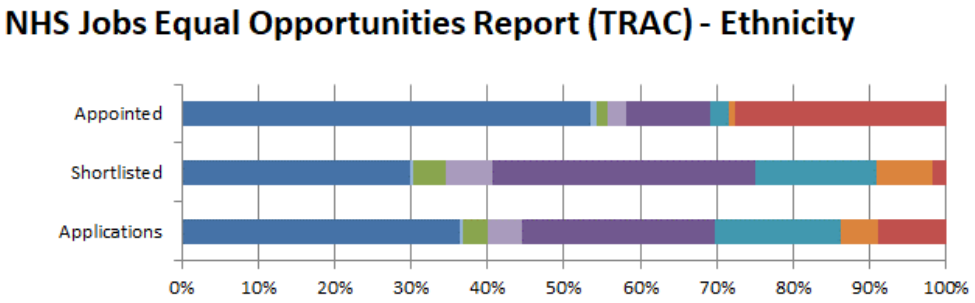
4.2% of applicants, 3.7% of those shortlisted and 3.6% of appointed staff declared themselves as disabled.



	All applications (%)	Shortlisting: (%)	Appointed (%)
I do not wish to disclose whether or not I have a disability	1.0%	0.6%	1.2%
No	87.0%	95.6%	67.3%
Yes	4.2%	3.7%	3.6%
Not stated	7.8%	0.1%	27.8%

Ethnicity

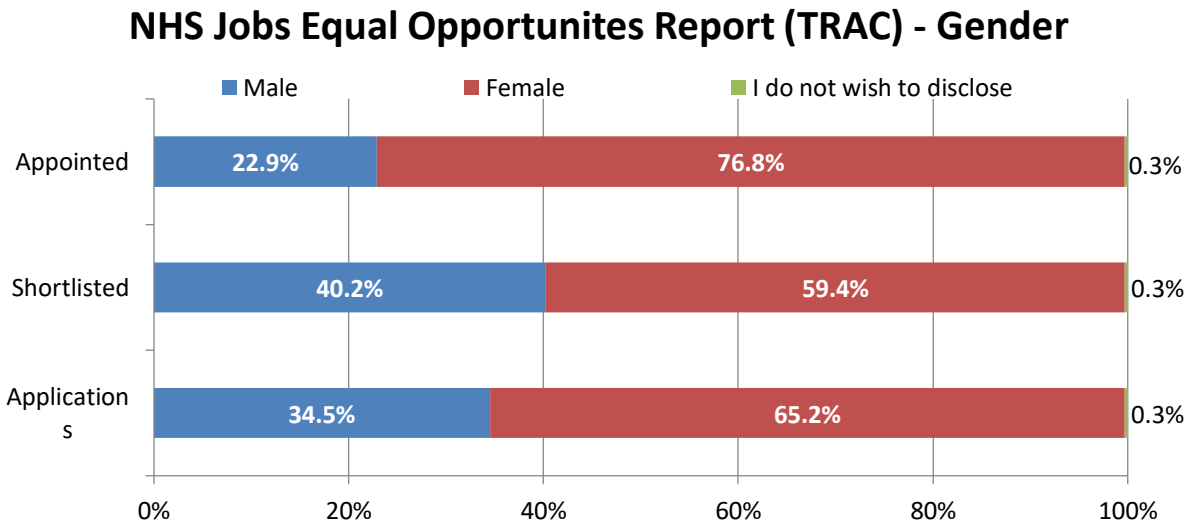
Most applications (36.3%), and applicants recruited (53.0%) identify as 'White – British'. Asian & Asian British are the most shortlisted group at 30.3%, however this group only accounts for 10.9% of those successfully appointed.



	Applications	Shortlisted	Appointed
WHITE - British	36.3%	26.4%	53.0%
WHITE - Irish	0.5%	0.3%	0.9%
WHITE - Any other white background	3.2%	3.8%	1.4%
Mixed Race	4.5%	5.5%	2.3%
Asian & Asian British	25.1%	30.3%	10.9%
Black & Black British	16.5%	14.1%	2.4%
Any other group (Including Chinese)	4.8%	6.4%	0.8%
Undisclosed	8.9%	1.6%	27.4%

Gender

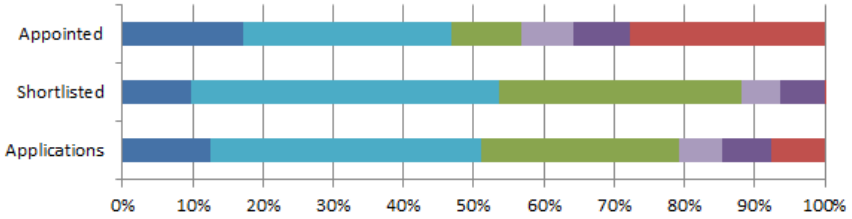
The majority of applications, applicants shortlisted, and applicants recruited are female.



Religion & Belief

The majority of applicants (38.5%), applicants shortlisted (43.8%) and applicants recruited (29.7%) identify as Christian.

NHS Jobs Equal Opportunities Report (TRAC) - Religious Belief

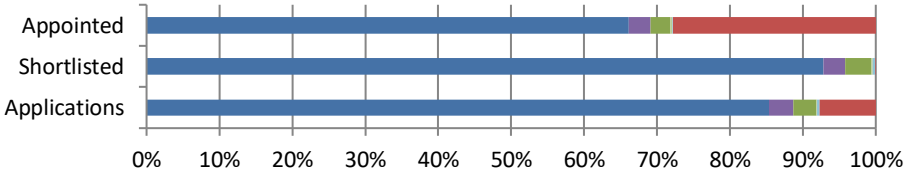


	Applications	Shortlisted	Appointed
Atheism	12.6%	9.8%	17.1%
Christianity	38.5%	43.8%	29.7%
Non Christian Religions	28.1%	34.7%	9.9%
Other	6.3%	5.5%	7.4%
I do not wish to disclose my religion/belief	6.9%	6.2%	8.1%
Not stated	7.7%	0.1%	27.8%

Sexual Orientation

The majority of applications, applicants shortlisted, and applicants recruited identify as heterosexual.

NHS Jobs Equal Opportunities Report (TRAC) - Sexual Orientation



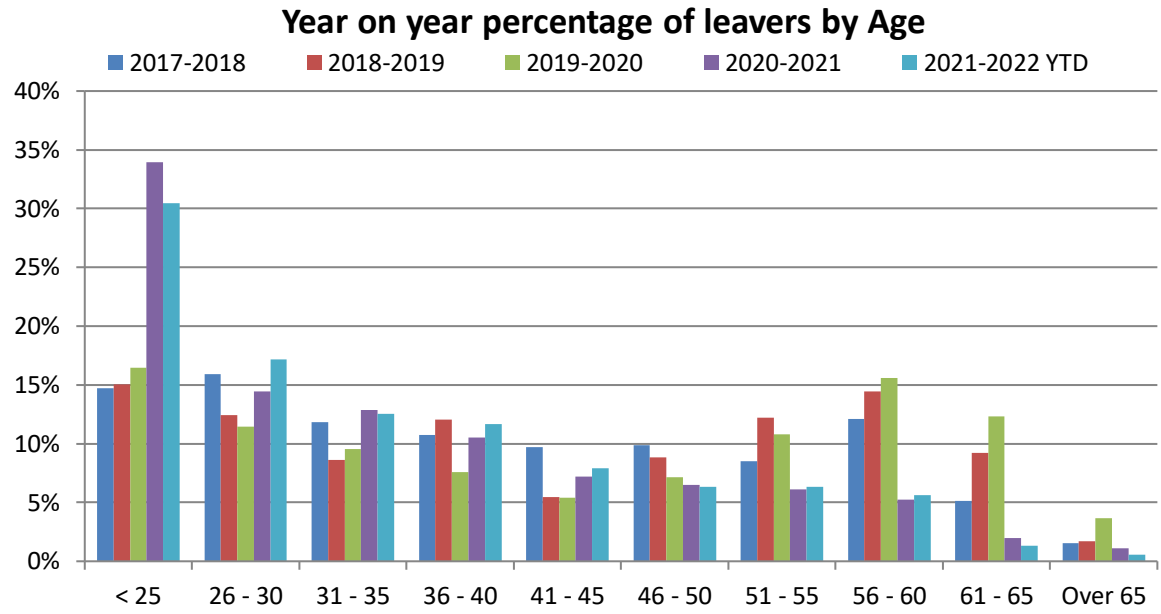
	Applications	Shortlisted	Appointed
Heterosexual or Straight	85.4%	92.8%	66.2%
Lesbian, Gay or Bisexual	3.3%	2.9%	2.9%
I do not wish to describe my sexual orientation.	3.1%	3.6%	2.8%
Other sexual orientation not listed	0.2%	0.2%	0.2%
Undecided	0.3%	0.4%	0.1%
Undisclosed	7.7%	0.1%	27.8%

4. Staff leaving the Trust

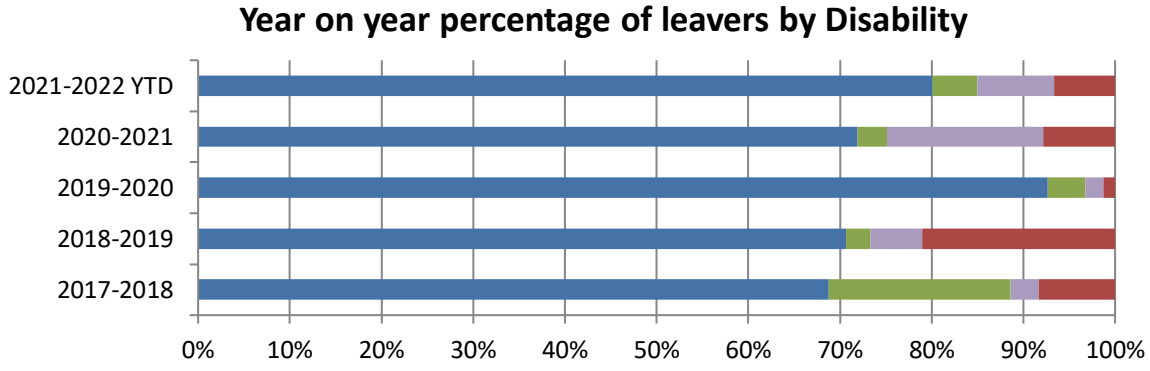
This section shows data regarding staff that left the Trust between 1 April 2017 and 31 December 2021; broken down using the equality and diversity indicators.

Age Profile

During the current year to date turnover is highest amongst staff aged Under 25 years (30.45%) followed by the 26-30 (17.17%) and 31-35 (12.55%) age groups.

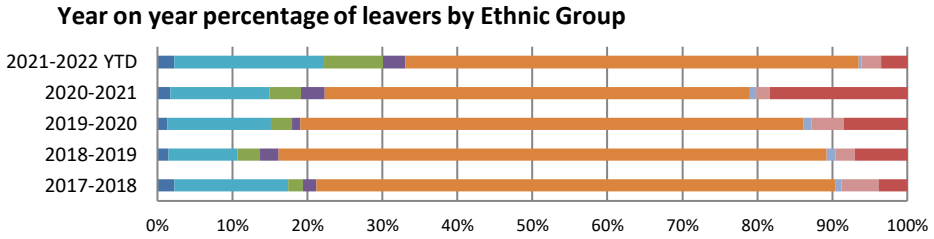


Disability



	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022 YTD
No	68.79%	70.68%	92.64%	71.94%	80.09%
Yes	19.85%	2.63%	4.11%	3.19%	4.91%
Not Declared	3.03%	5.64%	1.95%	17.03%	8.37%
Not Known	8.33%	21.05%	1.30%	7.84%	6.64%

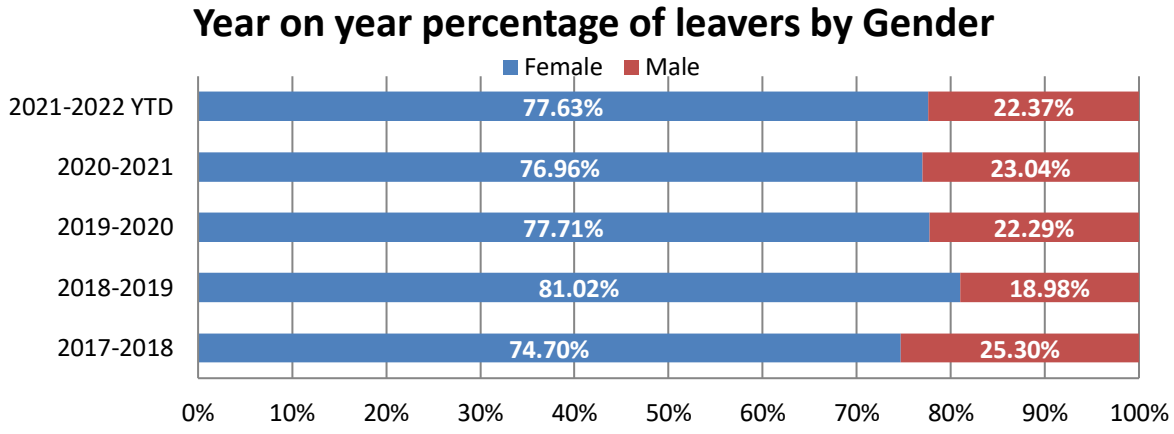
Ethnicity



	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022 YTD
Any other ethnic group (including Chinese)	2.27%	1.50%	1.30%	1.72%	2.26%
Asian and Asian British	15.15%	9.21%	13.85%	13.24%	20.00%
Black and Black British	1.97%	3.01%	2.81%	4.17%	7.82%
Mixed race (dual heritage)	1.82%	2.44%	1.08%	3.19%	3.01%
White - British	69.24%	73.12%	67.10%	56.74%	60.45%
White - Irish	0.76%	1.13%	1.08%	0.86%	0.30%
White (not British or Irish - includes White unspecified)	5.00%	2.63%	4.33%	1.72%	2.71%
Not Known	3.79%	6.95%	8.44%	18.38%	3.46%

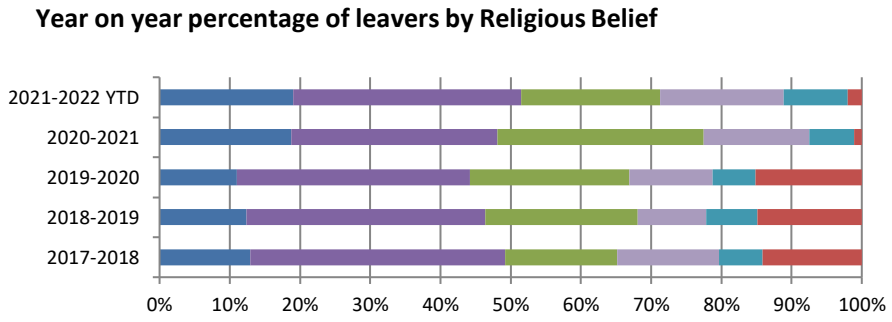
Gender

77.63% of leavers are female employees, however with the Trust employing a significantly higher number of female employees this is expected.



Religion & Belief

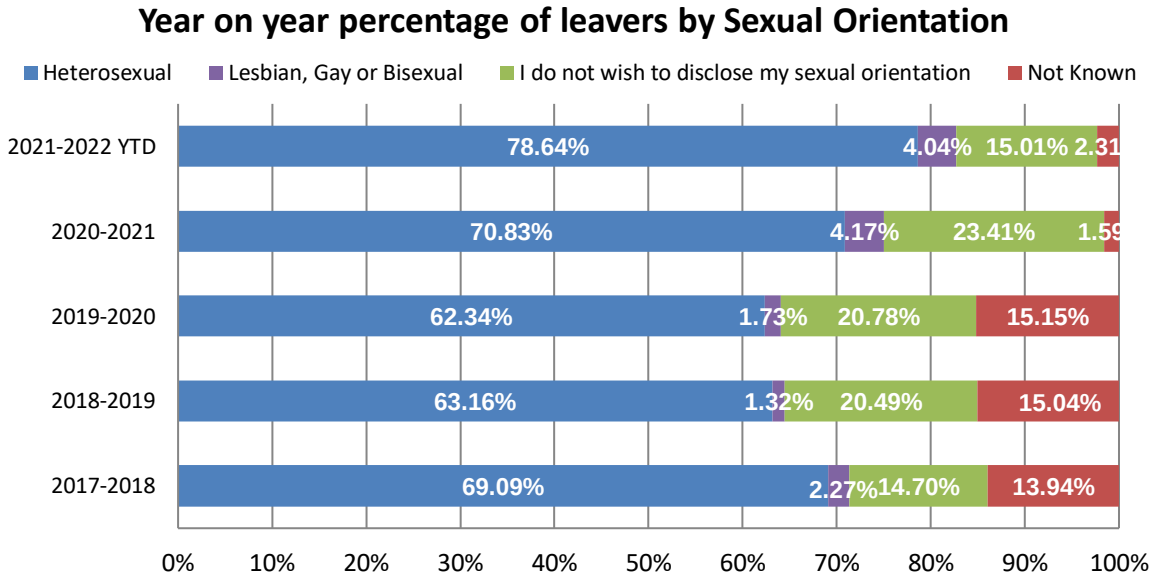
As with 2020-21, the majority of leavers in 2021-22 are Christians (32.47%).



	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022 YTD
Atheism	12.88%	12.41%	11.04%	18.75%	19.05%
Christianity	36.36%	34.02%	33.12%	29.41%	32.47%
I do not wish to disclose my religion/belief	15.91%	21.62%	22.73%	29.29%	19.77%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	14.55%	9.77%	11.90%	15.07%	17.60%
Other	6.21%	7.33%	6.06%	6.37%	9.09%
Not Known	14.09%	14.85%	15.15%	1.10%	2.02%

Sexual Orientation

The majority of leavers in 2021-22 are Heterosexual (78.64%) The percentage of leavers with an unknown sexual orientation has increased from 1.59% to 2.31%.



5. Staff profile by pay

The data below is a 'snapshot view' of the pay levels for all Trust employees as at 31 December 2021. This section looks at the organisation pay and measures this against the key equality and workforce indicators.

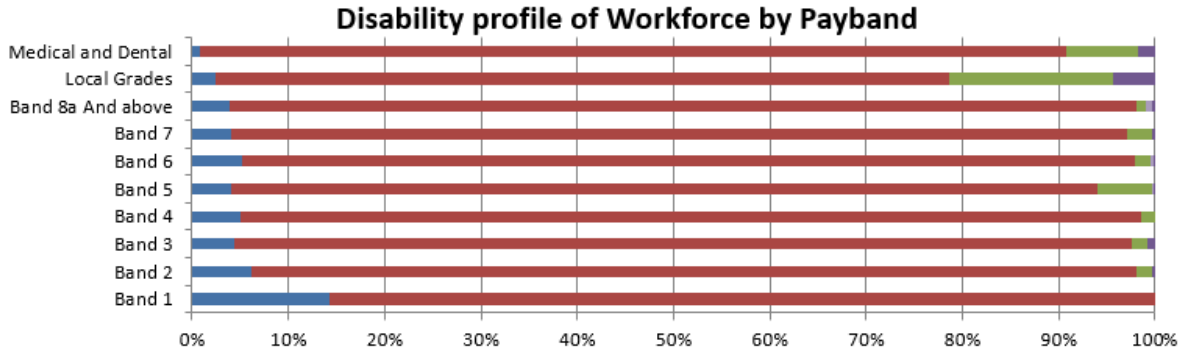
Age Profile

The most common pay band in the Trust is Agenda for Change band 2 with 21.32% of colleagues in this band. Band 5 comes in a close second with 21.20% of staff in this band. Within Band 2 the largest majority (15.24%) of people are in the age band 56-60.

Age Band	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Other	Medical and Dental
<25	0.00%	10.42%	13.51%	7.67%	15.32%	4.11%	1.78%	0.00%	40.48%	8.85%
26 - 30	0.00%	10.49%	14.04%	9.59%	17.82%	14.13%	10.70%	2.30%	5.95%	17.71%
31 - 35	7.14%	9.78%	11.40%	11.51%	12.83%	17.23%	11.94%	11.18%	7.94%	15.09%
36 - 40	0.00%	8.86%	9.82%	8.87%	11.19%	13.83%	14.44%	15.46%	7.54%	13.50%
41 - 45	0.00%	7.58%	8.95%	11.03%	8.91%	13.23%	14.80%	17.11%	7.14%	14.51%
46 - 50	21.43%	11.41%	11.58%	11.51%	10.98%	11.42%	18.00%	17.43%	5.95%	12.05%
51 - 55	7.14%	13.68%	10.53%	17.75%	9.76%	13.63%	15.15%	22.70%	9.52%	8.85%
56 - 60	50.00%	15.24%	12.63%	16.07%	8.41%	9.42%	9.98%	11.51%	7.94%	6.10%
61 - 65	14.29%	10.70%	6.84%	5.28%	4.21%	2.71%	2.85%	1.64%	5.56%	1.74%
Over 65	0.00%	1.84%	0.70%	0.72%	0.57%	0.30%	0.36%	0.66%	1.98%	1.60%

Disability

Information on the profile of the Trust's workforce in terms of disability has improved over the last 5 years and from work completed for the WDES submission. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Yes	14.29%	6.17%	4.39%	5.04%	4.06%	5.21%	4.10%	3.95%	2.38%	0.87%
No	85.71%	91.92%	93.16%	93.53%	90.02%	92.69%	93.05%	94.08%	76.19%	89.99%
Not Declared	0.00%	1.56%	1.75%	1.44%	5.70%	1.70%	2.50%	0.99%	17.06%	7.40%
Prefer Not To Answer	0.00%	0.07%	0.00%	0.00%	0.14%	0.20%	0.00%	0.66%	0.00%	0.00%
Unspecified	0.00%	0.28%	0.70%	0.00%	0.07%	0.20%	0.36%	0.33%	4.37%	1.74%
Not Known	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

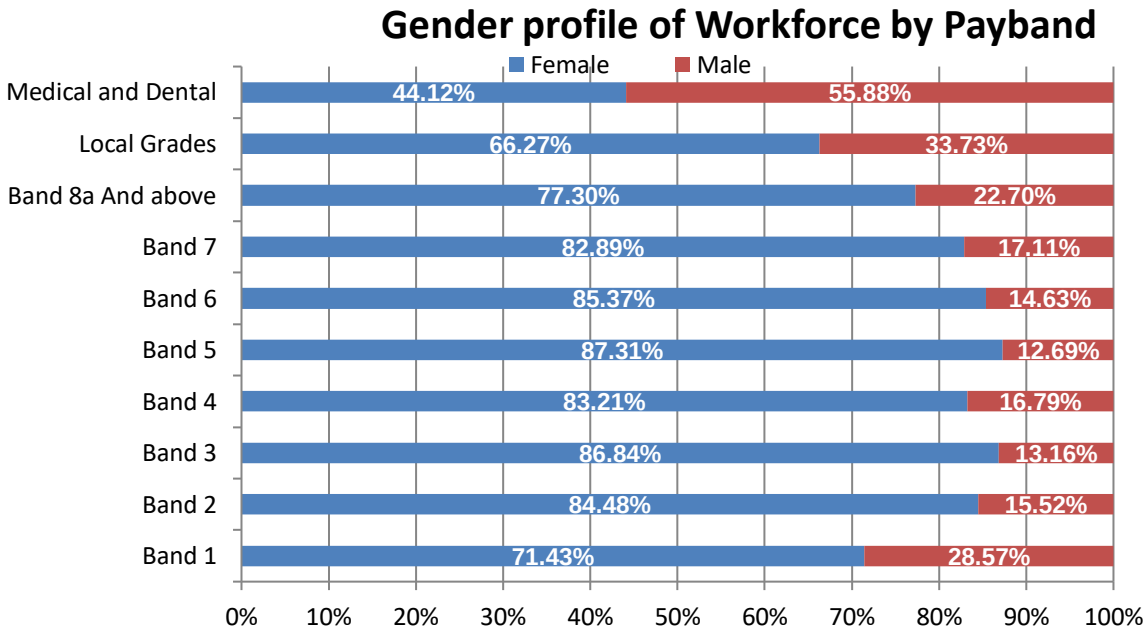
Ethnicity

Over all Agenda for Change pay scales, the majority of colleagues are White British. Medical and Dental have a greater distribution between White and other ethnic backgrounds, with a large proportion of those being Asian/Asian British.

Ethnicity	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Any other ethnic group (including Chinese)	0.00%	1.20%	0.18%	0.48%	3.06%	1.20%	0.53%	0.33%	0.40%	7.98%
Asian and Asian British	7.14%	7.94%	8.60%	6.00%	14.61%	6.91%	7.66%	4.28%	9.13%	35.12%
Black and Black British	14.29%	4.46%	1.75%	2.64%	5.70%	1.90%	2.67%	1.32%	5.95%	5.22%
Mixed race (dual heritage)	0.00%	2.48%	2.63%	2.40%	2.28%	1.40%	1.60%	1.32%	3.17%	3.63%
Not Known	7.14%	3.69%	3.33%	2.16%	4.42%	2.40%	1.43%	0.99%	7.14%	6.82%
White - British	71.43%	77.46%	82.46%	84.41%	66.93%	83.77%	84.31%	89.80%	71.83%	36.57%
White (not British or Irish - includes White unspecified)	0.00%	2.06%	0.70%	1.44%	2.00%	1.30%	1.07%	1.32%	2.38%	4.50%
White - Irish	0.00%	0.71%	0.35%	0.48%	1.00%	1.10%	0.71%	0.66%	0.00%	0.15%

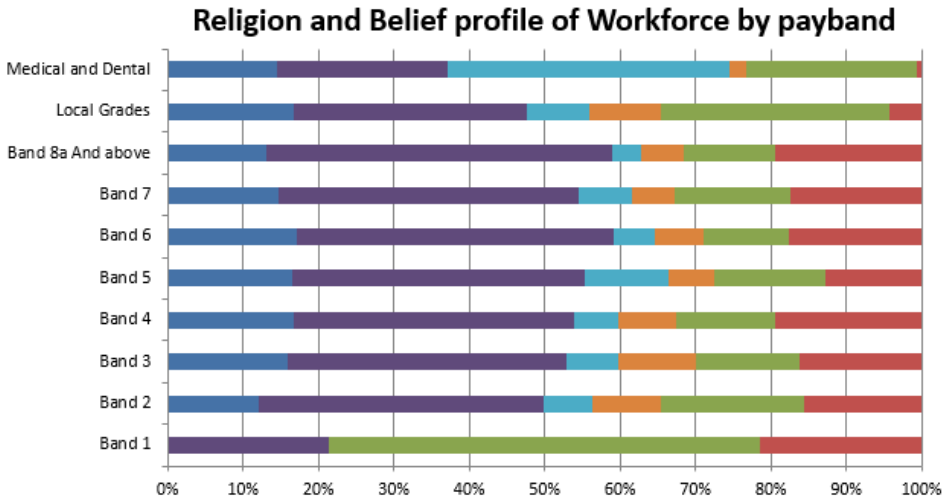
Gender

Men are more equally represented in the Medical and Dental pay band (55.88%) compared with the workforce profile where the majority of colleagues are female (79.95%)



Religion & Belief

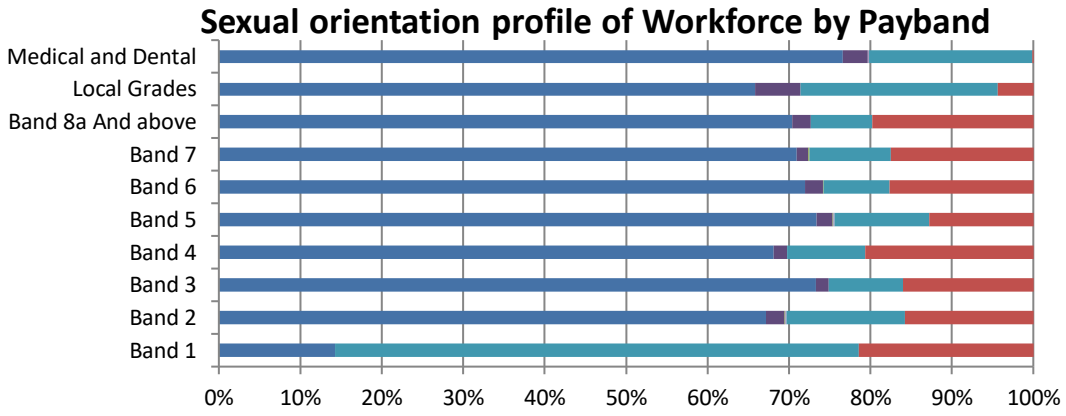
Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Atheism	0.00%	12.05%	15.96%	16.79%	16.46%	17.03%	14.80%	13.16%	16.67%	14.51%
Christianity	21.43%	37.77%	36.84%	37.17%	38.92%	42.18%	39.75%	45.72%	30.95%	22.64%
Non Christian religion (Buddisnm, Hinduism, Islam, Judaism, Sikhism)	0.00%	6.59%	7.02%	5.76%	11.05%	5.41%	6.95%	3.95%	8.33%	37.30%
Other	0.00%	8.93%	10.18%	7.67%	5.99%	6.41%	5.70%	5.59%	9.52%	2.32%
I do not wish to disclose my religion/belief	57.14%	19.06%	13.86%	13.19%	14.90%	11.32%	15.33%	12.17%	30.16%	22.64%
Not Known	21.43%	15.59%	16.14%	19.42%	12.69%	17.64%	17.47%	19.41%	4.37%	0.58%

Sexual Orientation

Heterosexual is predominant across the majority of pay bands. There is still a relatively high proportion of each pay band who do not which to disclose their sexual orientation (the most significant being in Band 1 (64.29%) – though this group contains a low number of staff.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Heterosexual	14.29%	67.19%	73.33%	68.11%	73.41%	71.94%	70.94%	70.39%	65.87%	76.63%
Lesbian, Gay or Bisexual	0.00%	2.27%	1.58%	1.68%	1.92%	2.20%	1.43%	2.30%	5.56%	3.05%
Undecided	0.00%	0.07%	0.00%	0.00%	0.07%	0.10%	0.18%	0.00%	0.00%	0.00%
Other sexual orientation not listed	0.00%	0.14%	0.00%	0.00%	0.21%	0.00%	0.00%	0.00%	0.00%	0.15%
I do not wish to disclose my sexual orientation	64.29%	14.60%	9.12%	9.59%	11.62%	8.12%	9.98%	7.57%	24.21%	20.03%
Not Known	21.43%	15.73%	15.96%	20.62%	12.76%	17.64%	17.47%	19.74%	4.37%	0.15%

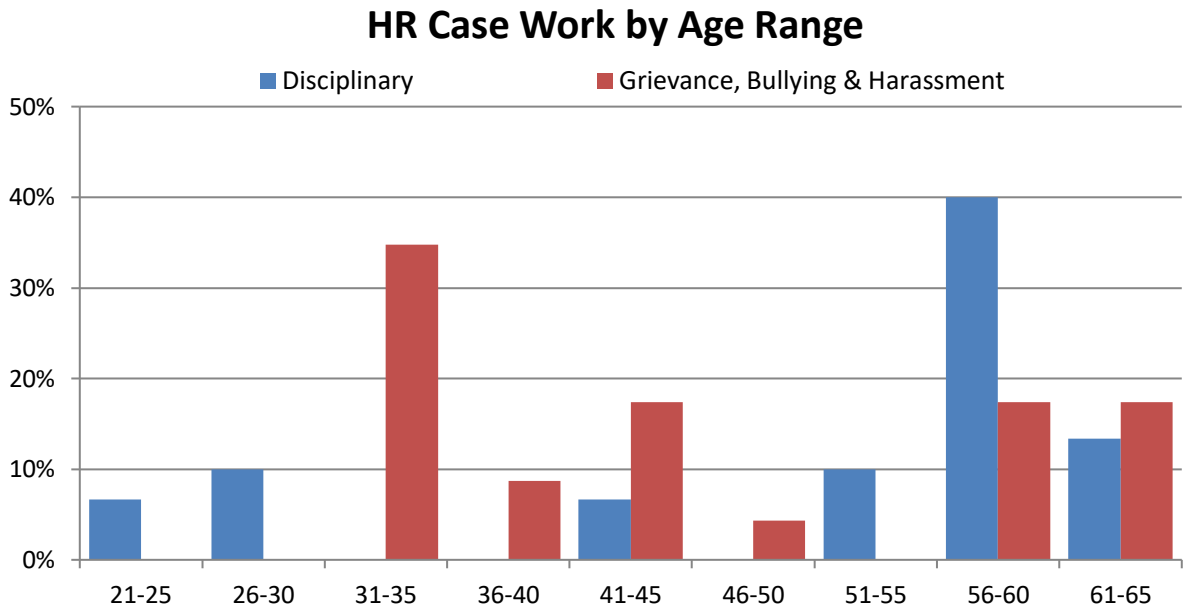
6. Disciplinary, grievance and bullying and harassment

Overall, between January 2021 and December 2021 there were:

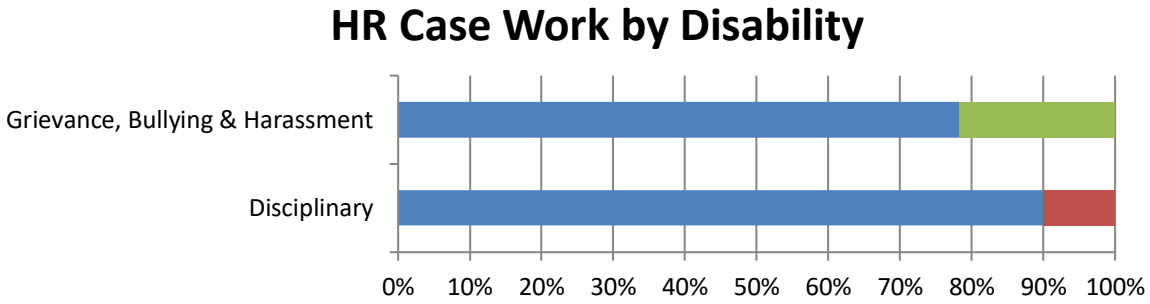
- 30 disciplinary investigations
- 23 grievance investigations

To ensure anonymity of the data, bullying, harassment, and grievance cases have been combined for reporting purposes. This section looks at the number employee relation cases and measures this against the key equality and workforce indicators.

Age Profile

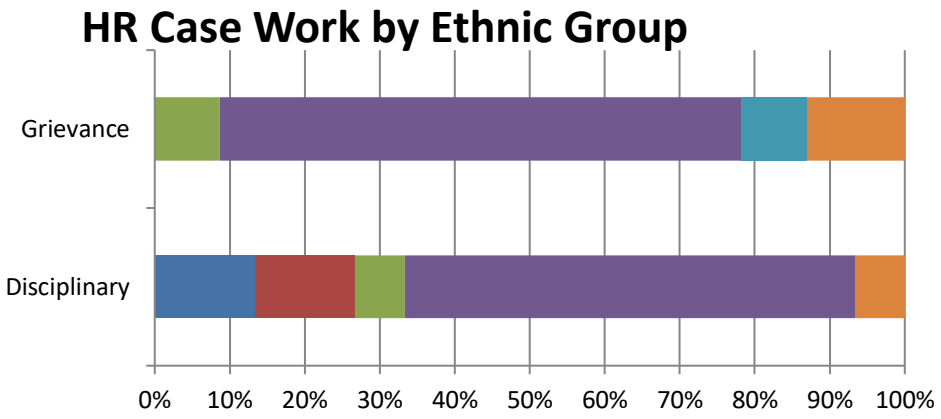


Disability



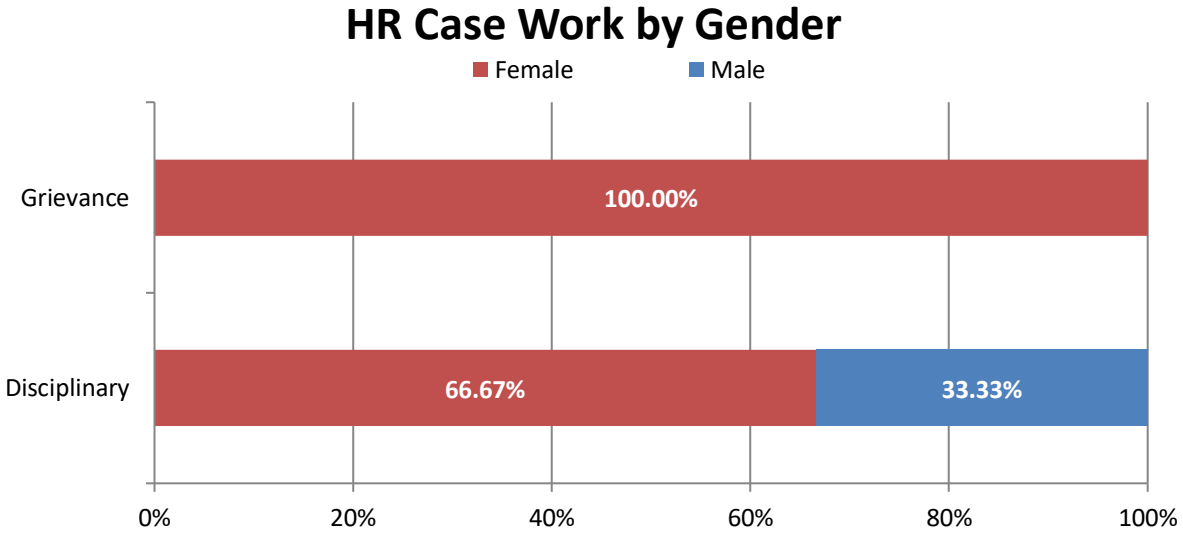
	Disciplinary	Grievance, Bullying & Harassment
No	90%	78%
Yes	0%	22%
Not Declared	10%	0%

Ethnicity

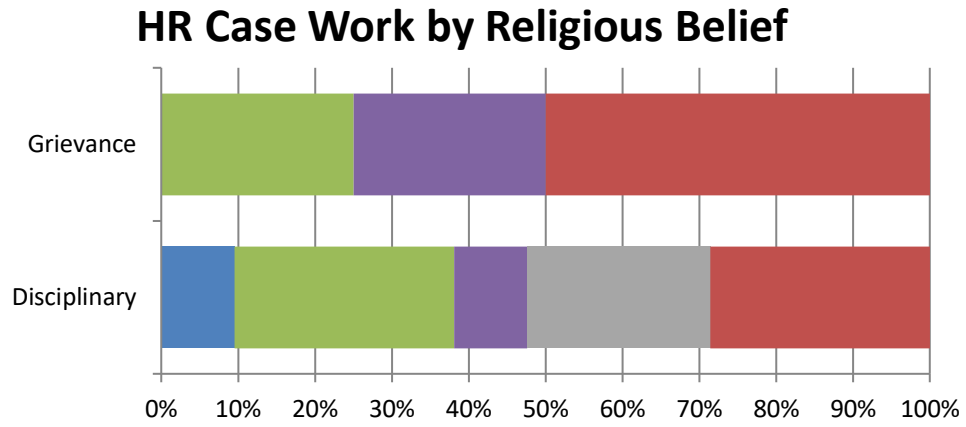


	Disciplinary	Grievance
Any other ethnic group (incl Chinese)	13.33%	0.00%
Asian and Asian British	13.33%	0.00%
Black and Black British	6.67%	8.70%
White - British	60.00%	69.57%
White (not British or Irish incl White unspecified)	0.00%	8.70%
Not known	6.67%	13.04%

Gender

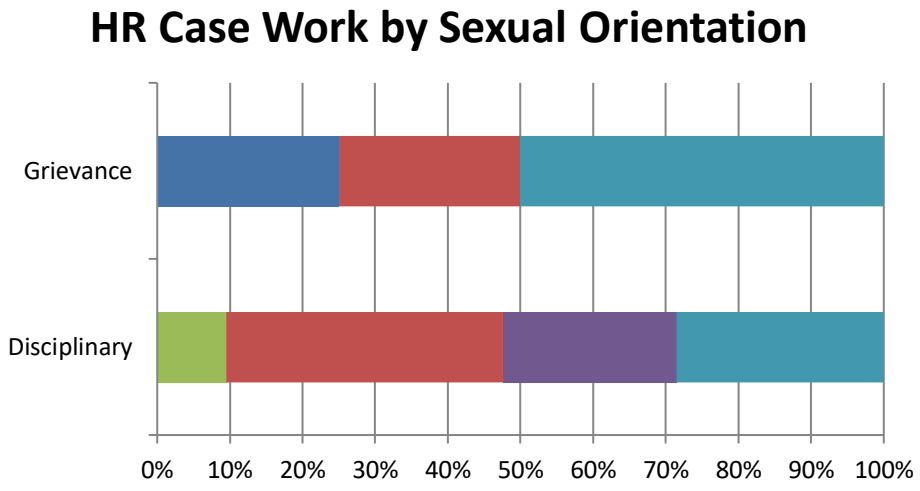


Religion & Belief



	Disciplinary	Grievance
Atheism	10%	0%
Christianity	29%	25%
Other	10%	25%
I do not wish to disclose my religion/belief	24%	0%
Not Known	29%	50%

Sexual Orientation



	Disciplinary	Grievance
Bisexual	0%	25%
Gay or Lesbian	10%	0%
Heterosexual or Straight	38%	25%
Other sexual orientation not listed	0%	0%
Not stated (person asked but declined to provide a response)	24%	0%
Not Known	29%	50%

7. Policies and programmes in place to address equality issues

The Trust continually reviews its policy framework in order to ensure that it is meeting its legal obligations and providing a supportive workplace environment for all of its employees. The Trust policies apply to all employees regardless of gender, ethnicity, disability, and sexual orientation.

The Trust Equality, Diversity and Inclusion lead ensures that the Trust board and all staff understand their collective and individual responsibilities and ensure compliance within the legal framework.

The Trust strives to widen participation into apprenticeship opportunities through ensuring the scheme continues to support people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation into the employment market. The Trust is a lead employer for Calderdale Project Search, an initiative to support young people with learning disabilities to gain valuable work experience. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting health and wellbeing. In most cases, completion of an apprenticeship at the Trust leads to a substantive position and therefore the opportunity to further develop and progress via advanced and higher apprenticeships.

Work is progressing within the Trust to ensure that we have accurate information about the workforce. This involves encouraging all colleagues to update their personal information via ESR Employee Self Service.

The Trust is committed to interviewing all applicants with a disability who meet the minimum criteria for a job vacancy and considering them on their abilities; to ensuring there is a mechanism in place to discuss the development of disabled employees; to making every effort when employees become disabled to make sure they stay in employment and, to taking action to ensure that all employees develop the appropriate level of disability awareness needed.

The Trust published its annual Workforce Race Equality Standard (WRES) in October 2021. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The standard has nine indicators and has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for Black, Asian, and Minority Ethnic (BAME) staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

As part of the Trust's BAME network, the Trust is committed to ensuring that a BAME representative is allocated to all interview panels for Bands 6, 7 and 8a posts to ensure equity and transparency during the selection process.

As a Trust our aim is to engage colleagues in a whole range of Diversity & Inclusion activities in order to bring our staff together, learn from one another and enhance levels of awareness around all types of difference.

8. Improving workforce equality data

In 2021, we have:

- Improved the quality of diversity information stored within the Electronic Staff Record (ESR).
- Encouraged colleagues to update their personal information via ESR Self Service.
- The Trust continued to support and recruit staff using the apprenticeship scheme.
- Published the Workforce Race Equality Standard (WRES) in October 2021 and the Workforce Disability Equality Standard (WDES) in October 2021.

25. Board Sub-Committee Chair Highlight Reports (Minutes in the Review Room)

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

To Note

Presented by Richard Hopkin, Denise Sterling, Andy Nelson and Karen Heaton

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Finance and Performance Committee
Committee Chair:	Richard Hopkin, Non-Executive Director
Date(s) of meeting:	31 January 2022
Date of Board meeting this report is to be presented:	3 March 2022

ACKNOWLEDGE

Overall IPR Performance Score of over 66% in December, highest since August, with Finance domain returning to Amber and improved metrics on complaints, FFTs and cancer.
Recovery performance still largely on track with revised trajectories (slight increase in P2s appears to be linked to Christmas and looks to be reversing).
Expecting to deliver 21/22 Financial Plan with risk rating reduced from 16 to 12.
Overall sickness absence rate reported to be 7.6% - lowest for some time.

ASSURE

Review of Recovery Performance to end of December against revised trajectories.
Review of approach to 22/23 efficiency target from Effective Resources Group ('ERG'), including major event involving 100+ colleagues to develop schemes.
5 Year Capital Plan reviewed together with likely available resource; results of Capital Planning Days (9/10 Feb) to be fed back to next F&P Meeting.
Continuing 'deep dive' held into Staff Absence and Availability to identify 'hot spots' and review actions being taken to improve performance.
Work Plan for 21/22 approved; Plan for 22/23 to be presented to next meeting.

AWARE

Continuing key IPR issues included – stroke indicators, #neck of femur, dementia screening, diagnostics, DTOC; both mortality indicators have also deteriorated.
High volumes and acuity of attendances in ED; only 73% achieved in Dec against 4 hour standard.
Overall waiting list backlog and average wait times still a major challenge.
Significant financial challenge for 22/23 – Efficiency target of £30m set by ERG; detailed draft plans to be presented to next F&P Meeting.
Discussions to be held with ICS re-funding allocations for 22/23 as these seem to have added additional pressures to CHFT in 21/22 compared with other trusts.
Enhanced bank payments cost £0.75m in December (YTD £3.9m) with questionable apparent impact on staff take up.

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
Dates of meetings:	5 January 2022 and 21 February 2022 (Chaired by Karen Heaton)
Date of Board meeting this report is to be presented:	3 March 2022

ACKNOWLEDGE

- High Level Risk Register - informed that work ongoing with Divisions regarding measurable outcomes to ensure mitigations are working and improving. Updated information provided for some risks presents an improving position.
- GIRFT report – update presented, and work continues to progress well. The approach used for the GIRFT programme at CHFT continues to receive national recognition. There is partnership working with the national GIRFT team on a number of initiatives. Ongoing time commitment is now a challenge that needs to be addressed.
- Committee received presentation on Safeguarding Update report which was well received.
- Incident Management Group policy and Duty of Candour Policy revised and approved.

ASSURE

- Good progress is being made on the actions to improve compliance with the required standards for medical gases and the medical gases agenda.
- Quality Report evidenced significant work on Carers Strategy, this will be signed off through the Patient Experience and Caring Group shortly. Noted service improvement programme within legal services. Dementia screening now added onto risk register, dementia team to be invited to present at Quality Committee. Update on the quality priorities.
- IPR Oct/Nov-ECS slight improvement on October position. Urgent care maintaining good experience for patients with focus on ambulance handovers.
- Update on Serious Incidents position and process which has improved and further work to continue. The draft terms of reference for the Serious Incident panel were supported with a few minor changes to membership.
- A report on the new national cleaning standards was received and no serious issues identified. It was agreed that post implementation of May 2022 an update on the ratings achieved across the Trust to be presented back to the Committee.
- Received report on the Trust's PSQB Q3 report. There were three areas highlighted for the Committee all of which were being addressed. There was concern about the low level of Medical Devices Training and it was agreed that the Patient Safety Specialist role should be a member of the PSQB.
- The Committee requested that the lead for dementia screening attend the next meeting to outline the plans for improvement.

AWARE

- The CQC inpatient children's experience report identified CHFT as an outlier, worse than other Trusts in regard to access to play areas, play specialists and food. An improvement plan is in development to be presented at March meeting and monitored by QC.
- IPR October improved performance from December position, areas of concern remain complaints, diagnostics 6 weeks, the emergency care standard and cancer at 62 days which is being monitored. Short term sickness absence which is now improving.

Calderdale and Huddersfield NHS Foundation Trust

CHAIR'S HIGHLIGHT REPORT
to the Board of Directors

Committee Name:	Audit and Risk Committee
Committee Chair:	Andy Nelson, Non-Executive Director
Date(s) of meeting:	25th January 2022
Date of Board meeting this report is to be presented:	3rd March 2022

ACKNOWLEDGE

- Nothing of note this period

ASSURE

- ARC approved the BAF and noted that the BAF is now being more actively used as a risk management tool as evidenced by the changing scores and thoroughness of updates provided. Some risks still require some more work in terms of identification of gaps and actions to close those gaps to meet target risk scores
- The updated Risk Management Strategy and Policy was approved
- The updated terms of reference for the Health and Safety Committee were approved
- The External Audit Plan was noted and agreed

AWARE

- Although some progress has been made in clearing Internal Audit recommendations there are still 44 overdue. This is an increase of 8 from October's meeting. These overdue recommendations are in a small number of audits. The chair of the committee and Finance Director will discuss this matter with the Chief Executive to determine what further action can be taken. In particular the committee wants to see the older recommendations cleared as soon as possible
- The completion of the audit plan is behind schedule due to operational pressures. The 'must do' audits have been identified and the committee felt assured these could be completed in time for the annual Head of Internal Audit Opinion to be provided. However, we were doubtful the full plan could be completed especially where audits would require access to ward staff

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:	Tuesday 15 February 2022
Date of Board meeting this report is to be presented:	Thursday 3 March 2022

ACKNOWLEDGE

The following points are to be noted by the Board following the meeting of the Committee on 15 February 2022.

- Deep dive into vacancies for Q3 showing a reduction in nursing vacancies partly due to the success of the international recruitment campaign. This was welcomed by the Committee.
- Deep dive into Admin and Clerical turnover which had increased over the previous year with an increase in staff choosing to retire earlier or seeking a better work life balance. This needs to be kept under review.
- The Trust's wellbeing package continues to evolve and is well received by staff.
- Assurance provided to the Committee through the Nursing and midwifery safer staffing report – recruitment was strong.
- IPR- concern over the level of short term sickness absence which is now showing signs of levelling off.
- Staff survey headline results were presented with plans in place for dealing with the areas requiring improvement. This item will be presented in more detail to the Board.

ASSURE

The Committee continues to keep a close watch on the level of sickness absence and expects a continued improvement in the number of RTWs undertaken. BAF risk remains unchanged for Medical Staffing. It was noted that the Committee felt assured by the actions underway as presented in the detailed report.

AWARE

Workforce metrics remain amber and concerns remain over the sickness absence rate, return to work interviews (RTW) and Data Security Awareness EST compliance. The wellbeing of the workforce is of continuing concern.

26. Items for Review Room

1. Calderdale and Huddersfield Solutions Managing Directors Report – January 2022

2. Council of Governors minutes of the meeting held 27.01.22

3. Organ Donation Committee minutes of the meeting held 05.01.22

4. Charitable Funds Committee minutes of the meetings held 22.11.21 and 08.02.22

To Note

27. Date and time of next meeting

Date: Thursday 5 May 2022

Time: 9:00 am

Venue: Microsoft Teams

To Note

Presented by Philip Lewer